“Pursuing Different Paths in Long-Term Care: Manitoba, Ontario and the Politics of Commercialization”

A Dissertation Submitted to the Committee on Graduate Studies
in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy
in the Faculty of Arts and Science

TRENT UNIVERSITY

Peterborough, Ontario, Canada

(c) Copyright by Amy Twomey 2014

Canadian Studies Ph.D. Program

May 2014

ABSTRACT

Pursuing Different Paths in Long-Term Care: Manitoba, Ontario
and the Politics of Commercialization

Amy Twomey

Because federal funding for long-term care was not included as part of Canada's publicly-funded universal health care system, provincial governments have been free to determine how much, or how little, they will rely on the for-profit sector to meet the long-term care needs of their senior populations. The proportion of beds in the for-profit sector differs in each province, demonstrating that policy approaches to this type of care have developed according to distinct provincial political contexts. In this dissertation I explain why governments in two provinces, Manitoba and Ontario, have come to rely on the proprietary sector to markedly different degrees. While in the federation Manitoba stands out for its restrained reliance on this form of care, Ontario stands out for its exceptional dependence on commercial provision. In the chapters that follow I employ an historical institutionalist framework of analysis to explain why these neighbouring provinces initially pursued different policy paths in long-term care and how these paths have been sustained over time.

Following an introductory chapter in which I explain the reasons for the marginalization of long-term care within national health policy making, I provide in-depth analysis of these case studies in policy divergence. I argue that contemporary policy differences between these neighbouring provinces cannot be understood in isolation from long-term historical processes. Focusing largely on the period from the 1960s to the 1990s, I emphasize that present differences in ownership are a reflection of the different constellation of actors, events, ideas and institutions that came together at critical

junctures in time, and the lasting legacies that these early windows of opportunity for reform have had on subsequent rounds of long-term care policy-making. In each province, diverging ideas about the appropriate role of the for-profit sector in meeting the long-term care needs of an aging population rose to prominence on the political agenda. Over time, rigidities developed in each system, making it difficult for actors advocating for new directions in ownership to realize their ambitions.

In both provinces policies put in place at earlier times greatly influenced future political dynamics, altered the guiding principles of government departments and policy makers, provided incentives for different interest group formations, and led to contrasting public expectations about the proper balance of the for-profit and non-profit sectors in long-term care provision. I conclude this dissertation by arguing that its findings can contribute in important ways to present discussions about long-term care reform in Canada generally and about the future role of for-profit providers specifically.

Key Words: long-term care, health care, provincial politics, comparative politics, interest groups, policy development, path-dependence, historical institutionalism

Acknowledgements

I am very thankful to those who have helped make this dissertation possible. Jim Struthers has been an incredible supervisor. Never wavering in his support and enthusiasm for my work, Jim has helped me reach heights I did not know were possible. I owe much to Jim for my growth as a student, and as a person, during my tenure at the Frost Centre. I am fortunate to have had his guidance, and to call him and his wife Betsy friends.

Collectively, my committee has made this long journey worthwhile and rewarding. I am thankful to Sally Chivers for her advice and support along the way. Sally was always encouraging of my work and offered much appreciated feedback. From Carleton, Hugh Armstrong provided me with helpful comments and advice on new research directions. In was pleased to have Dimitry Anastakis serve as my internal/external examiner. Since my first days in the program I have appreciated and valued Dimitry's input. I am also grateful to my external examiner Nelson Wiseman, who first encouraged me to study comparative provincial politics while I was an undergraduate student at the University of Toronto.

I am thankful to Trent University for financially supporting my research through the Dean's Ph.D. and Research Fellowship Grants, the Shelagh Grant Endowment Fund, and the John Wadland Scholarship. Receiving a scholarship in John's name is one of my fondest memories at the Frost Centre. John, along with Julia Harrison, helped make my experience as a doctoral student enjoyable. I would also like to thank the financial support of the Reimagining Long Term Residential Care SSHRC project. The project provided me with important research opportunities and greatly contributed to my development as a scholar.

I am thankful to the support of my family and friends. My parents, John and Lenore Twomey, instilled in me from an early age the belief that I can do big things. Pursuing a Ph.D. is an emotionally trying experience, particularly during the writing process. Feelings of grandeur and great accomplishment are easily exchanged with feelings of inadequacy and impossibility. When such feelings crept in, it was always helpful to call home and be reassured that I could indeed do this, and do it well. I am also very thankful to my sister Tracey and her husband Greg for their support and love in the lead up to my defence. Whether it was reading through my dissertation, indulging me as I practice Power Point presentations, or helping me forget about school and have fun on a Saturday night, they were a great source of support.

Finally, I am so very thankful to my partner Chris Grady. Completing a dissertation that I can feel a great deal of pride and accomplishment in has taken time. Throughout the entire process Chris has been patient, compassionate and incredibly supportive. In short, he has been my biggest fan. I dedicate this dissertation to him. I also owe much thanks to Chris's parents, Joan and Paul Grady, for their support. When you have a great group of people behind you, it is indeed possible to accomplish big things.

Table of Contents

Abstract ii

Acknowledgements iv

Table of Contents vi

Chapter 1: “Making Sense of Long-Term Care Policy Divergence in Manitoba and Ontario” 1

Works Cited 23

Chapter 2: “The Marginalization of Long-Term Care in National Health Policy Making: Canada, Britain and the Path of Least Involvement” 26

Works Cited 80

Chapter 3: ‘In from the Fringe’: Entrenching Non-profit Long term care within Manitoba's Welfare State, 1969-1999” 87

Works Cited 149

Chapter 4: “‘Open for Business’: Expanding Privatization within Ontario's Long-term Care Sector, 1966 1991” 154

Works Cited 219

“Conclusion: Lessons Learned and Future Directions in Long-Term Care” 225

Works Cited 244

Chapter 1. Making Sense of Long-Term Care Policy Divergence in Manitoba and Ontario

When thinking about those aspects of our social fabric that define us as a nation, many Canadians are often inclined to point to the health care system. Indeed, as Naylor has argued, “Canada’s publicly funded health care system is more than a social program; it is a unifying force, a national obsession, and, not least, one of the few features that allows Canadians to differentiate themselves from their neighbours to the south” (Naylor, 1999, p. 24). The defining features of Canadian medicare – that care provided in hospitals and physicians’ offices should be universal, publicly administered, comprehensive, accessible and portable – are viewed by many as “a hallmark of Canadian society” (Romanow, 2002, p. 60). As more people are living longer into old age with chronic conditions and long-term disabilities, and as media and political accounts often point to a looming demographic crisis, or ‘grey tsunami’, brought on by aging baby boomers, there is an increasing tendency to view seniors as a threat to Canada’s most cherished welfare state program (Gee, 2000; MacLean and Greenwood, 2002).

Although there is a long tradition in Canada of viewing seniors as a threat to scarce health care resources, in the contemporary era the idea that “increasing numbers (or ‘hordes’) of older people will bankrupt society, due to their incessant demands on the health-care system” has particular currency (Gee, 2000, p.5). As the population ages, and as more Canadians survive longer into old age with some degree of physical or cognitive impairment, provincial governments will need to significantly expand long-term care services. When it comes to facility-based care, for example, it is estimated that by 2041, provinces will collectively need to increase their capacity from the current 200,000 beds to at least 320,000 beds (McGregor and Ronald, 2011, p. 3). Although long-term care has

always been the poor cousin in Canada's health care system in which in universal access to care in hospitals and physicians' offices is privileged, some prominent actors in today's health reform debates aim to ensure that this remains the case in the future. At the provincial level, the Ontario Liberal government's guiding policy document on long-term care reform warns that policy makers must be vigilant in exercising fiscal prudence because "our demographic challenge could bankrupt the province," thereby putting in jeopardy "our health, social, community, and other programs that have come to define us as Ontarians and Canadians, as well as the progressive society that we live in" (Sinha, 2012, p. 6). At the federal level, Prime Minister Stephen Harper has warned that, Canada's aging population is "a threat to the social programs and services that Canadians cherish" (Friesen, 2012). Those who are entering into old age, in other words, pose a significant and worrisome challenge for the nation. To meet burgeoning long-term care demands with any degree of excess would put in jeopardy the progressive welfare state programs that have become defining features of Canadian identity.

Yet, as I argue in the following pages, when we shift our gaze from the mainstream medicare institutions to long-term residential care facilities, we become aware of the fact that Canada's system of care is anything but a unifying force, a national obsession, and, certainly not something we can celebrate as a defining feature of 'Canadianness'. When such institutions are considered, images of incessantly demanding seniors making unrealistic claims on the state can be seen for what they are: utterly false. Older Canadians in need of long-term care have always existed outside of medicare's mainstream, with no guarantee that the care they require will meet any of the guiding principles that citizens in need of acute care have come to expect. Most importantly, from

the perspective of this dissertation, they have never had the benefit of a legally enshrined right to publicly-provided long-term care.

Because federal funding for long-term care was not included as part of Canada's publicly-funded universal health care system, provincial governments have been free to determine how much, or how little, they will rely on the for-profit sector to meet the long-term care needs of their senior populations. The proportion of beds in the for-profit sector differs in each province, demonstrating that policy approaches to this type of care have developed according to distinct provincial political contexts. This dissertation is concerned with explaining why governments in two provinces, Manitoba and Ontario, have come to rely on the proprietary sector to markedly different degrees. In 2009, for example, 53 percent of long-term care beds in Ontario were in the for-profit sector while proprietary beds in Manitoba accounted for just 26 percent of total bed supply (CUPE, 2009, p. 50) While Manitoba is well below the Canadian average of 35%, Ontario stands out for its exceptional reliance on for-profit provision. How can we explain the different policy approaches in these two provinces? Why have Ontario and Manitoba come to rely on commercial care to such a different extent?

These neighbouring provinces have been selected as case studies in policy divergence because they provide important insights into how, in the absence of federal conditions, long-term care has evolved according to distinct provincial political contexts. The roughly forty year time span analyzed in this dissertation emphasizes that Manitoba and Ontario have been pioneers in seniors' care, but for markedly different reasons. While conditions unique to Ontario have made it an ideal place for commercial providers to make a profit, distinctive features of the Manitoba setting have made non-profit care

the guiding principle of long-term care policy. Manitoba and Ontario are ideal selections for comparative analysis because the policy paths pursued have been so remarkably different. As an area of the welfare state long ignored by the federal government, long-term residential care offers a unique glimpse into the contrasting policy pressures in these bordering provinces.

In this dissertation I take up the research questions introduced above by employing an historical institutionalist framework in which I pay particular attention to the path-dependent nature of long-term care policy in Manitoba and Ontario. I argue that contemporary policy differences between Manitoba and Ontario cannot be understood in isolation from long-term historical processes. Focusing largely on the period from the 1960s to the 1990s, I emphasize in the following chapters that present differences in ownership are a reflection of the different constellation of actors, events, ideas and institutions that came together at critical junctures in time, and the lasting legacies that these early windows of opportunity for reform have had on subsequent rounds of long-term care policy-making. In each province, diverging ideas about the appropriate role of the for-profit sector in meeting the long-term care needs of an aging population rose to prominence on the political agenda. Over time, rigidities developed in each system, making it difficult for actors advocating for new directions in ownership to realize their ambitions. Before entering into further discussion of how this dissertation is organized and the arguments advanced in the chapters that follow, it is first necessary to pause and consider the benefits of the historical institutionalist approach for a research project such as this.

Historical Institutionalism

On the surface, the argument that "The necessary conditions for current outcomes occurred in the past" (Pierson, "Increasing Returns" 2000, p. 263) is not especially novel. After all, at some level all social scientists can agree that history matters. Where historical institutionalists tend to separate themselves in their approach to research and analysis, however, is their desire to discover "the critical juncture or triggering events, which set development along a particular path, and the mechanisms of reproduction of the current path" (Pierson, "Increasing Returns", 2000, p. 263). Present conditions are often the result of important moments in history where windows of opportunity for reform opened as a result of events, ideas, interests, actors and institutions in the broader political arena. The historical institutionalist approach is particularly useful for explaining policy differences between like jurisdictions. As Boychuk notes of the Canadian setting, "the specific historical context and particular constellation of political forces in individual provinces will strongly determine provincial reactions to uniform pressures" (Boychuk, 1998, p. 114). Similarly, Hacker argues in his investigation into why Canada, the United States and Britain developed distinct approaches to national health insurance, that an historically grounded approach allows us to "identify and explain the important turning points" in policy trajectories across similar jurisdictions and to "suggest how policy developments in each… might have turned out differently had political conditions or choices been different than they were" (Hacker, 1998, p. 77). Although health insurance advocates in all three countries advanced similar arguments in the post-war period for the adoption of a publicly funded program, the obstacles and opportunities faced by reformers differed considerably in each country.

This dissertation is firmly grounded in the historical institutionalist tradition, arguing that the contrasting provincial reactions in Manitoba and Ontario to the pressures of an aging society are reflective of distinctive historical contexts and unique constellations of political forces. The constellation of forces prominent during a period where a window, or critical juncture, opens permits for the advancement of particular ways of thinking about a policy problem. Once ideas become consolidated in key areas of the policy community, including political parties, state departments, interest groups and program recipients, "rigidities" can develop "that make it difficult for social actors to escape from established paths" (Pierson, "Increasing Returns", 2000, p. 265). Identifying the critical moments, analyzing the key forces involved, and tracing the long-term path dependent processes are central objectives of historical institutionalist analysis.

Close attention to timing is of central importance to this approach because "it is not just a matter of what happens, but when it happens" (Pierson, "Not Just What, But When", 2000, p. 84). Returning to the example of cross national differences in health insurance schemes, differences between Britain, Canada and the U.S. have much to do with timing. The timing of British (1945) and Canadian reforms (1960s to early 1970s) stalled expansions in the growth of private insurance plans in the areas of hospital and physician care. The failure of American reformers to advance change at the national level contributed greatly to the advancement and consolidation of commercial care. The chances that a universal scheme providing benefits to all Americans, not just the poor and the elderly, could be advanced at the national level greatly diminished in the late 1970s as actors and institutions espousing the benefits of private provision became more entrenched and the ideology of neoliberalism rose to prominence (Hacker, 1998, p. 128). In Tuohy's words, once an opportunity for reform arises,

> what happens is shaped by a number of factors…the partisan complexion of the dominant set of political actors; the prevailing climate of policy ideas, both broadly and within the health care arena itself; the constellation of interests in the arena; and the strategic judgements made by both proponents and opponents of change. Because all these factors are in a state of flux, what matters critically is the timing of the opening of windows of opportunity for change (Tuohy, 1999, p. 123)

Health insurance is but one example of the fact that when "rare opportunities for fundamental policy change arise" at critical junctures in time the choices that are made, and, just as importantly, those that are *not* made, have important long-term consequences (Hacker, 1998, p. 59). Paying close attention to historical process can make us more aware of the reality that "Over time, 'the road not chosen' becomes an increasingly distant, increasingly unreachable alternative" (Pierson, "Not Just What But When", 2000, p. 74-75).

The key for researchers seeking to make sense of contemporary policy differences is to identify the critical moments, dissect the key forces at play, and trace the long-term path dependent processes. Before moving into a discussion of how I utilized this approach to make sense of the differences in Manitoba and Ontario, it is first important to pause and consider what factors are most likely to facilitate a critical juncture in long-term care policy. In *Agendas, Alternatives and Public Policies*, John Kingdon offers a particularly helpful framework for understanding policy windows in long-term care. A window opens when "A problem is recognized, a solution is developed and available in the policy community, a political change makes it the right time for policy change, and potential constraints are not severe" (Kingdon, 1995, p. 165). Whether or not an issue rises to prominence on the political agenda is largely dependent upon the existence of a united and engaged "community of specialists" (Ibid, p. 116). A community of specialists consists of researchers, academics, and advocacy organizations, all who have a shared

interest in developing and advocating for solutions to a problem in a particular policy field (Ibid). While the election of a new party can certainly make the political conditions more favourable to reform, the chances for issue salience increase when there exists a community of specialists that has taken the time, often a process that requires years, to develop and agree on a set of policy proposals that are affordable, workable and in step with government ideology (Ibid, p. 144).

Kingdon argued that a key factor forestalling the elevation of long-term care reform on the American political agenda in the 1970s was the absence of such a community (Kingdon, 1995, p. 14-15). Although it was no secret that Americans were getting older, and that demand for long-term care services would only increase in the coming decades as more people survived into old age with physical and cognitive impairments, long-term care was not an issue that health specialists in the United States prioritized (Ibid). For Kingdon, the lack of interest shown by health specialists was a key contributing factor to the non-salience of long-term care on the national agenda. A lack of ambition on the part of researchers, academics, and advocacy organizations to collaborate to develop policy alternatives, greatly increases the likelihood that “the subject either fades from view or never rises in the first place” (Ibid, p. 178). Long-term care’s status as a “back burner item” in American politics was not simply a reflection of a lack of political will to prioritize seniors’ care. It was also a reflection of a broader disinterest in geriatric issues within the health policy community (Ibid, p. 138).

Transformative change is likely when key actors in the halls of government recognize a social condition as a problem; when a community of specialists that has taken the time to develop and agree on a set of policy proposals that are affordable, workable and in step with current government thinking, recognizes the opening of a window and

moves their reform ideas forward in coherent and persuasive way; and when the constraints against reform are not prohibitive (Ibid, p. 88). As we shall see in the following chapters, when these conditions are in place, transformative change need not be equated with progressive change. Indeed, Ontario and Manitoba became pioneers in the federation for their contrasting reliance on the for-profit sector because of the coming together of these factors. The actors involved, the ideals they adhered to, and institutional opportunities and constraints they faced (both real and perceived) differed in each case, however.

At its core, political will can be defined as "the extent of committed support among key decision makers for a particular policy solution to a particular problem" (Post et al., 2010, p.650). In this dissertation I am above all concerned with the degree to which key decision makers have committed themselves to supporting non-profit solutions to address the problems of an aging society. In this comparative study I draw attention to the fact that "political will is highly dependent on contexts" (Ibid, p. 656). Manitoba and Ontario are compelling comparative case studies in large part because they illustrate how differences in such things as party systems, institutions, interest groups, the economy, and political culture account for variances in political will.

Overview of Dissertation

Chapter 2 "The Marginalization of Long-Term Care in National Health Policy Making: Canada, Britain and the Path of Least Involvement"

Before entering into an in-depth analysis of the factors contributing to divergence in the provinces of Manitoba and Ontario, I begin this dissertation with a chapter devoted to the marginalization of long-term care at the national level. Chapter 2 is concerned with

the fact that while much has been written about the political history and evolution of the hallmark institutions of hospital and medical care insurance, those of us seeking to understand how and why long-term residential care was not made an integrated part of Canada's national medical care system have few resources to draw upon. Chapter 2 questions the reasons for this marginalization in Canadian post-war politics in an effort to fill this void in the nation's welfare state history, and to set the stage for the provincial analysis that follows. Rather than looking at the Canadian case in isolation, I argue that much can be gleaned by utilizing the comparative approach and considering Canada in relation to Britain. The critical junctures and triggering events that set these broadly similar nations on like paths of development are analyzed, as are the mechanisms that have served to keep seniors' care at the fringes of these welfare states over time.

Chapter 2 begins by drawing attention to the fact that for-profit companies are increasingly assuming more responsibility for residential care in both nations, but that present trends towards for-profit ownership are connected to larger historical trends in national health policy making. While the Canadian provinces and British local authorities have been responsible for care home provision in the modern welfare state, central governments in both countries have structured their respective national health care systems in a manner that gives low priority status to long-term residential care. By breaking down central government approaches to the sector into three phases, I argue that successive Canadian and British governments have shared in common a lack of political will to put the sector on a coherent national footing. Those currently making a profit in the business that has become residential care in both countries owe much to the decisions made by key actors at critical junctures since the close of the Second World War to keep long-term care out of national policy.

Starting with the period from the late 1940s until 1970, I argue that the policy making environment in Canada and Britain was 'long term care averse'. The need to develop national solutions to observable problems in residential care was ignored, or deferred, by central government actors enamoured with designing public health care systems around hospital and curative medicine. The second phase, which can be referred to as 'long term care ad hoc-ism', applies to an approximately ten year window from the early 1970s to the early 1980s. This phase is characterized by piecemeal and, it would turn out, temporary, central government involvement. In the 1980s and 1990s British and Canadian governments resumed their aversion to long-term residential care. In Britain, this was demonstrated most acutely by the Thatcher government's policies to support private-sector provision. In Canada, through the exclusion of long-term care from the 1984 Canada Health Act as well as its marginalization in cost-sharing arrangements, federal governments of the period cemented the peripheral status of this form of care in the Canadian welfare state.

My central argument in the chapter is that private companies wishing to make a profit in long-term care have benefited from successive national governments in Canada and Britain that have pursued the path of least involvement. As Hacker rightly notes, understanding contemporary trends requires that we "look at the development of health policy not as a series of discrete political struggles, but as an ongoing historical process in which past public policies and political battles shape what is possible in the future" (Hacker, 1998, p.127). National health policy in both countries has been an ongoing historical process in which political battles have been waged over public health care delivered in hospitals and doctors' offices. While central government actors have been willing to spend the political capital necessary to uphold a public-sector ethos in these

areas, they have been unwilling to do so for the long-term care sector. The seeds for a future favourable to for-profit care were sown early on.

Chapter 3 "In from the Fringe': Entrenching Non-profit Long term care within Manitoba's Welfare State, 1969-1999"

In chapters 3 and 4, the focus of analysis shifts to the provincial level in Canada. As noted above, provincial governments have been given the freedom to determine how many beds they would like to allocate to the for-profit and non-profit sectors as a result of long-term care's omission from Canada's publicly-funded universal health care system. In Chapter 3 I spotlight those aspects of the Manitoba political environment that have allowed for the non-profit principle to become the guiding one in policy development. I begin by arguing that the foundations for a formidable non-profit presence in long-term care were laid in the 1970s because of the coming together of two factors unique to the province at the time. These were the election of the province's first social democratic government in the years 1969 to 1977, and the maturation of a cohesive community of geriatric specialists dedicated to advocating for long-term care reform on a not-for-profit basis.

When the New Democratic Party (NDP) government of Ed Schreyer published the 1972 *White Paper on Health Policy*, which stated its desire to make the health care system more responsive to those whose needs had been ignored under federal cost sharing arrangements, as well as its openness to reform proposals, there was a cadre of geriatric specialists that could demonstrate, through pilot projects and research initiatives in place since the late 1950s, the benefits of prioritizing non-profit approaches to long-term care. This community of specialists were increasing in number and expertise, and recognized the window of opportunity that was opened by the election of a government interested in

better serving those whose care needs were not being adequately met. In Kingdon's terminology, there was a government that recognized a social condition as a problem in need of addressing, a community of specialists that had long-been committed to developing workable policy alternatives, and an ideological compatibility between the two.

The coming together of these factors in the 1970s facilitated the incorporation of nursing home and home care services within Manitoba's health insurance scheme in 1973 and 1974. Long-term care was brought in from the fringes to the mainstream of the welfare state. In this formative period of policy making, the idea that long-term care, like hospital and physician-based care, should be delivered in the absence of a profit-motive took root. After a thorough analysis of this formative period in Manitoba history, I then turn to consider how non-profit care has been sustained over time against an onslaught of attacks from free-market advocates.

As noted earlier, historical institutionalist thought is concerned not just with the idea that history matters, but with explaining why "particular historical junctures have lasting consequences" (Pierson, "Increasing Returns," 2000, p. 263). While the election of the Schreyer government was an opportunity for non-profit reformers to influence the direction of seniors' care in substantive ways, proprietary interests were given new voice when Progressive Conservative premiers striving to take the province in neoliberal directions were elected to office in subsequent years. Two such premiers, Sterling Lyon (1977-1981) and Gary Filmon (1988-1999), tried to dramatically increase the role of commercial interests in long-term care. While the Lyon government was committed to bolstering proprietary interests in personal care homes, the Filmon government sought to privatize home care. In neither instance were their efforts realized, a reality that brings to

light two important features of the Manitoba political environment. One is that there are limits to the extent to which Manitobans are willing to support neoliberal premiers committed to dismantling key features of the provincial welfare state. This is evidenced by the fact that Lyon is the only Manitoba premier in the modern era to be given just one term by the electorate, and that his privatization initiatives were easily reversed when his government was defeated by Howard Pawley's NDP. The second relates to the formation of a long-term care welfare state constituency in Manitoba committed to maintaining benefits previously enacted. Filmon was forced to withdraw his plans to privatize the province's home care program after public sector home care workers, along with many seniors and their families, successfully mobilized against the erosion of a non-profit program that was largely meeting its objectives.

By analyzing the confluence of key actors, ideas, interests and institutions that facilitated the opening of a window of opportunity for long-term care reform in Manitoba, as well as the "sustained period of positive feedback" (Pierson, "Increasing Returns," 2000, p. 265) that forestalled commercialization, Chapter 3 explains why Manitoba's minimal reliance on for-profit care must be understood as part of a larger historical process.

Chapter 4 "Open for Business': Expanding Privatization within Ontario's Long-term Care Sector, 1966-1991."

Following the same timeline, Chapter 4 provides a dramatically different account of the Ontario policy making environment in long term care. Taking as my starting point the 1970s, I begin by arguing that no window of opportunity opened in Ontario in which advocates of non-profit long-term care could influence the direction of public policy in any significant way. In contrast to Manitoba, the 1970s marked the continuation of the

durable post-war Progressive Conservative Party dominance of politics in the province. While non-profit reformers in Manitoba benefited from the election of a new party interested in moving the old age welfare state in new and more expansive directions, the election of the Conservatives led by Bill Davis in 1971 was of little benefit to Ontario reformers. Although Ontario's community of geriatric specialists had always had difficulty convincing post-war Conservative premiers of the need to reduce the province's reliance on for-profit care, it became particularly difficult in the 1970s as the government became increasingly concerned with limiting the scope and responsibility of the Ontario welfare state. And, unlike in Manitoba, where the advice of geriatric reformers was sought out by government officials looking to broaden the capacities of the state in the field of long-term care, in Ontario the advice of the private sector was commissioned by officials looking to limit state responsibilities across a range of policy areas.

The interplay of forces in Manitoba and Ontario at crucial junctures in time differed in significant ways. In Ontario a policy window was opened, but with highly different consequences. During the remarkable longevity of the Progressive Conservative Party (1943-1985), an organized community of for-profit long-term care providers recognized the need to expand their influence and control within a field in which the majority of parties in the legislature had little interest. Over time, the idea that for-profit providers have a legitimate role to play in seniors' care became entrenched in Ontario politics. The well-organized commercial providers benefited from the 1960s onwards from Ontario's three party system. During the Progressive Conservative dominance both the Liberals and the NDP were competitive, splitting the votes not accorded to the governing party at election time. In Ontario's three party system commercial providers benefited from a legislative environment in which two out of three parties have been

supportive of their role in long-term care provision. They have also benefited from Liberal disinterest and NDP timidity to disrupt the for-profit nursing home industry when these parties were elected to office.

A central argument advanced in Chapter 4 is that governments of all political stripes have come to see for-profit providers as entrenched members of the long-term residential care environment in Ontario, particularly during times of fiscal restraint. In contrast to Manitoba, where the maturation of a long-term care welfare state constituency in the years following the Schreyer government's reforms stands out as an important factor in halting privatization efforts, in Ontario it is the constituency of commercial providers that have organized over time to defend the profit motive and establish themselves as central actors in the Ontario.

Taken together, chapters 3 and 4 demonstrate that "policies passed at one point in time shape subsequent political dynamics. Policies may alter administrative capacities, create incentives for group formation, teach specific lessons to policy makers, or give rise to widespread public expectations or vast networks of vested interests" (Hacker, 1998, p.77). In both provinces policies put in place at earlier times structured future political dynamics, altered the guiding principles of government departments and policy makers, provided incentives for different interest group formations, and led to contrasting public expectations about the proper balance of the for-profit and non-profit sectors in long-term care provision.

Chapters 3 and 4 are also a story about the contrasting influence of women as agents of welfare state reform in Manitoba and Ontario. A common theme running throughout the Manitoba chapter is the influential role played by women in designing and implementing long-term care reform in the 1970s, and the crucial role they played in

stalling privatization in subsequent decades. Experts such as Asa MacDonell, Evelyn Shapiro, Betty Havens and Enid Thompson mobilized in various ways to make long-term care a front-burner item in Manitoba politics. Their expertise in the field of geriatrics and sustained commitment to elevating long-term care within the Manitoba welfare state were key reasons why the Schreyer government relied on them when formulating policy. In the following decades these women continued to play an influential role in discrediting those seeking to expand the role of the for-profit sector. So too did the unionized and largely female contingent of home care workers. The reality is that "In a political environment the advocates of reform need to employ strategies to overcome the scepticism of others and persuade them of the importance of reform. In other words, they must create a discourse that changes the collective understanding of the welfare state, because doing so 'shapes the path' necessary to enact reform" (Cox, 2001, p.475). As I argue in Chapter 3, women played a key role in advocating for reform and helped to change the collective understanding of the place of long-term care within Manitoba's welfare state. Commercialization has been kept at bay, in part, because of the ability of a group of women to discredit those touting the benefits of market-based care.

In Ontario, the situation was different. Women who mobilized to pressure the provincial government to prioritize long-term care and to reduce reliance on commercial provision did not enjoy influence comparable to that of their counterparts in Manitoba. The contrasting role of women brings to light important differences in the institutional opportunities and constraints faced by those who mobilized for change in the provision of long-term care in Manitoba and Ontario. As Beland explains, "Historical institutionalism is grounded in the assumption that a historically constructed set of institutional constraints and opportunities affects the behavior of political actors and interest groups involved in

the policy process" (Beland, 2005, p.20). In the chapters that follow, I emphasize that the different opportunities and constraints in this policy field were integrally related to the different party systems in these two provinces, the differing influence of private industry on policy development, and the divergent position of organized labour in long-term care. Such institutional differences go a long way towards explaining why women played a central role in setting and maintaining a non-profit long-term care policy agenda in Manitoba, and why Ontario women seeking to push the ship of state in the direction of non-profit care struggled to have their voices heard.

In Chapter 5 I conclude this dissertation by suggesting what its findings can contribute to present discussions about long-term care reform in Canada generally, and about the future role of for-profit providers specifically.

Intended Readership

My study is directed to diverse audiences. Those who are interested in the evolution of Canadian health care policy, and who have, like me, struggled to uncover a deeper understanding of why long-term care was not included as part of our national health care program, will find much of interest in the pages that follow. While those wishing to understand the 'big bang' moments of Canadian health care history and politics have much scholarly work to draw upon, those of us seeking to understand the evolution, or non-evolution, of this fundamentally important sector in the national narrative find significant gaps. I hope that my dissertation will fill some of the very real voids that exist in Canadian health care policy history generally, and long-term care specifically.

Those who are most interested in comparative politics, whether at an international or provincial level, should also find this work valuable. The comparative analysis that is

presented in Chapter 2 on the marginalization of long-term care in Canada and Britain breaks new ground and will no doubt be of relevance to those interested in comparative accounts of welfare state development. In comparative welfare state literature, long-term care is an emerging focal point of study as scholarship has increasingly turned to consider the extent to which governments have been willing or able to adapt their welfare states to accommodate “new social risks” (Bonoli, 2007; Taylor Gooby et al., 1999; Pierson, 2011; Esping-Andersen, 2009). While governments across welfare states over the last few decades have shown a reluctance to dismantle social programs previously enacted, most have also been reluctant to take on new responsibilities (Pierson, 2011; Esping-Andersen, 2009; Bonoli, 2007; Zutavern and Kohli, 2010). Socioeconomic changes since the 1970s such as the deindustrialization of employment, large-scale entry of women into the labour market, declining stability of family life and the rise in unstable employment patterns, have brought new forms of vulnerability to large segments of society (Bonoli, 2007).

One ‘new’ risk that policy makers are presented with is dependency in old age. While aging itself is certainly not a new phenomenon, there are novel aspects about contemporary gender and demographic trends that have the potential to force policy makers to rediscover the importance of long-term care. To start with, welfare states are home to larger numbers of older people. By mid-century most affluent democracies will have seen their older population double, and increases in life expectancy in the post-war period means that the number of frail seniors with complex care needs is now greater than ever (Esping-Andersen, 2009, p.147; Pavolini and Ranci, 2008). The increased demand for long-term care is thus one reason why there is a relative newness to this policy area and why dependency in old age is classified as a new risk. Additionally, while states have relied on women’s informal caregiving to accommodate aging populations, steady

increases since the 1970s in women's labour market participation has made it more difficult for both women and the state to continue this practice (Bonoli, 2007; Peng, 2001; Esping-Andersen, 2009).

Although governments have long recognized the need to protect against poverty in later life through old age pensions, protecting against the risks of infirmity and disability through comprehensive long-term care policies is something that most states have delayed doing (Osterle and Heinz, 2010; Pavolini and Ranci, 2008). With the exception of the Nordic countries, which began reforming long-term care in the 1940s with universal programs, governments in most OECD countries have been content to leave long-term care strongly within the purview of the family (Osterle and Heinz, 2010, p. 379). While residual support has come from other welfare policies, such as pensions, health care, disability plans or housing programs, "the boundaries between policy sectors and the definition of long-term care responsibilities often remained vague" (Ibid). In contrast to the welfare state 'giants' of pensions and health care, long-term care has tended to be administered by a range of government departments (Anttonen and Sipila, 1996, p. 91; Osterele and Heinz, 2010). For the most part, older people with long-term care needs and their mainly female caregivers have rarely seen their concerns occupy national policy agendas (Bonoli, 2007; Pavolini and Ranci, 2008). Indeed, long-term care in most countries has never been part of the mainstream of the welfare state, instead being left in the hands of families, subnational governments, private and voluntary organizations (Costa-Font, 2010).

Since the 1990s, however, a handful of countries have undertaken reforms to incorporate this historically private and marginalized sector into the mainstream welfare state. Governments in Japan, Germany, France and Spain have each, as a result of a

confluence of pressures unique to their jurisdictions, developed distinctive national long-term care insurance programs. Because long-term care is a relatively new field of comparative welfare state study, identifying factors that contribute to the creation of new national programs can help us to gain a better understanding of the conditions that are likely to contribute to social policy expansion in this sector (Osterle and Heinz, 2010). Just as important, comparative studies of countries such as Canada and Britain can help us gain a better understanding of the conditions that forestall the expansion of new national programs and benefits.

Chapters 3 and 4 contribute to the important, but understudied, field of comparative provincial politics. Because it has been allowed to develop outside of the medicare mainstream and according to provincial variation, long-term care is an important site of scholarship for anyone interested in understanding key differences in provincial politics. As Prentice has argued in relation to child care, another policy area subject to provincial variation, distinct provincial responses to particular policy fields can provide a "lens" through which we can consider "the shape and content of welfare state restructuring" (Prentice, 2004, p. 195). "[V]ariation points to the significance of close study of similarities and differences in policy design and political arrangements, including the role of social actors" (Ibid, p. 194). In considering the reasons for, and implications of, the varied responses to long-term care provision in Manitoba and Ontario, this dissertation provides a lens through which we can closely examine the similarities and differences in political arrangements and the markedly different ways that governments have responded to the shared pressures of an aging society.

Above all, this study spotlights a sector that for too long has received insufficient attention, not just in the minds of academics and politicians, but in our everyday thoughts.

As Armstrong et al. rightly emphasize, “most of our efforts as a nation and much of that as individuals are focused on keeping ourselves and others out of long-term care facilities rather than on the work and the care within them. It is time to change the options” (Armstrong et al., 2009, p. 12). It is hoped that the following pages prompt us to think more closely about the position of long-term care facilities in our national and provincial narratives.

Works Cited

Anttonen, A., Sipila, J. European social care services: Is it possible to identify models? *Journal of European Social Policy*, 1996; 6.87: 87-100.

Armstrong, Pat et al. *They Deserve Better: The Long-Term Care Experience in Canada and Scandinavia*. Ottawa: Canadian Centre for Policy Alternatives. 2009.

Beland, Daniel. Ideas and social policy: An institutionalist perspective. *Social Policy and Administration*. 2005; 39.1, 1-18.

Bonoli G. Time matters: Postindustrialization, new social risks, and welfare state adaptation in advanced industrial democracies. *Comparative Political Studies*, 2007; 40.5, 495-520

Boychuk, Gerard. *Patchworks of Purpose: The Development of Provincial Social Assistance Regimes in Canada*. Montreal: McGill-Queen's University Press, 1998.

Canadian Union of Public Employees. Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care. Ottawa: Canadian Union of Public Employees. 2009 Retrieved from: http://cupe.ca/updir/CUPE-long-term-care-seniors-care-vision.pdf October 12, 2011

Costa-Font, J. Design limitations of long-term care insurance schemes: A comparative study of the situation in Spain. *International Social Security Review*. 2006; 59.4

Cox, R. H., The social construction of an imperative: why welfare reform happened in Denmark and the Netherlands but not in Germany. *World Politics*. 2001; 53.

Esping-Andersen. Gosta. *The Incomplete Revolution: Adapting to Women's New Roles*. Cambridge: Polity, 2009

Friesen J., Burry B. "Prime Minister Harper unveils grand plan to reshape Canada." *The Globe and Mail*. 2012 January 26. Available from http://www.theglobeandmail.com/news/politics/prime-minister-harper-unveils-grand-plan-to-reshape-canada/article542480/

Gee E.M. "Voodoo Demography, Population Aging, and Canadian Social Policy. In: Gee E.M., Gutman G.M., editors. *The overselling of population aging: Apocalyptic demography, intergenerational challenge, and social policy*. Don Mills: Oxford University Press, 2000. p. 5-25.

Hacker, Jacob S. "The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy." *Studies in American Political Development*. 12, 1998, 57-130.

Kingdon, John. *Agendas, Alternatives and Public Policies*. New York: Harper Collins College Publishers. 1995

Maclean, Michael J. and Jennifer Greenwood Klein. “Accessibility to Long-Term Care: The Myth versus the Reality.” *Continuing the Care: The Issues and Challenges for Long-Term Care*. Ed. Eleanor Sawyer. Ottawa: CHA Press, 2002. 67-87.

McGregor, Margaret J. and Lisa A. Ronald. Residential Long-Term Care for Canadian Seniors: Non-profit, For-Profit or Does it Matter? IIRP. 14(January 2011). Retrieved from: http://www.irpp.org/pubs/irppstudy/2011/irpp_study_no1.pdf

Naylor, David. “Health Care in Canada: Incrementalism Under Fiscal Duress.” *Health Affairs* 18.3 (1999): 9-26.

Österle A, Heinz R. Long Term Care. In Castles F.G. et al., editors. *The Oxford handbook of the Welfare State*. Oxford: Oxford University Press; 2010.

Pavoloni, E, Ranci, C. Restructuring The Welfare State: Reforms in Long-Term Care in Western European Countries. *Journal of European Social Policy*, 2008, 18.3: 246-259.

Peng E. Women in the middle: Welfare state expansion and devolution in Japan. *Social Politics*, 2001, Summer, 191-196

Pierson Paul. The Welfare State over the very long run. *ZeS- Arbeitspapier*, 2011; 2. Available from http://hdl.handle.net/10419/46215

Pierson, Paul. “Increasing Returns, Path Dependence and the Study of Politics.” *The American Political Science Review*. 94, 2000 251-267

Pierson, Paul. “Not Just What, but *When*: Timing and Sequence in Political Processes.” *Studies in American Political Development*. 14, 2000 , 72-92.

Post, Lori Ann, Amber N.W. Raile and Eric D. Raile. “Defining Political Will. *Politics and Policy*.” 38.4, 2010

Prentice, Susan. “Manitoba’s Child Care Regime: Social Liberalism in Flux.” *Canadian Journal of Sociology*. 29, 2004.

Romanow, Roy. *Building on Values: The Future of Health Care in Canada. Final Report. Commission on the Future of Health Care in Canada*. Saskatoon: Gibson Library Connections, 2002.

Sinha, Samir. *Living Longer, Living Well: Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to Inform a Seniors Strategy for Ontario*. 2012

Taylor-Gooby, P, Dean, H., Munro, M. Parker, P. "Risk and the welfare state." *British Journal of Sociology*, 1999, 50.2, 177-194.

Tuohy, Carolyn J. *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada*. New York: Oxford University Press, 1999

Zutavern, J. Kohli M. "Needs and Risks in the Welfare State." In Castles F.G. et al., editors. *The Oxford Handbook of the Welfare State*. Oxford: Oxford University Press, 2010

Chapter 2. The Marginalization of Long-Term Care in National Health Policy Making: Canada, Britain and the Path of Least Involvement

Those wishing to understand the politics behind the 'big bang' moments of Canadian health care have the benefit of drawing on a number of substantive works. Canadian historians and political scientists have spent a good deal of time analyzing the events and actors that led to the policy milestones of hospital insurance (1957), medical care insurance (1968) and the Canada Health Act (1984). Medical historian David Naylor's *Private Practice, Public Payment* (1986), for example, provides readers with information on the role of medical interest groups in health and medical insurance debates. Malcolm G. Taylor's (1987) *Health Insurance and Canadian Public Policy*, charts the political debates within federal and provincial governments in the lead up to medicare, a work that was informed by his experiences as a public health-care administrator and consultant. Public policy scholar Gregory P. Marchildon's (2012) edited collection *Making Medicare* adds to adds to our understanding of the political foundations of hospital and medical care insurance by considering a range of factors influencing the federal government to adopt the Saskatchewan model of medicare. Others, including Gwendolyn Grey (1991) Antonia Maioni (1998), Carolyn Tuohy (1999), and Gerard Boychuk (2008) have taken a comparative approach by analyzing the continuities and discontinuities of the Canadian health care system with that of the United States. The Canada Health Act, “a hallmark of Canadian society” (Romanow, 2002, p. 60), has received focus in these and other studies.

While the existing body of literature provides a foundation from which to grasp the political history of the Canadian health care system from a number of different angles, those of us seeking to understand how and why residential long-term care was negotiated

out of the national health care system have fewer resources to draw upon. While James Struthers (1997, 1998, 2003) has aided our understanding of the contentious political history of long-term care in the province of Ontario, and Megan Davies (2004) in British Columbia, less attention has been paid to the key actors and events that served to push facility-based care to the periphery of the nation's health care system. While scholars such as Pat Armstrong and Hugh Armstrong (for two examples see 2008, 2009), Margaret McGregor and Lisa Ronald (2011), and public interest research groups and organizations such the Canadian Centre for Policy Alternatives (2009), the Canadian Health Care Association (2009) and the Canadian Union of Public Employees (2009), have argued that a main consequence of this peripheral status has been corporatization of the sector, the need remains for an account of how and why we got the system we did.

Rather than looking at the Canadian case in isolation, I argue that much can be gleaned by considering it in relation to Britain. Given their similar cultural backgrounds, especially economies and political institutions, as well as similar battles over national health insurance schemes, the two countries are fitting points of comparison (Hacker: 1998, p. 60). They are also fitting given that for-profit companies are increasingly assuming more responsibility for residential care in both nations. In the Canadian province of British Columbia, for example, an increase of more than 20 percent has occurred in the number of for-profit beds since 2000, while the number of publicly funded non-profit beds has fallen by 11 percent (McGregor and Ronald: 2011, p.4). In Alberta, a 6 percent increase in for-profit beds occurred between 2000 and 2001, while approximately two-thirds of Ontario's new residential care beds since 2008 have gone to the for-profit sector (Ibid). In Britain, a similar increase in for-profit care has been occurring in local authorities. While in 1980, 45.8 per cent of residential care homes were

owned by local authorities and just 34.7 percent by private for-profit providers, by 1995 local authorities owned just 17 percent and the for-profit sector 67.8 per cent (Johnson et al., 2012, p.84). By 2000, the number of beds for elder care allocated to the for-profit sector increased to 193,000, up from 23,000 in 1983. The private sector now accounts for two-thirds of care beds, and the number of beds in the control of large American multinational companies has also increased (Kerrison and Pollock, 2001, p. 599).

In this chapter I argue that present trends towards for-profit ownership of residential care must be considered in relation to larger historical trends in national health policy making. While the Canadian provinces and British local authorities have been responsible for care home provision in the modern welfare state, central governments in both countries have structured their respective national health care systems in a manner that gives low priority status to residential care. By breaking down central government approaches to the sector into three phases, this chapter asserts that successive Canadian and British governments have shared in common a lack of political will to put the sector on a coherent national footing. Those currently making a profit in the business that has become residential care in both countries owe much to the decisions made by key actors at critical junctures since the close of the Second World War to keep long-term care out of national policy.

The following begins with an analysis of the period from the late 1940s until 1970. In Canada and Britain that era offered a policy making environment that was 'long term care averse'. The need to develop national solutions to observable problems in residential care was ignored, or deferred, by central government actors enamoured with designing public health care systems around hospital and curative medicine. While hospitals, especially acute care hospitals, and physicians' offices became privileged sites

of state involvement, long-term care facilities were largely ignored. The second phase, which can be referred to as 'long term care ad hoc-ism', applies to an approximately ten-year window from the early 1970s to the early 1980s. This phase is characterized by piecemeal and, it would turn out, temporary, central government involvement. For reasons both unique and shared, national governments in both countries rethought their lack of involvement in the sector, but only to a minor extent by providing some funding for the building of new homes. In the 1980s and 1990s British and Canadian governments resumed their aversion to long-term residential care. In Britain, this resumption was demonstrated most markedly by the Thatcher government's policies to support private-sector provision. In Canada, through the exclusion of long-term care from the 1984 Canada Health Act as well as its marginalization in cost-sharing arrangements, federal governments of the period cemented the peripheral status of this form of care in the Canadian welfare state.

It can be little wonder that private companies wishing to make a profit in the health care arena have over time looked to the long-term care sectors in Canada and Britain. As Jacob Hacker rightly notes, understanding contemporary trends requires that we "look at the development of health policy not as a series of discrete political struggles, but as an ongoing historical process in which past public policies and political battles shape what is possible in the future" (Hacker: 1998, p.127). National health policy in both countries has been an ongoing historical process in which political battles have been waged over public health care delivered in hospitals and doctors' offices. While central government actors have been willing to spend the political capital necessary to uphold a public-sector ethos in these areas, they have been unwilling to do so for the long-term

care sector. As this chapter now turns to explain, the seeds for a future favourable to for-profit care were sown early on.

1945-1970 Long Term Care Aversion in Britain and Canada

Considering the fact that a half century ago the British Labour government expressed its ambition to establish a "cradle to the grave" infrastructure of social policy, social policy commentators today find themselves asking "what went wrong?" when it comes to long-term care (Peace et al., 1997, p.9). Older people have not benefited from the British welfare state in the manner in which central government actors at the close of the 1940s claimed that they would. Health Minister Aneurin Bevan, for example, stated in 1947 that it was the intention of his Labour government to transform residential care by shutting down the workhouses held over from the Poor Law era and replace them with smaller, specially designed homes for the aging population (Johnson et al., 2012, p.24). Two years later, the Ministry of Health Report stressed that workhouses were being phased out of existence as local authorities were busily planning and opening smaller homes where older people could live comfortably in the absence of loneliness and with dignity (Means and Smith, 1998, p.155). One Public Assistance Officer predicted,

The old institutions or workhouses are to go altogether. In their place will be attractive hostels or hotels, each accommodating 25 to 30 old people, who will live there as guests, not inmates. Each guest will pay for his accommodation – those with private income out of that, those without private income out of the payments they get from the National Assistance Board – and nobody need know whether they have private means or not. Thus, the stigma of 'relief' – very real too, and acutely felt by many old people – will vanish at last (Ibid, p.155).

Such pronouncements on the part of local and central government actors seemed to indicate that extensive and progressive change was underway, and that long-term care would be a priority in the modern welfare state. Seniors requiring such care would no

longer be forced into large, ill-equipped and oppressive workhouses. Rather, they would enjoy unprecedented comfort and care in newly built facilities designed with their specific needs in mind. Just as hospital care would be transformed under the new NHS, so too would the care of seniors. The 1948 National Assistance Act stated that local authorities had the duty "to provide residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them" (Wanless, 2006, p.11). Thus, they would be responsible for residential care while hospital authorities were to care for those who were "sick." And, although few in number at the time, residential homes run by the private sector were required after 1948 to register with local authorities (Andrews and Phillips, 2000, p.207). When the National Assistance Act was passed government rhetoric depicted the dawn of a new era in residential care.

Yet, as Peter Townsend argued in his investigation into residential care in England and Wales, *The Last Refuge*, almost a decade after the 1948 legislation, former workhouses continued to play a significant role in the provision of long-term care. Although the workhouse was to be replaced under the National Assistance Act, Townsend discovered remarkable continuities in terms of the care provided and attitudes among staff and residents. In one visit to a residential care facility, he noted that the large Victorian buildings at the facility housed hundreds of residents in large and crowded rooms (Townsend, 1962, p.4). Between ten and twenty beds were squeezed into dormitories lacking floor coverings and anything more than the most basic and rudimentary furniture (Ibid). The day rooms were "bleak and uninviting. In one of them sat forty men in high-backed Windsor chairs, staring straight ahead or down at the floor" (Ibid). The Spartan living conditions combined with the minimal improvements in

staffing led Townsend to conclude that this group of older people were still waiting for the welfare state to arrive. Even the staff and the warden "seemed to be uncertain what the post-war legislation had achieved" (Ibid, p.6). Although grand public statements were made by politicians about a new paradigm in long term care, "here was one institution for several hundred people where change was barely perceptible" (Ibid, p.7).

Although in some local authorities, where volunteers were numerous and pressure groups active, innovations did take place, the reality was that most were uninterested in transforming residential care (Webster, 1994). Townsend found that of seniors admitted to residential care facilities in England and Wales in 1958, 47 per cent were sent to former public assistance institutions (Townsend, 1962, p.12). This compared with 28 per cent for local authority homes, and 25 per cent for private and voluntary institutions (Ibid). While the number of beds in those facilities had decreased to 35,000 by 1960 (down from a total of somewhere between 39,000 and institutions (Townsen, 1962, p.12). This compared with 28 per cent for local authority homes, and 25 per cent for private and voluntary institutions (Ibid). Thus, older people were still entering the former workhouses in significant numbers. While the number of beds in those facilities had decreased to 35,000 by 1960 (down from a total of somewhere between 39,000 and 40,000), this still represented 51 per cent of local authority accommodation (Ibid, p. 415). In other words, despite the fact that the National Assistance Act had been in existence for a decade, over half of the residential care beds were in facilities that were to have no place in post-war Britain. By 1960 the majority of county councils and boroughs still used former workhouses, and most chief welfare officers interviewed for *The Last Refuge* believed that the old accommodations would remain in use for years to come (Ibid). Although

some local authorities had ceased to use such facilities, others housed 10 per cent, 20 per cent and some as high as 75 per cent of their residents in them (Ibid, p.417).

In post-war Britain, a number of factors combined to create a situation in which the long-term care of older people was a policy issue with little political significance in central government thinking. These include an austere economic climate, the diversion of substantial economic and political resources to military ambitions, and, most importantly, a desire to limit the demands of older people on the ‘Beveridge’ welfare state. While the first two factors reflect a general climate of postwar restraint in which fiscal prudence often trumped social policy innovation, the third factor highlights a particular aversion to spending on old age and on the creation of elder care policies. The bulk of the following discussion focuses most intently on this factor.

The post-war period in Britain was one of economic decline, and party politics of the period was consumed with fiscal prudence. Like other parts of the world, Britain was experiencing the pressures of transitioning from a war time to a peace time economy and restrictions on expenditure were enacted across a number of departments (Means and Smith, 1998, p.166). Compared to economic growth in countries such as Japan, Germany and Finland, British economic growth, at an average annual rate of two percent, was “markedly lower” (Baldock, 2003, p.110). Consistent balance of payment issues and challenges to the value of the pound placed Britain in a precarious financial situation. Sterling crises occurred with regularity, such as those in 1947, 1956, 1967, resulting in “‘stop-go’ fiscal policies and abrupt and unplanned reductions in public and particularly social expenditures” (Ibid).

Low economic growth was occurring in conjunction with a desire to occupy ‘big power’ status on the world stage, which required the expenditure of considerable

economic and political resources (Baldock, 2003, 111). A significant portion of funding went to the military in order to retain a position as a nuclear power with significant influence, particularly during the cold war period, but also for the Korean War, for maintaining troops in Germany and other countries around the world, and in other international conflicts such as Suez, and the Arabian Gulf (Ibid). The slow retreat of the former British empire was also a factor that diverted economic and political resources away from social policy issues in the post-war period. In a climate dominated by austerity and the diversion of economic and political focus to 'big power' issues, commitments to expansions in existing social programs, as well as the introduction of new ones, were seldom made once the 'Beveridge welfare state' legislation was passed between 1944 and 1948 (Ibid, p.110). As Baldock argues,

> The cross-party acceptance of the Beveridge welfare state has been described as the 'post-war settlement', and in a fundamental sense it was understood by many in the political and administrative classes as quite literally that; arrangements that were settled and done after which the political elite returned to their former and rather grandiose preoccupations (Ibid, p.111).

The National Health Service (NHS) itself was considered "a profligate experiment" by the Treasury and limiting its growth was a priority at least until 1960 (Webster, 1994, p.146).

While austerity as a guiding principle acted as a bulwark against state investment across policy areas, older adults were particularly impacted. At first blush this statement may seem out of place given that state pensions were extended after the war, the NHS was established, and local authority duties in the provision of institutional and domiciliary services were outlined when the 1948 National Assistance Act replaced the poor law. Yet, as Baldock argues, "in all three areas the needs of older people were not the paramount object of the reforms. The consequences for older people were mainly the result of

hurried and hidden decisions, made by ministers or civil servants beyond public scrutiny" (Baldock, 2003, p.125). In fact, after universal retirement pensions were introduced in the 1946 National Insurance Act, the payments were used by the Treasury as justification for inattention to seniors' care. Because it believed that older people already benefited from an over-generous pension system, overextending scarce resources to design age-specific health care policies was wasteful in Treasury thinking (Webster, 1994, p.146).

Welfare state reforms were undertaken in a post-war environment in which frail seniors were viewed in a negative light (Baldock, 2003, p.126). At the close of World War 2 it was argued that investment ought to be directed towards those segments of society that could most contribute to a productive Britain. As Johnson et al. emphasize, the focus after the war was very much on "rejuvenating the population" and "building a new nation around the potential of young people" (Johnson et al., 2012, p.11). While expenditures on youth could be seen as a "hopeful investment," spending on the elderly was seen by many as wasteful (Means and Smith, 1998, p. 212). Spending ought to be limited to "the economically active of the present and the future" (Ibid, p.166). This was a philosophy expressed by influential social policy commentators and publications of the period. As Beveridge himself argued, "It is dangerous to be in any way lavish to old age until adequate provision has been made for all other vital needs, such as the prevention of disease and the adequate nutrition of the young" (cited in Johnson et al., 2012, p.11). This sentiment was echoed by the Royal Commission on Population (1949), which asserted that "the old consume without producing which differentiates them from the active population and makes of them a factor reducing the average standard of living in the community" (Means and Smith, 1998, p.212). Even the Nuffield Survey (1947), which exposed the dismal conditions faced by older people in institutional settings and the

community, repeatedly warned that the state should not overextend itself investing in the old at the expense of younger people and the working population (Ibid, p.211-212).

As Townsend found when researching residential care for *The Last Refuge*, no royal commission or government committee had thoroughly researched the subject and the information that was contained in government reports "was extraordinarily scanty and inept" (Townsend, 1962, p.7). Minor references to the care of seniors could be found in the Guillebaud (1955) and Phillips (1957) reports, but overall there was little indication the nation's political parties considered this policy area to be a priority (Ibid, p.394). In his words, "No serious attempt has been made by the Labour or Conservative Governments since the war to collect the necessary information or to review developments in policy," demonstrating that neither party was much interested in issues of long-term care (Ibid).

It was in this atmosphere that Health Minister Bevan, in close consultation with organized medicine, developed legislation to reform the British health care system. Bevan's primary goal was to establish a nationally administered and organized system of health care and he "was prepared to make concessions to the medical profession" in order to achieve this objective (Stewart, 2002, p.122). As Stewart points out, "Bevan often dealt directly with the doctors' leaders without reference to Parliament, the Labour Party, or even his own civil servants" (Stewart, 2002, p.124). The British Medical Association (BMA) was given a privileged role in health policy making in large part because of their claim to "medical expertise" (Ibid, p.123). Labour politicians were willing to make concessions to doctors in policy planning that they would not otherwise make to other professional groups, such as nurses (Ibid).

Bevan's close relationship with the medical profession is important to the story of long-term care because the preferences of the medical community influenced the type of health care that would be prioritized in the modern welfare state. In the medical community at that time geriatrics was a specialty with little influence. A general preference of the BMA was for "a situation wherein hospitals and hospital medicine came to dominate health service strategy" (Stewart, 2008, p.463). Hospital doctors looked pessimistically at older patients, hoping instead to prioritize and preserve a modernized hospital system for patients with acute care needs (Webster, 1994; Stewart, 2002,2008; Bridgen, 1991, Baldock, 2003). Most general practitioners had little desire to specialize in geriatrics and many were seeking part-time hospital positions, particularly in obstetrics (Webster, 1994, p.142). This tendency reflected the fact that in Britain "the late 1940s and early 1950s were quietly but significantly ageist and pro-natalist" (Baldock, 2003, 128). Bridgen notes that "the neglect and low professional status of geriatrics inhibited the development of a modern geriatric service" (Bridgen, 1991, p.512). While it is true that Britain was home to innovative geriatric thinkers such as Lionel Cosin and Marjory Warren, the reality was that geriatric medicine was not considered the stuff on which medical careers were made. Even as late as 1974 the general practitioner was criticized for the "poor service for pensioners on his list" and also for his tendency to "pessimistically perpetuate adverse assumptions about the inevitability and irreversibility of the problems of old age" (Webster, 1994, p.151).

Some of this pessimism reflected the lingering effects of the treatment of older people during the war. When the British government took control of many of the country's hospitals at that time in the expectation of extensive casualties, thousands of frail older people were quickly discharged to unprepared families, to poor houses and to

the few hospitals that were not part of the government's wartime plans (Baldock, 2003, p.126). As the war came to a close, public assistance hospitals and local authority residential homes were overcrowded with thousands of vulnerable seniors who had nowhere else to go (Ibid). The concern among Ministry of Health officials and medical professionals negotiating and planning for the new NHS was that older people would 'block' beds and absorb resources better reserved for acute care functions (Ibid).

These assumptions about aging guided government negotiations over the financing of local authority care and it was decided that this care would be almost completely of the institutional variety. Supporting seniors to remain in their own homes was something that could be left in the hands of families, neighbours and volunteer organizations (Baldock, 2003, p.129). The NHS was divided into a tripartite system comprised of hospitals (run by consultants committed to the practice of acute care), family practitioners, and the local authorities. While Bevan showed "hostility to any idea of local authorities being principally responsible for the running of the new service" he was willing to give local authorities, a sector with low status, the control over "non-curative aspects of the service" (Stewart, 2008, p.463). The decision to relegate long-term care to local authorities was significant. As Baldock observes, "This was the point at which care services for older people became cut off from the mainstream of the post-war welfare settlement and relegated to the relatively underfunded and lower status, local government backwater" (Baldock, 2003, p.126). London would be responsible for running a national health service for Britain that would attain a level of prestige and public support which would protect it relatively well from future retrenchment pressures, but long term care services were pushed to the periphery (Baldock, 2003, p.127). A "fundamental divide" between the NHS and residential care was created, with the former

funded on a universal basis and the latter subject to means-testing (Peace et al., 1997, p.111).

The snail's pace at which improvements to residential facilities took place, of course, was connected to the spending restraints discussed earlier. The shortage of both materials and labour "drastically affected plans to build new residential homes for elderly people" (Means and Smith, 1998, p.166). As Townsend made clear in his research, the central government was not releasing the funding necessary for local authorities to make innovations (Townsend, 1962, p.415). And, while a lack of central government funding meant that local authorities keen to pursue innovative reforms to residential care were hindered from doing so, it also afforded those with little desire to change existing practices an excuse to do so (Ibid). Yet, when at the close of the 1950s government purse strings were loosened as restrictions on capital investments in health and welfare projects were relaxed, long-term care remained low on the list of government priorities (Means and Smith, 1998, p.167). Evidence of this can be seen in the fact that although 1045 homes were opened between 1948 and 1959, just 60 were purpose-built (Johnson et al., 2012, p.24). Older people continued to be housed in former workhouses and in converted buildings purchased by the central government after the war (Means and Smith, 189). A number of homes converted initially were isolated and not constructed in ways conducive to comfortable living (Means and Smith, 189). Stairways were difficult to ascend, shortages of single rooms existed and toilets were poorly distributed (Means and Smith, 1998, p.189). Like the former workhouse, "Physical standards…in many converted properties left much to be desired" (Ibid). The building of new, purpose-built homes, to replace these facilities was slow to take place between 1948 and 1962 as local authorities and the Ministry of Health were reluctant to direct resources to this end (Ibid).

While the private sector did step in and construct some homes, there were problems with these as well. Although Townsend found that about a third of homes run for private gain met many of the resident's needs, the reality was that "in many homes the disadvantages greatly outweigh the advantages" (Townsend, 1962, p.425-426). These disadvantages included short-staffing, overcrowding and a general lack of amenities (Ibid, p.426). Additionally, anyone could open a private home regardless of their qualifications (Townsend, 1962, p. 426). Highly troubling for Townsend was the inevitable conflict between care and profit. As he argued, "A woman managing a private Home has to combine both functions – that of 'matron' and that of 'proprietress'" and thus "It is hard to conceive that such a conflict of roles can be in the best interests of the infirm residents requiring care" (Ibid, p.427). As discussed in more detail later in this chapter, private ownership did not truly escalate in Britain until the 1980s. While Townsend could certainly point to the problems of for-profit ownership at the time of his writing, private industry played only a minor role then. For now, it is important to recognize that in pushing the sector to the periphery of the nation's health care system and from the outset affording it low-priority status, government officials ensured that later on the sector would become a low risk target for cutbacks in state spending. While the NHS quickly came to be seen as "the crowning achievement" of the Labour government's welfare state reforms, something evidenced by the fact that opinion polls by the late 1940s illustrated that it was widely supported by the British public (Stewart, 2002, p.113), residential care was never given the chance to develop in the mainstream of the welfare state.

Another indication of the slow development of local authority residential care was the number of older people entering hospitals for social rather than medical reasons. The slow expansion of residential care beds in local authorities was something the BMA had

been complaining about for years. As early as 1948 some BMA members were asserting that "unless sufficient residential homes are provided for old people…hospital beds will inevitably become 'blocked' and the whole service will break down" (Means and Smith, 1998, p.164). Hospital authorities were arguing throughout the 1950s that it was the NHS that was being put at a disadvantage, having to care for seniors admitted for social reasons rather than medical ones (Ibid, p.163). There was merit to this argument. As Townsend discovered with residential care, 47 percent of residents in former PAIs were men who entered the institutions because they had nowhere to live (Johnson et al., 2012, p.7). A similar trend was occurring in mental hospitals where seniors were increasingly admitted because of a lack of beds in local authority homes and hospitals (Webster, 1994; Means and Smith, 1998). In 1953, seniors accounted for 41,600 of the 144,000 patients in mental hospital and two-thirds of these were women (Webster, 1994, p.147). The percentage of older people in such facilities increased from 17.5 percent in 1938 to 28.8 percent in 1953 and 32 percent in 1957 (Ibid). In the wider hospital population, older people were entering chronic care wards for lengthy stays. Webster points out that "Even hospitals in areas well-endowed with beds for the chronic sick tended to fill their wards to capacity, and also to generate long waiting lists" (Ibid). In 1951, 24.3 percent of NHS beds were occupied by those 65 and older with women outnumbering men and single people outnumbering married (Ibid). Such numbers indicate that older people were turning to the hospital system in a significant way (Ibid).

Hospitals and local authorities bickered with each other over who was responsible for the care in particular cases. Each pressured the other to take responsibility for seniors and many hospitals simply refused to take a referral from a local authority home unless the authority would assume responsibility for a patient from a geriatric wing of the

hospital (Means and Smith, 1998, p.184-185). A consequence of this situation was that some residents in homes received inadequate medical treatment and nursing care, that some seniors in homes and hospitals were "reluctantly" cared for by staff who believed them to be someone else's responsibility, and that a situation developed with "older people being bounced around between institutions with little regard for their social and psychological security" (Townsend, 1962, p.391). The result was that "Elderly people had few rights in this situation and it is likely that many continued to be moved around the various kind of institutional care, according to the balance of power between the various professionals involved" (Means and Smith, 1998, p.184-185).

The central government, concerned with the high cost of long-term hospital stays for older people enacted a geriatric bed norm in 1957 in order to reduce the non-acute care functions of hospitals (Bridgen, 1991, p.516). Although the government was aware of problems in accessing modern residential care and home care services (discussed in more detail below) it "nevertheless proceeded with efforts to restrict the amount of provision for older people in hospitals" (Ibid, p.509). As Bridgen explains,

> The overwhelming priority appears to have been to limit the 'burden' being placed on the hospitals; any impediments in the way of the establishment of alternative services that would make this possible without a reduction in the level of overall care for older people were a secondary consideration (Ibid, p.514).

While seniors with acute care needs could, like the rest of the British population, expect to benefit in important ways from the sector's high priority status within the central government, those with long term care needs experienced the other side of the health care system. Their care was of secondary consideration. The impetus for improvements to residential care in the 1960s tended not to come from a genuine concern about geriatric issues in their own right, but from a concern about limiting the burden of an aging society

on the nation's core health service. The 1962 Hospital Plan, the ten-year building plan to modernize the hospital system, reinforced and extended the geriatric bed norm (Bridgen, 1991, p.514). Based on "a technocratic approach which strongly favoured curative, and consequently also hospital-based medicine" the Plan was informed by the philosophy that "in new, and very large hospitals, heroic surgery and newly synthesized drugs were to be the solution to individual and national health problems" (Stewart, 2008, p.462).

Ten-year plans were developed in 1963 for health and welfare services, plans which pushed for a significant expansion of residential care (Means and Smith, 1998, p.204). All substandard facilities, including converted facilities and former workhouses were to be replaced and all homes were to be able to meet a national standard in ten years (Ibid). In the late 1960s and early 1970s, a "building boom" took place in which new residential homes were constructed to replace the former workhouses and converted properties that were bought after the war (Johnson et al., 2012, p.26). Into the 1970s, residential homes continued to increase, a reflection of demographic trends but also because of "inadequate alternatives in the form of domiciliary and/or day care services" (Ibid). Such services developed very slowly, plagued by the low priority afforded to them at the national level, lack of funding and staff shortages (Ibid, p.24). Although talk of helping people remain in their homes for as long as possible had been occurring within the Ministry of Health since the 1950s (Wanless, 2006; Means and Smith, 1998; Townsend, 1962), "During the first 20 years of the new welfare state, there remained a heavy reliance on residential care provision for older people" (Johnson et al., 1998, p.24). As Means and Smith explain, "most local authority and central government officials and politicians assumed that families should physically care for their frail elderly parents and that the bulk of this work would be carried out by women rather than men. Such self-

evident truths were not seen as requiring explicit statements" (Means and Smith, 1998, p.243). Townsend himself wanted the family to keep on caring. In his view, care in the family could not only provide security to the majority of old people, but also keep the demand for hospital, residential care and domiciliary services from spiralling out of control (Townsend, 1962, p.405).

In 1962 and 1968 the National Assistance Act was amended to make the provision of domiciliary services a duty of local authorities but it was not until 1971 that these changes came into effect with the creation of social service departments (Means and Smith, 1998, p.267). Means and Smith argue the delay clearly indicated the extent to which "Health and welfare services for elderly people were very low on the political agenda" (Ibid). There was little agreement on the extent to which local authorities should play a role relative to voluntary organizations (Ibid, p.270). When a debate was held in the House of Commons in 1967 on the LTC needs of the aging, attendance was quite low (Ibid, p.267). The issues that were grabbing the attention of the Labour government at this time were urban decay, poverty and race (Ibid, p.268). Such issues were seen to be important social priorities while "The need for more and better domiciliary services was...extremely low on the political agenda" (Ibid). While other issues were seen to require an active state, home care needs of older people could be met with active families, or, more accurately, active women.

Throughout the 1960s, the Ministry of Health, like other government departments, became concerned with planning and developing ten-year plans for progress (Means and Smith, 1998, p. 278). The Ministry's plans for long-term care failed to clearly specify program objectives and did not contain mechanisms for ensuring minimum standards were met by local authorities (Ibid). Local authorities for their part had little experience

with long term planning, lacked information and the ability to obtain it, were unsure about what services needed to develop and had fractious relationships with the central government (Means and Smith, 278). As Means and Smith argue, “the end product of this situation was enormous variation in service provision from one local authority to another which did not appear to bear any relationship to assessment of need” (Ibid, p.278).

The above discussion of the British experience between 1945 and 1970 has argued that this was a period that was ‘long term care averse’. The need to develop national solutions to observable problems in residential care was ignored, or deferred, by central government actors enamoured with designing national systems around hospital and curative medicine. While hospitals, especially acute care hospitals, became privileged sites of state involvement, long-term care facilities were not sites of government action and grand political debate. Remedying deficiencies in long term care was more likely to receive the attention of the central government when such deficiencies forced older people to make demands on the acute care sector. The Canadian situation was remarkably similar.

Canada

While Canadian provincial governments have been primarily responsible for health and welfare provisions since Confederation, with the exception of services for veterans and Aboriginal people, the federal government has used its spending powers to shape provincial policies in significant ways. By considering “the evolution of long-term care from the perspective of policy milestones, especially at the federal level” it becomes apparent that the federal government has played a significant role in shaping long term care (Alexander, 2002, p.5). More specifically, as the gatekeeper of national health priorities, the federal government has been reluctant to take on long term care

responsibilities. As I argue in the following section, Canadian federal policy between 1945 and 1970 closely resembled the British experience. Addressing problems in long-term care ranked low on the list of government priorities. As in Britain, geriatric issues were overshadowed by the ambitions of political actors committed to a national health system centred on hospital and curative medicine. While the Canadian policy making environment differed from the British one in a number of ways, including federalism, elevated economic growth and dissimilar military commitments, central government actors in Canada shared with their British counterparts a disinterest in long term care.

Canadian federal involvement in health occurred after 1945 in a gradual and staged process. While the central government in Britain embarked on health care reform in 1946 and 1948, the Canadian government was slower to become involved in the health care game, and hospital insurance (1957) and medical insurance (1966) legislation were separated by ten years. Perhaps if the federal Liberal government of Mackenzie King had been able to successfully implement its health and welfare state plans during the 1945 Dominion-Provincial Conference on Reconstruction, the content of the following pages could be quite different. Perhaps rather than this being a story about a disinterested Canadian state forestalling the development of a nationally structured long term care system with strong public sector involvement, things would have unfolded differently. As Alexander argues, in 1945 “a golden opportunity to establish an integrated health and social welfare system was lost and has never returned” (Alexander, 2002, p.10). Not only was the Canadian Medical Association (CMA) open to the idea of a government-run universal health care plan, but new ideas about state responsibility for disadvantaged groups had gained acceptance by a Prime Minister who was sympathetic to welfare state

reforms of Europe and eager to attract votes from the socialist Cooperative Commonwealth Federation (CCF) at home (Hacker, 1998, p.97).

Reports commissioned in preparation for the conference by the federal government of Mackenzie King on health care (Heagerty Report), housing (Curtis Report) and social security (Marsh Report) provided “a comprehensive blueprint for a welfare state” and a good number of their recommendations “would have greatly benefited the disadvantaged, especially through improved income security programs, universal medical care and affordable housing” (Alexander, 2002, p.10). However, as a result of federal-provincial disputes stemming from an increasingly hostile intergovernmental climate, the conference broke down with the only substantive policy to survive being federal grants for hospital construction (Hacker, 1998; Touhy, 1999). While we can only speculate on what may have been, had the opportunity to construct a welfare state that integrated health and welfare programs in a coordinated manner been taken up by the provinces and the federal government in 1945, there is the chance that older Canadians in search of long-term residential care today could depend on a welfare state that is responsive to their needs.

What we can say with certainty, however, is that when it comes to long-term care in the post-1945 period, “lethargy” has characterized the federal approach (Alexander, 2002, p.3). As in Britain, a preoccupation with hospital and physician care came to dominate government thinking in Ottawa. The federal government’s commitment to hospital construction, which arrived in earnest with the 1948 National Health Grants, contributed to a building spree for hospitals across the country. The grants had “unfortunate results” for older people as the political and economic commitments to hospital construction overshadowed the need to develop the long term care sector (Ibid,

p.12). In some provinces, like Ontario, hospitals had been a municipal government responsibility. The province required the municipalities to contribute significant financial resources to the federal cost-sharing for new hospitals, and the limited nature of municipal funding meant that municipalities could only afford to construct medium-size general hospitals (Ibid). These hospitals would prove incredibly popular and soon all communities, small and large, wanted hospitals of their own, a project politicians were eager to devote resources to (Alexander, 2002, p.12; Davidson, 2004, p.257). The result was that "general hospitals mushroomed across the country, further inhibiting the development of long-term care facilities, much less, community-based services, until at least the mid-1980s" (Alexander, 2002, p.12).

Hospitals became politically popular institutions in post-war Canada. The building of new hospitals meant construction jobs, and once opened the community could look to them as institutions providing well-paying jobs and infrastructure (Davidson, 2004, p.257). Moreover, because hospitals are "visible symbols that care is accessible around the clock", the public has tended to look with great favour on the spending of political and economic resources in the hospital sector (Naylor, 1999, p.14). The political popularity of post-war hospitals contributed to the federal government's decision to launch a national hospital insurance plan before medical insurance, as did the high cost of hospital care faced by Canadians. While a number of provinces had experimented with medical care insurance since the Depression, and although it is true that premiers from British Columbia, Saskatchewan, Manitoba and Ontario were by the mid-1950s asking for more federal leadership in health insurance, the political climate was not ripe for the introduction of something more than hospital insurance (Bryden, 2009, p.318). Even Conservative Ontario Premier Leslie Frost, who had revealed to the other premiers his

preference for a state run health insurance plan with coverage ranging from hospital insurance to home care, stressed that a national program should move forward gradually and in stages (Ibid).

A provincial climate partial to hospital insurance helps to explain the federal government's decision to share in the costs of that sector first, but so too does the changing nature of the CMA. One of the most significant impacts of the failed 1945 health care reforms was that the failure gave the private health insurance industry time to grow and establish itself as a formidable opponent to state run health care (Hacker, 1998, p.98). The CMA in the 1950s reversed its favorable position on public health insurance and came out in favor of voluntary insurance plans and government subsidies for those unable to afford private plans (Hacker, 1998, p.67). While never as vitriolic in its opposition as the American Medical Association, the CMA was a vocal and organized opponent to government health insurance in the 1950s (Ibin, p. 67). The organization "came out against all but the most modest of reforms" (Ibid, p.98). By the mid-1950s, "The growth of private plans effectively ruled out the possibility that Canada would follow British precedent and establish a national health service" (Ibid, p.99).

With the passage of the 1957 Hospital Insurance and Diagnostic Services Act (HIDSA), the federal government committed itself to paying for half of provincial hospital care costs. By 1961 all provinces had entered the plan (Tuohy, 1999, p.52). Like all Canadians, seniors in need of acute care services no longer, at least from an economic point of view, had to fear falling ill. The pan-Canadian focus on hospital care, which started with improvements to infrastructure and culminated with universal access to care, meant that seniors and all demographic groups alike gained from federal policy. Older Canadians in need of facility-based long-term care saw no change in their situation as a

result of the new legislation, however. As discussed in more detail below, in stark contrast to the hospital sector, no action was taken by the federal government to address the crippling costs of residential care borne by the elderly and their families, nor was a concerted effort made to improve the availability and quality of care provided. The 1966 Medical Care Act would similarly do nothing to put long-term care on a national footing.

As with hospital insurance, provincial innovations most notably in Saskatchewan and Alberta played a role in forcing the federal government's hand on health insurance, as did the Royal Commission on Health Services. The 1968 Medical Care Act, which became operational in all provinces in 1971, stipulated that provinces meeting the principles of universality, comprehensiveness, public administration and portability would have fifty percent of the costs of physician care covered by the federal government. While along with the hospital insurance, the program had the important impact of delaying and preventing levels of dependency that require older people to seek long-term care services by ensuring universal access to physician care, it too prioritized curative health care above all else (Alexander, 2002, p.12). Far from being revolutionary pieces of legislation, both acts involved governments using general taxes to purchase services that were already in existence (Armstrong et al., 2009, p.21). Because the federal government would pay half of the cost of doctors and hospital bills, the provinces had an incentive to put their money into those sectors rather than expand into new areas, long-term care being a striking example. As a result of these legislative acts "health care was not centrally linked to a larger, public, integrated commitment to state involvement in social supports" (Ibid, p.22).

Why was the Medical Care Act silent on long-term care? One reason lies in the fact that the federal Liberal Party itself was not fully committed to the idea of a national

medical insurance plan. As Penny Bryden observes, national health insurance of any form was far from an inevitable thing in a party with a wavering commitment to health care reform (Bryden, 2009). In fact, it is “doubtful” that the federal Liberal Party would have made a commitment to move beyond hospital insurance to national health insurance had the party not experienced losses in the 1957, 1958 and 1962 elections (Ibid, p.321). While the voices of social reformers such as Tom Kent, Walter Gordon, Maurice Lamontagne and Judy LaMarsh became more pronounced when the party underwent a period of introspection after 22 years in power, and were thereby influential in getting health insurance elevated on the party platform, the Liberal appetite for large new social programs was short lived (Ibid). When the party returned to power in 1963, the province of Saskatchewan was recovering from a bitter doctors’ strike over its health insurance scheme and “history had not yet cast the government as the dragon-slayer in this epic battle, and it was far from clear that the public was fully behind health insurance in Saskatchewan, let alone across the rest of the country” (Bryden, 2009, p.322). The Liberals chose “a wait-and-see approach on health” and moved forward with pension reform (Ibid).

The impact of the pension negotiations proved important for health insurance (Bryden, p. 322). Provincial governments, particularly those of Quebec and Ontario, illustrated that the provinces were becoming increasingly interested in shaping the content of social policy and had generated considerable expertise in social planning, making it impossible for the federal government to unilaterally impose a new national program (Bryden, 2009). In Bryden's words “The pension debate had made it clear that, in social policy formation, the federal government should underestimate the provincial agendas at its peril, and avoid constitutional wrangles as much as possible. These lessons were not

lost on the architects of national health insurance, whether at the elected or bureaucratic level" (Ibid, p.325). Alberta, Ontario and British Columbia in the early 1960s had launched investigations into private insurance (Bryden, 2009). Ontario, for its part, wanted to spend on housing ahead of health care, while finance ministers from all provinces, even Saskatchewan, were expressing concern about the costs of new legislation (Ibid).

When Volume One of the Hall Commission, appointed in 1961 by the Progressive Conservative government of John Diefenbaker, came out in 1964 with the surprising recommendation of a comprehensive universal health insurance plan, the Liberals were forced to act, but "Hard-learned lessons in other fields would now determine the manner in which national health insurance was implemented " (Ibid, p.324). By 1965, when the Pearson government decided to act on health insurance, the left-leaning voices within the party that had gained prominence at the start of the decade were increasingly being drowned out by the more fiscally conservative voices as the party was returned to power with another minority government (Bryden, 2009, p.326-327). The start date for medicare was delayed until 1 July 1968. As noted above, aside from attaching principles to the funding, the federal government plan did not significantly rock the boat by forcing provinces to move beyond physician care.

Another factor, one that parallels the British case, relates to the lack of interest in issues of geriatric care within the medical community and government thinking. In 1960, for example, Conservative MP Philip Rynard drew attention in Parliament to the lack of hospital doctors in Canada concerned with geriatric medicine (Rynard, 1960, p. 5303). As evidence of this lack, he pointed to the widespread shortage of enthusiasm for establishing geriatric units in hospitals across the country. In contrast to paediatric

medicine, which, since 1920 had established itself as a speciality with status, geriatrics had little influence and stature in Canadian medicine. While pediatric units were increasingly important components of Canadian hospitals, and professorships and chairs dedicated to advancing the speciality were growing in number in universities across the country, there was little momentum in geriatrics. (Ibid). The reality was that the medical community tended to be “youth-centred, acute illness oriented, and efficiency focused” (Senate of Canada, 1966, p.119). Like British doctors, few Canadian physicians were interested in pursuing careers in which curative medicine was not centre stage. In both countries an interest in young people and acute care dominated medical thinking.

The 1966 final report of the Senate Committee on Aging, discussed in more detail below, noted that government thinking resembled that of the medical community. It noted that “Health departments at present seem preoccupied with maternal and child health to the exclusion of other age groups” (Senate of Canada, 1966, p.121). Just as Townsend could argue in Britain in 1962 that neither of the nation’s political parties had shown much interest in understanding the long-term care needs of an aging population, Canadian commentators could point to a similar level of disinterest in the federal Liberal government. As CCF MP Herbert W. Herridge argued in Parliament in 1957, the National Health and Welfare department needed to do more to “study the problems of the ageing, to develop wider understanding...to do something to improve the present situation” (Herridge, 1957, p.2749). The reality was that little information existed on the lives of Canada’s older people. CCF MP Stanley Knowles pointed out that although the Welfare Council of Greater Winnipeg was addressing this issue on a local level through its Age and Opportunity report, the federal government was not taking the necessary steps to understand how seniors were doing on a national scale (Knowles, 1956, p.2147).

Progressive Conservative MP Alfred Johnson Brooks noted that “we are in many years behind other countries” when it comes to understand the housing needs of seniors (Brooks, 1956, p.3994), while another Conservative member noted “There does not seem to be the energy behind any move sufficient to meet that problem in an adequate way” (Green, 1956, p.3991).

The appointment of the Special Senate Committee on Aging in 1963, chaired by Liberal Senator David Croll, was an attempt by the federal government to gain a wider understanding of aging in Canada. Strong levels of economic growth in combination with increasing national concern on issues of social disadvantage led to a situation in which, at least for a moment, old age received national attention. The Committee’s final report released in 1966 was an important factor encouraging the federal government to create the Guaranteed Income Supplement in 1967, “one of Canada’s great social policy success stories helping to cut the poverty rate among Canadian seniors over 65 from 37% to 6% between 1970 and 2000” (Struthers, 2012, p.1). While the report can be viewed as a success story for its influence on income security policy, and for encouraging a wider participation in the field of gerontology (Ibid), the report was less successful in encouraging the federal government to assume a leadership role in residential long-term care. While this was not a central objective of the report, testimony and briefs presented to the committee painted the proprietary nature of long-term care facilities in a negative light. Evidence that this was a sector in need of federal leadership and a non-profit ethos was presented to the committee, which should have encouraged the federal government to re-evaluate its approach. This was not something the federal government, in the end, was willing to do.

In its final report, the Committee emphasized that during its hearings it was "reminded on all sides of the gaps and weaknesses in current facilities for meeting the health needs of older people" and of the "extreme shortage there is in Canada of facilities designed and equipped to meet the needs of long-term patients" (Senate of Canada, 1966, 28, 32). While the hospital grants had contributed to the expansion of hospitals across the country, the lack of attention to building up long-term care facilities was increasingly apparent by the mid-1960s. While the federal government, through the Canada Mortgage and Housing Committee (CMHC), had been contributing money to non-hospital facilities to help cover capital costs through loans and subsidized mortgage rates since 1946, the reality was that not enough facilities had been created. The Committee noted that many older people with long term care needs were ending up in hospitals because of a lack of nursing home beds, and in municipal homes for the aged (which were not originally designed to provide skilled nursing home care). "So desperate is the situation" the committee explained "that even nursing homes of such poor quality that according to the authorities they 'should not be in operation' have long waiting lists" (Ibid, p.32). Because nursing homes were not included under the hospital insurance program, unless admitted as indigent, older people or their families were forced to pay the costs of this care at an average of $8 to $10 a day and "often much higher" (Ibid).

The dearth of quality facilities and the entry of older people into hospitals bore remarkable similarity to the British experience at the time. In both cases the slow development and poor quality of residential care facilities reveals the extent to which long term care was given low priority status. Although, as will be emphasized in Chapter 4, in the province of Ontario efforts were made at an earlier date to construct a network of new publicly-run homes, albeit for a mainly ambulatory group of seniors. In Canada, the

Senate Committee noted that even more troubling than the shortage of long term care facilities was "the lack of clear policy" on long term care (Senate of Canada, 1966, p.32). No attempt had been made by the federal government to determine the types of facilities needed to meet the care needs of an aging society, to determine the standards that care homes should meet, to come up with an arrangement to cover the substantive costs faced by older people and their families, or to determine whether or not the private sector should be involved in long term care provision (Ibid, p.33). The Senate Committee pointed out that "By far the majority of nursing homes in Canada are proprietary" and that a "profit-making" ethos had come to dominate a field long ignored by government (Ibid, p.111).

The impact of privatization was noted in a number of submissions. As the Ontario Jewish Home for the Aged and Baycrest put it, "Nursing homes have developed, with few exceptions, as profit making ventures" (Jewish Home for the Aged and Baycrest, 1964, p. 142) Unless admitted as indigent, seniors in Toronto could expect to pay between $5 and $20 dollars a day, if space was available, to private nursing home providers who for the most part put financial gain ahead of all else. The brief argued that the federal government should step in and change this trend by providing grants for the construction of non-profit homes for the aged, just as it had been doing for hospitals. "[T]he need for grants is equally as great for our homes for the aged", it stressed (Ibid). While in provinces like Ontario the provincial government provided one-third of the cost of construction for homes for the aged, the time was ripe for the federal government to increase the non-profit presence across the country. The extension of a national form of insurance for long-term care, whether through hospital insurance or an insurance program

specifically designed for long-term care, was the appropriate next step of the federal government (Ibid, p.144).

One Senate Committee member pointed out in response to the briefs and committee testimony that if the federal government had taken the same approach with war veterans it would be highly unlikely that social services for that group would have developed to the extent they did. Senator Allister Grossart noted “I do not think anyone would suggest that if the veterans' affairs were left to the voluntary organizations such as the Canadian Legion, which has done great work...that the treatment of the problems of veterans would have been as well organized as it has been under the Department of Veterans Affairs which has taken on all the responsibility” (Grossart, 1964, p.91). While at least for one group of older Canadians the federal government was willing to assume responsibility, for the rest of this demographic a disinterest in coordinating care needs was characteristic.

The Associated Nursing Homes Incorporated of Ontario, representing an increasingly organized and vocal grouping of private nursing home operators, argued to the committee that for-profit companies played a necessary role in long-term care. Asked by the Senate Committee if the private profit nursing home had become an “anachronism” in Canadian society given that the trend in the hospital sector was for private hospitals to become non-profit entities, and that the Hall Royal Commission on Health Services was indicating that this would be the appropriate direction in, at least, physician care, the response of the group was an unequivocal 'no' (Morris, 1964, p.1096). Burrell D. Morris, past president of Associated Nursing Homes and co-owner of an Ontario nursing home argued that “private enterprise, we believe, can take up the slack. That is what we are doing. We think we are needed. We can provide these services and

can provide them more cheaply than the general hospitals" (Ibid). When asked by Committee Chair Senator David Croll "In view of the fact that this reaches across the whole country and affects very many people, is this not natural and normally a field for government rather than private enterprise?", the response of Morris was that "private enterprise can do the job" (Ibid). Rather than stepping in to reverse the trend toward private ownership, government should ensure that private operators "be given more avenues" to expand in the nursing home sector (Ibid). After all, Morris pointed out, in the United States "last year the nursing home business was a $2 billion industry" and there was no reason to prevent Canadian expansion (Ibid).

If government ownership of nursing homes were to become the norm, Morris argued, the trend would be towards large, impersonal facilities where the personal attention of residents is sacrificed (Morris, 1964 p.1096). In a government-owned facility "You are in a large ward with a number of people, as many as 25 in some cases. A person loses his individuality. A nursing home is smaller and usually there are not more than three or four rooms, so the person gets the individual attention and is still 'a person.' You do not find this to be the case in the large institutions" (Ibid). This endorsement ran counter to the growing body of evidence that proprietary homes provided worse care than the non-profit sector. Almost seven years earlier, a CCF member rose in Parliament to speak of a letter he received from a Port Hope, Ontario, man lamenting the fact that some residential homes housed between four and nine older people to a room, affording residents little privacy (Herridge, 1957, p.2749). The care provided to the residents, he emphasized, was of poor quality as the people running the homes were more concerned with making a profit than improving care. Herridge noted that although increases in

seniors' pensions had been implemented, this money was being absorbed by care home owners with little visible benefit to residents.

At the Senate Committee hearings, consultant R.E.G. Davis, Director of the University of Toronto's School of Social Work, questioned the superiority of for-profit care by pointing to an American study presented to the United States Senate. Referring to the study, Davis noted that although the authors did not recommend the removal of proprietary nursing homes from the American setting, they did stress that

> 'most proprietary nursing home operators do the best they can, within the limits of their income' then they go on to say 'they do not do it very well' then it says that the special committee also visited a number of religious and public facilities which provide nursing care for infirm patients. They say 'in general, the contrast was startling; the religious homes backed by community contributions were generally larger in size, airy, clean, safe, with registered and practical nursing physicians who were available around the clock, and some of them performed miracles of rehabilitation. The investment in staff and equipment was heavy but in so many of the institutions it paid off enormously.' (Davis, 1964, p.1097).

Davis asked the Associated Nursing Homes why, in light of such studies, there were not more non-profit homes operating in Ontario. Morris responded that "there are more of them all the time" but that they are ill-equipped when compared with the private sector to deal with infirmity (Ibid, 1097-1098).

One year later, Morris told the Ontario Legislature's Select Committee on Aging that neither the care nor financial records of many private homes were inspected (*Toronto Star*, 1965, p.21). The Ontario government left inspection up to the municipalities, many of which were lax in their approach and gave only "tender, solicitous slaps on the wrist" to homes with substandard conditions (Ibid). Operators of some homes, he claimed, fed blind residents the food left over from other residents (cited in *Toronto Star*, 1965, p.6). The strategy of the Associated Nursing Homes as in 1964, was the same. It is important, Morris argued, that "efforts be made to increase co-operation between proprietary and

government interests, to the effect that better health care for the aged may be assured" (Morris, 1964, p.1097). Through ensuring industry wide standards and by licensing nursing homes, government could elevate the status of the nursing home within the broader spectrum of health care facilities without taking over ownership. Through increased public funding for residential care, the state could ensure older people have reasonable access to privately provided care. As we will see in Chapter 4, the nursing home lobby in Ontario became increasingly influential in the province and highly effective at dictating the scope and parameters of government regulation.

While the federal government was committed to using its spending power to uphold conditions of public administration, comprehensiveness, universality, portability, and accessibility in hospitals and later medical care, a hands-off approach characterized its relationship to the long term care sector. "There is entirely too little emphasis on aging and on the overall care of the chronically ill at the federal level", the Committee argued (Senate of Canada, 1966, p.121). The reality was that

At present there is no real choice offered to the elderly. When isolated older persons are only slightly disabled, they are often unable to cope longer at home and there are only two major choices available to them in Canada: the public home for the aged and the private nursing home, neither of which is appropriate to their needs and both of which tend to sap whatever independence they may have had on admission (Ibid, p.112).

As the 1960s were drawing to a close, many older Canadians found themselves at the margins of the nation's health care system.

It was noted above that when we look back on British developments, we can identify the moment when long-term care became cut off from the mainstream of the country's health care system. For older people in Britain, that moment was 1948. Canadian seniors had to wait almost two decades longer for their national government to

formally relegate their care needs to the periphery of the health care system. While Ottawa would be responsible for cost-sharing hospital and medical care and ensuring a level of national uniformity and strong public sector involvement in the provision of such care, long term care services were left largely untouched. Like its British counterpart, the Canadian government did nothing in the period from 1945 until 1970 to put this sector on a national footing.

1970s 'Long-Term Care Ad-Hocism'

In the 1970s, pressure did grow for more government support for long-term care facilities. One factor leading to increased demand for long-term care beds was the changing labour market participation of women. In the 1960s, the female labour force rapidly expanded, increasing the need for more long-term care beds as more women found it increasingly difficult to balance caregiving duties for both their children and elderly parents (Ostry, 2006, p.192). The process of deinstitutionalization of patients in mental hospitals across the country which began in the 1960s was another factor. Closures of such facilities meant that many poor older patients with dementia and other psychiatric conditions ended up in general hospitals (Ibid, p.192). While federal funding did help defray hospital costs, such facilities were expensive and the demand for them exceeded the supply (Armstrong et al., 2009, p.22). The cost of hospital care was on the rise, a reflection in part of the increasing organization of the largely female care workers and their successful campaigns for wages that better reflected the work they performed (Ibid). Costs also increased because of sharp rises in the income of physicians, and from the growing costs of new technologies and drugs produced mainly by for-profit companies (Ibid). The cost of long-term patients was a concern, particularly as more people were living into old age, many with disabilities (Armstrong et al., 2009, p.22,

Ostry, 2006, p.192). Throughout the 1970s, the cost of health care continued to increase at a rate faster than any other sector (Ostry, 2006, p.59). Moreover, as economic expansion was coming to an end with the sharp rise in oil prices in 1973 and Canada, like most developed nations, experienced slow economic growth in combination with high inflation, cost containment rose to the top of the political agenda (Ibid, p.57).

By 1971, Ottawa had started negotiations with the provinces to transition from the system of conditional funding to block grants (Ostry, 2006, p.59). In 1977 changes were made to federal cost-sharing with the introduction of the Established Programs Financing (EPF), reflecting changing desires among both orders of government. While the federal government desired more extensive control over cost-sharing commitments in the face of rising provincial hospital and medical costs, the provinces wanted less federal control and involvement in their jurisdiction. The 1970s and 1980s saw the rise of regional autonomy in Canada as the cooperative federalism that had characterized the 1960 was replaced with increasing friction between the provinces and the federal government (Ibid, p.58). On the health care front, not only did the provinces want less federal control, but they also “felt hindered because federal funds could not be spent on long-term care beds” (Alexander, 2002, p.17). The new federal funding approach combined tax and cash components which gave the provinces more freedom in health care spending (Ibid, p.18). The publication in 1974 of the Lalonde Report, which advocated health promotion and less reliance on curative care, was a legitimating force for federal spending on care outside of hospitals and physicians offices (Ostry, 2006, p.197).

The EPF included federal cash for a new program, the Extended Health Care Services (EHCS) program. The EHCS was a separate small block of funding for provinces to spend on extended health care, defined as services delivered outside of

hospitals (Ibid, p.60). Originally set at $20 per capita in 1977-1978, the funds were put in place to encourage the provinces to shift their focus from expensive hospital and physician-based care delivery (Ibid). Opposition MPs had been pressing the Ministry of National Health and Welfare in the 1970s to enter into shared cost programs for nursing home and home care because “The care now is not adequate for our geriatric people” (Rynard, 1976, p. 1352; 1974, p. 63). As one New Democrat MP pointed out, since the passage of medicare in 1968, the federal government had refused to bring essential services within the mainstream of the Canadian health care system, nursing homes being a primary example (Rodriguez, 1976, p. 11037). New Democrat David Orlikow criticized the federal government for ignoring the nursing home sector and forcing the costs of long-term care onto the provinces, older people and their families, while it directed public funds to the hospital sector. The federal government, he argued, showed a marked lack of “will” when it came to treating the nursing home sector with any sense of national priority (Orlikow, 1976, p. 1305).

Former Saskatchewan Premier, and ‘father of medicare’ Tommy Douglas made an impassioned plea to Parliament as a New Democrat federal MP in 1976 for “altering the focus” of the Canadian health care system by bringing long-term care within the scope of Canadian medicare. In his words,

The provinces have been trying to persuade the federal government to join with them in instituting cost-shared programs for such services. A lot could be done in this country by the establishment of more nursing homes, the provision of home-care treatment, meals on wheels, more extended care units in hospitals…Those of us who through the years have talked about a new delivery system have been stressing the need for altering the focus on health care in this country. In the past we thought of the practice of medicine in terms of curative medicine and public health care, but many countries in the world now have switched their emphasis to preventative health programs…It is now eight years since we took the first step of establishing medicare in this country. It was a forward step…However, we have taken few steps since to begin to change the health delivery system to any serious extent, and we are paying the price because the whole delivery

system of merely curative medicine is expensive and will become increasingly expensive…What have we done about nursing homes? Some steps have been taken but they have been really meager (Douglas, 1976, p. 14623).

As Douglas rightly pointed out, long-term care needed to be brought in from the periphery of nation's health care system. The federal government had the power to alter the focus of Canadian medicare in order to ensure that the care needs of older Canadians could be addressed as part of the national program. Eight years after the passage of medicare, the limitations of a health insurance program fundamentally reliant on curative-based medicine were glaringly apparent.

While the ECHS funding did stimulate the development of more long-term care facilities in the provinces, and home care services, thereby addressing in some ways the gap in services that existed across the country (Alexander, 2002, p.18), the program did not signify a re-thinking of medicare in the manner which Douglas and others had argued. Unlike federal transfers for insured services, this portion of the EPF was mainly unconditional and it was short-lived. As Armstrong et al. explain,

Because this new federal money had no strings attached, provinces could spend it in any way they chose, even using it for other services. As a result, this funding model failed to significantly change access to residential care across the country or to make these services more similar. This program of federal funding was abolished in 1996, marking the end of what was in effect very limited federal support (Armstrong et al., 2009, p.24-25).

That it was never the federal government's intention to address long-term care through this program in a substantive way was made clear early on. National Health and Welfare Minister Monique Begin, when pressed in Parliament about federal support for the sector, replied "each province is at a different stage in the development of extended health care service, and for that reason we could not impose upon all the provinces the minimum standards that were applicable under the hospital insurance and medical care

programs" (Begin, 1978, p. 3114). Clearly, the political will that was shown in 1957 and 1968 to bring hospital and medical care into a national and publicly supported plan would not be spent on the long-term care sector.

Britain

As the 1970s dawned on Britain, the central government was faced with similar pressures to meet rising demands for long-term care. As Means and Smith explain, "In many ways, the situation in 1970 appeared the same as in 1960, when Ruck had lamented that 'although there are many services for old age, there is no policy for old age' (Means and Smith, 1998, p.278-279). As in Canada, the need to expand long-term care was becoming evident through changes to the hospital sector. Reductions in expensive acute care beds led to pressures to expand community and facility-based care (Wanless, 2006; Johnson et al., 2012). In 1971, local authorities were given funding to construct new homes, and 100 containing 4,544 beds were built, which enabled the closing of 14 former PAIs (Peace et al., 1997, p.12). As Johnson et al. note, "the late 1960s and early 1970s witnessed something of a building boom for new residential homes" as British leaders realized they could no longer defer construction (Johnson et al., 2012, p.26). Residential care was still largely in the hands of local authority provision. In 1971 only 14 percent of people over the age of 65 living in residential homes were in the for-profit sector (Peace et al., 1997, p.12).

In April 1971, the 1968 Health Services and Public Health Act came into being which imposed a duty on local authorities to provide care in the community. While community-based services were expanded, for a number of reasons local authorities continued to rely on residential care after this legislation was passed. For one, the death of Maria Colwell at the hands of her stepfather in 1973 focused much of the attention within

the newly established social service departments on childcare issues (Means and Smith, 1998, p.326). Secondly, the oil crisis ushered in a period of austerity and spending limits (Ibid). Moreover, a reliance on familial care remained prominent in government thinking and the expansion of domiciliary and day care services remained wholly inadequate in the 1970s (Johnson et al., 2012, p.26; Means and Smith, 1998). Despite government rhetoric about expanding domiciliary care, residential homes increased in number throughout the 1970s (Johnson et al., 2012, p.26). The Ministry of Health was committed to following through with an extensive building program of residential homes that came out of its ten year plans of the 1960s (Means and Smith, 1998). While Townsend argued in *The Last Refuge* for an abandonment of residential care as it had been conceived from government policy, his work could be used by the department to justify a building spree of new homes to replace the former workhouses (Ibid, p.209).

In 1976, of those 65 and older, 99,000 were residents in public sector homes, 33,000 were in homes run by the voluntary sector (14,000 of these received support), and 27,000 lived in private homes (2,000 of these received support) (Peace et al., 1997, p.13). "This represents an investment from public funds, channelled through authorities, with respect to 115,000 elderly people" (Ibid). In 1978 the Labour government released a discussion paper, "A Happier Old Age," which proposed a framework to protect the status quo and indicated that services, both residential and domiciliary, would continue to grow in order to meet the care needs of an ageing population (Ibid, p.14). As Peace et al. argue, the Labour government presented a generally "positive message" on long-term care in 1978 (Ibid). As in the Canadian setting, however, a seemingly positive legislative turn by the central government in the 1970s towards long-term care was short-lived.

The 1980s and Beyond

The election of the neoliberal Conservative government of Margret Thatcher in 1979 ushered in a new paradigm for older people in Britain in which the private sector would come to play a leading role in care provision. In conjunction with a larger privatization agenda which included deregulating public transportation, selling off public utilities and the shrinking of government responsibilities in a number of social policy areas, the residential long-term care sector opened-up to market principles (Peace et al., 1997; Johnson et al., 2012; Means and Smith, 1998). The low-priority position occupied by the sector in British government thinking and welfare state development since the close of the 1940s made it a particularly attractive target for a government committed to introducing market-principles wherever possible. As Player and Pollock observe, "The general popularity of the NHS posed a problem for the Conservative project of privatizing this element of the public sector, but the weakness of the position of long-term care offered an opening solution" (Player and Pollock, 2001, p.234).

Individual responsibility and familial care were increasingly touted as the answers to long-term care, something the 1981 White Paper, "Growing Older" made clear:

> Money may be limited but there is no lack of human resources. Nor is there any lack of goodwill. An immense contribution is already being made to the care and support of elderly people by families, friends and neighbours, and by a wide range of private, voluntary and religious organisations. We want to encourage those activities so as to develop the broadest possible base of services (DHSS 1981, p. 3, cited in Peace et al., 1997, p.98)

This was a clear statement of the government's intention to change the relationship between older people and the state. While the state had always relied on the informal care giving of a mainly female contingent to care for older people in the home, when it came to residential care the state had been the primary provider of care. The White Paper signalled a radical shift, in which non-state actors were encouraged to assume the

broadest range of responsibilities for residential care. Part of a general policy in the 1980s of encouraging private enterprise across a range of social policy areas, the private care home market grew at a considerable rate (Andrews and Phillips, 2000). And while the private sector assumed a larger role in the provision of a number of areas of health care, including critical care facilities for complex surgery and aftercare, some NHS hospitals and dental care, it was in the area of long-term care where a “dramatic” decrease in public provision occurred (Maarse, 2006, p.998).

A number of factors in the 1980s made the residential care sector an attractive one for private enterprise. As just noted, the election of a Conservative government committed to the expansion of market principles in health and social care and to disrupting the historical trend towards public ownership, meant that Britain was open for business. In addition, the increasing number and proportion of seniors between 75 and 85 years of age meant that there was demand for facility-based care (Peace et al., 1997; Andrews and Phillips, 2000). The closing of long-stay geriatric and psychogeriatric hospital beds added to the ranks of older people in search of facility-based care (Andrews and Phillips, 2000; Peace et al., 1997; Jonson et al, 2012; Rummery and Glendinning, 1999). Reductions to NHS services therefore left many older people looking to the residential care sector to meet their care needs. This increased demand for long-term care beds thus made the sector an attractive one for business. In addition, because residential homes were not subject to local property tax rates, and because the property market was in a boom phase in the 1980s investing in residential facilities was considered to be wise (Andrews and Phillips, 2000, p.208).

The single most important catalyst for private sector involvement, however, came in 1980 with the introduction of the Supplementary Benefits Regulations. This removed

barriers for low-income residents of voluntary and private sector homes to use their social security allowances to supplement board and lodging costs (Johnson et al., 2012, p.27). The Conservative government, looking "to encourage rapid growth and expansion of the private sector", recognized that amending the Social Security Act would be one way to facilitate a greater role for the commercial sector (Harrington and Pollock, 1998, p. 1806). This change permitted many seniors with low incomes, therefore, to enter private and voluntary-run homes with public funding, which "both reduced the risk involved in running such business and vastly increased the potential number of clients available" (Andrews and Phillips, 2000, p.208). This money was distributed, for the first time, through the benefits system by the Department of Social Security, in the absence of the requirement that care needs be assessed by the local authority (Peace et al., 1997, p.24). The social security changes allowed for the full cost of accommodation and care to be claimed only on the basis of financial need. The Conservatives' policy meant that "there were specific disincentives for publicly owned provision" and local authorities found it cost effective to offload their residential care responsibilities to the private and voluntary sectors (Johnson et al., 2012, p.28). Acute and long-stay hospitals also found this to be a cost effective option. As Hudson and Henwood explain,

Acute hospitals seeking to discharge older people who were 'blocking beds' and long stay hospitals wishing to reduce their size or close completely now had an alternative to painstaking negotiation with the local authority – an alternative that was cost-free to the NHS and that required no assessment of need other than that of a financial nature carried out by the DHSS (Hudson and Henwood, 2002, p.156).

The growth of private sector provision was significant. In the United Kingdom the number of privately-run residential care homes increased from 2,255 in 1979 to 7,240 in 1986, representing a yearly increase of over 18 percent (Andrews and Phillips, 2000,

p.209). In 1980, 45.8 per cent of residential care homes for older people in the UK were owned by local authorities and local authorities provided 62.7 per cent of the places whereas the private sector owned just 34.7 per cent of the homes and provided 19.9 percent of places (Johnson, 1999, p.84). By 1995, local authorities owned a mere 17 per cent of the homes and were responsible for providing 26.8 percent of the places. Private homes, on the other hand, had increased their ownership share to 67.8 per cent, providing 55.7 per cent of places. The voluntary sector owned 15.2 percent and provided 17.5 per cent of the places (Ibid). As a result of the funding changes introduced in the 1980 legislation, "residential care businesses became known for their financial security and profit-making potential with some estate agents even specializing in the sector" (Andrews and Phillips, 2000, p.209). Between 1983 and 1996, a 242 percent increase in beds in the independent sector occurred (Scourfield, 2007, p.158).

This growth led to a substantial increase in the social security bill as payments rose from L6million in 1978 to L200 million in 1984, and to excess of L2,500 million in 1993 (Peace et al., 2012, p.24). The reality was that "private residential homes soon became a major user of financial resources and by the late 1980s were significantly draining public social and health budgets" (Andrews and Phillips, 2000, p.209). By the late 1980s, the incentive to institutionalize following the Supplementary Benefits Regulations led to a renewed interest within government of community care alternatives (Peace et al., 2012, p.24). The introduction of the 1990 NHS and Community Care Act and its implementation in 1993 slowed the decade long growth of residential care. While the 1980s was characterized by private sector expansion of facility-based care with public funding, in the early 1990s policy shifted towards keeping older people in their homes for

as long as possible (Andrews and Phillips, 2000, p.209). While the stated goals of the legislation were, among other things, to make home care more responsive to need and to also provide support to informal care givers, the reality is that "policies pursued since 1994 have resulted in a sharp shift of public provision to those without informal care support. The policy of supporting informal carers has not been delivered" (Baldock, 2003, p.121).

In addition to the financial prerogative, reform was motivated by the fact that two aspects of the government's 'New Right" ideology were in conflict with the 1980 social security changes. For one, private enterprise was a key facet of the Thatcher government and a private sector held up by government coffers "was far from the government's ideal form of self-generating entrepreneurship" (Andrews and Phillips, 2000, p.209). In addition, the growing prominence of 'new moral authoritarianism' in government thinking, which embraced the positive aspects of family life and socially conservative values, was critical of the idea of state-funded institutionalization. "Placing elderly relatives in residential care and allowing the state to support them did not sit well with such values" (Ibid). The 1990 reforms removed guaranteed state funding for residential care.

While the removal of guaranteed state funding did make the market a less secure one for the private sector (Andrews and Phillips, 2000), the reality is that the residential care remained firmly in its hands. In the 1980s, the rapid growth of private provision consisted mainly of small businesses (Andrews and Phillips, 2000, p.207; Peace et al., 1997, p.25). In 1994, "the traditional small business entrepreneur continued to be a major provider, accounting for 40 per cent of newly registered beds" (Peace et al., 1997, p.25). Many homes were run by husband and wife teams who owned and managed only one

home, or a matron-manager who ran a home owned by several local business entrepreneurs (Ibid). Over time, however, the trend has been towards corporatization. Between 1988 and 1997 companies owning three or more LTC facilities were able to double their share of the for-profit market (Johnson et al., 2012, p.28). By 1999 over 30 per cent of the market was controlled by such companies and "the process of small home closures, mergers and acquisitions was resulting in the concentration of ownership of long-term care provision into fewer hands" (Ibid; Scourfield, 2007). Increasingly, Britain has seen "ownership of much of the sector in the control of a small group of 'players'" (Scourfield, 2007, p.156). As will be emphasized in Chapter 4, the process of corporatization occurred earlier in Ontario than it did in Britain. Given that this chapter is most concerned with developments at the national level, province-specific developments are reserved for the chapters that follow.

Canada

While residential care in Britain in the 1980s was the focus of government attention and policies were developed specifically for that sector with the goal of opening it up to private involvement, in Canada a great silence loomed over residential care. While the EHCS represented a brief recognition on the part of the federal government of the importance of directing public funds to residential care, beginning in 1986 the Conservative government in Ottawa took measures to limit EPF and EHCS growth and gradually clawed back federal health contributions (Alexander, 2002, p.19-20). From the perspective of aging Canadians with long-term care needs, the EHCS should therefore be seen as a minor break in an otherwise highly stable pattern of federal government non-involvement. Ottawa's return to non-involvement in residential care throughout the 1980s and 1990s, was as beneficial to the for-profit sector as the Thatcher government's overt

policy of encouraging privatization. Two actions by the federal government – the introduction of the Canada Health Act 1984 and the Canada Health and Social Transfer 1996 – made the residential care sector an increasingly attractive one for for-profit providers.

After the 1970s, federal government policy was to gradually and unilaterally reduce its share of funding for provincial health care insurance programs, while holding on to enough financial leverage to ensure that the provinces complied with the five principles of medicare (Tuohy, 1999, p.90). In the early 1980s, the federal Liberal government, faced with non-liberal governments across the provinces and increasing unpopularity at the polls, looked to the issue of extra-billing, which was occurring on a limited scale in some provinces for insured services (Ibid, p.93). As Tuohy points out, the Liberals "seized upon the issue of extra-billing as a way of symbolizing its commitment to preserving the universality of the nation's most popular social program" and began the process of developing national legislation to protect the 1957 and 1966 hospital and medical insurance programs (Ibid). The 1984 Canada Health Act received all party support in spite of strong opposition from medical associations and the provinces (Ostry, 2006, p.64). It combined the 1957 and 1966 legislation into one, banning extra billing for insured services and reaffirming the medicare principles of public administration, comprehensiveness, universality, portability and accessibility.

While the Act ensured that Canadians would be entitled to similar levels of care provided in doctors' offices and hospitals across the country, once again, long-term care was left out of the mainstream of Canadian medicare. The Act makes mention of "adult residential care service" and "nursing home intermediate service" as being part of "extended health care services", however, the federal government did not declare

regulations that would define such services, nor did it attach conditions to its funding of such services (CUPE, 2009, p.21). As such, long-term care was "defined out of the Canada Health Act" (Armstrong and Armstrong, 2008, p.46).

The exclusion of long-term care from the Canada Health Act has meant that the words public administration, comprehensive, universal, portable and accessible need not apply to the sector. Although for-profit companies had always been active in residential care in Canada, the designation of long-term care as merely an 'extended' service in this national legislative framework further opened the door to market principles in the sector. By defining long-term care out of the Canada Health Act, the federal government ensured that an area of care long relegated to the periphery of the nation's health care system would be forced to remain there. While the political will to enforce a new national program unpopular with the provinces and the medical community was demonstrated in the passing of the Act (Taylor, 1987), as with previous rounds of federal policy making, the will to expand the public focus of Canadian medicare beyond hospitals and doctors' offices was not there. As will be argued in the following chapter, while governments in provinces such as Manitoba were deeply concerned with expanding the boundaries of the Canadian health care system throughout the 1970s to better address the long-term care needs of older people, the federal government was uninterested in expanding the bounds of the system in any significant way. When it came to discussions about the Canada Health Act, federal policy makers were careful to limit public debate to the issue of extra billing, rather than institutional reform.

Despite the federal focus on extra billing and maintaining the current structure of Canadian medicare, arguments to make non-profit ownership of nursing homes part of any new national plan were presented to the federal government. The CMA, for example,

in response to the announcement of federal plans to move forward with the Canada Health Act, commissioned the Task Force on the Allocation of Health Care Resources to make recommendations of its own. Released in 1984, the task force made aging a critical part of its report and was highly critical of the growth of the for-profit nursing home industry and the lack of federal leadership to address it. It criticized the Canadian system which let homes "be run for profit under a lenient system of legislation and an impotent system of inspection" (cited in *Globe and Mail*, 1984, p. 6). "The Task Force opposes in principle the idea that our senior citizens, having worked all their lives towards building their country, should now contribute to the profits of others" (Ibid). It pointed out that non-profit homes "often exhibit a higher standard of care, food, rehabilitation, innovative recreational programs and, at the end of life, compassion, palliative care and respect for the individual" (Ibid). It recommended that for-profit care homes be phased out (Rich, 2010, p.12). This was an argument also being made by the United Seniors Citizens of Ontario. Its president, Joyce King, told the *Globe and Mail* in 1985, "we want to eliminate run-for-profit nursing homes" (cited in Steed, 1985, p.10).

Despite these and similar concerns expressed throughout the previous decades, the federal government ignored long-term care in the Canada Health Act. While the Canada Health Act reaffirmed that care provided in hospitals and doctors' offices was to be publicly funded and not-for-profit, its silence on long-term care served to reaffirm the notion that for-profit ownership and delivery of care was permissible and that co-payments and user fees were perfectly acceptable. Moreover, because the Canada Health Act has served to structure national health care debates in such a way that "the public, the politicians and even the taxpayers see health care only within the acute care system context", increasing privatization of long-term care has been allowed to occur largely

under the radar and outside of the democratic process (MacLean and Greenwood-Klein, 2002, p.76).

As it turns out, "The 1984 Canada Health Act marked the end of positive social program intervention on the part of the federal government" (Armstrong et al., 2009, p.29-30). Thereafter, welfare state programs were increasingly portrayed as threats to individual initiative and economic expansion (Ibid, 30). Inefficiency and ineffectiveness were terms that increasingly came to dominate government references to public programs. Federal and provincial governments concerned with rising debt and deficits cast social programs as the causes of irresponsible government spending, even though "tax cuts and a faltering economy were much more important causes" (Ibid, 30). The New Public Management philosophy rose to prominence in which "governments were to hand over as much as possible to be done by the for-profit sector, and any responsibilities that remained in government hands should be based on business principles" (Ibid, 30).

Between 1983 and 1993, the Mulroney Progressive Conservative government unilaterally changed the amount and nature of federal health care funding. This was continued under the Chretien Liberals in 1990s, who in the 1995 budget introduced the Canada Health and Social Transfer (CHST). The CHST rolled federal transfers for health care, post-secondary education and social assistance into a single block grant. The funding that had been previously reserved for extended health care services as part of the EPF was lost. As Marchildon argues, on the health care front, the CHST brought three significant changes (Marchildon, 2004, p.4). First, it meant that the provinces would have to increasingly spend from their own coffers to maintain their public health care systems during a period in which they had debt and deficit problems of their own. Secondly, federal funding under the CHST would be episodic and unpredictable given that the

escalator formula, which had tied increases in previous federal transfers to economic growth, was eliminated. Thirdly, it contributed to a highly acrimonious relationship between the federal and provincial governments in which discussions about the future of Canadian health care were dominated by dollars and cents. In this fractious climate, which lasted into the 2000s (albeit one that dissipated somewhat when federal funding was restored at the close of the 1990s), the possibility that any new shared-cost program could be introduced in which federal conditions attached was virtually nil (Marchildon, 2004).

While reforming the Canadian health care system in a meaningful way has been difficult under the best of circumstances, the “politics of blame avoidance” (Weaver, 2004; Pierson, 1996) made reform increasingly difficult. While all provinces in the late 1980s and early 1990s established task forces or commissions to investigate and give advice to policy makers on health care reform, nothing much came of these (Tuohy, 1999, p.97). On the seniors’ care front, “long-term residential care is largely invisible in Canadian policy debates” (Armstrong et al., 2009, p.12). The 2002 *Royal Commission on the Future of Health Care in Canada* made no recommendations to address residential long-term care. As the Ontario Coalition of Senior Citizens’ Organizations lamented following the Commission’s release, “the services most important to seniors – supportive home care and long-term residential care -- seem to have fallen off the Commission’s radar screen” (2002, http://dawn.thot.net/ romanow.html). In its “Report Card on the Romanow Report,” the National Union of Public and General Employees (NUPGE) was similarly critical of the inattention to long-term care. As it argued,

The Romanow report is a dismal failure on this objective. The report does not make any recommendations at all for institutional care. It assumes, for the most part, that through home care reform and increased coverage of acute and palliative home care services

under the CHA, you would be able reduce the demand for beds in long-term care institutions. The report does not recommend national standards for long-term institutions and it does not recommend new immediate public funding for long-term care. The total lack of recommendations in this area is clearly a major win for the huge private corporations involved in the long-term care industry, i.e. Extendicare. (NUPGE, 2002, http://dawn.thot.net/romanow.html)

As such responses clearly indicate, when it comes to long-term residential care the federal policy-making environment in the 2000s, like the 1960s, is characterized by an absent mandate.

Conclusion

I have argued in this chapter that central governments in Canada and Britain have structured their respective national health care systems in a manner that gives low priority status to long-term care. Focusing primarily on the issue of residential care, the preceding pages have illustrated that the care needs of older people have never been incorporated into the mainstream of these welfare states. By breaking down central government approaches to the sector into three phases, I have emphasized that successive Canadian and British governments have shared in common a lack of political will to elevate long-term care on the list of social policy priorities. From the late 1940s until 1970 the national policy making environment in both countries was ‘long term care averse’. The need to develop national solutions to observable problems in residential care was ignored, or deferred, by central government actors enamoured with designing public health care systems around hospital and curative medicine. An approximately ten year window from the early 1970s to the early 1980s, is characterized by piecemeal and, it would turn out, temporary, central government involvement. For reasons both unique and shared, national governments in both countries rethought their lack of involvement in the sector, but only to a minor extent by providing some funding for the building of new homes. In the 1980s

and 1990s British and Canadian governments resumed their aversion to long-term residential care. In Britain, this was demonstrated most markedly by the Thatcher government's policies to support private-sector provision. In Canada, through the exclusion of long-term care from the 1984 Canada Health Act as well as its marginalization in cost-sharing arrangements, federal governments of the period cemented the peripheral status of this form of care in the Canadian welfare state.

It can be little wonder that private companies wishing to make a profit in the health care arena have over time looked to the long-term care sectors in Canada and Britain. It was emphasized at the beginning of this chapter that understanding contemporary trends requires that we "look at the development of health policy not as a series of discrete political struggles, but as an ongoing historical process in which past public policies and political battles shape what is possible in the future" (Hacker: 1998, p.127). National health policy in both countries has been an ongoing historical process in which political battles have been waged over public health care delivered in hospitals and doctors' offices. While central government actors have been willing to spend the political capital necessary to uphold a public-sector ethos in these areas, they have been unwilling to do so for the long-term care sector. In the Canadian and British welfare states, long-term care has been a low priority.

In the following chapters I explore why two provinces, Manitoba and Ontario, have come to rely on the for-profit sector to markedly different degrees in the absence of federal leadership.

Works Cited

Alexander, Taylor. "The History and Evolution of Long-Term Care in Canada." *Continuing the Care: The Issues and Challenges for Long-Term Care*. Ed. Eleanor Sawyer. Ottawa: CHA Press, 2002. 1-53.

Alberta Union of Provincial Employees. Brief to the Commission on the Future of Health Care in Canada. May 2002. Retrieved from: http://aupe.nucleus.com/Romanow0402.pdf August 11 2012.

Andrews, Gavin J. and David R. Phillips. "Private Residential Care for Older Persons: Local Impacts of Care in the Community Reforms in England and Wales." *Social Policy and Administrati*on. 34.2. (2000): 206-222.

Armstrong, Pat and Hugh Armstrong. *Health Care*. Black Point, N.S.: Fernwood, 2008.

Armstrong, Pat et al. *They Deserve Better: The Long-Term Care Experience in Canada and Scandinavia*. Ottawa: Canadian Centre for Policy Alternatives. 2009.

Armstrong, Wendy and Raisa Deber. "Reading the Fine Print: Focus on Long Term Care Insurance: Will it Meet the Needs of Canadian Families and Communities?" Retrieved from: http://www.teamgrant.ca/M-THAC%20Greatest%20Hits/M-THAC%20Projects/All%20info/Reading%20The%20Fine%20Print/Publications/p401089.pdf July 22 2012.

Attonen, Anneli, Sipila, Jorma and John Baldock. "Patterns of Social Care in Five Industrial Societies: Explaining Diversity." *The Young, the Old and the State*. Ed. Anneli Attonen, John Baldock and Jorma Sipila. Cheltenham, UK ; Northhampton, MA : E. Elgar Pub., 2003. 167-197.

Baldock, John. "Social Care in the United Kingdom: A Pattern of Discretionary Social Administration." *The Young, the Old and the State*. Ed. Anneli Attonen, John Baldock and Jorma Sipila. Cheltenham, UK ; Northhampton, MA : E. Elgar Pub., 2003. 109-141.

Begin, Monique. Hansard. Canada. Parliament. House of Commons. February 22, 1978. 3114

Berta, Whitney et al. "A Pan-Canadian Perspective on Institutional Long-Term Care." *Health Policy*. 79 (2006): 175-194.

Boychuk, Gerard. *National Health Insurance in the United States and Canada: Race, Territory and the Roots of Difference*. Washington: Georgetown University Press, 2008.

Bridgen, Paul. "Hospitals, Geriatric Medicine, and the Long-Term Care of Elderly People 1946-1976." *Social History of Medicine*. 14.3 (1991): 507-523.

Brooks, Alfred Johnson. Hansard. Canada. Parliament. House of Commons. May 16, 1956. 3994.

Bryden. P.E. "The Liberal Party and the Achievement of National Medicare." *CBMH*. 26.2 (2009): 315-332.

Canadian Health Care Association. New Directions for Facility-Based Long-Term Care. Ottawa: Canadian Health Care Association. 2009. Retrieved from: http://www.cha.ca/wp-content/uploads/2012/11/CHA_LTC_9-22-09_eng.pdf August 24, 2012

CUPE (Canadian Union of Public Employees). Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care. Ottawa: Canadian Union of Public Employees. 2009 Retrieved from: http://cupe.ca/updir/CUPE-long-term-care-seniors-care-vision.pdf October 12, 2011

Cohen, Marcy, Jeremy Tate and Jennifer Baumbusch. An Uncertain Future for Seniors: BC's Restructuring of Home and Community Health Care Restructuring, 2001-2008. Ottawa: Canadian Centre for Policy Alternatives. 2009. Retrieved from: http://www.policyalternatives.ca/publications/reports/uncertain-future-seniors September 20, 2012

Davidson, Alan. "Dynamics Without Change: Continuity of Canadian Health Policy." *Canadian Public Administration*. 47.3 (Fall 2004). 251-279.

Davies, Megan J. *Into the House of Old: A History of Residential Care in British Columbia*. Montreal: McGill-Queen's University Press, 2003.

Davis, R.E.G. Senate of Canada Committee of Canada Testimony. July 16, 1964. 1097

Douglas, Tommy. Hansard. Canada. Parliament. House of Commons. June 17, 1976. 14623

Globe and Mail. "Options for Aging (2)." September 11, 1984. 6

Green, Howard Charles. Hansard. Canada. Parliament. House of Commons. May 16, 1956. 3991.

Gorsky, Martin. "The British National Health Service 1948-2008: A Review of Historiography." *Social History of Medicine*. 21.3 (2008)" 437-460.

Grossart, Allister. Senate of Canada Committee on Aging Testimony. March 15, 1964. 91

Grey, Gwendolyn. *Federalism and Health Policy: The Development of Health Systems in Canada and Australia*. Toronto: University of Toronto Press. 1991

Hacker, Jacob S. “The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy.” *Studies in American Political Development*. 12 (Spring 1998): 57-130.

Harris, John and Catherine McDonald. “Post-Fordism, the Welfare State and the Personal Social Services: A Comparison of Australia and Britain.” *British Journal of Social Work*. 30 (2000): 51-70.

Harrington, Charlene and Allyson Pollock. “Decentralization and Privatization of Long-Term Care in UK and USA.” *The Lancet*. 351 (1998): 1805-1808.

Herridge, Herbert W. Hansard. Canada. Parliament. House of Commons. December 21, 1957. 2749

Hollander, Marcus J. “The Continuum of Care: An Integrated System of Service Delivery.” *Continuing the Care: The Issues and Challenges for Long-Term Care*. Ed. Eleanor Sawyer. Ottawa: CHA Press, 2002. 54-67. Holden, Chris. “The Internationalization of Long Term Care Provision: Economics and Strategy.” *Global Social Policy*. 2.47 (2002): 47-67.

Hudson, Bob and Melanie Henwood. “The NHS and Social Care: The Final Countdown?” *Policy & Politics*. 30.2 (2002): 153-166.

Jewish Home for the Aged and Baycrest. Brief to the Senate Committee on Aging. Canada: Senate of Canada Committee on Aging. March 12, 1964. 142.

Johnson, Julia, Rolph, Sheena and Randall Smith. *Residential Care Transformed: Revisiting the ‘Last Refuge.’* Palgrave Macmillan. 2012.

Johnson, Norman. “The Personal Social Services and Community Care.” *New Labour, New Welfare State: The ‘Third Way’ in British Social Policy*. Ed. Martin A. Powell. Bristol: The Policy Press, 1999. 77-100.

Kerrison, Susan H and Allyson Pollock. “Caring for Older People in the Private Sector in England. *British Medical Journal*. 323.7312 (2001).

Knowles, Stanley. Hansard. Canada. Parliament. House of Commons. March 14, 1956. 2147.

Langan, Mary. “Community Care in the 1990s: The Community Care White Paper: ‘Caring for Peopl.e’” *Critical Social Policy*. 29 (1990): 58-68.

Maarse, Hans. “The Privatization of Health Care in Europe: An Eight-Country Analysis.” *Journal of Health Politics, Policy and Law*. 31.5 (2006): 981-1014.

Maclean, Michael J. and Jennifer Greenwood Klein. “Accessibility to Long-Term Care: The Myth versus the Reality.” *Continuing the Care: The Issues and Challenges for Long-Term Care*. Ed. Eleanor Sawyer. Ottawa: CHA Press, 2002. 67-87.

Maioni, Antonia. *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada*. Princeton: Princeton University Press, 1998.

Marchildon, Gregory P. “Three Choices for the Future of Medicare.” Ottawa: Caledon Institute of Social Policy. April 2004.

Marchildon, Gregory P. (Editor). *Making Medicare: New Perspectives on the History of Medicare in Canada*. Toronto: University of Toronto Press, 2012.

Morris, Burrell D. Brief from Associated Nursing Homes Incorporated of Ontario. Canada. Senate of Canada Committee on Aging Testimony. July 16, 1964. 1096.

Means, Robin and Randall Smith. *From Poor Law to Community Care: The Development of Welfare Services for Elderly People 1939-1971*. 2nd Edition. Bristol: The Policy Press, 1998.

McGregor, Margaret J. and Lisa A. Ronald. Residential Long-Term Care for Canadian Seniors: Non-profit, For-Profit or Does it Matter? IIRP. 14(January 2011). Retrieved from: http://www.irpp.org/pubs/irppstudy/2011/irpp_study_no1.pdf

Naylor, David. *Private Practice, Public Payment: Canadian Medicare and the Politics of Health Insurance, 1911-1966*. Kingston: McGill-Queen’s University Press, 1986.

Naylor, David. “Health Care in Canada: Incrementalism Under Fiscal Duress.” *Health Affairs* 18.3 (1999): 9-26.

Netten, Ann, Darton, Robin and Jacquetta Williams. “Nursing Home Closures: Effects on Capacity and Reasons for Closure.” *Age and Ageing* 32 (2003): 332-337.

Neysmith, Sheila. “A Failure of Vision and Political Will.” *A Place the Call Home: Long-Term Care in Canada*. Ed. Pat Armstrong et al. Black Point, NS: Fernwood, 2009. 89-96.

NUPGE. “NUPGE - Report Card on the Romanow Report”. 28 November 2002 http://dawn.thot.net/romanow.html

Ontario Society (Coalition) of Senior Citizens' Organizations. “Ontario Coalition of Senior Citizens' Organizations: Romanow Report Gets B+ From Ontario Seniors.” 28 November 2002. http://dawn.thot.net/romanow.html

Orlikow, David. Hansard. Canada. Parliament. House of Commons. April 29, 1976. 1305.

Ostry, Aleck. *Change and Continuity in Canada's Health Care System*. Ottawa: CHA Press, 2006.

Peace, Sheila M, Kellaher, Leonie A. and Dianne M. Willcocks. *Re-Evaluating Residential Care*. Open University Press. 1997.

Pierson, Paul. "The New Politics of the Welfare State." *World Politics*. 14.2 (1996): 143-179.

Player, Stewart and Allyson M. Pollock. "Long-term Care: From Public Responsibility to Private Good." *Critical Social Policy*. 21.2 (2001): 231-255.

Pollock, Allyson. "Where Should Health Services Go: Local Authorities versus the NHS?" *British Medical Journal*. 310 (1995): 1580-1589.

Rich, Pat. "Canada's Aging Population: Demographic Time Bomb or Economic Myth." *Elder Care Magazine*. 2010. Retrieved from: http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/WhatWePublish/LeadershipSeries/English/pg11EC.pdf December 20, 2012.

Rodriguez, John. Hansard. Canada. Parliament. House of Commons. February 17, 1976. 11037

Romanow, Roy. *Building on Values: The Future of Health Care in Canada. Final Report. Commission on the Future of Health Care in Canada*. Saskatoon: Gibson Library Connections, 2002.

Rummery, Kirstein and Caroline Glendinning. "Negotiating Needs, Access and Gatekeeping: Developments in Health and Community Care Policies in the UK and the Rights of Disabled and Older Citizens." *Critical Social Policy*. 19.3 (1999): 335-351.

Rynard, Phillip. Hansard. Canada. Parliament. House of Commons. June 23, 1960. 5303

Rynard, Phillip. Hansard. Canada. Parliament. House of Commons. October 3, 1974. 63

Rynard, Phillip. Hansard. Canada. Parliament. House of Commons. May 18, 1976. 1352

Scourfield, Peter. "Are There Reasons to be Worried About the 'Caretelization' of Residential Care?" *Critical Social Policy*. 27.2 (2007): 155-180.

Senate of Canada. Final Report of the Special Senate Committee on Aging in Canada. 1966

Steed, Judy. "Home Free: Some Old People Are Fighting the Notion that the Elderly Belong in Institutions." *Globe and Mail*. August 10, 1985. 10.

Stewart, John. "Ideology and Process in the Creation of the British National Health Service." *Journal of Policy History*. 14.2 (2001): 113-134.

Stewart, John. "The Political Economy of the British National Health Service, 1945-1975: Opportunities and Constraints?" *Medical History*. 52 (2008): 453-470.

Struthers, James. "Reluctant Partners: State Regulation of Private Nursing Homes in Ontario, 1941-1972." *The Welfare State in Canada: Past, Present, and Future*. Ed. Raymond B. Blake, Penny E. Bryden and J. Frank Strain. Concord: Irwin Publishing, 1997. 171-192.

Struthers, James. "'A Nice Homelike Atmosphere': State Alternatives to Family Care for the Aged in Post World War II Ontario." *Family Matters: Papers in Post-Confederation Canadian Family History*. Ed. Lori Chambers and Edgar-Andre Montigny. Toronto: Canadian Scholars Press, 1998, 335-354.

Struthers, James. "'No Place Like Home': Gender, Family, and the Politics of Home Care in Post-World War II Ontario." *CBMH* 20. 2. (2003): 387-417.

Struthers, James. "Framing Aging Through the State: Canada's Two Senate Committees on Aging, 1963-1966 and 2006-2009." *Canadian Review of Social Policy*, vols. 68-69, February, 2013, 1-9.

Taylor, Malcolm G. *Health Insurance and Canadian Public Policy: The Seven Decisions That Created the Canadian Health Insurance System and Their Outcome*. Kingston and Montreal: McGill-Queen's University Press, 1987.

Thane, Pat. *Old Age in English History: Past Experiences, Present Issues*. Oxford: Oxford University Press, 2000.

Toronto Star. Nursing Home Operators Angry. January 7, 1965. 21

Toronto Star. Garbage for the Blind. January 9, 1965. 6.

Townsend, Peter. *The Last Refuge; A Survey of Residential Institutions and Homes for the Aged in England and Wales*. Londong: Routledge and Paul. 1963.

Tuohy, Carolyn J. *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada*. New York: Oxford University Press, 1999.

Wanless, Derek. "Securing Good Care for Older People: Taking a Long-Term View." 30 March 2006. Retrieved from www.kingsfund.org/document.rm?id=6292

Weaver, R. Kent. "Pension Reform in Canada: Lessons for the United States." *Ohio State Law Journal*. 65.1 (2004): 45-74.

Webster, Charles. "The Elderly and the Early National Health Service." *Life, Death and the Elderly: Historical Perspectives*. Ed. Margaret Pelling and Richard Smith. Florence: Routledge, 1994. 138-160.

Willcocks, Dianne, Peace, Sheila and Leonie Kellaher. *Private Lives in Public Places*. London: Tavistock. 1987.

Chapter 3 'In from the Fringe': Entrenching Non-profit Long term care within Manitoba's Welfare State, 1969-1999

In this chapter and the next, the focus of analysis shifts to the provincial level in Canada. Because federal funding for long-term care was not included as part of Canada's publicly-funded universal health care system, provincial governments have been left to determine how much, or how little, they would like to rely on the for-profit sector to meet the long-term care needs of their senior populations. The proportion of beds in the for-profit sector differs in each province, demonstrating that policy approaches to this type of care have developed according to distinct provincial political contexts. The remainder of this dissertation is concerned with explaining why governments in two provinces, Manitoba and Ontario, have come to rely on the proprietary sector to markedly different degrees. In 2009, for example, 53 percent of long-term care beds in Ontario were in the for-profit sector while proprietary beds in Manitoba accounted for just 26 percent of total bed supply (CUPE: 2009). As with the previous chapter, the following pages emphasize the necessity of understanding contemporary trends in for-profit ownership in relation to larger historical patterns.

Focusing on Manitoba, I begin the present chapter by arguing that the foundations for a formidable non-profit presence in long-term care were laid in the 1970s because of the coming together of two factors unique to the province at the time. These were the election of the province's first social democratic government in the years 1969 to 1977, and the maturation of a cohesive community of geriatric specialists capable of advocating for long-term care reform on a not-for-profit basis. When the New Democratic Party (NDP) government of Ed Schreyer published the 1972 *White Paper on Health Policy*, which stated its desire to make the health care system more responsive to those whose

needs had been ignored under federal cost sharing arrangements, as well as its openness to reform proposals, there was a cadre of geriatric specialists that could demonstrate, through pilot projects and research initiatives in place since the late 1950s, the benefits of prioritizing non-profit approaches to long-term care. The fact that a government interested in broadening the scope of the provincial health care system beyond hospitals and physicians' offices was elected to office at a time when a community of geriatric specialists were increasing in number and expertise, was critically important. These developments in the 1970s, culminating with incorporation of nursing home and home care services within Manitoba's health insurance scheme in 1973 and 1974, reflected the ambitions of government and geriatric specialists to bring long-term care in from the fringes of the province's welfare state. In this formative period of policy making, the idea that long-term care, like hospital and physician-based care, should be delivered in the absence of a profit-motive took root.

The latter portion of this chapter is concerned with explaining how public-sector care has been sustained in the province over time. The election of the Schreyer government was an opportunity for non-profit reformers to influence the direction of seniors' care in substantive ways. However, proprietary interests were given voice when Progressive Conservative premiers striving to take the province in neoliberal directions were elected to office in subsequent years. Two such premiers, Sterling Lyon (1977-1981) and Gary Filmon (1988-1999), tried to dramatically increase the role of the private sector in long-term care. While the Lyon government was committed to bolstering proprietary interests in personal care homes, the Filmon government sought to privatize home care. In neither instance were their efforts realized. These failed attempts bring to light two factors that have worked to forestall the expansion of for-profit care in

Manitoba. The first is that there are limits to the extent to which Manitobans are willing to embrace ‘big C’ conservative leaders who aim to significantly dismantle key features of the provincial welfare state. Lyon was the first Manitoba premier in the modern era to be given only one term by the electorate, and his privatization initiatives were reversed when his government was defeated by Howard Pawley's NDP. The second relates to the formation of a long-term care welfare state constituency in Manitoba committed to maintaining benefits previously enacted. Filmon was forced to withdraw his plans to privatize the province's home care program after the province's public sector home care workers, along with many seniors and their families, successfully mobilized against the introduction of a proprietary ethos to a public sector program that was meeting its objectives.

The Schreyer Election and the Opening of a Window of Opportunity

Ed Schreyer’s 25 June 1969 victory marked the first time that a social democratic party outside of Saskatchewan had been elected to govern a Canadian province. The New Democrats were one vote shy of a majority government, however. And while some Conservative and Liberal MLAs talked of forming an “anti-socialist coalition” in order to prevent an NDP government, Liberal MLA Laurent (Larry) Desjardins crossed the floor to join the government, thereby facilitating a Schreyer majority (Former Manitoba MLAs Newsletter, 2007). The former funeral director who was first elected to the legislature in 1959 gave his support to the government on the condition that funding for denominational schools would maintain a prominent place in the government’s policy agenda (Ibid). A centrist like Schreyer, Desjardins would become an influential cabinet member, particularly in the health care portfolio. His crossing the floor helped to make it possible for the NDP, since making the transition from the Cooperative Commonwealth

Federation (CCF) in 1961, to form a government. It would take another year for the party to form a government in British Columbia and throughout the 1970s it would not be elected to power in any other province (McAllister, 1984, p.1). Given that the NDP and its predecessor CCF had been a third party in Manitoba politics during the 1950s and 1960s, garnering between 15 and 23 percent of the popular vote, Schreyer's victory was path-breaking and an indication that social democracy was no longer considered to be an alien presence in the province (Adams, 2008, Wiseman, 2010). With the exception of a brief resurgence of the Liberal party in the 1988 election under the leadership of Sharon Carstairs, the NDP would alternate with the Progressive Conservatives in holding the positions of governing party and official opposition.

At first blush, the argument that the Schreyer NDP was fundamental to the development of a non-profit long-term care sector in Manitoba can seem out of step if it is considered in light of some of the broader criticisms that have been made about its time in office. In *The Government of Edward Schreyer: Democratic Socialism in Manitoba*, James McAllister argues that "the NDP government moved only the minimum distance possible into the domain of the private sector" (McAllister, 1984, p.70). While McAllister acknowledges that the NDP did expand the scope of the public sector in 1971 by implementing public automobile insurance in the face of strong opposition from the insurance industry and its supporters, he argues that such legislation should be recognized as "a temporary aberration which was never to be repeated" (Ibid, p. 64). For McAllister, the overall picture of the Schreyer years was one of a government desperate to retain votes and reluctant to incur the wrath of private economic interests. Often eager to downplay the social democratic label, the government was "afraid to move as far as a Conservative, Liberal, or Social Credit government might have moved to increase the

scope of activity of the public sector" (McAllister, 1984, p. 70). Similarly, Nelson Wiseman argues in *Social Democracy in Manitoba: A History of the CCF-NDP*, that "little in the NDP governments' performance diverged from what non-NDP provincial governments did. The NDP operated in office much like its political opponents when they were in office" (Wiseman, 1985, p. 139). For Wiseman, "there was no evidence that the NDP government had actually threatened the interests or welfare of the dominant class in society. Rather, government activities were almost always within the bounds that threatened no one" (Wiseman, 1985, p. 139). Similarly, McAllister holds that there was a marked "failure to innovate", asserting that "Even where a need was recognized and the government was determined to take action, the end product of the policy process was slight, changes were at the margin, resulting in the least possible dislocation" (McAllister, 1984, p. 79). Overall, Manitoba's first NDP government is remembered for its moderation rather than its innovation.

If long-term care is not considered, there is some merit to such arguments. As a leader, Schreyer did embrace a moderate, centrist position on the ideological spectrum rather than an overt agenda of social democratic transformation. In many respects, the Schreyer years were an extension of the moderate, red-tory style of former Progressive Conservative premier Duff Roblin (1958-1967). Roblin coined the phrase "progressive centre" to describe the ideological middle ground from which a majority of Manitobans wish to be governed (Wesely, 2011, p. 147). The progressive centre, according to Roblin, was not a place for the ideological extremes of the right or the left, but rather a place where the tenets of economic liberalism and social democracy could be incorporated to move the province forward (Ibid). Wesely argues that the most successful premiers in the post-Roblin era, including Schreyer and Gary Doer, have emulated Roblin's progressive

centrism, not veering too far to the left or to the right (Wesely, 2011). When the political climate changed following Roblin's departure for federal politics in 1967, the NDP, under Schreyer, could be seen as a fitting alternative to his red tory style. In Roblin's absence the Progressive Conservative Party selected former highways minister Walter Weir, a figure committed to moving the party's and the province's political compass to the right (McCaffrey, 1986, p. 33). The Liberal party, under the leadership of Bobby Bend, was similarly moving rightward and the "dramatic lurch to the right" by both parties was off-putting for a majority of voters who had come to see government in a new light under Roblin's tenure as premier (Wiseman, 2010, p. 75).

Presenting himself to the electorate as a pragmatist and moderate centrist, Schreyer was able to connect with a majority of voters (Wiseman, 1985, p. 121). Moreover, as a German-Canadian Catholic able to speak in four languages, Schreyer could appeal to the province's ethnic minorities, many of whom had yet to see a leader of non Anglo-Saxon Protestant descent occupy the premier's office (Wiseman, 2010, p. 77). His charismatic performance in the NDP's first televised leadership debate helped to facilitate his victory, as did changes to the electoral map which increased the representation of Winnipeg in the Legislature prior to the 1969 election (Ibid).

While McAllister and others are not wrong to point to a general tendency of the Schreyer government to embrace a cautious, centrist position on the ideological spectrum during its years in office, allegations of non-innovation and an unwillingness to disrupt private-sector interests do not hold weight if long-term care is considered. When it came to long-term care, the NDP increased the scope of the public sector to a considerable extent and moved further than Conservative, Liberal or Social Credit governments across the country to bring nursing homes and home care within the mainstream of health care.

Reforms undertaken in 1973 and 1974 were unique and path breaking among Canadian provinces at the time. However, Manitoba-based political science and welfare state scholarship, like that produced in the broader Canadian setting and the international community, has tended to ignore long-term care. It is absent from McAllister and Wiseman's 1984 and 1985 accounts. More recent publications, including Christopher Adams' (2008) *Politics in Manitoba: Parties, Leaders, and Voters* and Paul G. Thomas and Curtis Brown's (2010) edited collection *Manitoba Politics and Government* similarly do not take up long-term care policy. While Adams, for example, considers in his analysis of the Schreyer years the creation of Autopac, the furthering of Manitoba Hydro development, support for medicare, the creation of a provincial pharmacare plan, new public housing programs, labour reforms, the creation of the Department of Northern Affairs, restructuring of the administration and government of greater Winnipeg, guaranteed incomes for seniors, and free day care, legal aid and employment training for low-income Manitobans, no mention is made of long-term care (Adams, 2008, p. 119-121).

The edited collection by Thomas and Brown contains chapters that provide historical background on a diverse range of social policy issues important to the province, but long-term care is not one of them. Even in his biography, *Keep True: A Life in Politics* (2011), Howard Pawley devotes his attention to pioneering aspects of Manitoba politics other than long-term care. Focusing instead on such innovations as Autopac, environmental protections, the Manitoba Jobs Strategy, and the general challenges and opportunities of being the lone social democratic premier in the federation, Pawley gives almost no attention to the story of long-term care. At one level, given what I argue in the following pages on the pioneering aspects of geriatric care in Manitoba, such an omission

is entirely surprising. On another level, however, given long-term care's lack of attention in broader Canadian scholarship, one ought never to be surprised when the sector is omitted. In considering the key actors and events in the political history of the sector, the following pages shed light on a fundamentally important component of the Manitoba welfare state.

The 1972 *White Paper on Health Policy*

In Chapter 2 of this dissertation, I emphasized the criticisms of a number of political actors and organizations surrounding the inattention to long-term care in federal health care thinking. The final report of the Canadian Senate's Committee on Aging argued that "There is entirely too little emphasis on aging and on the overall care of the chronically ill at the federal level" and that the well-being of seniors was hindered by "the lack of clear policy" on long term care (Senate of Canada: 1966, p.121, 32). During the 1960s and 1970s, NDP MPs in Ottawa were calling attention to the marked lack of political will shown by the federal government to treat the nursing home sector with any sense of national priority. As New Democrat MP Tommy Douglas argued, "A lot could be done in this country by the establishment of more nursing homes, the provision of home-care treatment, meals on wheels, more extended care units in hospitals"; however the federal government showed little interest in "altering the focus" of the Canadian health care system to make it more responsive to the unique needs of seniors (Douglas: 1976, p. 14623).

In stark contrast to the prevailing climate of disinterest in long-term care at the federal level and the lack of political will to make it a priority, altering the focus of medicare animated the Schreyer government in Manitoba. One indication of his government's interest in better meeting the needs of seniors came with the hiring of

leading gerontological thinker Betty Havens in 1971 to spearhead the Aging in Manitoba Longitudinal Studies (AIM). Along with Enid Thompson, the Consultant on Aging in the newly formed Division of Research, Planning and Program Development within the department of Health and Social Development, Havens helped the government achieve its goal of developing "a comprehensive knowledge base on the needs and resources for Manitoba" (Havens and Thompson, 1971, p. 7). Using interviews with Manitobans aged 65 and older, the AIM was established to gain a better understanding of the needs of seniors, including those related to mental and physical health, economic status, leisure activities, support networks and care services. Ten volumes were published by 1974 and the AIM Longitudinal Study would become North America's lengthiest continuous study of aging. Between 1971 and 2001 nearly 9000 older Manitobans were interviewed. (http://umanitoba.ca/centres/aging/research/funded_projects/1068.html).

In 1972, Havens was hired to the position of Research Director with Manitoba's Department of Health. While five years earlier the Final Report of the Senate Committee on Aging could rightly argue that "Health departments at present seem preoccupied with maternal and child health to the exclusion of other age groups" (Senate of Canada, 1966, p.121), Manitoba's department, by facilitating the AIM Longitudinal Studies and hiring Betty Havens as Research Director, indicated an intention to move in a new direction. The unique needs of seniors, which had long been marginalized in health policy making, were given new importance. Within this new environment, the idea to write the 1972 *White Paper on Health Policy* was born. The publication of this policy document was further indication of the government's desire to alter the focus of the province's health care system in order to bring older Manitobans from the fringes to the mainstream of the welfare state. It was authored by Saul Miller, who would hold a number of high profile

cabinet positions in the Schreyer government, including Health, Education, Finance, and Urban Affairs (Promsilow, 1993, p.B15). A former school board chairman, city councillor and mayor of the city of West Kildonan, Miller was elected to the Manitoba legislature in 1966 and was part of a small group of MLAs that occupied Schreyer's inner circle (McAllister, 1984, p. 77).

The selection of Miller to author the White Paper took place within a broader context of government restructuring and rethinking of health and social care. In Manitoba, as in other provinces, health and welfare had traditionally been under the control of separate ministries. In October 1971, however, the Department of Health and Social Development was formed, thereby integrating the two portfolios (Shapiro, 1977, p. 33). The amalgamation brought together three central bodies: The Manitoba Health Services Commission, which was responsible for planning and budgeting for hospitals as well as paying for medical services; the Department of Health, which supervised, planned and delivered public health programs; and the Department of Welfare, where responsibility for social services and the provincial Social Assistance program resided (Ibid). The *White Paper on Health Policy* was reflective of the government's desire to bring organization and coherence to health and social services throughout the province.

The government described the 1972 *White Paper on Health Policy* as "a prelude to reform, but also an open invitation to Manitobans in discussing how reform is to proceed" (Manitoba, 1972, p. 46). Reform was needed in 1970s Manitoba, it argued, not only because directing resources towards hospital and physician care was becoming increasingly expensive, but also because the care needs of certain populations, including those living in remote regions, the poor and seniors, were not being adequately addressed. The situation of older Manitobans in need of long-term care was particularly troubling for

the authors of the White Paper. While much government attention had been devoted to funding, planning and organizing hospital and physician care in the years following the implementation of the federal cost-sharing arrangements, long-term care services had developed in uneven ways. Designated as part of social care rather than health care, such services were “separated from ‘curative’ medicine by a tangle of financial, organizational and professional barriers” (Ibid, p. 31).

The financial barriers to long-term care resulted from the fact that nursing home and home care services were not insured under the federal cost-sharing agreements. About sixty percent of seniors residing in personal care homes, the White Paper pointed out, relied on the provincial social allowances program, demonstrating the limited financial means of older people (Ibid, p. 11). Since the organization began in 1957 Winnipeg's Age and Opportunity Bureau (which is discussed in greater detail below) had been critical of the financial barriers to nursing home care. In an investigation into the care needs of older Manitobans conducted in the latter part of the 1960s, the Bureau stressed that the financial barriers facing seniors upon leaving the hospital for a long-term care facility were extensive (*Winnipeg Free Press*, August 22, 1968, p. 1). “It has been widely recognized by professional and administrative leaders in the health and welfare community,” the Bureau emphasized, “that it is essential that steps be taken to bring an end to the highly unsatisfactory situation which exists in Greater Winnipeg with regard to the elderly and disabled persons in need of nursing home care” (Ibid). The organization believed that “the government should investigate the possibility of starting an insurance fund” for nursing home care in order to alleviate the financial barrier and bring the sector into the mainstream of the province's health care system (Ibid).

In addition to these financial arguments, the White Paper argued that another barrier to long-term care was the lack of organization. As with the broader Canadian setting, older people in Manitoba faced a “non-system” when it came to health care (Manitoba, 1972, p. 34). As the province entered the 1970s, the negative consequences accompanying the absence of planning and organization of long-term care services were becoming increasingly evident. When it came to facility-based care, the White Paper pointed out that there were 36 proprietary and 48 non-proprietary nursing homes in the province at the time of publication, with a total bed capacity of 6,230 (up from about 2,900 beds in 1960) (Ibid, p. 8). While the percentage of beds in the for-profit sector was not stated in the White Paper, as noted below the proportion of non-proprietary to proprietary beds would remain fairly stable in the 1970s and 1980s at about 5 to 2. The lack of organization and planning meant the province's long-term care beds were located in facilities that were of different age, that provided different levels of care, were built with different combinations of funding, operated according to different logics, and charged different fees (Ibid, p. 33). A typical Manitoba community was described in the following way. It

contains a number of institutions for elderly and infirm persons. These include a privately owned nursing home converted from the old hospital building which has since been replaced by the new district hospital. There is also a more modern personal care home and hostel which was built with provincial and municipal funds and is operated by a local board similar to the hospital. It serves mostly recipients of provincial social allowances. Further there is a motel-type housing project for senior citizens operated by a service club and subsidized jointly by the club, the province and the municipality. The newest addition to this complex of special accommodation is an elderly persons' housing project built by the Manitoba Housing and Renewal Corporation, managed by a municipal housing authority and subsidized jointly by MHRC and the Canada Mortgage and Housing Corporation. The rents charged for the newer MHRC housing are lower than those charged for the elderly persons' housing operated by the service club though both were provided and are subsidized under provincial government programmes (Ibid, p. 33)

Clearly, there was a lack of planning and coordination when it came to facility-based long-term care. A myriad of interests, public and private, were involved in building and running care homes and as a result it was impossible to speak of a long-term institutional care 'system'. A lack of continuity characterized the sector.

The Age and Opportunity Bureau Report was especially troubled by the lack of organization and planning. (*Winnipeg Free Press*, August 22, 1968, p. 1). The Report noted that in 1968, 1,802 beds in personal care homes existed in the Greater Winnipeg area and all were occupied (Ibid). 799 beds were in privately-owned facilities while the rest were in non-profit homes (Ibid). Of the 1,802 beds, 1,325 were in converted facilities that did not meet the building standards outlined in legislation developed four years earlier for new construction (Ibid). In its survey of personal care homes the Bureau discovered that out of the 18 privately-owned personal care homes in Winnipeg, half did not want to expand or replace their facilities, which were in aging, converted buildings (Ibid). Four non-profit homes were in the planning and construction phases to update or replace their facilities with the help of provincial grants (*Winnipeg Free Press*, August 22, 1968, p. 1). The Greater Winnipeg Social Service Audit spoke of the importance of improving the availability and quality of long-term care facilities in its 1969 report, and noted the tradition of poor quality care in privately-run homes in the province. It emphasized that the care and accommodation provided in a number of Manitoba's private homes was lacking and highlighted such things as overcrowding, insufficient heat and light, and inadequate supervision and treatment as evidence (*Winnipeg Free Press*, June 18, 1969, p. 38).

Saul Miller's 1972 White Paper also pointed to the lack of organization and planning for other long-term care services, including home care and rehabilitation

services for seniors. In 1967 there were three agencies providing home care services and eighteen involved in rehabilitation (Manitoba, 1972, p. 29). Quoting the 1969 Winnipeg Social Service Audit, it stressed that "as a result of the proliferation of agencies, the duplication and fragmentation, the client is often lost in the maze" (Ibid, p. 30). For the older Manitoban, the search for care that was high quality and affordable could thus be a highly complicated and complex process. In strong language, the White Paper explained that the fragmented, unplanned, and unorganized nature of long-term care services was a significant barrier to the well-being of Manitoba's older population:

It might be said that for old people, that such a system at its worst can be an unintended proxy for euthanasia of the spirit. The scientific knowledge is available to treat their pneumonia and their strokes. What is missing are those well-conceived, carefully executed programmes that ensure decent housing, nutrition, opportunities for socializing and early detection of physician complaints (p. 34).

In other words, while older people within the post-hospital and medical care insurance era could reasonably depend on the health care system to meet their acute care needs, the situation for long-term care was markedly different. While extensive resources had been devoted to the planning and upholding of the curative functions of the health care system, little had been done to take into consideration the unique long-term care needs of seniors. In contrast to some European nations where "it has been demonstrated that an integrated health-oriented approach can salvage many years of life that is much more than desolate vegetation," the Manitoba, and Canadian, health care system "is indeed inadequate, and unnecessarily so" (Ibid, p. 34).

In addition to the "extremely high costs in personal well-being" (Manitoba, 1972, p. 34) associated with fragmentation and lack of planning, there was the stark financial cost to the province. The White Paper pointed to the findings of the 1971 Commission of Inquiry into Hospital Admissions, chaired by Justice John Hunt, as evidence of the high

costs resulting from older people relying on the hospital system when they were unable to navigate the long-term care system. The Commission found that "Every submission from the hospitals in Winnipeg, supported by information from other areas, indicates that in acute care hospitals 10% to 30% of the patients occupying beds could be cared for at least as well and at less cost in extended care hospitals or nursing homes" (Ibid, 13-14). The number of seniors relying on acute care hospitals because of a severe shortage of nursing home and home care services was adding further cost to an already increasingly expensive system. The White Paper emphasized that in the ten year period between 1960 and 1970, hospital usage rose from 1,561,369 Manitobans per year to 1,923,684. In the same period costs increased from $32 million to $95 million. In per capita terms, this represented an approximate tripling of costs from $35.81 per person to $96.86 from 1960 to 1970 (Ibid, p. 8). The cost of physician care also rose from $21.86 to $54.13 per person (Ibid, p. 8, 19). [1]

As Saul Miller argued in his analysis, given the fragmented state of the health care system there was "no incentive and no effective mechanism to determine that the correct, sufficient proportions of the various kinds of facilities are constructed" (Ibid, p. 3). Although new nursing homes were "more urgently needed" in 1970s Manitoba than were new acute care hospitals, no "effective force" existed to ensure that they would be built (Ibid, p. 4). Existing outside of the mainstream health care system, long-term care could easily be starved of resources or delay building up the sector. A lack of high quality facilities combined with the absence of insurance meant that "There is little incentive and virtually no method by which the conscientious doctor can do anything else from time to

[1] Note: I have not been able to determine if these figures have been adjusted for inflation

time but to make the socially expensive decision of placing a person who could equally well be treated in inexpensive facilities into extremely costly facilities" (Ibid, p. 3).

In addition to fragmentation and cost, a third barrier to long-term care highlighted in the White Paper was professional. Just as the different health care facilities tended to exist as silos, with little effective communication between them, so too did the different health care professions in the province. The goal of "better health" which should be the objective of any well-functioning health care system, was hindered by the lack of cooperation and consultation between the various professionals (Ibid, p. 31). According to Miller,

> The barriers which have grown up between the different professional groups contribute to the problem. Physicians, social workers, psychologists, nurses, all have separate professional concerns which deter an efficient sharing of tasks. Within each professional system different levels of workers – licensed practical nurses, nurses, general practitioners, specialists – all function within an often rigid framework, with their tasks defined more frequently in terms of what they cannot do rather than what they can do (Ibid, p. 31).

While a lack of interdisciplinary collaboration characterized the health care system at large, in the domain of long-term care, which straddled the health and social care sectors, it was especially pronounced.

The professional, organizational and financial barriers were emphasized in the *White Paper on Health Policy* to illustrate the reality that not all groups benefit equally from the health care system. Although universal hospital and medical care had achieved important things, when one paused to consider the situation beyond the walls of the acute care hospital and the physician's office, the "unsatisfactory and illogical" nature of the federal-provincial cost-sharing arrangements became glaringly apparent (Manitoba, 1972, p. 43). The White Paper argued that the publication of such a document was necessary in 1972 not only to highlight the inequalities and deficiencies in the system, but also because

of the lack of political will shown by the federal government to improve the situation. While the federal government had begun to acknowledge in negotiations with the provinces "the negative effects of the rigidities in the present system", it also indicated that "it was not prepared to share with the provinces the expenditures required to effect a reasonably rapid redirection of their programmes" (Ibid, p. 44).

The White Paper was an indication that Manitoba had "called for a fundamentally different approach" to the organization and financing of health care (Ibid, p. 44). Although the federal government had an "obligation to ensure that disparities affecting all citizens of Canada are reduced and ultimately eliminated" the likelihood of continued federal inaction on health care reform meant that it was important for Manitoba, and other provinces, to start the process (Ibid, p. 44). Miller concluded by stating that the NDP government "is prepared to listen and to learn...it would like to hear what professionals and laymen alike have to say about what they may view as the difficulties that need to be overcome en route to an improved system" (Ibid, p. 45). One question asked was "Should home care services be very rapidly developed? Should nursing home and hostel services become high priority developments?" (Ibid, p. 46).

Manitoba's Community of Geriatric Specialists

In his seminal *Agendas, Alternatives and Public Policies*, John Kingdon was concerned with answering the following question: "What makes people in and around government attend, at any given time, to some subjects and not to others?" (Kingdon, 1995, p. 1). A key reason why issues make their way onto the government agenda, he argued, related to whether or not there existed a cohesive and vibrant "community of specialists" committed to developing and advocating proposals and policy alternatives (Ibid, p. 116). A community of specialists consists of researchers, academics, and

advocacy organizations, all who have a shared interest in finding solutions to a problem in a particular policy field (Ibid). Transformative change does not take place simply because a problem presents itself. Of the vast array of problems that could be alleviated by government attention, only certain issues become politically salient at particular points in time, and only in some instances are alternative approaches considered in earnest by policy makers. While the election of a new party can certainly make the political conditions more favourable to reform, the chances for issue salience increase when there exists a community of specialists that have worked out alternative ways of doing things. In Kingdon's words, "Having a viable alternative for adoption facilitates the high placement of a subject on a governmental agenda, and dramatically increases the chances for placement on a decision agenda" (144). A community of specialists that has taken the time, often a process that requires years, to develop and agree on a set of policy proposals that are affordable, workable and in step with current government thinking, is important for moving reform forward.

Kingdon argued that a key factor forestalling the elevation of long-term care reform on the American political agenda in the 1970s was the absence of such a community (Kingdon, 1995, p. 14-15). Although it was no secret that Americans were getting older, and "that long-term medical care will increasingly be a pressing problem for the society", health specialists in the United States rarely discussed the issue of long-term care (14-15). For Kingdon, the lack of interest shown by medical groups towards long-term care greatly hindered the chances that the subject would ascend to a position of any sort of prominence on the political agenda. When researchers, academics, and advocacy organizations are not working together in a cohesive way to develop

alternatives, it is highly likely that "the subject either fades from view or never rises in the first place" (Kingdon, 1995, p. 178). Kingdon explains that in the American setting

> The present and future aging of the population indicates a problem that will become most pressing, and the 'gray lobby' has shown sufficient political muscle to create abundant incentives for politicians to be interested. But advocates have not devised solutions that are affordable and that have worked out the modalities of matching patients to the appropriate facility or other type of care (Kingdon, 1995, p. 178).

In the health care community, one policy activist explained to Kingdon, long-term care is "a difficult thing to get people to concentrate on" (Kingdon, 1995, p. 129). Another respondent argued that

> Long-term care is a back burner item. I have heard people talk about it for years, but nobody can decide what to do. None of the health insurance proposals take it on. There is a simple reason for that. Nobody can figure out how to handle it, and they're scared to death of trying. The numbers rise so fast when you crank in the demographic facts plus the cost of long-term care, it really boggles the mind when you think of taking on this additional financial commitment. So people play around with the alternatives and they fuss about doing something about home care, but that's about it (Kingdon, 1995, p. 138).

As such responses indicate, there is more to the elevation of long-term care on the political agenda than the mere presence of observable problems.

In contrast to the situation in the United States, and for most of Canada in the 1970s for that matter, Manitoba had a community of specialists who were committed to figuring out what to do about long-term care. There existed individuals and groups that were committed from an early stage to ensuring that long-term care not be a back burner item in the Manitoba medical, academic and political arenas. People such as Betty Havens, Enid Thompson, Jack MacDonell, Asa MacDonell, Evelyn Shapiro, Paul Hentelff and David Skelton were committed to advancing alternatives to seniors care for at least a decade before the NDP decided to take on long-term care reform. The monikers often attached to the above names illustrate the pioneering nature of these members of the

Manitoba community of specialists. Havens is remembered as "a pioneer in the study of aging" (Manitoba Historical Society, 2005) MacDonell as "one of the founding members of geriatric medicine in Canada" (Struthers, 2010, p. 12), Shapiro as "the Mother of Public Home Care", and Henteleff as "a pioneer in hospice and palliative care" (Canadian Virtual Hospice, 2009). Skelton opened the country's first 'terminal care unit' at St. Boniface Hospital in Winnipeg (Macdonald, 2006, p. 22). When the Schreyer government asked in the White Paper: "Should home care services be very rapidly developed? Should nursing home and hostel services become high priority developments?" (Manitoba, 1972, p. 46), such individuals could be relied upon to offer informed answers and reform proposals. Indeed, they would be invited to work with the government to develop the country's first universal nursing home and home care programs. Before entering into a discussion of the 1973 and 1974 reforms, it is worth pausing briefly to consider some of the pioneering work and the progressive nature of Manitoba geriatric community in 1960s and 1970s in order to understand why this group became such a strategic resource for a government looking for policy solutions.

On the importance and uniqueness of the community of specialists in advancing long-term care reform in 1970s Manitoba, Betty Havens has said

> The right people [were] in the right place at the right time...Sometimes you get a critical mass of people who have similar philosophies or ideologies or concerns and because they are in the same place at the same time [they] can move things forward with great strides...[more] than would be possible for any of those people in any other situation (cited in Struthers, 2010, p. 18).

Importantly, many of the 'right people' in Manitoba at the time were women. As emphasized throughout this chapter, women played a key role in advancing the philosophy that care should be provided on a non-profit basis, and played a key role in moving reform forward. Havens emphasizes two important points in her description. One

is the critical mass of like-minded people with similar ideologies, philosophies and concerns. The second is timing. The time factor has already been emphasized in the above discussion of the Schreyer election and the publication of the 1972 White Paper. Having a critical mass of geriatric specialists committed to advancing non-profit long-term care reform at a time when the government was seeking out solutions made Manitoba unique within Canada during the 1960s and 1970s. While in 1966 the Canadian Senate Committee on Aging could rightly assert that advancements in geriatric care were stalled by a medical community that was "youth-centred, acute illness oriented" (Senate of Canada, 1966, p.119), in 1960s Manitoba a number of physicians were geriatric oriented and long-term care focused. Dr. Jack MacDonell and his wife Asa were two such physicians. At Deer Lodge hospital in Winnipeg, the MacDonells embarked on a series of innovations in long-term care for aging veterans. Almost two decades later, those working on the Aging Veterans Program in Ottawa would model their efforts to develop a national home care program for older veterans after the MacDonells' efforts (Struthers, 2010, p. 12).

As the head of geriatrics at Deer Lodge, MacDonell had the idea to develop a geriatric day hospital, an idea informed by his experiences visiting geriatric facilities in Europe in the 1960s. Made possible by a grant from a Winnipeg-based women's organization, MacDonnell was able to visit facilities in the United Kingdom, Belgium, Holland and Denmark, countries which he believed were "ten years or so ahead of North America" when it came to geriatric care (cited in Struthers, 2010, p. 12). The visits also allowed him to build relationships with leading geriatricians, such as Britain's Lionel Cosin., Marjorie Warren and Ferguson Anderson (Ibid). In particular, Anderson's belief that helping older people who were able and wishing to remain in their own homes should

be a goal of public policy, as well as his support for a multidisciplinary and collaborative approach to the care of older people, deeply influenced MacDonell (Ibid). Prior to becoming director at Deer Lodge, MacDonell was able to apply lessons learned from his European experiences while practicing medicine in the 1960s at Municipal Hospital in Winnipeg, a former TB and polio treatment centre (Struthers, 2010, p. 13). The polio epidemic that struck Manitoba in the 1950s led a number of hospitals in the province to become interested in developing home care (Struthers, 2010, p. 17, Carr and Beamish, 1999, p. 143). Carr and Beamish argue that the polio epidemic, along with the catastrophe that was the flood of 1950, “left no doubt that integrated planning and public funding of health services was essential” (Carr and Beamish, 1999, p. 152). With the threat of polio quelled, MacDonell was able to shift the focus to elder care. Because physicians and staff at Municipal Hospital already had experience ensuring that patients discharged with TB and polio had the proper care set up at home, MacDonell was able to build on the culture favourable to home care that was already in place (Struthers, 2010, p. 13).

MacDonell has described the experiences of transitioning the Municipal Hospital home care program to focus on seniors in the following way:

Then came the matter of sending them back home. Who was there? How capable were they to look after the elderly client? We had to interview family and look at the entire home environment. Were there stairs up to the front door? How easy was it to get to the bathroom? Do they have to climb stairs to get to bed? Could they dress themselves? Were they continent? Could there be continence training? When we went through that program and thought they were ready to go home, we’d be in contact with the family all along, and then we'd say ‘we would like to have a trial discharge, for maybe two weeks or a month, and see how things go.’ And then we’d call the VON to drop in at regular intervals...That was the basis of the program. And in a surprising number of cases it was possible to reduce the demand for long-term beds by at least 60 percent (cited in Struthers, 13-14).

As this description clearly indicates, MacDonell and those working with him on the home care initiative were concerned with anticipating potential problems and developing

strategies to mitigate challenges. Pausing briefly to note the importance of pilot projects such as this is important.

When the Schreyer government published the White Paper it stressed the importance of “experimental projects” to successful reform (Manitoba, 1972, p. 40). “[L]arger reforms have a solid basis”, it was argued, when they are “built upon structures that incorporate the knowledge of strong and weak points attached to change that only practical ventures can provide” (Ibid, p. 38). Experimental projects are beneficial to reformers because they “not only allow the new institutions to be tested, but allow them to be modified and improved as more is learned about their day-to-day operation, so that they can constantly be developed to meet the real health needs of the people at an affordable cost” (Ibid, p. 40). The White Paper went on to explain that,

> In practical terms, the most difficult problem at the provincial level is no doubt to participate in and guide a complex transition that affects many institutions and pre-existing administrative and financial structures. It is the more difficult because the transition must be developed in a deliberate and carefully paced way so that mistakes or miscalculation can be observed before they subvert the whole thrust of the reforms. It is the more difficult, too, because the reforms, even in their ultimate patterns, are to provide a pluralistic system, not something made simple and uniform on paper at the expense of being rigid and unworkable in its true substance (Ibid, p. 42).

In other words, while health care reform is a complex process requiring the spending of considerable resources, the process is made less so when reformers have the benefit of learning from pilot projects already underway. Although new policy ideas may make a great deal of theoretical sense, the reality is that unforeseen problems will almost always arise. Experimental projects have the benefit of revealing problems and potential solutions ahead of time. To use Havens’ terminology, reform was made easier when you had “a product you could show them [policy makers]” (Havens, 2003).

The MacDonells' experimental efforts would prove important for policy learning. At Deer Lodge they were able to expand on the Municipal Hospital program, focusing on the population of senior veterans (Struthers, 2004, p. 14). It was the first program to utilize a multidisciplinary team-based approach to assessing the long-term care needs of seniors in Canada, and involved a physiotherapist, an occupational therapist, a nurse, a doctor, a pharmacist, and a social worker or welfare officer from Veterans Affairs along with one or two hospital staff members who were familiar with the veteran (Ibid). While long-term care within the province at large was hindered by a lack of professional collaboration, at Deer Lodge the benefits of the interdisciplinary team-based approach were evident. Later, Evelyn Shapiro, recruited by the Schreyer government to help develop a universal home care program, would insist that the interdisciplinary, team-based approach was "required to ensure that the needs of the target population will be adequately identified" and that it was "the most important key to the effective use of all the components of the system" (Shapiro, 1979, p. 29).

The Schreyer reforms of 1973/1974 would incorporate key features of the Deer Lodge pilot programs. At Deer Lodge, following the assessment the veteran was moved into a long-term care facility or to home care, and some were transitioned to the new day hospital that MacDonell had pioneered (Struthers, 2004, p. 15). Later, building on policy learning from his European experiences, MacDonell added respite care for the wives of aging veterans as another pillar of the Deer Lodge program (Ibid). Run on a not-for-profit basis, the day hospital and respite care were paid for by administrative savings from the Deer Lodge staffing budget, with research support from Winnipeg's Age and Opportunity Bureau, and by volunteer contributions from the Winnipeg Legion branches which

allowed for the purchase of a van to help transport caregivers and veterans to the Day Hospital (Struthers, 2004, p. 17).

In addition to Deer Lodge, Winnipeg was also home to the Age and Opportunity Bureau. Launched in 1957 by Winnipeg's Social Planning Council, the Bureau marked “one of the first attempts in Canada to coordinate area planning and research on seniors' needs. It would become a springboard for developing programs in support of ‘aging in place’ within the city” (Ibid). MacDonell was one of the Bureau's first presidents. In the 1960s and 1970s, the Bureau was committed to publicizing the problems with long-term care and advocating for its elevation on the government agenda. In Chapter 2 it was pointed out that the Canadian Senate Committee on Aging, when expressing its frustration with the lack of attention to issues of aging in Canada, found the work of the Age and Opportunity Bureau to be a singular bright spot in an otherwise quiet landscape of scholarship. As noted above, the Bureau was active in creating public awareness about the barriers to long-term care, particularly those relating to financing, ownership and organization. Through its research, activism and volunteerism, it was able to make the issue of long-term care more salient. Evelyn Shapiro was Bureau president from 1969-1972. While at the Bureau, Shapiro worked to publicize the poor quality of care provided in for-profit homes and their negative consequences for seniors and care home staff. Shapiro also provided support to MacDonells’ initiatives at Deer Lodge and the work of other individuals working on seniors’ issues in the province (Struthers, 2004, p. 18).

The fact that Winnipeg was the site for these and other pioneering initiatives in long-term care is not surprising. When it comes to social reform, Winnipeg holds a special place in Manitoba history. As Wiseman argues, Winnipeg can be properly thought of as North America's “spiritual hub” when it comes to social democracy (Wiseman,

2010, p. 91). In contrast to neighbouring Saskatchewan, where the farming community was important to advancing collectivist ideology and facilitating the electoral successes of the CCF/NDP, in Manitoba "It is the city of Winnipeg that served as an incubator for the province's early left-wing political movements" (Adams, 2008, p. 99). Winnipeg was home to the social gospel tradition, the Winnipeg General Strike, the mayoralty of John Queen, an electoral base between the 1920s and 1980s that supported J.S. Woodsworth and Stanley Knowles, and the place where the Regina Manifesto was replaced by the Winnipeg Declaration as the statement of social democracy's tenets in Canada (Wiseman, 2010, p. 91). Winnipeg is thus home to a strong tradition of leftist politics and social activism. Along with its surrounding areas, it is also home to over half of the Manitoba population, making it uniquely influential in the political life of the province (Adams, 2008, p. 5).

When it comes to long-term care, Struthers argues that Winnipeg's "strong traditions of political and community activism" made the city "fertile ground" for the types of policy innovations occurring at Deer Lodge and elsewhere (Struthers, 2010, p. 17). Indeed, Shapiro has credited the strong sense of community in Winnipeg, made possible by a small population in which there exist vibrant ethnic communities committed to social advocacy, as central to Manitoba's pioneering efforts in seniors' care (Shapiro, 2003). Winnipeg was home to St Boniface Hospital where "the influence of the Grey Nuns promoted interest in the care of the elderly" (Carr and Beamish, 1999, p. 142). Under the leadership of Dr. David Skelton, and later Dr. Paul Henteleff, St. Boniface Hospital opened Canada's first palliative care unit (Macdonald, 2006 p. 22). Such Winnipeg-based initiatives could provide the government with examples of non-profit policy alternatives while the work coming out of the Age and Opportunity Bureau

provided data that could inform legislation. So too could the work on geriatric issues that was beginning to come out of the University of Manitoba in the early 1970s.

The early 1970s saw the hiring of a number of geriatric specialists. In 1972 Shapiro was hired as a professor in University's newly created Department of Social and Preventative Medicine The hiring of scholars interested in issues of aging was important to elevating geriatrics within the academic community. As Shapiro would later recall, “When I started there was very little published on home care. In journal after journal, you found little.” (cited in Silversides, 2010). Her main research interests when she began at the university centered on the factors contributing to successful aging and the negative consequences that occur when older people are admitted to long-term care facilities that are inappropriately staffed or equipped. (*Winnipeg Free Press*, November 18, 2010). Jack MacDonell was also involved in the university, helping to spearhead the Advanced Certificate Program in Gerontology as well as a Geriatric Clinical Teaching Unit, the first of its kind in Canada (University of Manitoba, 2011).

1973/1974 Reforms: The Elevation of Long-Term Care in the Manitoba Welfare State

Havens, MacDonell, Shapiro, Skelton and Hentelff all became involved in policy planning and development during the Schreyer years. Shapiro served as chairperson on the Manitoba Health Services Commission (MHSC), the organization responsible for administering health insurance to Manitobans, between 1972 and 1977. Thus, in an important period for long-term care policy-making, from the publication of the White Paper on Health Policy until the end of the NDP’s first term in office, Shapiro maintained an influential position. In 1974 she was appointed to head up a Geriatric Services Review Committee to study and make recommendations on the care needs of older Manitobans. Among the Committee members were MacDonell, Skelton and Henteleff (Jager, March

26, 1975, p. 1). Minister of Health Larry Desjardins argued that in appointing such figures to help with planning and policy development his government was helping to ensure that "Winnipeg could lead North America in the development of comprehensive geriatric services" (*Winnipeg Free Press*, March 15, 1975, p. 12).

In his role as Minister of Health and Social Development, Desjardins relied on the advice of Manitoba's community of geriatric specialists when formulating new policy. When, for example, he was questioned in the legislature why health department officials had not sought out the advice of the Manitoba Medical Association on issues on issues of geriatric care, Desjardins explained that "we felt that the best place to get expertise on this would be to go to the geriatricians, and we did exactly that" (Desjardins, March 19, 1975, p. 437). He emphasized the importance for government of being able to build on and learn from programs already in place, such as the Geriatric Hospital in St. Boniface, which was under the directorship of Dr. Skelton (Desjardins, May 27, 1975, p. 3085). The pioneering work that had been done at the Municipal and Deer Lodge Hospitals was also highlighted as important for the government. Desjardins stressed that Manitoba was fortunate to have such institutions because when it came to geriatrics "This is something new. It's a new field. It's a field that there are not too many people that are familiar with. It's a field that many doctors are not interested in. It's a field that is not glamorous at all" (Desjardins, May 29, 1975 p. 3212). As a policy maker in the province of Manitoba, however, the health minister had the benefit of a well-established community of experts. As Desjardins explained "I went to the people that were the best people and I've asked them to give me their ideas…they weren't expressing what they thought the 1,200 doctors would want. They were expressing without any conflict of interest what they felt in that vast and long experience, what they felt was good for these people" (Desjardins, May 29,

1975, p. 3212). While some MLAs were critical of the minister for ignoring the advice of certain groups (discussed in more detail below) while “sitting behind that desk in his office and…listening to the experts”, for Desjardins the expertise of the geriatric community was essential for moving the province forward when it came to developing programs for an aging society (Bilton, May 29, 1975, p. 3218). Desjardins’ predecessor, Saul Miller, was also inclined to rely on the advice of Manitoba’s community of geriatric specialists when formulating new policy. In the summer of 1974 Miller informed Evelyn Shapiro that the NDP government had decided to move forward with a universal home care program, the first of its kind in North America, and asked her to be its first director (Shapiro, 1977, preface).

Legislation was passed in the period leading up to the 1973 election campaign to cover the majority of costs of nursing home care by incorporating the sector within the province's health insurance scheme. Residents paid a flat per diem room and board charge, affordable to anyone receiving Guaranteed Income Supplement (GIS) payments along with Old Age Security. (Carr and Beamish, 1999, p. 143). In Shapiro’s words, “This allowed even the poorest elderly to retain $90.00 a month for personal use” (Shapiro, 1997, p.3). In 1974 home care became an insured service when the Continuing Care Program was established. The Report of the Manitoba Working Group on Home Care (1974), of which Shapiro was head, recommended that, because Manitobans were presented with no charges for hospital care, and only a minor room and board fee for residency in nursing homes, that those requiring home care should not be faced with the barrier of user charges (Shapiro, 1979, p.41). The Minister of Health and Social Services was keen to move forward with the home care program to temper the demand for facility-based care that followed the introduction of the popular personal care home insurance

(Shapiro, 1977, p. 46). The Office of Continuing Care was established in September 1974 with a mandate to budget and plan for long-term care services as well as to ensure that program standards were maintained across the province (Shapiro, 1997, p. 4). A central program objective was helping older people avoid or delay admission to personal care homes, and facilitating entry when necessary. Community care services were made available through the program to assist people returning home, or wishing to remain there. Although the majority of services were provided in the home, respite care and adult day care were also available in alternative settings (Shapiro, 1997, p.4).

Taking time to consider the context in which the Office of Continuing Care was established can help further illuminate the window of opportunity for reform that was opened during the Schreyer years. In the above discussion of policy windows it was emphasized that while policy makers face an array of problems that can be alleviated by government attention, only certain issues become politically salient at particular points in time, and only in some instances are alternative approaches to doing things considered in earnest government officials. A window for reform can open in which a particular social problem receives unprecedented attention when a political party is elected to office whose goals for reform are in line with those of a cohesive community of specialists. In inviting Shapiro to be the first director of the Office of Continuing Care, as well as giving her the power to select the people she desired to work with, including Enid Thompson and Betty Havens (authors of the 1971 Aging in Manitoba Study), Health and Social Development Minister Saul Miller helped to ensure that government's goals of a universal home care program would be advanced by some of the province's leading geriatric thinkers, whose ideas were in step with government thinking (Shapiro, 1977, preface).

Shapiro was able to make use of the favourable political climate to ensure that the Office of Continuing Care would have unique influence in the Department of Health and Social Development. For example, Shapiro stipulated that a precondition of her accepting the position of director was that she report to the Deputy Minister, not, as was the case with other program directors, to an Assistant Deputy Minister. In her words

A new program, with complex linkages to other parts of the health and social service system, needed access to the level of the Department which could respond quickly and decisively to questions of policy and problems. This condition was accepted, albeit somewhat reluctantly, and it proved to be invaluable. Initial start-up problems could be sorted out without delay and help could be sought on a day-to-day basis during delicate negotiations. It also enabled the Office of Continuing Care to respond quickly to problems at the field level (Shapiro, 1977, p. 79).

Shapiro's precondition thus ensured that the Office of Continuing Care would evolve as an institution with stature in the Department. The "high profile" nature of the Office and its unique relationship to the government can be gleaned from the resentment felt throughout the Department of Health and Social Development about the fiscal and human resources allocated to it (Ibid, 219). Shapiro "was regarded as an interloper who received undue recognition and support, and the relatively small staff of the Office of Continuing Care was nevertheless perceived as an incipient empire" (Ibid). Within the Department of Health and Social Development the Office of Continuing Care was thus recognized as an institution with clout. As will be argued in the next chapter, this marked a deep contrast with Ontario where offices created to deal with seniors issues were more symbolic than substantive.

By incorporating nursing homes and home care within the health insurance program, the government was addressing the financial, organizational and professional barriers to long-term care laid out in the 1972 White Paper. Like the settings of the hospital and physician's office, access to long-term care, whether delivered in a facility or

one's home, came to be based on need rather than ability to pay. A new emphasis, with the creation of the Office of Continuing Care, was placed on the planning and organization of long-term care services. Professionally, the emphasis on institutional cooperation and multidisciplinary team-based approaches to seniors' care meant that it became increasingly difficult for health care actors and institutions to exist as silos. Perhaps most importantly, during the Schreyer years efforts were made to elevate long-term care, which had been “perceived as peripheral and ancillary for many years” to “a status, a capacity, and an acceptance equal to all the other health care components in order for it to forge effective links and to play an important role” (Shapiro, 1979, p. 51). Key to developing a status with the other health care components was that care be delivered on a not-for-profit basis.

A number of features of the Continuing Care Program were path breaking for the time, including the single-entry point system in which care assessors determined the need for facility and home-based care. In taking control over the admissions process the Office of Continuing Care “limited nursing home admission…to persons who could not be safely and/or economically maintained at home” (Shapiro, 1997, p. 3-4). The program broke down boundaries between the community, the hospital and the nursing home; allowed for program referrals to come from a range of sources, including individuals seeking out long-term care on their own accord; provided long and short-term community care services on the basis of need and the absence of charge, thereby placing community care in the same category as insured nursing home and hospital care; and employed public sector workers to provide services and assess need (Shapiro, 1997, p. 3-4). These included professional services provided by occupational therapists, physiotherapists, social workers and nurses as well as Licensed Practical Nurses, home helpers and

personal support workers (Shapiro, 1997). The parallels with the Continuing Care Program put in place in 1974 and the pilot projects that had taken place under the supervision of MacDonell in the 1960s were pronounced.

Manitoba was not alone among Canadian provinces in the 1970s, of course, for reconsidering the importance of long-term to the health care system. Indeed, a number of provinces, by the 1970s, had become particularly worried about the high cost of hospital care and had initiated funding schemes for a range of large and small home care programs through grants to private organizations, the allocation of money to hospitals, or by providing services for seniors who qualified for Social Assistance programs (Shapiro, 1979, p. 1-2). Most provinces were inclined to fund home care programs through hospitals and Social Assistance because a portion of the cost could be recovered from the federal government. As a result "The structure, organization, and target populations of many home care programs were, therefore, influenced more by their capacity to recoup federal dollars than by the specific needs of the population requiring service" (Shapiro, 1979, p. 1-2). Manitoba's program was unique because it was designed with the specific purpose of meeting the particular needs of older people. In contrast to other provinces where "the preoccupation by public policy makers with institutional bed replacement as the main value of home care did little to facilitate taking a hard look at the general potentialities of home care" (Shapiro, 1979, p. 33), the Manitoba legislation made home care "a legitimate and vital component of the total spectrum of health and social services" (Shapiro 1979, p . 27). By incorporating home care and nursing homes within the broader health insurance program, policy makers elevated the status of seniors' care within the Manitoba welfare state and indicated that long-term care should be provided on a not-for-profit basis.

The unique status of the Office of Continuing Care within the Manitoba government is one indication of the desire of policy makers to elevate the status of long-term care within the provincial welfare state. Legislative debates of the mid-1970s, particularly those pertaining to the issue of proprietary care, also shed light on the degree to which the long-term care reforms were undertaken with the intention of establishing the sector as a central component of provincial social policy. When criticized for his government's lack of encouragement of commercial care Desjardins responded by stating

We are not going to do anything to encourage any more proprietary nursing homes. I'm not saying that they're not doing good work, but I think that once you start having a universal program and so on, and you got to worry about the standard and so on, I think it's quite different…when you have universal overage…the public has to own these homes…I think that this is the only way" (Desjardins, May 29, 1975, p. 3085).

In the Minister's opinion, for-profit providers should not be given a role of any significance in universal health care. Although nursing homes were later arriving to the provincial welfare state than were hospitals and doctors' offices, they were nonetheless legitimate members of Manitoba's system of health and social services. As such, long-term care should be delivered on a not-for-profit basis.

Desjardin also maintained that it was important that the Department of Health and Social Development not allow itself to be controlled by the dictates of for-profit providers. As he argued

I've had meetings with them…It has been very difficult now. At times they want more per diem rate, but they don't want to give us the information, and there's no way that we can set up a per diem without having a chance to see their budget, not only the budget that they put in, but their operating costs. And the most certain thing is that, we've got to be able to control, we've got to be able to insist on certain standards. There's a tendency of cutting corners…cutting staff and so on, and the care could go down. I'm not saying that they cost more money…they cost less money than some of the other nursing homes. But I don't think that the service is the same, and the complaints that I get…in general the complaints that I have, there's an awful lot more in the private nursing home. It's a difficult thing…if you're going to make money, and the only way you're going to do it is

try and economize and cut corners, but that's very serious and we could be in trouble with our standards (Ibid).

As will be argued in the next chapter, this marked a key difference between Manitoba and Ontario. While in Manitoba there was a clear recognition of the need to gain control over proprietary operators and assume responsibility for nursing home development in the years following the introduction of health insurance, in Ontario such operators were able to expand their share of the long-term care market in significant ways. In Manitoba, however, efforts were made to halt further expansions of for-profit care, and to halt expansions in residential care in general.

The lack of influence from the nursing home owners and advocates of proprietary care on long-term care policy development during the NDP tenure is evident. A 1974 *Winnipeg Free Press* article emphasized that nursing home owners were feeling increasingly left out of decision- making processes (*Winnipeg Free Press*, March 5, 1974, p. 1). The article pointed out that "communication between nursing homes and the provincial government has virtually disappeared" in the wake of the long-term care reforms (Ibid). William Smith, the executive director of the Winnipeg-based non-profit Middlechurch Home, was quoted as saying, "Now all that we find out from the health services commission is that something has happened or is about to happen" (Ibid). While supportive of the fact that care homes were now under medicare, Smith complained that decisions had taken place without industry consultation. "I believe that it was brought in too quickly with insufficient dialogue between government and the homes who are providing the actual care" (Ibid). No longer involved in the application process, Smith noted that home owners were feeling a loss of control (Ibid). Another *Free Press* article pointed out that nursing home owners felt that their institutional autonomy in the province

of Manitoba was being eroded by a government eager to assume more responsibility for the sector (Jager, March 24, 1976). The Manitoba Medical Association sympathized with nursing home owners, suggesting that it was the desire of the government to “regiment the individual” and to create “a dehumanized and depersonalized bureaucratic machine” to deal with seniors (Jager, July 18, 1975, p. 14).

The Progressive Conservatives were particularly troubled by the disregard shown by the Schreyer government towards proprietary nursing homes. As one opposition MLA put it, in assuming control for developing, organizing and planning long-term care “The government has pretty clearly indicated that no more private nursing homes are to be built and it’s pretty obvious those now in the field will have their operations changed or terminated” (*Winnipeg Free Press*, June 4, 1975, p. 7). In developing its universal long-term care program, the opposition lamented, the NDP was intent on phasing out the for-profit care home and removing the ability of its owner to make a profit (*Winnipeg Free Press*, May 30, 1975, p. 8, *Winnipeg Free Press*, June 4, 1975, p. 7). Support for the proprietary sector marked a clear difference of philosophy between the two parties, and it was a philosophy that the Progressive Conservatives would try to advance when they returned to office in 1977 under the leadership of Sterling Lyon.

The reluctance of nursing home owners to accept the new government responsibilities was an issue faced by Shapiro in the early stages of the Office of Continuing Care. Because nursing home owners had always had control over such things as who they chose admit and the order of placement on their waiting lists, new government powers over nursing home placement was perceived as a significant loss of control. In her words, “Traditional agencies had, by and large, found it difficult to accommodate to the changes required by the introduction of the new program. The

process of integration was marked by the agencies' reluctance in accepting the government's right to set policies and their resistance in responding to the practical implications of these policies." (Shapiro, 1977, p. 206). A central reason why the Office of Continuing Care was able to move forward with its reforms and overcome the aversion to change within Manitoba's community of long-term care providers was "The unequivocal and visible support of the Department of Health and Social Development" (Ibid).

In the years following the creation of the Continuing Care Program government focus was on establishing home care as "a major component of Manitoba's health care system, a viable alternative to institutional placement" (Desjardins, 1975, p. 29). The Department of Health and Social Development's *Annual Report* for 1975, for example, emphasized that although waiting lists for placement in personal care homes had not diminished it was important to recognize that the number of people awaiting placement had not increased for the first time in many years (Ibid). In May 1975 it was noted that in a six month period the home care program helped reduce the waiting list from about 1,500 to just over 1,000 (Desjardins, May 27, 1975, p. 3085). In 1975/76 Manitoba was spending $4.7 million on Continuing Care services and by 1986/87 the figure had risen to $36.8 million (Price Waterhouse Coopers, 1988, p. 1). By 1985 Manitoba was spending significantly more than other provinces for home care services on a per capita basis at $20.38. The next highest province was Ontario at $15.05, followed by Saskatchewan at $11.64 and Prince Edward Island at $11. 38 (Ibid, p. 28).[2]

Government focus was not on expanding the supply of personal care beds, but rather to "prevent the unnecessary building and utilization of institutional facilities" (Ibid,

---

[2] Note: I have not been able to determine if these figures have been adjusted for inflation

p. 2). In Shapiro's words, "Manitoba was the first province to treat nursing home beds as a scarce resource" (Shapiro, et al., 1992, p. 1344). One mechanism used by officials in the continuing care program to promote the notion that beds were a scarce resource was reserving beds for the highest need cases. When insurance was first brought in those who resided in a personal care home as of July 1973 were insured automatically; however all new residents were assessed and admitted on a needs basis (Ibid). Between 1974 and 1981 the number of nursing home beds in the province was kept at approximately 166 per 1000 people 75 years and older. After 1981 the government reduced the ratio to about 140 per 1000 (Ibid). By the dawn of the 1990s, the ratio of personal care home beds per 1000 people 75 years and over in Winnipeg was one of the lowest in urban Canada (Ibid, p. 1348). Workers employed in the community care field, and for informal caregivers, have thus been expected to provide care to increased numbers of older people who may have otherwise looked to an institution to meet their long-term care needs (Ibid). They have also had to care for younger disabled people as the continuing care program expanded its scope, and as early hospital discharges increasingly came to play a bigger role (Manitoba Health, 1990, p. 13-14, Price Waterhouse Coopers, 1988). It has also meant that those entering personal care homes in the post-insurance era are older and frailer (Ibid, p. 21).

In the previous two chapters of this dissertation I have pointed to the historical reluctance of leaders of western nations to bring long-term care within the mainstream of the welfare state. While some nations have recently begun to develop ways to bring the sector in from the periphery, others, including the central governments in Canada and Britain, continue to treat long-term care as a low priority. The efforts of the Manitoba NDP and the community of geriatric specialists in the 1970s to elevate the status of long-term care within the provincial welfare state, in contrast, were pathbreaking. The

following pages consider the failed attempts of two Progressive Conservative premiers to roll back the Schreyer reforms in their efforts to take the province in neoliberal directions. In the 1980s and 1990s, as the Manitoba premiership alternated between Progressive Conservatives and the NDP the issue of proprietary long-term care became a battleground for competing ideologies around the provincial welfare state. It is to the efforts of Sterling Lyon's Conservatives to reintroduce the profit motive in the nursing home sector that this chapter now turns.

Lyon's Privatization Attempts

In the provincial election of 1977 the Schreyer government was defeated by Sterling Lyon's Progressive Conservative Party. Concerns over rising inflation, unemployment and declining provincial investment helped to facilitate the election of Lyon, who campaigned on the slogan of "acute protracted restraint" (Thomas and Brown, 2010, p. 232, Adams, 2008, p. 42). In the latter part of the 1970s, Conservatives in Manitoba, like those throughout Canada and other Western nations, shifted further to the right as neoliberal ideology increasingly came to dominate political thinking. In mid-1970s Manitoba, red tory conservatives such as Duff Roblin "appeared out of step with the times" as notions of collective responsibility were progressively overshadowed by an ideology that stressed the importance of individual initiative and market solutions to social problems (Adams, 2008, p. 42-43). In Adam's words, "During the mid-1970s, Sterling Lyon became a perfect fit for the new times by forging together support from the PCs' rural wing and urban neoconservatives" (Adams, 2008, 42-43). Lyon argued in the lead-up to the 1977 election, "We must have a government with the will and energy to do those things that government must do, and the good sense and restraint to refrain from doing those things which history has demonstrated are beyond the effective capability of

any government" (cited in Wesely, 2011, p. 152). As argued in the following analysis, nursing homes were one area the Lyon Conservatives believed to be beyond the effective capability of government.

Shortly after being elected in 1977, the Lyon government closed down 194 beds in proprietary nursing homes because they violated the health and safety standards laid out by the Manitoba Health Services Commission (Sherman, April 10, 1978, p. 2392). The government also imposed a freeze on the construction of any new beds as part of an overall program of fiscal restraint. For the Lyon government, the need to close the proprietary homes was not an indication that there was something wrong with the for-profit sector. Rather, as Minister of Health and Social Development Bud Sherman argued in the Legislature, eight years of NDP rule had drained the proprietary sector of all incentive to invest in their facilities. Sherman, a former journalist and member of the Canadian House of Commons in the 1960s, was elected to the Manitoba legislature in 1969. During the Lyon government's tenure Sherman maintained the Health portfolio and was a strong supporter of proprietary nursing homes. In his opinion, "The previous government was not sympathetic to private operations in the personal care field…If you're going to be frozen out of a province, you're not going to spend much time, effort or energy, re-investing in your property" (Sherman, May 1, 1980, p. 3166). He went on to explain of the proprietary owners, "if they hadn't been forced into virtual decay through eight years in which it was made quite clear to them that there really wasn't going to be any place in the future for private operations, many of those plants would be in much better physical condition today" (Ibid, p. 3166).

The failure of the province's remaining proprietary homes, therefore, was not an indication that for-profit providers were likely to provide inferior care, but rather that

entrepreneurial initiative in the field had been eroded by the former government. The Schreyer government's support for the non-profit sector, combined with rules which permitted non-profit actors to borrow at two percent interest from the Canada Mortgage and Housing Corporation to construct new homes, but forced proprietary actors to borrow at market rates ranging from 12 to 14 percent, placed the for-profit sector “in an extremely difficult position” (Ibid).

When it came to facility-based care for seniors the Manitoba Conservatives, Sherman argued, “would like to see more private operations in the field” (Sherman, April 10, 1979, p. 2392). Bolstering the proprietary sector was desirable for a number of reasons, according to government thinking. For one, partnering with for-profit interests to meet the long-term care needs of older Manitobans was a responsible approach in a period of austerity. The waiting list for nursing home care in 1979 was between 1,800 and 1,900 and a number of seniors were forced to rely on the expensive acute care hospitals for lack of long-term care beds (Sherman, June 14, 1979, p. 5353). “We need the private sector participating in this field in order to supply those beds”, the Health Minister emphasized (Sherman, February 28, 1980, p. 156). In 1979, there were 24 proprietary homes providing 2,226 beds compared to 78 non-profit facilities providing 5,274 beds (*Winnipeg Free Press*, August 31, 1979, p. 3). Providing the private sector with incentives to participate in greater numbers could thus help the province meet the needs of its aging population. This, as will be emphasized in the next chapter, was an argument made successfully and with relative ease by the Ontario Conservative governments of the 1970s.

Manitoba seniors in need of nursing home care had nothing to fear from proprietary nursing homes, it was stressed, because “private operators are just as

compassionate" as those who run their homes on a not-for-profit basis (Sherman, May 1, 1980, p. 3166). The Health Minister explained to the Legislature, "I know of many private operators, proprietary operators, and I've known many people who have been in proprietary homes, who have received just as much tender, loving care, just as much attention, just as much compassion, as those who are in non-profit homes" (Sherman, May 1, 1980, p. 3166). While the opposition NDP expressed grave concern over such facilities, Sherman stressed that "I have no hesitation in saying that my experience both as a private citizen and as a Minister of Health with the private operators is that they do have compassion, they do have an interest in the care and well-being of their residents and they run very good operations" (Sherman, May 1, 1980, p. 3166). In other words, while organizations and individuals within the Manitoba geriatric community had been arguing for decades that homes run on a for-profit basis provided care that was inferior to that delivered by the non-profit sector, Manitobans ought to believe the Minister of Health that proprietary care was of high quality. According to Sherman "it is a disservice to many in the health field to suggest or imply that private operators have no place whatsoever in the nursing home field. There is something ugly and unsightly about that kind of denunciation" (Sherman, February 28, 1980, p. 156).

On the place of for-profit nursing homes within the Manitoba welfare state, Sherman proudly stated that the difference between the NDP and the Conservatives was "night and day…we don't say, for one instance on this side, that only government and only non-profit organizations possess the quality of love for one's fellow human being, compassion for his fellow human being, and commitment to service his human being" (Sherman, May 1, 1980, p. 3166). If proprietary owners were to come into the field in significant numbers, the benefits that would result from competition would be extensive.

In Sherman's words “some profit is an advantage in many ways…because it provides those of us in the area of responsibility…with a yardstick, a measuring stick, of facility against facility, method against method, program against program” (Sherman, February 28, 1980, p. 156-157). The health minister argued that,

> There is an advantage too, in terms of levels of staffing and nursing and medical care, of quality of diet, of quality of physical surroundings, and of cost efficiency in terms of the overall operation and if you can take a private operation and look at its operation against a public operation’s record you then, as a government or an opposition, are in a much better and healthier position to be able to say, ‘Well, this is the way it can be done and this is the way it should be done’(Sherman, February 28, 1980, p. 157).

Proprietary owners ought to be seen as a valuable addition to the nursing home sector because competition would lead to a better and more cost effective system of care for an aging population (Sherman, May 1, 1980, p. 3166). In addition because such owners paid provincial and federal taxes while owners of non-profit homes were exempt from doing so, private owners should be welcomed as “good corporate citizens” in the province (Sherman, May 1, 1980, p. 3166).

When the government lifted the freeze on the construction of new personal care beds at the start of the 1980s Sherman indicated that the proprietary sector would be given priority. The government had “an obligation” to the private sector, especially those forced to close down or scale back their operations when it came into power (Sherman, May 1, 1980, p. 3166). As of March 31, 1980 the breakdown of non-proprietary and proprietary beds was 5,269 non-proprietary and 2,211 proprietary, totaling 7,480 (Sherman, May 1, 1980, p. 3161). Approximately 30 percent of beds were thus in the proprietary sector. In addition to giving approval to a new private sector interest to build a 104-bed home in Selkirk to replace an older 72-bed home, approval was also given for the construction of 314 proprietary beds and 397 non-proprietary beds in 1980-

1981(Sherman, February 28, 1980, p. 159, Sherman, May 1, 1980, p. 3161). Such allocations illustrate the government's intention to have almost half of the new long-term care beds for the period go to the for-profit sector (Sherman, May 1, 1980, p. 3161). Sherman noted that although construction had not begun on the proprietary homes as of May 1, 1980 because of financing problems it was the government's hope to see the beds constructed (Sherman, May 1, 1980, p. 3161).

The response of private-sector operators was, not surprisingly, highly positive. Nursing home operators in Manitoba at the time were represented by primarily two groups. The Manitoba Long-Term Care Council, was a 30 member organization made up of mainly public homes (*Winnipeg Free Press*, March 25, 1981, p. 8). The Nursing Home Association of Manitoba, in contrast, had about 15 members and represented privately run homes (Ibid). This was in stark contrast with the situation in Ontario where large numbers of proprietary owners were able to organize into a formidable lobby group. Nursing Home Association president Herman Thorvaldson praised the government's "positive attitude" to proprietary homes, noting that their status had been precarious for too long in the province of Manitoba (Winnipeg Free Press, August 31, 1979, p. 3). Thorvaldson stressed that such homes had been forced to exist in a "grey area" in the province's long-term care landscape (*Winnipeg Free Press*, September 4, 1979, p. 6). Large corporations such as Central Park Lodge (a subsidiary of Trizec Corporation) and Villacentres, which together operated almost 40 percent of proprietary long-term care beds in Manitoba in 1980 (MacKenzie, 1980, p. 10), were likely also encouraged by the changing political climate.

Throughout the Lyon government's tenure, the debate within the legislature on the ownership of care homes was pronounced. The NDP was highly critical of what it called

a Conservative "compulsion of privatization" when it came to nursing homes (Parasiuk, February 28, 1980, p. 152). Health critic Wilson Parasiuk argued in the Legislature that the Health Minister's arguments for greater privatization ran contrary to the existing and mounting evidence surrounding for-profit care. Encouraging more proprietary interests to get into the care home field made little sense when

> we have example after example of private, profit-making nursing homes not doing a good job, not ever re-investing their profit into improving the facilities, but rather taking the money away and investing in land development and other activities, when in fact they should have been investing some of their profits into improving the quality of those personal care homes (Parasiuk, February 28, 1980, p. 152).

Encouraging such ownership made little sense when for-profit homes tended to pay their staff lower wages than the non-profit sector, were more likely to rely on drugs to sedate patients rather than invest in the necessary care, and usually provided a lower quality of food in an effort to secure profits (Parsiuk, March 11, 1981, p. 1603-1604). Strikes at the privately-run Golden Door Geriatric Centre and St. Adolphe Nursing Home in 1980 and 1981 were cited as examples of worker discontent in the proprietary sector, while a 1980 fire at a private Mississauga, Ontario Nursing Home that killed 21 residents was referenced to illustrate the substandard levels of care (Parsiuk, March 11, 1981, p. 1604, Parasiuk, July 16, 1980, p. 5717-5718).

The Manitoba branch of the Canadian Union of Public Employees (CUPE) was also highly critical of Conservative claims about the benefits of for-profit care. Whether it be in relation to such things as labour unrest or lower quality care, there was ample reason, the organization argued, not to pursue commercial care (MacKenzie, May 3, 1980, p. 10). Private sector interests such as Central Park Lodge and Villacentres operated personal care homes to make a profit, just as they did in the hotel, real estate and oil and gas sectors (Ibid). Although non-profit sector beds outnumbered proprietary ones by a

ratio of about 5 to 2, CUPE was critical of the government's attempts to bolster the sector any further (Ibid). In the Legislature, Parasiuk pointed to a February 2, 1982 *Financial Times Canada* article which noted the private sector tendency to invest their profits into such things as real estate and energy rather than back into their nursing homes. John Mainyard, executive director of the Ontario Nursing Home Association, was quoted in the article as saying that “Nursing homes are super businesses to own because of the high cash flow and the appreciation of property values” while the celebration of another analyst regarding “The excellent nursing cash flow also provides a primed pump for the heavy capital needs of both real estate and energy” was noted (Parasiuk, March 11, 1981, p. 1603). Later that month a *Globe and Mail* series on the negative consequences of privately run Ontario nursing homes was highlighted by Parasiuk to illustrate how out of step the Conservatives were with prevailing evidence (Parasiuk, March 19, 1981, p. 1922).

Particularly troubling for the NDP and advocates of non-profit care was the fact that while the government felt an obligation to help proprietary owners come back into the market it was denying applications from non-profit groups wishing to open more nursing home beds. Non-profit groups such as the Mennonite Homes in Steinbach and Grunthal, the Transcona Park Manor Personal Care Home, the Selkirk Hospital Board and the Fred Douglas Lodge were turned down by the government (Parasiuk, March 11, 1981, p. 1603). In an interview with the *Winnipeg Free Press*, Roland Bazinet, administrator of the Fred Douglas Lodge, a facility operated by the United Church, said that while they had applied several times to replace 65 of their 193 beds and add an additional 30 to 40 beds, the government chose to approve instead applications for 200 proprietary sector beds (FitzGerald, June 25, 1980, p. 3). Several NDP members pointed out that the

Minister of Health was more concerned with facilitating the economic development of private nursing home operators more than any other priority. Larry Desjardins criticized this approach, stating that "it is not the role of the Minister of Health to try to equalize the opportunity to have a certain group compete and make a profit" (Desjardins, May 1, 1980, p. 3173).

During the Schreyer years, nursing homes, as institutions, were elevated in status within the Manitoba health care system. Prior to 1973, only the settings of hospitals and doctors' offices were considered to be sites of collective responsibility and void of the profit motive. The incorporation of nursing homes within the medical care insurance program was a clear statement by policy makers that such facilities should exist alongside the hospital and the physician's office as a third pillar of the Manitoba health care system. Saul Miller rightly described the privatization efforts of the Lyon government as "turning back the clock" (Miller, February 28, 1980, p. 161). While the NDP believed that "there is no place for profit in Medicare, in our hospitals, or in our personal care homes", the Lyon Conservatives believed that making a profit on seniors' care was entirely acceptable (Pawley, February 25, 1980, p. 44, Pawley, May 1, 1980, p. 3170). The NDP argued that rather than turning back the clock to a period where long-term care was a peripheral component of the health care system, the World Health Organization definition of health as a state of social, mental and physical well-being, not simply the absence of infirmity or disease, should be at the forefront of policy- making (Parasiuk, April 17, 1980, p. 2624).

Several statements made by the NDP in opposition in the 1978-1981 period illustrate the extent to which the party had come to see non-profit care as an election issue. Howard Pawley, for example, stated that "the opposition is committed when it

forms a government to remove profit from personal care home activity in the future of this province" (Pawley, May 1, 1980, p. 3170). Parasiuk said of the Lyon Conservatives,

> this government has a philosophical bias in favour of the private profit-making nursing homes. We think that bias is wrong. We have a different particular philosophy on that and we believe that non-profit nursing homes should be given the first preference to providing for the nursing home needs of Manitoba citizens. This is a very clear, distinct difference between us and the Conservative party (Parasiuk, April 17, 1980, p. 2625).

On another occasion Parasiuk stressed that "the issue of non-profit personal care homes versus private profit-making corporations running personal care homes is a critical one", predicting "it is going to be a critical issue in the next election. I think that this government will lose out because of that" (Parasiuk, March 10, 1981, p. 1525). Eight months before the November 1981 election he argued in the Legislature "this will be an election issue and the Conservatives are on the wrong side of it, on principle, on financial terms, on humanitarian grounds, on moral grounds, on efficiency terms, virtually every criteria" (Paraisuk, March 11, 1981, p. 1602).

When NDP leader Howard Pawley launched his ultimately successful campaign for the premiership, he did so at the non-profit Parkview Lodge seniors' home in Winnipeg (Brosnahan, October 16, 1981, p. 10). The party's convention held earlier that year called for all personal care homes in the province to become non-profit, publicly owned and operated (*Winnipeg Free Press*, February 2, 1981, p. 9). As noted below, although the Pawley government did not succeed in making all care homes non-profit or publicly owned, it did halt further expansions to the commercial sector. As such, the NDP helped to reduce the ability of commercial interests in the Manitoba market place to enhance their profit making capacity as well as reduce the attractiveness of the province to future investors. Commercial operators in Manitoba were no doubt envious of their counterparts in Ontario who were viewed by the government as necessary partners in

meeting present and future long-term care demands. They were also likely envious of the sector's ability to expand and assert its influence during recessionary periods in Ontario. Indeed, as Pawley points out, Manitoba's diversified economy provided it with a greater degree of stability during periods of economic volatility than the manufacturing-dependent Ontario (Pawley, 2011, p. 236). In Manitoba, advocates of welfare state retrenchment were less able to play upon fears of economic collapse, job loss, and a lack of competitiveness in order to advance their cause of privatization.

Although in electing Lyon as premier Manitoba voters showed that neoliberalism was a political ideology with some level of attraction in the province, the fact that Lyon was the only premier in the modern, post-Roblin era, to be given just one term by the electorate illustrates that there were limits to the longevity of leaders committed to rolling back the Manitoba welfare state (Vogt, 2010, Wesely, 2011). When the Pawley NDP assumed office in the years 1981 to 1988, encouragement of the proprietary sector ceased. As Health Minister Desjardins made clear when pressed by a Conservative member in the Legislature to allow proprietary owners into the market, "It is too dangerous" to put the care of seniors in the hands of the for-profit nursing home providers (Desjardins, April 8, 1985, p. 677). To do so would compromise food quality, lead to reductions in staff, and a greater reliance on pharmaceuticals to keep residents sedated (Ibid). While the waiting list for care homes remained in the 1,700 range in mid-1980s Manitoba, improving access to quality care was not something that could be done through the for-profit sector (Desjardins, April 8, 1985, p. 631). As noted above, nursing homes were treated as scarce resources. Any gradual expansions in beds would go to the non-profit sector. One example of the government's reluctance to expand in the proprietary sector came in 1984 when two private nursing homes in Brandon, Manitoba were ordered to close for failure

to comply with government standards. No compensation was given to the owners and the residents were transferred to a new non-profit facility run by the Salvation Army (Rosner, December 26, 1984, p. 2).

The appointment of Betty Havens in 1982 as the first provincial gerontologist in Canada, with the capacity to act as "a major liaison between government, voluntary agencies, senior citizens' organizations, and individuals in meeting the needs and concerns of Manitoba's aging population" (Achenbaum and Albert, 1995, p.158), was one indication of the government's desire to address issues of long-term care through the public sector. The Lyon government's attempt to bolster for-profit facility-based care did not have a lasting impact on the long-term care sector in Manitoba. During its short stint in office, the government was unable to realize its privatization ambitions. In the decades that followed non-profit homes continued to outnumber for-profit ones by a considerable margin. I noted above that in March, 1980 the proprietary sector supplied just 30 percent of the beds. By 2009 just 26 percent of long-term care beds in Manitoba were in the proprietary sector (CUPE, 2009).

Gary Filmon's Home Care Privatization Initiative

While non-profit long-term care was protected under the Pawley regime, when the political climate changed again in Manitoba with the election of Gary Filmon's Progressive Conservatives in 1988, seniors' care once again became the target of privatization. In the 1988 election the party benefited considerably from the fact that the NDP and Pawley were "exhausted" from fighting a battle with a resurgent Liberal Party under Sharon Carstairs and within its own ranks (Adams, 2008, p. 48-49). In the NDP party, issues of French-language rights, the legalization of abortion, bulging deficits and conflict over rising public auto insurance rates created strife (Ibid). In a climate of NDP

collapse and economic downturn the Filmon Conservatives were elected to a minority government in 1988 and would go on to serve three terms. Ironically Larry Desjardins, who helped to facilitate the NDP's first majority, contributed to the Pawley government's collapse by quitting the legislature in protest of the NDP support for abortion rights. While Filmon originally portrayed himself to voters as a moderate centrist, over time he became "a premier whose convictions about a more limited role for government became stronger during his years in office" (Thomans and Brown, 2010, 242). Embracing ideas of new public management, Filmon embarked on "a reinvention and re-engineering agenda that was more ideological, radical, extensive, and aggressive than was the tradition of past Manitoba governments" (Thomans and Brown, 2010, 242). In the years following his election, Filmon increasingly spoke of the need for government to retreat from the provision of "non-core" services and the importance of relying on the private sector to do more (Thomas and Brown, 2010, 238). Perhaps learning from the Lyon government's failed attempts, personal care homes were not selected as an area where the government expected the private sector to do more. As the following table illustrates, while the proprietary sector witnessed a decrease in beds between 1987/88 and 1990/91, beds allocated to the non-proprietary sector increased:

Distribution of Personal Care Home Beds and Personal Care Home Residents by Type of Personal Care Home, 1987/88 and 1990/91

	1987/88		1990/91	
Type of PCH	# of beds	# of residents	# of beds	# of residents
Non-proprietary, juxtaposed to hospitals	871	1088	925	1122
Non-proprietary, freestanding	5013	5869	5175	5962
Proprietary	2355	2850	2311	2886
Total	8239	9807	8411	9970

(Source: Shapiro and Tate. 1993, p. 9)

By 1990/91, Manitoba spent nearly $270 million on personal care homes, or approximately $25, 735 per bed (Shapiro and Tate, 1993, p. 1). However, in the mid-1990s, the province's publicly-run home care program was selected by the government as an area that needed to be re-engineered in order to make room for a profit motive. By the 1990s, as in other provinces, the cost of home care services in Manitoba was on the rise. Hospital bed closures and quicker discharge times, reductions in the ratio of nursing home beds per 1000 people, along with the introduction of new technologies and treatment options facilitating the delivery of more care within the home contributed to rising costs (Shapiro, 1997, p. 7). An added pressure in Manitoba stemmed from the fact that between 1971 and 1991, the proportion of those over the age of 65 rose faster than in most other provinces. By the mid-1990s seniors represented 13 percent of the population, a figure

surpassed only in Saskatchewan (Shapiro, 1997, 7). By 1996, 24,000 people were receiving home care services in Manitoba and an additional 3,500 were employed in the program (Coalition to Save Home Care, 1996, p. 1). In April 1996, a number of months after the NDP leaked a Treasury Board document indicating the government's intention to privatize the delivery of home care services (which were provided by Manitoba Health employees), the government announced that it planned to privatize 25 percent of the personal care force in Winnipeg, citing potential cost savings of $10 million (Shapiro, 1997, p. 8).

In response to the government's plans, the province's unionized personal care workers who were represented by the Manitoba Government Employees Union (MGEU) walked off the job in a strike that would last five weeks. Just as the NDP was able to discredit the Lyon government's support for proprietary personal care homes in the legislature in the early 1980s, care workers, home care recipients, family members, community organizations and members of the geriatric policy community were able to effectively marshal evidence to discredit the Filmon privatization initiative. On the issue of cost, supporters of public home care could point to the fact that the program accounted for just four percent of the province's overall health care costs in the 1990s (Shapiro, 1997, p. 1). Data for 1988/1989 put the annual per person cost at $2,102, with $1,667 of that total going to direct services and the remainder to coordination, assessment and administration. When compared to the annual average cost to maintain a nursing home bed in the same period - $22,051 – the argument that home care costs were unsustainable became questionable (Shapiro, 1997, p. 6). Moreover, a government commissioned study by Connie Curran revealed that in 1992/1993 the hourly wages of Winnipeg personal care workers were lower than their counterparts in other major Canadian cities (Ibid, p. 9).

For opponents of privatization, the fundamental question became "Given Manitoba's already low labour costs for community care services how can a company make a profit without charging the government more than it is now paying for services of equal quality?" (Ibid). Three ways to save money were lower wages for workers, reduced supervision and staff training, and the pressuring of seniors to purchase unneeded additional services (Shapiro, 1997, Silver, 1997). Throughout the strike, the MGEU stressed lower rates of pay as a reason not to privatize (http://www.youtube.com /watch?v=thEHo4D8Cbs). Arguing that "this is the end of home care as we know it", the organization emphasized that personal care workers stood to lose if a private company was allowed to profit off of long-term care (Ibid). As Shapiro pointed out in a 1997 article published by the Canadian Centre for Policy Alternatives, the mainly non-unionized proprietary home care companies offered lower wages and had higher rates of employee turnover. Citing a British Columbia study, Shapiro noted that "the turnover rate of the direct service workers in BC is highest (almost 50% a year) among those who work in private companies and lowest for unionized workers at 32%. High turnover rates make continuity of care by the same personnel almost impossible" (Shapiro, 1997, p. 6).

At a town hall meeting held at the University of Winnipeg in April 1996, at public hearings held by the Coalition to Save Home Care in May 1996 and throughout the five week strike, arguments against privatization were expressed. Complaints were voiced by seniors who missed having their regular personal support workers, and felt that their well-being was compromised by the rotation of different replacement workers during the strike who were unaware of their individual needs (http://www.youtube.com/watch?v =thEHo4D8Cbs, http://www.youtube.com/watch? v=zsJsLmKk1rc, Shapiro, 1997, p. 10, Silver, p. 2). In Shapiro's words, "complaints during the 1996 strike centred on untrained

and unsupervised service workers and on the often inadequate response by the companies involved to service complaints" (Shapiro, 1997, p. 10). A number of seniors and the disabled also complained about being pressured to purchase additional, unneeded services (Ibid). In a petition to the government, the Coalition to Save Home Care gathered more than 21,000 signatures of home care clients opposed to the privatization of care. (http://www.youtube.com/watch?v=zsJsLmKk1rc). Also employed in the repertoire of contention was a "We Support Home Care" lawn sign campaign. On lawns in communities across the province, signs drew attention to public discontent with privatization (Ibid).

Throughout the five-week strike the government was forced to admit that its original projected cost savings of $10 million was not accurate. At one of the April 1996 public hearings the Minister of Health admitted that he did not expect any immediate cost savings as a result of privatization but that it was hoped that future increases to the cost of home care would be reduced (Shapiro, 1997, p. 8). Overall, the picture was one of a government that

failed to produce evidence to support its privatization initiative, to take account of the evidence available to it on the benefits of retaining public sector service delivery, or to use any other policy options it has, as the single payer of publicly-funded health care, to reduce future increases in community care costs. This suggests that the decision to privatize was made on ideological grounds and/or in response to political pressure from the business sector (Shapiro, 1997, p. 9)

The parallels with the Lyon approach to personal care homes are remarkable. In both instances evidence pointing to the benefits of non-profit care was ignored by leaders who believed that the long-term care sector was not a fundamentally important component of the Manitoba welfare state.

In the end a contract was reached between the Filmon government and home care workers to end the strike, stipulating that an experiment with privatization would be evaluated after two years, that privatization would be limited to a maximum of 20 percent of home care services, and that no layoffs would occur during the contract (Wilson and Howard, 2001, p. 230). In March 1997, it was announced that Olsten Health Services, an American-based corporation, had been given a $5.6 million contract to provide home support, home attendant and nursing services in certain areas of Winnipeg for all new long-term care clients, marking "the first major expansion of private, for-profit corporations in Manitoba home care" (Silver, 1997, p. 2 Wilson and Howard, 2001). Rather than the 20 percent ceiling, however, the government announced that the Olsten contract would be limited to 10 percent of the workforce. As Wilson and Howard explain, policy makers were forced to admit that "no private bids could provide the volume of service initially slated for privatization" (Wilson and Howard, 2001, p. 230). Minister of Health Daren Praznik acknowledged that a number of companies bidding on the contract "weren't able to give us any cost-saving, they were actually higher cost than our own estimates on our own cost of service" (cited in Silver, 1997, p. 8). The Minister noted of the tendering process, "One of the things this has demonstrated is that generally speaking our home care system is fairly well run on the cost side across the province" (Silver, 8). The government hoped, however, that Olsten would save it $500,000 annually (Ibid).

In 1997 Canadian Centre for Policy Alternatives' Chairperson, Jim Silver, published an article on Olsten Corporation. Silver noted that as the leading private proprietary home care company in the United States, and with 1300 offices globally in places such as Denmark, Norway, Sweden, Germany, the Netherlands, England and Wales, Puerto Rico, Argentina, Mexico and Canada, Olsten's reputation as a care

provider and corporate citizen was suspect (Silver, 3). As Silver pointed out, the company relied heavily on temporary employees, was mostly non-unionized, had been charged for failing to follow through on the instructions of physicians by the state of Washington, had its Florida offices raided by the FBI in 1997 in relation to Medicare fraud, and its employees in a New Mexico office were under investigation for fraud (Silver, 1). In the United States, where almost half of the home care system is occupied by for-profit companies, the actions of firms such as Olsten encouraged the Clinton administration to impose a moratorium in September 1997 on the entry of new proprietary providers (Ibid, p. 7). Silver argued that there was "only one simple conclusion to be reached" when one considered the evidence on Olsten: "The US experience demonstrates the risk of private, for profit care; the Manitoba experience underlines many of the benefits of publicly administered and delivered care" (Ibid, p. 8). The article concluded by recommending that Manitoba end its experiment with proprietary home care after the one-year contract with Olsten concluded.

In December 1997, the government announced that Olsten's contract would not be renewed. As Wilson and Howard point out, the announcement of the termination followed the Canadian Centre for Policy Alternative's investigation into the company (Wilson and Howard, 2001, p. 231). The overwhelmingly negative reputation of the company, combined with public's discontent over the privatization of an aspect of the welfare state they had come to see as fundamentally important, influenced the government to change course. The cancelation of the contract after only one year "clearly demonstrates both that privatization is a problem rather than a solution and that it can be reversed, given popular support and political will" (CCPA, 2000 p. 14). The influence of popular support on political will is important to the home care story. In Chapter 1 it was

argued that a central reason why particular welfare state programs have withstood retrenchment pressures and proven to be resilient even during times of "permanent austerity" is the mobilization of welfare state constituencies (Pierson, 2011). Social welfare policies enacted during the expansionist post-war years contributed to the formation of new interests with an important stake in maintaining their benefits (Pierson, 1996; Pierson, 2001; Pierson, 2011). This has been particularly true in the areas of health care and pensions, where welfare state constituencies, that is, "the political support coalitions that tend to grow up around and defend" social policies (Weaver, 2004, p.50), play an important role in forestalling retrenchment. Over time, health care and pensions have become "politically powerful" programs because politicians are hesitant to initiate large-scale reforms for fear of a backlash among voters (Pierson, 2011, p.20). Program areas where beneficiaries are more diffuse or less well mobilized, such as sickness and unemployment benefits, have been more vulnerable to cutbacks in austere times (Pierson, 1996; Pierson, 2001; Pierson, 2011).

It was argued in Chapter 1 that in most welfare states there is an absence of a formidable long-term care constituency. For the most part, outside of the Nordic countries, older people with long-term care needs and their mainly female caregivers have rarely seen their concerns occupy national policy agendas and have not been the beneficiaries of large scale programs around which they have felt the need to organize and defend. It was also emphasized that in the collective political conscience, long-term care tends to have a low salience. Many tend to greatly underestimate the likelihood that they will require long-term care services, and many try not to think about the undesirable topics of aging, dependency and decline (Morgan and Campbell, 2005, p.888; Morel, 2006, p.230). While just about everyone anticipates that they will one day retire and many

take pleasure thinking about the desirable subject of leisure time facilitated by years of pension contributions, long-term care is a subject many people delay thinking about until the time arrives that such services are required. Because the public largely underestimates the chance that they will need long-term care, union members typically have not pushed their associations to bargain for long-term care in a manner similar to pensions or health care and have not felt the need to make an issue that becomes a concern long after workers retire a component of labour activism. In addition, the relegation of caregiving to the family, private and volunteer sectors in most welfare states has meant that care giving is "a solitary activity which offers little potential for collective mobilisation" (Morel, 2006, p. 230).

The events surrounding the Filmon privatization initiative illustrate that a formidable long-term care welfare state constituency has developed in Manitoba. In the years following the Schreyer government's creation of Manitoba's, and Canada's, first universal home care plan, support coalitions had grown up around the program. A coalition of public home care beneficiaries, their families and employees developed in the post-1974 period which came to believe that they had an important stake in maintaining non-profit care. In selecting home care as a site for experiments in privatization, the Filmon government incorrectly believed that the program had not come to be regarded, in the minds of many Manitobans, as a core welfare state service. The widespread and organized backlash among program supporters came as a surprise to policy makers who assumed that they could move privatization forward by invoking weak and faulty arguments. The reality, however, was that in the collective political conscience of Manitoba, long-term care had developed into an issue of prominence. The five week strike by the province's home care workers, the public hearings in opposition to

proprietary ownership, the lawn sign campaign and other events during 1996 illustrated that long-term care was not a peripheral issue in the province. While in many jurisdictions dependency in old age tends to be an underestimated risk, and one that many prefer to avoid or delay thinking about, in Manitoba long-term care has achieved an important place in welfare state thinking. As the 1988 Price Waterhouse Coopers study pointed out, the home care program "appears to have become established in much of the public's mind as a valuable service in its own right, and one that is an essential element in the range of human services supported by the tax payer" (Price Waterhouse Coopers, 1988, p.49). It has also, as the MGEU demonstrated during the strike, become an important part of labour activism and a focus for collective mobilization.

Conclusion

This chapter, by shifting the focus of analysis to the provincial level in Canada, has provided a framework that explains why non-profit long-term care has been prioritized and maintained in Manitoba. Since long term care was left out of the nation's publicly-funded universal health care system, provincial governments have been left to determine how much, or how little, they would like to rely on the for-profit sector to meet the long-term care needs of their senior populations. In Manitoba, the reliance on proprietary care has been minimal. By incorporating an historical approach in the preceding analysis, this chapter has uncovered some of the key events, political actors and distinctive features of the Manitoba political context that have served to forestall the expansion of proprietary care. I have argued that the foundations for a formidable non-profit presence in long-term care were laid in the 1970s because of the coming together of two factors unique to the province at the time. The election of Manitoba's first social democratic government in the years 1969 to 1977, and the maturation of a cohesive

community of geriatric specialists capable of advocating for long-term care reform on a not-for-profit basis, were highlighted as fundamentally important. When the NDP government of Ed Schreyer published the 1972 *White Paper on Health Policy*, which stated its desire to make the health care system more responsive to those whose needs had been ignored under federal cost sharing arrangements, as well as its openness to reform proposals, there was a cadre of geriatric specialists that could demonstrate, through pilot projects and research initiatives in place since the late 1950s, the benefits of prioritizing non-profit long-term care. The fact that a government interested in broadening the scope of the provincial health care system beyond hospitals and physicians' offices was elected to office at a time when a community of geriatric specialists was increasing in number and expertise, was important to elevating non-profit long-term care on the political agenda and bringing the sector from the fringes of the province's welfare state to the mainstream in the mid-1970s.

The latter portion of this chapter was concerned with explaining how public-sector care has been sustained in Manitoba over time. While the election of the Schreyer government was an opportunity for non-profit reformers to influence the direction of seniors' care in substantive ways, proprietary interests were given voice when Progressive Conservative premiers striving to take the province in neoliberal directions were elected to office in subsequent years. Two such premiers, Sterling Lyon (1977-1981) and Gary Filmon (1988-1999), tried to dramatically increase the role of the private sector in long-term care. While the Lyon government was committed to bolstering the proprietary interests in personal care homes, the Filmon government sought to privatize home care. In neither instance were these efforts realized. These failed attempts bring to light two factors that have worked to forestall the expansion of for-profit care in Manitoba. The

first is that there are limits to the extent to which Manitobans are willing to embrace leaders who aim to significantly dismantle key features of the provincial welfare state. Lyon was the first Manitoba premier in the modern era to be given only one term by the electorate, and his privatization initiatives were reversed when his government was defeated by Howard Pawley's NDP. The second factor relates to the formation of a long-term care welfare state constituency in Manitoba committed to maintaining benefits previously enacted. Filmon was forced to retire from his plans to privatize the province's home care program after the province's public sector home care workers, along with many seniors and their families, successfully mobilized against the introduction of proprietary ethos to a public sector program that was largely meeting its core objectives.

Works Cited

Achenbaum, Andrew and Daniel Albert. *Profiles in Gerontology*. Westport: Greenwood, 1995.

Adams, Christopher. *Politics in Manitoba: Parties, Leaders, and Voters*. Winnipeg: University of Manitoba Press, 2008.

Bilton, James. Hansard. Manitoba. May 29, 1975, p. 3218

Brosnahan, Maureen. "Pawley promises seniors improved personal care." *Winnipeg Free Press.* October 16, 1981, p. 10

Campbell A., Morgan K. Federalism and the politics of old-age in Germany and the United States. *Comparative Political Studies*, 2005; 38.8: 887-914

Canadian Centre for Policy Alternatives. "Health Care, Limited. The Privatization of Medicare." A synthesis report prepared by the CCPA for the Council of Canadians with guidance from CCPA Research Associates, Pat Armstrong, Hugh Armstrong and Colleen Fuller in collaboration with the Canadian Health Coalition. November 2000.

Canadian Union of Public Employees. Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care. Ottawa: Canadian Union of Public Employees. 2009 Retrieved from: http://cupe.ca/updir/CUPE-long-term-care-seniors-care-vision.pdf October 12, 2011

Canadian Virtual Hospice. "Paul Henteleff". May 2009. Retrieved February 1, 2013 from http://www.virtualhospice.ca/fr_CA/For+Professionals/Take+a+Bow/Dr_+Paul+Henteleff.aspx

Carr, Ian and Robert Beamish. *Manitoba Medicine: A Brief History.* Winnipeg: University of Manitoba Press, 1999.

Coalition to Save Home Care. Profit-Making Has No Place in Home Care. 1996

Desjardins, Laurent. 1975 Annual Report. Manitoba Department of Health and Social Development.

Desjardins, Laurent. Hansard. Manitoba. March 19, 1975, p. 437

Desjardins, Laurent. Hansard. Manitoba. May 27, 1975, p. 3085

Desjardins, Laurent. Hansard. Manitoba. May 29, 1975 p. 3212

Desjardins, Laurent. Hansard. Manitoba. April 8, 1985, p. 677

Desjardins, Laurent. Hansard. Manitoba. May 1, 1980, p. 3173

Douglas, Tommy. Hansard. Canada. Parliament. House of Commons. June 17, 1976. 14623

FitzGerald, Mary Ann. “Four care homes to be built.” *Winnipeg Free Press*. June 25, 1980, p. 3

Havens, Betty and Enid Thompson. *Aging in Manitoba: Needs and Resources. Volume 1*. Manitoba Department of Health and Social Development/ Division of Research, Planning and Program Development. 1971.

Havens, Betty. Telephone interview with Dr. James Struthers, 27 October, 2003.

Jager, Manfred. “Nursing home officials cautious over government plans.” *Winnipeg Free Press*. March 24, 1976.

Jager, Manfred. “Health Commission gives basic OK to three institutions for elderly.” *Winnipeg Free Press*. March 26, 1975, p. 1

Jager, Manfred. “MMA sees dangers in geriatric plan.” *Winnipeg Free Press.* July 18, 1975, p. 14

Kingdon, John. *Agendas, Alternatives and Public Policies. Second Edition*. New York: Harper Collins College Publishers. 1995.

“Larry Desjardins.” *Former Manitoba MLAs Newsletter*, Winter 2007.

MacKenzie, Glen. “Private care homes hit.” *Winnipeg Free Press*. May 3, 1980, p. 10

Manitoba Government Employees Union. “Yes We Did” 1997 Part 1 http://www.youtube.com/watch?v=thEHo4D8Cbs

Manitoba Government Employees Union. “Yes We Did” 1997 Part 2 http://www.youtube.com/watch?v=zsJsLmKk1rc

Manitoba Government Employees Union. “Yes We Did” Part 3 http://www.youtube.com/watch?v=WKNg7L3mfQc

Manitoba. Legislative Assembly. *Cabinet Committee on Health, Education and Social Policy. White Paper on Health Policy.* 1972.

Manitoba. *Report of the Health Services Review Committee. Volume I: Summary and Recommendations*. 1985.

Manitoba. *Report of the Health Services Review Committee. Volume III: Sub-Committees’ Reports.* 1985.

Macdonald, Neil. “The Development of Palliative Care in Canada.” *Textbook of Palliative Medicine.* Eds. Eduardo Bruera, Irene J. Higginson, Carla Ripamonti, and Charles F. Von Gunten. Boca Raton: CRC Press, 22-28.

McAllister, James. A. *The Government of Edward Schreyer: Democratic Socialism in Manitoba*. Kingston: McGill-Queen’s University Press, 1984.

McCaffery, Shaun. “Study of Policy Continuity Between the Progressive Conservative and the New Democratic Governments of Manitoba, 1958-1977.” Masters’ Thesis. Department of Political Studies, University of Manitoba, 1986.

Miller, Saul. Hansard. Manitoba. February 28, 1980, p. 161

Morel, N. Providing coverage against new social risks in Bismarckian welfare states The case of long-term care. In Armingeon, K., Bonoli, G., editors *Politics of Post-Industrial Welfare States : Adapting Post-War Social Policies to New Social Risks.* Florence, KY, USA: Routledge; 2006

Parasiuk, Wilson. Hansard. Manitoba. March 10, 1981, p. 1525

Parasiuk, Wilson. Hansard. Manitoba. March 11, 1981, p. 1603-1604

Parasiuk, Wilson. Hansard. Manitoba. March 19, 1981, p. 1922

Parasiuk, Wilson. Hansard. Manitoba. February 28, 1980, p. 152

Pawley, Howard. Hansard. Manitoba. February 25, 1980, p. 44

Parasiuk, Wilson. Hansard. Manitoba. April 17, 1980, p. 2624

Parasiuk, Wilson. Hansard. Manitoba. July 16, 1980, p. 5717-5718

Pawley, Howard. Hansard. Manitoba. May 1, 1980, p. 3170

Pawley, Howard. *Keep True: A Life in Politics*. Winnipeg: University of Manitoba Press. 2011

Pierson, Paul. “The New Politics of the Welfare State.” *World Politics*. 14.2 (1996): 143-79

Pierson Paul. *The New Politics of the Welfare State*. Oxford: Oxford University Press, 2001

Pierson Paul. The Welfare State over the very long run. *ZeS- Arbeitspapier*, 2011; 2. Available from http://hdl.handle.net/10419/46215

Price Waterhouse Coopers. *Review of the Manitoba Continuing Care Program*. 1988.

Promislow, Helen. “Quiet politician Miller left life as he lived it.” *Winnipeg Sun*. September 16, 1993, B15.

Rosner, Cecil. “Closing order upsets owners of nursing homes.” *Winnipeg Free Press*. December 26, 1984, p. 2.

Senate of Canada. *Final Report of the Special Senate Committee on Aging in Canada*. 1966.

Shapiro, Evelyn. *History of the Implementation of Universal Home Care Program in Manitoba*. 1977. (University of Manitoba Archives)

Shapiro, Evelyn. *Home Care: A Comprehensive Overview*. Canada. Department of National Health and Welfare. 1979.

Shapiro, Evelyn. “Continuum of Care: The Institutional-Community Connection.” Presented to Annual Meeting of the Ontario Hospital Association, Toronto, Ontario, October 1989.

Shapiro, Evelyn, Tate, Robert and Ellen Tabisz. “Waiting times for nursing-home placement: the impact of patients’ choices.” *Canadian Medical Association Journal*, 146.8 (1992):1343-1347

Shapiro, Evelyn and Tate, Robert B. *Assessing Quality of Care in Manitoba Personal Care Homes by Using Administrative Data to Monitor Outcomes*. Manitoba Centre for Health Policy and Evaluation. November 1993.

Shapiro, Evelyn. “The Cost of Privatization: A Case Study of Manitoba Home Care.” Canadian Centre for Policy Alternatives. 1997.

Shapiro, Evelyn. Interview with Dr. James Struthers, 22 October, 2003.

Sherman, Bud. Hansard. Manitoba. February 28, 1980, p. 156.

Sherman, Bud. Hansard. Manitoba. May 1, 1980, p. 3166

Sherman, Bud. Hansard. Manitoba. April 10, 1979, p. 2392

Sherman, Bud. Hansard. Manitoba. June 14, 1979, p. 5353

Sherman, Bud. Hansard. Manitoba. April 10, 1978, p. 2392

Silver, Jim. “The Cost of Privatization: Olsten Corporation and the Crisis in American For-Profit Home Care.” Canadian Centre for Policy Alternatives. 1997.

Silversides, Ann. “Manitoba activist brought home the importance of care for the elderly.” *Globe and Mail*, December 15, 2010.

Struthers, James. "Comfort, Security, Dignity: The Veterans Independence Program, A Policy History." Veterans Affairs Canada: 2004.

Thomas, Paul G. and Curtis Brown. "The Past, Present, and Future of Manitoba's Civil Service." *Manitoba Politics and Government: Issues, Institutions, Traditions*. Eds. Paul G. Thomas and Curtis Brown. Winnipeg: University of Manitoba Press, 2010, 227-256.

University of Manitoba. Aging in Manitoba (AIM) Longitudinal Study. Study Description. http://umanitoba.ca/centres/aging/research/funded_projects/1068.html

University of Manitoba. "John A. MacDonell." April 29, 2011. Retrieved February 1, 2013 from: http://umanitoba.ca/outreach/retirees/media/OBITMACDONELL.pdf

Vogt, Paul. "The Manitoba Cabinet." *Manitoba Politics and Government: Issues, Institutions, Traditions*. Eds. Paul G. Thomas and Curtis Brown. Winnipeg: University of Manitoba Press, 2010, 181-204.

Weaver R. Kent. "Pension Reform in Canada: Lessons for the United States." *Ohio State Law Journal*. 65.1 (2004) 45-74.

Wesely, Jared J. "Staking the Progressive Centre: An Ideational Analysis of Manitoba Party Politics." *Journal of Canadian Studies*. 45.1 (2011): 144-168.

Chapter 4 'Open for Business': Expanding Privatization within Ontario's Long-term Care Sector, 1966-1991.

In the previous chapter it was argued that the 1970s were a formative period of policy making in the field of long-term care in Manitoba. That a government interested in making the health care system more responsive to those whose needs had been ignored under federal cost sharing arrangements, was elected to office at a time when a community of geriatric specialists were increasing in number and expertise, was fundamentally important to the elevation of non-profit long-term care on the political agenda. The window of opportunity for reform that was opened by the election of the province's first NDP government is central to the story of non-profit care in Manitoba. The ability of the NDP to maintain a competitive position in Manitoba's two party system in subsequent decades, alternating with the Progressive Conservative Party in the positions of government and official opposition, was an important factor forestalling the expansion of for-profit care. Within the legislature the NDP made non-profit care a central component of its platform and at key times the party was able to forestall Progressive Conservative attempts to bolster the position of proprietary operators in the province. The previous chapter also pointed to the role of a long-term care welfare state constituency as another contributing factor that has worked against commercialization, particularly in the 1990s.

Following the same timeline, the present chapter offers a dramatically different account of the Ontario policy making environment in long term care. Taking as its starting point the 1970s, this chapter begins by arguing that no window of opportunity opened in Ontario in which advocates of non-profit long-term care could influence the direction of public policy in any significant way. In contrast to Manitoba, the 1970s

marked the continuation of a durable post-war Conservative Party dominance of provincial politics. While non-profit reformers in Manitoba benefited from the election of a new party interested in moving the old age welfare state in new and more expansive directions, the re-election of the Progressive Conservatives led by Bill Davis in 1971 was of little benefit to Ontario reformers. Although Ontario's community of geriatric specialists had always had difficulty convincing post-war Ontario premiers of the need to reduce the province's reliance on for-profit care, it became particularly difficult in the 1970s as the government became increasingly concerned with limiting the scope and responsibility of the Ontario welfare state. And, unlike in Manitoba, where the advice of geriatric reformers was sought out by government officials looking to broaden the capacities of the state in the field of long-term care, in Ontario the advice of the private sector was commissioned by officials looking to limit state responsibilities across a range of policy areas. The benefits to commercial long-term care providers in this atmosphere are emphasized below.

Another benefit to commercial providers, both in the 1970s and in subsequent decades, has been the dynamic of Ontario's three party system. While the Conservative Party's winning record in the years 1943 to 1985 certainly stands out as a remarkable period of one-party dominance in Canadian provincial politics, both the Liberals and the NDP have been competitive in the Ontario political arena, splitting the votes not accorded to the Conservatives at election time. I argue that in Ontario's three party system commercial providers have benefited from a legislative environment in which two out of three parties have been supportive of their role in long-term care provision. Although the Ontario NDP, like its counterpart in Manitoba, has been a vocal opponent of proprietary care, the party has had difficulty advancing its vision of long-term care reform in the

more competitive Ontario political environment where the majority of parties have tended to see little wrong with affording the commercial sector a primary role in seniors' care.

Yet, this is more than the story of a well-intentioned social democratic party unable to effect change in an inhospitable political climate. After all, when the NDP got its first taste of governing in the years 1990 to 1995 one of its first orders of business was to acquiesce to the demands of private nursing home owners for more provincial funding. When in power the NDP government of Bob Rae acted much like a Liberal or Conservative administration when it came to residential long-term care. I argue that the disconnect between NDP criticisms of for-profit care while in opposition and in government are evidence of a lack of political will to move forward with reform as well as the extent to which Ontario governments of all political stripes have come to see for-profit providers as entrenched members of the long-term residential care environment, particularly during times of fiscal restraint. In contrast to Manitoba, where the maturation of a long-term care welfare state constituency in the years following the Schreyer government's reforms stands out as an important factor in halting privatization efforts, in Ontario it is the constituency of commercial providers that have organized over time to defend the profit motive and establish themselves as central actors in the field of long-term care within Ontario.

Before moving into an analysis of the impact of Progressive Conservative Party dominance on the development and expansion of proprietary nursing home care in Ontario, a brief note on where this chapter fits into the broader Ontario political science and welfare state literature is in order. As was the case with Manitoba, long-term care is understudied. With the exception of one chapter in the five editions of *The Government and Politics of Ontario* (see Novick, 1985), long-term care is not a policy area that

scholars have gravitated towards to explain the uniqueness of Ontario politics or the continuities and discontinuities of the provincial welfare state. Work by Tarman (1990) and Struthers (1997, 1998) has, however, helped to draw attention to the importance of Ontario's residential care sector as a site of scholarship. Building on such work and presenting new arguments and analysis on the key actors and events in the political history of the sector, the following pages contribute to an understanding of residential care in Ontario.

The 1970s and the Absence of a Window of Opportunity

The PC party dynasty in the years 1943 to 1985 can be explained by a number of factors. These include the prolonged period of fiscal prosperity, the party's selection about every ten years or so of a new leader giving the party the appearance of rejuvenation, the ability of the party to appeal to centrist voters, a vibrant party organization, and the splitting of votes between the Liberal and NDP parties (Tanguay, 1997, Manthorpe, 1974, Morton, 1997). Stasis in post-war Ontario politics has been a contributing factor in the development and expansion of proprietary residential care in the province.

In the early 1970s Ontario private nursing home owners faced a remarkably different situation than their counterparts in Manitoba. Uninterested in assuming further welfare state responsibilities, there was no policy document like the Manitoba *White Paper on Health Policy* influencing Ontario government thinking. In Ontario, privatization had taken on an increased importance in government thinking and the 1970s were a "formative" decade which led to a rethinking of government's social welfare priorities and responsibilities (Evans and Shields, 2011, p. 133). The 1969, 1970 and 1971 Ontario budgets expressed a growing concern with containing public-sector spending

amidst rising inflation, unemployment and a bulging provincial debt (Evans and Ibid, p.136). In this atmosphere it was “the virtues of public non-intervention” that increasingly came to dominate government thinking (Novick, 1985, p. 332). To government officials like Ontario's right-wing Treasurer of the mid-1970s, Darcy McKeough, the end to the province’s enviable post-war boom was being ushered in by overly generous welfare state commitments. According to McKeough “one of the root causes of the current inflation problem in Canada is excessive government spending and unnecessary growth in the size and complexity of the public sector” (cited in Evans and Shields, 2011, p. 138). Given that it was McKeough’s party that was responsible for the design and scope of the Ontario welfare state, there was certainly a level of irony to his criticisms of social policy mismanagement.

Novick explains that “Initiatives by the Ontario government in the early seventies were largely attempts to redirect, manage and restrain the social policy field. The responsibility for developing and implementing appropriate strategies fell to professionals recruited from the industrial sector” (Novick, 1985, p. 331). While government officials in Manitoba were inviting members of the geriatric community into policy making circles to develop new strategies to expand the boundaries of the old age welfare state, in Ontario it was members of the business community that were invited in to develop strategies to limit state responsibilities across a range of sectors. Two reports published in the 1970s illustrate this particularly well. The report of the Committee on Government Productivity (COGP), which was established by the Robarts government in 1970 to re-examine the organization of government and recommend ways to improve efficiency, and released after the newly elected Progressive Conservative government of Bill Davis took to office, was one influential report. The COGP argued for a scaling back of public sector spending,

stating that "In future, selective reprivatization of program delivery could tap community skills and resources needed to meet policy objectives" (COGP, 1970, p. 51). Government needed to become more efficient and the private sector ought to be relied upon to deliver public policy objectives. The Social Planning Council of Metropolitan Toronto has argued that the COGP provided an incentive for the Davis government "to lean towards privatization" (SPC, 1984, p. 23) while Evans and Shields note that it "set the stage for the Ministry of Treasury, Economics and Intergovernmental Affairs to play an expanded role in coordination, planning, and the control of expenditures" (Evans and Shields, 2011, p. 137).

The second document was the Report of the Special Program Review in 1976. Chaired by Darcy McKeough, and another fiscally conservative actor, former auditor general of Canada Maxwell Henderson, the Review committee was tasked with the goal of discovering "ways and means of restraining the costs of Government through examining issues such as the continued usefulness of programs, alternative lower cost means of accomplishing objectives, and the problem of increased public demand for services in an inflationary period" (McKeough, 1975, p. i). Lacking representatives from the social policy or labour fields, the Review was composed of three senior public servants, two Cabinet Ministers and three members of the business community (Novick, 1985, p. 34). Its central conclusion was that Ontario's public spending commitments were the cause of the province's economic woes and that "The most urgent problem facing all governments today is not merely to exercise extraordinary vigilance in containing current spending, but to face up to the difficult job of cutting it back" (McKeough, 1975, p. 1). What Ontarians needed in other words, was not a government committed to doing more but to doing less.

Rather than take on more public policy commitments in social assistance, health care, education and other areas, the provincial government needed to "shift the responsibility" to other actors, including the federal government, municipalities, individuals and the private sector (McKeough, 1975, p. 17). Overly generous and expansive welfare state commitments, according to McKeough and his colleagues, were the cause rather than the solution to Ontario's problems. The government would be in a far better position to advance the province's economic interests at home and abroad if citizens' expectations of what the provincial state ought to provide for them were tempered. As well as limiting future welfare state commitments government needed to reduce current spending commitments through such mechanisms as closing hospital beds, reducing the rate of spending increases in education, and decreasing and tightening social assistance benefits.

When it came to long-term care, it was recommended that no new facilities be built for three years (Ibid, p. 290). While the freeze on new construction would prove beneficial to large for-profit providers (as discussed below), perhaps the most important benefit to be had by nursing home operators was the ideological justification of private sector provision offered by the Special Program Review. The Review stressed that Government would do best to keep in mind the notions that "people should do more for themselves" and that "where [a] new service is needed, if possible contract out to [the] private sector rather than increase public service" (Ibid, p. 362, 359). Although post-war Conservative governments in Ontario had always afforded a central role in nursing home provision to the proprietary sector, the arguments put forth in the Special Program Review, as well as the Committee on Government Productivity, provided an ideological justification for a sustained private sector presence. Momentum towards privatization

increased in the mid to late 1970s as the province pursued a program of fiscal restraint and the private sector was celebrated within government circles as being more “flexible, innovative, responsive, and efficient” than the public or non-profit sectors (SPC, 1984, p. 5). During each of the years between 1975-6 and 1982-3 provincial spending as a proportion of GPP declined in Ontario. A likely consequence of the restraint program was that the Davis government was reduced to a minority position in the elections of 1975 and 1977 (Evans and Shields, 2011, p. 138)

Within the Ministry of Health, the idea that the private sector ought to be relied upon wherever possible found a receptive audience. When, for example, in the face of sustained hospital bed shortages combined with growing public discontent over the crippling costs of nursing home care in an age of universal health insurance, government officials agreed to extend health insurance to residents in nursing homes in 1972 (Dunlop, 1969, p. 01, Struthers, 1997 p. 3), the private sector was told that it would play a significant role. As a program co-ordinator for the new extended health care program, G.S. Chatfield explained in the legislature “As the nursing home segment of this program is almost totally private ownership, a great challenge is thus presented for private enterprise and for government to work together to develop a mutually satisfactory program in this important health care segment of our social structure” (Rae, December 14, 1983, p.1005). Nursing home policy, in other words, was not to be developed without the interests of commercial providers in mind. While for-profit providers in Manitoba at the time were beginning to state their discontent with their lack of influence in government, in Ontario private operators were told that government recognized the need to develop nursing home policy in a manner that was mutually beneficial. In 1972 Deputy Health Minister Stanley W. Martin told the annual convention of the Ontario

Nursing Home Association, an industry lobby formed in 1959 to advance the interests of proprietary operators, that his government appreciated the integral role it played in nursing home provision and looked forward to the industry continuing "in partnership with the government" (cited in Hollobon, 1972, p. 14).

In the field of long-term care, between 1974 and 1986, Ontario was one of just three provinces that continued to expand its commercial long-term care sector to a greater extent than the public sector. Like the governments of Newfoundland and Prince Edward Island, the Davis government in Ontario looked disproportionately to the for-profit sector (Tarman, 1990, p. 38-39).

	Proprietary Special Care Beds for the Aged, 1974	Proprietary Special Care Beds for the Aged, 1986	Difference
Newfoundland	23%	29%	+6
Prince Edward Island	18%	33%	+15
Nova Scotia	54%	43%	-11
New Brunswick	52%	27%	-25
Quebec	-	22%	N.A.
Ontario	46%	54%	+8
Manitoba	42%	32%	-10
Saskatchewan	14%	8%	-6
Alberta	41%	23%	-18
British Columbia	65%	38%	-27
Canada	45%	37%	-8

(Tarman, 1990, p. 39).

As the above data indicates, while beds in the proprietary sector in Ontario increased by 8 percent between 1974 and 1986, in Manitoba there was a decrease of 10 percent in the same period. Between 1979 and 1983, for-profit involvement in facility-based long-term care rose by 38.9 percent in Ontario while the voluntary sector witnessed an increase of

8.8 percent and the municipal sector 5.5 percent (Tarman, 1990, p. 23). The proportion of the industry controlled by large chains also increased.

Health officials in Ontario had long depended on for-profit providers to help it meet the demands of an aging population. It is worth pausing to consider some of the reasons why the government had come to see its relationship with the industry as one of partnership by the early 1970s. One reason why for-profit nursing homes were able to increase their presence in Ontario in the decades following the end of the Second World War relates to the preoccupation of the provincial and municipal governments with building 'homes for the aged'. Begun in 1947, the homes for the aged program encouraged the building of new institutions to replace Ontario's dilapidated and ill-reputed county houses of refuge (Struthers, 1997). Designed with the care needs of a mainly ambulatory group of seniors in mind, government officials promoted the new facilities by arguing that those growing old in post-war Ontario could look forward to life in "ultramodern" publicly-run homes that were "comfortable, attractive, bright, and cheerful" and could "match with the finest of hotels" (cited in Struthers, 1998, p. 337). Unlike in the poorhouse, residents in these new facilities could expect to "enjoy all the physical comforts of a family home" (Stuthers,1998, p. 337). Providing a 75 percent subsidy to municipalities willing to construct homes for the aged, the provincial government encouraged expansion in an era of unprecedented economic growth (Struthers, 1998).

Government rhetoric at the time gave the impression that Ontario was home to a highly progressive and forward-thinking group of state officials committed to advancing geriatric care. Premier Leslie Frost, for example, claimed to voters that the homes for the aged program illustrated that "Our treatment of the aged has been just as spectacular as

the development of Ontario in other phases" and that "No other authority on this continent is giving such careful attention to the special needs of the aged group than is the case here in the province of Ontario" (cited in Struthers, 1998, p. 346). Minister of Public Welfare Louis Cecile argued in the Ontario Legislature in 1963 that "the government has used excellent judgment in making generous funds available for the construction of fine, modern new homes" (Cecile, March 26, 1963, p. 2231). The "modern, up-to-date structures" were a "Godsend" to Ontario, Cecile emphasized, noting that "There is no sign of a let-up in the on-going development of homes for the aged" (Ibid).

A program designed for the needs of the ambulatory, rather than for older citizens with more complex medical needs, however, did not represent a long-term care policy informed by a real understanding of the changing needs of Ontario's seniors. The new single-story 100 to 300 bed buildings, with their focus on style and modern amenities, may have been a 'spectacular' representation of Ontario's fiscal capacity and its commitment to providing new entitlements to the province's pensioners, but they were not an indication that 'careful consideration' had been given to the shortage of long-term care beds that existed for seniors with chronic conditions (Struthers, 1997, 1998). Medical and nursing care were not the mandates of homes for the aged, something evidenced by the fact that the Department of Public Welfare (later the Ministry of Community and Social Services), and not the Ministry of Health, was given responsibility for the facilities (Struthers, 1998, p. 339). Moreover, the division of responsibility for long-term care that would develop between the two departments (after the Ministry of Health assumed control of nursing homes) did not represent a careful consideration of the state capacity and organization necessary to coordinate seniors care.

Although nursing homes had always existed as profit-making ventures in Ontario, by focusing resources and political will towards the construction of homes for the aged the government gave proprietary interests time and space to expand their position. As Struthers explains,

Had less money been spent on providing expensive institutional care for the ambulatory and active elderly in these years, Ontario might have been able to concentrate on developing a system of public nursing homes for those who truly needed ongoing medical attention. Instead, the province devoted its capital resources to building domiciliary institutions for the aged which had only a vaguely defined health-care mandate. As a result, the field of nursing home care was left wide open to profit (Struthers, 1998, p. 346).

Those wishing to continue making a profit on nursing home provision in Ontario, and those looking to get into the business, could thus consider the provincial climate a favorable one. In the 1950s and 1960s the private sector was largely left alone while the government focused on building up institutions that went only a minimum distance to meeting the real long-term care needs in the province. By 1969, 89 homes for the aged had been built, providing care for more than 15,000 residents at a cost of $110,000,000 (Struthers, 1998, p. 335).

Although policy makers briefly flirted with the idea of building a parallel system of public-nursing homes in the mid-1960s, a concerted effort was not made to disrupt proprietary care. In 1966 Ontario's Department of Public Welfare passed the Rest Homes Act in an effort to develop a network of public nursing homes in the province. The legislation included provisions for a 70 percent operation subsidy and 50 percent capital funding to municipalities that were committed to constructing and administering 'rest homes' (Struthers, 1997, p. 181). Such facilities were to be developed with a mandate different from that of the municipally-run homes for the aged because they would accommodate seniors with care needs exceeding the ambulatory level. Officials from the

department justified rest homes by arguing that if long-term residential care was not put on a mainly public or non-profit basis “there would be a never-ending pressure on the Government from proprietary operators to meet increased rates in order that they might maintain an adequate profit level” (cited in Struthers, 1997, p. 181). They stressed that Ontario nursing home policy should be informed by lessons from south of the border where the American states were “completely over a barrel due to their over-reliance on proprietary nursing homes” (cited in Struthers, 1997, p. 181). As the 1960s were drawing to a close, it was important for the Ontario government to disrupt its growing reliance on the for-profit sector by directing resources to the construction of non-profit facilities.

The idea of public or not-for-profit nursing homes was supported by a number of groups in Ontario at the time of the proposal. A report by the Ontario Welfare Council in 1965, for example, argued that the province should begin the process of phasing out proprietary homes, noting that while the private nursing home “will undoubtedly continue to play its part, the Ontario Welfare Council believes that immediate consideration should be given to government leadership in developing non-profit homes throughout the province” (cited in Mortimore, 1965, p. 01). The Welfare Council pointed out that few nursing homes had regulations to safely store drugs and patient records; that just fifty-four percent of homes contained fire alarms and a mere thirty-five percent conducted fire drills; that poor record keeping was characteristic of the industry; inadequate staffing and training was common; that a shortage of homes existed in Northern Ontario; and that inspections were irregular in municipalities lacking full-time medical officers of health (Ibid). The deficiencies in care that pervaded nursing homes, the Welfare Council asserted, provided ample reason for the provincial government to lessen its reliance on commercial care by building up the non-profit sector.

The Welfare Council's concerns about for-profit care were similar to those found in a study released fifteen years earlier by the Ontario Health Survey Committee. In 1950 the Committee released the findings of its investigation into the conditions of the province's nursing homes, which found them to be "overcrowded, and showed a deplorable shortage or complete absence of competent nursing care. Aged bed patients were found in a most unsatisfactory condition. The preparation and service of food was such the meals were neither palatable nor regular" (cited in Tarman, 1990, p. 52). The Committee called for the province to become more involved in the field of nursing home provision, a position echoed in 1957 when the province was home to the country's First Conference on Ageing. For the first time doctors, social workers, gerontologists, nursing home operators and government representatives came together to converse on issues of aging and long-term care, with poor conditions in proprietary nursing homes occupying a prominent place during conference proceedings (Struthers, 1997, p. 176-177). In 1965, Toronto Mayor Philip Givens came out in favour of publicly operated nursing homes, noting "Nursing homes at present are run by private enterprise to make a buck...Let them make a buck some other way. Nursing homes should be on a governmental basis" (*Globe and Mail* Jan, 1965, p. 04).

There was also the Canadian Senate Committee on Aging (1966) and the Ontario Select Committee on Aging (1966) which pointed to the drawbacks of proprietary care. In Chapter 2 the criticisms of for-profit care made by such groups as Ontario's Jewish Home for the Aged at Baycrest to the Senate Committee on Aging was noted. Testimony at the Ontario Select Committee was equally damning. Chair of the Ontario Hospital Services Commission, Dr. John B Neilson, for example, testified that "From what I've seen of nursing homes, I hope if I become chronically ill, somebody will not put me in one"

(*Globe and Mail*, January 8, 1965, p. 1). Having experience in directing some chronic care patients to private nursing homes in order to ease the burden on an overcrowded hospital system (a relationship whose importance is discussed in more detail below,) Neilson could speak first hand to the problems in care. The Ontario Hospital Association for its part was "concerned at a lack of any non-profit facilities, other than homes for the aged, to which patients can be discharged from long-term care hospitals (*Globe and Mail*, October 25, 1966, p. 13). Burrell Morris, past president of the Associated Nursing Homes Incorporated of Ontario (ANHIO), the forerunner to the Ontario Nursing Home Association, also provided a scathing critique of conditions in private homes, telling Ontario's Select Committee that a number of owners were making "profits as high as 30 and 40 percent in homes where blind patients were served scrapings off the plates of others" (cited in Struthers, 1997, p. 179). Some homes were so lax about record keeping that operators "don't even know how long some patients have been there" and when it came to medication "in most cases there is little or no control" (cited in Struthers, 1997, p. 179). While Morris's arguments were in no way a call for public nursing homes his testimony, and his arguments along with those of others, should have provided ample reason to move forward with the rest homes program.

Yet, despite all of the mounting evidence of the problems with for-profit care the rest homes program went nowhere. Just two were constructed, one in Port Colborne and the other in Sarnia, hardly sufficient to offset Ontario's reliance on the commercial sector (Struthers, 1997, p. 182). The important thing to remember is that while Ontario, like Manitoba, did not lack advocates of non-profit care, in Ontario proprietary interests had more influence. The reality was that proposals for non-profit nursing homes had little chance of succeeding in the midst of extensive opposition from nursing home operators

and a Ministry of Health sympathetic to industry concerns. As Struthers explains, “Private nursing home owners, through the ANHIO, lobbied furiously against the bill, arguing that state-subsidized competition was both unfair to them and a waste of taxpayers’ money” and health officials “for the most part agreed” (Struthers, 1997, p. 182). Association president George Newbold argued that Cecile's proposal was frightening away potential industry investors and that the minister should not be “meddling” in the affairs of nursing homes (*Toronto Star*, June 9, 1966, p. 40). As Burrell Morris put it,

“I don't see why there is so much being said by Queen's Park about making the nursing homes public. All this does is make it impossible to borrow money for improvements...There's a real need in this province – in Canada – for private nursing homes. Everywhere there are waiting lists. We feel we can do a good job if we get some break from the government. Instead of talking about making money available for setting up public homes, they could give us a chance to borrow that money to raise standards and do what we can for the people in the country” (*Globe and Mail*, February 26, 1966, p. 11).

As demand for long-term nursing care remained high, and as Ontario's post-war fiscal strength and commitment to investing large sums in the building of new institutions began to fade in mid-1960s, the provincial and municipal governments increasingly came to see the private sector as a necessary partner in the provision of seniors' care. Even though Health Minister Matthew Dymond had argued to the legislature that the private nursing home owners “are concerned about one thing only, making as much money as possible and giving as little as possible in return to the patients”, and to premier John Robarts in 1961 that homes were “in such dreadful condition...that I have feared for many months a virtual explosion”, the Department of Health was reluctant to displace proprietary nursing homes (Struthers, 1997, p. 181, p. 179). Health officials justified their support for their opposition to the rest homes proposal by arguing that with the private sector providing 14,000 long-term care beds in the province “it would be impractical and

unjustified to eliminate private enterprise in favour of charitable non-profit or Governmental agency operations" (cited in Struthers, 1997, p. 182).

By the mid-1960s private nursing home owners had become "integrated into the provincial health care system" in Ontario as the government relied on the facilities to meet demands for long-term care and to care for some chronic care patients impacted by a hospital bed shortage stemming from the lack of wartime construction (Struthers, 1998, p. 346, Struthers 1997). As the *Globe and Mail* rightly observed, any criticisms of the nursing home industry made by a government increasingly dependent upon its services must "be taken in all quarters with a grain of salt" (Schiff, 1965, p. 1). The reality was that

> chronic care hospitals, homes for the aged and other institutions either do not exist or where they do, are too overburdened to handle the load if residents of inadequate nursing homes were transformed to their care...Medical officers of health are aware that strict bylaw enforcement would require the closing of some homes. In view of the inadequacy of other institutions for the aged...they are not prepared to curtail an admittedly faulty but necessary service" (Ibid).

By the mid-1960s, therefore, the falsity of pronouncements that had been made by people such as Leslie Frost that Ontario was on the leading edge of geriatric care was obvious. Government increasingly came to endorse and accept the notion that if the long-term care demands of an aging society were to be met with any level of sufficiency the private sector would have to play a central role. This was a position that was also supported by the opposition Liberal leader Andrew Thompson, who argued to the annual convention of the ANHIO in 1965 that he did not believe that there was a need for the province to disrupt proprietary ownership. As he explained, "there is nothing wrong in making legitimate profit so long as it is born out of concern for the well-being of the aged and not at the expense of human misery" (*Globe and Mail*, September 25, 1965, p. 13).

While the proprietary sector certainly benefited from growing acceptance in government circles of the necessity of its services, it also stood to benefit from the culture of institutionalization that was developing throughout Ontario as a result of the homes for the aged program and the lack of focus on developing community care options. During the 1960s, the attraction of the 75 percent provincial subsidy led most municipalities to avoid directing resources to non-institutional long-term care alternatives. Developing community-based alternatives, such as home care, homemaking services and 'meals on wheels' programs, which could allow older Ontarians to remain in their homes for longer, received little priority. Despite the fact that some members of the medical community, local authorities, community agencies, and some members of the provincial government wanted such alternatives to be developed, there existed a bias towards institutional care (Baum, 1977, Struthers, 2003). And although Premier Frost had advocated for the inclusion of home care as part of the hospital insurance program in negotiations with the federal government in 1956-1957, home care fell off the Ontario political agenda when it was left out of the national scheme (Struthers, 1998, p. 394). With institutionalization as the guiding principle of long-term care policy, nursing home owners had the benefit of not having to compete with a well-structured public home care program that gave a majority of older people the option of delaying or avoiding entering a residential care facility.

A combination of factors, including the negative portrayals of nursing homes by organizations such as the Ontario Welfare Council, testimony at the Ontario Select Committee on Aging and the Canadian Senate Committee on Aging, along with the increasingly negative newspaper coverage of nursing home conditions, the urging from Ministry of Health officials, and the prospect of an impending election prompted the

government of John Robarts to become more involved in the nursing home sector (Struthers, 1997, p. 180). The Ontario Nursing Homes Act was passed in 1966, making licensing and regulation of nursing homes a responsibility of the Department of Health for the first time. The ANHIO, for its part, was keen to see the Ministry of Health assume licensing and regulation responsibilities as owners came to see it as a way to diminish competition in a sector that was becoming more and more crowded with new operators looking to make a profit (Tarman, 1990). With government implementing and enforcing the rules of the game, the industry argued, Ontarians could rest easy leaving nursing home care in the hands of the private sector.

With responsibility for nursing homes being transferred to the Department of Health "Nursing homes attained greater credibility as health care institutions" in Ontario (Tarman, 1990, p. 58).). In Struthers's words,

For those operators belonging to the ANHIO this was a key victory. Provincial regulation promised to bring some semblance of order through regulated competition to their expanding industry. It also cemented an uneasy partnership between private enterprise and the Department of Health to ensure that profitability could be reconciled with Ontario's burgeoning fiscal priorities as well as the long-term care needs of the elderly (Struthers, 1997, p. 180).

When representatives from the Ministry of Health spoke of the importance in 1972 of working in partnership with the nursing home industry to achieve mutually beneficial objectives they were thus referring to a partnership that had become entrenched years earlier. In just three years following provincial licensing and inspection nursing home care in Ontario grew by 114 percent. This meant an increase in beds from 8,500 to 18,200 (Struthers, 1997, p. 180). By the close of the 1960s, more than half of the province's nursing home proprietors had been in operation for fewer than six years, an indication of

the perceived benefit of regulated competition on the part of commercial interests (Struthers, 1997, p. 180).

It is important to note that while prior to 1966 the ANHIO had to contend with the fact that government inaction in the nursing home field in an era of increasing demand for long-term care was leading to the entry of “the unscrupulous, the undercapitalized, and the unskilled into the nursing home business”, which contributed to lower profits for ANHIO members and a poorer public image of private care, this same government ambivalence towards the industry also gave it time and space to mobilize (Struthers, 1997, p. 187-188). In the end, “indecisive state planning created both the shortage of public or non-profit long-term care beds, and the breathing space needed for nursing home operators to organize themselves into an effective private lobby” (Struthers, 1997, p. 187-188). Robarts admitted in 1965 that he could not explain the precise legal definition of a nursing home, an indication both of the government’s overall lack of understanding of the industry and long-term care’s low priority on the political agenda (*Globe and Mail*, January 15, 1965, p. 1). Policy makers quickly realized in negotiations with the ANHIO over such things as the settings of per diem rates that the industry was prepared and eager to push government officials as far as possible to achieve increasingly higher rates (*Toronto Star*, April 16, 1968, p. 29).

When it came to per diem rates Dymond expressed frustration with the fact that within the span of three years the ANHIO went from agreeing to a daily rate of $6.50 to quickly and successfully demanding that rate be increased to $8.50, to then retaining the consulting firm of Woods Gordon to develop a proposal suggesting that a rate of $12.50 per day from government was appropriate (Struthers, 1997, p. 182-183). The unwillingness of the industry to be passive participants in long-term care policy making

became especially evident in 1968 when a number of Toronto nursing homes threatened, unless the city agreed to pay the $12.50 rate, to evict residents that were in receipt of welfare payments. City officials countered by proposing to move its welfare client base to nursing homes willing to accept the rate of $8.50 outside of Toronto. A number of residents refused to move, an act which gained large support from the public and the media. The *Globe and Mail* referred to it as "one of the most callous and disgusting episodes this city has seen in a long time (*Globe and Mail* May 11, 1968, p. 6). While nursing home owners and the government in the end agreed to a daily rate of $10.50 "the ugliness of the incident was a harbinger of how difficult it had become to reconcile caring and profit" (Struthers, 1997, p. 183).

When in 1972 officials from the extended care program emphasized the need for private operators and government to work together to reach mutual goals, such statements were informed by both the realization that the province depended on the industry to meet demand and that the industry had developed an unyielding belief that it had a legitimate right to influence the scope and parameters of its own regulation. For the NDP this was a clear signal that nursing home policy would unfold in Ontario with the interests of three groups in mind: the government, nursing home owners and seniors. While Ministry of Health officials characterized long-term residential care as a sector dependent upon a close working relationship between the commercial sector and government, members of the NDP stressed that the well-being of seniors would suffer. They argued that in a majority of the province's 378 nursing homes "owners of the homes are cutting corners in order to enhance profits" (Warner, 1977, p. 2453). Citing such practices as short staffing, unlicensed nurses dispensing medication, insufficient training, baths being provided only once a week, unsanitary food handling, a lack of focus on nutrition, and residents and

family members having to hire private nurses at a cost as high as $900 in order to ensure a higher level of care, the NDP argued that Ontario's nursing homes should not be left to commercial interests (Ibid). In 1978, New Democrat Dave Cooke proposed a bill that would require all nursing homes to become incorporated as charitable, non-profit corporations in order to receive a license under the Nursing Homes Act (Cooke, 1978, 1886).

The response from Conservative and Liberal members of the legislature to the proposal reveals the extent to which members from both parties were wedded to the idea that the proprietary sector should play an important role in the provision of long-term care. The Conservatives argued that the NDP proposal made little sense because it would require “that the Ontario government abandon the proven system of providing for the health-care of its elderly citizens needing nursing home care” (Turner, May 11, 1978, 2409). John Turner, the Progressive Conservative MPP for Peterborough, argued that although a non-profit ethos had come to dominate other aspects of health care provision in Ontario, when it came to long-term care “It has been proven that the government and the private sector can work together to provide services for the needs of the elderly people” (Ibid). Ontarians “are receiving good value for our health dollars from the private nursing home operators”, it was stressed, and to lessen the province’s reliance on their services was simply bad policy (Ibid, 2410). Advocates of non-profit care needed to recognize that

To legislate the private nursing home operator out of business would have a number of negative results. There would be a loss of tax revenue to the province. A tremendous amount of capital would have to be poured into a rapidly expanding area and additional funds would have to be allocated to provide a service that is already being provided by very dedicated and conscientious people in co-operation with the ministry (Ibid).

In other words, co-operation with the industry, not confrontation should be the foundation of long-term care policy making in Ontario. Improving or maintaining the quality of care could be achieved by insisting that nursing home operators, who are "good corporate citizens", adhere to standards laid out in the Nursing Home Act (Ibid).

The Liberal Party also opposed moving towards a non-profit system of care. As health critic Sean Conway argued with respect to nursing homes, a majority of Ontario Liberals believe "that there is a role for private involvement in this field; that the ambit of government activity has been too generously expended in the past few years" (Conway, May 11, 1978, p. 2411). In line with the types of arguments advanced by McKeough and his colleagues in the Special Program Review two years earlier, the Liberals stressed that in an era of fiscal restraint the government must not concern itself with broadening the scope of its social welfare responsibilities. Moreover, the private sector had the potential to provide Ontario's aging population with the highest quality of care. Improving long-term care depended not on transferring responsibility to the non-profit sector, but rather in recognizing that "the inspection procedures which are in place provide much of the solution. It's simply a matter of getting the Ministry of Health and his officials to enforce more effectively the regulations which are presently in place" (Ibid). The response from another Liberal MPP was that government "should be looking at a massive plan to build private nursing homes across the province" to accommodate seniors (Cunningham, May 11, 1978, p. 2416). For the Ontario Liberals, a party that regularly positioned itself to the right of the Conservatives prior to their 1985 election (Wiseman, 1997), such an endorsement of the private sector was fitting.

For the Liberals and Conservatives, therefore, long-term care was an area of the welfare state where for-profit provision was entirely acceptable. Provided officials from

the Ministry of Health regularly inspect nursing homes and enforce the standards laid out in the Nursing Home Act there was no need for policy makers to tamper with ownership trends. Ontario had a ‘proven system’ of meeting the long-term care needs of an aging population which depended on the participation of commercial interests. Although devoting the resources necessary to transition to a system of mainly non-profit care made little sense at the best of times, considering such action in austere times was a particularly bad idea. While the Lyon Conservatives would have difficulty advancing the kinds of arguments made by Ontario Conservatives and Liberals when they tried to bolster the position of commercial providers in Manitoba the late 1970s, in Ontario such arguments were made with relative ease. Unlike in Manitoba where the NDP was the only other voice in the legislature (with the exception of a brief Liberal Party resurgence in the late 1980s), in Ontario the Conservatives benefited from an opposition split between two parties, one of which was entirely supportive of proprietary nursing homes.

In Ontario, advocates of non-profit care confronted a state eager to absolve itself of social welfare responsibilities and to rely on the private sector to do more. Even Larry Grossman, who was regarded as one of the more red-tory of the members of the Conservative Party, argued as Treasurer in the early 1980s that “We must now consider the fundamental relationship between the public and private sectors. We must invite more private sector sharing of what has come to be considered as public sector responsibilities” (cited in Evans and Shields, 2011, p. 139). Facing a recession in the early 1980s, the equivalent of which had not been seen since the 1930s in Ontario, made worse by declining world commodity prices and reduced demand for manufactured products (particularly automobile exports and parts to the United States), the government embarked on a program of deeper social spending cuts and private sector promotion

(Brownsey and Howlett, 1992, p. 161-162). In the field of health one example was the introduction in 1983 of the Business-Oriented New Directions (BOND) initiative for hospitals, which encouraged administrators to see hospitals as a business by allowing them to retain the surplus they could generate in such areas as shops, parking lots and cafeterias (Dutil, 2011, p. 334). Another example was health care premiums. One of just three provinces to rely on health care premiums to finance the system, along with Alberta and British Columbia, Ontario raised OHIP premiums to off-load more costs onto individuals (Ibid).

In this atmosphere of growing private sector reliance, critics of for-profit care, including the NDP, the Canadian Union of Public Employees (CUPE), the Social Planning Council of Metropolitan Toronto, and newly formed activist groups such as Concerned Friends of Ontario Citizens in Care Facilities Inc. became more vocal in their calls for reform. Founded in 1980 by Betty Hatt and *Toronto Star* Columnist Lotta Dempsey, Concerned Friends was (and remains) a women-led advocacy organization dedicated to reforming long-term care (http://www.concernedfriends.ca/about-us/interview-betty-hatt-founder-concerned-friends). Like their counterparts in Manitoba, women have mobilized by forming advocacy organizations and participating in other forms of activism. The institutional challenges faced by Ontario women in advocating for reform, particularly when it comes to the issue of proprietary care, however, have been far more pronounced and extensive. In contrast to Manitoba, it has been members of private industry that have consistently found themselves 'in the right place at the right time' when it comes to long-term care policy.

Within the legislature NDP leader Bob Rae made it clear that his party believed that "there is something very wrong in the government's attitude to senior citizens and to

the role and place of private enterprise in the health care field" (Rae, April 25, 1983, p. 139). While both the Conservatives and the Liberals had argued throughout the 1970s that the private sector has a vital role to play in the provision of long-term care, and that problems could easily be rectified through the enforcement of regulations, Rae set himself apart from the other party leaders by asserting:

I am suggesting that the private profit model, the private profit method of delivery of care, the private profit system is what is wrong, and no amount of fiddling around on the edges or fiddling around with the regulations is going to affect that particular problem and that particular issue. We have a system in this province that gives each and every nursing home operator a stake in providing less service than should be provided (Ibid, p. 145).

To illustrate that a "philosophy of cutback" dominated the nursing home field recurring problems were cited such as inadequate nutrition, lack of cleanliness, insufficient staff training, over-medication, unexplained injuries and bruises, bedsores, a paucity of stimulation and leisure activities, and lack or resident and relative input in care provision (Ibid, 148). As another NDP MPP put it, there existed a "structural pressure in a private enterprise nursing system to squeeze profit out of the levels of care" (McLellan, 1983, p. 1842). Legislation was needed "to replace the present private profit system with a network of nonprofit facilities" (Ibid, 1844). It was argued that "there is still time to draw back from the path that this government has embarked on in the last 10 years. There is still time to draw back and go a different route" (Ibid).

One way that the party attempted to elevate the issue on the political agenda was with the publication of the 1984 Report of the NDP Caucus Task Force *Aging with Dignity*. The Report put forth a number of arguments for disrupting Ontario's historical reliance on proprietary care and focusing attention on building up the non-profit sector. In addition to restating concerns regarding quality of care that the party had expressed in the legislature, the Task Force raised a number of other issues. For one, in its desire to

maintain its mutually beneficial partnership by placing co-operation ahead of confrontation the government was reluctant to prosecute nursing home owners or revoke licenses. Nursing home inspection reports, which the Ministry of Health agreed to make public in 1983, revealed that homes averaged at least 20 violations of the Nursing Home Act when inspected, an indication that the industry was failing to meet regulatory expectations (NDP, 1984, 21). This was a view point shared by CUPE. In two investigations during the early 1980s the union found that thermostats and hot water tanks were kept at uncomfortably low temperatures in order to save money; that owners were reluctant to spend money on such items as new linens, sterile gowns and gloves, fabric softener, bleach, toilet brushes and disinfectant, and on high quality meat and other groceries (Rae, April 25, 1983, p. 143-144). CUPE also highlighted the practice of short-staffing as a cost-cutting measure in commercial nursing homes.

CUPE was also critical of the care provided in the publicly run homes for the aged. In November 1981 it released the findings of a report into the Greenacres home for the aged in Metro Toronto, which underscored such problems as staffing shortages and lack of clothing, medical and cleaning supplies (CUPE, 1981, *Globe and Mail*, 1982). CUPE released another report in February 1982 that drew attention to the plight of seniors throughout Metro's homes for the aged. Staffing shortages, irregular toileting for incontinent residents, reliance on tranquilizers to compensate for the lack of activities for the more active residents, prevalence of bedsores resulting from residents not being turned every few hours, and lack of fire drills were common features in the homes for the aged (CUPE, 1982, McLaren and Baker, 1982, p. 5). CUPE's critique of the homes for the aged illustrated that Ontario's shortcomings in long-term care resulted not just from commercial ownership but from the crisis driven nature of policy making in the sector.

Policy changes in Ontario tended to occur not to anticipate potential problems but rather only after a problem had reached a breaking point. The Ontario Medical Association was also critical of the crisis-driven nature of long-term care, arguing that the government's reluctance to be proactive was "callously indifferent to residents' needs" (Roseman, 1987, p. A19, Hickl-Szabo, 1986, p. A8).

The NDP's *Aging with Dignity* report was focused on commercial care and emphasized that government was reluctant to prosecute nursing home owners because of the high demand that existed for beds (Rae, April 25, 1983, p. 143-144) Ibid, p. 21). In addition, the NDP argued that Ontario seniors suffered from "a provincial bureaucracy which was overcommitted to institutional funding and afraid to expand community alternatives" (Ibid, p. 14). Although some municipalities, including Niagara, Windsor and Ottawa were developing innovative non-profit community alternatives such as day care and day hospitals, demand for such programs was exceedingly high and the government placed "low priority" in facilitating their growth or expansion (Ibid, p. 6). Across the board the Task Force "found too many examples of seniors having to chase the system and fit themselves into it" (Ibid, p. 13). Although the Ministry of Health had begun to experiment with Placement Coordination Services to assess need and facilitate placement in nursing homes and homes for the aged, nursing homes still had considerable control over the process as many turned away the heaviest care patients that tended to require more labour and thus be less profitable (Ibid, p. 18). The reality was that "in exchange for coordination, the system perpetuates the right of the private sector nursing home to take the easiest patients and increase the burden on the public sector" (Ibid, p. 19). In contrast with Manitoba, where coordination had been made a central objective of the Schreyer

government in the early 1970s, private operators in Ontario maintained a significant level of influence.

The central argument of the Task Force was that the elimination of proprietary ownership was a necessary step to improving seniors care and it recommended that no new extended care beds be granted to the for-profit sector in the future (NDP, 1984, p. 26). Growing old in Ontario was made more challenging than it needed to be by a "provincial government [that] actively promotes for-profit provision to seniors more than it promotes the provision of better care" (Ibid, p. 1). Of the nursing homes visited by Task Force members, a non-profit home in Thunder Bay, Bethammi Lodge, appeared to provide the highest quality care, thus demonstrating that the non-profit sector could be relied upon to meet the needs of seniors (Ibid, p. 20).

The Social Planning Council of Metropolitan Toronto (SPC) also released a report in 1984 highlighting the dangers of the trend towards commercial ownership in Ontario. In *Caring for Profit* the SPC noted that with austerity as the guiding principle informing policy development in Ontario since the 1970s, the idea that the public sector could not be as productive or efficient as the private sector when it came to delivering services had taken on a new level of orthodoxy at Queen's Park. The Ministry of Health, for its part, had come to accept and embrace the role of the commercial sector in those areas of health care that it could get away with doing so. In 1984 the Minister of Health, Keith Norton, stated that "There is no overall policy with respect to which services may be provided by for-profit operators, but rather each situation must be considered on an individual basis" (SPC, 1984, p. 28). Nursing home care was a situation where the ministry believed that for-profit care was permissible. As Norton explained to the Ontario Nursing Home Association in 1983, "the government of Premier William Davis does believe that private

enterprise has a place in the provision of health care services in this province" (cited in SPC, 1984, p. 27). This was evidenced by the fact that between 1972/73 and 1983/84 private nursing homes witnessed a 29.8 percent growth in their number of extended care beds while the municipally run homes for the aged saw a growth of just 7 percent (Ibid, p. 33). The "noticeable increase in the number of commercial home health care agencies" providing home care services in Ontario were also presented as evidence of the growing private sector presence (SPC, p. 39).

Also troubling for the SPC was the close connection between the Ministry of Health and the Ontario Nursing Home Association. Citing a portion of a report conducted by Argyle Communications into the industry it was noted that there existed

> an extremely high level of awareness of the role and purpose of nursing homes within appointive and elective ranks of the Government of Ontario. It is evident that individual nursing homes have made their presence known to MPPs and to the Ministry of Health over the years, and that the Ontario Nursing Home Association has reinforced these contacts with a comprehensive and sustained degree of lobbying and liaison (cited in SPC, 1984, p. 90).

This is something the NDP had been drawing attention to in the legislature. As Rae put it "a big industry has grown up in this province that has a stake in providing private profit care, a big industry that has very close ties to the Tory party and indeed to the Minister of Health in this province under a Tory administration" (Rae, April 25, 1983,p. 152). The vice president of Extendicare Ltd, for example, was former Ministry of Health official G.S. Chatfield who had stressed in 1972 how important it would be "for private enterprise and for government to work together to develop a mutually satisfactory program" in the nursing home field (Rae, December 14, 1983, p. 4116). There was also the issue of campaign contributions. The NDP found that in 1982 campaign contributions made by the nursing home lobby to the Ontario Conservatives reached almost $100,000.

Canadiana Nursing Homes Ltd. contributed the most, at $10,900. The Ontario Liberals received contributions totaling $4,375 (Tarman, 1990, p. 69).

While the ANHIO had been “successful in attaining high visibility and substantial influence” within the Ontario government (Tarman, p.90), advocates for non-profit reform faced difficulties effecting change, particularly as the Davis government embraced a program of restraint. This was due to not only to the fact that policy makers increasingly welcomed private sector provision but also because of the ability of the private sector to accumulate the money needed for capital costs and responding to government tenders (Ibid, p.97). Companies such as Extendicare, which in 1983 operated close to 9000 beds in Canada with earnings of $24.3 million, were particularly adept at marshalling the necessary resources (Ibid, p. 54).

The Canadian Medical Association’s 1984 *Task Force on the Allocation of Health Care Resources* also called for an end to for-profit nursing home care. Based on submissions received from such organizations and Concerned Friends of Ontario Citizens in Care Facilities Inc. and The Ontario Association of Registered Nurses the Task Force made the following conclusion

Permitting nursing homes to be run for profit under a lenient system of legislation and an impotent system of inspection is a measure of societal negligence we can no longer allow to continue. When an institution becomes the only answer for the care of an elderly person, it must be one that is run on a principle of loving care, not one of tender, loving greed. It is recognized that within the uneven system that prevails, some provinces and some nursing homes serve the elderly better than others. In comparison between old age homes run for profit and those run by non-profit ethnic or religious organizations, it is the latter that often exhibit a higher standard of care, food, rehabilitation, innovative recreational programs, and at the end of life, compassion, palliative care and respect for the individual (CMA, 1984, p. 36).

Noteworthy is the fact that the arguments against for-profit care highlighted in the Task Force came primarily from Ontario-based groups. With the country’s highest proportion

of beds in the for-profit sector representatives from Ontario could speak authoritatively on the implications of proprietary care. The CMA Task Force recommended "that all jurisdictions move as quickly as possible towards the elimination of 'care for profit' institutions and establish non-profit facilities" (Ibid, p. 36). This certainly differed from the position taken by the Manitoba Medical Association (MMA) during the 1970s when the organization bristled at the idea of more extensive government regulation and control. Had commercial interests played the significant role in Manitoba that they did in Ontario, however, it is very likely that the MMA's attitudes would have differed.

By 1984, just like in 1966, an Ontario Conservative government was presented with a number of reports highlighting the negative consequences of proprietary care. And, like in 1966 the government was unwilling to reconsider its reliance on the commercial nursing homes. Remarks made by Health Minister Grossman in the legislature in 1983 summarize this fact nicely

I say, with regard to the ongoing remarks between the New Democratic Party and me on the issue of nursing homes, that I do not mind and have never minded their determination that there should be no further private nursing homes in the province; this is a position they are welcome to take. I do not happen to share it; neither does the Liberal Party of Ontario and neither, I would suggest, do many people whose friends and relatives are being looked after in nursing homes (Grossman, June 20, 1983, p. 1854).

Mechanisms other than disrupting for-profit care were employed by the Davis government to quell the growing discontent coming from such groups as Concerned Friends of Ontario Citizens in Care Facilities Inc., the Social Planning Council of Metropolitan Toronto, the Canadian Medical Association, the NDP and the media. Legislation was introduced in 1983 to give the Ministry of Health broader powers to revoke an operator's license when health and safety were being undermined as well as to permit the ministry to take over negligent homes on an interim basis. Also included were

provisions to make inspection reports public as well as encouraging the use and expansion of residents' councils (Grossman, June 20, 1983, p. 1832). Yet, as Tarman rightly observes, such legislation

places government in the role of prompting or persuading nursing home owners rather than taking a more active and direct interventionist role in challenging the proprietary nature of nursing homes. These measures represent relatively conservative symbolic interventions, in the face of the more expensive alternative measures interest groups have called for, such as changing the proprietary nature of nursing homes or creating viable community alternatives (Tarman, 1990, p. 82)

The Illusion of a Window of Opportunity: The Liberal Government 1985-1990

In 1984 Davis retired from politics amidst, among other things, controversy surrounding his decision to fully fund separate schools (Tanguay, 1997). The Conservatives selected Frank Miller to lead the party. In the previous two leadership changes the Conservatives had enjoyed success by selecting a representative that signified "a transfer to a new generation" and conveyed a centrist conservative message to the electorate (Lewis, 2011, p. 86, Manthorpe, 1977, Brownsey and Howlett, 1992). Older than Davis and publicly committed to a neoliberal platform of limited government, Miller was neither of these things. In the 1985 election large numbers of middle-class voters left the Progressive Conservative Party in support of either the Liberals or the NDP, and the Conservatives witnessed their share of seats in the Legislature drop dramatically (Brownsey and Howlett, 1992, p. 162). Recognizing that the Miller government would likely fall on a vote of non-confidence, David Peterson's Liberals were able to form a government by entering into an accord with the NDP. The 'Liberal-NDP Accord', which would last for the duration of two years, was based on a written statement outlining policy areas that the government would concentrate on, including environmental protections, rent review, pay equity, and bans to extra billing. In selecting Miller as their leader the

Conservatives failed to recognize the growing importance of such issues to a large segment of Ontario voters (Brownsey and Howlett, 1992, p. 162).

I have argued throughout this chapter that a key difference between the Manitoba and Ontario settings is that Ontario's community of non-profit reformers have consistently had little influence on policy, particularly when they are considered in relation to the community of proprietary interests. Between the 1950s and 1980s the concerns of non-profit advocates such as the Ontario Welfare Council, Jewish Home for the Aged at Baycrest, Concerned Friends of Ontario Citizens in Care Facilities Inc., the Social Planning Council of Metropolitan Toronto and the NDP were rarely taken seriously. In Ontario government thinking, whether in the Treasury, the Premier's office, or the Ministry of Health, the idea that commercial interests had a legitimate and central role to play in seniors' care informed policy development. Although it is true that Conservative ministers of health had from time to time criticised the profit motive of nursing home owners, in the end nursing home provision was left firmly in the hands of the proprietary sector.

During the Liberal administrations of 1985 to 1990 the party gave the appearance of wanting to correct the imbalance between non-profit and for-profit providers. Just two months into office Peterson emphasized that when expanding the number of nursing home beds in Ontario "our emphasis will be...on the nonprofit sector" (Peterson, July 9, 1985, 2:40). While the premier was "not ruling out the use of so-called private hospital care or private nursing homes" he explained that "the emphasis with respect to licensing from this government will be on the nonprofit sector. They will get the breaks" (Ibid). The Minister of Health, Murray Elston, echoed the premier's support for non-profit care by stating that his department had come to consider "ownership and concentration of

ownership" in the nursing home sector as problems that needed to be addressed by government (Elston, November 3, 1986, 14:20). As part of a package of amendments made to the Nursing Homes Act in 1987 Elston singled out nursing home ownership, along with financial disclosure, quality of life, residents' councils and resident's rights as focal points of government attention (Elston, December 16, 1986, 13:41). It was important, the Ministry argued, to give preference to non-profit applications for nursing home contracts, particularly in communities where ownership was concentrated in the hands of a single interest.

Although the Liberal government gave the appearance of opening wide the window of opportunity for expansions in non-profit nursing home care during its years in office and reducing the reliance on commercial care in Ontario, the reality was different. While for a brief period during their early years in government the Liberals appeared to 'rediscover' the non-profit sector, towards the end of their five years in office, particularly after the accord with the NDP ended, the Liberals once again began to resemble the Conservatives in their attitudes towards ownership. Towards the end of their five years in office, and when they were returned to opposition status following the NDP victory in the 1990 election, the Liberals reassumed their ambivalent attitude towards for-profit long-term care. As their 1990 report on long-term care reform *Strategies for Change: Comprehensive Reform of Ontario's Long-term Care Services* stressed, any sensible approach to reform must begin with the recognition that Ontario's "existing" mix of for-profit and not-for-profit services provide the foundation for "an effective long-term care and support service system" (Ontario, 1990, p. 3, 54). While the document emphasized the importance of achieving better integration and coordination of long-term care services along with a focus on expanded access to community-based alternatives to

institutional care, through the creation of what it called ‘Service Access Organizations’, the document contained none of the concern for ownership that the Liberals displayed early in their mandate. Rather, As Baranek et al. note, the Liberal reform plan “was explicitly incremental, in that it was intended to work within the framework of the existing delivery network” (Baranek et al., p.85). Ideas about addressing ownership and concentration of ownership in facility-based care were shelved in favour of an approach that stressed keeping seniors out of institutions. Frail seniors, the group that stood to benefit most from a government that took ownership seriously, were not a vocal and mobilized constituency. Thus the Liberals were able to focus on non-institutional care, an issue of concern to an increasingly vocal contingent of ‘well’ seniors along with members of the disability community (Ibid, p. 69). Promising an infusion of $52 million in the fiscal year and annual funding increases of $640 million for service improvements by 1996-1997, the government planned to focus the bulk of its attention on home and community care (Ibid, p. 85).

The following offers some analysis to explain why the Liberal government appeared to take seriously the need to alter ownership trends after taking office in 1985 but showed little concern for such action in its second term. One key factor that must be taken into account is the impact of the two year Liberal-NDP Accord. As Brownsey and Howlett explain “The political effect on the Liberal-NDP Accord was to provide the Liberals with a policy agenda that concentrated on social reform rather than economic development” (Ibid, p. 164). While the Ontario Liberal Party had historically positioned itself to the right of the Conservatives, the opportunity to interrupt 42 years of Conservative dominance by working with the NDP certainly provided an incentive to reconsider party ideology. Moreover, given that the Ontario economy had entered out of

the doldrums of recession and into a boom period by the mid-1980s, focusing on social reform was made more palatable (Brownsey and Howlett, 1992, p. 164). Haddow and Klassen argue that the Liberal government era in the 1980s, including the two year coalition with the NDP and the period following the party's victory in the 1987 election, "moved the province significantly to the left." This was evidenced by such things as increased public expenditures and taxation, as well as in labour-market reforms which focused on workers' compensation, health and safety and training (Haddow and Klassen, 2006). In the field of health care, the Liberals invested in 1986 an additional $850 million towards hospital expansions, the first time an increase of such magnitude had occurred for hospital building since the mid-1960s (Dutil, 1011, 335). In addition, the practice of extra-billing by doctors was disallowed and OHIP premiums were reduced and later eliminated, two issues included in the Liberal-NDP Accord (Ibid). The Liberals also established the Social Assistance Review Committee (SARC) in 1986 to review the province's social assistance regime. Its final report *Transitions* was released in 1988 and marked "a watershed moment in Ontario, one that presented an opportunity for substantial reform and the hope of eventual poverty reduction" (Maxwell, 2009, p. 1). In a number of respects the Liberal period points to an expansion of public sector activity and a willingness of the government to assume more welfare state responsibilities. As with the issue of ownership in long-term care, however, the Liberal's appetite for reform would diminish in during their second term in office.

In the field of long-term care the Ontario NDP, particularly under the leadership of Bob Rae, made opposition to commercial care a central issue within the party. Along with arguments made in the legislature against for-profit care, the publication of *Aging with Dignity* in 1984 was a clear indication of the NDP's desire to advance the cause of

non-profit residential care on the political agenda. The party's desire to increase the salience of the issue in Ontario politics was made particularly evident in December 1983 when Rae stated to the Legislature:

> I want to tell the government if it thinks in this past year it has seen some questioning with respect to the nursing home sector, the health care sector, the private profitization and the growth of the merchants of care providing care in the health care field, it has not seen anything yet…We have just begun to do the documentation and research that we think is going to show clearly, as it has in the past, that there is a real conflict between the merchants of private gain and private enrichment, who are so close and dear to the hearts of the Tory party and the provision of quality care in this province (Rae, December 14, 1983, p. 4117).

Setting the province on a new path when it came to nursing home provision was thus an increasingly important component of the NDP platform. One condition of the NDP's support for a Liberal government in 1985 was that the government investigate and develop a plan to address the growing involvement of commercial interests in health care (McMonagle, 1986, A11). The coalition with the NDP from 1985 to 1987 is certainly a factor that must be considered in accounting for the 'rediscovery' of non-profit care residential care in the Liberal Party.

Other factors were also important, including the realization within the Ministry of Health that the nursing home industry was becoming more adept at setting the parameters of its own regulation. Shortly after the Liberals assumed office the ministry approved the purchase of two nursing homes by a company previously found to be in violation of the Nursing Home Act after the owners threatened the government with legal action if it failed to give its approval (McQuaig, 1985, p. 5). In a letter to Concerned Friends of Ontario Citizens in Care Facilities Inc. Elston lamented the fact that government powers to regulate the industry were "seriously deficient" (Ibid). One month later this deficiency was made more apparent when the Ontario Supreme Court dropped 38 of 88 charges

against a Downsview nursing home, arguing that under the Nursing Home Act owners could not be held legally responsible because the legislation designated caregivers and administrators as responsible for health and nursing home care (Tarman, 1990, 83, Clark, 1985, A18). As Tarman explains, the court case was one indication of "Government's inability to control the nursing home industry" (Tarman, 1990, p. 83).

This lack of control was something that the 1986 *Report of the Nursing Home Residents' Complaint Committee,* led by Dorothea Crittenden, stressed. Retired by 1986, Crittenden had been an influential deputy minister of Community and Social Services during the 1970s under Bill Davis. Within policy circles and the media Crittenden remained a figure whose opinion carried credibility. The Ministry of Health's Nursing Homes Branch, she argued, had become little more than "an inspection and licensing organization" for the province's 331 nursing homes (Crittenden,1986, p. 13). While the Ministry allocated about $256 million a year to nursing home operators to care for close to 30,000 residents, little had been done within the department "to assume a leadership function in the further development of the Nursing Home system" (Ibid). For the Residents' Complaint Committee, which was established in March 1985 to investigate and make recommendations to the Ministry of Health on resident complaints, the lack of leadership and passivity of the department towards nursing home development was detrimental to the well-being of Ontario seniors. Although the Committee found that non-profit homes run by municipalities, hospitals, ethnic and religious organizations "provided extremely good nursing home care," facilitating the development and expansion of non-profit facilities had been given little priority in a ministry that had historically limited its responsibilities to funding, licensing and inspection (Ibid). The Committee's visits to more than 183 of the province's nursing homes led it to conclude

that "In a profit-oriented system, operators are motivated to decrease costs – in this case food, staff, time, luxuries, etc. – in order to increase or maintain their profit margin" (Ibid, 19). This was something made evident in 1985 when a coroner's report into the death of 19 residents at a London, Ontario, nursing home pointed to inadequate kitchen and food standards as the cause (Tarman, 1990, 83). The Residents' Complaint Committee found that some operators were spending as low as $2.10 per resident/per day on food (Crittenden,1986, p.19).

The objective of government policy, it was argued, should be to ensure that "The residents are not there to serve the needs of the industry – the industry exists solely for the benefit of the residents" (Ibid, 7). That the profit motive prevented the industry from existing solely for the benefit of the residents was an argument advanced in Ontario since at least the 1950s. Something that helped to give the argument traction in 1986 was the growing demands of the nursing home lobby for more funding from the province. While Elston had given the industry an additional $14 million in that year to improve their standards, and an additional $1.30 per resident per day to homes that became accredited and invested in incontinence care and patient activity, the industry demanded increasingly more money (Tarman, 1990). At an ONHA press conference in 1986, for example, Carl Hunt, Vice President of Extendicare and Vice Chairman of the ONHA, told reporters that although Extendicare made a profit of $8 million the previous year on the 60 homes it owned in Canada, his company, along with the other nursing home operators, needed more money from the province (Hickl-Szabo, 1986, A5). While the $14 million was a start, the industry argued that nothing short of $173 million was appropriate. The ONHA threatened the government by stating, "without moving on our initiatives right now, we will only continue to operate in a way that falls short of residents' true needs and their

family's expectations of levels of service" (cited in Cooke, December 4, 1986 NDP 14:50).

Faced with such bold demands, Elston admitted "I am very concerned about people who, basically, are indicating they are no longer able to provide that service without, first, advising the Ministry of Health that they have decided not to proceed with the obligations they take on as a result of the licensing" (Elston, December 8, 1986, 14:20). In this atmosphere of heightened industry demands, feelings of impotence within the Ministry of Health regarding its ability to assert control, public scrutiny over for-profit provision, and a legislative alliance with the NDP, the government argued that non-profit providers should have preference when came to allocating new long-term care beds. In drafting amendments to the Nursing Home Act in 1986 to strengthen the Ministry's position in nursing home development the Health Minister acknowledged that "ownership of nursing home licences and management contracts are likely to affect the daily operations of homes and can have a direct bearing on the quality of care therein" (Elston, December 16, 1986, 13:41). It was important, he argued, that the Minister of Health have "the right to issue or refuse a nursing home licence on the basis of the public interest" and that officials "take into account criteria such as concentration of ownership and the balance between profit and nonprofit ownership" (Ibid). Taking into account the 'public interest' was an idea that also informed the creation of the Office of Senior Citizens' Affairs. A ministry without portfolio, it nonetheless served the "symbolic function" of giving voice to older Ontarians within the Liberal government (Baranek et al., 2001, p. 61-62). In 1987 Elinor Caplan, then Health Minister, re-emphasized her party's concern for ownership by stating "My commitment for the future and the announcement from this

government is our approach to expansion of the non-profit sector in the nursing home environment" (Caplan, November 25, 1987, 1500).

Had the Liberal government maintained the adversarial approach adopted during its first years in office towards commercial providers and remained committed to the idea of advancing the position of non-profit care homes, the period from 1985 to 1990 could rightly be characterized as an important window of opportunity for reform. As NDP health critic David Cooke pointed out, the focus on ownership in the 1987 amendments was a positive step for Ontario nursing home development but "the most important aspect of any controls on ownership, obviously, is whether or not the minister has the will to exercise the control" (Cooke, February 3, 1987, 1740). With over 90 percent of nursing home beds in the for-profit sector and 44 percent of beds in the control of ten nursing home chains, government officials would have to employ the political will necessary to start the province on a different path (Ibid).Although Caplan argued in 1988 that "progress is being made" because the proportion of beds awarded to the non-profit sector under the liberal regime ranged between 62 and 66 percent (Caplan, June 6, 1988, 1410), by 1988 there was indication that the government had exhausted its political will to effect the balance of ownership. In the end, the Liberal's proposed long-term care reforms, which would not be realized due to the party's unexpected loss in the 1990 election, were "intended to leave largely untouched the existing system of service delivery by both formal and informal providers and the balance of public and private responsibility in the financing and delivery of these services" (Baranek et al., 2001, p. 67).

As the *Globe and Mail* and *Toronto Star* pointed out, while the Ministry of Health had taken an adversarial approach with the industry in first years in office, the department had become far more lenient, tolerant and accepting of for-profit providers. It was noted

that from 1983 to 1987, 844 charges were laid by the nursing homes branch for violations of the Nursing Home Act, which amounted to approximately 169 charges a year. In 1988 the number of charges had decreased to six (MacLeod, 1989, A11). This was representative of "a change in philosophy by the nursing homes branch" whereby the officials try "to avoid appearing as the adversary of nursing homes. It now works more closely with nursing homes to resolve problems…Violations are documented only when the home shows an unwillingness to cooperate" (Ibid). *Toronto Star* columnist Thomas Walkom noted that the turn towards "cooperation over confrontation" was remarkably similar to the approach of the previous Conservative governments. As Walkom put it "Regulated private enterprise; incentives to encourage the behaviour the government wants…if these ideas seem familiar, it is because they are" (Walkom, 1989, p. A25). Also familiar were the campaign donations to the governing party. By 1989 the nursing home industry had become one of the biggest donors to the Ontario Liberals since the party came to office in 1985 (Story, 1989, p. A1).

With the Liberal-NDP Accord in the rear view mirror the pressure to alter the focus of nursing home policy was certainly lessened in the Liberal's second term. Assuming the Ontario government's traditional role of cooperation over confrontation, the party was back in familiar territory. While various justifications for reliance on the for-profit sector have been advanced in the post-war period, including the idea that commercial operators are 'good corporate citizens' capable of providing quality care when standards are enforced, in times of fiscal restraint Ontario policy makers have been especially inclined to see the merits of for-profit provision. By 1989 signs that the Ontario economy was once again falling into recession were evident and policy makers were eager to find savings, particularly in the increasingly expensive health care field (Dutil,

2011). A more significant development was the federal government's decision to reduce Established Programs Financing (EPF) contributions (in 1979-80 Ottawa was contributing 51.8 percent of Ontario's EPF expenses and by 1987-8 the figure had fallen to 39.3 percent), and to limit its CAP contributions starting in 1990 to 5 percent a year in Ontario (along with Alberta and British Columbia), actions which left the provincial government in a more precarious fiscal position (Dutil, 2011, p. 336). The 1989 federal budget included a reduction in transfer payments of $560 million to Ontario for health care and education. With the provincial government fulfilling its election promise to eliminate OHIP premiums, finding new ways to save health care dollars became a key priority (Ibid, 338). The decision to place responsibility for the community-based long-term care that took centre stage in *Strategies for Change* within the Ministry of Community and Social Services, rather than the Ministry of Health, can be taken as one indication of the government's desire to contain the health care budget (Baranek et al., 2001, p. 77). Shifting the focus to the "seemingly less expensive forms of care" in the home and community animated government thinking (Ibid, p. 91).

Former NDP Saskatchewan Finance Minister, Janice MacKinnon, has argued that:

> Health care is engaged in a David and Goliath battle for scarce provincial resources. The Goliath is a public so committed to medicare that it evokes terror in its politicians who would rather face angry students over high tuition fees or disgruntled mayors complaining about crumbling infrastructure than confront irate seniors or baby boomers concerned about health care...The Davids are the other funding priorities – education, training, research and development, poverty reduction, environment and infrastructure – which always play second fiddle or poor cousin to the mighty Goliath of Health care. (2003, p. 246)

Although an accurate assessment, one must not forget that within the health care field there are Davids as well. Long-term care, especially in Ontario, has always played second fiddle in the battle for scarce health care dollars. Interested in cost-containment and

minimizing cuts to the Goliaths of hospital financing and physician care, the Liberals, like successive Conservative governments before them, found it easier to cooperate with than confront the private sector.

The NDP 1990-1995: Timidity and Missed Opportunities

In 1990 the NDP government of Bob Rae was elected "by capturing the smallest plurality of votes for a majority government in Ontario history" (Evans and Shields, 2011, p.142). It was the first time the party was elected to power in Ontario, and the first time that the NDP formed a government to the east of Manitoba. The result of a number of factors including voter discontent with a worsening economy, the distaste of many who perceived Peterson's election call to be premature, and an unwillingness of large numbers of voters to return to the Conservative Party contributed to the NDP's surprise win (Tanguay, 1997, Walkom, 1994). Interested in developing their own long-term care reforms, in 1991 the NDP released "*Redirection of Long-Term Care and Support Services in Ontario: A Public Consultation Paper*" authored by the Ministry of Community and Social Services, Ministry of Health, and Ministry of Citizenship (which replaced the Office of Senior Citizens' Affairs and assumed responsibilities for seniors, persons with disabilities and anti-racism, reflecting the Rae government's concern with diversity). "Emphasizing the importance of process as product", the government encouraged province-wide consultations and provided funding to seniors groups, disability advocates and service organizations to participate in a five month consultation process (Baranek et al., 2001, p. 115). The government estimated that throughout that time period close to 75,000 individuals and 110 associations participated in about 2,900 local and provincial level meetings, and 87,000 copies of *Redirection* were distributed in French, English,

braille and audio cassette while an information pamphlet was published in 33 languages (Ibid, p. 123).

Unlike the Liberals, the NDP was able to pass long-term care legislation. On 31 March 1995, the Long-Term Care Act, 1994 was proclaimed. Multi Service Agencies (MSAs), which formed the crux of the government's legislation, were to provide senior's with a single access point for non-profit community-based long-term care services and entry to long-term care facilities. Delays leading to the passage of the legislation, however, resulting from a number of things including a down turn in the economy, seemingly endless disagreement among interested parties on the scope and content of reform, and a general backlash against the government from key NDP supporters thrust the issue of long-term care reform into an election cycle (Baranek et al., 2001). More importantly, a marked lack of political will within the government to move forward with reforms early into its tenure, rather than in 1994 when it was clear that the party no longer attracted a contingency of voters numerous enough to grant it a second term in office, contributed to delays in passing legislation and provided a window of opportunity for the Conservative government of Mike Harris to reverse the NDP's vision of long-term care reform after winning the 1995 election.

While a thorough analysis of the NDP's community care reform efforts has been written (see Baranek et al., 2001), less is known about NDP approaches to long-term residential care. It seems clear that while in government the NDP acted much like the Liberal and Conservative governments before them. Although the Rae government brought in some reforms desired by advocacy groups, such as increasing the minimum daily nursing care requirement from one hour to 2.25 hours and bringing charitable homes, homes for the aged and nursing homes under the control of one department – the

Ministry of Health (OHC, 2001, p.4), the reality was that the NDP was not that different from previous Ontario governments when it came its dependence upon and acceptance of facility-based proprietary care. Indeed, like previous Ontario governments the NDP found private operators to be convenient partners capable of delivering seniors' care, freeing up government officials to focus on what they perceived to be more pressing issues in need of state attention. Something that the NDP did have to contend with after 1988, that previous governments did not, was the Canada-U.S. Free Trade Agreement. The political and economic ramifications of minimizing and/or eliminating the position of Ontario's increasingly numerous American-based long-term care providers did pose a new legal and fiscal challenge. Acknowledging that this new challenge loomed in the background for decision makers, the following pages provide insight into NDP approaches to the sector as well as explanations for the continuity with previous Ontario governments.

On the surface, the argument that NDP approaches to proprietary nursing home operators were similar to Liberal and Conservative approaches seems out of step. After all, given the fact that the Ontario NDP had resembled closely the Manitoba NDP when it came to its attitudes on for-profit residential care there was reason to believe that the party would resemble its Manitoba counterparts while in office. The Ontario party had portrayed itself as the tireless advocates of non-profit care while in opposition. The quote introduced above from Rae, who argued that the Liberal government "has not seen anything yet" when it came to his party's opposition against for-profit nursing homes is a particularly good example of the party's desire to promote itself as the defenders of non-profit care in the Ontario political arena (Rae, December 14, 1983, p. 4117). Ross McClellan, a key architect of the Liberal-NDP Accord (and later a prominent policy advisor to Rae during the NDP government), also touted his party's role as non-profit

reformers, noting that New Democrats "put the government on notice...We will continue to monitor conditions in private sector for-profit nursing homes with as much vigilance as we have over the past 10 or 15 years" (McClellan, February 4, 1987, 1530). In contrast to the Liberals and the Conservatives, it was asserted, the NDP recognized that "the basic policy premise of the Ontario government is fundamentally flawed and that the reliance on private sector for-profit nursing homes is a dangerous policy." (Ibid). As the party's health critic, Dave Cooke, argued in 1987

We remain convinced in this caucus that there will never be fundamental change in the motivation for providing care in Ontario's nursing home system as long as the for-profit system is dominant. In fact, we believe very strongly that the for-profit system should be phased out and the nonprofit system should be brought in, where the only motivation is quality of care and quality of life. Then it does not matter; there are no profits in the picture at all. Today, our system is primarily based on profit and return on investment for shareholders (Cooke, May 25, 1987 1510)

Just a little over a year into its mandate, however, the NDP appeared to show none of its commitment to reversing Ontario's long-standing 'dangerous policy' that it displayed while in opposition. This was made evident when the government quickly acquiesced to industry threats concerning funding levels. On 30 September 1991 the Ontario Nursing Home Association told the government that unless the industry received an additional $20 million from the province by 15 October, that nursing home owners would reduce staff by 10 percent in order to find cost savings. Association president, Harvey Nightingale, argued that "we've reached a point where we simply can't survive" (cited in Sweet, 1991, p. A1). Nightingale's organization had long-been critical of the differential funding levels between nursing homes and homes for the aged. In contrast to the homes for the aged, nursing homes did not receive capital grants for renovations or deficit funding, and nursing homes were required to pay business and real estate taxes

(Tarman, 1990, p. 46). Fifteen of Ontario's 331 nursing homes were in receivership and Nightingale argued that up to 40 homes could file for bankruptcy if they did not receive more money from the government (Ibid). Health Minister Frances Lankin responded initially by arguing that "in some very tough fiscal times" the Nursing Home Association could not expect to receive anything in the amount of $20 million (cited in Wong, 1991, p.A8). By 5 October, however, Lankin stated that the government would be giving an additional $37 million to long-term care facilities over the next two years, with $30.9 million going to private nursing homes and approximately $6 million to charitable and municipal ones (Simmons, 1991, p. A17, Ferguson, 1991, p. A20).

For a party that had long-pledged its commitment to phasing out proprietary nursing homes while in opposition and was so critical of the influence of the industry on government decisions, the choice to give in to the demands of nursing home owners so quickly, and to do so at a time when the government was cutting back funding to a whole host of areas, certainly called into question the NDP's political will to chart a new path. Although the party rarely missed an opportunity to remind previous governments that it was not too late to reverse ownership trends and set the province on a new course, ambitions for residential care reform were tempered following the NDP's ascent into office. As president of Concerned Friends, Harvey Simmons rightly pointed out, the choice to give in to industry demands was an indication that under the Rae NDP government, just like the Liberal and Conservative governments before it, "private nursing homes will continue to play a major role in providing residential care for the elderly" (Simmons, 1991, A17). Following on the announcement of new funding the Health Minister provided more good news to the industry by stating her party's commitment to addressing a long-held demand of nursing home owners to provide

nursing home residents with the same level of funding received by those in homes for the aged. In Lankin's words “no government has ever agreed that nursing home clients require the same level of care funding as clients in homes for the aged or charitable homes. This government recognizes that and is committed to that” (Lankin, October 1, 1991, 1420).

Like the Liberal and Conservative governments before them, the NDP accepted the status quo in residential long-term care while it focused on other issues. Although on the one hand the *Redirection* consultation paper stated that “Long-term care facilities will be an important part of the service system, but not a growing segment…The number of long-term care beds in total will not increase for the next several years” (NDP, 1991, p. 30), thus indicating limitations on the capacity for profit generation, the document was void of the party’s long-professed philosophy that residential care should be non-profit. In other words, the balance of ownership would stay as is while the government focused on non-institutional reforms. The New Democrats thus mirrored closely the Peterson Liberals in their approach. As the following set of questions posed in *Redirection* illustrate, issues of ownership were not included in the list of topics the government believed were pertinent to public debate on institutional care (Ontario, 1991, p. 36).

- How can ability to pay accommodation costs be determined with as little intrusion into people’s personal affairs as possible?
- What role is there for long-term care facilities in delivering community-based services?
- What additional safeguards could be introduced to make sure long-term care facility residents are well cared for and maintain as much dignity and independence as possible?
- What process could be used to respond to concerns from residents in long-term care facilities?
- What are the most important quality of care standards to include in legislation and how should they be enforced?

- What are the factors to be considered in your community when trying to determine the number of long-term care beds needed?
- What could facilities do to make their services sensitive to people with different cultural, linguistic, racial and religious backgrounds?
- What other services would be effective in supporting people in the community in order to reduce reliance of long-term care facilities and chronic hospitals?

While just a few years earlier New Democrats were arguing in the legislature that "there will never be fundamental change in the motivation for providing care in Ontario's nursing home system as long as the for-profit system is dominant", in *Redirection* there was no talk of moving forward with a fundamental change in the delivery of institutional care. Instead, highlighting such issues as resident complaints, quality of care and the importance of enforcing standards the government composed a set of consultation questions that could have easily come from a document authored by a Liberal or Conservative government.

One explanation for the continuity between the Rae government's approach and that of the Liberals and Conservatives is that the NDP simply did not have a plan worked out to lessen the province's reliance on proprietary nursing homes. Although the party could speak authoritatively against the commercial nature of Ontario's nursing home industry and marshal ample evidence regarding why commercial care should be phased out while in opposition, their surprise 1990 election win thrust a party inexperienced at governing into office. The reality was that "Many NDP candidates had run in the belief, and perhaps even the hope, that they would not be elected; other highly experienced candidates from that party had declined to seek re-election" (Baranek et al., 2001, p. 106). An indication of the lack of experience can be gleaned from the fact that just fourteen of the sixty New Democrats elected in 1990 had experience as elected politicians (Walkom

1994, p 51). It is plausible that the timely acquiescence to industry demands for more funding and the inattention to ownership in *Redirection* relates to the party's inexperience and unpreparedness.

A more important factor was the province's worsening fiscal position. Although the final Peterson budget for 1990 projected a $30 million surplus, four days into their electoral mandate the Rae government discovered that in reality it faced a deficit of $2 billion, which was later recalculated to be closer to $3 billion (Evans and Shields, 2011). With the province heading into a deepening recession the NDP's first foray into government was certainly marked with fiscal challenges. By the time the Rae administration released its first budget in 1991 the deficit had increased to $9.7 billion and by 1992 the desire to control the provincial deficit became the key policy objective of the government (Evans and Shields, 2011, p. 144). Finance Minister Floyd Laughren indicated that government transfers to universities, school boards, municipalities and hospitals would be capped at 1 percent for 1992 and 2 percent for 1993 and 1994. The 1992 budget outlined the government's commitment to halting public spending by noting that "Not since 1953 has the Government of Ontario had a spending increase lower than his year's 4.9 percent" (cited in Ibid). In 1993 the government announced its planned 'social contract' with the public sector to control the deficit by effecting wage cuts, spending reductions (of $6 billion) and tax increases. For public-sector unions and NDP supporters, the Rae government had come to resemble little of what it represented in opposition. The social contract was a clear indication that "The New Right argument that the state sector had become too large and expensive came to be accepted by the NDP (Evans and Shields, 2011, p. 146).

Although the idea that nursing homes would close was based on industry "rumours", the threat that even some of the close to 30,000 seniors living in private nursing homes would become the state's responsibility was taken seriously by a government increasingly devoted cost-containment (Simmons, 1991, p. A17). And while the image of seniors left homeless in the wake of large-scale nursing home closures was powerful on its own in the minds of the public, the added image of care home staff left out of work at a time of high unemployment added fuel to the fire. Some nursing home owners, capitalizing on the public mood, provided post cards to friends and relatives of residents, asking that they write the government to demand more funding (Ibid). As the president of Concerned Friends argued, "Faced with a barrage of letters and fearing the consequences of large-scale closures, the health ministry caved into the operators' demands" (Ibid).

Uninterested in spending money on new beds or facilities, the NDP, like previous Ontario governments, relied on for-profit providers to meet bulging residential care demands. It froze nursing home bed expansion and justified its reluctance to spend more money on institutional care by arguing that "Our government will reduce the over-reliance on facility services and will shift emphasis to the development of creative, community-based service options" (Akande, June 11, 1991, 1400). Promising an infusion of $647 million in long-term care funding by 1996-1997, with $440 million of the new money going towards developing community care services to help seniors remain in their homes, the government promised to "realign resources" in long-term care (Ibid). There was certainly political incentive to focus on the community care sector. As noted earlier, frail elderly Ontarians in institutions tended not to have the capacity to mobilize for long-term care reform. The potential political gains to be had by realigning long-term care

resources to meet the needs of the more organized and growingly vocal contingent of seniors wishing to remain in their own homes for longer could be greater than potential gains with institutional reform. Additionally, cost-containment pressures in the hospital sector to discharge patients earlier and rely more extensively on day procedures thrust more patients within the community in need of care services (Baranek et al., 2001, p. 124). Moreover, unlike the institutional sector, which was dominated by for-profit companies, primarily four non-profit organizations purchased home care services in Ontario: the Red Cross, St. Elizabeth Health Care, the Victorian Order of Nurses and the Visiting Homemakers Association (Armstrong and Armstrong, 2001, p. 179). In few Ontarian regions were more than 10 percent of services purchased from commercial agencies at the time of the NDP reforms (Baranek et al., 2001, p. 151-152). Thus if a success story was to be had by the government in terms of promoting non-profit approaches to care, the community care sector was certainly the path of least resistance when compared to the institutional sector.

Within the legislature there was little pressure for the NDP to adopt the level of political will needed to follow through with their long-held arguments against proprietary nursing homes. Liberal leader Lyn McLeod, for example, argued that what seniors needed was not a government that wasted time “debating ideologies” when it came to ownership, but rather one that would “protect the service now offered to residents in nursing homes” (McLeod, June 12 1991, 1450). Moreover, McLeod noted, “Jobs are jobs” and to make the climate an unfavourable one to commercial nursing home operators was to risk further unemployment (McLeod, June 3, 1993 , 1400). Another Liberal MPP, Barbara Sullivan, pointed to what she believed were unrealistic demands of organizations such as the Ontario Public Service Employees Union who argued that “Instead of bailing out private

nursing homes, the government should convert them to non-profit organizations" (cited in Sullivan, December 3, 1992, 2240). To force the private operators out of business and encourage them to invest their capital outside of Ontario, Sullivan countered, was both costly and unnecessary given that commercial sector was "capably operated" (Ibid).

If the NDP were to drive private nursing home investment out of Ontario, Liberal Bob Callahan asked, "Who's going to pick up the shortfall? Who's going to pick up the gap? You as government can't, and if we or the Conservatives were the government we couldn't, and because of the tremendous downturn in the economy it's going to be even more difficult" (Callahan, December 8, 1991, 1600). Callahan pointed to events in Manitoba where Gary Filmon's Conservative government was trying to expand the role of for-profit home care as evidence that non-profit provision was an idea whose time had passed. Having realized "the extreme inefficiency and rigidity which has developed due to bureaucracy and unionization" as a result of the province's reliance on non-profit providers, "Manitoba's going back. They're trying to bring back the entrepreneurs to supplement the not-for-profit providers" (Ibid). Although, as was argued in the previous chapter, such claims of inefficiency and rigidity were successfully discredited by Manitoba's community of geriatric specialists, long-term care recipients and their families, as well as long-term care workers, in Ontario such claims were finding an increasingly attentive audience.

Conservative Elizabeth Witmer, who would later become the Minister of Health under the Conservative Government of Mike Harris, stressed that "If we're going to continue to provide the social safety net we have been so proud of in this province, it's absolutely critical that the private sector continues to play an important and supportive role in the delivery of services to people in this province" (Witmer, December 7, 1992 ,

2120). In Witmer's view "If the private sector can provide those services, we need to continue to allow them to do the job that they've done so effectively up until now" (Ibid). Another future Conservative Health Minister, Jim Wilson, explained that any attempt to spend the political and economic resources required to shift the balance of ownership away from commercial operators made little sense when "We have example after example of the government really not being able to provide services cheaper and more efficiently than the private sector" (Wilson, December 7, 1992, 2310). Wilson explained that,

We have a history in this country and in this province that clearly indicates the private sector must be an integral part of our health care system, of our social services, and to simply want to drive it out, to spend millions of dollars not creating any new services but replacing services that are being provided effectively and efficiently by the private sector with a so-called non-profit sector or not-for-profit sector just doesn't make any sense to me (Ibid)

Cam Jackson, who would become the Minister of Long-Term Care and Seniors in the Harris government (a position created in 1998), cautioned against any government action that "would unnecessarily and inappropriately tamper and interfere" with commercial providers (Jackson, December 8, 1991, 1730). To improve access to long-term care government needed to "harness the financial resources of the private sector", Jackson stressed (Ibid). Another Conservative MPP argued that to chase aspirations of non-profit care made little sense because

We cannot afford to own, operate and subsidize every aspect of care from the cradle to the grave for the people in this province, nor should we want to… it does not cost more in the private sector than in the non-profit sector to the users, and very often the care can be better and always it certainly is as good, if not better…This question of non-profit everything in the provision of all kinds of services in this province has to go, because there is simply no way that we can afford it. We cannot afford those policies in this province (Marland, December 3, 1992, 2330)

Although the opposition Liberals and Conservatives portrayed the NDP as a socialist regime bent on ridding the province of proprietary nursing homes, the reality was that commercial providers had little to fear from the Ontario's first NDP government. While it is true that feminist members of the government, such as Marion Boyd, were able to pressure the premier to invest $105 million to expand non-profit child-care centres in Ontario (Walkom, 1994, p. 213), and although non-profit home care providers were given preference in the NDP's 1994 proposed long-term care reforms, such actions were the exception. Tanguay argues that

> the Rae government seemed to lack the stomach or the necessary resources to take on the business community, preferring instead to trim its ideological sails in the hopes of placating the ever-important foreign creditors who held a large chunk of the province's mushrooming debt. On a number of key policy initiatives, when faced with adamant business opposition, the NDP either backed away from long-standing party commitments or went into a delaying action, ensuring that no reforms would ever be implemented (Tanguay, 1997, p. 19).

This was evidenced by such things as the government's decision to back away from its 1990 election promise of implementing public auto insurance (a staple of NDP platforms across Canada), its decision not to support the federal NDP in opposing Ottawa's plans to extend patent protection for multinational drug companies, its decision to back away from tax reforms that would see business pay a more equitable share, in its proposed plan to 'partner' with the private sector to build new highways in Ontario, as well as to open up state-run casinos and allow Sunday shopping (Tanguay, 1997, Walkom, 1994). The government's decision not to implement the recommendations of SARC's *Transitions* report was another example. While it is true that the federal government's cap on CAP and restrictions to Unemployment Insurance placed more pressure on Ontario's social assistance program, the premier's public support for U.S. president Bill Clinton's workfare programme in 1993 was an indication of the government's disinterest in moving

forward on its previous commitment to progressive social assistance reform (Maxwell, 2009, p. 10).

While the NDP were not believers in market-based care they did not exert the political will necessary to place Ontario on a new path. Too timid to act, the party prolonged public consultations while in government, in the hopes that the economy and Ontario's fiscal health would improve. When they finally acted in 1994 it was clear that they did not have the support necessary to govern for another term and thus a window of opportunity was lost. Like previous Ontario governments the NDP relied on private operators to deliver institutional care while it focused on achieving reform in other areas. Similar to Conservative governments of the 1950s and 1960s who found it convenient to leave nursing homes in the hands of the proprietary sector while it focused on building up the publicly-run homes for the aged, the NDP government of 1990-1995 relied on proprietary operators while they focused their attention on building up non-profit community-based services. The government's reform ambitions, however, were largely undermined by its lack of political will to move forward with reforms early into its mandate. The drawn-out public consultations provided opportunities for those opposed to aspects of the NDP's long-term care proposals to form coalitions and build bridges with other groups opposed to the Rae regime (Baranek et al., 2001).

Commercialization Excels: The Conservatives Return to Power (1995-2001)

The Harris government was elected on their neoliberal-informed 'Common Sense Revolution' (CSR), receiving the highest vote total for the Conservative Party since 1971 (Tanguay, 1997, 19). Cutting personal income tax cuts, making Ontario more business friendly, dismantling labour protections and freezing the minimum wage in order to ensure worker flexibility, contracting out public services, balancing the budget and

drastically cutting social assistance rates were all part of the CSR (Evans and Shields, 2011). While nursing home owners had fared well under previous Conservative governments, the CSR's assertion that "many of the things that government does can be done cheaper, faster, and better if the private sector is involved" (cited in Evans and Shields, 2011, p. 149), was an argument long-advanced by the industry to justify its existence in Ontario. Moreover, Conservative Party MPPs who in opposition argued the importance of maintaining and enhancing the role of for-profit providers, including Cam Jackson, Jim Wilson and Elizabeth Witmer, would all play prominent roles in long-term care policy making.

Included in the Conservative's election campaign was the promise that MSAs would be abolished should the party be elected as the government. Given that such little progress had been made towards establishing MSA structures throughout the province it was not a difficult ambition to realize (Baranek et al., 2011, p. 223). In contrast to the New Democrats, the Harris government came into office with firm objectives for reform in mind and limited the scope of consultation considerably so as not to delay its goal of expanding market principles in long-term care. As Baranek et al. argue, "The Conservatives were intent on bringing the market to LTC and did not want to be distracted" (Baranek et al., 2001, p. 235). Using the former government's Long Term Care Act as the legislative framework for its reforms, and repealing aspects of the legislation which it deemed entirely unpalatable (such as the non-profit preference), the Harris regime was able to move quickly on its reforms in the absence of public debate (Ibid, p. 273-274). In 1996, 43 Community Care Access Centres (CCACs), the centerpiece of the Conservative model, were established across the province to assess and arrange for community and facility based care. In contrast to the MSA concept, CCACs

would not provide home and community care services but arrange for them to be provided through a competitive Request for Proposals (RFP) process. CCAC's were given funding envelopes, set by the province, to purchase the best quality services for the best price.

Although the shift to market-based care occurred in stages, with established providers having to compete for 10 percent of their services in 1996-1997, 20 percent the following year and 30 percent during the third year, there were no protections after that and no funding assistance to help inexperienced providers prepare competitive bids (Armstrong and Armstrong, 2001, p. 180). Although quality and price were stated objectives behind the move to CCACs, the focus on cost-containment within the market-oriented government benefited for-profit providers adept at offering the lowest bid, particularly as limitations were placed on funding envelopes. Pressures for cost-containment encouraged CCACs, "regardless of their commitment to quality, to take the lowest bid" (Ibid, p. 183). In the city of Windsor in 1999, for example, the Victorian Order of Nurses lost much of its share of long-term care provision to Olsten Health Services (Ontario Health Coalition, 2001). As emphasized in the previous chapter, Olsten lost its contract to provide home care services in Manitoba when the Filmon Conservatives ended their short experiment with privatization. The overwhelmingly negative reputation of the company, combined with public's discontent over the privatization of an aspect of the welfare state they had come to see as fundamentally important, influenced the government to change course. The cancelation of the contract after only one year in Manitoba demonstrated "both that privatization is a problem rather than a solution and that it can be reversed, given popular support and political will" (CCPA, 2000 p. 14).

In Ontario privatization was embraced as *the* solution to the problems of long-term care by the Harris government and policy makers expended the political will necessary to ensure its expansion. In addition to facilitating the expansion of proprietary care through the competitive bidding process, the Conservatives were able to enhance market principles in other ways. A number of non-profit community care providers discovered that "The only way for them to compete in this environment was to become more like the FPs (for-profits)" (Baranek et al., 2001, p. 266). In the residential care sector privatization was also encouraged.

As part of its plan to restructure the health care system by shifting more care out of hospitals and into the community, the Conservatives appointed the Health Services Restructuring Committee to order closures. The appointment of the Committee was another example of a Conservative government inviting a community of business experts to influence policy. As Armstrong and Armstrong note, "the 11-member body was dominated by the business sector – including the deputy chair of an insurance company; a former executive of General Motors; two lawyers, one of whom is a former president of the Ontario Chamber of Commerce; a senior executive in a private broadcasting corporation; and the executive director of an organization representing for-profit nursing homes" (Armstrong and Armstrong, 2001 p.168). Thirty-five hospitals were ordered to close and the combination of closures and mergers impacted home and institutional long-term care services in significant ways. Although the Health Services Restructuring Committee made its recommendations in the belief that services would be put in place to compensate for the closed beds, it did not have the power to ensure that this would be the case (Ibid) By 1996, 24 percent of Ontario's acute hospital beds that had existed in 1991 had closed (Dutil, 2011, p. 340). It quickly became apparent that seniors and the disabled

would no longer be the main users of community and home care services, but rather all people with acute-care needs (Baranek et al., 2001, p. 294). Seniors who were forced to wait for care, or could not find the care they needed, found themselves looking to the institutional sector, thus reversing the policy trend of discouraging the use of institutional care (Ibid).

In response to growing demands on a system of non-institutional care increasingly governed by the dictates of cost-containment, the Harris government announced in May 1998 that it would create 20,000 new long-term care beds by 2006, at a cost of $1 billion, and that an additional 16,000 beds would be upgraded. In what the Ontario Health Coalition has called a "building bonanza for the private sector", over two-thirds, or 67.7 percent of new beds were awarded to proprietary interests, with the large chain companies of Leisureworld, Extendicare and Central Park Lodges receiving 39.5 percent of the beds (OHC, 2001, p. 15). As the Ontario Health Coalition explains,

> The outcome was not unexpected, in large part because of the RFP process itself. Interested parties were required to submit lengthy, detailed proposals…proposals which demand hours and hours of dedicated staff time to prepare. For many not-for-profit organizations, putting together an RFP of this magnitude is simply outside their area of expertise, not to mention their budgets. By contrast, private sector operators, particularly large, multi-national corporations, have the money as well as the time and the staff to put together comprehensive proposal packages. Most importantly, they have access to much needed start-up capital, and absolutely crucial element of any proposal (OHC, 2001, p. 15).

The proportion of beds operated by the for-profit sector in 1996/1997 was 56 percent, and by 2001 it had increased to 59.6 percent. Beds in government-owned homes decreased from 26.3 percent to 22.6 percent while religious and lay non-profit homes remained the same (Berta et al., 2004 76).

While the RFP process certainly benefited the private sector, the capacity of commercial interests to make a profit was also enhanced by the Conservative's decision

to remove the minimum daily care requirement as well as the requirement that a registered nurse be on duty at all hours of the day (OHC, 2001, p. 5). So too did restrictions on facility choice. The government reduced the number of homes that seniors could have their names waitlisted for from five to three, and stipulated that if a bed became available admission had to be accepted or else they would lose their position on the waiting list (Baranek et al., 2001, p. 299). With more people of all ages in the community trying to access a limited range of home care services, commercial providers benefited from a cadre of seniors whose only option was to seek their services.

Conclusion

In this chapter I have argued that no window of opportunity opened in Ontario in which advocates of non-profit long-term care could influence the direction of public policy in any significant way. While non-profit reformers in Manitoba benefited in the 1970s from the election of a new party interested in moving the old age welfare state in new and more expansive directions, the re-election of the Progressive Conservatives led by Bill Davis in 1971 was of little benefit to Ontario reformers. Although Ontario's community of geriatric specialists had always had difficulty convincing post-war Conservative premiers of the need to reduce the province's reliance on for-profit care, it became particularly difficult in the 1970s as the government became increasingly concerned with limiting the scope and responsibility of the Ontario welfare state. Unlike in Manitoba, where the advice of geriatric reformers was sought out by government officials looking to broaden the capacities of the state in the field of long-term care, in Ontario the advice of the private sector was commissioned by officials looking to limit state responsibilities across a range of policy areas. This was of benefit to commercial long-term care providers. Commercial providers benefited from the more competitive

Ontario political environment where the majority of parties have tended to see little wrong with affording the commercial sector a primary role in seniors' care.

I have also emphasized that this is more than the story of a well-intentioned social democratic party unable to effect change in an inhospitable political climate. When in power the NDP government of Bob Rae acted much like a Liberal or Conservative administration when it came to residential long-term care. The disconnect between NDP criticisms of for-profit care while in opposition and in government are evidence of the extent to which Ontario governments of all political stripes have come to see for-profit providers as entrenched members of the long-term care environment, particularly during times of fiscal restraint. In contrast to Manitoba, where the maturation of a long-term care welfare state constituency in the years following the Schreyer government's reforms stands out as an important factor in halting privatization efforts, in Ontario it is the constituency of commercial providers that have organized over time to defend the profit motive and establish themselves as central actors in the Ontario long-term care environment. It should be of little surprise that when the Conservatives were elected back into office in 1995 they increasingly looked to the private sector to meet bulging long-term care demands.

Works Cited

Akande, Zanana. Hansard. Ontario. June 11, 1991, 1400

Armstrong, Pat and Hugh Armstrong. "Women, Privatization and Health Care Reform: The Ontario Case." *Exposing Privatization: Women and Health Care Reform in Canada*. Aurora: Garamond Press, 2001. 163-215,

Baker, Alden. "Inspections not carried out: Medical standards inadequate in homes for aged, report says." *Globe and Mail*. February 25, 1982, p. 5.

Baranek, Patricia, Raisa Deber and A. Paul Williams. *Almost Home: Reforming Home and Community Care in Ontario*. Toronto: University of Toronto Press, 2004.

Baum, Daniel J. *Warehouses for Death: The Nursing Home Industry*. Don Mills: Burns and MacEachern, 1977.

Berta, Whitney, Audrey Laporte and Vivian G. Valdmanis. Observations on Institutional Long-Term Care in Ontario: 1996-2002. *Canadian Journal on Aging*. 2005, 24(1): 71-84.

Brownsey, Keith and Michael Howlett "Class Structure and Political Alliances in an Industrialized Society." *The Provincial State: Politics in Canada's Provinces and Territories.* Eds. Keith Brownsey and Michael Howlett. Peterborough: Broadview Press, 1992

Callahan, Bob. Hansard. Ontario. December 8, 1991, 1600

Caplan, Elinor. Hansard. Ontario. November 25, 1987, 1500

Caplan, Elinor. Hansard. Ontario. June 6, 1988, 1410

Cecile, Louis. Hansard. Ontario. March 26, 1963, p. 2231

Concerned Friend Concerned Friends. "An interview with Betty Hatt." 2011. Retrieved from: http://www.concernedfriends.ca/about-us/interview-betty-hatt-founder-concerned-friends January 1, 1014.

Conway, Sean. Hansard. Ontario. May 11, 1978, p. 2411

Cooke, David. Hansard. Ontario. 1978, 1886

Cooke, David. Hansard. Ontario. December 4, 1986 NDP 14:50

Cooke, David. Hansard. Ontario. February 3, 1987, 1740

Cooke, David. Hansard. Ontario. May 25, 1987 1510

Dunlop, Marilyn. “Nursing homes: No insurance forces elderly into poverty” *Toronto Star.* Saturday, Aug 9, 1969, p. 01

CUPE. “Greenacres: Report by CUPE Local 79 on the Situation in Greenacres Home for the Aged,” 5 November 1981.

CUPE. “Homes for the Aged: Report by CUPE Local 79 on Urgent Problems in Metro’s Homes for the Aged,” 16 February, 1982.

Cunningham, Eric Gordon. Hansard. Ontario. May 11, 1978, p. 2416.

Dutil, Patrce. “Guardians in Check: The Impact of Health Care on the Ontario Budget, 1960-2004.” *The Guardian: Perspectives on the Ministry of Finance in Ontario*. Ed. Patrice Dutil. Toronto: University of Toronto Press, 2011.

Elston, Murray. Hansard. Ontario. November 3, 1986, 14:20

Elston, Murray. Hansard. Ontario. December 8, 1986, 14:20

Elston, Murray. Hansard. Ontario. December 16, 1986, 13:41

Evans, Bryan and John Shields. “From Pragmatism to Neoliberalism: Ontario’s Hesitant Farewell to Dr. Keynes.*” The Guardian: Perspectives on the Ministry of Finance in Ontario*. Ed. Patrice Dutil. Toronto: University of Toronto Press, 2011.

Ferguson, Derek. “Nursing, seniors' homes to get $37.9 million boost.” *Toronto Star* Oct 5, 1991 A20

Globe and Mail. “Givens suggests nursing homes should be government-operated.” Jan, 1965, p. 04
Globe and Mail. “Many nursing homes condemned as fire traps by hospital chief.” Jan 8, 1965, p. 01

Globe and Mail. “Robarts confirms he’ll go ahead on voluntary medicare scheme.” January 15, 1965, p. 1

Globe and Mail. “Thompson asks provincial licensing of nursing homes in Ontario.” Saturday, September 25, 1965, p. 13.

Globe and Mail. “Nursing homes fear cost jump when act passed.” February 26, 1966, p. 11

Globe and Mail. "Public nursing homes proposed by hospitals." Tuesday, October 25, 1966, p. 13

Globe and Mail. "Welfare, did they say?" May 11, 1968, p. 6

Globe and Mail. "Delays for aged." March 15, 1982.

Grossman, Larry. Hansard. Ontario. June 20, 1983, p. 1854

Haddow, Rodney and Thomas Klassen. *Partisanship, Globalization, and Canadian Labour Market Policy: Four Provinces in Comparative Perspective*. Toronto: University of Toronto Press, 2006.

Hickl-Szabo, Regina. "Grist plan tighter rein on homes for seniors." *Globe and Mail*. May 29, 1986, p. A5

Hickl-Szabo, Regina. "OMA urges action on 'growing crisis' in nursing homes." *Globe and Mail*. November 18, 1986, p. A8

Hollobon, Joan. "Nursing home regulations may be eased" *Globe and Mail.* Wednesday, Oct 18, 1972, p. 14

Jackson, Cameron. Hansard. Ontario. December 8, 1991, 1730

Lankin, Francis. Hansard. Ontario. October 1, 1991, 1420

Lewis, J.P. "Priority Setters and Guardians: The Relationships between Premiers and Treasures in Ontario, 1960-2001." *The Guardian: Perspectives on the Ministry of Finance in Ontario*. Ed. Patrice Dutil. Toronto: University of Toronto Press, 2011

MacKinnon, Janice. *Minding the Public Purse*. Montreal-Queen's University Press, 2003

MacLeod, Robert. "Ontario too soft on nursing homes, critics say." *Globe and Mail*. October 14, 1989, p. A11.

Marland, Margaret. Hansard. Ontario. December 3, 1992, 2330

Maxwell, Glynis. "Poverty Reduction Policies and Programs: Poverty in Ontario – Failed Promises and the Renewal of Hope." Social Development Report Series, 2009. Commissioned by Canadian Council on Social Development

McClaren, Christie and Alden Baker. "Homes for elderly must wait 2 months for needed workers." *Globe and Mail*. February 22, 1982, p. 5

McLeod, Lyn. Hansard. Ontario. June 12 1991, 1450

McLeod, Lyn. Hansard. Ontario. June 3, 1993 , 1400

McMongale, Duncan. “Health care for profits to be probed.” *Globe and Mail*. July 17, 1986, p. A11.

McQuaig, Linda. “Ontario set to alter nursing home laws.” *Globe and Mail.* September 20, 1985, p. 5

Montigny, E. *Foisted upon the Government? State Responsibilities, Family Obligations, and the Care of the Dependent Aged in Late Nineteenth-Century Ontario*. Montreal: McGill-Queen's University Press, 1993

Mortimore, G.E. “License nursing homes, welfare group urges.” *Globe and Mail*. Tuesday September 28, 1965, p. 01

Peterson, David. Hansard. Ontario. July 9, 1985, 2:40

Manthorpe, Jonathan. *The Power and the Tories*. Toronto: Macmillan, 1974.

McKeough, Darcy. Ontario. *Special Program Review*. 1975.

McLellan, Ross. Hansard. Ontario. 1983, p. 1842

McClellan, Ross. Hansard. Ontario. February 4, 1987, 1530

Morton, Desmond. “*Sic Permanent*: Ontario People and Their Politics.” *The Government and Politics of Ontario*. Ed. Graham White. Toronto: University of Toronto Press, 1997.

Novik, Marvyn. “Social Policy: The Search for a New Consensus.” *The Government and Politics of Ontario*. Ed. Donald C. MacDonald. Scarborough: Nelson, 1985.

New Democratic Party of Ontario Caucus Task Force on Caring for Seniors. Aging with Dignity: Report of the NDP Caucus Task Force on Caring for Seniors. 1984

Ontario. *Committee on Government Productivity*. Interim Report. 1970.

Ontario Ministry of Health and Long-Term Care. Dorothea Crittenden. *Report by Nursing Homes Residents’ Complaint Committee to the Minister of Health*. 1986

Ontario. Minister for Senior Citizens Affairs. *New Agenda: Health and Social Service Strategies for Ontario's Seniors*. 1986

Ontario. Min. of Community and Social Services *Strategies for Change: Comprehensive Reform of Ontario’s Long-Term Care Services*. 1990

Ontario. Min. of Community and Social Services. *Redirection of Long-term Care and Support Services in Ontario: A Public Consultation Paper*. 1991

Ontario Health Coalition. Secrets in the House Homecare Reform in Ontario 1997 – 2000. 2001. http://www.web.net/ohc/docs/secret.htm

Ontario Health Coalition. Ownership Matters: Lessons from Ontario's Long-Term Care Facilities. May 2002.

Rae, Bob. Hansard. Ontario. April 25, 1983, p. 139

Rae, Bob. Hansard. Ontario. December 14, 1983, p. 4116

Roseman, Ellen. "Nursing home proposals missing mark, critics say." *Globe and Mail*. February 26, 1987, p. A19

Schiff, Marvin. "Enforcing rules would shut many Ontario nursing homes." *Globe and Mail* Wednesday, January 13, 1965, p. 01

Simmons, Harvey. "Who cares for the Aged?" *Globe and Mail*, November 22, 1991, p. A17

Social Planning Council of Metropolitan Toronto. Caring for Profit: The Commercialization of Human Services in Ontario. 1984.

Story, Alan. "Nursing homes gave Liberals too much." *Toronto Star.* November 20, 1989, p. A1.

Struthers, James. "'No Place Like Home': Gender, Family, and the Politics of Home Care in Post-World War II Ontario." *CBMH* 20. 2. (2003): 387-417

Struthers, James. "'A Nice Homelike Atmosphere': State Alternatives to Family Care for the Aged in Post World War II Ontario." *Family Matters: Papers in Post-Confederation Canadian Family History*. Ed. Lori Chambers and Edgar-Andre Montigny. Toronto: Canadian Scholars Press, 1998.

Struthers, James. "Reluctant Partners: State Regulation of Private Nursing Homes in Ontario, 1941-1972." *The Welfare State in Canada: Past, Present, and Future*. Eds. Raymond B. Blake, Penny E. Bryden and J. Frank Strain. Concord: Irwin Publishing, 1997.

Sullivan, Barbara, Hansard. Ontario. December 3, 1992, 2240

Sweet, Lois. "Budget squeeze puts care of seniors at risk." *Toronto Star* September 30, 1991, p. A1

Tanguay, Brian. "Not in Ontario! From the Social Contract to the Common Sense Revolution" *Revolution at Queen's Park: Essays on Governing Ontario*. Ed. Sid Noel. Toronto: Lorimer, 1997.

Tarman, Vera Ingrid. *Privatization and Health Care: The Case of Ontario Nursing Homes*. Toronto: Garamond Press, 1990.

Task Force on the Allocation of Health Care Resources. Health: A Need for Redirection. Ottawa: Canadian Medical Association, 1984.

Toronto Star. “Nursing homes denied loans.” Thursday, June 9, 1966, p. 40

Toronto Star. “Nursing homes plan daily charge of $12.” Tuesday April 16, 1968, p. 29

Turner, John. Hansard. Ontario. May 11, 1978, 2409.

Van Horne, Ron. “A New Agenda: Health and Social Service Strategies for Ontario Seniors” Ron Van Horne Minister Senior Citizens Affairs. 1986.

Walkom, Thomas. “Ontario health care, a policy pattern emerges.” *Toronto Star*. November 22, 1989, p.A 25

Walkom, Thomas. *Rae Days: The Rise and Follies of the NDP*. Toronto: Key Porter, 1994.

Warner, David. Hansard. Ontario. 1977, p. 2453.

Wilson, Jim. Hansard. Ontario. December 7, 1992, 2310

Witmer, Elizabeth, Hansard. Ontario. December 7, 1992 , 2120

Wong, Tony. “Bailout of nursing homes ruled out.” *Toronto Star*. Oct 1, 1991, p.A8

Wiseman, Nelson. “Change in Ontario Politics.” *The Government and Politics of Ontario.* Ed. Graham White. Toronto: University of Toronto Press, 1997.

Conclusion: Lessons Learned and Future Directions in Long-Term Care

This dissertation has focused on three overarching questions. Why was long-term care not included as part of Canada's universal publicly funded health care system? In the absence of federal leadership, why did Manitoba and Ontario come to rely on the for-profit sector to such a different extent? How have these different policy paths been sustained over time? In this concluding section I offer some perspectives on the all-important 'so what' question. What can the findings of this dissertation contribute to present discussions about long-term care reform in Canada generally, and about the future role of for-profit providers specifically? As the population ages, and as more Canadians survive longer into old age with some degree of physical or cognitive impairment, provincial governments will need to make choices about where to allocate long-term beds in the near future. Recent developments in certain provinces are potentially calling into question the extent to which Ontario will remain the exception rather than the standard when it comes to its reliance on commercial care. As McGregor and Ronald warn,

> In spite of US and Canadian research finding a link between for-profit ownership and inferior quality in residential long-term care for seniors, and the fact that vulnerable seniors are more likely to receive the quality of care they require in non-profit facilities, the for-profit sector in Canada is expanding at the expense of the non-profit sector (McGregor and Ronald, 2011, p.3)

The roughly forty year time span analyzed in this dissertation offers important lessons for thinking about future directions in long-term care. Although such increases in for-profit beds are indeed troubling, the likelihood that provinces will engage in a 'race to the bottom' by converging around the Ontario model of market-based care is slim. The durability of established provincial policy paths is one reason to believe that such a

convergence is unlikely. The potentially influential role of an increasingly informed, vocal and cohesive community of geriatric specialists across Canada is another. As provincial governments search for ideas about how to meet new long-term care demands, what they can learn from policy lessons in other provinces will play a role in policy development. Although dissuading policy leaders to rely less on the private sector in times of austerity is no easy objective, there is reason to believe that this expanding community of scholars can help to forestall provincial convergence around the Ontario model. A fourth, although unlikely factor, that could prevent a race to the bottom is the re-discovery of long-term care in federal government thinking around health care policy. The election of a national government committed to broadening the scope of the Canada Health Act to include long-term care, or introducing parallel legislation, could serve to make the Canadian landscape unfavourable to commercial provision. Below, each of these points is considered.

The Durability of Established Paths: Lessons from Manitoba and Ontario

The path dependent nature of long-term care policy is one reason to believe that the provinces will not converge around the Ontario model. As emphasized in the preceding chapters, when we pay close attention to “the centrality of historical processes in generating variation in political life” we become more aware of the degree to which contemporary policy actors are often constrained by choices made at early points in time (Pierson, “Increasing Returns”, 2000 p. 251). Both provinces have been pioneers in long-term care, but for markedly different reasons. As case studies in policy divergence, Manitoba and Ontario spotlight the need to understand present differences in long term residential care ownership as a reflection of the different constellation of actors, events, ideas and institutions that came together at critical moments. In each province, diverging

ideas about the appropriate role of the for-profit sector in meeting the long-term care needs of an aging population were elevated on the political agenda. Over time, rigidities developed in each system, making it difficult for actors advocating for new directions in ownership.

Ontario's leading role in the for-profit model of long term care is not the result of sporadic occasions in which market-friendly policy makers opened the province for business. Rather, it is the reflection of a long historical process in which the idea that for-profit providers are legitimate and desirable members of Ontario's old age welfare state became institutionalized in key areas of decision making. Important sites of dissemination include the platforms of the Conservative and Liberal parties, the ministries of Health and Finance, and the nursing home industry itself. Over time, the idea that commercial providers are legitimate members of the Ontario old age welfare state has "sedimented" (Nelson, 2003, p. 561) into key areas of the province's political and social arenas. By comparing Ontario in relation to Manitoba we can clearly see how institutional constraints distinctive to Ontario have circumscribed the capacity of non-profit advocates to effect change. Such constraints include the province's three party system, the highly influential role of the for-profit nursing home industry on government decision making, and economic imperatives (both perceived and real). An institutional constraint shared by all provinces, the North American Free Trade Agreement, is one that is especially pronounced in the Ontario context following decades of expansion of American-based commercial providers into the market. The further Ontario went down the path of market-based care, the more distant and unreachable became the notion that "there is still time to draw back from the path that [Ontario] has embarked on…There is still time to draw back and go a different route" (McLellan, 1983, p. 1844).

By comparing the Ontario experience with that of Manitoba, we see that it is far from inevitable that provincial governments will want to tilt long-term care provision towards the market end of the spectrum. Importantly, the comparison reveals that expanding the role of for-profit providers is not always a straightforward or easily achievable objective. The opportunities and constraints faced by those with a vested interest in long-term care reform in Ontario and Manitoba have differed greatly. The durability of the non-profit preference in Manitoba is something that the Progressive Conservative governments of Sterling Lyon and Gary Filmon became acutely aware of when they attempted to set the province on a different path of care provision. Just as distinctive features of the Ontario environment aided proprietary expansion, key features of the Manitoba environment served to minimize it. The idea that caring for profit is dangerous policy became embedded in the province's uniquely placed community of geriatric specialists, the influential NDP, and among a significant number of long-term care providers and care recipients. By analyzing the failed attempts of Progressive Conservative leaders to expand the profit motive in the residential and home care sectors, I have emphasized in this dissertation a fundamental difference between the Manitoba and Ontario long-term care policy making environments. In Manitoba, it is the objective of commercialization that has become increasingly unreachable over time.

The Manitoba case study provides important justification for believing that provincial convergence around the Ontario model is neither imminent nor likely. If we broaden our scope beyond these two provinces to consider variations in bed allocations throughout the federation we should also be relatively confident that divergence from a primarily for-profit model of long-term residential care will remain the order of the day:

	Non-Profit	For-Profit	Total Beds	%non-profit	%for-profit
British Columbia	17028	7588	24616	69.00%	31.00%
Alberta	10230	4424	14654	70.00%	30.00%
Saskatchewan	8273	671	8944	92.00%	8.00%
Manitoba	7280	2553	9833	74.00%	26.00%
Ontario	35748	40210	75958	47.00%	53.00%
Quebec	35638	10453	46091	77.00%	23.00%
New Brunswick	4175	216	4391	95.00%	5.00%
NFLD & Labrador	2747	0	2747	100.00%	0.00%
Nova Scotia	41900	1796	5986	70.00%	30.00%
Prince Edward Island	578	400	978	59.00%	41.00%
Canada	125887	68311	194178	65.00%	35.00%

(Source: CUPE, 2009, p. 50. Based on data for the year 2008)

As the above data clearly indicates, Canadian provincial governments have yet to reach a shared understanding about the role of for-profit providers. In the absence of federal incentives to allocate beds to the non-profit sector, provinces, for the most part, have still been reluctant to pursue commercial care to the extent pursued within Ontario. The varying reliance on such care points to the distinctive ways that long-term care has evolved in the federation and to Ontario's exceptional position when it comes to this policy sector. The durability of contrasting policy paths taken by Manitoba and Ontario underscores the difficulties of changing course and the likelihood that divergence, rather than convergence, will be a defining feature of provincial care regimes. Path dependence, however, is only one reason to suspect that it is unlikely that provinces will converge around the Ontario model as they seek to meet burgeoning long-term care demands.

Another, and perhaps more important factor, is Canada's expanding community of long-term care researchers.

Canada's Expanding Community of Geriatric Specialists: Lessons from Manitoba

In my introductory chapter I noted that long-term residential care has received insufficient attention in Canada, not just in the minds of academics and politicians, but in our everyday thoughts. The reality is that, "most of our efforts as a nation and much of that as individuals are focused on keeping ourselves and others out of long-term care facilities rather than on the work and the care within them" (Armstrong et al., 2009, p. 12). At present, a movement is underway to change this situation. A multidisciplinary community of academics who share a common interest in shaping and informing current and future policy debates are focusing their efforts on spotlighting promising practices in long term residential care through comparative research initiatives. This growing community, by focusing their efforts on the production of policy-relevant research in this long-marginalized sector of Canadian scholarship, have the potential to be "key knowledge production agents" (Atkinson et al., 2013, p. 124) for policy makers. By drawing attention to the lessons that provincial governments can learn from each other, and from governments abroad, new research that focuses on care outcomes in for-profit vs. not-for-profit facilities can provide provinces with incentives not to pursue the market model. Before considering some of the pioneering initiatives presently underway and their potential to effect positive change, it is worth pausing briefly to reflect upon the pivotal role played by Manitoba's leading community of geriatric specialists.

One of the great strengths of historical institutionalist research is its ability to "suggest how policy developments in each [jurisdiction]… might have turned out differently had political conditions or choices been different than they were" (Hacker,

1998, p. 77). In 1970s Manitoba the political conditions for long-term care reform were made favourable with the election of the province's first NDP government, led by Ed Schreyer. It is essential to recognize, however, that although the Schreyer government was open to thinking about health care beyond the walls of the hospital and physician's office, without Manitoba's community of geriatric specialists advocating for reform it is unlikely that long-term care would have received the attention that it did within the halls of government. As Wiseman (1985) and McAllister (1984) have argued, the Schreyer era was not one that was particularly disruptive to the private sector. Eager to downplay the social democratic label, the government staked out a moderate and centrist position on the political spectrum, one that was often unrecognizable from that of a Progressive Conservative or Liberal government throughout the rest of Canada. Without the influence of pioneers such as Betty Havens, Enid Thompson, Jack MacDonell, Evelyn Shapiro, Paul Hentelff and David Skelton, there is reason to believe that Schreyer's NDP government would not have moved to implement pioneering initiatives in nursing home and home care programs, and that the number of beds allocated to the for-profit sector would be higher than it currently is.

For at least a decade before a window of opportunity opened in the political arena, such thinkers had been working closely together on non-profit pilot projects and research initiatives to find solutions to the financial, organizational and professional barriers to long-term care. At a time when few Canadian researchers were focusing on this long-marginalized feature of the Canadian welfare state, there existed in Manitoba individuals and groups that were committed from an early stage to ensuring that long-term care not be a back burner item in the Manitoba medical, academic and political arenas. The idea that "It is too dangerous" to put the care of seniors in the hands of the for-profit nursing

home providers (Desjardins, April 8, 1985, p. 677) informed Ministry of Health and Social Development thinking in large part because of the ability of such thinkers to demonstrate the comparative benefits of non-profit care. To use Havens' terminology, they had "a product you could show them" (Havens, 2003). Drawing upon lessons learned from pilot projects and research initiatives such as those at Municipal Hospital, Deer Lodge, St, Boniface Hospital, and the Age and Opportunity Bureau, Manitoba's geriatric community presented arguments that were difficult for the NDP to ignore. Indeed, as Desjardins argued when Minister of Health, in "a field that there are not too many people that are familiar with…a field that is not glamorous at all" it was important that he seek out the ideas of "the people that were the best people", to discover "what they felt in that vast and long experience, what they felt was good for these people" (Desjardins, May 29, 1975, p. 3212).

In Manitoba, "The right people [were] in the right place at the right time" (cited in Struthers, 2010, p. 18). The community of experts and the NDP relied on each other to move the province forward in mutually beneficial ways. The competitive position of the NDP in Manitoba's two party system in subsequent decades, and the sustained commitment of people such as Havens and Shapiro to advancing non-profit care, were key features of the political environment that helped to stall commercial expansion. Havens and Shapiro remained active in the field until their deaths in the early 2000s. Havens continued to work on the Aging in Manitoba Longitudinal Study, acted as the country's first provincial gerontologist, and published extensively on issues of geriatric concern in order to ensure that long-term care remain a salient issue. Shapiro was also committed to this end, something demonstrated not only through her role in the Office of Continuing Care and her continued academic focus on long-term care, but also through

the activist role she played in the mid-1990s against the privatization of home care. Along with other members of the geriatric policy community, including the NDP, the Manitoba Government Employees Union, the Coalition to Save Home Care, and the Canadian Centre for Policy Alternatives (CCPA), Shapiro played an important role in discrediting the Filmon government's privatization plans. Through such actions as speaking at the public hearings and publishing an influential article with the CCPA, Shapiro helped to convey to a significant number of Manitobans the faulty premises of government arguments. Evidence from other jurisdictions was effectively employed to illustrate that a for-profit company such as Olsten would not save the province money, would not improve care or work conditions, and would not meet the policy objectives of providing good quality care in a manner comparable to the publicly run system.

In light of the Manitoba experience, there is reason to believe that Canada's expanding community of long-term care specialists can play a role in discrediting provincial governments seeking to rely on the commercial sector to do more. Recognizing that the present context is a critical one for charting future directions in care, an emerging cadre of Canadian scholars are committing themselves to the production of research that can inform public policy. Two collaborative research initiatives presently underway illustrate this emergence. Margaret McGregor and her colleagues at the University of British Columbia, recognizing that Canadian researchers have lagged behind their American counterparts when it comes to producing the types of comparative research on care outcomes in for-profit vs. non-profit facilities, are focusing their efforts towards filling this gap (McGregor and Ronald 2011; McGrail et al., 2007; McGregor et al., 2006; McGregor et al., 2005). As they note, their ongoing research project *Long-Term Care: For-Profit Vs. Non-Profit*, can play an important role in providing justification for bed

allocations to the non-profit sector. In their words, “As governments are increasingly seeking to expand for-profit care delivery as a possible solution to budgetary constraints, this study will play an important role in understanding the performance of this sector compared to the not-for-profit sector in the Canadian setting” (http://www.chspr.ubc.ca/research-area/project/long-term-care-profit-vs-non-profit-ownership). By “beginning to acquire evidence” on differences in staffing levels and care outcomes, Canadian scholars “can provide information that is essential to planners as they make funding decisions about long-term care” (McGrail et al., 2007, p. 58).

Of course, as McGregor and colleagues acknowledge, and as the Ontario case aptly reveals, non-profit facilities are not without their problems. The early 1980s CUPE investigations highlighted in Chapter 4 illustrate this particularly well. CUPE’s critique of Greenacres and other homes for the aged in Metro Toronto point to the fact that Ontario’s shortcomings in long-term care are not just a result of commercial ownership. The crisis driven nature of policy making in the sector has meant that reforms have most often occurred only after a problem has reached a breaking point, rather than in anticipation of potential problems. Over time, the high tolerance for nursing home scandals, along with the more recent harmonization of the bidding process for new contracts, has led to a situation in which some non-profit providers have found little incentive to differentiate themselves from their commercial counterparts. This was something made evident in the 1990s after the introduction of Community Care Access Centres by the Harris government. Although quality and price were stated objectives behind the move to CCACs, the overwhelming focus on cost-containment within the market-oriented Harris government, benefited for-profit providers adept at offering the lowest bid, particularly as limitations were placed on funding envelopes. Pressures for cost-containment encouraged

CCACs, “regardless of their commitment to quality, to take the lowest bid” (Armstrong and Armstrong, 2001 p. 183). A number of non-profit organizations discovered that “The only way for them to compete in this environment was to become more like the FPs (for-profits)” (Baranek et al., 2001, p. 266).

In addition to illustrating the limitations of for profit care, the goal of research projects such as that out of UBC are about prompting governments to pursue promising practices. By identifying promising practices through comparative study, scholars are working to fill a significant gap in Canadian research, one that has heretofore benefited some policy makers who are intent on expanding the commercial sector. In Ontario, successive Conservative and Liberal governments have been able to expand the commercial sector with relative ease based on the faulty claim that it provides a comparable and often superior level of care when compared to the non-profit sector. Over time, the accumulation of comparative data illustrating that this is not the case can play a role in shaming provincial governments that ask the commercial sector to do more. “[T]he emergence of potential institutional challengers from the population of actors whose interests and ideas are not adequately served by the existing order” is important to changing policy directions (Myeong-Gu and Creed, 2002, p.232). By challenging the justification for proprietary care, emerging Canadian scholars can make it difficult for policy makers to increase their reliance on the sector. As noted below, however, with reference to the recently released Ontario Seniors Strategy, *Living Longer, Living Well* (Sinha, 2012), challenging the institutional frameworks of Ontario long-term care will be no easy task.

Another project currently underway that can work towards this end is based out of York University. *Reimagining Long-Term Residential Care: An International Study of*

Promising Practices, is a seven year comparative research project that seeks to identify, both domestically and abroad, promising approaches to organizing, planning and thinking about long-term residential care (http://reltc.apps01. yorku.ca/). Recognizing the importance of learning from distinctive policy approaches throughout the provinces as well as from the international community, this project involves an interdisciplinary team of academics from five Canadian provinces, two American states, Sweden, the United Kingdom, Germany and Norway. Also included are the perspectives of unions, employer associations and community organizations representing older people. As the title of the project indicates, its central objective is to re-imagine our approaches to long-term residential care by learning from other jurisdictions. Ownership is a key area of focus for researchers involved with the project.

The York and UBC initiatives are two examples of the growing recognition on the part of long-term care researchers that "Idea production, information sharing, and collaborations are all key network activities in which policy learning takes place" (Atkinson et al., 2013, p. 147). Having been given significant responsibilities for welfare state development under the Constitution Act 1867, Canadian provinces have since acted as laboratories for social policy innovation. As sites of innovation, provinces have shown willingness "to accept ideas developed in other provinces and…imitate successful policy developments and avoid obvious failures" (Atkinson et al., 2013, p. 53). What provinces view as obvious successes worthy of emulation and failures to be avoided in long-term care will play a crucial role as they determine bed allocations in the future. The different paths taken by Manitoba and Ontario reveal the degree to which provincial governments can have remarkably different notions of what constitutes obvious success and failures in policy development. Indeed, policy makers in both jurisdictions have at various times

cited the other as a failure. In Manitoba the NDP has used lessons from Ontario as a reason to avoid expansions in commercial care. Whether it was "the tragic fire" in a privately run home in Mississauga, Ontario, that took the lives of 21 residents (Parasiuk, July16, 1980, p. 5717-5718); condemnation of the Ontario Nursing Home Association's vision of residential care as "a super business to own because of the high cash flow" (Parasiuk, March 11, 1980, p. 1603); or the need for government to recognize that "if you didn't have the regulations here in Manitoba…we'd have what exists in Ontario and what exists in the United States" (Parasiuk, March 19, 1981, p.1923), Ontario's for-profit model has been portrayed as something to avoid emulating. Indeed, even Progressive Conservative Health and Social Development minister Bud Sherman was keen to differentiate his privatization plans from those of Ontario. As he conceded in the legislature,

I have to go back to the basic facts and give the previous government credit for this system, the program; we have, in Manitoba, a highly supervised, monitored, regulated, demanding system. It is not a free-wheeling open market business field. In Ontario most nursing homes are proprietary operations (Sherman, March 19, 1981, p. 1922).

In Ontario, advocates of for-profit care have portrayed the Manitoba example as a failure. As one Progressive Conservative MPP put it, the Filmon privatization initiative reflected nothing more than a desire to overcome "the extreme inefficiency and rigidity which has developed due to bureaucracy and unionization" (Callahan, December 8, 1991, 1600). Although such claims of inefficiency and rigidity were successfully discredited by Manitoba's community of geriatric specialists, long-term care recipients and their families, as well as long-term care workers, in Ontario such claims were able to find an increasingly attentive audience. As provinces search for ways to meet the long-term care demands of the near future, a growing body of research that identifies promising practices can help to discredit false claims of market superiority. What provinces can learn from

each other will play an important role in decisions about future bed allocations. As Harrison rightly points out, "While it is reasonable to assume that politicians devise policies primarily in response to political support and opposition within their own jurisdictions, their ability to gain political credit and avoid blame from their own voters may depend on what other jurisdictions do" (Harrison, 2006, p.3). Based on what has been gleaned from the Manitoba case study, and based upon the increasingly active role of Canada's growing community of researchers in the field of long-term care in identifying and promoting promising ideas, there is reason to believe that provinces will be reluctant to emulate Ontario.

When it comes to 're-imagining' long-term residential care for the future, the most challenging task for reformers will be encouraging Ontario to pursue a different path. This dissertation has revealed the extent to which advocates of non-profit care have been forced to the fringes of long-term care policy making in Ontario. Advocates of non-profit care between the 1960s and 1990s presented Ontario's Conservative, Liberal and NDP governments with information similar to that advanced in Manitoba on the dangers of commercial provision. The lack of receptivity to these ideas at Queen's Park reveals in important ways the reality that "Across Canada, the variable interests within… provincial policy networks go a long ways toward explaining why similar access to information has resulted in divergent policy choices" (Atkinson et al., 2013, p. 124). Unlike in Manitoba, such advocates had to compete with the formidable nursing home lobby in their efforts to encourage policy makers to pursue non-profit alternatives. The nursing home lobby has proven itself adept at marshalling the support of a majority of the province's political parties, playing on the emotions of residents and family members, and threatening legal

action when it feels that its stake in the long-term care sector is in danger of being undermined.

A key ingredient for reform that has been missing in Ontario is political will. All Ontario governments at some point have come to view the commercial sector as a key institution in the old age welfare state. By paying close attention to policy debates surrounding the appropriate role of this sector in Manitoba and Ontario I have illustrated that "The political arena is a structured arena of conflict" (Beland, 2005, p. 12). In Ontario, conflicts over how to meet the challenges of an aging society have, over time, become structured in such a way that the majority of key policy makers have come to believe that there is no alternative. In other words, while we can look to the recent past and identify moments where the will to follow through with minor changes in ownership distribution would have made a difference over time, political leaders have wavered when confronted with the challenges of overcoming the institutional constraints standing in the way of true reform. As emphasized in the previous chapter, the Peterson Liberals and Rae NDP lacked the appetite for circumscribing the power of commercial nursing home providers in the face of intense lobbying from the industry, downturns in the economy, and pointed attacks from opposition MPPs.

The Harris Conservatives were able to move so swiftly on their market agenda because for-profit care, to use Hay and Wincott's terminology, had become "a taken-for-granted and institutionalized convention" in Ontario long-term care policy (Hay and Wincott, 1998, p. 953). Although certainly more aggressive and enthusiastic than previous governments in brining care to the market, the Harris regime was building on a long tradition in this policy sector. The present Liberal administration's guiding policy document on long-term care, *Living Longer, Living Well* (2012), suggests that this

continues to be the case, and that Ontario will remain open for business. Its author, Mount Sinai geriatrician Dr. Samir Sinha, invokes the language of 'apocalyptic demography' to reinforce the long-entrenched idea in Ontario politics that, in times of fiscal restraint, the government must not burden itself with too many responsibilities for older people. In Sinha's words, "older adults in general – and those with complex issues in particular – drive health care costs" (2012, p. 5). If the present Liberal government does not show fiscal prudence in developing policy responses "our demographic challenge could bankrupt the province," thereby putting in jeopardy "our health, social, community, and other programs that have come to define us as Ontarians and Canadians, as well as the progressive society that we live in" (Ibid, p. 6).

Sinha suggests that Ontario avoid building new long-term care homes and focus its attention on home and community care. Seniors (through means-testing) and the for-profit sector (through expanding into new areas) are asked to do more in order to facilitate this transition. It is recommended that operators of long-term care facilities "consider rebranding the sector, in recognition that LTC homes currently, and should in future, offer much more than just long-term residential care" (131). Eager to take on new responsibilities in the now more profitable areas of retirement homes, supportive housing, home care, as well as day and night programs, Ontario's for-profit providers appear, at least for now, to have a bright future in the province (OLTCA, 2012).

As Streeck and Thelen explain, the likelihood of transformative change is dependent upon "to what extent the fringe and the core can peacefully coexist, or whether the fringe can attract enough defectors from the core eventually to displace it" (Streeck and Thelen, 2005, p.43). If Ontario's advocates of non-profit reform are to have a chance at displacing the core position that commercial providers occupy in Ontario, Canada's

expanding community of long-term care researchers will need to play an active role. Short of electing a government in Ontario that is committed to doing what no regime before it has been willing to do, the answer to tempering the province's reliance on commercial care may very well rest with this community. Ontario maintains its exceptional status in the federation because of features distinctive to the province. If long-term care is to come in from the fringes of the welfare state in Ontario, more comparative provincial studies drawing attention both to the anomalism and the dangers of its policy path will be necessary. Dr. Sinha is not wrong in arguing that "Ontario can be the best place to grow up and grow old" (Sinha, 2012, p. 24). In order to do so, however, Ontario will need to learn from other provinces.

A Role for the Federal Government? Reflections on National Responses

In recent years, organizations such as the Canadian Health Coalition and CUPE have been calling on the federal government to take a leadership role in long-term care reform. By working with the provinces to bring long-term care within the bounds of the Canada Health Act, the Health Coalition argues, the federal government can facilitate "the second stage of Medicare" (Canadian Health Coalition, 2010, p. 10-12) through standards which would require provinces to "provide residential long-term care on a not-for-profit basis to ensure that public dollars go to care, not profit" (Ibid, p. 12). CUPE has taken a similar position, arguing that

If equal access to health care is a core Canadian value, we should provide health care free of charge at the point of use no matter the setting. The arrested development of medicare (limited at present to hospital and physician services) made little sense 50 years ago, when federal health care programs came together. It makes even less sense today, when our society is rapidly aging and more seniors need high-level, complex care. Paying for residential long-term care as a society and guaranteeing equal access to care is smart from an economic point standpoint and fair from a societal standpoint. Wiser yet would be to

cut profit-making from the system, putting all of our available resources into care (CUPE, 2009, p. 5)

It is time, in other words, to bring long-term care from the fringes to the mainstream of our national medicare narrative.

The argument for federal leadership is based on the historical need for national incentives. If the federal government had not acted upon the recommendations of the Hall Royal Commission in the 1960s, for example, there is every reason to believe that the Canadian health care system would closely resemble the American one today. Alberta, Ontario and British Columbia in the early 1960s had all launched investigations into the merits of private insurance (Bryden: 2009). Ontario, for its part, wanted to spend on housing ahead of health care, while finance ministers from all provinces, even Saskatchewan, were expressing concern about the costs of a new national medicare program (Ibid). Without federal leadership it is highly unlikely that Canadians today would be citing universal access to hospital and physician care as a defining feature of their national identity.

As emphasized in Chapter 2, the will to expand the public focus of medicare to include long-term care has never been exerted by a Canadian federal government. Little has changed since 1966 when the Canadian Senate Committee on Aging drew attention to the fact that “There is entirely too little emphasis on aging and on the overall care of the chronically ill at the federal level” (Senate of Canada, 1966, p.121). In every decade since the 1950s, federal governments have ignored calls to take a leadership role in long-term care. With the exception of piecemeal and temporary central government involvement during the 1970s and early 1980s, the federal approach to long-term care has been characterized by an absent mandate. While a rediscovery of long-term care at the federal

level could indeed go a long way towards realizing the types of reforms called for by CUPE and the Canadian Health Coalition, governments in Ottawa have been just as reluctant as those in Ontario to chart a new path. Federal disinterest in new home care transfers recommended in the 2002 Romanow Commission Report is one of the more recent examples of Ottawa's aversion to long-term care. Although the Report's recommendations for expanded federal involvement in this one aspect of long-term care was seen as a positive start by many, as was its assertion that "The answer…is not to look to the private sector for solutions" (Romanow, 2002, p. 8), over ten years later it is clear that Ottawa was never truly committed to altering the focus of medicare to benefit older Canadians. Barring a significant transformation in federal attitudes toward long-term care, the findings of this dissertation suggest that the provinces will be the most likely sites of progressive reforms.

Works Cited

Armstrong, Pat and Hugh Armstrong. "Women, Privatization and Health Care Reform: The Ontario Case." *Exposing Privatization: Women and Health Care Reform in Canada*. Aurora: Garamond Press, 2001.

Armstrong, Pat et al. *They Deserve Better: The Long-Term Care Experience in Canada and Scandinavia*. Ottawa: Canadian Centre for Policy Alternatives. 2009.

Atkinson, Michael M. et al. *Governance and Public Policy in Canada: A View from the Provinces.* Toronto: University of Toronto Press, 2013.

Baranek, Patricia, Raisa Deber and A. Paul Williams. *Almost Home: Reforming Home and Community Care in Ontario*. Toronto: University of Toronto Press, 2004.

Beland, Daniel. "Ideas and Social Policy: An Institutionalist Perspective. *Social Policy and Administration*. 2005; 39.1, 1-18.

Bryden. P.E. "The Liberal Party and the Achievement of National Medicare." *CBMH*. 26.2 (2009): 315-332

Canadian Health Coalition. "Building a Continuum of Care" 2010 Accessed from: http://healthcoalition.ca/main/issues/continuing-care/

Canadian Union of Public Employees. Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care. Ottawa: Canadian Union of Public Employees. 2009 Retrieved from: http://cupe.ca/updir/CUPE-long-term-care-seniors-care-vision.pdf October 12, 2011

Desjardins, Laurent. Hansard. Manitoba. May 29, 1975 p. 3212

Desjardins, Laurent. Hansard. Manitoba. April 8, 1985, p. 677

Hacker, Jacob S. "The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy." *Studies in American Political Development*. 12, 1998

Harrison, Kathryn. "Provincial Interdependence: Concepts and Theories." In *Racing to the Bottom: Provincial Interdepenence in the Canadian Federation* ed. Kathryn Harrison. Vancouver: UBC Press, 2006.

Havens, Betty. Telephone interview with Dr. James Struthers, 27 October, 2003.

Hay, Colin and Daniel Wincott. "Structure, Agency and Historical Institutionalism." *Political Studies*. 1998, XLVI.

McAllister, James. A. *The Government of Edward Schreyer: Democratic Socialism in Manitoba*. Kingston: McGill-Queen's University Press, 1984.

McGregor, Margaret J. and Lisa A. Ronald. "Residential Long-Term Care for Canadian Seniors: Non-profit, For-Profit or Does it Matter?" IIRP. 14(January 2011).

McGregor, Margaret et al. "Care Outcomes in Lon-Term Care facilities in British Columbia, Canada: Does Ownership Matter?" *Medical Care*. 44.10, 2006

McGregor, Margaret et al. "Staffing Levels in Not-for-Profit Long-Term Care Facilities: Does Type of Ownership Matter?" *CMAJ*. 172.5., 2005.

McLellan, Ross. Hansard. Ontario. 1983, p. 1842

Myeong-Gu Seo and W. E. Douglas Creed. "Institutional Contradictions, Praxis, and Institutional Change: A Dialectical Perspective." *The Academy of Management Review*. 27. 2 2002

Nelson, Lise. "Decentering the Movement: Collective Action, Place, and the 'Sedimentation' of Radical Political Discourses." *Environment and Planning D: Society and Space*. 2003, 21, 559-581

Parasiuk, Wilson. Hansard. Manitoba. July 16, 1980, p. 5717-5718

Parasiuk, Wilson. Hansard. Manitoba. March 11, 1981, p. 1603-1604

Parasiuk, Wilson. Hansard. Manitoba. March 19, 1981, p. 1922

Pierson, Paul. "Increasing Returns, Path Dependence and the Study of Politics." *The American Political Science Review*. 94, 2000.

Senate of Canada. *Final Report of the Special Senate Committee on Aging in Canada*. 1966

Sherman, Bud. Hansard. Manitoba. March 19, 1981, p. 1922

Sinha, Samir. *Living Longer, Living Well: Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to Inform a Seniors Strategy for Ontario*. 2012

Streeck, Wolfgang and Kathleen Thelen. Introduction: Institutional Change in Advanced Political Economies. In *Beyond Continuity: Institutional Change in Advanced Political Economies*. Cary, NC: Oxford University Press. 2005

Wiseman, Nelson. *Social Democracy in Manitoba: A History of the CCF-NDP*. Winnipeg: University of Manitoba Press, 1985