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How Will COVID-19 Alter the Politics of Long-Term Care? A Comparative Policy Analysis of Popular Reform Options

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Article

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Résumé

Cette analyse des politiques passe en revue trois propositions populaires bénéficiant d'un important soutien politique et qui visent l'amélioration des soins de longue durée, définis ici au sens large pour inclure les établissements de soins de longue durée, les soins à domicile et les soins communautaires, dans le sillage de la crise de la COVID-19 : normes nationales, autonomie provinciale et déprivatisation. Les propositions sont résumées succinctement et suivies d'une analyse néo-institutionnaliste des obstacles à leur mise en œuvre. Ces obstacles ont été identifiés lors d'une série d'entretiens menés avant la COVID-19 avec de hauts fonctionnaires des provinces canadiennes, dans le cadre de la rédaction d'un livre qui a été publié récemment (Marier, 2021), et en tenant compte de considérations politiques. Bien que le gouvernement fédéral ait poursuivi la voie de l'instauration de normes nationales, les provinces ont clairement exprimé leur désir d'obtenir des transferts fédéraux plus élevés en santé et de poursuivre les réformes des SLD par elles-mêmes. Compte tenu de la diversité des dispositions en matière de SLD dans les diverses provinces, qui elles ont un impact sur la politique des SLD de chaque juridiction, et de la présence de nombreux gouvernements conservateurs dans les capitales provinciales, Ottawa est confronté, dans son initiative de transformation profonde des soins de longue durée, à un défi de taille.

Abstract

This policy analysis reviews three popular proposals with significant political endorsement to enhance long-term care (LTC), here defined broadly to include residential care facilities, home care, and community care, in the wake of the coronavirus disease (COVID-19) crisis: national standards, provincial autonomy, and de-privatization. The proposals are summarized succinctly followed by a neo-institutionalist analysis of the obstacles to enact them based upon a series of interviews conducted prior to COVID-19 with senior civil servants in Canadian provinces for a newly published book (Marier, 2021) and political considerations. While the federal government has pursued the avenue of instituting national standards, the provinces have clearly expressed a desire to secure higher federal health transfers and pursue LTC reforms on their own. Considering the diversity of LTC arrangements across the provinces, which impact the politics of LTC within each jurisdiction, and the presence of many Conservative governments in provincial capitals, Ottawa faces an uphill battle to transform profoundly the LTC landscape.

Introduction

It is an understatement to mention that coronavirus disease (COVID-19) has had a major impact on older adults. As of February 20, 2021, the Public Health Agency of Canada estimates that 12,194 older adults have died of COVID-19 in residential care facilities and retirement residences (Public Health Agency of Canada, 2021). Long-term care (LTC), here defined broadly to encompass the range of programs and services, including residential care (nursing homes), home care, and community care, has been marginalized in policy debates for years, despite multiple governmental reports calling for reforms. Estabrooks et al. (2020) mention over 150 reports on nursing homes in the past 10 years, which typically refer to the need to introduce substantial reforms (p. 9). Few governmental investigations have even focused on the entire continuum of care. For instance, the British Columbia Ombuds Office conducted a thorough and highly critical assessment of LTC policies in the multi-volumes, *The Best of Care* (British Columbia, Office of the Ombudsperson, 2012). The Office of the Auditor General in many provinces has also pointed out insufficient funds to achieve program objectives, different

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interpretations of ministerial guidelines within provinces, lack of comparable data, poor (or non-existent) planning, and staffing issues in both home care and residential care (Marier, 2021). Hence, in Canada, as in elsewhere, LTC requires (substantial) investment in both facilities and home services (Grabowski, 2021).

The ongoing pandemic represents a "focusing event," as it opens a rare policy window to enact meaningful reforms in the LTC sector (Béland & Marier, 2020). LTC, most notably residential care, has made its way into the forefront of governmental agendas. Some provinces, such as Ontario, are currently engaged in various forms of inquiries, and there are growing calls for a pan-Canadian response across the country. In this wake, there has been a flurry of reform proposals originating from a plethora of sources to improve LTC at both federal and provincial levels. Beyond the proposals put forth by political parties analysed in this article, interest groups and researchers have joined this policy debate by proposing multiple recommendations and even new LTC public programs. More specifically, this includes, for example, the creation of a mandatory pan-Canadian LTC insurance (Tuohy, 2021), a Quebec LTC insurance plan (Clavet, Décarie, Hébert, Michaud, & Navaux, 2021), the creation of a Canadian cash-for-care benefit (Flood, DeJean, Doetter, Quesnel-Vallée, & Schut, 2021), and targeting of the workforce crisis in residential care facilities (Estabrooks et al., 2020).

This article presents a policy analysis of the three most popular proposals to reform LTC to provide better care and services post-COVID-19 in Canada. Specifically, it aims to present an accurate portrait of the multiple obstacles to expand the access and generosity of LTC. This contribution also discusses the extent to which the three proposals provide a reform path to resolve underlying issues in LTC. Most political parties at both provincial and federal levels have openly engaged within these debates and joined forces with various coalitions of advocacy groups. Hence, as is frequently the case in public policy, the acknowledgement of a crisis and a need for policy change result in a window of opportunities for policy entrepreneurs who can navigate the political arena and gather substantial public support while proposing a feasible solution (Kingdon, 2003). In the policy literature, multiple actors within (or with access to) high-level decision makers have the potential to become policy entrepreneurs; these include politicians, senior civil servants, experts, and even an advocacy group that can connect influential actors to push for a reform agenda, but this typically requires a substantial investment of resources in terms of time, energy, money, and expertise (Frisch Aviram, Cohen, & Beeri, 2020).

The Canadian policy environment surrounding LTC is both complex and highly fragmented. For instance, provinces have developed distinctive LTC policies with minimal involvement from the federal government. Most provinces, with the exception of New Brunswick, have integrated LTC within health-based organizations, but with their own sets of rules and regulations. These differences are most notable in the field of home care, a policy area featuring at least four types of delivery models with diverse interactions between private, public, and not-for-profit actors across and within provinces (Marier, 2021). This results in a challenging environment for policy entrepreneurs regardless of the level of government. Still, a key point of departure is the widespread acknowledgement along with political engagements that LTC reform is clearly needed in the wake of the COVID-19 crisis. This is a crucial step when it comes to policy change. The broad recognition of a policy problem is key to fostering policy change, for instance, within the well-known punctuated-equilibrium theory built upon the premise that agenda setting plays an essential role in explaining policy reform (Baumgartner, Jones, & Mortensen, 2018). As a result, a wide range of policy actors, including advocacy groups, professional associations, political parties, and researchers, has actively promulgated reform ideas to improve LTC.

As public administrations in Ottawa and provincial capitals explore various policy reform options, senior civil servants occupy a unique and influential position within the policy process having to transform proposals into policy (Peters, 2019) and can even play a policy entrepreneurial role in the policy process (Roberts, 1992). Contrary to the government and, more specifically, the ministers they serve, they have tenure allowing them to develop an in-depth appreciation and expertise of public programs and policies over time. This allows them to identify quickly key barriers to secure the legislation of a program/policy reform. This research offers a viability and compatibility analysis of three popular policy proposals by focusing on the views from provincial civil servants, such as senior policy analysts and deputy ministers, from various departments and offices. Among these interviews, some feature senior civil servants whose primary functions is not to participate in the policy process, but rather to bring forth program assessments (such as the Office of the Auditor General), administrative complaints (Ombuds Office), and general concerns from Seniors (Office of the Seniors' Advocate) or Women (such as offices or agencies aiming to improve the status of women) to the legislature (or specific minister for the later in some provinces).

The findings reveal a large gap between proposals aiming to expand the responsibilities and financing from the federal government and the views held by senior civil servants in Canadian provinces. From the perspective of the provinces, enhancing the Canada Health Transfer (CHT) is the most desirable avenue to inject new funds within LTC and alternatives such as creating national standards and deprivatizing face opposition that is strengthened by the institutional structure of the federal system and policy feedbacks from LTC policy choices made within the province, but also the CHT. The depressed CHT from the federal government, which stands far from the initial 50%, has had rippled effects into other provincial social programs and has been identified as the primary source of underfinancing in LTC. It will be difficult for the federal government to assume a leadership role in the field of LTC without first addressing CHT.

This article is divided into six sections. Firstly, it introduces the theoretical framework underpinning the analysis and briefly summarizes the policy environment structuring the politics of LTC in Canada with an eye on what makes Canada unique relative to other industrialized countries. Secondly, it reviews succinctly the literature on the importance of civil servants and the role of policy feedbacks in the development and implementation of public policy. The third section introduces the method of inquiry, followed by results. The fifth section presents a comparative analysis and discussion of the three most popular reform proposals. The conclusion summarizes the findings focusing on the major difficulties faced by both the federal government and the provinces to enact LTC reform and why it will be difficult for authorities to move beyond the status quo.

Neo-Institutionalism and Long-Term Care: Institutions, Policy Feedbacks, Timing, and Problem Definitions

There is an extensive literature on the impact of institutional arrangements on the politics and, as a consequence, on the

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policy-making process (Lecours, 2005). This typically involves the analysis of how formal political institutions, such as the presence of bicameral legislature and/or federalism, affect policy output (Huber, Ragin, & Stephens, 1993). While our bicameral legislature is rarely an obstacle in the enactment of federal legislation, the division of power and responsibilities between provinces and the federal government is. Provinces have the primary responsibility for social policies, and they are also the source of most policy adaptations and developments (McArthur, 2007). This state of affairs is frequently ignored in comparative analysis and studies even though provinces can be quite distinct (Daigneault, Birch, Béland, & Bélanger, 2021). The federal involvement in the social policy sphere has typically come via lengthy negotiations with the provinces and, for the most part, has focused on income transfer programs (such as the Canada Pension Plan and Old Age Security) or cash transfers (such as the CHT) (Banting, 2005). With a high number of "veto-players" (Tsebelis, 2002), federal policy arrangements occurring within provincial jurisdictions are difficult to initiate and to alter. For instance, the Canada Pension Plan reform requires not only the support of the federal government, but also the endorsement of seven provinces representing at least 50% of the population. As a basic rule, the higher the number of veto players, the less likely movement is away from the status quo (Tsebelis, 2002).

The literature on neo-institutionalism goes well beyond formal political institutions by analysing how the enactment of new policies generates policy feedbacks (Béland, 2010). In a nutshell, this builds upon the argument that "policy creates politics" and posits that the enactment of policies results in the creation of stakeholder groups, which aim to sustain and to improve benefits with policy decisions becoming increasingly more difficult to reverse over time for social programs. This makes policy change highly path-dependent (Pierson, 2000). Policy feedback is particularly relevant at a time when states have sought to retrench the welfare state and enact austerity measures (Blyth, 2013), resulting in the deployment of blame avoidance strategies (Weaver, 1986) and the use of non-visible reform instruments, such as freezing the indexation of cash benefits (Jensen, Arndt, Lee, & Wenzelburger, 2018).

This environment is not conducive to the enactment of new social programs, which has led scholars to turn their attention to timing and the public protection gap between old (pensions, sickness, unemployment) and new social risks (such as daycare and LTC). Bonoli (2007), for instance, demonstrates that Scandinavian countries have succeeded in establishing generous day care programs because these were first introduced in the 1970s prior to efforts to curb the growth of the welfare state. A similar parallel can be drawn with LTC while analysing data on access and generosity in industrialized countries. Countries that introduced LTC reforms to bolster access and generosity in the 1990s such as South Korea, Germany, and Scandinavian countries perform significantly better than those that have failed to do so, like Canada and the United States (Organisation for Economic Co-operation and Development, 2019).

Canadian Specificities in the Politics of Long-Term Care

The Canadian public policy infrastructure reflects and contributes to the marginal status of LTC. LTC is an "extended service" in the Canada Health Act (CHA), meaning that there are no federal standards in place. As a result, provinces have developed distinctive models of LTC, for instance, resulting in various public/community organization/private/policy mixes and home care arrangements (Canadian Home Care Association, 2013; Palley, Pomey, & Forest, 2011) and even different (formal) expectations with regards to the role of family members and caregivers. Most provinces state explicitly that governmental responsibilities consist of supplementing rather than replacing the assistance provided by informal caregivers. Provinces navigate these waters differently in practice, and even within them. Although Quebec has a clear official guideline that caregiving is a choice and is not part of formal assessment, there have been multiple reports demonstrating that this does not occur in practice (Marier, 2021, p. 184).

Provincial differences in LTC policies and programs are more extensive than those found within the health interventions covered by the CHA due to the absence of harmonized criteria and conditions (or other forms of substantial coordination) at the federal level in LTC. Consequently, LTC is far more sensible to the ebbs and flows of provincial partisan politics than policy areas harmonized and/or coordinated at the federal level such as public pensions (Marier, 2021). For example, LTC was highly contested politically in Ontario in the late 1980s and early 1990s, resulting in successive reforms from Liberal, New Democratic Party (NDP), and Conservative governments (Skinner & Rosenberg, 2005; Williams, Barnsley, Leggat, Deber, & Baranek, 1999). The Conservative government under Mike Harris has embraced a policy to expand the scope and reach of private sector providers in LTC. The subsequent electoral successes of the Conservative government effectively cemented this approach across the continuum of care. As a result of policy feedback, the involvement of the private sector – and most notably large operators – is ubiquitous in Ontario in this policy area, and the Liberal Party did little to alter the policy legacy of previous Conservative governments while in power (2003-2018) (Armstrong, Armstrong, MacDonald, & Doupe, 2020). This results in a predominant role and space for private for-profit providers with 58% of the residential care homes (Ontario Long Term Care Association, 2019, p. 13). Private for-profit providers account for a large share of residential care facilities also in British Columbia (34%) and Nova Scotia (45%) (CIHI, 2020).

This stands in stark contrast with Manitoba with private for-profit personal care homes (i.e., residential care facilities) accounting for only 13% of all facilities, a figure similar to Quebec (14%) (CIHI, 2020). New Brunswick has a unique community approach with 88% of residential care homes owned by private not-for-profit organizations. As stated above, similar differences exist in home care. In a nutshell, each province has their own unique policy legacy with regards to LTC, which makes collaborative efforts at the federal level far more difficult now than when the CHA was adopted.

Still, regardless of the province, LTC continues to operate at the margins within health care systems (with the noticeable exception of New Brunswick and its Social Development Department). Strongly embedded in health organizations in nine provinces, LTC has not had the opportunity to flourish elsewhere, such as within municipalities, which is the case in the frequently cited Scandinavian countries. Consequently, LTC occupies a small portion of spending within all health budgets (13%) (Grignon & Spencer, 2018), which has facilitated the growth of diverse unregulated care providers (Afzal, Stolee, Heckman, Boscart, & Sanyal, 2018). In addition, consistent with our institutional bias in the delivery of health care, Canada distinguishes itself from other industrialized countries with a higher proportion of its LTC budget devoted to nursing homes. At 82%, this represents 20 percentage basis points above the Organisation for Economic Co-operation and Development (OECD) average. Reflective of our relatively low

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public spending on LTC, Canada ranks slightly above the average when it comes to the number of LTC beds (48.5 vs. 46.2 places per 1,000 individuals ages 65 and over) (OECD, 2019).

Prior to the pandemic, provinces, dealing with reduced federal funding and other cost pressures, had been engaged in an exercise of "bending the cost curve in health care" (Marchildon & Di Matteo, 2015). Medical services and hospital care have been better shielded by health authorities since they have the status of being essential. When health authority managers – and decision makers within the ministry of health – are faced with the choice of cutting hospital care or LTC, the latter rarely stands a chance. Many indicators and governmental reports suggest that residential care facilities faced important cutbacks in the aftermath of the 2008 economic crisis. For instance, in Québec, the number of beds per 1,000 inhabitants ages 65 and over shrunk 17% during the 2010/2011 to 2016/2017 period, which contributed to accentuate the number of individuals on waiting lists (Commissaire à la santé et au bien-être, 2017); while the number of subsidized beds in BC rose by 16.8% during the 2005-2018 period, it actually shrank by 12.1% if one uses the number of bed per inhabitants ages 65 and over (Marier, 2021, p. 146). COVID-19 exposed these flaws in a dramatic fashion.

Policy Influence of Civil Servants

Career civil servants play a key, and yet frequently understated role, in the policy-making process dating back to the construction of the welfare state (Heclo, 1974). Most notably in Canada, civil servants from the "Saskatchewan mafia," who joined the federal civil service at the end of the Tommy Douglas tenure in the 1960s, were instrumental in the development of federal standards in health care (Johnson, 2004; Tuohy, 2018, pp. 137–138). Contrary to the highly politicized Nova Scotia civil service, the impartiality and strength of the New Brunswick civil service led to the launch of the Extra-Mural Hospital program in 1981, despite the opposition from the medical profession (Cooper & Marier, 2017). In contrast, Nova Scotia became the last province to adopt a home care program in Canada (Richardson, 1990). To this day, there is an important gap between both provinces when it comes to the generosity and access to home care with New Brunswick among the leaders in Canada (Canadian Home Care Association, 2013).

Within the context of COVID-19 and the ensuing widespread political acknowledgement of a crisis in LTC, it should be noted that civil servants' influence is heightened when governmental authorities face a crisis (Dahlström, 2009). Also, with the uproar and growing mobilization of a large group of policy actors, research indicates that civil servants are well positioned to translate such social movement into concrete policy problems and solutions (Gilad, Alon-Barkat, & Weiss, 2019). As such, with federal-provincial negotiations to improve the LTC policy landscape looming, comprehending the established view of provincial public administrations goes a long way to assess the viability and potential forms of policy reforms.

Methods

There are two core components for the ensuing qualitative analysis. Firstly, with COVID-19 still ongoing across the country, conducting interviews with the highest ranked civil servants who are fully engaged with the current pandemic would have been very difficult. As an alternative, this contribution revisits interviews conducted with highly ranked civil servants in all 10 Canadian provinces as part of a recent book on the challenges of an aging society (Marier, 2021). The recruitment strategy consisted of e-mail and phone exchanges with the offices of deputy ministers in ministries and with the head of administrative agencies (or units) where population aging has been identified in the public policy literature as an important policy concern (executive council, finance, health, labour, social affairs, seniors, pensions, women's office, social services, and community affairs). These exchanges also facilitated the identification of other senior officials playing a key role in the "aging file" with provincial administrations beyond those already contacted. The civil servants interviewed include primarily deputy ministers, clerks of the privy council (or equivalent), senior policy analysts, and even some senior officials in regional health authorities. To secure a consistent treatment and analysis of the interview material, all 125 interviews occurred individually with the author and tended to last 1 hour during the years 2008-2016 featuring a set of specific questions on population aging and its consequences followed by open-ended questions on a variety of themes such as gender, older adults, and cooperation across ministries. Members of the research team transcribed the content of the interviews. With each provinces having different policy mixes, programs, administrative infrastructures, and even terminology (for instance, there are multiple names for nursing homes), the author combed through each interview to code and to classify broadly the policy content. This features, for example, an LTC-Problem note within a comment (in word) when a civil servant offered a policy problem formulation in LTC. The content of the interviews was then analysed in conjunction with policy documents (such as action plans, spending analyses, and publicly available evaluations), reports from third-party organizations (such as policy think-tanks and the OECD), and peer-reviewed contributions to identify similarities and discrepancies, to compare policy problem formulations across administrative units within each province (within the same policy area but also across policies and programs), to denote provincial differences, and to study the extent to which the interview content reflects recent evaluations performed within the civil service (such as those conducted by the Auditor General and the Ombuds Office) and policy studies in the scientific literature.

A total of 23 interviews were specifically with civil servants involved closely in health care policy, but discussions on the importance and challenge of LTC were also highly popular with a wide variety of other influential actors throughout the civil service, such as central agencies (i.e., Finance Department and Cabinet Office) and units responsible for community affairs. LTC was also frequently raised as a key gender issue in advocacy offices (such as the ones representing women and seniors) while labour market issues in this sector were stated frequently even by labour departments. Overall, 48 interviews included content on LTC. These interviews provide insight into the respective position of Canadian provinces, as they embark into discussions with the federal government to reform LTC. To ensure anonymity, steps have been taken to ensure the preservation of identity by either stating the province of origin or by naming a position specifically but within a broader set of provinces. Each interview received a randomly assigned number and these were used for attribution purposes. This project received approval from the university ethics board of the principal investigator.

Secondly, as discussed above, there have been multiple ideas and proposals put forth to reform LTC across the country. Primarily as a means to narrow down alternatives currently discussed in the political sphere, we conducted a basic media search of policy

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proposals to reform LTC in the Canadian News Stream Database to tease out the most popular reform ideas over nearly a year (April 1, 2020, to March 11, 2021). This research involved the terms "long-term care" along with either "solving" or "solutions." This resulted in 10,912 articles, which were fleshed out further by adding independently "national standards" (3,718 articles), "privatization" (464 articles), and "for-profit" (393 articles). A research assistant then searched these articles, focusing on those with more depth (i.e., more than 1,000 words), to identify the most common narratives and arguments. This involves, for instance, specifications as to what national standards consist of to identify the extent to which there is a wide divergence on this element. This media search also served as the basis to identify the LTC policy positions adopted by the major political parties – including those in government – in the provinces and at the federal level. In addition, to ensure accuracy in terms of political positions, the search extended to other media sources and the websites of political parties.

Results

Old Problems and New Solutions? National Standards, Provincial Autonomy, and Deprivatization

Three main proposals stood out in the scan of the newspaper articles: the adoption of national (federal) standards in LTC facilities, sustaining provincial autonomy in LTC by raising federal transfers in health care, and the deprivatization of LTC facilities. From the interviews with civil servants, the issue of national standards cannot be decoupled from the diminished health care transfers from the federal government. Hence, this section is divided into two sections, one discussing national standards and provincial autonomy while the second addresses the deprivatization proposals.

National Standards Versus Provincial Autonomy

The most popular solution in Canadian newsprint media is by far the adoption of national standards for LTC with close to 4,000 articles on the subject. This policy option is also the one currently pursued by the Liberal government at the federal level, as indicated in the Throne's Speech in 2020 and most recently in the mandate letter of the Health Minister Patty Hajdu. The letter states explicitly that the Minister of Health is expected to work collaboratively with the Minister of Seniors and the provinces and territories "to set new, national standards for LTC so that seniors get the best support possible" (Office of the Prime Minister, January 15, 2021). In its most basic form, the adoption of federal standards assumes a noticeable, even perhaps substantial, influx of funding from Ottawa in return for the establishment of basic standards upon which provinces must abide for in order to receive this financial assistance. In essence, it is mimicking the formula of the CHA and essentially aims to address the "extended service" status of LTC. The current federal government has also indicated that it would not advocate the deprivatization of the LTC sector. Whilst most discussions have centred on standards for residential care facilities, governmental communiqués simply mention LTC.

This federal solution to improve LTC is still in its infancy and requires a lot of clarification. What would be the nature and scope of the national standards? Do these apply to only residential care facilities, which have been under the spotlight prominently as a result of the multiple deaths throughout the pandemic and the focal point of most proposals for national standards, or do they apply to home care as well? Also, due to the lack of federal standards, each province has developed its own sets of standards and guidelines. The diversity of LTC arrangements across the country, partly illustrated by the differences with regards to private for-profit operators in residential care, represents a major hurdle to enact a pan-Canadian response. This prompts the question as to whether new federal standards would cater to the lowest denominator or actually force some, if not most, provinces to make important adjustments. The former clearly would be far below the hopes and expectations of most advocacy groups seeking a substantial departure from the status quo.

In addition, what kinds of adjustments will occur as a result of national standards? There is currently a wide diversity of ideas circulating on residential care facilities, including higher staff/resident ratios, providing better overall working conditions, more frequent site inspections, and higher minimum hours of daily care. Many of these ideas could apply to home care services. Most of these ideas have strong support among advocates, practitioners, and researchers in LTC. Still, the selection of standards would have political and practical implications for the priorities enshrined in provincial frameworks and strategies and many elements related to LTC. For political scientists and policy analysts, the selection of policy instruments has multiple consequences going well beyond intended consequences even when these are considered to be fairly minor. For instance, streamlining assessment tools can have important repercussions on the type of support provided. The standardization of the need assessment tool in New Zealand, where the InterRAI-HC was chosen to replace the previous assessment tool with regional variations, led to a shift in resources away from social support and caregivers in favor of rehabilitation services and health prevention screens (Parsons et al., 2013). Interviews with civil servants already revealed substantial issues with the deployment of one-size-fits-all provincial assessments and services. For instance, they tend to have a city bias, as they tend to understate (or simply ignore) service needs like transportation that are crucial away from urban centres.

The interviews with senior provincial servants are particularly informative when it comes to comprehending provincial responses to the federal push to create national standards. Firstly, within the context of an aging population and diminished federal transfers, how to contain health care costs and avoid a "crowding-out" effect, where health care squeezes public spending in other policy areas (Marchildon & Di Matteo, 2015, p. xvi), is omnipresent within provincial administrations (and confirmed in the civil service interviews), most markedly in Atlantic Canada and Alberta. The cutbacks in health transfers initiated by the federal government in the 1990s were stated explicitly on few occasions. In the words of a Clerk of the Executive Council, the highest ranked civil servant in a province, "Everything begins and ends with health care" (Interview 15). There are thus tremendous pressures from ministries of finance to ensure that health care costs are contained. This, in turn, puts tremendous pressures on health departments to curb their spending, and they typically prioritize curative interventions. Hence, the marginalization of LTC in health budget priorities was a recurring theme across many provinces. As a result, provincial administrations were already primed for the conclusion that augmenting federal dollars in health would result in additional resources in other policy areas, *including* LTC.

Secondly, as discussed above, the federal government has historically not been actively involved in LTC even when it comes to facilitating knowledge transfer. For instance, few senior civil servants, who worked in different ministries throughout their career, indicated that there is no institutionalized pan-Canadian venue to

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discuss LTC akin to the Federal-Provincial-Territorial (FPT) forum in health, pensions, and with seniors. A senior LTC manager in a Western province expressed this bluntly: "What we do in this unit is not part of any FPT" (Interview 69). In a small province that typically relies strongly on the input from FPT meetings, a senior civil servant succinctly stated: "Ottawa is not necessarily a huge facilitator" (Interview 14). This is in stark contrast with other policy areas where FPT forums frequently came up in interviews, which provide opportunities for collaborations and interprovincial exchanges of knowledge.

Deprivatization

Deprivatization has been strongly advocated by the NDP at the federal level and by many NDP provincial parties such as those in British Columbia, Ontario, Manitoba, and Saskatchewan. The NDP at the federal level seeks to end for-profit LTC by 2030 and inject $5 billion dollars in this sector. Currently, the BC NDP forms the government and, consequently, it is partly in a position to take meaningful steps towards deprivatization. However, there was nothing concrete in the December 2020 Throne's Speech beyond a commitment to "make the investments needed to deliver better care for seniors, and stability and safety for long term care workers" (British Columbia. Legislative Assembly, 2020, p. 6).

On the question of privatization/de-privatization, the interviews from senior civil servants across Canadian provinces are quite telling. There are in fact two manners upon which the role of the private sector has been typically discussed in the area of LTC. Firstly, it refers simply to the political agenda of (mostly) right-wing governments with its usual emphasis on markets, choices, and low public costs. As such, it is anchored within an ideological position from the government made available by the "extended service" status of LTC in the CHA. For instance, the Deputy Minister of Finance in a Western Canadian province stated that the government "is committed to create arrangement to let the private sector meet the demand for services geared towards seniors within the Canada Health Act" (Interview 18).

Secondly, it relates to the constrained budgetary situation imposed within public administrations discussed above. Simply put, civil servants are pressured to favour the development of LTC solutions that increase capacities at the lowest public cost possible while avoiding additional long-term financial commitments. Hence, many public administrations have embraced solutions that externalize LTC costs, such as favouring partnership with the private sector to enhance the number of rooms. Privatization is put forth primarily for pragmatic reasons in these cases since there are no genuine public alternatives available to those initiating policies. This explains in large part why the private sector has continued to grow even in provinces that have not been led for lengthy periods by right-wing governments committed to this objective. As expressed by a former Clerk of the Executive Council, "the growth of private LTC facilities has been amazing…the decisions of the 1990s…to remain passive has had long-term consequences for LTC" (Interview 84).

Complementary, many provinces have strongly embraced home care, by far the most popular policy solutions when discussing an aging population across provincial administrations. In the words of a senior official in LTC, "home care is the catch phrase for everything these days" (Interview 69) and expanding home care was recurrent in all 10 provinces. In a nutshell, civil servants typically mention well-known arguments, including some that are well-documented in scientific studies, such as its cost (Bakx, Wouterse, Van Doorslaer, & Wong, 2020; Chappell, Dlitt, Hollander, Miller, & McWilliam, 2004), its positive socio-health outcomes (Stabile, Laporte, & Coyte, 2006), the wishes of older adults, the declining number of family caregivers (Carmichael, Charles, & Hulme, 2010), and the societal forces to de-emphasize the institutionalization of individual living with chronic conditions and incapacities.

Discussion and Analysis

Do Reform Roads Go Through Ottawa or Provincial Capitals?

This section provides an analysis of the neo-institutionalist framework and assesses its contribution to the current LTC debate when it comes to the three leading reform proposals. The interviews from senior civil servants and the current responses from provincial governments align with theoretical expectations.

National Standards Versus Provincial Autonomy

There is a clear push/pull dynamic when considering the relationship between Ottawa and the provinces when it comes to LTC. On the one hand, the introduction of national standards represents a policy solution from the federal government that is reminiscent of earlier social policy interventions. The federal power of the purse has been instrumental to expand its power within the social realm and facilitate compromises with the provinces in the field of income security (Banting, 1987) and in the creation of the Canadian health care framework (Radin & Boase, 2000). In essence, this would imply an innovative agreement on LTC or an extension of the CHA that would incorporate LTC.

On the other hand, LTC is a provincial responsibility, and provinces have substantially improved their policy capacity over the course of the last decades (Brownsey & Howlett, 2001). As a result of the exclusion of LTC from the CHA, provinces have instituted their own policies and programs without an overarching federal framework. Hence, like multiple other social programs, provinces are clearly the leading policy actors and assume the primary programmatic responsibilities (McArthur, 2007).

With regards to formal institutions, the federal government faces the presence of many veto players. Firstly, it must ensure that it has the support of at least another federal party to secure a majority in the House of Commons since it currently does not form a majority government. Secondly, Ottawa must secure the support and approval of provincial governments to launch such a plan. Beyond the difficulties of negotiating an agreement with a large number of actors, this is far more difficult in an increasingly polarized political landscape in Canada (Cochrane, 2015). For instance, the establishment of the CHA rested on the collaboration between a pragmatic Conservative government in Toronto and a Liberal government in Ottawa. It represented a "rare period of relatively cooperative intergovernmental relations" (Tuohy, 2018, p. 128). Today, the federal government led by the Liberal Party faces much stronger opposition not only from Quebec, but also from Conservative governments in provincial capitals, such as in Toronto, Regina, Fredericton, and Winnipeg. Quebec rapidly expressed their opposition to the idea of federal LTC standards, claiming that the federal government should restore health care transfers to 35% instead without any additional conditions. Members of the *Assemblée Nationale* even adopted a unanimous motion to this effect (Richer, 2020). There is already a precedent to move ahead without Quebec, via the negotiation of an asymmetrical arrangement, as evidenced by the 2017 agreement to improve

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access to home and community care resulting in the transfer of $6 billion over 10 years (Government of Canada, 2017).

Provincial opposition goes well beyond Quebec, however. The Conservative government in Toronto has aimed to sustain the position of private operators while promising a slow and gradual improvement in standards in 2024-2025. Premier Higgs in New Brunswick recently stated that he "doesn't want to be restrained by (national) standards based on other province's needs" (CBC News, 2020). Both Premier Ford (Ontario) and Moe (Saskatchewan) have emphasized the need for additional funding to improve LTC instead of national standards (Gallant, 2020). It would also be surprising that Alberta would support such an initiative while currently engaged in an exercise aiming to re-negotiate its participation in federal programs such as the Canada Pension Plan and the Canada Health and Social Transfers (i.e., the Fair Deal Panel) (Government of Alberta, 2019). Hence, there is currently substantial provincial opposition to Ottawa's involvement in LTC.

In terms of policy feedback, provinces have enacted their own LTC programs and policies for over 50 years outside of a federal framework. As a result, each province has its own unique policy legacy and developed its own path. Interestingly, however, most provinces have opted to integrate LTC within their health systems with access frequently granted on the basis of need and resources. Still, the governance of LTC differs strongly across provinces and LTC programs (i.e., residential care, community care, and home care). This has important consequences in terms of the actors involved within the policy process. For example, senior civil servants interviewed evoked the political presence and influence of private operators in provinces where they provide an increasing portion of residential care rooms such as in Alberta, British Columbia, and Ontario.

An analysis of LTC reform cannot ignore policy feedbacks generated from the CHA. As stated by Banting and McEwan (2018), the federal government lost some of its leverage in the field of social policy in the 1990s, mostly as a result of budget compression. This has had tremendous consequences in federal health transfers, which dipped below 15% of public health expenditure, a far cry from the 35% level in the 1970s and the initial 50% (Advisory Panel on Healthcare Innovation, 2015). The analytic lens of the politics of welfare state retrenchment provides a nice illustration of the dual impact of the federal reductions in financial support, as this represents a systemic retrenchment since the cuts have undermined the foundation of the health care systems co-constructed by the federal government and provinces (Pierson, 1994). From the point of view of the federal government, the reduction of health and social transfers obfuscates who is responsible for cuts to health care programs while improving substantially federal public finances. From the perspective of the provinces, they have faced the brunt of criticism and responsibilities to sustain the public health care system under the CHA conditions while also facing serious financial challenges. This has led provinces to focus on core health programs and services (Bhatia, 2010), which do not include LTC.

The 2008 economic crisis prompted another round of austerity measures across departments in provincial capital, notably in LTC (Marier, 2021). A recent article on the public finances of provincial and federal governments emphasizes the long-term impact of a reduced CHT over time, which is a major contributor to the upcoming "large and persistent gaps between projected revenues and program expenditures" in most provinces (Tombe, 2020, p. 1104). It is within this constrained fiscal environment that provinces have put forth initiatives to tackle LTC, a new social risk (Bonoli, 2007). While political leaders have been quick to acknowledge the importance to expand LTC access and coverage, most provinces did so without securing a reliable and dedicated source of funding within provincial budgets by integrating LTC programs and services within health care departments/regional health authorities (with the noticeable exception of New Brunswick). The lack of meaningful shift towards home care, despite being a clear and quasi-universal policy priority across the country, is indicative of the difficulties to transform policy objective into concrete policy outcomes. Home care efforts represent on average 2.5% of public health expenditure, and the proportion of LTC financial resources going to home care has not shifted in the past 20 years (Grignon & Spencer, 2018)! By virtue of not being a core health program, LTC budgets have been more vulnerable to the ebbs and flows of fiscal politics than other health sectors (Marier, 2021, p. 161).

With these theoretical elements in mind, it comes as no surprise that provincial responses to the federal call to introduce national standards have consisted of mild enthusiasm and opposition. Provinces have opted to reframe the LTC crisis into a broader debate on federal financing for health care, which has been a recurring theme in FPT meetings. The Premiers have been pushing for a substantial increase in the federal share of health spending from the current 22% to 35%, which would represent $28 billion in additional transfers yearly (Delacourt, 2021).

Deprivatization

This proposal originates from many studies – in Canada and abroad – pre-dating the pandemic, indicating that the quality of care from private residential care facilities, most specifically those operated by large scale operators, has been (far) worse than public and private not-for-profit establishments (Armstrong & Armstrong & Armstrong, 2020; Harrington et al., 2017; Hsu, Berta, Coyte, & Laporte, 2016), including some governmental reports in Canada such as BC Seniors' Advocate (Office of the Seniors Advocate [BC], 2018). An Ontario study also points out that private-for-profit establishments have had higher mortality rates after a COVID-19 outbreak occurred (Stall, Jones, Brown, Rochon, & Costa, 2020).

The policy proposal from the federal NDP party differentiates it clearly from centre/right-wing parties across the country, which have promoted the expansion of the private sector and/or continue to support it. The preferred solution for the latter consists in increasing standards via regulatory tools while increasing funding (which vary across provinces). In this vein, a Danish study comparing public and private operators suggests that it is possible for governments to deploy tools and standards to ensure similar quality of care (Hjelmar, Bhatti, Petersen, Rostgaard, & Vrangbæk, 2018). A good example of this approach is the CAQ's commitment to ensure that all 20 private facilities operate under the same standards as those of the Ministry of Health and Social Services (MHSS) in Quebec, including working conditions (Lacoursière & Gagnon, 2021). With Québec having 83% of public residential care facilities (CHSLD), the private/public debate has taken a very different turn than in Ontario. There are three kinds of residential care facilities (i.e., CHSLD) – public, private with an MHSS agreement resulting in similar environment (*conventionné*), and private without any agreement (*non-conventionné*). An inquiry from *La Presse* a year into the pandemic revealed that the public and conventionné CHSLDs had very similar mortality rates of older adults (14.2% and 14.6%, respectively) while the non-conventionné's rate stands at 18.5% (Gagnon & De Lorimier, 2021). As

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a result, in Québec, the debate has focused much more on the overall quality of residential care facilities and those *non-conventionné*, as opposed to the more dichotomous private-public debate in Ontario.

The likelihood of adoption of this proposition remains unlikely for two key reasons. Firstly, there are simply too many veto players (i.e., provinces) in stark opposition to this idea. Mandating deprivatization at the federal level would most likely be considered a highly ideological and wedge issue by current Conservative governments (Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, and PEI) with some of the Premiers in these provinces already at loggerhead with Ottawa over other policy issues such as the carbon tax. It is highly unlikely that the role of the private sector is curbed under these governments; increased governmental funding combined with stricter provincial standards and regulations are more likely to occur. In a nutshell, despite the overwhelming critiques surrounding for-profit residential care, LTC continues to be framed primarily as a compliance issue where governments must compel a third party to achieve their desired outcomes.

Secondly, this proposal is a vivid illustration of policy feedback following the privatization of LTC services and its multiple consequences, which is highly path dependent (Pierson, 2000). The major obstacle with this proposal is that government must expand capacity in this sector while improving substantially the environment of existing residential care facilities (and/or build up quickly a public home care service). It is politically difficult to invest in deprivatization while at the same time argue that this is a better investment than building alongside an existing infrastructure that could be enhanced with other policy tools. The cost of policy reversal varies strongly across provinces along with the breadth and depth of previous privatization efforts. For instance, Ontario has embarked in an aggressive opening of the private sector in the 1990s across the continuum of care, which would be far more difficult to reverse than in other provinces that have been far more cautious in their engagement with the private sector.

Conclusion

Moving Beyond the Status Quo?

Despite a wealth of governmental reports and inquiries on the difficulties in LTC, governments have historically failed to make it a priority. The ongoing pandemic has finally pushed LTC to the forefront of governmental agenda. This contribution presented a succinct summary of three proposals – national standards, provincial autonomy, and de-privatization – and confronted them with both current positions from political parties and views from provincial senior civil servants obtained in a pre-COVID-19 research.

The neo-institutionalist analysis highlights the substantial barriers that a government must overcome to move beyond the status quo, even though a large majority of policy actors concur on the need to ameliorate LTC. Firstly, the Canadian political system requires that federal solutions, such as the establishment national standards, obtain the approval of another political party at the federal level (as long as there is a minority government) and the participation of the provinces. This is all the more difficult to achieve due to increased polarization in Canadian politics (Cochrane, 2015). Hence, advocates for a federal solution must compose with a high number of veto players and a polarized political landscape, which tend to be associated with negotiated outcomes near the status quo (Tsebelis, 2002). The recent disengagement of the federal government from the 1990s onward, most notably in health care, has also weakened its bargaining power with the provinces.

Secondly, provinces have the primary responsibility to enact social policies and programs and have developed unique LTC arrangements within their borders. The COVID-19 crisis, previous rapports from governmental offices, and scientific studies have all pointed in the same direction: the access and generosity of LTC ought to be improved. As alluded in this article, the autonomy of the provinces has been severely constrained by the fiscal impacts of reduced federal health transfers, which has had ripple effects in other provincial programs. Bleak long-run financial projections (Tombe, 2020) and the "extended service" status of LTC in the CHA have facilitated the rapid growth of the private sector, even among provincial governments that were not committed to a privatization agenda. Consequently, it comes as no surprise that provinces first approached LTC negotiations by requesting a substantial increase of the CHT so that the federal contribution would represent 35% of public health expenditure. In this context, it would be difficult to imagine an LTC reform path forward with the federal government without addressing the CHT.

This study did not engage with another important Canadian particularity when it comes to LTC, which has a major impact on the type of policy responses advocated: the marginal role of municipalities. LTC is firmly rooted within health departments and ministers, with New Brunswick being a notable exception. Hence, the standards, regulations, and guidelines occupying most of the public spheres tend to be those involved closely within health care, such as geriatricians. At the same time, there is increasing attention given to other LTC arrangements such as Denmark's, which features prominently in André Picard's (2021) book, *Neglected No More*. However, the success of the Scandinavian countries and their inspiring approach to LTC is in large part due to the fact that municipalities have had that responsibility for decades and operate at arms lengths from health authorities (Kraus et al., 2010). This involves primarily policy actors who operate within the realm of social interventions, such as social workers who end up occupying managerial roles in LTC in these municipalities.

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References

Advisory Panel on Healthcare Innovation. (2015). *Unleashing innovation: Excellent healthcare in Canada*. Ottawa, ON: Health Canada.

Afzal, A., Stolee, P., Heckman, G. A., Boscart, V. M., & Sanyal, C. (2018). The role of unregulated care providers in Canada – A scoping review. *International Journal of Older People Nursing*, **13**(3), e12190. https://doi.org/10.1111/opn.12190

Armstrong, P., & Armstrong, H. (Eds.). (2020). The privatization of care: The case of nursing homes. New York: Routledge.

Armstrong, P., Armstrong, H., MacDonald, M., & Doupe, M. (2020). Privatization of long-term residential care in Canada: The case of three provinces. In P. Armstrong & H. Armstrong (Eds.), The privatization of care: The case of nursing homes (pp. 87–101). New York: Routledge.

Bakx, P., Wouterse, B., Van Doorslaer, E., & Wong, A. (2020). Better off at home? Effects of nursing home eligibility on costs, hospitalizations and survival. *Journal of Health Economics*, **73**, 102354. https://doi.org/10.1016/j.jhealeco.2020.102354

Banting, K. G. (1987). *The welfare state and Canadian federalism*. Kingston, ON: McGill-Queen's University Press.

https://doi.org/10.1017/S0714980821000489 Published online by Cambridge University Press

Banting, K. G., & McEwen, N. (2018). Inequality, redistribution and decentralization in Canada and the United Kingdom. In M. Keating & G. Laforest (Eds.), Constitutional politics and the territorial question in Canada and the United Kingdom (pp. 105–133). Camden, UK: Palgrave Macmillan.

Banting, K. G. (2005). Canada: Nation-building in a federal welfare state. In F. G. Castles, S. Leibfried, & H. Obinger (Eds.), Federalism and the welfare state: New world and European experiences (pp. 89–137). Cambridge, UK: Cambridge University Press.

Baumgartner, F. R., Jones, B. D., & Mortensen, P. B. (2018). Punctuated equilibrium theory: Explaining stability and change in public policymaking. In C. Weible & P. A. Sabatier (Eds.), Theories of the policy process (4th ed.) (pp. 55–102). London: Routledge.

Béland, D. (2010). Reconsidering policy feedback: How policies affect politics. *Administration & Society*, **42**(5), 568–590.

Béland, D., & Marier, P. (2020). COVID-19 and long-term care policy for older people in Canada. *Journal of Aging & Social Policy*, **32**(4/5), 358–364. https://doi.org/10.1080/08959420.2020.1764319

Bhatia, V. (2010). Social rights, civil rights, and health reform in Canada. *Governance*, **23**(1), 37–58. https://doi.org/10.1111/j.1468-0491.2009.01466.x

Blyth, M. (2013). Austerity: The history of a dangerous idea. Oxford, UK: Oxford University Press.

Bonoli, G. (2007). Time matters: Postindustrialization, new social risks, and welfare state adaptation in advanced industrial democracies. *Comparative Political Studies*, **40**(5), 495–520. https://doi.org/10.1177/0010414005285755

British Columbia. Legislative Assembly. (2020). *Speech from the Throne, 42nd Parliament, 1st Session*. Victoria, BC.

British Columbia. Office of the Ombudsperson. (2012). The best of care: Getting it right for seniors in British Columbia (Part 2). (Public Report No. 47). Victoria, BC: Ombudsperson.

Brownsey, K., & Howlett, M. (Eds.). (2001). The provincial state in Canada: Politics in the provinces and territories (1st ed.). Peterborough, ON: Broadview Press.

Canadian Home Care Association. (2013). Portraits of home care in Canada 2013. Mississauga, ON: CHCA.

Canadian Institute of Health Information (CIHI). (2020). *Long-term care homes in Canada: How many and who owns them*. Ottawa, ON: CIHI. https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them

Carmichael, F., Charles, S., & Hulme, C. (2010). Who will care? Employment participation and willingness to supply informal care. *Journal of Health Economics*, **29**(1), 182–190. https://doi.org/10.1016/j.jhealeco.2009.11.003

CBC News. (2020, November 6). Labour group calls for N.B. cooperation on national care home standards. https://www.cbc.ca/news/canada/new-brunswick/labour-group-care-home-1.5792581

Chappell, N. L., Dlitt, B. H., Hollander, M. J., Miller, J. A., & McWilliam, C. (2004). Comparative costs of home care and residential care. *The Gerontologist*, **44**(3), 389–400. https://doi.org/10.1093/geront/44.3.389

Clavet, N.-J., Décarie, Y., Hébert, R., Michaud, P.-C., & Navaux, J. (2021). Le financement du soutien à l'autonomie des personnes âgées à la croisée des chemins. *Cahier de recherche CEDIA*, **21**(1), 1–51.

Cochrane, C. (2015). Left and right: The small world of political ideas. Montréal and Kingston, ON: McGill-Queen's Press.

Cooper, C. A., & Marier, P. (2017). Does it matter who works at the center? A comparative policy analysis of executive styles. *Journal of Comparative Policy Analysis*, **19**(1), 1–16. https://doi.org/10.1080/13876988.2015.1031543

Dahlström, C. (2009). The bureaucratic politics of the welfare state crisis: Sweden in the 1990s. *Governance*, **22**(2), 217–238.

Daigneault, P.-M., Birch, L., Béland, D., & Bélanger, S.-D. (2021). Taking subnational and regional welfare states seriously: Insights from the Quebec case. *Journal of European Social Policy, First View* 1–11. https://doi.org/10.1177/0958928721996651

Delacourt, S. (2021, March 7). Canada's Premiers want more money for health care. Will it take a federal election for them to get it? *Toronto Star*. Retrieved March 31, 2021, from https://www.thestar.com/politics/political-opinion/2021/03/07/canadas-premiers-want-more-money-for-health-care-will-it-take-a-federal-election-for-them-to-get-it.html.

Estabrooks, C. A., Straus, S., Flood, C. M., Keefe, J., Armstrong, P., Donner, G., *et al.* (2020). Restoring trust: COVID-19 and the future of long-term care. Ottawa, ON: Royal Society of Canada.

Flood, C., DeJean, D., Doetter, L. F., Quesnel-Vallée, A., & Schut, E. (2021). Assessing cash-for-care benefits to support aging at home in Canada. *IRPP Study*, **83**.

Frisch Aviram, N., Cohen, N., & Beeri, I. (2020). Wind(ow) of change: A systematic review of policy entrepreneurship characteristics and strategies. *Policy Studies Journal*, **48**(3), 612–644. https://doi.org/10.1111/psj.12339

Gagnon, K., & De Lorimier, T. (2021, March 18). Le palmarès du pire. *La Presse*. https://www.lapresse.ca/covid-19/2021-03-18/enquete-sur-les-chsld/le-palmares-du-pire.php.

Gallant, J. (2020, December 8). *Provinces on a collision course with Ottawa over national standards for long-term care. Toronto Star*. Retrieved March 20, 2021, from https://www.thestar.com/politics/federal/2020/12/08/provinces-on-a-collision-course-with-ottawa-over-national-standards-for-long-term-care.html.

Gilad, S., Alon-Barkat, S., & Weiss, C. M. (2019). Bureaucratic politics and the translation of movement agendas. *Governance*, **32**(2), 369–385. https://doi.org/10.1111/gove.12383

Government of Alberta (2019, November 9). Members, mandate for Fair Deal Panel announce. *Press release*. Retrieved March 31, 2021, from https://www.alberta.ca/release.cfm?xID=660703586B9AE-F7E2-CD86-7AB592226325179E#jumplinks-2.

Government of Canada (2017). A common statement of principle on shared priorities. Ottawa, ON: Government of Canada.

Grabowski, D. C. (2021). The future of long-term care requires investment in both facility- and home-based services. *Nature Aging*, **1**(1), 10–11. https://doi.org/10.1038/s43587-020-00018-y

Grignon, M., & Spencer, B. G. (2018). The funding of long-term care in Canada: What do we know, what should we know? *Canadian Journal on Aging/La Revue canadienne du vieillissement*, **37**(2), 110–120. https://doi.org/10.1017/S0714980818000028

Harrington, C., Jacobsen, F. F., Panos, J., Pollock, A., Sutaria, S., & Szebehely, M. (2017). Marketization in long-term care: A cross-country comparison of large for-profit nursing home chains. *Health Services Insights*, **10**, 117863291771053. https://doi.org/10.1177/1178632917710533

Heclo, H. (1974). Modern social politics in Britain and Sweden. New Haven, CT: Yale University Press.

Hjelmar, U., Bhatti, Y., Petersen, O. H., Rostgaard, T., & Vrangbæk, K. (2018). Public/private ownership and quality of care: Evidence from Danish nursing homes. *Social Science & Medicine*, **216**, 41–49. https://doi.org/10.1016/j.socscimed.2018.09.029

Hsu, A. T., Berta, W., Coyte, P. C., & Laporte, A. (2016). Staffing in Ontario's long-term care homes: Differences by profit status and chain ownership. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, **35**(2), 175–189. https://doi.org/10.1017/S0714980816000192

Huber, E., Ragin, C., & Stephens, J. D. (1993). Social democracy, christian democracy, constitutional structure, and the welfare state. *American Journal of Sociology*, **99**(3), 711–749.

Jensen, C., Arndt, C., Lee, S., & Wenzelburger, G. (2018). Policy instruments and welfare state reform. *Journal of European Social Policy*, **28**(2), 161–176.

Johnson, A. W. (2004). Dream no little dreams: A biography of the Douglas Government of Saskatchewan, 1944–1961. Toronto, ON: University of Toronto Press.

Kingdon, J. W. (2003). Agendas, alternatives, and public policies (2nd ed.). New York: Longman.

Kraus, M., Riedel, M., Mot, E., Willemé, P., Röhrling, G., & Czypionka, T. (2010). A typology of long-term care systems in Europe. Bruxelles, Belgium: ENEPRI.

Lacoursière, A., & Gagnon, K. (2021, March 16). Québec doit serrer la vis. *La Presse*. https://www.lapresse.ca/actualites/2021-03-16/chsld-prives-non-conventionnes/quebec-doit-serrer-la-vis.php.

Lecours, A. (Ed.) (2005). New Institutionalism: *T*heory and analysis. Toronto, ON: University of Toronto Press.

Marchildon, G. P., & Di Matteo, L. (2015). Introduction and overview. In G. P. Marchildon & L. Di Matteo (Eds.), Bending the cost curve in health care:

Canada's provinces in international perspective (pp. xv–xxxvii). Toronto, ON: University of Toronto Press.
Marier, P. (2021). The four lenses of population aging: Planning for the future in Canada's provinces. Toronto, ON: University of Toronto Press.
McArthur, D. (2007). Policy analysis in provincial governments in Canada: From PPBS to network management. In L. Dobuzinskis, M. Howlett, & D. Laycock (Eds.), Policy analysis in Canada: The state of the art (pp. 132–145). Toronto, ON: University of Toronto Press.
Ontario Long Term Care Association. (2019). This is long-term care 2019. Toronto, ON: Ontatio Long Term Care Association.
Office of the Prime Minister (Canada). (2021). Minister of health supplementary mandate letter. Ottawa, ON: Government of Canada.
Office of the Seniors Advocate (BC). (2018). From residential care to hospitals: An emerging pattern. Victoria, BC: Office of the Seniors Advocate.
Organisation for Economic Co-operation and Development. (2019). *Health at a glance*. Paris, France: OECD.
Palley, H. A., Pomey, M.-P., & Forest, P.-G. (2011). Examining private and public provision in Canada's provincial health care systems: Comparing Ontario and Quebec. *International Political Science Review*, **32**(1), 79–94. https://doi.org/10.1177/0192512110385291
Parsons, M., Senior, H., Mei-Hu Chen, X., Jacobs, S., Parsons, J., Sheridan, N., *et al.* (2013). Assessment without action: A randomised evaluation of the interRAI home care compared to a national assessment tool on identification of needs and service provision for older people in New Zealand. *Health and Social Care in the Community*, **21**(5), 536–544. https://doi.org/10.1111/hsc.12045
Peters, B. G. (2019). The politics of bureaucracy after 40 years. *British Journal of Politics and International Relations*, **21**(3), 468–479.
Picard, A. (2021). Neglected no more: The urgent need to improve the lives of Canada's elders in the wake of a pandemic. Toronto, ON: Random House Canada.
Pierson, P. (1994). Dismantling the welfare state? Reagan, Thatcher, and the politics of retrenchment. Cambridge, UK: Cambridge University Press.
Pierson, P. (2000). Increasing returns, path dependence, and the study of politics. *American Political Science Review*, **94**(2), 251–266.
Public Health Agency of Canada. (2021). Weekly epidemiology update (14 to 20 February 2021). Ottawa, ON: Public Health Agency of Canada,
Radin, B. A., & Boase, J. P. (2000). Federalism, political structure, and public policy in the United States and Canada. *Journal of Comparative Policy Analysis: Research and Practice*, **2**(1), 65–89.
Richardson, B. G. (1990). Overview of provincial home care programs in Canada. *Healthcare Management Forum*, 3(3), **3**–10. https://doi.org/10.1016/s0840-4704(10)61267-7
Richer, J. (2020, December 2). L'assemblée nationale rejette le projet d'Ottawa. *La Presse*. https://www.lapresse.ca/actualites/sante/2020-12-02/normes-federales-dans-les-chsld/l-assemblee-nationale-rejette-le-projet-d-ottawa.php.
Roberts, N. C. (1992). Public entrepreneurship and innovation. *Policy Studies Review*, **11**(1), 55–74. https://doi.org/10.1111/j.1541-1338.1992.tb00332.x
Skinner, M. W., & Rosenberg, M. W. (2005). Co-opting voluntarism? Exploring the implications of long-term care reform for the nonprofit sector in Ontario. *Environment and Planning C: Government and Policy*, **23**(1), 101–121. https://doi.org/10.1068/c0434
Stabile, M., Laporte, A., & Coyte, P. C. (2006). Household responses to public home care programs. *Journal of Health Economics*, **25**(4), 674–701. https://doi.org/10.1016/j.jhealeco.2005.03.009
Stall, N. M., Jones, A., Brown, K. A., Rochon, P. A., & Costa, A. P. (2020). For-profit long-term care homes and the risk of COVID-19 outbreaks and resident deaths. *Canadian Medical Association Journal*, **192**(33), E946–E955. https://doi.org/10.1503/cmaj.201197
Tombe, T. (2020). Finances of the nation: Provincial debt sustainability in Canada: Demographics, federal transfers, and COVID-19. *Canadian Tax Journal/Revue fiscale canadienne*, **68**(4), 1083–1122. https://doi.org/10.32721/ctj.2020.68.4.fon
Tsebelis, G. (2002). Veto players: How political institutions work. New York: Russell Sage Foundation.
Tuohy, C. H. (2018). Remaking policy: Scale, pace, and political strategy in health care reform. Toronto, ON: University of Toronto Press.
Tuohy, C. H. (2021). Federalism as a strength: A path toward ending the crisis in long-term care. Montreal, ON: Institute for Research on Public Policy.
Weaver, R. K. (1986). The politics of blame avoidance. *Journal of Public Policy*, **6**, 371–398.
Williams, A. P., Barnsley, J., Leggat, S., Deber, R., & Baranek, P. (1999). Long-term care goes to market: Managed competition and Ontario's reform of community-based services. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, **18**(2), 125–153. https://doi.org/10.1017/S0714980800009752