evolution in the federal government strategy for maintaining a degree of pan-Canadian integration compared to the post-war shared cost programmes. Federal-provincial summit negotiations now tend to produce framework agreements setting out broad principles and a menu of policy priorities and commitments. While provinces have a wide degree of flexibility in allocating resources and defining programme parameters across and within these priorities, they do commit to informing the public of their plans, to collecting and monitoring information about results, and to communicating with the public. Accountability for the use of federal monies is ensured both through the recognition of the federal contribution in provincial reports, and through provincial publics holding their governments to account for outcomes. Some examples from a variety of different policy fields are discussed

(e.g. diagnostic equipment, primary health reform, catastrophic drug coverage). Each reinvestment thus entails more federal steering. This moved from accepting the Premiers' promise to spend the money on health in 1999 to more elaborate provisions about reporting and elaborating outcome indicators in 2003.

The 2004 agreement, set out in "A 10-Year Plan to Strengthen Health Care" follows in this vein. The governments again agreed to a broad statement of principles, followed by commitments to develop solutions to specific problems like waiting times, human resources, home care and primary care reform. The agreement binds governments to develop plans for overcoming these problems, to report annually to citizens on their progress, and to share best practices amongst themselves. Once again, the agreement provides a fair degree of flexibility, albeit with federal involvement in setting agendas and steering reform. The 2004 side-agreement setting out how the agreement is interpreted for Quebec, introduces an element of political asymmetry in providing Quebec greater flexibility in defining its plans to meet certain problems and in providing for different reporting requirements (i.e. reporting to the Quebec Health Commissioner rather than to the Health Council). This is nevertheless a thin political asymmetry, since the side-agreement underlines that Quebec will continue to work with the other provinces in developing indicators and sharing best practices, and that it will largely work on the same reform priorities.

In sum, these frameworks point to the federal government honing new tools for ensuring some degree of pan-Canadian social policy integration. These tools are, at least on the face of them, weaker than the post-war national standards. They certainly do not have the provincial governments preparing detailed financial statements to send to Ottawa in order to qualify for cost-sharing. Indeed, given the federal Finance department's opposition to open-ended cost-sharing, these new agreements limit federal contributions to set amounts. Given more circumscribed financial participation and more diffuse means of enforcing accountability, the federal government now shows greater tolerance for provincial diversity, in the sense of different provinces emphasizing different parts of the federal agenda, for instance with some choosing to invest early childhood development monies in child care, and others in healthy pregnancy. At least for now, provinces are required to report to their citizens, and not to the federal government, and federal funding does not ride on obtaining particular results. What counts is that provinces sign onto the agenda set by the federal government, and agree to participate in an ongoing policy-learning process through public reporting, the development of performance indicators, and the spread of best practices. This is clearly a softer form of federal control than the use of national standards, but it is perhaps a more effective form when the goal is to lead the reform of the programmes and institutions inherited from the post-war era, rather than to create new branches of the welfare state. For instance, others have noted that the ***Canada Health Act*** does not provide the federal government with much leverage in renewing the health system, except by vetoing particular courses of action. The Health Accords, in conjunction with the deployment of pilot projects and new centres of expertise, do allow the federal government to portray itself as a reform leader, and to encourage all provinces to move in largely the same direction.[5]

Federal leadership based on an agenda setting and steering role may have a greater tolerance for mundane asymmetry in the precise policy mix in a given field. What matters is that the provinces are being steered in the "right" direction. This tolerance for mundane asymmetry is likely to give rise to greater political asymmetry, within certain bounds. If the federal aim is to steer provincial efforts, agreements that set out a different configuration of accountability and reporting requirements do

[5] See also Gérard Boismenu and Peter Graefe, "The New Federal Toolbelt: Attempts to Rebuild Social Policy Leadership," ***Canadian Public Policy***, 30, 1, 71-89; Denis Saint-Martin, ***Coordinating Interdependence: Governance and Social Policy Redesign in Britain, the European Union and Canada***, Research Report F|41 (Ottawa: Canadian Policy Research Networks, 2004), 30-37.

not fundamentally undermine federal leadership. It is one thing to opt-out of a shared-cost pan-Canadian programme and demand compensation to be used for a competing initiative, and another to tinker with reporting relationships. In the first