Review and options to strengthen the National Housing Strategy

Prepared for

The Office of the Federal Housing Advocate

by Steve Pomeroy

Focus Consulting Inc, and

Executive Advisor, Canadian Housing Evidence Collaborative (CHEC) and

Senior Research Fellow, Carleton University Centre for Urban Research and Education (CURE)

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The opinions, findings, and conclusions or recommendations expressed in the document are those of the author and do not necessarily reflect the views of the Canadian Human Rights Commission or the Federal Housing Advocate.

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Executive summary

This paper was commissioned by the Office of the Federal Housing Advocate at the Canadian Human Rights Commission (CHRC), the division supporting the work of the (pending) Federal Housing Advocate, as a background review of the National Housing Strategy (2017). It provides an analysis and assessment of the National Housing Strategy programs and their efficacy, to date, in the progressive realization of a Right the Housing. It also explores opportunities to strengthen the impact of the NHS.

Since inception as a $40 billion ten-year strategy the NHS has received additional funding commitments of $31.25 billion. It is notable that more than three-quarters (79%) of the additional $31.25 billion is in the form of non-budgetary loans, rather than grants and contributions. While this is helping to add to housing supply it is debatable how much of this incremental new funding is targeted to serving the most vulnerable.

Based on this review and assessment, a number of recommendations are included on potential refinements and enhancements to the NHS, with a particular focus on supporting the progressive realization of the right to housing.

The paper details a range of issues, and specific aspects of current programming and identifies potential refinements. These are presented first in relation to initiatives being delivered by the provinces and territories under the bilateral agreements; and subsequently for those programs and initiatives being directly delivered by the federal government, via CMHC or ESDC.

Proposed refinements in Bilateral programs (delivered by provinces/territories)

Canada Housing Benefit: *as the CHB is implemented and greater insight gained in to both the average benefit level required and the duration of need for assistance, the budget should be gradually increased to ensure achievement of the 300,000 target of households assisted on an ongoing basis.*

Provincial-Territorial Priorities Fund: *Given CMHC delivery challenges under the NHCF described below, including shallower levels of capital grant, it may be useful to explore how to reallocate funding from NHCF or delegate delivery responsibility to utilize this now underused PT (and municipal) capacity.*

Canada Community Housing Initiative: *Given the very recent commencement of expiring Operating Agreement, and insights gained from analysis of the FCHI portfolios, it is critical to review the planned expenditure to ensure that this existing stock remains viable and does not unfairly burden PT expenditures.*

Proposed refinements in Unilateral Federal Programs

Rental Construction Financing Initiative: *Revise the affordability threshold? to require rents that are more consistent with accepted levels of affordability – either using the median market rent, or recalibrate the income measure to reflect the lower median income of rents (at 50 or 60% of median income).*

Review the basis for this program and redirect the low-rate loan funds toward non-profits that have a stronger inclination to exceed the affordability criteria while building sustainable mixed income development. [1]

National Housing Co-Investment Fund: five refinements are identified under the NHCF

NHCF (1): *Review and revise the assessment criteria to allocate higher weighting to affordable outcomes and permit a larger level of grant contribution; Eliminate and replace the social housing retrofit stream, as described below.*

NHCF (2): *Recognizing the substantial contributions from PTs outside of the bilaterals, reallocate grant funds from NHCF to those provinces that are willing to increase commitments under the PTPF and utilize the capacity and proven expertise of PTs to deliver, and to selective portfolio agreements with larger professional providers; meanwhile reduce CMHC role to a lender role providing low-cost long-term finance*.

And add parameters on some form of fair share or needs based allocation of funding to avoid the skewing of funds (currently strongly in favour of those jurisdictions with greater capacity or willingness to contribute partnership shares, i.e., Ontario municipalities).

Amend application matrix to formally recognize PT contributions to ongoing operating expenditures

NHCF (3): *CMHC should review the business process and refine and streamline to expedite conditional approvals, prior to requiring extensive investment in reports and studies. This includes adding greater certainty through a phased approval process and expediting payments once agreements in place.*

NHCF (4): *The social housing retrofit stream of the NHCF should be eliminated and funds reallocated to support new construction and acquisition (as below).*

NHCF (5): *Add a new funding stream under the NHS to support and facilitate non-profit acquisition of existing affordable rental assets to preserve and mitigate the issue of erosion due to purchase by private investors and REITs that result in rising rents above affordable levels*.

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[1] It is noted that many RCFI projects have been undertaken by non-profit proponent – in large part because this provides access to the same favourable financing as in NHCF while avoiding the far more onerous criteria of NHCF. And the fact that NHCF at best provides only minimal grant contributions groups with other funding choose to avoid this option.

Federal Community Housing Initiative: *Extend the FCHI agreement to include all federally administered Section 95 providers, regardless of agreement expiry date.*

Reaching Home Homeless initiatives): *Explore the option of reallocated delivery of the RHI to PTs, under an amended bilateral, and recognize PT ongoing contributions to operating and support costs for the purpose of cost matching. This should be delivered through existing PT delivery mechanisms and coordinated with PTs responsible for ongoing homelessness support services.*

Indigenous Housing in urban and rural communities: *In collaboration with the CHRA Indigenous Caucus and other interested Indigenous serving organizations to explore the necessary steps to expand capacity among urban Indigenous housing providers and to support this by providing dedicated funding to construct more housing for Indigenous by Indigenous.*

Data to support the NHS: *Reinstate the former practice of enumerating starts and completions to identify when a project is receiving funding under NHS programs, and maintain a publicly accessible database with this information alongside other data in the CMHC Housing Market Portal.*

Data transparency and detail: *Create and provide publicly available data sets, and differentiating between commitments versus implemented assistance (i.e., households receiving subsidy or units completed and occupied) would establish more objective and useable data and support third party research and analysis.*

Explicit reporting on right to housing: *Design key metrics and collect data to evaluate the progressive realization of the right to housing. This should explicitly report data to reveal the degree to which all policies and programs funded under the Strategy put people first and build on the human rights principles of accountability, participation, non-discrimination, and inclusion*

Potential refinement to overall framing: *Expand framing to take a housing systems perspective and increase insight into interactions and impacts across the housing system with a more comprehensive lens including the impacts of the ownership and rental market on affordability and need.*

1. Introduction

This paper was commissioned by the Office of the Federal Housing Advocate at the Canadian Human Rights Commission (CHRC), the division supporting the work of the (pending) Federal Housing Advocate, as a background review of the National Housing Strategy (2017). It builds on a companion paper written as a background primer on Canada's housing system. [2]

The current paper provides an analysis and assessment of the National Housing Strategy programs and their efficacy in the progressive realization of a Right the Housing; and identification of ways to strengthen the NHS. This includes a review of funding and the characteristics of the funding underpinning the NHS against its targets and the achievement of these targets.

Structure of paper

The paper begins with a brief review of the original goals articulated in the NHS, its objectives and funding budget. It then describes the subsequent additions mainly in the form of additional budget allocations, and one additional program, the Rapid Housing Initiative, prompted by an urgent need to add permanent supported housing in response to the Covid19 pandemic.

The paper then briefly highlights key changes in the evolving context for housing policy interventions and, based on this updated context, then reviews the various programs implemented under the NHS to identify issues and concerns realized during the implementation phase.

The paper suggests potential enhancements and refinements across the range of initiatives that could strengthen the strategy and improve its capacity to progressively realise the right to housing for vulnerable households.

[2] Steve Pomeroy. *Background Primer on Canada's Housing System*, May 2001

2. Overview of NHS goals and objectives (as of Nov 2017)

Announced in November 2017 after an extensive consultation and policy development process, the National Housing Strategy was presented as

> *"Canada's first ever National Housing Strategy (NHS), an ambitious $40-billion plan to help ensure that Canadians have access to housing that meets their needs and that they can afford"*. [Message from the Minister, NHS p 3]

The strategy proposed a rights-based approach to housing and detailed a range of specific policies and programs with a ten-year financial plan intended to make progress on two primary goals to be pursued over the decade 2018-28:

- Removing 530,000 Canadian families from housing need;[3] and
- Reducing chronic homelessness by half over the next decade. [4]

The stated primary focus of the NHS is on meeting the needs of vulnerable populations, such as women and children fleeing family violence, seniors, Indigenous peoples, people with disabilities, those dealing with mental health and addiction issues, veterans, and young adults.[5] As such the NHS is framed more of an affordable housing and homeless strategy, rather than a comprehensive strategy that embraces housing as a system and seeks to strengthen the market as well as manage any externalities or issues of market failure. And while headlining reduction in homelessness as a goal, is thin on details about how this will be integrated into a housing focused agenda.

The Minister's message also promised that the government would *"track and report on our success, and adapt our approach as needed as the Strategy unfolds*." As discussed later, reporting to date has lacked objectivity and does not support critical analysis.

2.1. Delivery via two parallel funding streams

The NHS embraces two primary funding streams:

- Programs delivered by provinces and territories (PTs) under bilateral agreements that require cost matching funding; and
- Unilateral federal funding and delivered programs.

The bilateral programs include:

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[3] While the NHS initially set the goal of reducing renter need by 50% and presented the number 530,000, this number is revised in the Bilateral agreements to 490,000.

[4] This target has been raised to 100%. The government promised, in the Speech from the Throne, and reiterated in the 2020 FES that it is now focused on eliminating chronic homelessness in Canada.

[5] These are the "vulnerable groups" enumerated in the NHS, and may not be fully inclusive of gender as cross-cutting priority.

- The Canada Community Housing Initiative (CCHI) – which renews and replaces expiring federal and existing cost shared PT funding to legacy housing, in order to preserve this stock (of some 600,000 social housing units constructed before 1994) and to sustain the existing affordable rent-geared to income (RGI) characteristics in this legacy stock.
- Provincial-Territorial Priorities Fund (PTPF) – renewal and extension of Investments in Affordable Housing (IAH, the main affordable housing funding program since 2002, also cost matched).
- Canada Housing Benefit (CHB) – a housing allowance to directly address affordability issues with payments direct to eligible tenants, to be designed and implemented by the PTs starting April 2020.

The intent and objectives of each are detailed in the bilateral agreements which also dictate that all PTs prepare an Action Plan detailing how the fund will be allocated between eligible purposes, with specific annual targets intended to contribute to the overall goals of the NHS. All PTs (except Quebec) have published Action Plans covering the first three years (2019-22).[6]

Together over the 10 years of the NHS, these streams were (as of November 2017) budgeted to receive $7.4B in federal funding, cost matched by PTs to total $14.8B (with a further $300Million to the NWT which is not cost matched).

In addition, ongoing long-term federal subsidy for projects completed prior to 1994 will total $8.4 billion from 2018 to 2028, and much of this is cost shared, or exceeded, by PT spending on these portfolios.[7]

The Unilateral federal programs (all delivered by CMHC except Reaching Home at ESDC) include:

- The National Housing Co-investment Fund (NHCF) – which provides loans and contributions to incent and support local initiatives that must add additional partnership resources to achieve both retrofit and new construction of affordable housing. This was announced as the centerpiece of the unilateral federal delivery and had the single largest budget of all NHS initiatives ($13.2B of the originally announced $40 billion commitment).[8]
- Rental Construction Finance Initiative (RCFI) – a financing program to stimulate market rental construction. RCFI does not directly contribute to the primary goals of the NHS as it is a market supply program. It does however include a modest affordability criterion

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[6] Bilateral Agreements and action plans can be found here: https://www.placetocallhome.ca/progress-on-the-national-housing-strategy

[7] The amount of federal funding is predetermined, based on prior commitments, and formalized in schedules to bilateral Social Housing Agreements. PTs are responsible for subsidy and administration and are expected to expend more than this federal level, but there is no cost sharing claims mechanism.

[8] NHCF was initially announced as a $15.7B initiative, but this included the previously (2016) announced $2.5B Rental Construction Finance Initiative (RCFI), which was subsequently separated out, and expanded.

that 20% of units must be at "affordable rent" – this introduced a new benchmark of affordability, discussed later). [9]

- The Federal Community Housing Initiative (FCHI), which parallels the PT cost shared CCHI, but only for federally administered social housing (mainly co-ops and non-profits in Quebec; and Co-ops in 4 other provinces - BC, Alberta, Ontario, and PEI).
- A number of smaller ancillary initiatives including Funding for Northern Housing ($300 million) the Affordable Housing Innovation Fund ($200 million) to support testing innovative finance and design options; a fund to offset cost to make surplus federal lands available for affordable housing ($208 million); funding for research and demonstration ($241 million) and $225 million to develop programs for indigenous off reserve (these are still pending, and part of a broader discussion on a separate indigenous housing strategy, including programming for First Nations, Metis and Inuit).
- Budget 2017 and Budget 2018 identified $1.5 billion to support a First Nations-led housing Strategy ($600 million over 3 years), an Inuit-led housing plan ($400Million/10 yrs.), and the Métis Nation's housing strategy(500Million). While the budget allocations are identified under the NHS "progress to date" no details are provided on the implementation of these three strategies and funds flow via ISC, rather than via CMHC).
- Reaching Home – the rebranded Homeless Partnering Strategy, through which unilateral federal homeless funding is delivered. This is administered by ESDC, not through CMHC. And notably, while reducing chronic homelessness (by 50%) is one of the two main objectives of the NHS, Reaching Home received only $2.2 billion of the initial $40 billion announced funding, less that 5% of planned spending.

The elements of the NHS were scheduled for implementation gradually, commencing with federal unilateral in April 2018 with the NHCF and the smaller ancillary initiatives, while the federal lands program was implemented in June 2018. Announced prior to the NHS the RCFI was implemented in April 2017.

The initiatives under the bilateral agreements commenced April 2019, except the CHB which was scheduled to be implemented in April 2020.

While it is still early in the implementation phase, there is already some experience and insight into the various components of the NHS and some useful lessons. These suggest several potential refinements to strengthen and enhance the NHS and improve the trajectory of outcomes toward realizing the goals of the NHS – reducing housing need and chronic homelessness, each by at least 50%.

[9] Initially announced in 2016 at $2.5B, this has subsequently been expanded through 3 budgets, as discussed later.

2.2. Initial budget allocations

The allocation of funding across the various elements of the NHS is summarized in the table below. This includes both budgetary (forgiveable loan or grant) and non-budgetary (loan) funding, and also includes a mix of pre-existing ongoing funding to legacy social housing agreements and PT cost-sharing of various cost-shared initiatives.

Funding for the NHS ($ billions), as initially announced November 2017

Type	($ Bill)	Associated program
Existing non-Discretionary	$8.40	Fed existing (ongoing) social housing transfers
Renew expiring legacy subsidy	$4.80	Funding to preserve condition and RGI subsidy in pre 1994 social housing (CCHI, FCHI)
New grants and contributions	$10.90	National Housing Co-investment Fund (NHCF – grant), renew IAH (as Provincial Partnership Fund) Homeless Partnering Strategy (HPS), Canada Housing Benefit (CHB), Indigenous Housing, Research & Fed lands
New Loan facility	$8.50	NHCF (loans)
PT cost sharing	$7.40	(on CCHI PPF, CHB)
Total	**$40.0**	Note: Excludes RCFI $2.5B (loans), which would raise to $42.5 billion

This table excludes the RCFI (initially funded at $2.5B and announced within the NHCF) but not aligned with the outcomes of the NHS. This is a non-budgetary expenditure, drawing from the crown borrowing facility, plus an administrative spread for CMHC, to finance low-rate loans to developers of new market rental housing.[10]

2.3. Subsequent additions to NHS since inception

Initially announced as a $40 billion strategy, subsequent federal budgets have incrementally added funding, both to planned initiatives as well as adding new initiatives (mainly related to COVID emergency assistance). These additions raise the total funding in the NHS up to $73.75 billion.[11] Annual increments are described below:

Budget 2018 (added $4.0 billion)

The RCFI was augmented with another $1.25B over 3 years (through fiscal 2023)

A total of $1.5 billion was added specifically to address indigenous housing need to include

[10] By utilizing the crown borrowing facility and adding an allowance (35-50 basis points) to cover any administrative costs, there is no formal budgetary expenditure associated with RCFI. This does however exclude the forgone premiums that would be collected for mortgage insurance at the end of 10 years, when the direct loan is refinanced with private lending – at that point CMHC issues a loan insurance policy but waives the premium (usually up to 4.5% of the loan amount) and application fee – so this is an implicit cost to the Mortgage Insurance Fund.

[11] Includes original $2.5 billion for RCFI announced in 2016 prior to NHS

- $600 million over three years for a First Nations housing strategy and the repair and construction of housing units on First Nations reserves;
- $400 million over 10 years to support the Inuit Nunangat Housing Strategy and the repair/construction of housing units in Nunavik, Nunatsiavut and the Inuvialuit Settlement Region; and
- $500 million over 10 years to support a Métis Nation Housing Strategy.

Note however that while budgeted, the promised distinct Indigenous strategies are only now being implemented and there is no reporting to date on progress or type of expenditure and outcomes.

A further $1.25B in non-budgetary loans was identified for a new element targeting home purchase through a shared equity loan fund to assist first time buyers (the First Buyer Incentive) with $1.25B in funding over 5 years. Another $100 million was allocated to similarly assist first time buyers but directed via Non-profits that specialize in building assisted ownership products for this target group.

Budget 2019 (added $10.6 billion)

- Most ($10.0B) of this additional funding was in the form of expanded loan authority for the RCFI (extends over 9 years to 2028)
- The remainder was in the form of grants and contributions with $300M directed to the Federal of Canadian Municipalities (FCM) to deliver a social housing retrofit program as a separate sleeve of its existing Green Municipal Fund; and $300M toward a new Housing Supply Challenge.[12]

2020 Fall Economic Statement (Added $13.4 billion, including $409.4 for Covid)

- Again, the single largest amount was for the RCFI in the form of loans at $12 billion
- The FES also announced a $1.0 billion new capital program to build /convert to permanent supportive housing the Rapid Housing Initiative.

In addition to these aforementioned budgets, directed through CMHC, additional funding was provided first in supplementary spending bills and subsequently in the FES to address both COVID19 costs absorbed by homeless serving agencies and municipality; as well as expending funding for Reaching Home. This included:

- Three announcements (totalling $409.4 million) related to offsetting costs related to managing homelessness to minimize COVID19 impacts with an initial $15M at onset of pandemic for urban centres; and additional distributions of $157.5M in spring 2020 and $236.7M in fall 2020.

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[12] The Housing Supply Challenge was a separate initiative announced in Budget 2017 under the auspices of Impact Canada. Announced in Budget 2017, Impact Canada is a Government of Canada-wide effort that will help departments accelerate the adoption of innovative funding approaches to deliver meaningful results to Canadians. CMHC has been directed to implement the Supply Challenge on behalf of Impact Canada. So, while linked, it is not a formal component of the NHS. More information can be found here: https://impact.canada.ca/en/challenges/housing-supply-challenge-round-2

1. Budget 2021 (new $3.1 billion, plus $1.3 billion accelerated)

The 2021 Budget added new funds as well as bringing forward already announced planned spending. Advanced spending includes:

- $1.0 billion under the NHCF ($750M for both new construction and repair; with $250 million allocated specifically for shelters and transitional housing for women fleeing violence); and
- Repurposing $300 million of planned RCFI loans to facilitate purchase and conversion of non-residential properties into market housing

New funding (all over 7 years, remainder of NHS duration, except RHI) announced to:

- Extend RHI with additional $1.5 billion over one year (2021-22);
- Add additional $600 million over to the Affordable Housing Innovation Fund;
- Add $315M for a special allocation under CHB for low-income women fleeing violence;
- Augment the FCHI with a further $118 million for preserve affordability in existing federal social housing.
- Reaching Home (homeless funding) was increased by $567 million over two years, beginning in 2022-23. Plus $45 million, also over two years for a new pilot a program aimed at reducing Veterans' Homelessness.

Summary of the incremental additions to NHS Funding (Budgetary and Non-budgetary, $billions) (excludes reallocated and accelerated funds already accounted for elsewhere)

Year	Budgetary funds		non-Budgetary (Loans)	
2018	Indigenous Housing	1.50	Rental (RCFI)	1.25
			Ownership Shared Equity	1.35
2019	FCM Energy retrofit	0.30	Rental (RCFI)	10.0
	Supply Challenge	0.30		
2020 (FES+)	Rapid Housing Initiative (RHI)	1.0	Rental (RCFI)	12.0
	Reaching Home (COVID)	0.409		
2021	Rapid Housing Initiative (RHI)	1.5		
	Innovative Housing	0.6		
	CHB (Women fleeing violence)	0.315		
	Reaching Home (incl Vets)	0.612		
	Augment FCHI (existing stock)	0.118		
Totals (post 2017)		**$6.65**		**$24.6**

It is notable that over three-quarters (79%) of the additional $31.25 billion is in the form of non-budgetary loans, rather than grants and contributions.

While such low-rate financing can be effective in stimulating and supporting new supply, it has less efficacy in achieving deep targeting to meet the needs of the most vulnerable, especially those seeking to exit homelessness. To meet these needs additional capital as well as ongoing

operating and/or rental assistance is required from other sources – and this form of assistance for newly created housing is far more limited.

As such it is debatable how much of this incremental new funding is directed to serving the most vulnerable and toward the progressive realization of the right to housing.

2.4. Evolving context since inception of NHS

The NHS was designed in 2016 and early 2017, and as such relied on somewhat outdated 2011 census data (e.g., to establish the quantum of renter need). It also sought to respond the then current market issues – a significant one of which was the very low level of new rental construction that had prevailed since the mid 1990's. More recent data is now available and can help to inform the nature of the challenges and to suggestion areas where refinement and augmentation to the NHS initiatives may be warranted.

The companion *Background Primer on Canada's Housing System (May 2021) details* the current and emerging issues that should be addressed in the National Housing Strategy, so are not repeated here, beyond a brief overview.

Key Market trends

The key trend in the market part of the housing system has been the well documented and Covid exacerbated rise in home prices. With an array of macro-prudential policy changes intended to manage issues of excessive household mortgage debt, high prices and policy trends have acted together to constrain access to ownership for new purchasers.

This in turn has had the undesired effect of leaving demand in the rental part of the housing system. And the consequence of heightened rental demand is downward pressure on rental vacancy rates and upward pressure on rents, thereby impacting affordability (including for low income more marginalized and vulnerable groups).

As rents have trended upward rental properties have become a more attractive asset class and are being sought out by investors, including Real Estate Investment Trusts (REITs) as well as other capital funds, private corporations and individual investors, a process typically framed as financialization. Frequently these investors seek out "underperforming assets", notably those with rents below average levels, where there is greater potential to increase rents and thus investor yields.

This has the effect of eroding the existing stock of relatively affordable rental units, of which there already an insufficient number, compared to the number of lower income renter households seeking low rent more affordable accommodation. For example, in the 2016 census there were almost 934,000 renter households with annual income below $20,000, so at 30% of income can afford rent of no more than $500 per month; but there were only 570,000 rental units below $500 per month – a shortfall of 364, 000 low rent homes.

Analysis of census data from 2011-2016 revealed a decline of over 60,000 units per year in the number of existing rental units with rents below $750 per month (affordable at 30% to income

of $30,000 per year). This rate of erosion is expected to have persisted through 2021 and will have a serious impact on outcomes under the NHS, potentially negating all new affordable production.

Technology platforms enabling a short-term rental market (e.g., Airbnb) have recently expanded and also remove potential rental properties from the long-term regular rental market. A number of municipalities are implementing bylaws to try and minimize this short-term rental impact and loss, but leakage remains.

And concurrently, municipal (and provincial) policies to manage growth boundaries and encourage intensification often have the unintended effect of demolishing older more affordable lower density rental properties that were built and exist more in the central older part of metropolitan regions.

At the same time, rising rents and strong "retained rental demand" from frustrated aspiring homebuyers have improved the viability of rental construction and the number of new purpose-built rental starts has expanded substantially – from less than 20,000 units per year prior to 2015 to over 60,000 in 2020.[13]

This increased new rental supply is a welcome outcome, although few of these units (outside of those developed by non-profit proponents under some NHS programs) are remotely affordable. Most are coming onto the market at rents that are at least 40% higher than the prevailing local average market rent in each city. This strong market response, far beyond that associated with RCFI, does suggest that the merits of expanding funding for RCFI should be examined.[14]

Meanwhile, the supply of new affordable rental units remains extremely low, and even when assisted under the NHS programs tend not to be much below 80% of the market average, and thus still beyond the affordability of the most vulnerable. [15]

Impact of the COVID19 pandemic

The impacts of the pandemic are mixed and somewhat offsetting.

On the one hand the large and extensive wage subsidies appear to have had the desired effect of enabling many that lost employment income to continue paying rent or mortgages (also assisted by deferral policies) and to remain housed. And with universities and borders closed, the usual demand for rental housing from students in general and international migration, has softened. But these represent only temporary relief – as borders reopen and new immigration targets come in to play it is more likely that new and increased rental demand will emerge – and will squeeze the limited stock of lower rent units.

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[13] As discussed later, this substantial rise in new rental construction is only marginally attributable to the RCFI program

[14] As discussed in a subsequent section, RCFI assisted projects account for less than 5% of all new purpose-built rental construction.

[15] Current reporting out on NHS progress is lacking in detail on the depth of assistance provided – this is based on anecdotal evidence, review of some specific approved projects, and press release information.

On the other hand, there is a small segment, including some on fixed incomes and income assistance that lost their exempted earnings but were unable to qualify for wage subsidy that have accumulated arrears. Others ineligible for wage subsidy have persistently struggled to make ends meet and pay unaffordable (to them) rent, and have also accumulated arrears. While temporarily protected by rent regulation and moratoria on eviction, some have over time accumulated substantial arrears, and will be vulnerable when the moratoria are listed.

Analysis by Falvo (2020) suggests that the economic downturn caused by the pandemic is likely to increase homelessness in Canada but with a delayed impact. The full effects may not be realized until several years after the pandemic ends due to a combination of complex factors (labour market recovery, housing market, income assistance systems, homelessness system planning, migration patterns).[16]

The Covid pandemic has focused a spotlight on the issue of homelessness, (images of tent cities, as individuals seek to avoid crowded environment of emergency shelters) raising the profile of this issue both in the minds of the public and politicians. As noted in the review of incremental budget announcements, special funding was allocated to the provinces and to municipalities to help manage additional costs to rehouse homeless persons in more socially distanced temporary accommodation. But what will happen when such temporary accommodations end? Some new initiatives, such as the Rapid Housing Initiative (RHI) and redeployment of some RFCFI funding to convert offices to housing may assist, but the quantity of need relative to these small initiatives is not well quantified.

And the realization that the mantra "go home and stay home" simply cannot apply to the homeless, has inspired elevated policy concern, including one of the only new features of the NHS – the Rapid Housing Initiative (RHI), seeking to quickly create new supply of permanent supportive housing using modular construction. The initial $1 billion (Fall 2020) has been allocated to build 4,700 new spaces, and the additional $1.5 billion in budget 2021 is expected to increase the number of units created above 10,000.

Persisting and growing core housing need

The NHS goal is to reduce renters in housing need by roughly half a million households (premised on a 50% reduction from the 2011 count of core need).[17]

Analysis of historic trends in renter core need reveal that income change is a much more powerful influence than affordable rental supply or lack of new affordable production.[18]

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[16] Falvo, Nick. December 2020. *The long-term impact of the COVID-19 Recession on homelessness in Canada: What to expect, what to track, what to do?* Accessed at https://www.homelesshub.ca/resource/long-term-impact-covid-19-recession-homelessness-canada-what-expect-what-track-what-do

[17] The NHS cited a reduction of 530,000; the Bilateral agreements with the PTs identify the federal target at 490,000. Meanwhile the 2016 census identified a total 1,119,915 renter households in core need, implying a reduction of 560,000 (50%).

[18] This blog briefly presents an analysis: http://chec-ccrl.ca/2021-census/

For example, between 1996 and 2001, a period when the federal government was not funding any new social-affordable housing, the count and prevalence of core need counter-intuitively declined – the reduction in core need was mainly due to employment and income growth.

Since 2016 we have seen substantial increase in rents and ongoing erosion of existing affordable units, coupled with only modest income gains, prior to COVID assistance.

Reviewing the range of influences on need, in the absence of the pandemic and temporary income boost this created, it is speculated that the number of renters households in core need would have substantially increased between 2016 and 2021, and no progress would have been made on the NHS goal of a reduction in renter housing need.

Because the census collects data on income in 2020, the effect of the temporary wage boost captured in that annual income statistic likely offset the negatives of minimal affordable rental supply (and few housing allowances), erosion of the existing affordable stock, and the substantial and compounding increases in rent levels since 2016.

This will likely mean that while the number of renter households in core need may have not gone up, neither will the number have declined. In short 5 years into the NHS when data are released in spring 2022 it is anticipated that we will see no discernable progress in meeting one of the two primary goals of the National Housing Strategy – a 50% reduction in renter need.

And because the wage boost is temporary and creates an artificially high level of income in 2020, once incomes revert to their normal basis – earnings and income assistance for those in deep poverty – the new base number in need in 2022 will be higher.

As a consequence, the next census period will be counting from well behind the starting line and therefore face a greater challenge in catching up with the goal (50% reduction in renter need) by 2026. And because incomes have such an important impact on affordability trends, it will be difficult to determine attribution to the NHS. Equally this suggests that more aggressive pursuit and implementation of a poverty reduction strategy (and the potential of the CHB within this) can be a critical component to achieving the goals of the NHS.

Accordingly, it is necessary to refocus and strengthen the initiatives in the NHS to get back on track to ending chronic homelessness and substantially reducing the number of renter households in need.

3. Review and critique of original NHS elements

As outlined earlier, the NHS embraces two primary funding streams:

- Programs delivered by provinces and territories (PTs) under bilateral agreements that require cost matching funding; and
- Unilateral federal funding and delivered programs.

This assessment first reviews the three initiatives cost matched and delivered by PTs under Bilateral Agreements; it subsequently examines those delivered by the federal government under CMHC or the ESDC-Homeless Partnering Secretariate (HPS)

3.1. Bilateral Initiatives

This includes the following three initiatives, the first two of which commenced implementation April 1, 2019, while the third (CHB) was scheduled for implementation April 2020, but in some jurisdictions has been delayed by to challenges related to managing the Covid19 pandemic:

- The Canada Community Housing Initiative (CCHI)
- Provincial-Territorial Priorities Fund (PTPF)
- Canada Housing Benefit (CHB)

Bilateral agreements have been executed with all thirteen provincial and territorial jurisdictions. In each case the PT was required to develop and publish an Action Plan detailing the specific mutually agreed-to targets and outcomes over the period of the Action Plan, which are intended to support and advance progress toward to overall goals of the NHS and specifically the aggregate national outcomes (text box below).

Federally Developed Targets for aggregate national outcomes

(a) Eliminate or significantly reduce Housing Need for at least 490,000 households overall, which includes at least 300,000 households adequately supported through a Canada Housing Benefit.

(b) Based on the number of Units still supported by Social Housing Agreements or federal-provincial agreements as of March 31, 2019:

> (i) 330,000 Units continue to be offered in Social Housing, including no net loss of Urban Native Social Housing Units available to households in Housing Need;
>
> (ii) At least 20% of existing Social Housing Units repaired (approximately 60,000 units), including that retained Urban Native Social Housing Units are repaired to good condition;
>
> (ill) The number of rent-assisted Social Housing Units expands by 15% (approximately 50,000 units).

It is noted that the bilateral agreements do not formally engage the PTs in collaborating in the target of reducing homelessness. However, the programs that deliver community supports, health care and other wrap around services to formerly homeless are almost exclusively funded under PT programs. So, there is extensive implicit PT cost sharing in the homelessness arena.

General comment:

With the cost shared programs under bilateral agreements implemented only in April 2019, there has been only minimal reporting on progress. A triennial report tabled in parliament May 31st highlighted some results in terms of funding commitments for new units (2,580), existing social housing units retrofit (60,100) and households provided with rental assistance (19,590), but no details have been published with breakdown by PT. Nor is there any detailed breakdown by vulnerable group and gender.[19] It is also noted that due to Covid related issues, some PTs have not yet reported, as per bilateral requirements.

Canada Housing Benefit

Given the NHS objective to reduce housing need by 50% and with more than 80% of households in core need facing primarily an affordability problem, the CHB is a critically important mechanism to quickly and directly assist in reducing extreme shelter cost affordability problems.

The initial budget of $2 billion federal plus $2 billion cost-matched funding is however insufficient to achieve the state goal of assisting 300,000 households. The budget assumes an average affordability gap of only $2,500 per year (roughly $200 per month). Assistance grows as additional households are assisted, unless an equally number “graduate” off the benefit due to improved employment and income.

To date six jurisdictions have executed bilateral amendments, plus Quebec where the CHB is part of the original Canada-Quebec NHS bilateral. All are required to publish amended action plans, and while not yet released, all target more vulnerable households described in the bilateral agreements to include: women and children fleeing domestic violence, seniors, Indigenous peoples, people with disabilities, those dealing with mental health and addiction issues, homeless individuals, and those at risk of homelessness, veterans, racialized communities, and young adults.

Targeting these lower income households, especially those seeking to exit homelessness is likely to require a deeper level of benefit that the estimated average of $2,500. This was the estimated affordability gap (rent less 30% of income) in a 2008 CMHC analysis. [20] Given the rate of rent increases over the past decade, as well as the absolute lack of lower rent units (thereby

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[19] The Triennial report (May 2021) includes as a footnote: *As of February 2021, NHS funding targeting and supporting the needs of women and their children for the NHCF, RCFi, FLI and* IF is $2.9B and over 39,000 units, but with no additional detail.

[20] England, John, Willa Rea, and Jennifer Yuen. The Dynamics of Housing Affordability. CMHC 2008

forcing households into higher rent units, often exceeding 50% of income) the gap likely now exceeds $4,000 annually.

It is too early to determine the efficacy of the CHB but as it continues to roll out the funding level and average per person or household should be monitored and as appropriate the budget should be increased to ensure capacity to meet the target of 300,000 households assisted.

Proposed refinement to CHB: *as the CHB is implemented and greater insight gained in to both the average benefit level required and the duration of need for assistance, the budget should be gradually increased to ensure achievement of the 300,000 target of households assisted on an ongoing basis.*

Provincial/Territorial Priorities (formerly IAH)

PTs have been delivering programming under a cost shared funding framework that commenced in 2002. This includes affordable rental development, rehabilitation, rental allowances, and some small affordable ownership initiatives.

Initially in Budget 2017, the proposed renewal of what was then Investments in Affordable Housing (IAH) was $3.1 billion (roughly $300 million annually, which would have represented a small increase (22%) in the funding to these PT delivered programs. However, a decision was made (and there is some question on whether the PTs were either consulted or concurred) to reallocate $2 billion out of this envelope to fund the CHB (an approach not initially contemplated in Budget 2017)

As discussed below, the implementation and roll out of CMHC unilateral programs, notably the NHCF) has been onerous and slow, mainly because CMHC has been absent from direct delivery (except on reserve) since 1986, and has consequently lost much of its capacity and expertise.

Compared to CMHC's lost capacity (it no longer has a large branch network with local expertise) and steep learning curve to re-engage in direct program delivery; and given the established experience and capacity of the PTs, it would be more effective to direct a larger portion of funding through the PTs to lever this expertise (although capacity and competencies do vary across jurisdictions and not all have the more established competencies of BC and Quebec).

In addition, because the NHCF is designed to require partnership funds especially if any degree of affordability is to be achieved, and because other sources are limited, by default, PTs in several instances have become funding partners in the NHCF, outside of and above amounts in the bilateral agreements.

Accordingly, it would be more efficient and effective to direct an increased quantum of funding via the PTs and formalize this through amended bilateral agreements.

This could be achieved by:

- Simply increasing the funding quantum under the PTPF initiative, to at least the previously planned $3.1 billion level;
- Formally invite the PTs that wish to take responsibility for increased delivery of part of the NHCF initiative to do so, with an amendment to the bilateral agreement and action

plan. This would also help more fairly allocate NHCF funds, which are currently heavily skewed to Ontario.

- And in the case of indigenous need, including protecting the legacy stock of Urban Native uunits, it may be appropriate to create a separate distinct funding stream directed through indigenous organizations, rather than via the PT bilateral agreements.

Proposed refinement to PTPF: *Given CMHC delivery challenges under the NHCF described below, including shallower levels of capital grant, it may be useful to explore how to reallocate funding from NHCF or delegate delivery responsibility to utilize this now underused PT (and municipal) capacity.*

Canada Community Housing Initiative (CCHI)

Most legacy social housing was developed either under unilateral federal or cost-shared PT non-profit and coop programs with long-term (35-50 year) operating agreements that provided operating subsidy to ensure units could be provided at affordable rents.[21] These programs were terminated in 1993, but pre-existing projects continued to receive federal subsidy. In 1996 the federal government implemented a transfer of administrative responsibility to the PTs to provide portfolio management and subsidy administration to these providers. The federal share of related long-term operating subsidy flowed via the PTs and was augmented with PT subsidy.

These operating agreements and subsidies have begun to expire and meanwhile the assets are aging. Expiring subsidy is partially (or in some cases fully) offset by the maturing of mortgages and elimination of any mortgage payments. This was the case for most pre 1985 projects (annual mortgage payments were greater than annual subsidy, so when both end it improves viability) – most of these agreements expired between 2014-2021.

However, with changes implemented in the post 1985 program notably including a return to targeting and much high proportion of RGI households, most projects will be non-viable at End of Agreement/Mortgage (EOA/EOM). This era of operating agreements begins expiring in 2021 and many providers will face operating challenges, especially those with a high proportion of deep targeted RGI.

Without new extended subsidy many will be unable to retain existing RGI rents. In addition, many have insufficient capital reserves to undertake necessary capital replacement. Some aging properties also have underutilized sites so there may be opportunities to intensify, including demolishing and replacing some existing units.

The CCHI is intended to provide a funding mechanism to facilitate all these activities: extension of RGI where required, retrofit and intensification and redevelopment. PTs have only recently completed Action Plans describing plans to allocate funding toward these eligible activities, and

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[21] The earliest versions of co-op and non-profit programs under sec 27 and 61 of the NHA had no embedded subsidy – these were only concessionary loans. Beginning in 1974, rent supplements were stacked to improve ability to house low-income households at 30% RGI. It is now the expiry of the stacked rent supplement that is a concern.

these reveal that in all cases the CCHI funds are being integrated with provincial funding across an array of initiatives.

In the parallel FCHI where CMHC delivers these “top-up” funds it has been recognized that funding levels announced in 2017 for the FCHI were insufficient and accordingly Budget 2021 allocated an additional $118 million to this program. If the situation in the much larger provincially administered legacy stock is similar there will be insufficient level of funds – an unfunded obligation that currently PTs will be required to unilaterally absorb. Again, abrogating the principle of fairness in the bilateral cost matched programming.

The other risk is that there are serious viability issues in the PT owned and managed public housing portfolio (older, greater need for capital replacement, no replacement reserve and with 100% RGI, minimal rent revenues). Given the scale of need in the public portfolio there is a risk that funding to private non-profits and provincially administered cooperatives could be crowded out by PT priorities for public housing renewal, and insufficient overall funding.

Proposed refinements to CCHI *Given the very recent commencement of expiring Operating Agreement, and insights gained from analysis of the FCHI portfolios, it is critical to review the planned expenditure to ensure that this existing stock remains viable and does not unfairly burden PT expenditures.*

3.2. Unilateral federal initiatives

The NHS includes a variety of initiatives, but the two primary and most significant ones in terms of funding and anticipated output are the National Housing Co-investment Fund (NHCF) and the Rental Construction Financing Initiative (RCFI). Both these and the various ancillary initiatives (Innovation Fund, Federal Lands) are not stand-alone, but available to combine or stack. And the NHS initially framed the RCFI as being integrated into the National Housing Co-Investment Fund (with the original $2.5 billion funding for RCFI previously announced in 2016 included in the NHS funding for NHCF, but subsequently separated out). As described below, the RCFI is somewhat tangential to the main thrust of the NHS – it is primarily a supply program to incent market rent construction, it is not targeted to the most vulnerable, as is most of the NHS.

Rental Construction Financing Initiative (RCFI)

The RCFI was the first of the new initiatives to be implemented (Spring 2017) and is primarily intended to stimulate private purpose-built rental construction to address the minimal level of such construction over the past 30 years. While one-third of households rent, from 1995-2015 only 11% of new housing starts were intended as rental, and these were skewed to Quebec, so proportionately fewer in most other jurisdictions. So, in 2016, there was an objective basis supporting a rental stimulus program.

RCFI provides very favourable lending terms to rental developers (and can also be used by non-profits seeking to developed mixed income-rent projects). In exchange for the favourable financing, overall rents are required to be set marginally below full market potential (i.e., a discount 10% to full market).

In addition, 20 % of units must have affordable rents, defined as rents that are affordable at 30% of income to households with income below 30% of area median household income.[22] This is a new definition of affordability, unique to RCFI – in other programs such as the previous Investments in Affordable Housing and now in the NHCF affordability is defined as *30% of units being required to have rents at less than 80% of median market rents, for a minimum of 20 years.*

The problem with this new affordable definition is that the benchmark is not well targeted or consistent with the goal of the NHS to assist most vulnerable households. Median total household income is typically quite high – and is heavily weighted by owners, whose incomes are more than double that of renters. Using 30% of median family income results in rent levels that in all but two cities are well above 150% of the average market rent. Appendix A details median incomes (2018 are the latest available), the affordable rent at 30% and the comparable (2019) average 2 bed rent.[23]

This creates two issues:

1. First while notionally a market supply program the imposition of an affordability requirement (even a poorly designed soft one) is an irritant to private investors, so many are dissuaded from using the program because they perceive a requirement to leave rent revenue on the table. The fact that since 2017, fewer than 4% of new rental starts have utilized this program confirms overwhelming disinterest from developers.[24] Meanwhile due to more favourable market conditions and demand, new rental construction has expended three-fold since 2015, unrelated to the RCFI incentive. That is to say, the data reveal that ongoing stimulus incentives are no longer necessary.

2. Second, press releases and ministerial announcements on new RCFI projects highlight that "*20% of units in the projects will be at affordable levels, below 30% of median incomes*". The media and public, not generally aware of median income statistics interpret this at face value and assume that the rents will indeed be affordable (thinking close to or below the market average). And the announcements also imply these are contributing toward the affordable goals of the NHS. Neither is true.

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[22] The two criteria can be accommodated together. When rents in 20% "affordable units" set low enough, these can enable the overall average to meet the criteria of being 10% below potential market at the aggregate project level such that 80% of units can be at full market. In other cases, developers may choose to establish the non-targeted units at 90% of potential market and set affordable rents at the max possible (30% of median income), such that they are not truly affordable, as described below.

[23] Ideally the criteria should be set as 30 per cent of median renter income – however, data sources that can furnish this data do not exist outside of the census, so cannot be updated for intercensal years.

[24] The small percentage of developers that have used RCFI are ones that are opportunistically taking advantage pf the favourable loan terms – but would likely have proceeded in the absence of RCFI. In supporting expansion of RCFI loan authority, CMHC officials have asserted that the RCFI is oversubscribed, even though this represents a small fraction of units being constructed.

If this is a rental supply incentive, the affordability criteria should be removed, thereby eliminating developer reluctance. The fact that the market has already responded to increased rental demand, with a substantial increase in purpose built rental construction begs the question, is an incentive even needed? [25]

Alternatively, if government wishes to have RCFI contribute to the NHS outcomes, the affordability benchmark should be recalibrated. A more realistic benchmark would be to either adopt the median market rent level in each CMA market, or apply a factor to adjust incomes to reflect the much lower incomes of renters – e.g., use 60% of overall median, and then apply the 30% calculation. The current required "affordable" benchmark as well as this alternative 60% benchmark are presented for all CMAs in appendix 1.

A further option would be to refocus RCFI to create supply more explicitly in the intermediate market, and with a designated funding stream for non-profit providers. While affordability criteria in other programs use the metric of rents below 80% of median rent, newer market rental construction typically comes on market at 140% of median and above. Thus, there is a gap, labelled here as the intermediate market. Imposing criteria to fill this intermediate rent band can be an effective way for non-profit providers to create supply with no subsidy (as these rents will cover debt service on high-ratio, low-rate loans, potentially up to 100% of cost). Because the units are created by non-profits, with no natural motive to maximize rents and returns, the units will gradually become increasingly affordable relative to the market median (e.g., within 10-15 years, as market median moves up, these non-profit rents may fall below the median level, even with modest rent increases to cover inflating operating costs). Financing this form of affordable intermediate rental with non-profit proponents would have a much more significant impact in adding modest rent supply and avoiding loss of affordable stock, as happens under private market-based ownership (see discussion on financialization).

The lack of alignment of RCFI with the NHS objectives and fact that the market is responding to demand signals, without need for a stimulus begs the question why the RCFI funding (loan authority) level has been increased three times in budget 2018, 2019 and the 2020 FES and now stands as the single largest element of the NHS at $25.75 billion over the decade of the NHS window.

In addition, Budget 2021 reallocated $300 million to support acquisition and conversion of commercial properties into market rent. This is a high cost (average $375,000 per unit) and again directed to creating market rentals for which, as noted incentives seem unnecessary. It is uncertain if the usual RCFI affordability criteria will apply but seems unlikely that units will be created at levels affordable to vulnerable households.

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[25] RCFI, with an affordability criteria could be a useful vehicle for non-profit developers to strengthen their income and diversify their portfolio beyond just deeply targeted units. With no profit motive they might be effective in creating added supply in the intermediate market (e.g., 120-140% of AMR versus 80% of more affordable and 160% plus for full market. However, few non-profits have yet evolved into the more entrepreneurial culture this requires.

Potential refinement to RCFI

Revise the affordability to require rents that are more consistent with accepted levels of affordability – either using the median market rent, or recalibrate the income measure to reflect the lower median income of rents (at 50 or 60% of median income).

Review the basis for this program and redirect the low-rate loan funds toward non-profits that have a stronger inclination to exceed the affordability criteria while building sustainable mixed income development. [26]

National Housing Co-investment Fund (NHCF)

The NHCF was intended to support partnership approaches with organizations with some of their own resources (cash reserves, land, capital campaigns, or access to in-kind benefits like municipal waivers of fees and charges). Initially when conceived, it was expected that other federal departments with interests in housing might bring their separate resources to the table to create housing for client groups – e.g., veterans and indigenous groups. As implemented, the initiative looks more to non- federal contributors.

The NHCF provides some mix of grant (forgiveable loan) and low-rate financing to facilitate affordable development. The overall budget for the NHCF combines $4.7B for contributions with $8.5B in financing with generous terms (very low rates and up 50-year amortization).

With two-thirds of the funding in the form of loans this is primarily a loan program. That said grants (administered in the form of a forgiveable loan) are reported to represent generally between only 2%-10% of project cost.[27] On a per unit basis these grant portions are well below those provided previously under IAH (more typically 40-50% of total cost). Minimal grants and the loan feature are found to undermine achievement of affordability outcomes in favour of mixed rent development that can support loan repayment.[28]

Since its inception several issues and concerns have surfaced in the NHCF:

- Misplaced emphasis and weighting of ancillary outcomes, notably energy efficiency and accessibility, displacing affordability outcomes;
- Unintended overlap and dependence on PT contributions, despite being outside of bilateral agreements;
- Skewed allocation of funds;

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[26] It is noted that many RCFI projects have been undertaken by non-profit proponent – in large part because this provides access to the same favourable financing as in NHCF while avoiding the far more onerous criteria of NHCF. And the fact that NHCF at best provides only minimal grant contributions groups with other funding choose to avoid this option.

[27] Based on correspondence with CMHC official - detailed data on the characteristics of assistance and depth of grant are not published or available. There is no reporting out on systematic data on projects proposed, those funded, and the funding allocations per project.

[28] Mixed income models with a blend of intermediate market and lower affordable units can be effective in creating more viable projects and to diversify non-profit portfolios and balance sheets, but the current funding mechanisms minimize the proportion of units affordable to very low income most vulnerable households.

- Onerous and lengthy application and approval process;
- Overlap and duplication with multi other existing social housing retrofit streams;
- Omission of any support for acquisition.

Each of these is reviewed below, with proposed refinements

1. Misplaced emphasis and weighting of ancillary outcomes

In order to secure funding under the NHCF projects must meet or surpass a set of ascending criteria in a social outcomes matrix (SOM), which weight each group of criteria and gradually adds additional points as increasing outcomes are achieved. The accumulation of these points determines the level of grant eligibility. The SOM uses four groups of criteria: affordability, accessibility, energy performance and partnership contributions.

A critical issue is that these criteria allocate higher weight to energy and accessibility than they do to achieving affordable outcomes. So, this may be consistent with ancillary federal goals, especially climate change but undermines ability to achieve affordability, which should be primary.

Under each group points are awarded with increased scores as great outcomes are achieved. For example, for affordability 0 points are awarded when 30% of units are below 80% median rent (a minimum requirement), 15 points if 31-40% of units have rents below 80%, and the most points if more than 50% are below 80%. Additional points are earned if rents are set even further below median rent, with maximum (75) points earned when rents are less than 50% of median (vs. just below 80% of median).

Similarly, there are ascending points for stronger energy performance. At a minimum, projects must achieve a 25% reduction in energy use and greenhouse gas emissions compared to 2016 building code, but this is a basic threshold; 0 points are earned. A 26% reduction against code earns 15 points. And maximum 75 points are earned if the project achieves net zero emissions.

A project that has 50% of units with rents below 50% of median rent, which would be extremely affordable, maxes out points at a contribution of 15% of total cost. The matrix tops out with a 40% contribution, but only if it maximizes points in the other two criteria: with energy efficiency at net zero and 31% of more units meet accessibility standards.

While also awarding points for the amount of partnership contribution, this considers only capital up-front contributions and overlooks ongoing operating or support payments (e.g., in supportive housing), typically 100% funded by provinces. Requiring accessibility implies housing higher-need tenants, many of whom are dependent on ongoing support funding, yet this ongoing provincial funding obligation is not recognized in the scoring matrix.

In short, the two ancillary criteria (energy efficiency and accessibility) generate more points toward earning a grant than maximizing affordability – which is ostensibly the primary intent of the program and is most consistent with the progressive realization of a right to housing for vulnerable populations.

These are theoretical outcomes using the scoring matrix. In reality, CMHC officials advise that projects will never achieve this full theoretical max and most projects approved to date have earned a minimal grant contribution between 2% and 10% of capital cost [29]

This speaks only to the grant contribution. The project may be eligible for a favourable loan for up to 95% of cost (no approved projects to date have come close to this level). But this too has a problematic design.

To service a mortgage loan, sufficient rental income is required. Projects that seek to maximize affordability and earn "affordability points" in the SOM, (i.e., minimum 50% of units at rents less than 50% area median rent) consequently have insufficient net income to service significant debt.

Perversely, CMHC determines that such projects – seeking to maximize outcomes toward meeting the NHS goal of reducing need by lower rent to meet the affordability criteria – are not viable and are consequently rejected under this funding program – unless they have substantial partner funding.

The only way to secure funding support is to amass substantial contributions from other sources – free or discounted land (e.g., from municipalities or churches), substantial waivers of municipal fees and charges, and donations from other parties. With projects only providing a few units at moderate rent, municipalities or other contributors are reluctant to dedicate their scarce resources to these projects – they may prioritize others, such as IAH/PTPF projects where they can achieve greater affordability impact.

In the absence of local contributions viability requires substantial contributions from the province or territory – an issue discussed further below.

In Budget 2021, $250 million in NHCF funds are reallocated to specifically target women and children fleeing violence. The funding is to construct and repair an estimated 560 units of transitional housing. Notably, the budget also states this funding will cover operating costs – a significant deviation from the current practice of leaving such costs the PTs. It remains to be seen how this will be implemented.

Since the budget for NHCF includes one-third grant (i.e., 35% of budget is in grant/forgiveable loan) and two-thirds loan, one might expect that projects could achieve something closer to this mix, but the track record of only 2%-10% grant seems to suggest this is not happening. Recalibrating the criteria to enable projects to qualify for grant contribution closer to 35% of cost would be more consistent with the NHS objective to assist most vulnerable households. As drafted, the criteria result in weak targeting, creating affordability to moderate core need, but not deep need.

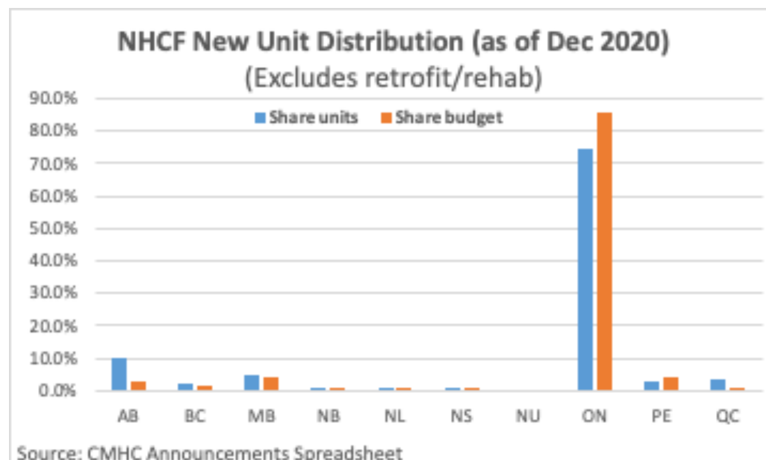
Experience to date, both for (the very few to date) approved projects and most notably for applications that have been rejected or withdrawn, or not even submitted, suggest that NCHF

[29] Based on feedback from CMHC official

is ineffective in supporting affordable housing outcomes, and errs in favour of the ancillary outcomes – energy performance and accessibility. [30]

While encouraging and incenting other partners to help achieve affordability helps to leverage and extend federal funding, such partnership contributions are not always available, at least not in the quantum needed to achieve a viable project. Relying exclusively on other sources and minimizing support via NHCF is likely to result in the NHS falling well short of its goals.

It is also creating a skewed distribution in the allocation of funding. To date the vast majority of NHCF approvals have flowed to Ontario projects, in part because Ontario has a much larger presence of large municipal housing corporations, with the professional staff capable of working through onerous requirements, sustaining applications through an uncertain approval process, and access to municipal resources as co-investments. Due to a statutory obligation to actively support housing and homeless programming, Ontario municipalities also tend to more frequently provide contributions, including discounted land, cash contributions and in-kind waived fees and charges. The result is that Ontario has captured more than 85% of funding (and 75% of units) committed for new construction under NHCF through December 2020.



And applying the same energy performance and accessibility criteria to the social retrofit stream makes it almost impossible to do a retrofit as these requirements are much harder to achieve and far more expensive to include, compared to new construction. Unsurprisingly, very few retrofit proposals have been submitted, and to date none fully approved. [31]

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[30] This is not to suggest these outcomes should not be supported, the issue is the relative priority and balance in the scoring system. There is also need for greater reporting and transparency on project funding details and associated depth of affordability.

[31] Based on listing from CMHC through Jan 31st, 2020, which distinguishes projects that have a final agreement from those with only conditional approval and pending. The one important exception is a single very large "portfolio' allocation of $1.3B to assist TCHC retrofit its large portfolio of 58,000 homes. The quarterly summary of announced projects with location, year, and type (new construction, retrofit etc.) is posted on the NHS website here https://assets.cmhc-schl.gc.ca/sites/place-to-call-home/nhs/nhs-announced-projects.xlsx

Potential refinement – NHCF (1)

Review and revise the assessment criteria to allocate higher weighting to affordable outcomes and permit a larger level of grant contribution; Eliminate and replace the social housing retrofit stream, as described below.

2. Unintended overlap and dependence on PT contributions

As highlighted earlier, the NHS is designed with two primary funding conduits – a cost matched PT delivered component (reviewed earlier) and a unilateral federal stream. PT funding commitments are secured under bilateral agreements.

As the unilateral federal part, of the NHS the Co-investment fund should not be seeking to impose additional financial contributions from the PTs, beyond those in the bilateral arrangement.

But the evidence to date reveals that to achieve viable projects, with some modicum of affordability it is often necessary to rely on PT contributions. Indeed, all but two of the final approved projects to Dec 2020 include PT contributions, and often significant contributions. For example, one NHCF project in BC involved a $3.9m NHCF contribution (primarily in the form of a loan) while the province is contributing $8.7 million, along with a small in-kind contribution (fee waiver) from the City of Kelowna.

Clearly NHCF is reliant on substantial PT (and municipal) support. Yet it is structured outside of bilateral agreements. This is imposing unrealistic and unfair obligations on PTs, and/or resulting in low construction in provinces where such additional contributions are not forthcoming.

Also as noted above, in the criteria for assessing partnership contributions the criteria only consider capital and ignore very substantial PT congoing contributions to wrap around support costs (especially in Reaching Home and RHI).

It is noted that when announced in November 2017, the NHS substantially reduced the allocation of funds to the PTPF (budget 2017 announced $3.1 B; NHS in November 2017 reduced this to $1.1B, reallocating $2B to the CHB).

And processing time under PT-delivered IAH and now PTPF is substantially shorter than the CMHC-delivered NHCF (largely since PT's have more than 15 years of recent delivery role, and CMHC lost all its delivery expertise and capacity more than 25 years ago).

While the fiscal capacity of some PTs may be limited, given the inappropriate reliance on PTs as significant funding partners to make the NHCF workable, it may be more effective to reallocate part of the NHCF to those PTs that would be willing to take on the delivery role, and reduce the proportion directly delivered by CMHC.

For example, reallocate the $2B reduction from budget 2017 from NHCF to PTPF. And this should ideally be the grant portion to enhance affordability, as noted above. CMHC could continue to act as lender, drawing on the favourable financing rates and terms that it can provide.

Another way to simplify and expedite delivery is through portfolio agreements with the larger more professional providers – although this may create a biased distribution as in already evident in early approvals – with majority of funding going to Ontario large municipal providers)

Potential refinement – NHCF (2)

Recognizing the substantial contributions from PTs outside of the bilaterals, reallocate grant funds from NHCF to those provinces that are willing to increase commitments under the PTPF and utilize the capacity and proven expertise of PTs to deliver, and to selective portfolio agreements with larger professional providers; meanwhile reduce CMHC role to a lender role providing low-cost long-term finance.

And add parameters on some form of fair share or needs based allocation of funding to avoid the skewing of funds (currently strongly in favour of those jurisdictions with greater capacity or willingness to contribute partnership shares, i.e., Ontario municipalities).

Amend application matrix to formally recognize PT contributions to ongoing operating expenditures

3. Onerous and lengthy application and approval process

While most PTs (and in Ontario, municipalities) delivering funding under IAH programs since 2002 have been able to review and issue conditional approvals within 90 days, as of spring 2020, the CMHC process required a minimum of 300 days. CMHC have since made commitments to reduce this processing time by 50% but updated data on approval duration has not been published. And even at this accelerated timeframe most this still exceeds PT processing timeframes.

The NHCF process is also fraught with extensive requirements for details (requiring substantial investment in consultants) prior to receiving any form of conditional approval. Even after conditional approval, the required documentation is often revised and extended. And in several reported cases, submitted documentation has been lost and newly requested. These issues reflect the inexperience and lack of delivery capacity, and steep learning curve as CMHC gets back into direct delivery after 30 years on the sidelines.

The Ontario Non-Profit Housing Association (ONPHA) has reported from its members that applicants can expect to spend upwards of $300,000 to prepare the necessary reports and studies required.[32] That's a big expenditure, and money few have, especially for an uncertain and low-probability application.

And when projects have been approved, advancing of funds has been extremely slow, in a number of cases requiring proponents to secure bridge financing for as many as 15 months while awaiting funds to be advanced from CMHC.

[32] Some proposal development seed funding is available to assist

And most frustrating for groups seeking to delivery to their traditional low-income clients is the realization that after meeting these extensive requirements, as already noted, the NHCF provides minimal assistance, well short of the levels required to deliver on affordability objectives (substantial portion of units with rents below 80% of the AMR).

As noted earlier it depends almost entirely on the proponent assembling contributions from a variety of other partners (with firm commitments), before CMHC will issue its conditional approval.

Potential refinement – NHCF (3)

CMHC should review the business process and refine and streamline to expedite conditional approvals, prior to requiring extensive investment in reports and studies. This includes adding greater certainty through a phased approval process and expediting payments once agreements in place.

4. Overlap and duplication with social housing retrofit streams

The NHCF has two funding streams, one for new construction, the other to support retrofit of existing social housing. As noted earlier, the requirements to achieve energy and accessibility outcomes are extremely difficult to achieve in a retrofit (vs. new construction).

Evidence to date reveals few applications (11 projects with 769 units) to date for repair or retrofit (other than a large portfolio allocation to TCHC (Toronto Community Housing Corporation), which alone received 75% of funding).

Furthermore, the previously noted CCHI and FCHI are already intended to support renewal of existing legacy assets. Retrofit and renewal is also permitted under the PTPF. In addition, in budget 2019, the federal government created a new $300M fund to be delivered by FCM to support green retrofit of existing social housing as part of their Green Municipal Fund.

And with most of the legacy social housing now being administered by PTs this funding stream of the NHCF overlaps with PT responsibilities, as established in the Social Housing Agreements (SHAs) and is in direct conflict with the objective of the SHA process, as stated in 1996: to reduce or eliminate overlapping federal and PT roles in portfolio administration.

So there are now five different funding streams, all seeking to support retrofit, and among these the NHCF is the least attractive in terms of fit and funding. This raises the question of whether a NHCF social housing retrofit funding stream is really necessary.[33]

Potential refinement – NHCF (4)

The social housing retrofit stream of the NHCF should be eliminated and funds reallocated to support new construction and acquisition (as below).

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[33] A notable exception is the large allocation of $1.3B to TCHC to support large scale retrofit shows that when allocated on a portfolio basis the NHCF can be effective for retrofit. This allocation relaxes energy and accessibility criteria, which are difficult to achieve in retrofit, but applying the criteria at a portfolio vs project level. And Ontario is unique in devolving funding responsibility for Public Housing to the municipal level – will CMHC follow this example and approve large scale NHCF portfolio allocations to PTs that face the same renewal issues as TCHC?

5. Omission of any support for acquisition

While the NHS encompassed initiatives to construct new affordable housing and to preserve and improve the stock of legacy social housing created since 1950, it completely overlooks a serious issue of erosion of "naturally occurring affordable housing" (NOAH). This is private rental stock, much built in the 1960's through 80's, where rents remain at moderate levels, often below 100% of the AMR.

The problem is that due to market forces, this stock of existing older private affordable housing is rapidly eroding, and undermining NHS efforts to reduce housing need:

- Between 2006 and 2016 the number of units renting below $750/month across Canada declined by over 800,000 units (322,000 between 2011-16). If this pace continues (i.e., loss of 60,000 units annually since 2011) this will dwarf the NHS goal of adding on average 16,000 affordable units annually by a factor of four to one.
- Nationally while purpose-build rental construction since 2000 has added 420,000 new rental units; the CMHC universe of rental units in its survey has grown only by 260,000; implying that some 160,000 previously existing rental units have disappeared – most were likely older lower rent properties demolished for redevelopment under municipal intensification policies.

Some properties (e.g., 160,000 change in CMHC purpose built since 2000) are physically lost due to intensification and redevelopment; many more still exist but have seen rents rise dramatically. This is caused both by large capital funds, often purchasing portfolios of properties and by small investors acquiring properties with expectations to capitalize on rising rents. For example, in Ottawa average rents were up 8% year on-year from 2018-19; and for vacated units rents rose over 18%. Commercial realtors were marketing this great "upside potential to increase net income" and pricing the sales price based on this anticipated higher net operating income.

It may be challenging to prevent market forces (REITs, Capital funds and individual investors) pursuing such acquisitions (of what they define as "under-performing" properties). However, the problem of erosion could be partly mitigated by enabling non-profits to emulate the behavior of private REITs and similarly acquire these existing NOAH properties. This can help to preserve current modest rents and where future redevelop is possible, redevelop under non-profit ownership to ensure inclusion of affordable units. And where appropriate seek funding to retrofit for increased accessibility and energy efficiency.

But few non-profits have the cash resources to pursue acquisition, and even those that do immediately tied up these funds in an initial purchase. To perpetuate capacity to pursue acquisitions and thereby preserve existing modest affordable units, they require some level of program support to repatriate and recycle their funds.

Generally, this requires assistance with an equity down payment – the existing rents can carry debt. But currently none of the NHS programs permit or enable acquisition – the only exception

is the provincial priorities fund, but funding in that envelope has been substantially reduced so most PTs favour investing their limited funds to build new.[34]

And the NHCF does not facilitate acquisition (in fact it discourages it) due to both the energy and accessibility criteria and due to the lengthy approval process, which results in potential acquisitions being lost to more nimble private funds.

Ideally an acquisition fund, designed to enable expeditious acquisition is required. This could be funded by reallocating part of social housing retrofit stream of the NHCF and designing a mechanism that explicitly supports and encourage acquisition by non-profits.

Potential refinement – NHCF (5)

Add a new funding stream under the NHS to support and facilitate non-profit acquisition of existing affordable rental assets to preserve and mitigate the issue of erosion due to purchase by private investors and REITs that result in rising rents above affordable levels.

Federal Community Housing Initiative (FCHI)

The FCHI is a parallel funding stream to the CCHI, although more narrowly focused and thus has a smaller budget ($500 million over 10 years). This funding level was however enhanced in Budget 2020, with an additional $118 million (over 2 years 2021-2023).

It is targeted to existing social housing where projects remain under CMHC administration. This is a much smaller subset of projects (compared to CCHI portfolios) and captures mainly co-ops in 4 provinces, as well as unilateral federal non-profit projects in Quebec and PEI, which have not executed Social Housing Agreements to take over administration of legacy social housing.

It is intended to fund three types of activity: extension of RGI where required, retrofit and intensification and redevelopment. That said at the behest of the co-ops, the focus of activity to date has primarily been on addressing impacts on low-income RGI renters (co-op members).

The FCHI has been delivered in 2 phases, the first to create some breathing room for projects with recently expired agreements, and running through to April 2020; the second phase, now in implementation, was intended to implement a new form of operating subsidy – although for co-ops it has essentially narrowed on extending operating subsidy.

Prior to the NHS, as co-op agreements began to expire, housing stakeholders, led by the Co-operative Housing Federation of Canada, took the position that if federal assistance was to be discontinued, the providers would have difficulty housing low-income residents at rents (called housing charges in housing co-operatives) they could afford. The federal position was that, with no mortgage payments to make, the housing co-operatives could afford to reduce the rents of low-income households to rent-geared-to-income (RGI) levels without government assistance.

The co-op housing sector disagreed. Its position was that any savings made, from no longer having mortgage debt to service, would have to be redirected to reinvesting in the properties,

[34] Because the NHS emphasized adding new affordable units and preserving existing social housing, the option of acquiring existing private modest rent properties falls outside of cabinet approved criteria form the NHS.

either through greatly increased capital reserve allocations, new mortgage debt to finance substantial repairs and renovations, or a combination of the two. This has turned out to be the case.

On this basis CMHC agreed and made a commitment in the NHS to continue to provide assistance for low-income households at the same level as immediately prior to operating agreement expiries.

Housing providers wishing to benefit from FCHI phase2 are required to opt-in to the program. The program conditions require providers to enter into an agreement with CMHC under which a provider must submit its audited annual financial statement annually and complete an annual reconciliation of the assistance provided. There will be a reference guide that stipulate the form of reporting. Potentially these kinds of reporting requirements provide an opportunity to integrate human rights and disaggregated data collection into reporting. Variables like # units below a specified rent threshold; # households below a specified income threshold; # households members of priority groups.

The FCHI-2 agreement also requires providers to develop an action plan within 12 months of signing the agreement. The action plan covers four areas of operations: governance, social Inclusion, financial viability, and asset management. The plan must be updated every three years. A provider must report every year on its achievement against the plan although progress against the plan in not a condition of continuing to receive FCHI phase 2 assistance.

The main issue arising is that this arrangement was only made available to projects with an operating agreement expiring at the end of March 2016 or later. Providers with operating agreements that expired before that date were not eligible and have consequently fallen through the cracks. Although there were not a lot of missed projects, it is important to remedy this oversight.

Potential enhancement – FCHI

Extend the FCHI agreement to include all federally administered Section 95 providers, regardless of agreement expiry date.

Enhancing Reaching Home to create permanent supportive housing

One of two primary targets of the NHS is to reduce chronic homelessness by 50%. Ending chronic homelessness is a key policy of many local and provincial plans and aligns with the NHS goal. But it will be extremely difficult to achieve this goal, given the minimal allocation of funding directed to homelessness. Of the more than $40B NHS original budget $2.1B was allocated to ending homelessness, only 5% of original NHS funding.

Funding has been increased by $600 million (excludes $409 million in extra funding to manage Covid related expenses), plus $2.5 billion for the new Rapid Housing Initiative (RHI). This raises the total share of NHS budget to 7.5%, still insufficient to achieve the enhanced goal of ending chronic homelessness.

The RHI will fund 100% of the capital cost to build and install modular construction units for permanent supportive housing targeting those exiting homelessness.

One irritant in RHI is that it only funds the capital cost, and is silent on how operating and supports costs will be funded – implicitly leaving these as a PT obligation. This could be an effective partnership, but it is not clear that the associated operating funding with the PTs was discussed and agreed to as a priority. This has caused some PTs to raise concerns on lack of open consultation and again additional spending obligations outside of the bilateral agreements.[35]

Homeless funding flows via ESDC, mainly through local community entities, and is outside of CMHC's direction (except for RHI). And while capital investment to build transitional or permanent supported housing is notionally an eligible expenditure in Reaching Home, both the total quantum of funding and focus of this homelessness stream on supporting coordinated planning activities means that little of these already minimal funds will flow to create supported housing construction.

While funding rental assistance (which might be pursued under CHB assistance) to enable individuals to rent in the market is one form of assistance under Housing First initiatives, there is mounting evidence that such dispersed models contribute to social isolation and exacerbate mental health challenges of the chronically homeless. For those at higher acuity levels building permanent supportive housing may be a preferred option, but there is a distinct lack of funding to support this type of development – although the RHI is a welcome start (leaving aside issues of how ongoing support funding was or was not negotiated in advance of the federal announcement).

ESDC is not experienced in delivering capital construction programs, so creating a capital funding program delivered by CMHC is an effective way to address this earlier oversight in the NHS. But this could also be delivered via PTs through an amended bilateral, especially given PT capacity and expertise, as developed during the 2001-2019 delivery of IAH and the PT role in funding operating and support costs.

While there is a strong partnership with municipalities (via FCM) the PTs via both housing agencies, health, and community services, already fund most support spending to address homelessness and (outside of Ontario) are directly involved with the community agencies delivering support services, which will be required under RHI. Delegating delivery of construction to the same level would be more effective in aligning the necessary ongoing support funding.

Potential refinement – Reaching Home

Explore the option of reallocated delivery of the RHI to PTs under an amended bilateral and recognize PT ongoing contributions to operating and support costs for the purpose of cost

[35] Capacity among PTs varies, but the primary issue here is the nature of apriori negotiation and true partnership, versus imposing obligations and forced partnerships.

matching. This should be delivered through existing PT delivery mechanisms and coordinated with PTs responsible for ongoing homelessness support services.

Expand supply of urban indigenous housing with a for Indigenous-by-Indigenous Funding stream

The NHS allocated $225 million to support urban indigenous housing, partly in recognition that most Indigenous people do not live in First Nations, Inuit, or Metis communities. Migration to both small and large communities, is associated with a variety of push and pull factors including colonial policy and related traumas, substance abuse and violence, the lack of economic opportunity on reserve, and a desire to seek further education and employment. However, many Indigenous individuals that have moved into cities face rampant discrimination in both housing and labour markets, and many consequently descend into homelessness.

Enhancing housing stability and life success in these urban communities requires an expansion of housing that is owned and operated by Indigenous providers. The NHS proposed the development of three distinct Indigenous Housing strategies – First Nations, Metis and Inuit. These have been negotiated and are in implementation, but the more critical element is for an urban, rural, and remote strategy targeting Indigenous and especially First Nations living off reserve in rural and urban communities (which accounts for most of the First Nations population).

Potential refinement – Indigenous Housing in urban and rural communities

In collaboration with the CHRA Indigenous Caucus and other interested Indigenous serving organizations, explore the necessary steps to expand capacity among urban Indigenous housing providers and to support this by providing dedicated funding to construct more housing for Indigenous by Indigenous.

Improve transparency in reporting on outcomes

The NHS makes a commitment to improving research and data to improve insight and understanding about the housing market and system. In addition, the government committed to monitoring and reporting progress and outcomes.

> *We will track and report success, and adapt our approach as needed as the Strategy unfolds. Our primary focus will be on meeting the needs of vulnerable populations, such as women and children fleeing family violence, seniors, Indigenous peoples, people with disabilities, those dealing with mental health and addiction issues, veterans, and young adults.* [Message from Minister, NHS p 3]

Ideally, information on programs under the NHS should include data sets with details that researchers can then use to independently assess and evaluate the outcomes. Such constructive third-party analysis helps to add insight and suggestion improvements and refinements to strengthen impact and outcomes (and can support the work of the national Housing Council and the Federal Housing Advocate).

Historically the annual publication of very detailed information through Canadian Housing Statistics provided a source of detailed information, including details on the program support assisted housing, and associated subsidy expenditures by province and sub-provincial geographies. Much of this information is no longer available, as this publication has been discontinued. Market data is available in interactive data sets, but administrative data (e.g., units under administration) is no longer published, and new data, such as disaggregation of who has been assisted by NHS and GBA variables could be readily added in on-line dashboard.

The removal and termination of detailed statistical data is inconsistent with the promised commitment to strengthen research and data.[36]

One of the great failures of the past 20 years has been the absence of transparent reporting on the outputs and outcomes under the IAH framework (there is only a cumulative aggregate tabulation on CMHC website).[37] This practice is being perpetuated under the NHS.

While reporting requirements were expanded in 2011 IAH bilaterals, reporting remained weak. It remains to be seen what level of detail will be made available under the new NHS bilaterals (although the agreements do specify requirements for detailed Action Plans and reporting against these).

There is no aggregate national count of the number of affordable housing units added to the pre 2001 legacy stock, nor the number of households being assisted with rental allowances through the FPT IAH initiative, despite millions of federal dollars being allocated to these purposes.

Going forward a simple, and costless option to at least enumerate new affordable housing construction would be to reinstate the practice of identifying and separately reporting on new housing construction assisted under NHS or PT programs. Prior to 2002, CMHC undertook such enumeration as part of its monthly enumeration of new housing starts and completions and published a separate tally of social housing in both monthly statistics and in the annual compendium Canadian Housing Statistics. The starts and completions survey remains in place, except for social - NHS starts).

It is recognized that with multiple funding under partnership arrangements that it is more challenging to identify and avoid double counting of assisted units.[38] But the single opportunity is at the construction start (and reaffirmed at completion by the CMHC enumerator).

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[36] While it is not necessary to sustain all detailed tables and to incur the cost of printing an annual compendium, there is no reason the key data could not be reported, using the CMHC/NHS websites. The historical data did not cover issues such as who lived in the housing and which vulnerable groups are being serviced, but these important elements could be added to reporting going forward.

[37] And in a 2019 research report commissioned by CMHC to assess the investments made under the IAH from 2011-17, the consultant (Malatest and Assoc. Ltd) reported that in assembling data they were unable to align one quarter of the funds allocated to specific projects and were thus unable to accurately determine counts.

[38] Currently "reporting" of output under the NHCF and RCFI is limited to a summary of press releases, and there is already evidence of double counting and exaggeration. One media release in BC bundles 3 projects totalling 250

This would not provide information on retrofit units nor households assisted via housing allowances (variations of CHB) but would make an important contribution to starts data and cumulative additions to the stock of social and affordable housing – at no cost to government (it simply requires adding a box on the CMHC enumeration form/screen).

This would provide a reliable and detailed count (structure type and location) to augment administrative reporting via PT information requirements and ensure that the impact of assisted starts can be distinguished from market housing, especially in the rental area. Currently there is no published data that identifies how affordable housing initiatives have contributed to the substantial increase in so called "purpose-built rentals" currently reported in CMHC monthly starts data.

And since CMHC is already enumerating the start, there is no cost to add and report on this data field. This can capture units added under both the federal stream (NHCF) as well as under the bilateral funded streams.

Potential refinement - starts enumeration

Reinstate the former practice of enumerating starts and completions to identify when a project is receiving funding under NHS programs, and maintain a publicly accessible database with this in formation alongside other data in the CMHC Housing Market Portal.

Strengthen data collection and reporting

While various progress reports have been released (November 2018, June 2019 and more recently the Triennial Progress Report (May 2021, reporting through December 2020) the information provided is not clearly and transparently reported.

And with initiatives spread across different departments/agencies there is often a lack of reporting on other initiatives. Homeless data and outcomes are monitored by ESDC; and indigenous programming flows via ISC. For example, there is a lack of reporting on outcomes under the $1.5Billion allocation for three distinct Indigenous strategies, funded in Budget 2018.

The Triennial report narrates results and cites commitments to households assisted, units to be built or retrofit, but lacks detailed information. Then information is presented in a way that double counts because different initiatives are stacked and contribute to the same project. For example, an infographic on p 6 summarizing the planned output and progress conflates different initiatives. It combines the Affordable Housing Innovation Initiative and Federal Lands Initiative to create a new outcome:

- *$402 M over 10 years in loans and contributions to build 8,000 new affordable housing units*
- It then reports progress to date (December 2020) as *Committed over $203 M to support the creation of 19,200 units, of which 17,000 will be affordable.*

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units, even though only one of the 3, with 40 units is assisted under the NHS (NHCF). Reporting to date has been highly politicized and lacking in objective accounting and details.

It is unclear how this outcome relates to the original goal, and how it has more than doubled the planned output? An appendix table subsequently reports on the "achievements per initiative" under three categories:

- Build it (new units committed to be built);
- Repair it (units committed to be repaired); and
- Make it affordable, number of households assisted with affordability support, i.e. CHB, or via shared equity mortgage assistance)

The number of units in this table are reported against each individual initiative, but it is not specified when there is stacking and thus double counting. Nor is the information provided by province/territory.

And for initiatives like the RCFI where the definition of affordable is debatable, the outcome is reported as total units being built, with no detail on how many are affordable or the nature of affordability – i.e., will these "affordable RCFI units target and be helpful to primary focus populations – meeting the needs of vulnerable populations?

Several large commitments have been made on a portfolio basis – e.g., a large commitment to Toronto Community Housing Corp to repair and retrofit existing stock, and this funding will flow over a number of years, but is reported now as a commitment, versus a real outcome.

While the headline NHS goals highlight only removing households from need and reducing chronic homelessness the initiatives are much broader. It is important and cost effective to preserve exiting social and affordable projects/units, but the reporting should distinguish between units added, units (that already exist) retrofit, households directly assisted (e.g., with housing allowance, CHB) and existing unassisted but affordable units lost.

With the promise to pursue a rights-based approach, and enactment of the NHS Act it is also critical to improve metrics with the obligations under progressive realization of the right to housing:

- take immediate measures to address urgent human rights violations such as homelessness
- prioritize those most in need
- employ all appropriate means
- dedicate maximum available resources
- set targets and benchmarks to move towards full realization of the right in the shortest time possible

Potential refinement – data transparency and detail

Create and provide publicly available data sets, and differentiating between commitments versus implemented assistance (i.e., households receiving subsidy or units completed and occupied) would establish more objective and useable data and support third party research and analysis.

Potential refinements – explicit reporting on right to housing

Design key metrics and collect data to evaluate the progressive realization of the right to housing. This should explicitly report data to reveal the degree to which all policies and programs funded under the Strategy put people first and build on the human rights principles of accountability, participation, non-discrimination, and inclusion.

Broadening the strategy as a fully comprehensive strategy

While described as a comprehensive housing and homeless strategy, the NHS is in fact more narrowly targeted on deep need and addressing problems of vulnerable populations. It makes token reference to the ownership part of the market but minimal reference to the rental sector.

> *While the primary goal of the National Housing Strategy is to make safe and affordable housing accessible for the most vulnerable Canadians and for those struggling to make ends meet—the Strategy also addresses housing needs across the entire housing continuum. This includes supporting affordable homeownership for Canadians in stable and competitive housing markets.* [*Chapter 9 Improving Homeownership Options for Canadians. P 22]*

This inclusion to encourage and enable access to ownership, without parallel discussion of rental housing simply reinforces a historic policy bias that positions ownership as an aspiration of all, and owners as better citizens (implicitly denigrating renters).

The strategy fails to frame housing as a system and to take a systematic approach recognizing that what happens in one part of the system reverberates through other parts. If young families cannot access home ownership, they remain renting and add to demand. This exacerbates affordability issues and squeezes lower income households out of more affordable stock – contributing to excess shelter cost burdens, placing households at risk, and contributing to homelessness.

Meanwhile the insufficient stock of lower rent units and drastic erosion of this lower rent stock though both intensification policies (municipal) and the process of financialization also makes it extremely difficult to find lower rent housing for any low- or moderate-income households and especially for those seeking to exit homelessness via Housing First and other avenues. And as currently designed the NHS interventions only marginally assist in responding to deep affordability need.

The NHS also must not be limited to providing housing that is affordable – a human rights approach means housing must meet all criteria for adequacy – including accessibility, habitable conditions & appropriate location – qualities which households must often sacrifice to obtain housing they can afford.

The issues of stock erosion also relate to the phenomenon of gentrification and as such can act to undermine NHS goals to create and sustain inclusive communities.

While some research funding is directed to exploring some of these issues. Including the CMHC-SSHRC funded research nodes and some Solutions Labs, there is an absence of a comprehensive

and system perspective in the NHS. This undermines the capacity of the NHS to identify and manage/solve issues in a comprehensive way.

For example, an array of macro-prudential policies directed at managing high levels of household debt have has substantial and sometimes inadvertent impacts on the housing system yet have been pursued completely outside of the parameters of the NHS. Meanwhile the NHS has embraced a small initiatives in the form of shared equity financing to improve access to ownership, but this does not encompass the broader systemic impacts of constrained access to ownership – in part created by the independent macro-prudential policy decisions, taken outside of the NHS framework. Nor does it address the now heightened issue of excessive home prices and the system wide impacts of that situation.

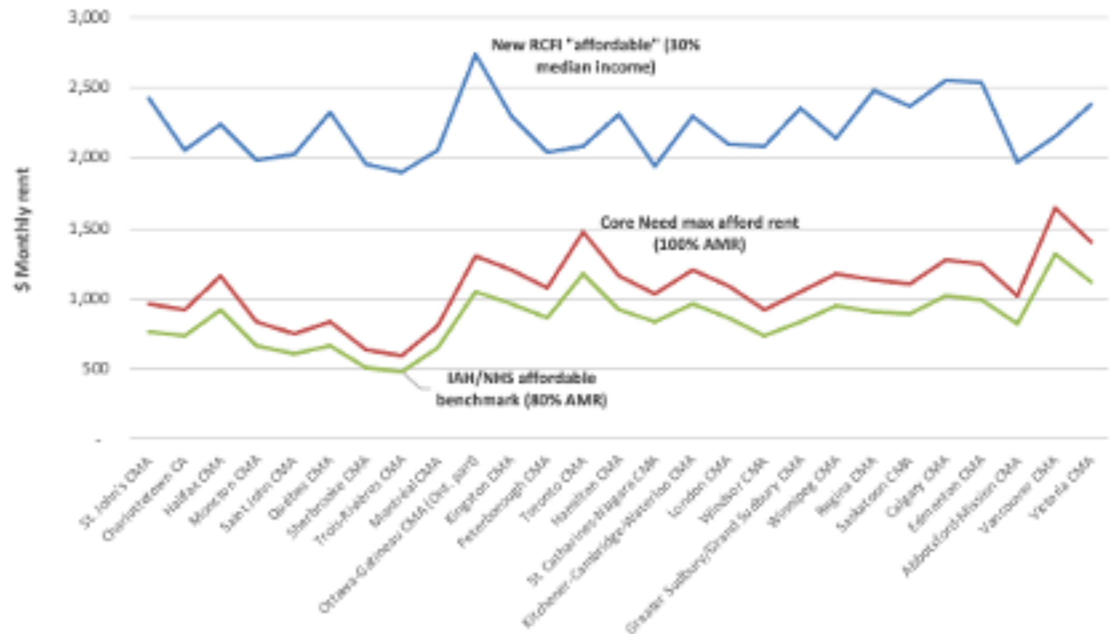
And while the RCFI has emerged as a single largest funded element of the NHS, its position in supporting and enabling a healthy housing system is not explicitly discussed (the RCFI and challenges in the rental part of the housing system is barely mentioned in the NHS)

Potential refinement to overall framing

Expand framing to take a housing systems perspective and increase insight into interactions and impacts across the housing system with a more comprehensive lens including the impacts of the ownership and rental market on affordability and need.

Appendix A: Examining RCFI affordability criteria

Examining CMHC Affordable rent criteria in RCFI					Suggested method = use 60% median		
	Median total income, all families (2017)	"afford" max rent = 30% median per month	Ave 2 bed rent 2018	"Afford" as percent average	60% median family income	More realistic afford at 30% (of 60%)	Realistic as % AMR
Canada 10,000+	84,950	2,124	1,025	207%	50,970	1,274	124%
St. John's CMA	97,110	2,428	961	253%	58,266	1,457	152%
Charlottetown CA	81,970	2,049	921	223%	49,182	1,230	134%
Halifax CMA	89,510	2,238	1,156	194%	53,706	1,343	116%
Moncton CMA	79,460	1,987	831	239%	47,676	1,192	143%
Saint John CMA	80,760	2,019	755	267%	48,456	1,211	160%
Québec CMA	92,690	2,317	839	276%	55,614	1,390	166%
Sherbrooke CMA	78,120	1,953	639	306%	46,872	1,172	183%
Trois-Rivières CMA	76,050	1,901	601	316%	45,630	1,141	190%
Montréal CMA	82,000	2,050	809	253%	49,200	1,230	152%
Ottawa-Gatineau CMA (Ont. part)	109,550	2,739	1,301	211%	65,730	1,643	126%
Kingston CMA	91,790	2,295	1,200	191%	55,074	1,377	115%
Peterborough CMA	81,410	2,035	1,077	189%	48,846	1,221	113%
Toronto CMA	83,020	2,076	1,467	141%	49,812	1,245	85%
Hamilton CMA	92,090	2,302	1,158	199%	55,254	1,381	119%
St. Catharines-Niagara CMA	77,870	1,947	1,036	188%	46,722	1,168	113%
Kitchener-Cambridge-Waterloo CMA	91,580	2,290	1,210	189%	54,948	1,374	114%
London CMA	83,880	2,097	1,087	193%	50,328	1,258	116%
Windsor CMA	83,210	2,080	915	227%	49,926	1,248	136%
Greater Sudbury/Grand Sudbury CMA	93,860	2,347	1,052	223%	56,316	1,408	134%
Winnipeg CMA	85,660	2,142	1,179	182%	51,396	1,285	109%
Regina CMA	99,240	2,481	1,130	220%	59,544	1,489	132%
Saskatoon CMA	94,810	2,370	1,110	214%	56,886	1,422	128%
Calgary CMA	102,060	2,552	1,272	201%	61,236	1,531	120%
Edmonton CMA	101,190	2,530	1,246	203%	60,714	1,518	122%
Abbotsford-Mission CMA	78,660	1,967	1,022	192%	47,196	1,180	115%
Vancouver CMA	86,140	2,154	1,649	131%	51,684	1,292	78%
Victoria CMA	95,250	2,381	1,406	169%	57,150	1,429	102%
NOTE typical new market rentals are priced roughly at 135-150% of the AMR. Requiring "affordable rents at 30% median, will in most cases be higher than the overall projects overall rents set at 10% discount to market (i.e. approx 125%					**This is more geared to renters - whose incomes typically are less than 60% that of owners.**		
Source for rents - CMHC 2019 Rental Market Survey (Canada table 1.0)							
Source for income (as linked to CMHC RCFI page) - latest published is 2017							
Statistics Canada. Table 11-10-0009-01 Selected income characteristics of census families by family type							
https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1110000901							


Comparing affordable benchmarks
(Core need, IAH and RCFI)
3,000
2,500
2,000
1,500
1,000
500
-
$ Monthly rent
New RCFI "affordable" (30% median income)
Core Need max afford rent (100% AMR)
IAH/NHS affordable benchmark (80% AMR)
St. John's CMA
Charlottetown CA
Halifax CMA
Moncton CMA
Saint John CMA
Québec CMA
Sherbrooke CMA
Trois-Rivières CMA
Montréal CMA
Ottawa-Gatineau CMA (Ont. part)
Kingston CMA
Peterborough CMA
Toronto CMA
Hamilton CMA
St. Catharines-Niagara CMA
Kitchener-Cambridge-Waterloo CMA
London CMA
Windsor CMA
Greater Sudbury/Grand Sudbury CMA
Winnipeg CMA
Regina CMA
Saskatoon CMA
Calgary CMA
Edmonton CMA
Abbotsford-Mission CMA
Vancouver CMA
Victoria CMA
Souce: Median income Statistics Canada; AMR from CMHC Rent Survey