THE NEW FEDERAL TOOL BELT: ATTEMPTS TO REBUILD SOCIAL POLICY LEADERSHIP

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Recent writing on Canadian federalism abounds with new labels and monikers such as Social Union Federalism (Inwood 2000), collaborative federalism (Dion 1999; Lazar 1998b; Cameron and Simeon 2002), instrumental federalism (Phillips 2001), without forgetting 9-1-1 federalism (Gibbins 1999) and handshake federalism (Torjman 2001). This explosion of descriptors reflects a feeling that Canadian federalism has entered a new period, particularly as Canadian governments produce balanced budgets. The pattern of federal deficit shifting and provincial outcry no longer holds as both the federal and provincial governments turn to agendas of social program reform and renewal. Yet, we are not back to the cooperative federalism of the 1950s or the competitive federalism of the 1970s either. While the scenario of a cash-rich and jurisdiction-poor federal government seeking to assert social policy leadership is reminiscent of earlier times, two decades of restraint have seriously undermined its legitimacy and made leadership tools inherited from an earlier era unusable.

Much of the analysis of this new period of federal-provincial relations emphasizes questions of hierarchy, although democratic questions such as responsiveness to citizens are also addressed. To be schematic, many have argued that the federal loss of legitimacy has led to a collaborative form of federalism where the federal government plays a far less hierarchical role. The opposite position, associated most clearly with Alain Noël (2000a, 2001), insists that the federal

government has in fact increased its hierarchical position by regularly circumventing the provinces altogether.

We consider that it is too soon to offer conclusive answers in this debate. While the signing of the Social Union Framework Agreement (SUFA) in 1999 dealt a firm blow to the idea of a solely interprovincial social union, and sidelined Quebec's binational conceptions, it has done far less to settle contentious questions of social policy development or to develop shared norms and institutions (Cameron and Simeon 2002). Nevertheless, we believe that positions in the debate remain underspecified in their treatment of the question of federal leadership, and are unable to account for bath unilateral federal action and the federal government's ongoing engagement in intergovernmental bargaining. The general emphasis on the federal spending power, and on the linked question of who sets national standards, is a wise one given the importance this power played in constructing a pan-Canadian social citizenship in the postwar period. In this paper, though, we argue that it is necessary to pose the question more broadly to consider how the federal government has attempted to renew its legitimacy and its social policy leadership since the watershed 1995 federal budget. Of particular interest is how it has attempted to shape the development of existing and new policy fields. Using new money to provoke provincial action is certainly one of the tools, but we argue that it is unlikely to be a primary one for reasserting leadership. On the other hand, the tools of accountability, expertise creation, and structuring investments are currently being honed to ensure a federal role in social policy renewal. We will consider how the federal government is using these tools in three vital policy fields, namely health policy, child policy, and employability policy. The use of three fields seeks to underline that these tools are not idiosyncratic to one single policy area, and to demonstrate that the relative importance of particular tools varies according to the inherited policy legacy. We conclude that although the federal government is seeking to renew its hierarchical predominance, the means to this end is not unilateralism so much as the use of new tools to shape policy change.

CANADIAN FEDERALISM: LEGITIMACY, CASH AND CONTROL

The Federal Government's Retreat from Leadership

The federal government's attempts to renew its social policy leadership, or at least its legitimacy, must be placed within the context of how it lost its earlier leadership. Wh ile the federal government played a central role in the postwar years in financing social provision in Canada, including in areas of provincial jurisdiction, this role declined persistently from the mid-1970s to the late 1990s as the federal government sought to control and eliminate its deficit. Federal-provincial negotiations are at one levet about the exchange of money for control and leadership: the restraint period therefore slowly eroded the federal government's moral leadership. The trend started with the Established Programs Financing (EPF) agreement in 1977, where the federal government insulated itself from provincial spending decisions by ending cost-sharing in health care and postsecondary education. It instead created a block grant adjusted to inflation and population growth delivered in part through a cash transfer, and in part through dedicated tax points (Smith 1997; Provincial and Territorial Ministers of Health 2000, 3-4)[2]. This withdrawal came at the cost of exempting provinces from stricter accountability mechanisms, of allowing them the flexibility to allocate the grant between postsecondary education and health (Maioni 2002), and of transferring tax points to the provinces.

The 1980s and early 1990s were marked by friction as the federal government unilaterally retreated from its EPF commitments through a string of measures to de-index the transfer (and thus have inflation erode its value), and tore-impose conditions on the transfer's use (particularly the 1984 *Canada Health Act*, and the related notional division of EPF into health and education components) (Maioni 2002; Cohn 1996, 172). The other major cost-shared program, namely the Canada Assistance Plan (CAP) (for cost-sharing provincial social assistance), was capped for half of Canada in 1990, and for the whole country in the 1994 budget. The 1995 federal budget rolled CAP and EPF into a single block grant, while amputating the base of this grant by roughly $6.2 billion, or 33 percent, between 1994-95 and 1997-98

(Provincial and Territorial Ministers of Health 2000, 8). Although the new block grant had fewer attached conditions than the sum of the earlier ones, the federal government's legitimacy to apply any conditions was open to question (Boadway 1995, 101; Courchene 1995; Maslove 1996; Phillips 1995). Indeed, in 1996 the Ontario government circulated a much-publicized discussion paper setting out a model whereby the provinces would take al most full control of social programming, and would set shared standards, norms, and conditions solely amongst themselves (Courchene 1996).

The cause of this loss of legitimacy came from the sharp drop in federal transfers for provincial social spending, a drop decided unilaterally by the federal government. Federal cash transfers for health, postsecondary education, and social assistance fell from 23 percent in 1984-85 to 19 percent in 1989-90, to 11 percent in 1998-99 (Québec 2001a, 10). Overall, cash transfers to the provinces as a percentage of federal revenues fell from a peak of 26.7 percent in 1983-84 to roughly 14 percent in 1999-2000. This brings federal cash transfers back to the levels of the tate l960s, when the newly-minted health-care and social assistance programs were in their growth phase (Québec 2001b, 6). This trend is mirrored in terms of provincial revenues, where the share of federal transfers, including equalization, has dropped from nearly a quarter in the early l980s, to about 15 percent today (Québec 2001a, 11). In other words, a federal government with fewer cost pressures and greater revenue raising capabilities than the provinces nevertheless off-loaded its financial responsibilities on the latter through two decades of transfer cuts (see also Ruggeri 2000, 2-3).

Collaborative Federalism or Federal Unilateralism?

It is hard to decipher what is taking shape in response to these changes. After the 1995 Quebec referendum, the federal government appeared set to renounce its leadership by hemming in its spending power, and by partially transferring responsibility for training, housing, forestry, mining, and tourism to the provinces. Given that social policy leadership is one of the few tools left at its disposal to maintain pan-Canadian integration in a period where economic space is both regionalized and continenta-

lized (Boismenu and Graefe 2003), and given that the government did not perceive broad public support for radical decentralization (Lazar 1998b, 8), this stance quickly gave way to moves to keep the federal government in the game. The 1996 budget promised that cash transfers would not drop below $11 million (as compared to nearly $19 billion in 1995), which provided some leverage to enforce standards in health. Nevertheless, the option of centralization was foreclosed due to a Jack of money and the reluctance of the provinces who were still feeling the effects of the federal government's bro ken funding commitments to existing programs (*Ibid.*). Since the federal government was not going away, and the status quo ante was no longer an option, the issue of how to renew federal-provincial relations was placed on the table.

Crudely speaking, there are two dominant assessments of what has transpired since: collaboration and continued federal unilateralism. Those arguing collaboration make the point that the federal government has more or less renounced its pretensions to leaders hip, and is seeking to engage the provinces as equals. Rather than pursuing high-stakes constitutional politics, the federal and provincial governments have found common cause in the need to renew social policy, and have tried to identify non-constitutional solutions and to strike collaborative agreements at the executive level (Lazar 1998a, 114, 126-29; Inwood 2000, 130, 133; Cameron and Simeon 2002). This evolution reflects the importance of new public management ideologies within the federal government, which are then extended into federal-provincial relations as a means of managing interdependence (Dion 1999; Battle 2001, 17).

New institutions have been created to maintain this collaboration, including the Ministerial Council on Social Policy Renewal (in both its provincial/ territorial and its federal/provincial/territorial versions) and the 1999 Social Uni on Framework Agreement. Lazar (2000, lOO) argues that SUFA "could turn out to be a major innovation in the workings of the federation. heralding a new era of collaboration, mutual respect among orders of government and a more coherent and systematic approach to policy making" (although he also notes that it could be ignored and simply become a historical footnote). It is the capstone of the collaborative process, with its various rules

and provisions committing the parties to consult before undertaking a range of activities, as weil as to report to their citizens. A key provision compels the federal government to gain the consent of six provinces before using its spending power to create new "Canada-wide initiatives supported by transfers to provinces and territories" in areas of provincial jurisdiction, and to give a year's notice and an offer to consult before changing existing transfers (Gagnon and Segal 2000, 243-49). This constricts the use of the spending power as a tool of federal leadership, even white restricting the federal government's ability to unilaterally reduce transfers in the manner described in the ear lier section.

While there is merit in this analysis, those arguing federal unilateralism make a number of cogent counter-arguments. First, certain key provisions of SUFA, particularly those pertaining to the spending power, are weak and unlikely to greatly constrain the federal government (Tremblay 2000, 170-74: Noël 2000b, 15-17; Robson and Schwanen 1999, 3). The federal government still appears to possess a "unilateral reflex": the annual reports of the provincial/territorial ministerial council provide examples of federal failures to consult and collaborate as per SUFA provisions (e.g., Ministerial Council on Social Policy Renewal 1999, 7; 2000, 5, 20, 22, 25), white the report of Quebec's *Commission sur le déséquilibre fiscal* catalogues an extensive number of recent federal initiatives in areas of provincial jurisdiction (Québec 2002, Table 19). The federal government's disinterest in pushing forward with SUFA by establishing a dispute-resolution mechanism or by firming up the spending power provisions suggests that it does not see such collaborative mechanisms as the institutional centrepiece of renewed federal-provincial policy-making (Ministerial Council on Social Policy Renewal 2000, 5; Western Premiers' Conference 2001). The "thinness" of social policy measures resulting from social union-style negotiations (Noël 2000b; Boychuk 2001b) also raises the possibility that collaborative mechanisms will lose legitimacy (since they lead to roadblocks and lowest common denominator solutions) and thus allow the federal government to act alone.

The champions of the collaborative model increasingly recognize the disconnection between the language of collaboration and federal

strategies, for instance in health care (e.g. Institute of Intergovernmental Relations 2002; St-Hilaire and Lazar 2003). They nevertheless hold to the argument that recent developments and institutions, including the Social Union, the maturation of the Annual Premiers Conference, and the Council of the Federation, point to a lessening of hierarchy, not its immediate disappearance. In other words, they believe that the situation should be judged relative to the unilateralism of the preceding periods of federal disinvestment and competitive federalism, and not in absolute terms. Nevertheless, given the evidence raised by their critics, this relative change is small enough to leave collaborative federalism as a project that remains unfinished in many key respects.

The partisans of the "federal unilateralism" position hold that recent federal-provincial relations are built around unilateral federal initiatives seeking to interact directly with citizens. The current period thus builds on a preceding period of large unilateral transfer cuts. Instead of restoring transfers (at least outside health care) or transferring tax room to the provinces, the federal government is intent on developing new high visibility initiatives in health care, education, and child poverty (Hobson and St-Hilaire 2000, 183). Indeed, one of the weaknesses of SUFA's spending power provisions is the silence on the unilateral use of the spending power in are as of provincial jurisdiction, such as through direct transfers to individuals delivered through the tax system (Tremblay 2000, 174; Noël 2000a, 13). The most complete accounting of this new unilateralism is provided by Quebec's *Commission sur le déséquilibre fiscal*, which notes not only direct transfers to individuals, but also direct spending (e.g., Canadian Institute for Health Information; Millennium Scholarship Foundation) and tax expenditures (e.g., Registered Education Savings Plans) (Québec 2002, 122-24).

The "federal unilateralism" analysis is fairly convincing, but it is incomplete on at least two counts. First, it groups a variety of federal interventions under the single head of "federal unilateralism" without fully unpacking the variety of federal strategies put to use. Below, we will argue that recent federal initiatives show traces of at least four different instruments for ensuring a federal presence, each with its own particular logic. Even where the diversity of the instruments is

partially recognized, as with Quebec's *Commission sur le déséquilibre fiscal*, this merely leads to the normative critique about distorting provincial priorities (e.g., Québec 2002, 125-26). This leaves aside the analytical questions of how the different tools are used together and of how effective they are in reaching federal objectives, particularly compared to earlier tools like conditional shared-cost and block grants.

The second shortcoming of the unilateral argument is the emphasis on the idea of the federal government recovering its social policy leadership by "going it alone." However, by unpacking the variety of the federal government's instruments, one observes that the federal government's "unilateralism" is not divorced from continued engagement and negotiations with the provinces. Of course, proponents of the unilateralism argument recognize the importance of negotiations, but tend to treat them as illustrations of continued hierarchy as the provinces lack the legitimacy and independent analysis required to challenge federal designs in areas of provincial jurisdiction. Negotiations appear to be unilateralism by other means since the provinces (other than Quebec) are seen as capitulating as soon as the least bit of pressure is brought to bear upon them (see, e.g., Noël 2000a, b). Our contention is that this characterization ignores a potentially more subtle interaction of unilateralism and negotiation, whereby unilateral action is used as a tool for increasing leverage in negotiations, and for legitimizing a claim to leadership. It is indeed noteworthy that despite the host of "boutique" programs introduced by the federal government since 1997, the vast majority of federal reinvestment has gone back into the Canada Health and Social Transfer (CHST) and equalization (Lazar 2000, 121). And while the programs have been criticized, they seem designed to limit provincial outcry outside Quebec. As such, the federal government may not be running away from its old joint commitments, so much as deploying new tools to shape their meaning.

NEW FEDERAL TOOLS

In our view, contemporary federal-provincial relations are marked by the federal government experimenting with a variety of instruments for

participating in provincial social policy fields. The scenario of an inter-provincial social union is by now a dead letter, even less realistic than the Quebec government's call for a return to the practices of classical federalism (see Boismenu and Jenson 1997). The same also applies to any return to the postwar forms of federal dominance. For the federal government, the game is one of pulling what it can out of the old tools of money and accountability, while creating new levers through expertise and policy experimentation.

New Money

In the postwar period, the federal government's social policy leadership was cemented by a willingness to spend money. While individual provinces might experiment with new programs (most famously Saskatchewan in the health field), the generalization of policy relied on the federal government putting money on the table and staring down the recalcitrant provinces (Quebec, and often Ontario). In the quarter century after the Second World War, the federal government slowly "spent" its dominance in the field of taxation (acquired to fight the war, and legitimated for several years thereafter on the grounds of national defence, as demonstrated by the expense of the Korean War) to acquire the role of social policy leadership in such domains as hospital insurance, medicare, social assistance, and pensions (Smith 1997).

The current situation is not entirely without echoes of the postwar period, such as the presence of a growing vertical fiscal imbalance[3]. The federal government continues to occupy significant tax room, while predicted expenditure growth is concentrated in provincial spheres of jurisdiction, particularly in health and education (Ruggeri 2000; Provincial and Territorial Ministers of Health 2000). Yet there is a difference from the postwar situation that reduces the likelihood of a "new money" strategy to buy federal leadership. That difference is the presence of the postwar programs, from which the federal government has withdrawn largely unilaterally through a variety of cost-cutting exercises over the past quarter century. New federal funds in these old programs will be simply seen as replacing funds previously withdrawn, but not as giving rise to any legitimate leadership. Investing

new money in large-scale unilateral federal programs, or in proposals for significant new federal-provincial programs is in turn likely to run into legitimacy problems as existing core programs (and particularly health) face important cost pressures, and public opinion shows strong support for increased spending in health and education (Hale 2000, 67).

Accountability

The use of money to buy leadership has traditionally been associated with an accountability tool. This ensures that the money is being put to use to meet the objectives set by the program. It also ensures a certain measure of federal control over provincial policy and expenditure decisions. The prototypical form of accountability in the postwar period was cost-sharing, whereby the federal government would reimburse the provinces a certain percentage of eligible costs. This was an intrusive process, with provinces often sending detailed accountings of their spending to the relevant department in Ottawa, which would then determine which expenses were eligible for cost-sharing, pursuant to the provisions of the relevant federal-provincial agreement. With ti me, the provinces gained the administrative capacity and political clout to challenge the affront these agreements present to the constitutional division of powers, and the degree of intrusiveness was relaxed. Still, the ability of the federal government to exert close control through this mechanism is evident (Smiley 1971).

Provincial opposition to this oversight, coupled with Ottawa's desire to control costs led to the replacement of many of these measures with block funding, as for instance with the 1977 Established Programs Financing agreement for health care and postsecondary education. Continued federal withdrawal during the 1980s and early 1990s undermined the legitimacy of federal accountability requirements, and the CHST dealt the death blow. Battle (2001, 48-49) thus concludes that the "days of conditional federalism are all but gone... Ottawa has neither the will nor the guile to restore conditionality of its social transfers by means of stealth."

As a result, the federal government has had to impose much more subtle controls on the provinces in exchange for new federal money. The vocabulary now centres on "reporting" and having provinces submit reports on where money is spent, and on mutually agreed upon performance measures. While a much blunter tool than cost-sharing, it nevertheless provides the federal government with some leverage. It can hold the provinces to spend funds within certain broad envelopes (e.g., broad fields of early child development), or on occasion fairly narrow ones (e.g., diagnostic equipment). The choice of performance measures can also be deployed to push provinces to focus on particular problems, or ultimately to justify further federal intervention to rectify recurrent under-performance. Finally, the federal government can steer the emphasis on public accountability to its favour, as citizens can use reports to pressure outlier provinces to conform. If the federal government can no longer hold the provinces to account, perhaps the public will do so for them if given the "right" information (Phillips 2001, 8-9, 17).

This tool is contrary to the federal principle in that it creates a hierarchical relationship of accountability and control, and stresses outcomes over legal constraints and formal procedures (Noël 2000b, 10-12). It is nevertheless worth evaluating how the federal government and provinces negotiate the terms of this relationship in order to better specify the extent of this hierarchy, particularly in comparison with earlier and more direct forms of accountability.

Creation of Expertise

Another tool for exerting control and leadership is to monopolize social policy expertise. The federal government, as the relay to international organizations, possesses a certain advantage over the provinces in this respect.

Of even more significance, however, is the ability to shape these ideas through a selective cultivation of research themes and expertise. As we will document in the sections below, the federal government has been aggressively investing money in the creation of specialized institutes and foundations. These investments promise to create a

form of "social demand" for new policy directions and decisions, a demand that the federal government can partially control through the deployment and mandating of these foundations/institutes. In other words, the federal government is creating a series of expert interlocutors with whom it can debate policy options. This can play a crucial agenda-setting role, particularly since these ideas and directions are legitimized using the scientific reputation and stature of the specialists. In a broad sense, endowing the Canadian Foundation for Innovation (CFI), creating Centres of Excellence, and establishing a Canada Research Chairs (CRC) program all work to establish direct links between leading knowledge producers and the federal government. As Polster (2002, 287-88) points out, the bundle of requirements and incentives induded in the CFI and CRC programs are already having a structuring effect on university planning and priorities.

This dynamic promises to open new doors for federal intervention. This may be particularly the case in established policy sectors where a set of stakeholders and programs already exist, and where the resulting "social demand" is likely to be for the federal government to return the money it previously cut. Creating a new social demand backed with the legitimacy of scientific expertise to which the federal government can then seek to answer provides one way of renewing federal leadership without the investment of substantial new monies. While this is a form of "unilateralism," it is worth noting that the ultimate goal is not so much to set up federal programs to run alongside provincial ones, so much as to deflect existing federal-provincial interactions onto new agendas privileged by the federal government. It is also not without its limits and dangers, as the relationship between expertise and federal policy strategies is unlikely to be one-to-one.

We advance as a working hypothesis that the recourse to this instrument will be greater in well-established fields of intervention like health and labour market policy, where stakeholder structures and established policy repertoires exist, than in developing fields such as children's policy where interests are less well organized and institutionalized.

Structuring Investments

This fourth tool bears some resemblance to the third one. Structuring investments can be seen as relatively small investments that nevertheless attempt to shape the overall direction and philosophy of existing programs. Taking such forms as pilot projects, strategic initiatives, or transition funds, these investments seek to set the direction of policy change by building a repertoire of measures and ideas for reform to existing programs, and by creating related administrative capabilities. These structuring investments thus provide another means of exerting leverage on provincial reform choices and priorities.

The following sections seek to establish these claims. To do so, we examine three different policy sectors, dealing with health, the labour market, and children. In each case, we catalogue how the federal government has deployed the tools at its disposal to rebuild claims to social policy leadership.

PUTTING THE NEW TOOLS TO WORK

Health Care

In a recent overview of federal health-care spending, Gerard Boychuk argues that the federal government reaps support as the defender of the health system's integrity, but that this political capital is dissipating as provincial problems grow. He argues that the government is following a three-prong strategy: "it portrays the health care system as being in crisis; it carefully denies any responsibility for this crisis; and, simultaneously, it ensures Ottawa will have a central role in any remedial prescriptions" (2002, 123). The difficulty with this strategy, however, is the loss of federal legitimacy from earlier federal transfer cuts, which makes both the denial of responsibility and the assignment of a central reform role highly problematic (Boychuk 2002, 125; Adams 2001, 76).

If there is a pattern in recent federal-provincial relations over health care, it is of conflict at the peak level over funding, where a period of intensifying provincial demands for more money (or the lifting of the *Canada Health Act* [CHA]) places the under-funding

of the health system at the federal government's door. At this point, the federal government feels the need to salvage its credibility as the protector of medicare and puts some money on the table to secure a deal with the provinces. This is followed by a few months of peace, before provincial demands begin anew[4].

The federal government has put new money on the table on a variety of occasions. In order to save some last vestiges of legitimacy as en forcer of the CHA, the government promised to implement a "cash floor" for the CHST in 1996[5]. The level of this floor was raised from $11-$12.5 billion following the 1997 election. This floor was nevertheless not so much new money as a means of stopping the decline of cash transfers, which fell from $14.7 billion in 1996-97 to the $12.5 billion floor in 1997-98 and 1998-99 (Canada. Department of Finance, various years). These were therefore minor moves. They were unlikely to deflect the attacks on the federal enforcement of the CHA coming from the provinces, who were seeking a formalized interprovincial or bilateral dispute-resolution system for policing health standards (Ministerial Council on Social Policy Reform and Renewal 1995, 11-12; Conference of Provincial/Territorial Ministers of Health 1997).

The new money tool was deployed more successfully in early 1999, as the promise of substantial new investments tipped negotiations concerning the SUFA greatly in the federal government's favour (Noël 2000a). A five-year agreement was reached whereby the federal government would bring the CHST floor to $14.5 billion for two years, and then $15 billion for an additional three years (through to

2003-04). In return, the premiers agreed that this new money would be full y committed to core health services in accordance with the health-care priorities of their respective provinces. While this promise did not greatly constrain provincial activity, particularly since there were no reporting requirements, it reduced the supposed flexibility of the CHST (whereby provinces choose how to divide it between health, postsecondary education, and social assistance), and thereby brought the situation somewhat back to practices in effect before the 1977 EPF agreement (Hobson and St-Hilaire 2000, 177). The

February 2000 budget in turn raised the CHST floor to $15.5 billion for 2000-01 to 2003-04.

The September 2000 health accord between the federal government and the provinces again used the money tool. The federal government promised $18.9 billion worth of graduated CHST cash increases through to 2005-06, raising the transfer 's cash portion to $21 billion in the final year (although this included $500 million for Early Childhood Development). A further $1 billion was earmarked for provinces to allow them to acquire modern diagnostic and treatment equipment, especially MRIs (First Ministers' Conference 2000b).

In this case, new money was more clearly tied to an accountability tool. The health accord included a document setting out a vision, principles, and an action plan for health. The vision and principles sections mostly contained motherhood statements, but underlined that provincial/territorial governments held the principal role in managing and financing health services, and stressed the importance of innovation, information-sharing, and regular reporting. The action plan committed the governments to various ends, including: providing timely access to health services; investing in health promotion; reform of primary care; improving education, training, recruitment, and retention of health professionals; intensifying investment in home- and community-based care; reducing prescription drug prices; working on the health "infastructure" and interjurisdictional compatibility; and investing in equipment and new technologies. The document included an accountability framework that called for clear public reports audited by a third party to increase productivity and help meet these priorities. It noted that the point of measuring outcomes was to increase accountability to the public and not to other governments, such that federal funding is not contingent on meeting targets (First Ministers' Conference 2000a). The 2003 *First Ministers' Accord on Health Care Renewal* largely continues down this path. The federal government agreed to a $2.5 billion CHST cash supplement (over three years), $1.5 billion for a Diagnostic/Medical Equipment Fund (to be drawn down by the provinces over three years), and a $16 billion transfer to the provinces (over five years) for a Health Reform Fund. This fund, which may be rolled into the CHST when it expires, is to

be spent on primary health-care reform, home care and catastrophic drug coverage, and comes with reporting requirements on progress and key outcomes (First Ministers' Conference 2003).

In sum, in terms of the money and accountability tools, we note a shift away from the practices associated with the CHA. The federal government clearly Jacks the legitimacy to return to setting strong centralized norms, and is forced to adopt new forms of bringing provinces to account. At the same time, the federal government has managed to present itself as a central actor in setting out a vision and action plan for the health system. As Adams (2001, 65) points out, even if the federal government had not undermined its legitimacy to enforce the CHA, it might still need new tools to ensure federal leadership in the current context. The CHA deals with "what" coverage, "who" pays, and "where" coverage applies, but does not speak to restructuring imperatives of quality, responsiveness, efficiency, effectiveness, and affordability. With the 2000 and 2003 health accords, the federal government has provided itself with a seat at the table.

The shift to weaker forms of accountability can be compensated with a directive role if the federal government can provide the necessary expertise to lead health restructuring. In other words, while new money does not buy much direct control, the government can reclaim leadership by shaping the priorities to which existing monies are devoted.

One means to this end involves creating and mobilizing expertise. The federal government has been quite active on this front since the 1995 budget cuts. The 1996 budget made an initial gesture in this direction by setting up a Health Services Research Fund, with $65 million of funding over three years to examine the results of accepted procedures, the effectiveness of health services, and variations in the modes of service provision. The 1997 budget took the additional step of providing $50 million to improve the Canadian Health Information System, and the Medical Research Council's budget was increased by $134 million over three years in the 1998 budget. The 1999 budget goes yet further, including $95 million for the Canadian Institutes for Health Information to develop health indicators and

data standards, to fill data gaps, and generally to build capacity. Health research was also aided by: an additional $150 million given to the research granting agencies; another $90 million in endowment and $2.5 million in operating funds for Health Canada's Health Services Research Foundation (including a $25 million endowment for nursing research); and $65 million and $175 million in additional funding for the Canadian Institutes of Health Research for 2000-01 and 2001-02 respectively (Canada. Department of Finance, various years). These measures were flanked by the creation of the Canadian Foundation for Innovation in 1997, and its renewal in 2000. The CFI, an independent organization created and endowed by the federal government, aims to modernize the research infrastructure in universities and teaching hospitals. As of 1999, roughly 45 percent of the foundation's funds had been earmarked for the health sector (*Ibid.*, 1999). The creation and endowment of this fleet of health research organizations, albeit with budgets dwarfed by CHST commitments, positions the federal government as the prime governmental interlocutor of the health research profession, and thereby gives it preferential access to expertise.

This research emphasis is reinforced by a series of structuring investments, attempting to shape the priorities and trajectories of provincial health systems as they are reformed. As early as the 1997 budget, the federal government invested $150 million in a Health Transition Fund to help provinces move toward new forms of delivery. The 1999 budget went further, investing $75 million in two networks that had already been tested as pilot projects, namely the National Health Surveillance Network and the Canadian Health Network. An additional $115 million was set aside to test pilot projects using technologies like "Telehealth" and "Telehomecare." A further $287 million was promised for preventative and other health measures such as the Canada Prenatal Nutrition Program, modernizing the food safety program, and encouraging innovative approaches to rural and community health. The 2000 health accord went even further in this direction. We have already noted the $1 billion investment (over two years) in diagnostic and treatment equipment. ln addition, $500 million was earmarked for an independent foundation, to be invested in cutting edge health information technologies. A final $800 million

(over four years) was placed in the Health Services Transition Fund to accelerate access to primary care innovations (First Ministers' Conference 2000b; Canada. Department of Finance 2000). The 2003 federal budget indeed balanced the health accord with the provinces with new money for expertise and structuring investments. These included $500 million (over four years) for research hospitals via the CFI, $45 million (over five years) "to develop a Canadian Strategy for Technology Assessment," and $205 million (over five years) for governance and accountability measures.

This raft of measures enables the federal government to set parameters for health policy both in giving it ready access to a tested repertoire of reform ideas, and in giving monetary incentives for provinces to invest in particular areas (cutting edge technology, new means of service provision) when redesigning their health systems. In conjunction with research expertise and the new forms of accountability sketched out above, it is clear that scuffles over the interpretation of the CHA are but one part of the federal-provincial dynamic in the field. While the federal government's legitimacy to lead in health policy in the old manner has been severely weakened, its new tools hold the promise of deflecting decisions in the health field in directions preferred by the federal government.

Child Policy

The field of child policy is far Jess institutionally developed and entrenched than health care, providing the federal government with greater latitude to act. As well, federal disengagement had been less severe. Federal child benefits (Family Allowances) were partially de-indexed in 1985, growing at the rate of inflation less 3 percent (Battle 1999, 53, 57). In 1989, these benefits were clawed-back from high-income families. In 1993, the Conservatives ended the universality of Family Allowances by introducing the income-tested Child Tax Benefit (CTB) (Myles and Pierson 1997, 457). Despite these changes, overall federal spending on child benefits has remained steady at around $6 billion between 1980-81 and 1998-99 (in constant 2000 dollars) (Battle 2001, 7).

The federal government's plan took form in the 1997 budget with the announcement of the National Child Benefit program. This responded to provincial suggestions, voiced through the Ministerial Council on Social Policy Reform and Renewal (1995, 14), that both orders of government consider "the possible consolidation of income support for children into a single national program, jointly managed by both orders of government." The announcement involved two initiatives arising from joint action by the federal and provincial governments. First, the federal government "would increase and reconfigure the Child Tax Benefit as the Canada Child Tax Benefit." Second, the provinces would take their resulting savings from reduced welfare spending for children and reinvest them in programs for low-income children. The federal government bundled $5.1 billion of existing CTB and Working Income Supplement (WIS) with additional monies announced in the 1996, 1997, and 1998 budgets. Significant new sums have since been devoted to the child policy sector. The sums are expected to bring spending on the Canadian Child Tax Benefit to $9 billion in 2004, of which about $6 billion is targeted to low-income earners. This arguably is not new money so much as recycled CAP dollars (Pulkingham and Ternowetsky 1999, 106). Indeed, the amounts spent on low-income earners come 2004 are still well below what was spent on CAP in 1995, even before accounting for inflation (Boychuk 2001a, 128).

This new money was supposed to leverage provincial action in terms of providing "new or enhanced supports for low-income families in key areas" such as Children's Benefits and Earned Income Supplements, Child Care, Early Childhood Services and Children-at-Risk Services, and Health Benefits. There was a fifth, "other" category, into which work incentive programs and "training initiatives that help parents find and keep work" were included. During 1999-2000, provinces, territories, and First Nations spent over $484 million in NCB initiatives, "including additional investments of approximately $80 million," and this grew to $734.7 million in 2001-02 (Canada 2001; National Child Benefit 2002). The federal government's new money therefore managed to leverage provincial action in a range of defined are as, but provincial acceptance of the agreement was

dependent on allowing for a great deal of provincial autonomy, so as not to challenge the "tough on welfare" stance of certain provinces (Boychuk 2001a, 10-11).

A second major development in the child policy field is the Agreement on Early Childhood Development reached in September 2000. This agreement committed an addition al $2.2 billion of federal funding over five years to provincial initiatives in the priority are as of promoting healthy pregnancy, birth and infancy; improving parenting and family supports; strengthening early childhood development and care; and strengthening community supports. In return, provinces were required to provide annual reports to Canadians on their investments and the progress made in enhancing services in the priority areas, and they agreed to start by establishing a baseline of current early childhood development expenditures and services. In addition, all governments agreed to spend two years developing a shared evaluation framework, including "jointly agreed comparable indicators." Provinces will not lose funding if performance lags (Canada 2000). This pattern was largely repeated with the signing of the Multilateral Framework on Early Learning and Child Care in March 2003, where the federal government promised $900 million (spread over five years) to the provinces for early childhood programs. In return, provinces committed to reporting on how they spent the money, and to providing indicators of "availability," "affordability," and "quality" in funded early learning and childcare programs (Federal-Provincial-Territorial Meeting 2003).

New money has therefore not given the federal government a great deal of power to set program details. Martha Friendly (2001, 80), for instance, concludes that the Early Childhood Development (ECD) Agreement "is designed to allow provinces to pursue different children's policies based on ideology and financial resources." Laurel Rothman (2001, 91) similarly sees the ECD as an "open buffet where choice reflects individual taste, not nutritional balance," whereas more federal money might have at least led to a balanced diet where first ministers would have agreed to firm targets and deadlines for meeting objectives. On the other hand, it is widely felt that child policy has been effectively redefined in terms of child poverty and increasing

the attachment of poor parents to the bottom of the labour market, to the exclusion of other poss ibilities such as services to aid in work/home life balance (McKeen 2001, 187-88; Jenson 2000, 20).

These new investments have come with accountability mechanisms: provinces face some reporting requirements, but provincial pre-emption of the child policy issue means these are not strongly binding. An NCB Governance and Accountability Framework was agreed to in March 1998. The Framework for the National Child Benefit has deci sion-making and accountability flow from three mechanisms: Federal/Provincial/Territorial Ministers responsible for Social Services for overall strategic policy direction and dispute resolution; F/P/T Deputy Ministers Responsible for Social Services for general management, implementation, and operation of the program; and Federal/Provincial/Territorial NCB Working Groups of Officials for supporting the deputy ministers and for identifying solutions to emerging issues. In addition, "each level of government undertakes to make provisions for the levet of information sharing as agreed toby the partners and required for program management and implementation, as well as for program evaluation, including statistical and related data." Reporting to the public, in turn, "is an integral part" of the accountability framework. All participating governments committed to provide an annual report on the performance of NCB initiatives. There is also a commitment to focus on program outcomes "as the primary goal of reporting" (Canada 1998b). Early proposed outcome indicators (Canada 1998a) nevertheless rely on indices that are easy to establish (e.g., change in the percentage of the total income of low-income families that result from employment, change in the number of families with children on social assistance, changes in the depth of poverty), rather than on rigorous program evaluations (e.g., outcomes for participants versus those in a control group) (see also National Child Benefit 2002). Given the breadth of reinvestment activities, accountability is unlikely to lead to the development of standards to govern such programs. Still, Battle argues that the reinvestment agreement "is a sort of back door, softly-softly form of conditional cost-sharing" that will main tain but not increase the existing diversity of programs (1999, 58, 51).

Another means of shaping how provinces develop services to children involves creating and harnessing policy expertise and a social demand for certain types of interventions. There has been less investment in such institutions in the case of child policy as compared to health, but it is nevertheless worth underlining the creation of five Centres of Excellence in child welfare, with funding of $20 million over five years. These centres were announced in the 1997 Throne Speech, and their creation coincides with federal action on the NCB. The objective of this program was to increase understanding of child welfare and development and improve the capacity to respond to the needs of children. This research mission nevertheless had a number of policy-related functions such as advising governments, providing information to a broad audience, and organizing networks of groups working in the child welfare sector (Canada 1997; Canada. Department of Finance 1997). The federal government's creation of these centres is therefore likely to create a policy agenda, a social demand for federal intervention, and close links with cutting-edge research and expertise. Despite spending on expertise, we note very little in terms of structuring investments, probably due to the limited number of existing federal-provincial programs in the field[6].

For child policy, then, we note that the money and accountability tools have leveraged provincial action, but within very loose constraints of federal oversight. Nevertheless, given the newness of the field, there is less need for control to overhaul existing programs and practices. In this context, even relatively minor investments in expertise may be sufficient to provide a federal leadership in policy development.

Labour Market Policy

As compared to health care and child policy, federal leadership in labour market policy came under fire early. In the 1980s and early 1990s, the federal government seemed ready to assume a high profile role in training and labour force adjustment policy in order to spur Canada to global competitive success. From the Canadian Jobs Strategy to the Labour Force Development Strategy to the creation of the Canadian Labour Force Development Board, there was no shortage of federal ambition

(Prince and Rice 1989; Yates 1995; McFayden 1997). Yet the legitimacy of federal leadership was always open to question on two fronts. First, jurisdictional responsibility remained contested, with the provinces wary of any federal activity that would undermine their provincial training systems built around public institutions (Bakvis 1996a, 136; Haddow 1995). Second, federal financial commitments stagnated even as policy ambitions grew. The Liberals further reduced financial commitments following their election in 1993, leaving inflation-adjusted spending on active labour market policy in 1999-2000 11 percent lower than in 1993-94 (Haddow 1998, 103; Bakvis 1996b).

This situation of little money and contested jurisdictional authority has forced the federal government to forge new tools. New money was lacking to meet even a modest version of federal plans, let alone purchase provincial cooperation. The federal solution was to offer provinces administrative control of federally funded training, in return for joint federal-provincial deliberations in designing training measures. In other words, rather than coming up with additional funds, existing federal funds would be transferred to provincial administrations, but the federal government would exert a planning and oversight function. It would steer, while the provinces rowed.

Financial pressures and the razor-thin result of Quebec's 1995 referendum further eroded federal legitimacy, forcing additional concessions in the final offer to the provinces. In addition to giving provinces administrative control over the administration of the five new EI-funded labour market activation measures, it allowed provinces to lake over counselling and placement services. The trans fer of authority was formalized in bilateral Labour Market Development Agreements (LMDA) that set minimum conditions for devolved services (Haddow 1998, 107-08). To date, the LMDAs have taken three forms. The first, taken up by New Brunswick, Quebec, Manitoba, Saskatchewan, Alberta, the Northwest Territories, and Nunavut, is the "full transfer" model where provinces take responsibility for labour market policy and program delivery within federal funding and client eligibility guidelines. Newfoundland, Prince Edward Island, British Columbia, and the Yukon have adopted a "co-management" model where there is joint management of program design and delivery but

no transfer of federal staff and resources. Finally, Nova Scotia has signed a joint partnership agreement that commits the federal and provincial government to collaborate and coordinate their efforts (Klassen 2001, 177). To give an idea of the resources tied to these responsibilities, in 1997-98, HRDC made $1.53 billion and 3,620 full-time equivalent staff available for transfer under Labour Market Development Agreements, reserving $250 million for national labour market information and active-labour market measures for not receiving employment insurance (EI) clients including immigrants, youth, the disabled, and Aboriginals (Klassen 2001, 175).

This transfer of responsibility has not bought a great deal of control or accountability. Haddow (1998, 108-09) concludes that "Ottawa's capacity to set priorities will be limited," although that capacity will vary depending on the type of LMDA. The federal government is left with two points of leverage. First, the provinces have agreed to targets on three performance measures, namely: the number of clients served by employment benefits and measures; the number of EI clients returned to work; and savings for the EI account (Klassen 2001, 186; Haddow 1998, 109-110). Second, provinces (other than Quebec) who accepted the full transfer model agreed to offer employment benefits and supports similar to those offered under Part II of the EI Act, namely wage subsidies, temporary earning supplements, self-employment assistance, training loans/grants, and hiring subsidies (Haddow 1998, 110). Neither of these elements is particularly constraining. The first says little about important policy choices (what skills? who sets skill priorities? who will receive the benefits), although it does set up an incentive structure favouring training for immediate labour-force participation, regardless of job quality (Klassen 2001, 181, 185). The second element is also limited since the categories of eligible measures are broadly drawn , and the agreements do not specify the distribution of funding between categories (Haddow 1998, 110-11)[7].

The question of failing federal leadership becomes less clear cut when we move away from money and accountability to the other tools. The labour market policy field has been less marked by attempts to create scientific expertise than health or indeed child policy, but extensive use has been made of structuring investments. In some cases,

these investments were set up with the goal of being demonstration projects, thereby providing lessons that could be generalized across provinces. Indeed, the LMDAs, with their accountability measures aimed at low-cost, labour-force attachment measures, seem to consecrate the federal government's policy direction since the *Canadian Jobs Strategy* in the mid-1980s. The signing of the Employability Enhancement Accords in the mid-1980s, which committed federal CAP dollars and matching provincial investments to labour force re-insertion policies for social assistance recipients, was an important first step. The accords, while making modest financial investments, validated the provincial welfare-to-work pilots of the early 1980s, gave the go-ahead to more punitive workfare reforms in the mid- and late 1980s in Saskatchewan and Quebec, and encouraged a wide range of provincial experimentation.

The federal government continued on this track in the early 1990s by supporting a number of pilot projects. For instance, in 1992, HRDC signed on as a co-sponsor of the NB Works Demonstration project. HRDC and the provincial departments responsible for social assistance and training cooperated in providing as much as three years worth of education, training, and employment placement services to parents on social assistance, in the hope of creating sufficient human capital to command family-supporting wages on the labour market (New Brunswick 1992). Another important structuring investment, also announced in 1992, was the Social Sufficiency Project, which attempted to evaluate if providing extensive wage supplements to single mothers on social assistance who found full-time employment would increase their participation in paid work and reduce their use of social assistance (SRSA 2002, s-2). In both cases, the federal government set the "welfare wall" as a significant policy problem, and funded projects that developed a repertoire of interventions for solving the problem.

A final example of strategic investments along these lines was the government's Strategic Initiatives program, announced in the 1994 budget. The goal of this program was to support pilot projects testing new approaches to employment, training, apprenticeship, income support, and services. Particular emphasis was placed on employability development and training initiatives, especially those

that dealt with obstacles to employment deemed to create long-term welfare dependence or that flanked existing programs and improved their success. In addition, the projects aimed to improve mechanisms of program design of delivery and to extend partnerships between orders of government, as well as between the public, private, and not-for-profit sectors. While the program's original $800 million budget (over two years) was sliced in the 1995 budget to $413 million, it nevertheless funded 24 projects reaching roughly 100,000 people (Canada. HRDC 1998).

As a result, while the federal government has given up some space in the labour market field, it has by and large already defined the content of that space: training policy will focus on employability development and be activation biased. The labour-force attachment emphasis of child policy further reinforces this tendency. Between the admittedly weak accountability tool of the LMDAs and earlier structuring investments, the federal government has steered labour market policy toward employability. The basis for future federal leadership is nevertheless murky: the government has made the gesture of devolution, while not formally swearing off all responsibility for labour market programs. In some sense, leadership here has not been necessary, as the centre of policy attention shifts from the figure of the male breadwinner to that of the child (Jenson 2000). Still, the interest shawn in school-to-work transitions and in postsecondary education suggests the federal government is experimenting with other ways of shaping the labour market should attention return to this field.

CONCLUSION

Our consideration of health, child, and labour market policy leads us to be cautious in describing the ongoing relations between the federal and provincial governments as collaborative federalism or federal unilateralism. What is clear from the three cases is that the federal government squandered much of its social policy leadership through budgetary restraint, and that it is seeking to craft some new tools to rebuild its legitimacy. The means to this end include adapting older tools of new money and accountability, but these are less useful than before since

provincial governments can resist by calling the federal government to first restore transfers to their pre-restraint levels. In light of these limitations, the federal government has experimented with new tools to shape provincial priorities, particularly through the creation of expertise and through structuring investments.

This focus on how the federal government has sought to renew its leadership is useful in making sense of both its interest in unilateral "boutique" programs and its continued engagement in negotiations with provinces. Unilateral investments in expertise and demonstration projects provide the federal government with a means to shape the direction of policy change and renewal, and thereby partially compensate for the inability to exercise old forms of centralized oversight and control in joint initiatives with the provinces.

These new tools were crafted at a time of weakness, when the federal government recognized that it did not have the new money to buy itself a place at the table. They have been relatively successful in allowing it to participate in setting the direction of policy change. It remains to be seen if they will be successful enough to recreate a hierarchical leadership reflective of the 1950s, or whether they will simply be sufficient to permit a federal seat at the social policy table.

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2 The Ministers of Health argue that the trend started in 1972 with the imposition of a 15 percent annual growth ceiling on postsecondary education transfers - a ceiling that started restricting entitlements by 1974-75.

3 The size (indeed the presence) of the vertical fiscal imbalance has been hotly debated, and hinges in part on the policy goals being pursued by the federal and provincial governments. For an accessible and even-handed overview, see St-Hilaire and Lazar (2003).

4 For example, the federal CHST investments in the February 1999 budget were followed in May 1999 by calls from the western finance ministers for a CHST increase. This was taken up in August 1999 by the Annual Premiers' Conference and by a meeting of the Atlantic and Northern leaders. In the lead-up to the 2000 budget, Alberta released a backgrounder reiterating this demand, and this was followed on 3 February 2000 by a letter to the prime minister signed by all the premiers and territorial leaders calling for the restoration of the CHST to 1995 levels with a suitable escalator. When the budget did not meet these demands, the chair of the 1999 Annual Premiers' Conference wrote to the prime minister demanding a First Ministers' Conference on health. This finally led to a federal willingness to negotiate, but it was only after the western and Atlantic finance ministers made further demands that an agreement was struck in September 2000. In early 2001, the cycle started anew with a western finance ministers' report on fiscal imbalance.

5 As the CHST was first structured, the amount of cash transferred to provinces would eventually fall to zero as economic growth increased the value of the tax-point portion of the transfer. However, since the tax points were only notionally under federal control, the only means of enforcing the CHA involved withholding the diminishing cash part of the transfer.

6 Although the Early Childhood Development Agreement (ECDA) could conceivably be considered in this light as it invested in a certain number of measures, the breadth of the permitted investments was sufficiently large that it is difficult to see them as directly structuring provincial action.

7 We would not deny Rocher and Rouillard's (1998) point that the LMDAs represent deconcentration rather than decentralization. Nevertheless, while the federal government has not formally ceded jurisdiction, and while it is able to set some performance standards, the LMDAs change the federal-provincial dynamics in labour-market policy to the extent that major new federal initiatives will likely either come from "outside the box" (e.g., labour market activation through child policy) or involve a substantial infusion of new money.