THE ‘POOR COUSIN’ OF HEALTH POLICY

THE ‘POOR COUSIN’ OF HEALTH POLICY - COMPARING HOME CARE POLICY CHANGE IN ONTARIO AND SASKATCHEWAN IN THE ERA OF AUSTERITY

By SPENCER NAYLOR, M.A., B.A.

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Abstract

As Canada's older demographic has expanded in recent decades, increasing attention has been focused on home care as part of a broader trend in health reform emphasizing Aging-in-Place. However, despite this, public home care policies and programs across Canada have generally stagnated over the same period, struggling to keep up with growing demand. To help understand why this has happened, this study compares the evolution of home care policies in Ontario and Saskatchewan from the late 1980s to early 2000s using a process-tracing approach. It finds that policy legacies established by early institutional decisions in each province's home care program shaped the ideas of policymakers and empowered some interest groups over others to cause divergent home care reform choices in response to common challenges experienced within each province's health system. These reform trajectories set Ontario and Saskatchewan on different reform paths,which occurred despite increased interest in seeing home care play a greater role in each province's health system. However, the study also identified provincially distinct dynamics by which home care found itself temporarily the focus of increased attention from governments. Specifically, distinct legacies of policy decisions made in the early years of each province's home care program formation led to the establishment of different ideas regarding home care's potential as a cost-saving alternative to acute care. These provincially distinct decisions in home care program development also established a unique arrangement of stakeholders in home care, who had differing degrees of influence on policy directions considered during the study period. The thesis concludes by suggesting that home care's historically marginal role as the "poor cousin" of provincial healthcare systems is the result of a lack of sustained interest from policymakers in investing in home care for the sake of home care, rather than as a means of achieving ulterior goals in health system reform.

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List of Acronyms

CAP - Canada Assistance Plan
CAC - Consumers' Association of Canada
CCAC - Community Care Access Centre
CHC - Community Health Centre
CMSO - Comprehensive Multi-Service Organization
CPC - Community Providers Coalition
HSRC - Hospital Services Restructuring Committee
HSURC - Health Services Utilization and Research Commission
IHP - Integrated Homemaker Program
LTC - Long-Term Care
MCSS - Ontario Ministry of Community & Social Services
MPP - Member of Provincial Parliament
MOC - Ontario Ministry of Citizenship
MOH - Ontario Ministry of Health
MSA - Multi-Service Agency
OCSA - Ontario Community Support Association
OCSCO - Ontario Coalition of Senior Citizens' Organizations
OHIP - Ontario Health Insurance Plan
OMA - Ontario Medical Association
OPA - Ontario Physicians Association
NDP - New Democratic Party
RHA - Regional Health Authority
SAO - Service Access Organization
SAHO - Saskatchewan Association of Health Organizations
SASCH - Saskatchewan Association of Special Care Homes
SCA - Service Coordination Agency
SCCA - Senior Citizens' Consumer Alliance for Long-Term Care Reform
SGEU - Saskatchewan Government Employees Union
SHA - Saskatchewan Health-Care Association
SHCA - Saskatchewan Home Care Association
SPHERU - Saskatchewan Population Health and Research Unit
SUN - Saskatchewan Union of Nurses
USCO - United Senior Citizens of Ontario
VHA - Visiting Homemakers Association
VON - Victorian Order of Nurses
WHO - World Health Organization

Introduction

Why Past Changes to Home Care Matter Today

Canada is in the midst of a significant demographic transition, with individuals aged 65+ representing the fastest growing population group in the country. Currently, this population represents 19 per cent of the population but already accounts for 47 per cent of all health spending (Gibbard, 2018). By 2031, Canadians aged 65 years and older will make up nearly one quarter of the population, but the health care and support systems of the country have not kept pace with the growth in this population (National Institute on Ageing, 2022). Provinces and territories, whose governments are most responsible for managing public health care spending, are struggling to meet the care needs of their older populations, a significant portion of which are represented in the provision of long-term care (LTC) services. These publicly funded services include care provided both in LTC institutions, also known as nursing homes, and in the private dwellings of patients through home care and through homemaker and home support programs.

In the context of this dissertation, home care policies concern two forms of care. The first is typically provided by nurses and includes procedures that require professional training, such as taking blood pressure, administering intravenous fluids or medication, applying or changing the dressing on wounds, and other similar procedures: this is termed “home care”. The second form of care typically falls under the label of “home support” or “homemaking” and includes activities that care recipients would be able to do themselves under circumstances of normal health, such as taking a bath/shower, buying and storing groceries, getting dressed, and other related activities. In some jurisdictions, these two forms of care are governed by the same group of

policies and administered by the same group of providers. In other jurisdictions, these forms of care are governed and administered separately. In Canada, since health policies are primarily the responsibility of provincial governments, home care policies differ substantially between provinces, which have made what was already historically a patchwork system within individual provinces an even more complicated and scattered system nationally. There are, however, sufficient similarities between provincial home care policies to at least identify home *care* and home *support* as being distinct types of care that nonetheless fall within the broader category of home care from a policy standpoint.

Home care policies in Canada tend to be bundled with LTC policies, which target both institutional forms of care (long-term care homes) and home & community care. These policies are typically the purview of a provincial Ministry of Community & Social Services, Seniors, Long-Term Care, or Health, depending on the government of the day. In this sense, it is rare to observe home care discussed as a policy issue on its own, as its relevance is routinely tied to policy debates more broadly concerned with the welfare of older adults or within debates on long-term care strategies. This has been disadvantageous for the home care sector, as historically, public LTC spending on institutional forms of care in nursing homes has eclipsed the spending on home and community-based forms of care. This has occurred despite the overwhelming preference of Canadians to receive care in their own homes, and the fact that between 11 and 30 per cent of patients admitted to LTC homes are estimated to have been better served by home and community care options (CIHI, 2022c).

The first reason to care about past decisions regarding home care, therefore, is that deprioritizing it has led to the excessive institutionalization of a vulnerable population. This reality has become perhaps most evident in the province of Ontario, where desperate attempts to free up hospital beds in the wake of rising COVID-19 cases at the end of summer 2022 led to the passage of Bill 7, a law allowing hospitals to force patients to be discharged to LTC homes up to 70 kilometers away or to face an up to $400 per diem fine from the hospital (CTV News, 2022). More broadly, the COVID-19 pandemic has placed additional pressures on provincial LTC systems which were already struggling to provide adequate care for vulnerable populations, namely older adults and people living with disabilities.

Indeed, provincial LTC systems across Canada have struggled over the past few decades to meet increasing demand for services as the older aged demographic has continued to grow (Béland et al., 2017). With LTC representing an "extended" service in the Canada Health Act[1], the sector has found itself frequently ignored, even in high profile health care commissions and strategic consultations (Béland & Marier, 2020). With home care representing only one piece of provincial LTC systems, it has thus historically received limited attention in policymakers' agendas. The exception to this was the late 1980s to early 2000s, a time when home care enjoyed a sudden period of salience to provincial governments across Canada, who were scrambling to reform their health care systems in the wake of federal decisions to scale back Established Programs

[1] The Canada Health Act is a piece of federal legislation establishing the criteria and conditions related to insured and extended health care services that provinces and territories must fulfill to receive federal funding for their health systems under the Canada Health Transfer (CHT).

Financing[2]. These cuts in federal support to healthcare systems occurred at a time when the public finances of the provinces and territories were already in poor shape, and subsequently made worse by an economic recession (Lazar et al., 2016).

It is not surprising that home care would receive greater attention than usual in the context of a search for cost-savings in health care. Evidence that costs to the public sector for care in the home setting can be considerably lower than that of LTC homes and hospitals – particularly when targeted to individuals vulnerable to losing their independence –has long been acknowledged (Challis & Hughes, 2003; Chappell et al., 2004). However, the divergent directions taken by some provincial governments on home care during the late 1980s to the early 2000s are remarkable. This divergence in situating home care within health system reforms is particularly surprising considering the provinces' shared need to identify cost saving opportunities in healthcare provision in the wake of cuts in federal health funding to the provinces.

Many significant changes to home care emerged in specific provinces throughout the 1990s that are worthy of investigation. Ontario's transition to a market-oriented managed competition model, Saskatchewan's centralization and expansion of its home care program facilitated by cuts to acute care provision, and myriad evolutions to home care in Quebec, including the introduction of The Program of Research to Integrate the Services for the Maintenance of

[2] The Established Programs Financing (EPF) was a financing program created by the Pierre Trudeau government in 1977 to contribute funding to provincial healthcare and high-education systems through transfer payments. The EPF was combined with the Canada Assistance Plan into a block-fund fiscal arrangement in the 1996-1997 fiscal year called the Canada Health and Social Transfer.

Autonomy (PRISMA) all stand out. Other provinces made limited changes to their home care programs, and in some cases only scaled back existing frameworks. British Columbia and Manitoba are prime examples of this. However, a Canada-wide comparison of provincial home care programs is beyond the scope of this project. Instead, this dissertation will investigate a series of questions that emerge in observing this period of focused political attention to home care that occurred amidst broader health reform efforts that were underway in Ontario and Saskatchewan. This health reform movement began largely in response to fiscal pressures that emerged in the late 1980s and continued to impact provincial health policy decisions up to the early 2000s. As such, the first question that we are faced with is that, if home care suddenly became relevant to provincial policy actors in the context of a search for cost-saving, then why were the changes observed so distinct? This leads to a broader research question:

Research Question: *Why do subnational governments choose different strategies for home care in the context of broad health policy reforms when faced with similar constraints?*

Historically, home care programs have made up a small portion of provincial health care budgets, so it is possible that provincial governments sought to increase the proportion of health system funding dedicated to home care in the hopes of achieving cost savings in more expensive institutional forms of care. However, home care programs had also expanded rapidly in the years since their inception in the 1970s. Between 1975 and 1985, provincial spending on home care as a percentage of total public health expenditures among Canadian provinces grew from 0.65 per cent to 1.51 per cent (Health Canada, 1998). As such, it is also possible that provincial

governments might have seen the rate at which costs in home care were rising as a concerning trend that demanded government intervention to control future growth.

Indeed, from the late 1980s until the turn of the century, provincial governments were broadly concerned about the long-term sustainability of health care in Canada. It was a period which saw substantial provincial experimentation with reforms, most notably in widespread regionalization of health administration and service delivery. However, it is important to recognize that it was also a period where reforms were primarily couched in terms of cost-related concerns, with provinces scrambling to make up for revenue shortfalls introduced by the combined effects of reductions in federal transfers and recessionary circumstances. As such, the interest held by provincial governments at the time in home care would have been inevitably couched - at least partially - around either its potential to reduce health system costs or its existence as a program that could have cost control mechanisms introduced within it. As chapter 2 will demonstrate, it is this backdrop of the widespread need for health system cost-control measures among Canadian provinces during the study period that informs my hypotheses.

The study period culminated with the publication of two federal reports on the future of health care in Canada, one by a Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby (2001), and one by the Royal Commission on the Future of Health Care in Canada, led by the former Premier of Saskatchewan, Roy Romanow (2002). Despite both reports making strong recommendations in support of expanding home care programs in Canada, very little change to home care ultimately came in the wake of their publication. Indeed, despite the Kirby and Romanow reports inspiring the Prime Minister and

Premiers to sign onto both the *First Ministers' Accord on Health Care Renewal* in 2003 and *A 10-Year Plan to Strengthen Health Care* a year later – two health accords that committed to specific action on home care – very little change actually occurred to home care programs during that period (Health Council of Canada, 2013). This is why I have selected the late 1980s to early 2000s as the study period for my analysis, as it represents the most recent period where substantial changes to home care programs and their role within provincial healthcare systems occurred.

Ultimately, by studying the home care reforms that occurred throughout the late 1980s to early 2000s, this thesis assesses the potential for political change which places healthy ageing at the centre of discourse on health policy. Fast forwarding to today, the COVID pandemic has shaken much of the public's faith in LTC homes as a place to age healthily, with a recent National Institute on Ageing survey finding that 85% of Canadians of all ages, and 96% of those aged 65 years and older, "will do everything they can to avoid moving into a LTC home" (National Institute on Ageing, 2021). This has led to an increased interest in alternative modes of continuing care. Though reforming home care across the country represents only one facet of a larger series of changes needed to better address the needs of older Canadians, it is an integral piece of a system-wide approach that will ideally serve to emphasize the integrity, independence, and health outcomes of Canadian seniors by allowing them to age in the right place. This is the underlying motivation that drew me to research provincial home care policies here in Canada.

A Brief History of Home Care in Canada

One hundred years ago, receiving health care at one's home was commonplace in Canada. Indeed, in rural communities it was essentially the norm. General physicians who conducted their operations in these circumstances did so for little in terms of income, (typically they would charge patients a fee for service based on their perceived ability to pay) but were still able to derive much psychological satisfaction from the doctor-patient relationship (Goldbloom, 1963). With the modernization of healthcare came the venue shift from the home to the hospital. This transition, alongside the gradual introduction of public health insurance – via the Hospital Insurance and Diagnostic Services (HIDS) Act in 1957 and the Medical Care Act in 1966 – transformed healthcare across the country, culminating in the Canada Health Act in 1984. While the quality of care, as well as access to care and general quality of life in Canada has undoubtedly increased with the introduction of these publicly funded health measures, it is worth highlighting the transition that occurred alongside them which made hospitals the gateway to the Canadian healthcare system and physicians the gatekeepers.

The Medical Care Act and Canada Health Act were the last major changes to healthcare in Canada to occur at the federal level. They also served to entrench important dynamics of power within the healthcare system. Most notably, these Acts established hospitals and physician services as the core of Medicare in Canada. As a result, physician interests have been prominently entrenched in federal and provincial health policy dynamics, and the needs of acute care providers have historically dominated public and government health policy agendas.

At the provincial level, health care policies have continued to gradually change alongside the decline of the federal government's proportion of investment in health care (Boychuk, 2009). This has particularly been the case for forms of care not covered within the Canada Health Act, and home care has been a key example of this. Though all provinces have had some form of home care for over 100 years, provincially administered, publicly funded programs only emerged between 1970 (with Ontario being the first) and 1988 (with Nova Scotia being the last). Prior to this, home care – if available at all – was provided primarily by non-profit organizations like the Victorian Order of Nurses and the Red Cross via local/community programs or through local hospitals, and tended to focus on professional home nursing service and acute care (Health Canada, 2000).

The amount and/or value of services administered has always varied between the provinces. Some have opted to cap home care services based on monthly costs. Saskatchewan is one such example, along with New Brunswick, Nova Scotia, and the other prairie provinces. The other provinces opted for limits based upon the hours of service. Much of the variance between provinces in terms of cost/hour limits is based upon differing metrics. Ontario, for example, factors in the number of daily visits. Newfoundland uses a different metric of hours for seniors. Manitoba and British Columbia each factor in the patient's required level of care when determining monthly limits. The result is a system of public home care coverage that differs significantly between each province (Canadian Healthcare Association, 2009; Coyte & McKeever, 2001).

In the decades following the emergence of provincial home care programs, public investment in home care expanded rapidly as the Canadian population aged and demand for care outside of hospitals grew. As Matteo and Matteo (2001) note, between 1975 and 1985, per capita public home care spending in Canada experienced an annual growth rate of over 10 percent. This was followed by the emergence of a number of experiments with regionalization among the Canadian provinces in the 1990s, most notably in Saskatchewan and Quebec, which precipitated an almost uniform transition to regional home care services (Boychuk, 2009).

However, though public investment in home care expanded considerably throughout the 1970s and 1980s, there has been limited data collected on it until relatively recently. This has had a negative impact on the reliability of past analyses of provincial home care programs costs – particularly those assessing the cost-effectiveness of home care – as well as presenting a methodological challenge for this research. Specifically, there are three issues with the limited data that exists on home care funding in Canada. The first is that there is virtually no data available on provincial home care funding specifically, as all public home care funding reported by the Canadian Institute for Health Information (CIHI) and Health Canada, includes other public sector funding, including federal & municipal governments, social security, and workers' compensation board funds (see CIHI 2022a). This makes it difficult to pinpoint the exact impact of provincial government funding decisions on home care, as fluctuations in reported funding from year to year could have been impacted by changes made in multiple funding streams. Fortunately, however, data within one Health Canada report by Dumont-Lemasson, Donovan, and Wylie (1999) suggests that provincial expenditures on home care in Ontario and Saskatchewan made up virtually the entirety of public home care expenditures in each province,

at least by 1996. That said, it is not clear whether this reality was different prior to the federal government's cuts to established program financing from the 1980s to 1995 or after 1996.

The second issue with Canadian home care spending data is that, outside of the 1975-1996 data available in Health Canada (1998) and Matteo & Matteo (2001), the only other source of data on provincial home care funding is the Canadian Institute of Health Information (CIHI)'s yearly National Health Expenditure Trends publication, which, until 2012, did not separate home and community care funding into its own expenditure category, and instead included it within the category of "Other Health Spending: Net of HCC". This category includes expenditures on health research, medical transportation, hearing aids & other appliances/prostheses, and miscellaneous health care expenses. This limited the capacity of my research to investigate home care policy impacts on provincial spending beyond 1996, as the only provincial home care funding data for 1997-2012 available was bundled with other health expenditures, further diluting the reliability of spending data to reflect provincial action on home care spending specifically.

The third issue with Canadian home care spending data is the result of provincial variation in the definitions, mix of services, and funding sources across provinces. Each province has a distinct breakdown of how home care is defined (some distinguish it from other forms of community care, and others combine funding for home and community care programs), delivered (provincial ministries of health, community & social services, or even both may have jurisdiction over home care), and funded (the mix of public and private funding varies across provinces, as does the existence and rates of user fees), which further complicates the task of identifying complete and

accurate estimates for home care funding (CIHI, 2022b). As a result, the bulk of my thesis works with qualitative data, since the limited quantitative data on home care in Canada is plagued by issues that impact its validity and reliability for the purposes of comparative provincial analysis. That said, occasional reference will be made to tables I have provided in my dissertation's appendix, which present what little data is available on home care spending in Ontario and Saskatchewan.

Case Selection

Although every province in Canada has adopted some form of publicly funded model for home care, the (Canadian Healthcare Association, 2009) has identified four different service delivery models:

1. Saskatchewan, Manitoba, the northern Territories, Québec and Prince Edward Island use a public provider model, wherein the provincial/territorial government is responsible for both the administration and delivery of home care and home support services.
2. British Columbia, New Brunswick and Newfoundland and Labrador, use a mixed model, with professional care services delivered by public employees, but home support services are delivered by private agencies.
3. In Alberta and Nova Scotia, both public and private employees provide professional home care services; public employees provide the administration; and home support services are contracted out.

4. Ontario has used a unique system wherein Ontario Health employees coordinate all professional home care and home support services[3], which are then provided by private contractors.

These models suggest that there is a significant amount of variation between provinces in terms of how home care is provided, both at the level of administration and delivery. Further discrepancies exist between individual provinces in terms of care eligibility, including the varying presence of income testing, the exclusion of children from home care in some provinces, and service availability in rural versus urban areas (Canadian Healthcare Association, 2009).

Of primary interest to me in this project was the divergence seen in provincial governments' strategic policy trajectories for home care. However, knowing that comparing cases with distinct service provision models would allow me to determine the degree to which those models might have impacted the distinct policy reform decisions seen in each province, I chose to focus specifically on Ontario and Saskatchewan. These two provinces, in addition to their distinct home care service provision models and policy trajectories between the late 1980s and early 2000s, also experienced distinct instances of party control during this period. This allowed me to also test the degree to which political partisanship could have explained the policy trajectories observed in each province.

[3] This was previously done through Community Care Access Centres (CCACs), but the Local Health Integration Networks (LHINs) eventually absorbed the role in response to recommendations made by the Auditor General of Ontario in 2015 (see Lysyk 2015; Sheppard 2019). LHINs were then dismantled in 2019 and replaced by Home and Community Care Support Services (HCCSS) coordinators, which were then amalgamated into the province's new super agency, Ontario Health, in 2021.

In Ontario during this period, home care shifted from being a service covered by the Ontario Health Insurance Program (OHIP) to a strictly rationed system governed by market principles with the introduction of Community Care Access Centres (CCAC) as care coordinating bodies and a managed competition model regulating contract negotiation processes between the CCACs and non-profit & for-profit provider organizations in the province. Saskatchewan, on the other hand, moved to all but eliminate the contracting out of home care services to community provider organizations and centralize administration of home care under the umbrella of Regional Health Authorities (RHAs), as well as introducing a one-way funding lever to allow for unspent acute care budgets to be redirected to home and community care programs. These divergent home care reform trajectories in two provinces with otherwise similar institutional arrangements as subnational governments and economic circumstances during the study period form the locus of this paper's theoretical interest in home care policy change.

Policy Puzzles and Research Question

Considering the timing of the study period, there are two potential interpretations of the sudden interest in home care policy seen across Canadian provinces at the end of the 1980s. The first is that provincial governments sought to increase the proportion of health system funding dedicated to home care in the hopes of reducing costs incurred from a historical reliance on the institutional forms of care. The second is that provincial governments – having seen the rate at which costs in home care were rising as reason for concern – targeted home care as an area of health spending to limit future growth. The existence of these two opposing impressions of home care programs by provincial policy actors could potentially explain the difference in policy path seen in Ontario and Saskatchewan.

One potential explanation for the divergent home care policy paths taken by Ontario and Saskatchewan is represented by the differences in political party governance in each province throughout the study period. Saskatchewan and Ontario had distinct patterns of partisan control of government throughout the late 1980s to early 2000s. Indeed, Saskatchewan experienced only one shift from Conservative leadership to more than a decade of NDP leadership under Premier Roy Romanow from 1991 to 2001, and then his NDP successor, Lorne Calvert, from 2001 to 2009. Ontario, on the other hand, saw two significant shifts in governance – first with the Liberal government of David Peterson ending over 40 years of Conservative rule in 1985, and then with the province's first NDP government under Premier Bob Rae in 1990 – before the return of a Conservative government under Premier Mike Harris in 1995.

Although the political directions of party and government leadership among the provinces were distinct, as Graefe (2006) notes, the degree of similarity in terms of *policy trajectory* (i.e., trends in policy reforms taken during the period), particularly among Canadian social democratic governments during the early 1990s was "remarkable", and that social democratic ideology at the time experienced a shift in part due to the impact of "neoliberal federalism". Though Graefe's work examines social assistance policies, the trend of neoliberal federalism also applies to health policy changes that occurred in my study period. Indeed, just as federal governments of the period pursued strategies that limited opportunities for social democratic provincial governments to pursue progressive social assistance policies, so too did their cuts to provincial health transfers limit the options for health system reform among provinces in the 1990s (see Lazar et al. 2016).

As chapter 3 will demonstrate, even though three different political parties were in government in Ontario during the study period, the political trajectory for home care reform played out in a relatively consistent manner between governments. This makes the political situation in Ontario more like Saskatchewan than one might otherwise have suspected. Indeed, chapter 4 will further demonstrate how, even in circumstances of consistent governance by the social democratic NDP, fiscal pressures imposed by federal government cuts to provincial health funding worked to limit the potential for truly transformative change to the healthcare systems.

The overall lack of change in Ontario's political trajectory for home care from the beginning to the end of the 1990s suggests that partisanship does not sufficiently explain the distinct trajectory in home care policy change observed between Ontario and Saskatchewan during the study period. Indeed, despite Ontario experiencing three governments with significant differences in their general ideology and vision for LTC reforms, the home care reform choices that were ultimately implemented by each government were relatively consistent in terms of their attempts to reduce program expenditures. Though home care was at time the subject of partisan discussion throughout this period, this divergence between parties on home care was primarily focused on the relative mix of for-profit and non-profit delivery of care, not on the role home care played in terms of reducing health system costs.

It's important to note that provincial policy variation in home care is not inherently surprising, as such discrepancies between provinces is very much the norm in Canada due to its federalized governing structures. However, the variation in provincial home-care policies is interesting since provinces generally shared a concern with significant health funding shortfalls due to changes to

the federal transfer payment funding model, and during the study period all were searching for cost savings within their own healthcare systems. This makes the degree of divergence in terms of political strategies regarding home care among Ontario and Saskatchewan of theoretical interest, as it suggests health policy decision makers in each province held differing impressions of how home care could serve to address glaring issues of health system costs. By identifying the points of departure between the political goals of leading provincial parties during the study period, this project thus works to identify the sources of pressure that determined the divergent strategies pursued by health policy decision makers in each province. It also aims to shed light onto what motivates political actors to pursue retrenchment policies instead of program expansion policies, something that has long been a concern for retrenchment theorists (Starke, 2006).

Alongside shared concerns with health system costs, both Ontario and Saskatchewan's home care reform strategies were established during a period which saw substantial convergence in health system reforms more generally across the country, particularly in terms of decentralizing decision-making authority to regional governing bodies. Many provincial health care commissions and task forces assembled during this time recommended decentralizing decision-making in health care systems to local or regional bodies (Angus, 1991). Indeed, as Matre & Deber (1992) note, regionalization was recommended almost universally by provincial commissions and task forces convened in the 1980s across the country to chart new direction for health care in the following decade.

Saskatchewan was among the first to commit to this process of regionalization in 1992, alongside PEI and Manitoba. British Columbia was the last province to do so in 1997. At the same time, Ontario developed regional authorities for the specific purpose of regionalizing home care. Though it did not follow through with a full process of health care regionalization until 2005, Ontario did establish Community Care Access Centres (CCACs) in 1997, which functioned similarly to regional health authorities in other provinces as far as the provision of home care was concerned. As such, Saskatchewan and Ontario can both be said to have developed regional health authorities responsible for the administration of home care services, as well as developing needs-based funding models within them. They differed, however, in terms of the degree to which regionalization represented a policy tool for the purpose of home care reforms. While CCACs in Ontario were specifically implemented to introduce changes to home care administration and governance protocols, Regional Health Authorities (RHAs) in Saskatchewan were introduced facilitate a system-wide overhaul of health service administration, of which home care represented only a piece, albeit an important one for the government at the time of implementation.

Though there was widespread agreement among provincial commissions and task forces across Canada that regionalizing health systems was an effective strategy for health care reform at a time when fiscal pressures were rising, the actual approaches undertaken by provinces differed substantially (Church & Barker, 1998; Lewis & Kouri, 2004). Regionalization in Ontario, as noted above, was limited to home care, with a full rollout of regionalized health care not occurring until 2005. Saskatchewan undertook an approach to regionalization that was far more typical of provinces in the 1990s, fully integrating its healthcare system through newly established

Regional Health Authorities (RHAs) that coordinated care between all elements of the health care system as part of a shift from "illness" care to "wellness" services (Marchildon, 2005b). Regionalization thus represented a policy tool available to policymakers in each province that could be flexibly implemented in different ways to achieve different health reform goals. It is therefore important to understand regionalization in the context of provincial home care policy reforms, as Ontario and Saskatchewan's approaches to regionalization represented key manifestations of government divergence in reform strategies.

Considering that regionalization of home care programs in Ontario and Saskatchewan occurred within a 5-year window (1992 in Saskatchewan and 1997 in Ontario), as well as the shared goals of cost-cutting and improved efficiency prior to regionalization, it is surprising that there was not a greater degree of home care policy convergence within the regional models adopted by each province. Indeed, even though CCACs in Ontario did not meet Lewis and Kouri's (2004) definition of a regionalization model,[4] as chapter 3 will further demonstrate, they were implemented to achieve many of the same goals that Saskatchewan RHAs sought, including the integration of services, improving accountability, increasing service quality, and transitioning to a needs-based service model. That said, CCACs and RHAs had very distinct goals for home care, with the former ultimately being a mechanism to allow for increased control over program costs and the latter

[4] It is also worth noting that the only core feature of a regionalization example not shared by CCACs is their lack of responsibility for a "range" of health services. They otherwise meet the remaining criteria: being defined by geography, existing at the pleasure of the provincial government, and consolidating authority previously distributed more locally.

partially serving as a means of allowing for more resources to be diverted from acute care to home care.

It is ultimately this key difference between the regionalization strategies of Ontario and Saskatchewan that serve to demonstrate the distinct paths each province took regarding home care. Chapters 3 and 4 will show how the distinct regionalization mechanisms utilized by Ontario and Saskatchewan were implemented to achieve divergent goals of reducing rates of increase in home care spending (in the case of Ontario) versus increasing the proportion of total health system funding that went toward home care (in the case of Saskatchewan).

Research Contribution and Goals

This dissertation seeks to investigate the institutions, ideas, and interests that influenced the distinct home care policy trajectories taken in Ontario and Saskatchewan through the analysis of government communications and reports alongside interview data from conversations with decision-makers and stakeholders involved with and/or impacted by the policy changes pursued in each province. It ultimately seeks to understand why home care played different roles in provincial health system reforms in Ontario and Saskatchewan, and how regionalization tools were implemented in each province to facilitate the divergent strategies for home care reform.

The primary goal of this research is to explain some of the variation that exists between home care programs among the Canadian provinces. In doing so, it will serve to fill gaps in the literature on home care in Canada. Much of the work that has been done analyzing home care policy change in Canada has been undertaken in the form of single-province case studies. While

these studies are useful to expanding our understanding of policy change in subnational governments – indeed, many case studies of home care in Ontario (see especially Abelson et al. 2004; Aronson, Denton, and Zeytinoglu 2004; Baranek 2000; England et al. 2007; and O'Connor 2004) inform my background understanding of home care's reform trajectory in chapter 3– they do not help us to understand the many observable differences in how health policies have evolved across Canadian provinces.

In terms of comparative analyses of home care in Canada, a recent systematic review of home care for elderly Canadians undertaken by Shanthi Johnson and colleagues identifies significant research gaps. The paper found "an imbalance in the source province/territory for much of the literature related to home care", with half the comparative studies focused on Ontario, followed by Québec and British Columbia, and no research even meeting the review's inclusion criteria from Newfoundland, Prince Edward Island, Saskatchewan, or the territories (Johnson et al. 2018). Most notably, none investigated home policy change dynamics that existed between provinces.

Indeed, beyond broad acknowledgements of there being a number of different funding and administration models, as well as policy differences in terms of data collection, service limits, the use of income testing and/or user fees and the requirement of a physician order in certain jurisdictions (see Canadian Healthcare Association 2009; Shapiro 2002), little work appears to have been done in terms of improving the understanding of why home care policy differences exist among the provinces. The only specific examples of analyses investigating distinct home care policy trajectories between Canadian provinces are Jenson and Phillips' (2000) and Jetté

and Vaillancourt's (2011) works, both of which compare home care policy change in Ontario and Quebec.

While these works both present interesting demonstrations of distinct policy trajectories between these two provinces, their specific focus on the relative roles of the state and volunteer sector in home care delivery and how policy changes impacted them reveals only one piece of the broader puzzle surrounding distinct provincial trajectories in home care policies. Though the involvement of the volunteer sector is relevant to the discussion of provincial home care policy trajectories, as my chapter investigating Ontario further demonstrates, it alone cannot explain the divergence seen between Ontario and Saskatchewan. Also, the fact that the only two comparative analyses of home care policy change that exist investigate the same provinces further demonstrates the knowledge gap that exists in this research area. My decision to compare Ontario with Saskatchewan will therefore allow for my work to expand our collective understanding of causality regarding inter-provincial differences in this policy area.

Addressing these gaps in our broader understanding of home care policy will also provide insight to policy makers and scholars interested in the potential for future reform to home care at the provincial and federal level. Indeed, an understanding of the political and administrative issues seen in different provinces regarding the delivery of home care services can and should serve to inform future policy decisions, particularly if there is a long-term goal of incorporating home care services into the Canada Health Act, as has been recommended since the days of the Commission of the Future of Health Care in Canada (Romanow, 2002). Prior to his reelection in 2019, Prime Minister Justin Trudeau promised to invest in home and community care as part of a

$6 billion commitment to public health care (Liberal Party of Canada, 2019). Though much of this largely back-ended funding has yet to fully materialize, recent negotiations made between the federal and provincial governments to increase the federal share of health system funding have been predicated on a requirement that a portion of the funding go towards bolstering and improving access to publicly funded home care services. While this represents a far cry from the national strategy for home care that has been recommended for decades, it still stands as a promising development for home care. It is my hope that the results of this study could thus serve as a point of discussion for future attempts to determine what strategies for health system reform can most effectively ensure home care is able to fulfill the role it is meant to have in maintaining population health.

The remainder of the thesis is organized as follows. Chapter two provides a review of the literature and theoretical perspectives underpinning my research as well as outlining my methodology. It also gives context into what makes provincial homecare policies so distinct, traditional understandings of why retrenchment policies are enacted, and the significance of health system regionalization in the Canadian provinces as mechanisms for the implementation of government health reform goals, as well as outlining my core hypotheses.

Chapter three focuses on the evolution of home care policies in Ontario, from their inception in the 1970s to the managed competition model introduced by Premier Mike Harris in the mid-1990s. It demonstrates how three successive governments, despite being run by different parties pushing for distinct forms of LTC policy change, each found themselves converging on a reform agenda influenced slowly but surely by an increasing perception of need to offload home care

program costs onto regional administrative bodies. It goes on to discuss the impacts of the Harris government reforms and how the combined effects of broad health system retrenchments, competition between private sector and non-profit home care providers, and delays in reinvestments from the acute care sector into home care led to difficult outcomes for the home care space in the province.

Chapter four looks at home care policy change in Saskatchewan and its role in the broader shift towards a healthcare system emphasizing a health promotion agenda in the province. It demonstrates how the NDP government under Premier Roy Romanow navigated historic recessionary circumstances and public vilification for its closure of rural hospitals to attempt to make home and community care programs play a more pivotal role in health promotion and illness prevention in the province's healthcare system. It further demonstrates how fiscal and public pressures ultimately held back the potential for home care to play a significant role in the province's health system going into the 21st century, with the Calvert government ultimately abandoning most of the ambitious reform goals established by its predecessor in favour of a more moderate approach to reform that made little attempt to challenge the status-quo placement of acute care at the center of health policy discussions.

Chapter five discusses my findings and draws parallels between the state of home care in Canada at the start of the study period and present day, before presenting my conclusions on what can be learned from this research about home care policy change and how those lessons can be applied to Canadian health care reforms in the wake of the COVID-19 pandemic. A key takeaway from this analysis of home care policy trajectories in Ontario and Saskatchewan is that provincial

governments that are serious about improving home care programs need to be willing to reduce their health system's reliance on institutions via resource transfers from acute care to home care. Perhaps most crucially, they must also be willing to accept the negative political consequences that could result from that decision and be willing to see through a reform agenda that prioritizes the prevention of illness in favour of illness treatment. Until policy decision makers – and ideally also the general public – are sufficiently motivated to stay the course in changing healthcare systems to emphasize the provision of care close to home, home care will likely continue to be the poor cousin of acute care within provincial health systems.

Explaining Provincial Home Care Policy Change: Theories and Approaches

What do we know about Provincial Home Care Policy Change?

My interest in home care policy changes in Ontario and Saskatchewan is informed by the distinct reform directions taken by the two provinces and what this variation can teach us about subnational health policy variation more broadly. In Ontario, we observe the pursuit of cost-savings in health care leading to retrenchment in home care policies. This began with the removal of the Home Care program from OHIP coverage in 1995 and continued with the offloading of administration and funding responsibilities onto regional governing bodies in the form of Community Care Access Centres (CCACs) in 1997. In Saskatchewan, we instead see the pursuit of cost-savings in health care through a tradeoff of expanding home care via cuts to acute care, specifically through centralization via the introduction of Regional Health Authorities

(RHAs) in 1993 and the introduction of a global funding pool for all health services[5]. This allowed the government to introduce a one-way funding provision that allowed RHAs to take funding from acute or long-term care and apply it to home care, but not vice versa. The goal of this thesis is to explain why Saskatchewan and Ontario chose these distinct strategies for home care reform when faced with similar constraints and to investigate the relative role institutions, ideas, and interests played in determining the home care policy paths taken in each province. To do so, we need to first consult the literature that exists on home care policy change within Canadian provinces.

Analyses on home care policy change in Canada are limited, as noted in the previous chapter. They tend to fall into one of three categories. The first category includes the large-n analyses published in reports by national agencies and organizations such as the Health Council of Canada (2012) and the Canadian Healthcare Association (2009). It also includes a more recent environmental scan by the Saskatchewan Population Health and Evaluation Unit (S. Johnson et al., 2017). These analyses provide primarily quantitative comparisons of home care program outcomes across Canada, drawing attention to distinctions between provinces in demographics served by home care and raising concerns around patient accessibility, the working conditions of service providers, and a general need for more federal leadership and funding (Canadian Healthcare Association, 2009; Dumont-Lemasson et al., 1999; Health Council of Canada, 2012; S.

[5] Health system funding among Canadian provinces had historically been parceled out into separate pools for acute/emergency health care (i.e., services regulated by the Canada Health Act) and other services. The number of pools varies between provinces, but acute care has always had its own pool in Ontario and Saskatchewan up until Saskatchewan's health system regionalization.

Johnson et al., 2017; Le Goff, 2002). While these studies provide a valuable empirical assessments of home care programs across Canada – as well as outlining differences that exist between provincial programs – they do not focus on causal analysis or attempt to explain how the home care policies that exist in Canada came to be, nor do they explain why the differences between provinces came to exist.

The second category includes small-n analyses that compare a sample of Canadian provinces' home care programs. This represents the smallest category of Canadian analyses of home care, and it has tended to focus on Ontario, Quebec, and British Columbia, but is generally lacking focus on home care policy *development*. The main exception is Jenson and Phillips, (2000) comparison of home care policy directions in Ontario and Quebec, as noted in the Introduction chapter. This article provides a more detailed history and comparison of home care policy trajectories than any other research on the topic to date, albeit one built primarily on a review of existing literature that is focused mainly on how home care policy changes impacted the non-profit sector. Jenson and Phillips' (2000) finding that health care restructuring efforts of the mid-1990s were "driven in large part by financial goals" and that the actors, institutions, and ideas in play between the two provinces were distinct, despite the similar policy direction that had been identified across jurisdictions going into the 1990s, were similarly identified in my own research, as will be demonstrated in later chapters.

Another entry to the small-n analysis category is Willson and Howard's (2000) analysis on the effects of health care privatization on women in Manitoba and Saskatchewan. Though home care plays a more peripheral role in this piece, as the analysis provides more of an overview of health

policy change in both provinces more broadly, it does focus on a similar study period to this project. However, the paper's lack of attention to home care policy development prior to the reform period also limits its capacity to distinguish policy trajectories in either province it studies. More broadly, the focus of its comparison is to identify similarities between its two case studies for the purpose of demonstrating the impacts of policy changes that have privatized the delivery of healthcare in both jurisdictions on female formal and informal caregivers. This project, on the other hand, is less focused on current impacts of policy change on a particular group, but on the historical context of home care policy change and how it explains current program arrangements.

However, neither of the above examples of the small-n analysis group of analyses seek to achieve what my project set out to do, which was to conduct an in-depth, comparative analysis of two institutionally similar provinces with distinct home care policy trajectories to explain their unique policy decisions. Other small-n analyses of provincial home care have compared adverse events and home care worker job satisfaction, which offer important contributions to current understandings of interprovincial distinctions in terms of home care policy outcomes (Blais et al., 2013; Panagiotoglou et al., 2017). However, as Johnson et al. (2018) note, considerable knowledge gaps exist in this area, particularly outside of Ontario, which is analyzed in over half of existing home care studies.

The third category of Canadian home care analyses is composed of single-n studies. This category is the most diverse of the three, though it is still one that is underrepresented by analyses of policy development in specific provinces. Of the 50 studies included in the systematic

review of home care analyses conducted by Johnson et al. (2018), 40 were single-case analyses, 22 of which took place in Ontario. These studies were primarily focused on home care clients, nurses, case managers, and support workers, with no notable analysis of policy development included within them. The studies that have investigated provincial home care policy development are few and far between, as well as sharing the issue of a provincial coverage gap with other small-n analyses, with most studies looking at Ontario, and none which investigate the Prairie or Atlantic provinces (see Johnson et al. 2018). However, those that have been conducted present important insights that have helped inform the analysis undertaken in this thesis.

There is a consistent retrenchment narrative in provincial home care policy analyses. Analyses of Ontario and British Columbia show a gradual but systemic retreat of the state from the provision of home care beginning in the mid-1990s and continuing into the early 2000s, which had negative implications on home care recipients, their unpaid family carers, and the formal workers within the sector (Aronson & Neysmith, 1996, 1997; Sharman et al., 2008). On the other hand, one analysis of home care policy development in Quebec by Jetté and Vaillancourt (2011) observed an expansion of home care in the mid-1990s with the introduction of domestic help social economy enterprises which saw an expanded role of the Quebec state working alongside existing third sector service providers in home support service delivery. However, the paper also noted a curtailing of the expansion of state involvement in the home care sector during the early 2000s, demonstrating an eventual return to the status quo of state retrenchment from home care.

The most in-depth analysis of Canadian home care policy development is Patricia Baranek's (2000) thesis examining community based long term care reform in Ontario more broadly, the content of which forms the base of her 2004 book *Almost home: reforming home and community care in Ontario*, co-authored with Paul A Williams and Raisa B. Deber at the University of Toronto's Department of Health Policy, Management, and Evaluation. Following the same institutionalist approach and investigating a similar time period to this analysis, Baranek's work tracks the development of community LTC policy in Ontario from 1985-1996. Baranek's findings serve as a valuable frame of reference for my analysis of home care policy development in Ontario, particularly when it comes to verifying the account of home care policy development under the Liberal government led by David Peterson and the NDP government led by Bob Rae. However, as chapter 3 will demonstrate, there is much to be gleaned from the home care policy trajectory in Ontario by looking even a few years beyond the time period analyzed by Baranek, an opportunity explored by my dissertation, which more deeply investigates the impacts of the policies implemented by Mike Harris' Conservative government on provider organizations. Though O'Connor's (2004) work provides useful context for the reform period that follows the timeline analyzed by Baranek, the added comparative element introduced by this analysis allows for my project to meaningfully build on the important contribution to the topic of community health policy development by these scholars.

Theories of policy change

With the knowledge gap in understanding home care policy change identified, the next step is to unpack current understandings of policy change more broadly. Policy change is generally broken down into two categories: radical change; and gradual or incremental change. Radical policy

change has historically been encapsulated within a 'punctuated equilibrium' model characterized by extended periods of stasis being sharply and suddenly disrupted by some form of exogenous 'shock' that would allow for potentially more radical policy reconfigurations (Jones & Baumgartner, 2012). These exogenous events historically were presented as the sole means by which thoroughly path-divergent changes could emerge, establishing 'critical junctures' at which opportunities to set new policy precedents materialize (Pierson and Skocpol 2002; Thelen 1999). Without the presence of exogenous shocks, institutions - including policies - were perceived as being subject to increasing returns from existing institutional arrangements. As Pierson (2000) argues, a process of increasing returns entails that "the probability of further steps along the same path increases with each move down that path. This is because the relative benefits of the current activity compared with other possible options increase over time". This notion of "positive feedback" encourages institutions to remain generally stable. Thus, exogenous events have traditionally been presented as the sole means by which thoroughly path-divergent changes could emerge, establishing 'critical junctures' at which opportunities to set new policy precedents materialize.

However, the focus on exogenous events by theories of radical policy change downplays the intricacies of policy feedback mechanisms. External shocks are inherently difficult for actors to predict or prepare for. In addition, while positive feedback mechanisms can at times facilitate path dependent processes, it is important to note that they do not necessarily guarantee that events will follow a particular path. Though early events are the most important in a sequence, actors in path dependent scenarios still possess agency and the ability to steer later events toward a preferred endpoint. It is also important to consider that the incentives that motivate

actors may not necessarily align with the incentives that are generated by positive feedback mechanisms. Political actors may be motivated by their own ideas and beliefs concerning policy (Jacobs 2009) or may have/represent interests that conflict with decisions that one would otherwise expect them to make due to policy feedback. They may subsequently be highly motivated to push for path-diverging changes despite the positive feedback processes associated with path dependent outcomes (Streeck and Thelen 2005).

Generally speaking, policy decisions that are part of social policy retrenchment agendas (i.e. goals related to reducing the amount or rate of increase in state funding and/or responsibility for a particular program) are considered to be quintessential examples of decisions that positive feedback processes are expected to protect against (Pierson, 1993, 1996; Starke, 2006). However, many health policy decisions that occurred during the study period under investigation in this project were part of a systemic retrenchment agenda from federal governments (Graefe & Bourns, 2008) and most Canadian provinces (Lazar, 2009). This was largely a response to the fiscal crisis that was being experienced across the country at the time, one which also largely served to inform widespread provincial interest in health system regionalization mechanisms.

Within the context of Canadian home care policy and regionalization, it can be argued that the sudden cutbacks in federal funding to provincial health programs beginning in the mid-1980s - alongside the burgeoning deficit of the early 1990s- constituted an exogenous shock to the provinces. What can be observed in the wake of these changes, however, is not wholesale radical policy change among the provinces, certainly not to home care. Instead, a patchwork of new policies emerged throughout the 1990s among the provinces in the context of

regionalization. Human agency is also an important variable to consider here, particularly that of policy actors like politicians and bureaucrats, as the occurrence of an exogenous shock does not necessarily entail a subsequent radical change in policy, only the opportunity for actors to bring it about. Action requires the involvement of policy entrepreneurs capable of seeing an opportunity for change and who stand to gain from pushing for path-diverging reforms (Kingdon, 1995). Katznelson (2003) further argues that agency within institutions becomes increasingly relevant in 'unsettled' times, which can create circumstances wherein policy entrepreneurs can aggregate and form collective internal pressure to alter institutions. Therefore, the cuts to federal funding of provincial health programs could be seen as providing provincial political actors the opportunity to become agents of change, either individually in the way that Kingdon suggests or through coalition building per Katznelson.

However, Katznelson's focus on political agency in turbulent times is still based upon the assumption that these instances of instability will necessarily lead to path-breaking policy shifts. It is also possible that, even in circumstances where path-breaking opportunities for policy change become present, agents would simply choose to follow the status quo, or make only small adjustments to existing policy. This was essentially the case in my own analysis, as neither of the cases I selected to investigate involved instances of substantial, path-breaking home care policy shifts during the period of study, despite there being an opportunity available for reformists. Indeed, with the need for health system changes amidst the fiscal crisis that occurred during the study period and the availability of a flexible policy tool in regionalization many historical institutionalist theories would suggest there was a ripe opportunity for significant policy change to occur in home care. However, what we observe instead was a redirection of

existing home care policies to meet new policy goals that became prevalent during the 1990s and which varied between provinces in terms of the direction of change taken. This is significant because it demonstrates that *policy reform* opportunities do not necessarily represent *political* opportunities for policy actors.

However, these observations are not made to suggest that agency has no role in my analysis of home care policy change. Indeed, agency is very much a prerequisite for policy change in the cases I analyze, and Ontario and Saskatchewan present distinct contexts for policy actors in government and among stakeholder groups to exercise agency during the study period.[6] However, it is not an explanatory variable when it comes to the distinct paths of home care policy change in Ontario and Saskatchewan. Part of this is due to the lack of coalition building dynamics observed that would otherwise be expected by more sociological institutionalist frameworks to determine the policy direction taken in either province. Emmenegger (2021), for example, presents a "coalitional" perspective of institutional/policy stability, creation, and change that situates agency within an actor-centered context of coalition building. Emmenegger argues that institutions/policies "are both supported and challenged by social coalitions", in that a coalition of defenders of a particular institutional status quo can actively prevent change from

[6] As Chapter 3 demonstrates, Ontario had 3 different governments in power (Liberal, NDP, then Conservative) over the course of the study period. Home care in the province was also a policy space in which stakeholder groups (namely community provider organizations) had the agency necessary to mobilize to influence policy change. This mix of agency dynamics was quite distinct from that of Saskatchewan, which – as Chapter 4 demonstrates – was run primarily by the NDP, who did not have to contend as much with organized opposition to its health reform agenda.

occurring but can also be successfully challenged by opposing social coalitions, particularly during critical junctures where institutional constraints are weakened by exogenous events.

However, though Chapter 3 discusses the presence of some short-term coalition building among home care provider organizations in Ontario to oppose policy changes pursued by the NDP government, these efforts ultimately only delayed their implementation. While the subsequent election loss of the NDP to the Conservatives led to a different set of policies being implemented which were seen as less problematic to the provider coalition, these changes were ultimately not implemented through providers' influence on the Conservative party as much as the government's own reform agenda. In Saskatchewan, meanwhile, there was no coalition that could be identified as being built for the purpose of influencing policy change.

Based on these dynamics observed in my research, the sociological institutionalist framework is therefore less applicable in the context of my analysis for explaining the distinct paths for gradual home care policy change undertaken in Ontario and Saskatchewan. However, it does reaffirm the importance of agents of change having momentum behind them in their push for specific reform goals for those goals to be achieved. As later chapters will demonstrate, though the initial reform directions of Ontario and Saskatchewan were distinct, the end state of home care programs in each province were similar in that they both returned to occupying a position of relatively low salience in each province's healthcare system. While meaningful differences between Ontario and Saskatchewan's respective home care programs continue to exist today - particularly in responsibility for the delivery of care and the labour conditions for personal support workers - both programs fell into political obscurity from the early 2000s up until the

COVID-19 pandemic. This result can ultimately be tied to a lack in the momentum required to facilitate the necessary changes to home care programs by health reformists in both provinces throughout the study period. While it does not explain the different home care policy choices I observe, the agency of health reformists in the context of the fiscal crises experienced by Ontario and Saskatchewan still represents an important secondary variable in understanding how home care programs found their way onto health reform agendas in each jurisdiction in the first place. After all, it is not enough for policymakers to have ideas about how home care programs should be reformed. They must also be afforded sufficient opportunity to see those ideas implemented in practice for a reform agenda to be pursued.

A more compelling theoretical background for agency in my analysis is the constructivist institutionalism presented by Hay (2011). Rather than situating policy actors' power within a schema built primarily upon their potential to form coalitions, Hay's constructivist understanding of agency is built first on the contextual circumstances established by existing institutions, which in turn influence the ideas space, within which perceptions of interests are developed and held by policy actors. Hay's notion of actors' decisions being manifested through perceptions of interests is key, as it moves away from rational, material understandings of interests which portray them as simple, logically derived, naturalistic reflections of the context in which the actor is located. Instead, actors' behaviours are informed by perceived interests, which are internally constructed but also subject to external forces of persuasion and manipulation.

The perceived interests of actors can therefore be distinct from the "real" or material interests determined by the context (i.e. institutional environment) in which an actor operates (Hay,

2011). This is particularly relevant when it comes to situating the interests of political decisionmakers involved with home care in my analysis, as there is little electoral benefit to be gained from home care reform due to the tangible results of investing in home care being limited in comparison with the construction of hospitals and/or long-term care homes. This was most evident in the context of health reform in Saskatchewan, where the tradeoff of converting 52 rural hospitals to community health centres to transfer financial resources from acute care provision to home and community care provision was devastating for the NDP's support among rural voters (Eisler, 2022; MacKinnon, 2003a). However, as my analysis of Ontario and Saskatchewan also demonstrated, policy actors are capable of perceiving interests associated with home care reform in certain contexts (namely, a fiscal crisis in healthcare). As (Béland, 2009) further argues, the contextual environment informs policy actors' perceptions of their interests through ideational processes.

This constructivist understanding of actors' interests and ideas necessitates the deep process tracing undertaken in my analysis, as the motivations that inform actors' behaviour can thus not be inferred through simple observation, but instead gleaned through interviews with policy makers themselves. It also suggests a hierarchical structure in terms of the sequential role played by institutions, ideas, and interests in determining home care policy change. This structure to my theoretical framework places the institutional power of policy legacies (defined later in this section) at the top, due to their preliminary role in establishing the context for potential change as well as the stakeholders who become interest groups whose existence become tied to the success and expansion of the home care program and are therefore committed to protecting their role within it (Marier, 2015). In this framework, policy legacies are

distinct from institutions in the sense that legacies emerge as a result of institutions becoming embedded.

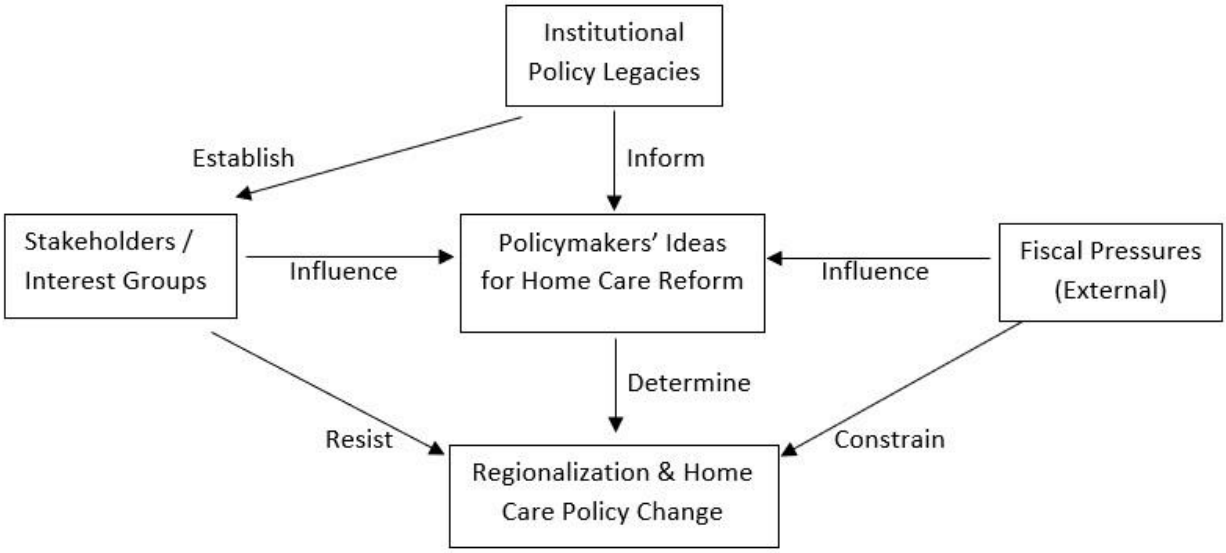
The key determinant of whether institutions become entrenched and establish policy legacies is the resource investment involved in establishing the institution. Resource investment matters because the funding that goes into implementing institutional changes cannot be recovered, they are sunk costs. As such, the greater the investment made into a particular institutional approach or policy path, the more governments are incentivized to see that approach fully implemented – or are discouraged from investing in a costly alternative path. Furthermore, as Pierson (2000) notes, institutions establish learning and coordination effects that are built around the initial investment, as well as adaptive expectations which serve to reinforce the stability and continued development of those institutions. Therefore, the most important institutions in my analysis of home care policy in Ontario and Saskatchewan - i.e. the ones that established policy legacies in each province - are those which had an identifiable impact on program funding trajectories and the recipients of that funding. In Ontario, these included the inclusion of home care within OHIP and the subcontracting of home care service delivery to private, for profit and nonprofit organizations. In Saskatchewan, they included the centralization of service delivery by the state and early introduction of means testing and user fees into home care.

Ideas - and the policy decisionmakers who hold them - are placed in the centre of the framework, constructed as they are through the combined influence of multiple variables, including policy legacies established by institutional contexts and external variables such as the

presence of fiscal crises (Hay, 2011). Though distinct from policy legacies - which I classify as institutional variables - ideas in my analysis take hold in the mind of policymakers first through the influence of entrenched policy legacies. This framing of ideas as being largely conditioned by policy legacies is reflective of a broader observation that although novel or innovative ideas regarding health may inspire research and bureaucratic initiatives within health minstries and departments across Canada, they tend to struggle with challenging institutional norms within healthcare systems in the long term, and have not had an identifiable impact on the actual health of Canadians over time (Lavis, 2002; Lazar et al., 2016).

Policymakers' ideas are also informed by interest groups, who are situated parallel to ideas due to their similar emergence from previously established policy legacies. In the case of my chosen study period, significant fiscal pressures incurred by poor economic conditions in Canada also had an influence on policymakers by constraining the availability of policy options available, particularly when it came to program expansion. This combination of ideational sources in turn worked to influence the mechanisms and characteristics of home care policy change observed in Ontario and Saskatchewan. That said, as this thesis will demonstrate, the ideational content that was most important to the development of home care during the study period was its status as either a cost driver or an efficient investment vehicle to reduce health system costs. Whether one or the other of these divergent ideas took hold in the province being investigated was primarily determined by legacies established by previous home care policies that determined cost trajectories for the programs in place. My hypothesized framework can thus be presented as follows:

Figure 1: Theoretical Framework



The remainder of this chapter focusses on expanding discussion of institutionalist literature on the 3 'I's of institutions, interests, and ideas. Applying this "3I" framework to my analysis echoes similar strategies used in other cross-provincial analyses of health policy change, such as those of Baranek 2000; Lazar et al. 2016; Lavis, Ross, and Hurley 2002; Lavis et al. 2012. My project makes a similar attempt to investigate the relative influence of institutions, ideas, and interests on home care policy trajectories in Ontario and Saskatchewan built on a constructivist understanding of institutionalism promoted by Hay (2011). As will be demonstrated throughout the dissertation, there is a sequential hierarchy among the 3Is in how they impact policy change in the cases I am analyzing, with Institutions (represented by policy legacies) being situated at the top of the chain of influence, and Ideas and Interests serving as intermediaries between the

historical impact of policy legacies and the actual policy change mechanisms implemented by policymakers.

To understand the distinctions between provinces in terms of home care policy change, my framework proposes that we start with an investigation of policy legacies, which both informed the ideas for home care policy reform held by policymakers and established the relevant stakeholders and interest groups involved in the decision-making process. Policymakers – armed with ideas based on the legacies established by the earliest home care policy decisions and then influenced both by fiscal pressures and stakeholders/interest groups – subsequently pursued their vision for home care policy change through regionalization, which served as a flexible mechanism for meeting a range of policy ends. The implementation of regionalization and home care policy changes in each province were in turn resisted by stakeholders and interest groups involved with the existing home care institutions (particularly in Ontario) and constrained by the ongoing fiscal pressures prevalent in each province throughout the study period.

My framework thus reflects a key notion of historical institutionalism: that the sequence of events matters (Arthur, 1989; Hacker, 1998; Mahoney et al., 2009; Pierson & Skocpol, 2002). The legacy of early choices about home care spending shapes policymakers' ideas about the programs and interest group beneficiaries. Policymakers are also influenced by other external pressures, notably, the fiscal pressures that existed during the study period via the economic circumstances and federal funding decisions, as well as those imposed by interest groups utilizing coordination effects to maintain the existence of institutions they benefitted from. The goal of this analysis is thus to assess the degree to which this framework of home care policy

change is accurate, as well as to understand the influence that the variety of institutions, ideas, and interests had on the home care policy trajectories observed in the provinces being studied.

Institutions and the Power of Policy Legacies

As discussed in the previous section, policies, once enacted, tend to create positive feedback effects that increase the longer they remain enacted (Mahoney and Thelen 2009). Positive feedback mechanisms may refer to any features that provide incentives or resources for interest groups, government elites, or mass publics to act on. These incentives and/or resources can – for better or for worse – encourage actors to "lock in" policies to establish path dependency (Pierson, 1993). In essence, they serve to gradually increase the costs associated with divergence from a particular set of policies or institutions over time by increasing the positive incentives associated with maintaining the institutional status quo (Pierson, 2000).

In the case of home care policy legacies, the positive incentives associated with the status quo are most visibly demonstrated by the example of the subcontracting of services to provider organizations in Ontario. These provider organizations benefit from having access to government funding that subsidizes their delivery of home care services. The early choice to fund particular providers makes them increasingly powerful veto players as their market share and power within the existing institutional arrangements grows over time, increasing the potential costs for governments to attempt to change those institutional arrangements in a way that would redirect or remove funding from groups who initially benefitted.

Path dependency also increases the predictability of outcomes, causes early events in a sequence to be more difficult to cancel out, and leads to potential path inefficiency in that 'increasing' returns would not necessarily entail 'better' returns (Arthur, 1989). Pierson (2000) also adds a point of particular relevance to policy analysis, namely that these are processes "in which sequencing is critical. Earlier events matter much more than later ones, and hence different sequences may produce different outcomes."

When it comes to provincial home care programs, I define policy legacies as the institutional effects of policy decisions made in the early stages of program development, which increase over time via temporal feedback effects established through the learning, coordination, and adaptive processes of stakeholders (see Pierson 1993). This conceptualization of policy legacies reflects similar framings by Béland (2005) and Marier (2015), who both speak to examples of the initial adoption of policy or formative moments of program development that establish feedback effects which influence later policy decisions. Specifically, if institutions generally represent the rules and administrative arrangements associated with a particular program, then policy legacies represent the institutional trends and norms that emerge and become entrenched as a result of those rules and regulations. Using the subcontracting home care services to community organizations in Ontario as an example again, over time, the entrenchment of these organizations as providers meant that any attempt to disrupt their role in service delivery would create both political fallout (in the form of public pushback from those organizations and their supporters) and administrative issues (such as those regarding care worker employment and continuity of care). Pierson (2000) refers to these feedback mechanisms associated with policy legacies as coordination effects.

As such, since the formation of policy legacies occurs prior to the establishment of the stakeholders/interest groups and ideas they inform, policy legacies represent the most important variable in understanding later policy decisions. In addition to the significant costs associated with early policy decisions made as home care programs were established, the gradual entrenchment of those institutional rules and norms underlying provincial home care programs increased their influence, establishing policy legacies. These policy legacies in turn built up positive feedback through coordination effects facilitated by the beneficiaries of those entrenched policies. These processes of establishment and entrenchment for certain policy legacies and their associated beneficiaries also worked to restrict the opportunity for opposition to mount against them due to the high costs associated with starting up and organizing efforts to compete. As Pierson (1993) notes, the significant barriers that limit the ability for organizations seeking to change policy to compete with established organizations that benefit from existing policy legacies allow the latter group to easily maintain the status quo and their role within it unless their performance is very poor.

As later chapters will demonstrate, early home care program policy decisions made in both Ontario and Saskatchewan determined distinct groups of beneficiaries of the status quo early in the study period, which in turn influenced the relative ease by which home care policies could be altered in each province. Therefore, understanding the temporal influence of policy decisions made early in the development of provincial home care programs and the institutional legacies they established is key to understanding the policy decisions made to home care in Ontario and Saskatchewan during the study period. In addition to the example of institutional arrangements determining whether program services were provided by the state or subcontracted to

community organizations, the other key policy legacies in my analysis were those established by funding mechanisms, such as the inclusion of home care services in provincial health insurance and the use of individual or program service caps. As my analysis will demonstrate, these policy legacies served to inform future ideas regarding either the need for additional cost controls in home care or the potential for the controlled expansion of it. In both cases, policy legacies will be shown to facilitate gradual processes of change, respresenting examples of the more typical instances of institutional change highlighted by Mahoney & Thelen, (2009). My findings regarding the enduring impact of policy legacies on later reforms also echo the results of more recent analyses of policy change built off of existing policy instruments in response to the COVID-19 pandemic examined by Béland et al., (2022).

In Canada, health policy is perceived to have been locked into an established path as the result of policies introduced with the passage of Medicare and the Canada Health Act that has 'frozen' a paradigm, one that has permeated the cultural fabric of the nation (Lazar et al., 2016). Home care, however, lies outside the frameworks of the Canada Health Act. As a result, home care is subject to provincially distinct policy legacies defined by important administrative decisions in the development of each program that served as critical junctures in establishing their funding trajectories and beneficiaries. In the case of Ontario, the most important policy decisions regarding its home care program were its inclusion as an entitlement within the provincial health insurance plan (OHIP) in 1982 and the decision to subcontract the delivery of home care to community organizations - particularly those in the nonprofit sector - since the program's inception in 1970. Saskatchewan, in contrast, gradually subsumed the nonprofit sector's market share of home care delivery from 1978 up until the NDP government eventually decided to all

but eliminate the contracting of home care services to community provider organizations with its passage of the *Health Districts Act* in 1993. The province had also chosen not to fully cover costs for home support services, choosing instead to implement user fees for them that would scale based on the recipient's income.

These provincially distinct administrative decisions for home care policy established sufficiently unique policy legacies to allow for the divergent reform trajectories seen in Ontario and Saskatchewan. Specifically, Ontario's key home care policy legacies going into the study period were the rapid expansion in program costs associated with its inclusion within OHIP and the privileged role of the non-profit sector in the subcontracted delivery of services. Saskatchewan's key home care policy legacies going into the study period, on the other hand, were a gradual expansion of programs costs and centralization of service delivery by the state via an expansion in the coverage of eligible services provided with legislation passed in the early 1980s.

However, institutional theories tend to explain change to policies as either being the result of exogenous shocks that establish critical junctures during which extreme changes to the institutional status quo are more likely to occur (i.e. "punctuated equilibrium" as discussed by Jones and Baumgartner 2012), or by gradual processes of displacement, drift, layering conversion, or exhaustion (Mahoney & Thelen, 2009; Streeck & Thelen, 2005). Traditional institutional theories of policy change have thus been most concerned with describing the degree and/or direction of a particular policy change takes and conceptualizing policies as either following established paths or veering from them. More recent theories, however, have been constructed to better account for ideas and interests as variables impacting policy change. This

dissertation builds on Hay's (2011) portrayal of constructivist institutionalism, which more broadly establishes institutions as responsible for establishing the context within which ideas and interests can be constructed within policy spaces.

Institutions and legacies alone do not provide a comprehensive explanation for the divergent home care policy changes seen among the provinces under investigation. However, the legacies of home care policies established prior to the study period serve as key pieces of the 3I framework when ideas and interests are viewed through the lens of the distinct trajectories they facilitated. These policy legacies inform the ideas held by policy makers about home care, as well as determine the stakeholder population within home care and its capacity to mobilize for or against policy agendas.

Power In, Over, and Through Ideas

Institutions within Shearer et al.'s (2016) application of the 3I framework act as a form of "scaffolding" that policy networks are built upon, with ideas being transmitted through the network ties built between actors. This is a useful way to think about the relationship between institutions and ideas in home care policy development in Canada, as institutions are represented by the existing rules, regulations, and policies in place within the sector, which in turn establish certain boundaries for ideas regarding policy change. At the very least, existing institutional arrangements can shape what policy ideas are considered radical or gradual. In the extreme case, they can mean that certain policy ideas are perceived as outright impossible to implement, which can be reinforced by interest groups operating within those institutional arrangements. This will be later demonstrated with the example of Multi-Service Agencies

(MSAs) proposed by the NDP government in Ontario and speaks to the persuasive *power in ideas* introduced by Carstensen and Schmidt (2016) manifested within institutional hegemonies (i.e. ideas that have become so prevalent that they function as institutions themselves).

Power in ideas manifests through the establishment of dominant forms of thinking (in this case regarding home care and its costs) which can work to limit the perceived viability of conflicting policy options while supporting similar ones in the minds of policy actors. Carstensen and Schmidt (2016) also distinguish it from two other forms of ideational power: *power through ideas*, which emphasizes the use of ideas by actors as a persuasive mechanism to influence others to adopt and/or embrace their views; and *power over ideas*, defined as an actor's power to impose or resist the inclusion of ideas that challenge the status quo into the policy arena. It is important to note, however, that these forms of power need not be mutually exclusive, and that Carstensen and Schmidt (2016) suggest that "different dimensions of ideational power may combine and intertwine in concrete empirical cases" (pg. 333).

Ideas serve a key role in mediating institutional arrangements and the strategies adopted by political actors aiming to change policy. This concept is put forward by Jacobs (2009), who notes that "actors' mental models of the domains in which they are operating systematically guide their attention within processes of decision making." These mental models of specific domains are formed via the presence of entrenched knowledge structures (i.e., grounded notions of reality) in that domain. This means that preexisting ideas focus actors' attention, usually leading to self-reinforcing confirmation biases and institutional stability. This serves to demonstrate how

policy legacies manifest their long-term effects, with political actors' ideas as one mechanism through which an institutional status quo is enforced.

Evidence of ideas as a persuasive tool of power to shape policy outcomes in Canadian health policy has already been demonstrated to exist (see Bhatia and Coleman 2003; Lavis 1998). These earlier works primarily focused on the use of power through ideas wielded by actors to achieve specific policy goals. More recently, research by Boothe (2013) has demonstrated how power through ideas was utilized (albeit unsuccessfully) by political actors and bureaucrats at multiple points in the development of Medicare in Canada to incorporate pharmaceutical coverage. A similar project – albeit on a much larger scale – was undertaken by Lazar et al. (2016) in their book *Why Is It So Hard To Reform Health Care Policy In Canada?*, which looked at health care reform in general across five Canadian provinces between 1993 and 2003, then again between 2004 and 2011.

The findings from these projects indicate that several ideas, interests and institutions (including the original formation of Medicare, the 1984 Canada Health Act, and the dynamics of Canadian federalism, to name a few) worked to impact health care policy reform (and the lack thereof) across Canada, more reflective of the power in ideas manifested in preexisting institutional frameworks. As far as Canadian home care policy is concerned, each form of ideational power could be relevant in understanding the dynamics of reforms across the provinces. As such, my analysis follows Carstensen and Schmidt's (2016) agency-oriented approach to understanding how ideational power manifested itself in home care policy reform processes.

My analysis also is based on the expectation that political actors would have used power *through* ideas to persuade their peers – particularly those involved in the policy reform process – as well as the general public to accept and embrace certain positions on home care. It also considers the possibility of power *over* ideas having been exercised by specific interest groups seeking to manipulate the discourse surrounding policy change, such as physician lobbyists or representatives of the private home care sector. However, my analysis ultimately assumes an underlying prevalence of power *in* ideas manifested through perceptions of existing home care arrangements in each province as having the greatest impact on actors' beliefs, as demonstrated by Boothe (2013) and Lazar et al. (2016). It anticipates these preexisting institutional arrangements as shaping the mental models of actors, as found by Jacobs (2009), and establishing cognitive biases, as suggested by Carstensen and Schmidt (2016).

My work here investigates a similar period of history as the research by Lazar et al. (2016) but at a smaller scale in terms of policy. The political dynamics influencing home care policy reform are not necessarily identical to those that influence health care more broadly, but the work done by Boothe, as well as Lazar and his co-contributors, provides us with a useful roadmap in terms of identifying the relevance of ideational power in home care policy change. These works point to an emphasis on the power in ideas manifested by the institutional frameworks for Canadian health care set forth by the founding principles of Medicare and the language of the Canada Health Act. These frameworks set clear boundaries for the public sector's funding obligations for health care provision. Boothe's (2013) work in particular demonstrates how reformers have historically struggled to implement pharmaceutical coverage in Canada due in part to institutional constraints on the ideas held by policy makers regarding the plausibility of

implementing pharmacare in Canada, especially with regards to their cost. The exclusion of pharmaceuticals from nationally mandated "medically necessary" publicly funded health services further justifies my hypothesis regarding the prevalence and manifestation of ideational power in home care. Namely, it suggests that the entrenched frameworks established by previously enacted policies have a substantial effect on political actors in terms of influencing their perception of what policy options are considered as available or viable, even in times where reforms are widely considered as vital.

The distinct home care policy changes that emerged in the 1990s between Ontario and Saskatchewan suggest that even if there was a dominant ideological paradigm surrounding home care as a means of cost-savings in provincial health systems at the time, it was not so dominant to have made policy change consistent across jurisdictions. My analysis is therefore built on the assumption that a few distinct ideas regarding home care policy emerged in each province amidst the reforms in the 1990s, and that these ideas influenced the policies within each province going forward. However, ideas do not emerge in a vacuum, so when faced with a situation where one policy issue is potentially framed by competing actors with contradictory ideas spread across multiple jurisdictions, one must ask what could cause this divergence in ideas to emerge. I address this question in my hypotheses, which will be highlighted at the end of the theory section of this chapter**.**

The first explanation for the divergent reform trajectories in Ontario and Saskatchewan I test in my analysis is that the contrast between the two provinces in terms of the rate of increase in home care expenditures – particularly in the 1980s, where Ontario's rate of increase was double

that of Saskatchewan – contributed to differing ideas held by policymakers in each province regarding home care investment as a means of introducing cost savings within health reform strategies. Indeed, as the next chapter will demonstrate, an external analysis of the home care program in Ontario conducted near the end of the 1980s expressed concern with expenditure trends which subsequently informed policy recommendations made to the Liberal government regarding its LTC reform strategy (Price Waterhouse, 1989). Analysis of the home care program in Saskatchewan conducted by the Saskatchewan Commission on Directions in Health Care (1990), which informed the NDP government's health reform agenda following their election in 1990, in contrast, did not express any concern with cost trajectories for home care under existing policy arrangements.

My analysis also considers the political climate surrounding health care during the study as being ripe for experimentation with systemic reforms due to the interest in regionalization that had accumulated among health policy experts. As mentioned earlier, with the momentum behind initiatives to regionalize health care rising among provinces, policy decisionmakers would have been in a unique position to advocate for and ultimately implement specific health reforms within a broader package marketed as part of a regionalization process. However, such a reform package would still need to be tailored to the province it was being introduced to in terms of the costs and benefits it would offer in contrast with existing health policy arrangements alongside considerations of the social, economic, and political situation of that jurisdiction. In this sense, any provincial distinctions regarding health policy issues that existed at the time would need to have been reflected in a particular model of health system regionalization.

One of the key commonalities between provinces with respect to health reform was an overarching concern about health system costs (Lazar, 2009). I thus suspected early in my research that the existence of policy makers' provincially distinct perceptions of home care as either a cost burden or cost benefit within the health system might help explain the divergence seen in home care policy reform trajectories. As the tables in the Appendix demonstrate, one of the most notable distinctions that exists between the two provinces under investigation is home care's relative portion of total health spending in the years leading up to the study period, with Ontario's growth in this metric between 1980 and 1990 (from 1.09% to 2.75%) far exceeding that of Saskatchewan's (from 1.32% to 1.84%). Based on the differences in proportional spending trajectories between Ontario and Saskatchewan, my hypotheses pose ideas regarding home care in the context of health system cost concerns serving as a potential early catalyst for the different forms of policy change that emerged. In the case of Ontario, perceptions of rapid and drastic increases in home care costs served to subsequently inform policy recommendations focused around controlling home care spending, which was perceived as spiraling out of the control of provincial governments. As I argue in chapter 3, these steep and rapid increases in costs, coupled with the cuts to federal funding of provincial health systems, made home care programs in Ontario particularly susceptible to retrenchment despite the relatively low percentage of the provincial health budget they occupied.

By situating ideas regarding cost savings as a key variable in discussions surrounding home care reform among the provinces, my analysis anticipated political actors' stances on reform being couched in terms of what option would present the greatest possible cost reductions. Considering the differences in costs among provincial home care programs prior to the

regionalization period, it is also likely that perceptions of home care among political actors in each of the provinces would have differed. Most notably, my analysis anticipates Saskatchewan's consistently lower home care costs and growth rates in costs as being likely to have distinguished the positions of political actors in the province regarding home care's potential role in decreasing health care costs from those of similar actors in Ontario.

Subsequently, I anticipated that the decision to expand home care funding as part of the introduction of regional health authorities in Saskatchewan was at least partially a reflection of the relative lack of concern associated with rising home care costs in the province. I suspected that policy actors would have instead been concerned primarily with institutional care costs. Indeed, as Chapter 4 will demonstrate, Saskatchewan entered the 1990s with the highest number of hospital beds per capita of all the Canadian provinces, a fact which was used by the NDP government under Premier Roy Romanow to justify closing rural hospitals.

While cost concerns would need to have been balanced with other priorities within provincial health systems, since home care programs otherwise represent peripheral elements of those systems, it is not necessarily surprising that they would be susceptible to cuts. As a peripheral element of the province's health system, such cuts would be less obvious to a discerning public than those to more visible elements like hospitals and could theoretically be justified within a broader strategy of rationing health care in hard economic times. However, rationing health care is generally difficult to justify politically, so any attempts to do so would have benefited from a strategy that allowed for the blame associated with rationing decisions to be passed on to other actors. This is one context where regionalization would potentially have been attractive to policy

entrepreneurs: as a mechanism of blame avoidance for health retrenchment policies. CCACs in Ontario stood out as a prime example of this, as Chapter 3 will demonstrate.

However, while the regionalization of provincial healthcare systems found wide support among Canadian provinces in the 1990s, this support was not universally based on the potential in regionalization for offloading program costs and administration responsibilities onto local decision-making bodies. In fact, regionalization was typically seen as a means of *centralizing* power that had previously been fragmented among more localized decision-making bodies to improve the coordination of services and – in theory – increase equity of access to services (Church & Barker, 1998; Lewis & Kouri, 2004). Devolution and decentralization of certain responsibilities were also typically justified on the basis of the potential to make health programs more sensitive to local needs and allow for increased citizen participation in health care decision-making. This was particularly the case in Saskatchewan, which maintained a strong interest in facilitating citizen participation in decision-making on its regional health authorities throughout its health care reform trajectory in the 1990s – as will be demonstrated in Chapter 4 – but a similar consolidation of decision-making power also occurred with regionalization in British Columbia, Alberta, Quebec, and Nova Scotia (Church & Barker, 1998).

Even Ontario saw some promise in the centralization element of regionalization, as the policy decision to implement CCACs by the Conservative government early in its tenure served to regionalize its home care program, replacing a scattered approach which saw home care administered by a mix of Public Health Units, hospitals, and in some cases VON service providers themselves (Baranek, 2000). Indeed, as chapter 3 will demonstrate, the themes of cost

containment, efficiency & efficacy, and accountability within the health system that informed the regionalization processes in other provinces (Church & Barker, 1998; Lewis & Kouri, 2004) informed Ontario's reforms to home care, including the regionalization elements within it.

However, it is important to recognize the key distinction between Ontario and Saskatchewan. While Ontario used regionalization tools to specifically target and implement reforms for its home care program, Saskatchewan levied regionalization mechanisms as part of a broad overhaul of its entire health system. While this process allowed for home care to receive greater funding and play a more significant role in Saskatchewan's "Wellness" approach to healthcare, regionalizing home care was not a specific end goal. Rather, as chapter 4 will demonstrate, the Wellness reforms introduced alongside regionalization in Saskatchewan allowed for home care to see its role in provincial healthcare delivery expanded in the province as part of a broader goal to see the province's health system less reliant on acute care delivery.

These differences between Ontario and Saskatchewan in terms of their application of regionalization mechanisms serve to partially demonstrate the distinct ideas held by policymakers regarding home care and its role in broader health system reforms. The power in these ideas in turn partially manifested in the divergent approaches to regionalization that were undertaken by each province in the 1990s. My analysis thus works to demonstrate that the ideas held by provincial political actors in Ontario and Saskatchewan regarding home care – at least in terms of its cost performance – diverged at the onset of the reform period. It anticipates that this variation in the ideas about home care held by political actors in Ontario and Saskatchewan

could explain the differing roles that home care played within broader health system reforms introduced in each jurisdiction.

This section has demonstrated the various forms of power that exist in, over, and through ideas while also suggesting that – as far as home care policy change in Ontario and Saskatchewan is concerned – power *in* ideas was most prominent in influencing the distinct reform paths taken in each province. As the theoretical framework diagram shown earlier suggests, my thesis highlights the power in ideas manifested and wielded by key policy decisionmakers and informed first and foremost by the distinct policy legacies that existed in each province. This demonstrates the manifestation of the Institutional and Ideational pillars of the 3I framework. As the next section suggests and subsequent chapters elaborates, the Interest-based piece of the framework within home care policy change in Ontario and Saskatchewan was primarily represented in stakeholder mobilization to resist the policy reform strategies pursued by decisionmakers in each province and was far more prevalent in Ontario than Saskatchewan.

Interests, Stakeholders, and Maintaining the Status-Quo

The core hypotheses of this study emphasize the roles of Institutions and Ideas within the 3I framework, but there is also a role a role for interests in explaining home care policy variation. As later chapters will demonstrate, the degree of influence by interest mobilization on home care policy change was quite different between Ontario and Saskatchewan, as well as distinct in terms of the interests involved from what might have been expected from past research on interest group involvement in health policy change. However, it is worth noting that the relative lack of involvement from interest groups traditionally involved with health policy reform in home

care policy reform also reflects a dynamic identified by Lazar and Forest (2016), wherein forms of health care that do not fit cleanly under the umbrella of hospital or medical insurance (i.e. what is legislated by the Canada Health Act), remain outside the attention of key interests within the healthcare system. Specifically, the authors argue that "Medicare supporters are better able to protect what they have won than to secure new victories" (Lazar and Forest 2016, pg. 325). It is thus not necessarily surprising that the interest group dynamics observed in this analysis of home care policy change do not align with those identified in previous studies on other forms of policy change.

This understanding of interest group involvement in home care policy reform aligns well with Thomas Oliver's articulation of the role of interests in health policy change. Specifically, Oliver (2006) speaks to the establishment of "concentrated" interests within health systems as they develop, which go on to rebuff the efforts of external, diffuse interests throughout the political processes associated with policymaking. He argues that this dynamic allows concentrated interests to resist comprehensive health reform efforts, often forcing policymakers to adopt more incremental health policy changes. The logic underlying this argument is that concentrated interests benefit from the status quo arrangement of the health system they operate within and are thus materially motivated to resist changes that would negatively impact the benefits they derive. This argument builds off Pierson's (1993, 2000) suggestion that positive feedback from policy legacies creates coordination effects between interest groups that benefit from existing institutional structures within the healthcare system. The material benefits these interest groups receive from existing institutional arrangements incentivize them to protect their privileged position within it (Marier, 2015).

Historically, the most prominent non-government interests involved in health policy decision making – and subsequently the ones most influential in terms of maintaining the health system status quo – among the Canadian provinces have been their respective medical associations. As Contandriopoulos et al.'s (2018) analysis of interest group influence on health policy reform in Quebec found, physicians' associations had a great deal of power over policy decision making (which was consistent with previous research conducted by Contandriopoulos and Brousselle 2010), to the point that they had a "de facto veto in policy making", sometimes with the support of another medical union. Indeed, as Lazar et al. (2016) notes, between 1993 and 2003, provincial medical associations were the "quintessential insiders" of interest representation and maintenance of the institutional status quo in health policy, particularly when it came to the interests of physicians. However, my analysis found notably very little involvement in home care policy change decisions from physician groups in both provinces. This lack of involvement from physicians in the home care policy reform process is not surprising due to the tendency for discussion around home care policy to be couched in terms of its potential for reducing pressure on hospitals and physicians. It might also reflect the fact that home care was never considered to be a replacement for physician care in either province.

This study also considers the power and influence of interests more directly affected by home care policy (i.e., the home care population, home care workers, and home care providers). However, apart from the Canadian Home Care Association – a national advocacy group that develops policies, generates awareness, and provides networking and education services regarding home and continuing care in Canada – it is difficult to identify any interest group representation for home care workers or patients in Canada. Research by Aronson and Neysmith

(1996; 1997) has illuminated how the retreat of the state from long-term care and home care provision has led to the depersonalization and exploitation of home care workers' labour and how this process led to negative care outcomes for home care patients. This reality suggests that home care workers and patients do not have strong interest group representation in terms of influencing policy, a fact that was confirmed in my interviews with home care policy actors in both provinces.

Non-profit providers, such as the Red Cross and Victorian Order of Nurses (VON)s represented a more influential interest group when it came to home care policy changes in Ontario. Indeed, as Chapter 3 will demonstrate, non-profit providers went on to aggressively lobby to prevent the implementation of Multi-Service Agencies (MSAs) poised to be introduced by the NDP government in the mid-1990s out of concern for their status as employers within the proposed changes, while the Ontario Nurses Association largely supported MSAs. Subsequent policy changes introduced by the Conservative government under Mike Harris were carefully couched in terms of their benefit to the non-profit sector and presented in direct contrast to the multi-service agency model touted by the Conservative government's NDP predecessors.

Looking at Saskatchewan, in contrast, interest group influence on home care policy change appears to have been much less prevalent during the study period. Having effectively pushed legacy stakeholders in home care delivery (namely non-profit organizations) out of the policy space over the 1980s, the government of Saskatchewan essentially had full control over home care by the 1990s. As a result, rather than having to get entrenched interests on board with their health reform agenda, the NDP government found itself primarily focused on trying to sell its

"wellness" model to the public. Interest mobilization in Saskatchewan was therefore not as dominant a factor in determining the direction of home care policy change by the provincial government, as home care was not a focal point in its reform strategy, at least outwardly.

As will be seen in later chapters, the influence of interests on home care policy change specifically was primarily represented in such instances of resistance to potential change. The key example of interest mobilization of this sort occurred in Ontario under the Rae government, where non-profit providers were able to establish themselves as concentrated interests in home care policy through their legacy role in program service delivery. They subsequently went on to resist home care policy changes proposed by the Rae government which would have seen their role in home care service delivery largely supplanted by the state. We therefore see a confirmation of the theorized manifestation of interest group influence on health policy outlined by Oliver (2006). Such instances of interest group mobilization are also seen in other policy areas, such as Nowlin's (2016) analysis of interest mobilization in nuclear waste management, which argues that policy change can "activate" latent policy actors that view themselves as potentially "losing" as a result of that policy change.

Observing interests operating in such a manner with provincial home care programs is also not surprising when considered through the lens of historical institutionalism and path dependency . Specifically, seeing interest groups act in a manner which seeks to protect status quo policies in home care is something to be expected due to the positive feedback effects of prior policies which established beneficial roles for those interest groups in home care, who would in turn be naturally expected to maintain their privileged status within existing programs.

Hypotheses

To determine the relative role of ideas, interests and institutions in home care policy change, my analysis investigates whether political actors' ideas surrounding home care policy change are epiphenomenal (i.e. materially bound by more observable circumstances) or otherwise independent (see Berman et al. 2001). As highlighted above, my analysis anticipates that political actors' perceptions of home care policy would have been primarily influenced by their perceptions of the performance of existing institutional arrangements at the time. It also predicts the potential for interest group mobilization as being similarly dependent on policy legacies.

In the case of Saskatchewan, my analysis is built upon the notion that the limited growth in home care expenditures prior to regionalization was an influential factor in determining the role home care played within the government's initial health system reform agenda. Centralization of administrative power and service delivery of home care would have made sense as part of a scheme to refocus health care investment into community initiatives since the province had not previously invested heavily into home care. In contrast, Ontario was already coping with rapidly rising costs by the late-1980s as a result of its investments into home care to date, and so increasing investment into that sector of health care may not have seemed as appealing to political actors in that province. Ultimately, my analysis poses that the most proximate cause of the differences in policy outcomes seen among the provinces was how political actors interpreted the problems associated with policy legacies established by existing home care institutional frameworks in the wake of funding challenges. My first hypothesis is:

Hypothesis 1: *The legacy of provincially distinct roles and administrative arrangements for home care in provincial health systems shaped actors' perceptions about the need for either retrenchment or expansion of home care programs.*

During the reform period, regionalization emerged as a flexible policy tool available to policy actors to achieve a variety of goals. Indeed, as Lewis and Kouri (2004) note, regionalization involved a continuum of centralization and decentralization of both authority and service provision. As such, the degree to which provinces would have sought to centralize or decentralize home care administration and funding was likely dependent on the strategic role home care played in healthcare cost reduction.

Political actors in Ontario, being less convinced of the potential for cost savings in home care investment, may have been motivated to pass retrenchment policies but would have wanted to do so without taking the public blame that would normally be ascribed in instances of full accountability. Regionalization would have facilitated this, a point which is touched on by Jordan (2009), who argues that regionalization served to establish an extra level of bureaucracy that served to buffer provincial governments from public anger in response to cutbacks to health services. Indeed, as Naylor (1999) argues, regionalization was driven "in part by a desire to decentralize the burden of coping with fiscal restraints".

Looking at Saskatchewan, in contrast, we can see that they did not pursue a retrenchment strategy for home care reform. In the decade leading up to its sweeping reforms of the early 1990s with regionalization, the province had gradually expanded its role in the provision of home care – which also pushed the non-profit sector out of that role – but did not see the same

precipitous rise in costs associated with home care seen in Ontario. By the time the NDP government came into power, however, the administration associated with home care was highly fragmented among 45 home care boards. Under these circumstances, regionalization was better suited for centralizing home care governance by reducing the number of boards governing care delivery and allowing the province to redirect expensive health services such as hospital care to community initiatives as a cost saving strategy. These provincially distinct applications of regionalization mechanisms in health system reforms informed my second hypothesis, which is as follows:

Hypothesis 2: *These policy legacies in turn impacted the character of regionalization as a mechanism for adjusting home care's role in the healthcare system, allowing it to present as either a means for administrative decentralization and blame avoidance for funding reductions or administrative centralization and increased resource allocation within each province's health system.*

The difference in relative involvement of interest groups in home care policy reform decisions between Ontario and Saskatchewan has also been discussed. What remains to be determined is what informed these distinct patterns of interest group influence on home care policy decision making. Here again the influence of policy legacies becomes relevant, as the institutional arrangements that existed in each province prior to the reform period established a distinct set of stakeholders and participants in the home care policymaking process between Ontario and Saskatchewan.

As chapter 3 will demonstrate, non-profit providers in Ontario – who played a historically important role in the delivery of home care there – had substantial influence on government decision making regarding reforms to the home care program. Their ability to find common ground with for-profit providers – with whom they shared the home care delivery market – on opposing a home care reform model (the NDP's Multi-Service Agencies) which would have seen the state supplant community organizations in the employment of caregivers effectively worked to prevent its implementation. In contrast, chapter 4 discusses how Saskatchewan saw the state gradually absorb the non-profit sector's share of the home care market over the 1980s. This positioned the NDP government to easily move away from contracting home care delivery out to community providers, who by the early 1990s had neither the means nor the interest to compete with the state in attempting to provide those services, which were already largely delivered by unionized employees of the public sector. These important legacies of home care program delivery dynamics in Ontario and Saskatchewan inform my final hypothesis:

Hypothesis 3: *Policy legacies establish the population of entrenched interest groups and impact their capacity to react to potential reforms.*

Methodology

With my hypotheses established, policy legacies evidently play a central role in this project. This in turn requires that my analysis is developed across a sufficient timeframe to demonstrate the relevant developments in each province's home care field. Identifying relevant policy developments (i.e., those which established institutional legacies) in home care therefore required me to begin my analysis by process tracing home care policy trajectories in Ontario and

Saskatchewan from each program's outset to the beginning of the study period. The process tracing involved identifying the scale of services covered by each program, their funding mechanisms, and structural arrangements determining responsibility for service delivery (i.e., whether services were delivery by the state or nonstate actors) leading up to the late 1980s. This process involved qualitative analyses of Provincial Legislative Assembly (PLA) Hansard transcripts, electoral platforms and speeches, official government discussion papers, policy communications and reports, and news media to trace the processes associated with significant policy events in Ontario and Saskatchewan. Once relevant policy legacies were identified in each province, I continued to process trace health policy events throughout the study period. My process tracing was directed by the 3I framework outlined earlier in this chapter, with the broad goal of weighing the relative influence of institutions, ideas, and interests through process tracing home care policy events in Ontario and Saskatchewan.

Case selection in my project is guided by a comparative case study design involving a controlled comparison of a small number of cases as described by George and Bennett (2005). My choice in Canadian provinces for comparison is based upon John Stuart Mill's method of difference, with the Ontario and Saskatchewan representing sufficiently similar provinces, and their main difference for the purpose of my analysis being the home care policies that existed both before and after regionalization reforms. The home care policy choices made in each province therefore represent the dependent variable in my analysis. It is also important to note that, while efforts have been taken to ensure that the provinces selected as cases were as similar as possible apart from their home care policy outcomes, there are still inherent issues with the use of Mill's

method of difference, particularly that of there being "too many variables, too few cases" (see George and Bennett 2005).

With the goal of addressing this, my approach to process-tracing follows that of Theda Skocpol (1979) in her book *States and Social Revolutions.* The information gathered through my analysis of Hansard data, government documents, and interviews serves to unravel the historical narrative surrounding provincial home care policy within the cases I selected. The intent of process-tracing here is to open the "black-box" of decision making, allowing for insight into the motivations and factors that influenced the decisions of political actors to reform home care policy among the cases analyzed, following recommendations made by Berman (1998). The documents I gathered served not only to provide information about the policy context/legacies mentioned above, but also to identify the relevant actors participating in the policy space and situate their positions within broader themes and ideas I identified within that space.

Provincial Legislative Assembly transcripts were selected as the result of a search for all mentions of the word "home" on provincial Hansard data collections. Exchanges surrounding the use of the word were subsequently scanned. The following exclusion criteria were applied to identify those directly tied to the concerns of this project:

1. Only mentions of the terms "home care", "home support", and/or "homemaker" were considered for inclusion. All other discussion related to homes (such as housing policy) was excluded.
2. Within those mentions, direct quotes were only included for:

a. Initial announcements of a new program or funding for an existing program.

b. Debate regarding existing programs or the possibility of new programs.

My desire here was to focus solely on home care and homemaker programs, and so the phrases "home care", "home support", and "homemakers" were not specifically highlighted for inclusion unless they were part of a dialogue on home care or homemaker programs specifically. Passing mentions of home care or homemaker programs and/or funding that amounted to reiterations of previous announcements of these programs or funding packages that were not made in the context of a broader discussion of home care or homemaker programs specifically have also been excluded to avoid collecting redundant discourse. Ultimately, I considered the *frequency* of discourse from policy makers regarding a specific funding commitment as being less important to my analysis than evidence of its *presence*.

Following the data filtering process, Hansard transcript data was parceled into files organized by date and parliamentary debate topics (the introduction and subsequent debate of bills/legislation, confidence motions and subsequent debate related to management of provincial healthcare, and emergency debates related to health crises are some examples of the parceling that was conducted). These files were then coded by the speaker's party affiliation, status of the party at the time of the quote (in government vs. opposition), and content within the discourse. Content-related codes included government announcements such as funding commitments and changes to home care programs, as well as thematic elements within the discourse such as cost-savings dialogue, elimination of bureaucracy / efficiency, and concerns regarding access to care.

Electronic copies of government reports (such as commissions appointed by Ministers), ministry communications (particularly statements made by Ministers or Deputy Ministers regarding home care), and other documents (such as orientation documents for new programs) were searched for via Google Scholar & McMaster University's grey literature database search engine, Omni, and consultation with stakeholders and policy experts interviewed during my research. Data from these sources was imported onto NVivo and scanned for mentions of home care in a method similar to that of the Hansard data. Physical reports that had executive summaries and chapters on home care were closely read. Relevant quotes were input onto a word document which was imported onto NVivo. Codes that applied to the Hansard data were used for this data as well, and relationships between the codes were subsequently mapped in a similar fashion.

For news media discourse, I used specific parameters in the Factiva database to isolate the time period and content relevant to my research. For each province, I entered the term "home care" into the search bar, selected that province as well as "Canada" as the regions to focus on, and eliminated any articles associated with other provinces or the United States. I then isolated the date range for each province based around the first and final years that governments held power within my period of interest, allowing me to capture the political policy dynamics associated with regime changes in the event that such changes might have impacted home care policy change proceedings. For Saskatchewan, the Factiva data available was quite limited, so I used a date range that spanned the entire study period. Even through casting such a wide net, however, the number of Factiva articles that met my criteria throughout the entire study period was limited to 6.

From these search results, I then viewed and isolated articles that included direct quotes and/or interviews with political party or government representatives. This allowed me to better isolate public discourse of actual policymakers. I was less concerned with public opinion on home care policy than I was with how governments and politicians responded to / built upon public discourse on home care policy, as the goal associated with news discourse data collection was to isolate additional examples of home care discourse from actual policy actors. Much of the discourse within the Factiva data was tied to punditry (and as a result, not viewed as eligible for inclusion). The one exception to this was for newspaper editorials written by individuals who represented specific interest groups (such as private or non-profit home care providers), as their views were more likely to represent a form of pressure on policymakers than the average pundit. Articles that qualified within this criterion were then copied into NVivo and coded with the same methodology applied to the previous data. This provided me with supplementary discourse data to verify certain actors' expressed views on home care policy.

In Ontario, this process translated to two scans of home care articles; one from January 1st, 1989 – December 31st, 1991 (representing the initial years of action on home care by the Liberal government and the election of the NDP government), and one from January 1st, 1993 – December 31st, 1996 (covering the span of the NDP's development of and public consultation for its MSA model, the election of the Conservative government and Premier Mike Harris, and the implementation of CCACs). The first search turned up 358 headline results, of which 19 were coded into NVivo based on the relevance of their content. The second search turned up 624 headline results, of which 27 were coded based on content relevance. The Saskatchewan search, in contrast, only offered 8 headline results, of which 3 were coded based on content relevance.

As with the other data collected, themes were isolated within the content and coded within NVivo, and relationships between political parties and these themes were mapped accordingly.

Isolating themes within the content being analyzed and tracking similar examples of them across governments and policy events was an important element of my coding strategy, as dominant themes served as evidence for policy actors' ideas. Relationships between codes were subsequently mapped to keep track of which parties referenced what themes. This allowed me to isolate themes that were specific to certain parties when they were in power, as well as establish what the lines of agreement and disagreement were between parties regarding home care and health care more broadly. Applying parallel strategies across provinces helped me to keep track of thematic similarities between them, as well as distinguishing themes specific to certain provincial cases. Tracking these variables allowed me to identify dominant themes in home care policy discourse among parties and/or governments, which would go on to help me establish dominant ideas within my process tracing. These dominant themes subsequently served as discussion points for the dissertation, as well as markers to look for in interviews, which would serve to corroborated event accounts and triangulate my qualitative approach to process tracing, as recommended by Denzin (2017).

I followed suggestions made by Dexter (2006) and structured interviews to allow the interviewee to enlighten me as to what the issues surrounding home care policy were around the time of reforms. A total of 25 interviews were conducted. Subjects were initially selected based on their proximity to home care policy decisions during the study period or - in the case of academics - the depth of knowledge they demonstrated on the topic through their writings. All interviewees

were asked 6 core questions, most of which were open-ended, with the underlying goal of making the interviewees comfortable enough to be as detailed and specific as possible in their responses. The analysis itself incorporated a search for overlap both among actors and between their accounts and the policy development narrative I uncovered from the earlier scan of government documents in terms of their accounts of policy decisions, accompanying rationales, and underlying themes. I knew policy decisions varied among the provinces and expected the rationales and themes associated with them to follow suit in terms of differences, but also anticipated shared concerns around issues such as administrative fragmentation and budgetary constraints. Based on the policy trajectories for home care observed in Ontario and Saskatchewan, I surmised that the core distinction between the two provinces would be the role that home care reforms were portrayed as playing in addressing issues within preexisting programs brought up by political actors. These issues could have gone beyond cost savings to include concerns such as care outcomes in patients, access to care and human resources in care provision. I also initially anticipated that the prevalence and concern with these issues would vary between the provinces.

Observable Implications

In the event my hypotheses were supported, I expected to find observable links between the strategic goals expressed by provincial political actors and the reforms that were enacted in the provinces. Specifically, I expected to find references in documents and from policy actors themselves to the financial constraints imposed on the provinces prior to enacting home care policy reforms, as well as references to regionalization mechanisms (i.e., CCACs in Ontario and RHAs in Saskatchewan) as a means of or opportunity for cost-savings. I also predicted that

political actors' perceptions of the costs and/or efficiency of home care would be shaped by pre-existing institutional arrangements surrounding home care, and that these perceptions would have further incentivized them to pursue reform. Investigating whether this was the case allowed me to develop a strategic narrative explaining how reforms to home care were able to come to pass. The narrative would subsequently address:

a) Political actors' perceptions of home care programs pre-regionalization.
b) what strategies were being considered by political actors in the wake of federal transfer payment cutbacks;
c) how opportunities were leveraged within the institutional framework of provincial governance;
d) the role that regionalization played in achieving goals for policy reform; and
e) to what extent actors were successful in achieving their political ends.

I anticipated that the narratives would be distinct between the provinces, just as the policy reforms ultimately undertaken in each were. In Ontario I predicted that political actors' narrative regarding home care institutions pre-regionalization would be negative to some degree, with specific reference to uncontrolled costs and administrative inefficiencies. However, I also suspected there would be reference to difficulties associated with transitioning away from the existing policy arrangements due to the entrenched role of non-profit organizations as care providers. I also anticipated references to the relative difficulty of navigating the legacy of non-profit providers by Liberal and NDP government representatives, with there being less of a difficulty under the Conservative government. From Conservative government representatives specifically, I anticipated references to regionalization (more specifically, the introduction of

CCACs and the managed competition model) in Ontario as an opportunity to introduce reforms without disrupting this policy legacy. As noted earlier – and discussed in more detail in chapter 3 – the Conservative government presented its CCAC model for home care as one that would allow for the non-profit and volunteer sector to maintain its role in the delivery of home care across the province, so I anticipated similar reference to this goal by associated policy decision makers in that government.

In Saskatchewan, in contrast, I hypothesized that the narrative regarding home care pre-regionalization would be less concerned with the costs associated with it and more concerned with care coordination, access, and standardization. I further suspected home care to be perceived as an investment opportunity that could lead to long-term health system savings, and that the legacy of non-profit provision would have been less of a prevalent concern among policy actors. I subsequently expected regionalization in this province (i.e., the creation of RHAs) to serve at least partially as a mechanism for the NDP government of the time to assume control over the home care sector and that language surrounding the establishment of RHAs would be used to justify the government's home care policy reform strategy.

To measure the degree to which my hypotheses were actually reflective of what happened in Ontario and Saskatchewan, I focused on triangulating narrative consistencies between mediums of expression by the executive. In essence, if I identified similar references to the same idea (be it a policy goal, concern, limitation, etc.) being directly associated with a given policy initiative across two distinct sources of data (interviewee quotes or government documents), I interpreted that as compelling evidence that an idea shaped policy. Since the home care policy decision

making bodies in Ontario and Saskatchewan were composed of a relatively small group of policy actors, and subsequently would have had a concentrated set of ideas, it was reasonable to consider such examples of ideas being associated with policy as evidence of said ideas informing policy.

This chapter has provided a breakdown of the literature on policy change and its relationship to the 3Is of Institutions, Ideas and Interests in previous research. It has also provided context for the core hypotheses of my analysis, as well as outlining my methodology and preliminary expectations and implications of my research approach. As the next two chapters will demonstrate, much of what I anticipated to see in the content I analyzed was present in the data. My analyses of home care policy reform trajectories in Ontario and Saskatchewan will ultimately demonstrate that the processes were highly complex and influenced by range of distinct institutional home care policy legacies, conflicting ideas regarding the potential for cost savings in home care, and differences in the degree of interest mobilization in opposition to policies that were being pursued.

Specifically, chapter 3 will demonstrate how precipitously rising home care costs going into the recessionary circumstances of the 1990s led health policy makers across political parties to perceive the home care program's status as an OHIP entitlement to be unsustainable in the long-term. It will further show how organized stakeholder interests – particularly non-profit provider organizations – mobilized to oppose reforms to the home care contracting process, ultimately preventing the NDP government from enacting its regionalized care coordination package. This served to reinforce the status quo of home care service delivery, which was further maintained

via the subsequent Conservative government's introduction of CCACs and managed competition to home care administration in the province.

In chapter 4, the contrasting case study of the NDP government in Saskatchewan will demonstrate how health policy legacies had created an overabundance of acute care beds and facilities in the province. This in turn informed the perception of policymakers that there was a need for health system resources to be transferred from providing acute care to home and community care. This was attempted via an overhaul of the health system which regionalized all health system administration into Regional Health Authorities and introduced a global funding pool which ensured funding could be diverted from acute care to home & community care, but not vice versa. However, the casualty of this approach were 50 rural hospitals, which were converted into community health centres. The public's reaction to this change and the government's inability to effectively respond to it led the government backsliding on its initial commitment to refocus health system investments into home and community care and to scrap the provision in its global funding policy preventing the diversion of funds from home & community care to acute care in the late 1990s. Though the Calvert government made some progress with refocusing health reform efforts away from acute care with its emphasis on bolstering primary care, home & community care was never able to relocate its place on the government agenda that it had found under Romanow in the early 1990s.

The final chapter of this dissertation reiterates the conclusions arrived at from chapters 3 and 4 as well as demonstrating the existence of the hierarchy of influence imparted by institutions, ideas, and interests on the distinct home care policy trajectories observed in Ontario and

Saskatchewan. It will ultimately demonstrate that the focus on agency in new institutionalist theory must nevertheless be couched in terms of the power of dominant ideological paradigms established by policy legacies.

The Complexity of Perceiving Cost-Effectiveness: Home Care Policy Reform in Ontario in the 1990s

Home Care's Origins in Ontario: A "Hodgepodge" of a system.

A publicly funded home care program was formally established by the Government of Ontario in 1970. Eligibility for care was and continues to be based on medical need, and the province does not use an income assessment process to determine a financial contribution from care recipients. Of all the home care programs in Canada, Ontario's offers the broadest range of professional services to care recipients [7] (Dumont-Lemasson et al., 1999). For the first two decades of its development, the system evolved in response to local needs and the availability of government program funding in an organic, albeit uneven process across the province's non-profit sector (O'Connor, 2004). In essence, home care in Ontario was driven by a "natural" process of grassroots efforts by non-profit providers of home care (particularly the Victorian Order of Nurses and the Red Cross) to lobby for funding from the provincial government as local needs arose.

The core range of services and eligibility determinants have not changed for the most part since the program's inception, nor has its reliance on contracts with private and non-profit

[7] Professional services refer to nursing and therapy services, and include speech therapy, dietician and social work services.

organizations to provide services and employ care workers. What has changed over the course of the program's existence are the administrative processes associated with it, particularly in the 1990s when provincial governments became much more involved in managing the program. While political actors of all stripes have historically spoken well of the quality of care and service within the home care program, toward the end of the 1980s it became clear that seniors faced issues with accessing the community services available to them due to a lack of government communication, poor coordination of services, and duplication of administration/intake procedures (Progressive Conservative Party of Ontario, 1986; Van Horne, 1986). These also represented a fiscal challenge that drew the attention of health system reformers as Canada began to reckon with rapidly declining economic conditions and a scaling back of health system funding from the federal government. Throughout the subsequent decade, fiscal pressures dominated policymakers' concerns with social service provision, which also served as partial motivation for the sorts of health system restructuring that would occur in the province with the election of the Harris Conservatives in 1995.

When studying home care policies and the reforms associated with them in Ontario, it is important to note the distinctions between the various terms that will be used in this chapter. The first is the generalized term "home care", which for the purposes of this chapter encompasses the range of in-home services that include Home Care, Outreach Attendant Care, the Integrated Homemaker Program, Homemakers and Nurses Services, and the Home Support

Program homemaking services provided in Ontario.[8] The second is the more specific reference to the "Home Care program" itself, which is important to distinguish from other forms of homemaking and home support services (i.e., non-medical forms of home care) due to its historical inclusion in the Ontario Health Insurance Plan (OHIP). Unlike the other forms of in-home services, the Home Care program was originally under the jurisdiction of the Ministry of Health (MOH) due to it being a medical service provided primarily by nurses. However, as later sections of the chapter will demonstrate, the Home Care program eventually went on to be bundled in with other in-home services, where they subsequently fell under the jurisdiction of the Ministry of Community and Social Services (MCSS). These policy decisions were part of a larger bundle of reforms in the province which targeted the broader sector of Long-Term Care (LTC), which included home care services along with community service programs and institutional forms of long-term care (i.e., nursing homes). As such, throughout this chapter, distinct references will be made to Ontario's home care services, the Home Care program more specifically, and LTC where appropriate. Understanding the distinctions that exist between these three terms will help the reader to better follow the reform trajectory for home care that occurred in Ontario throughout the study period.

It would be easy to focus exclusively on the home care reforms introduced by the Conservative government as a sudden and rapid instance of radical policy change as part of the neoliberal "Common Sense Revolution" agenda. Indeed, many previous analyses of home care policy

[8] The use of the term "In-Home Services" to refer to this bundle of services eventually entered the lexicon of the Liberal government in 1990, as will be seen later in the chapter.

development in Ontario have done just that[9]. However, Fanelli and Thomas (2011) portray the neoliberal shift in Ontario politics as having begun in the late 1980s during the Liberal government under David Peterson. This chapter, which takes a closer look at discourse by political actors both inside and outside parliament from the late 1980s to the end of the 1990s, builds on this portrayal to paint a picture of a more gradual neoliberal shift in policy change that occurred across three different Ontario governments. The need to reform the province's fragmented long-term care system (of which home care was becoming an increasingly important piece) was first brought forward by Liberal Minister of Health Elinor Caplan late in the tenure of the Peterson government and became an important element of both the NDP and Conservative platforms throughout the 1990s[10]. Though the Harris Conservatives certainly finalized changes to the home care program with their introduction of Community Care Access Centres and the managed competition model which has since defined home care in the province, much of the groundwork for the Conservative reforms were laid by their predecessors.

There was also disagreement between parties on how to proceed with implementation during the study period. Specifically, changes to service delivery and the balance of funding for institutional & non-institutional forms of care were presented by all parties as a means of addressing these issues, but the nature of service delivery changes and the ideal balance of funding for institutional vs. non-institutional forms of care varied. However, the chapter will also demonstrate that the fiscal realities in Ontario from the late 1980s to the late 1990s led to a

[9] See especially Abelson et al. 2004; Aronson et al. 2004; and England et al. 2007.
[10] Geoffrey Quirt (former Assistant Deputy Minister of Health and Executive Director of the Ontario Government's Long-Term Care Division) in discussion with the author, December 2021.

surprising degree of convergence between the three parties on home care policy intervention in terms of offloading responsibilities onto regional decision-making bodies via regionalization mechanisms and introducing program cost controls.

Home care policy legacies also worked to determine the relevant stakeholders and interest groups in positions of influence throughout the study period. As will also be demonstrated in this chapter, those entrenched stakeholder interests – particularly non-profit organizations that had established themselves as legacy providers of home care in the province – worked to influence the direction taken with home care reform. This is most readily apparent in the non-profit sector's opposition to the NDP government's proposed home care reform package – which was viewed by the non-profit sector as an existential threat to their role in home care delivery – and their subsequent embrace of the Conservative government's managed competition model, which emphasized a continued role for the sector in home care delivery.

Indeed, a key finding from this chapter is that the non-profit sector's dominant role in home care delivery going into the reform period allowed it to influence the province's reform trajectory. This finding is reinforced by the relative lack of influence on home care policy that less entrenched interests[11] – namely advocacy groups for seniors and workers such as visiting homemakers, home support workers, and Meals-On-Wheels employees – had on the policy changes that were ultimately implemented. Unlike nonprofit groups, the influence of these less

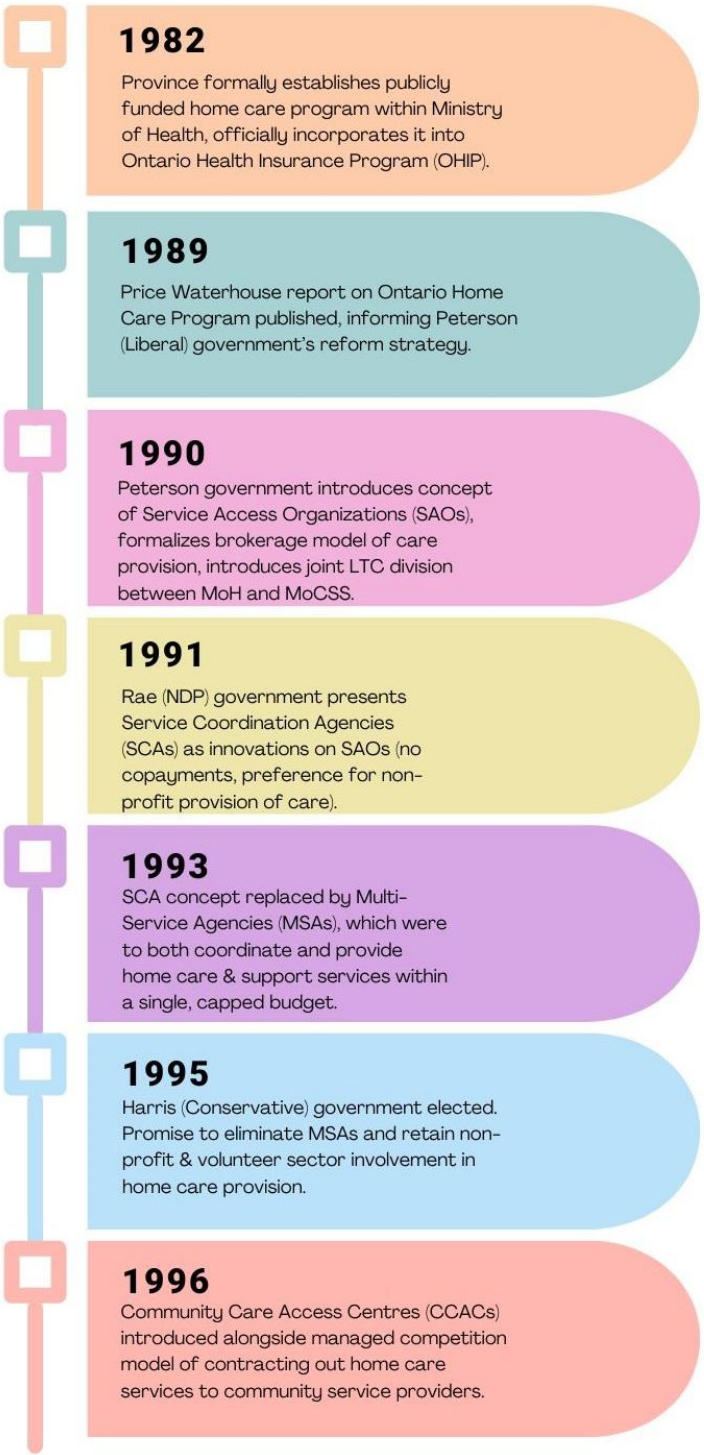
[11] The degree to which interests were considered as entrenched in my analysis was largely determined by the responses given by interviewees when asked during our conversation about who they believed had the greatest degree of influence on home care policy throughout the study period.

entrenched interests was very much determined by their alignment with the preferential ideas of the party in power. Nonprofit groups, on the other hand, were able to impose oppositional pressure on government (particularly the NDP) as well as being a group that all parties were obliged to demonstrate support for throughout the reform period due to their legacy role in home care provision in the province. This is further contrasted by the Saskatchewan case study in chapter 4, where the non-profit sector was gradually crowded out of the home care delivery space by the public sector prior to the onset of its health reform period.

In the next section, I provide background for the home care policy framework that existed in Ontario prior to the study period. I go on to pinpoint the underlying conflict between the Ministry of Health and public health boards in the province and how it precipitated the perceived need by governments to introduce accountability mechanisms into home care by reforming its service delivery system. Following that, I demonstrate how the successive buildup of fiscal pressures from federal health transfer cutbacks – notably those in the 1986-1987 and 1989-1990 fiscal years – and an economic recession forced the Liberal government to pursue retrenchment policies that would be built upon by the NDP and Conservative governments in the mid to late-1990s. This is followed by a discussion of how these fiscal pressures, combined with the mobilization of interests from entrenched stakeholders to oppose a more grassroots formulation of a new LTC agenda – which would have seen the public sector take on a larger role in home care provision – delayed the NDP government's implementation of it. These powerful interests were able to see the institutional status quo maintained with the return of the Conservative party to power in 1995.

The Conservative government went on to implement a LTC reform strategy that prioritized institutional long-term care over home and community care, as well as putting in place regional administrative bodies (Community Care Access Centres) responsible for home care delivery that they would be able to introduce spending caps to. Later in the chapter, I maintain that this was the unsurprising result of the offloading of responsibility for home care funding onto local administrative bodies that had been imposed by the previous NDP government's decision to remove Home Care from OHIP coverage. I will also draw attention throughout the chapter to contextual elements of the Ontario home care policy reform journey that were distinct from the one undertaken in Saskatchewan. Below is a timeline of the major policy events associated with the Home Care program in Ontario.

TIMELINE OF HOME CARE IN ONTARIO



Setting the Stage for Reform: Establishing the Need for Change

The existence of consensus between political parties on the costs and benefits of home care investment – particularly in contrast to institutional long-term care and hospital care – was well-established in both the Ontario government and its health system bureaucracy from the late 1980s onward. There is a clear acknowledgement among politicians across parties who spoke on home care from the later years (1989-1990) of the Peterson Liberal government to the early years (1995-1996) of the Harris government that:

a) People in need of long-term care would rather receive it in the comfort of their own homes and subsequently have better health outcomes[12].
b) Dollars invested into home care represent dollars saved in acute care settings.[13]
c) The work of existing home care and home support providers (particularly the VON and Red Cross) was incredibly important, and efforts had to be taken to ensure that these programs remained functional.[14]

More interesting, however, was the growth in consensus on the need for substantial reforms to how health care resources were directed and distributed. According to the then-Executive

[12] See especially OLA Hansard transcripts from April 22nd to June 1st, 1986 (33rd Parliament, 2nd Session) regarding the Peterson government's throne speech and health budget announcements.
[13] See (Byrne, 1990; *Resolution 9: That the Government of Ontario Should Establish a Framework to Allow for the Relatives of Frail Elderly, Chronically Ill and Disabled Persons to Care for Them at Home by Compensating the Care Giver at the Same Rate as Qualified Homemakers.*, 1989; Toronto Star, 1990)
[14] See especially the OLA Hansard transcript for January 9th, 1989 (34th Parliament, 1st Session) regarding an emergency debate on the Red Cross homemaker service, as well as Jim Wilson's comments in the OLA transcript for June 6th,1994 and Brennan's 1994 article in the Waterloo Region Record responding to the NDP's plans for multi-service agencies and their impacts on the nonprofit providers of home care.

Director of the Long-Term Care Program – a bureaucratic position specifically established by Liberal Minister of Health Elinor Caplan to address LTC sector reforms – going into the 1990s, health care spending was determined by regional, quasi-municipal health boards, who received their funding from the provincial government, but weren't required to demonstrate how money was spent.[15] This meant that the amount of home care funding distributed across public health regions was based on local priorities rather than those of the provincial government. Home care at the time was lumped in with public health, and therefore had to compete with other local priorities, like vaccination programs and water purification, for funding. As a result, the amount of funding provided to home care in health regions was dependent on the degree to which it was prioritized by local public health officials. The former Long-Term Care Program Executive Director went on to note that:

> It wasn't really any of the Ministry of Health's business how much health care got done across the province as far as the providers were concerned... particularly at the hospital board level... Their first loyalty is to their patients and to their local community, and if a bureaucrat tells them that they're spending way more than their fair share... they wear that as a badge of honour... So, the same applied to home care across the province prior to the late 80s-early 90s... For example, the per-capita spending on home care in Kingston was roughly 4.5-5 times as much as it was in Hamilton. And why was that? Well, the local medical officer of health in Kingston thought it was a good idea![16]

Due to this dynamic, inequities emerged and solidified across the province, with health regions that were run by those who were more skilled at lobbying the provincial government for funding receiving more than others, regardless of need. Historically, home care policy arrangements had

[15] Geoffrey Quirt (former Assistant Deputy Minister of Health and Executive Director of the Ontario Government's Long-Term Care Division) in discussion with the author, December 2021.
[16] *Ibid.*

established the role of the Ministry of Health as the "insurer" and quasi-municipal public health boards as "managers".[17] This meant that if concerns about the quality of care or any incidents that occurred related to home care were brought to the Ministry, they would be able to respond that actual spending decisions and how care was administered were ultimately the responsibility of the local public health boards.

This relationship between the Ministry of Health and local health boards had historically been one of convenience for both parties, as the Ministry could avoid culpability for negative outcomes in the health care system and the health boards had jurisdictional authority on how spending was allocated. With the economy going strong and health system costs being relatively easy to manage, governments were content to play the role of insurer throughout the 1970s and first half of the 1980s. However, as health costs and gaps in community care provision between regions grew alongside a slowing growth in the Canadian economy, tensions began to emerge between local and provincial governing bodies regarding this arrangement. The first person in government to challenge this legacy of health governance and resource distribution was Elinor Caplan. As Minister of Health in the Peterson Liberal Government, Caplan came to realize that the Ministry had limited influence on funding distribution for the province's health system. This became particularly problematic in the wake of the 1986-1987 and 1989-1990 cuts to health transfers from the Federal government to the provinces, as 93% of the province's health budget was allocated to hospital and physician funding and could not be easily decreased. This created a

[17] *Ibid.*

strong incentive for ensuring that the remaining 7% of funding could be influenced by and accountable to the Ministry of Health.[18]

It was therefore clear to governments as far back as that of the Peterson Liberals in the late 1980s that home care spending could not function as a means of cost saving in other venues of care if the government had no control of the actual allocation of that funding. The first step in their home care policy reform strategy, then, was to introduce accountability into the system to ensure that dollars marked for home care not only went where they were intended, but also to where they were needed most.[19] However, when the Liberal government suffered a surprise election loss to the NDP in 1991, much of the work put in place by the Ministries of Health and Community & Social Services had been left unfinished. The NDP government was similarly unable to implement its ideal home care reform agenda, this time because of fiscal pressures combined with interest group opposition and succeeded only in following through on cost-control measures. As a result, by the time the Conservative government under Premier Harris came into power, the groundwork had already been laid by their predecessors to see a home care reform agenda emphasizing the offloading of costs from the government onto service providers promptly implemented.

Table 1 below reproduced from Baranek (2000) outlines the policy design decisions made by the Liberal, NDP, and Conservative governments in Ontario within their respective service delivery

[18] Elinor Caplan (former Ontario Minister of Health from 1985-1990) in conversation with the author, June 2022.
[19] *Ibid*

models for LTC services. Within each party's policy designs for LTC reform were plans for home care, and each model from 1990 onward included a specific financing change to ensure home care funding was capped. Though the chart demonstrates clear distinctions between the parties' LTC delivery models, as the rest of this chapter will demonstrate, the underlying reform goals that were being pursued by each model were more similar than they were different. It will also show how the home care reform trajectory ultimately pursued in Ontario was not the result of a sudden, drastic policy change by the Harris Conservatives, but rather a gradual one which had its roots in the policy legacies of its OHIP inclusion and the privileged role of nonprofit delivery of services established in the 1980s.

Table 1: LTC Policy Designs by Ontario governments (1987-1996)

Gov't	Model	Financing	Allocation	Delivery
Liberal (1987)	One-Stop Shop	*Who:* persons over age 65 *Public-Private Funding:* a) fully provincially funded services: in-home services (professional, homemaking), functional assessments, placement services b) public/private financing: community support services	new agency to broker (informal contracts and purchase of service agreements) in-home services from external providers; direct provincial funding for community support services; cooperative model; purhaser/provier split.	existing mix of for-profit and not-for-profit providers; One-Stop Access would provide information for all services, coordinate access to, deliver or purchase in-home services, and coordinate access to institutions.
(1990)	Service Access Organization (SAO)	*Who:* persons over 65 and disabled population *Public-Private Funding:* a)fully provincially funded services: in-home services; b) public/private financing : community support services (co-payments based on income rather than assets). c) regional funding envelope; d) capped budget for Home Care	SAO broker in-home services from external providers; direct provincial funding for community support services; cooperative model; purchaser/provider split.	existing mix of for-profit and not-for-profit providers; SAO would provide information for all services, coordinate access to, deliver or purchase in-home services, and coordinate access to institutions.
NDP (1991)	Service Coordination Agency (SCA)	(same as SAO) except community support services receive 100% of approved budget after revenues.	(same as SAO)	(same as SAO) except not-for-profit provider preference

(1993)	Multi-Service Agency (MSA)	*Who:* elderly and disabled population *Public-Private Funding:* a)fully provincially funded: in-home services, case management, placement. b) public/private financing: co-payments for community support services based on income c)MSAs must provide a defined basket of services which include community support services d) home care/support services in single capped budget	Regional planning; Government allocate all funding for both in-home and community support services to MSAs who pay salaried employees; cooperative model; no purchaser/provider split. People with disabilities funded directly to purchase their own services; market model; purchaser/provider split.	single not-for-profit agency (MSA) to provide *all* care; upto 20% of MSA budget for purchase of external service from for-profit and not-for-profit agencies
P.C. (1996)	Community Care Access Centre (CCAC)	*Who*: elderly and disability population *Public-Private Funding*: a) in-home services provincially funded; b) public/private financing: community support services; c) capped budget for home care	Government provides CCACs with budget to contract in-home services from external providers through competitive process; competitive market model; purchaser/provider split. Government fund community support service agencies directly; cooperative model; purchaser/provider split	Mix of for-profit and not-for-profit providers but managed competition contract process will likely give preference to for-profit agencies.

Source: Baranek (2000).

Institutional Shifts Under the Peterson Government

The provincial election of May 2nd, 1985 marked the end of a forty-year dynasty of the Progressive Conservative party in Ontario. Though they were able to win a plurality of seats in the Legislature, it was not enough to form a majority government. The Liberals and NDP – who each won 48 and 25 seats, respectively – formed an agreement wherein the NDP would back the Liberals via an accord to provide the Liberals with a stable minority government. It was not a true coalition government, as the NDP indicated they did not want cabinet seats in order to maintain a credible distance from the Liberal party agenda, but the NDP's backing allowed the Liberals to form government under Premier David Peterson on June 4th after a non-confidence vote defeated the Conservative government.

This initial period of Liberal governance was one where reforms to home care in the province were primarily couched in terms of broader discussions of long-term care reform. One of Peterson's first acts as Premier was to appoint Ron Van Horne as Minister for the Office of Senior Citizens Affairs (OCSA) with the responsibility of guiding reforms to social services targeting older adults in the province. It was the first time in Canadian history that a Cabinet Minister portfolio had been associated with the OCSA, which was an advocacy ministry solely focused on issues concerning older adults. This action could be seen as signifying the influence of seniors' advocacy groups on the Liberal government's LTC reform trajectory, as indeed, groups representing older adults had long lobbied for a spokesperson in Cabinet to represent their interests, as the programs that were provided to them spanned several ministries, including but not limited to Health, Community and Social Services, Housing, Municipal Affairs, and Finance (Baranek 2000).

However, establishing the OCSA was also done with the intent of giving the government greater control over LTC reform by wrestling control over the portfolio from the Ministries of Health and Community & Social Services. In this sense, the appointment of a Minister to the OCSA is perhaps better characterized as an institutional change which attempted to allow for LTC reforms to occur without concerns of inter-ministerial conflict. The political appeal to seniors' advocacy groups was more likely a secondary benefit associated with the decision. Indeed, as Baranek (2000) notes, the Liberal government's LTC reform mandate at this stage amounted to little more than a "gathering of information and the suggestion of what future reform would look like" (pg. 50). Had the government's goal been to acquire additional votes from the senior demographic, it

is likely they would have pursued more tangential policy changes through the appointment of Van Horne.

The appointment of Van Horne was followed shortly by an announcement from him that the OCSA would conduct a public consultation to inform its review of programs and services available to seniors. This consultation revealed an underlying consensus on the problems in existing services for seniors in the province, most notably the lack of coordination among the Ministries of Health, Community & Social Services, and Housing, and the need for better coordination at the level of the provincial government. Respondents also indicated a desire to remain in their homes as long as possible, as well as the presence of a single access point at the community level for information and referral to all services available to seniors. Also highlighted were the gaps in homemaker services, particularly the inability to access these services without a physician's referral. Change to this system was recommended, as was a decreased reliance on institutional care and expanded community services and supports (Office for Senior Citizens' Affairs, 1985).

Despite the fact that the OSCA's review of programs targeting seniors narrowed the scope of reform to community-based services – of which the MCSS provided approximately 80% of those which targeted seniors – and health – of which the MOH funded 80% of all expenditures on services to seniors via the Home Care program – the OSCA remained the lead agency for coordinating reform (Baranek 2000). In June of 1986, OSCA Minister Van Horne tabled *A New Agenda: Health and Social Services Strategies for Ontario's Seniors,* which detailed the Liberal government's strategic plan for improving health and social services for older adults. The white

paper put forward five strategies which emphasized building up community-based services to promote illness prevention and functional independence, improved service coordination, and introduce local planning (Van Horne, 1986).

Though not accompanied by any direct reforms itself, *A New Agenda* marked two important changes for how Home Care was approached by the government. The first was that its focus on illness prevention and health promotion to allow older adults to maintain their independence in their communities marked the initial stages of a shift away from a medical model of Home Care that emphasized supporting institutional forms of care. The second was that there was less of a programmatic focus in the report. As Baranek (2000, p.55) notes: "Rather than focusing on community-based services as a set of services for all the clients who currently used them, the government decided to focus on a defined group of users; namely, seniors… By taking this approach, the government was indicating that they needed to create a system that dealt with the complete needs of the elderly from community care to acute and chronic institutional care." These changes indicated a shift in the ideas regarding healthcare away from the status-quo approach built around supporting hospitals and LTC homes, and towards an emphasis on providing care at home and within local communities.

This shift also situated a specifically targeted demographic – older adults – at the core of the Liberal government's reform strategy. The One-Stop Access pilot project was a prime example of this. Announced in June of 1987, the proposal specifically noted that its primary intended purpose was to serve the needs of the elderly. One-Stop Access points would offer functional assessment of older adults in search of community health and social services and take

responsibility for bringing those services to seniors in their own homes (Office for Senior Citizens Affairs, 1987a, 1987c). Each of the five pilots was given the freedom to develop its own administrative model if it fit within the constraints of provincial criteria. Specifically, each local authority was unable to reallocate funds from provincially designated programs without provincial approval (Office for Senior Citizens Affairs, 1987b).

Though the Liberal government distinguished itself from subsequent NDP and Conservative governments in giving freedom to their community agencies to locally determine their administrative models, the imposition of provincial approval for funding reallocation also represented the first example of a funding accountability mechanism introduced in home care management. Funding for service provision was to be transferred from the provincial government to the One-Stop Access authorities, who would in turn be fully accountable for those funds and responsible for ensuring they went to the appropriately designated target programs. Any efforts to see program funding reallocated would require provincial approval, and One-Stop Access authorities were intended to have a similar aggregate planning relationship to District Health Councils as hospital boards and public health units (Baranek, 2000).

In this sense, the One-Stop Access proposal did not represent a radical change to the existing delivery system for community health and support services. Though One-Stop Access sites were given substantial freedom to coordinate their own administrative model as local authorities, the existing system of service delivery by formal and informal providers was left unchanged, and all new funding to community health and social services was targeted at improving geographic equity, addressing cultural needs, and securing the viability of informal and social supports

(Office for Senior Citizens Affairs, 1987b). The balance of public and private responsibility in the financing and delivery of these services did not shift. One-Stop Access sites were thus very much a trial program in senior-targeted community health and social service delivery.

Another trial program introduced with the *New Agenda* was the Integrated Homemaker Program (IHP) in 1986, which represented another element of the Liberal government's strategy to gradually introduce more social support elements to LTC. Funded by the Ministry of Community and Social Services (MCSS) but administered by the Ministry of Health, the intention of the IHP was to aid families with caregiving tasks like shopping, meal preparation, cleaning, laundry, and personal care. The IHP was gradually introduced to 20 home care programs across the province and was poised to expand to 38 under the NDP but was never fully integrated by the Conservatives within their LTC reform approach. The positioning of the IHP within the Liberal government's *New Agenda* document indicated a desire to see the Home Care program expanded to include home support services so as to help older adults to avoid having to rely on more expensive acute care (Van Horne, 1986). In this sense, the Liberal government's perception of home care in the mid-1980s appeared to be that it represented a cost-saving alternative to institutional forms of care. However, this perception was one that ultimately appeared to be quite tentative for the Liberal government, and not one that would be able to overtake the concerns that arose in subsequent years regarding the rising costs of the Home Care program in Ontario established by previous policy decisions, as later sections will demonstrate.

Indeed, the IHP represented the province's last true attempt at an expansion of the Home Care program in terms of its scope of service provision, but also – as a pilot project – did not

represent a drastic change to it. Indeed, many of the reforms under consideration by the Liberal government did not constitute a major realignment of the systems in place, and even the IHP as a new program was short-lived, ultimately being eliminated by the NDP government before it could be fully expanded across the province. This further demonstrates that the idea supporting the creation of the IHP – expanding the range and extent of home support services in Ontario, was not one that became entrenched in the health policy agenda in the late 1980s.

Indeed, while the Liberal government's early changes represented a preliminary shift in policy priorities for the bureaucracy in both the Ministry of Health (MOH) and Ministry of Community & Social Services (MCSS) towards an increased focus on expanding home and community care programs, this shift was ultimately reversed in the 1990s. However, they did facilitate increased attention to LTC reform when the Liberals secured a majority victory in the election of summer 1987.

With a legislative majority established and preliminary institutional changes to the provincial health bureaucracy in place, in 1987 the Liberal government's health reform mandate ramped up significantly with the shift to a non-medical, lower cost population health approach accelerating rapidly, particularly regarding LTC policy. Several institutional structures and processes were introduced to facilitate this. The first and perhaps most notable was the Premier's Council on Health Strategy, formed in December of 1987 following the publication of three major health care reports from the Ontario Health Review Panel (chaired by Dr. John Evans), the Panel on Health Goals (chaired by Dr. R. Spasoff), and the Minister's Advisory Group on Health Promotion (chaired by S. Podborski). These reports – which went on to be referred to

as the Evans, Spasoff and Podborski reports – emphasized a broader spectrum of health – along with its social determinants – and suggested a refocusing of the system on community care, health promotion and disease prevention. Elinor Caplan – the Minister of Health at the time – referred to these reports and their conclusions as important sources for guidance on health reform direction in the months leading up to the formation of the Premier's Council on Health Strategy (MOH, 1989). While only the Evans report made recommendations to Health Minister Caplan regarding home care specifically, each broadly emphasized the need for Ontario's healthcare system to make a shift toward focusing on health promotion and disease prevention, with community care programs (like home care) situated as a key element in strategies associated with this goal (Evans et al., 1987; Podborski et al., 1987; Spasoff et al., 1987). However, even in the case of the Evans report, home care was really only discussed in terms of recommendations to increase its integration with hospital care, demonstrating home care's relatively low priority for health system experts and the Premier's Council.

The reports went on to inform Ministry of Health restructuring efforts taken on by Caplan in 1988 to "expand its former role as administrator – insurer, funder, and claims payer – to take a leadership role in safeguarding the strengths of Ontario's health care system" (Caplan 1989, p. 6). The Premier's Council also credits its "Vision of Health" as owing much to the work in these three reports (Premier's Council on Health Strategy, 1989a). Chaired by the Premier, with Caplan as vice-chair, the Council formally adopted the World Health Organization's (WHO) definition of health, which incorporated more recently acknowledged economic, environmental, and lifestyle determinants of health. This provided a key institutional support for the population health approach the Liberal government sought to implement, as it served to ideologically align the

government's political and bureaucratic arms. As will be shown in the next chapter, the NDP government in Saskatchewan made similar acknowledgements and commitments related to the WHO definition of health in the early stages of its health reform strategy, demonstrating the existence of an institutional policy trend that was being adopted across multiple provinces as an ideological justification for health reforms. However, the trajectory in each province also saw similar results at the end point of the study period in terms of home care ultimately not playing the role in the reformed health systems initially envisioned by the respective policy actors associated with the early stages of the period of change in each jurisdiction.

The Premier's Council's work contributed substantially to the environment of long-term care reform in the province at the end of the 1980s. One interviewee in Baranek's (2000) investigation of long-term care reform in Ontario went as far as to suggest that the Council guided health and LTC reforms more so even than the Ministry of Health. The Liberal government's decision in 1989 to make John Sweeney, the Minister of Community and Social Services, the lead on LTC reform was emblematic of this. The Premier's Council's "Vision" of Health emphasized its social and economic determinants, and its first health goal was for the province to pivot away from an illness response model focused on institutional care towards a health promotion and illness prevention model through community service investment (Premier's Council on Health Strategy, 1989a). The Ministry of Community and Social Services was seen as better suited to meeting this health goal due to its history of promoting a non-medicalized approach to health in contrast with the Ministry of Health. However, this move also represented an opportunistic attempt by the Liberal government to impose cost-saving measures on the Home Care program.

On the one hand, the Premier Council's Vision of Health represented a continuation of the Liberal government's thinking regarding LTC reform, at least thematically with its stated focus on shifting toward health promotion and illness prevention through stated commitments to increasing funding for home and community care. However, its decision to shift responsibility for LTC services – and most notably Home Care – to the Minister of Community and Social services also served to situate them for the introduction of cost controls in the form of funding caps and cost-sharing with the Canada Assistance Plan, and eventually user fees. This duality of focus with regard to the Home Care program as being something seen as both requiring more investment, but also more cost control measures represented a shift that appears to have emerged between the publication of the Liberal government's *New Agenda* and Vision documents. This becomes clearer when we investigate the work that was done by the Premier's Council before it presented its Vision.

Following its formation, the Premier's Council went to work putting together two consulting studies. The first was intended to evaluate the funding and incentive mechanisms in place and recommend new incentives that could be used to better utilize the health resources available. The second was undertaken to examine options for future improvements to the community services sector. Stevenson Kellog Ernst and Whinney was chosen to undertake the first study and Price Waterhouse was chosen for the second. Each project began in August 1988 and their final reports were received in March 1989. These reports, alongside an expert panel conference that occurred in January of 1989, culminated in a report by the Health Care System Committee (1989) of the Premier's Council titled *From Vision To Action*, which provided strategy directions for the Ontario government regarding hospital funding systems, physician payment methods,

community services development opportunities, and organization & system linkages. Though this report made limited mention of the Home Care program, the community services study performed by Price Waterhouse included a comprehensive operational review of the Home Care program. This report detailed a reform strategy for Home Care which went on to inform a key element of the Peterson government's cost-containment strategy for LTC reform.

When reviewing the Price Waterhouse (1989) report on the Ontario Home Care program, it becomes quickly evident the authors' greatest concern throughout their analysis of the program was the need to introduce cost controls within it. After a short introduction of the program within the executive summary, the report jumps straight into highlighting Home Care's rapidly increasing growth in spending and utilization over the previous decade, making specific reference to a 144% increase in per capita use of the program from 1978-1986 and warning that the open-ended nature of the Home Care program as an OHIP-insured service "provided little impetus to manage such program growth". Following this, the report's overview of the program's design and role within the province's health system noted the review's intent to both "enhance the scope and effectiveness" of the Home Care program while also providing recommendations on mechanisms for "containing program expenditures" (pg. II).

Indeed, the goal of "managed growth" touted by the Price Waterhouse report's authors seems built primarily around interventions intended to control rising program costs, with the first two guiding principles the report lists for defining the Home Care program's role and design being related to improving cost-effectiveness and preventing rising expenditures, respectively (pg. 34). These principles are presented almost immediately following a discussion by the authors on the

difficulty of making home care a cost-effective alternative for institutional care in general (making reference to Weissert 1985). They note the "challenging predicament" faced by the Ontario Home Care program and its capacity to offer a "full and cost-effective alternative to institutional care while not having a design that leaves the program vulnerable to unacceptably high levels of utilization and program spending" (pg. 32). The report also highlights the existence of a "cost-effectiveness gap" in terms of the Home Care program's ability to serve as a cost-effective alternative to hospital care and institutional long-term care. Its authors argued the gap stemmed from the fact that home care service limits on individual recipients were forcing a substantial population of those who could be more cost-effectively served by home care to seek more expensive hospital or institutional care (pg. 30). In essence, the problem was that the limits set on the amount of publicly funded home care any individual could receive was below the threshold necessary to address the home care service requirements of many recipients, forcing them to look to alternative care options to provide their unaddressed care needs.

The Price Waterhouse report's recommendation to address the cost-effectiveness gap was to raise individual service limits while introducing cost controls in the form of a cap on the number of clients served by the program. Though the report's authors note that this approach would allow for more direct control of cost, they also note that it could lead to other disadvantages, including the tendency for services to be diluted as a result of the hard caps, contributing to a further widening of the gap the approach was intended to address in the first place. The other key recommendation was for the government to divide the "social" elements of the Home Care program (namely Homemaker services and Meals on Wheels) and the "medical" elements (namely home nursing services and post-acute care rehabilitation services & therapy) into

distinct programs. The intent of this proposed change was to address the ambiguity regarding the purpose of the Home Care program in terms of it having a "treatment/rehabilitation focus or a support/maintenance focus" and whether it was "meant to serve as an alternative to institutional care" (pg. II). Most notably, formalizing the distinction between the two programs would allow for the "social" iteration to be transferred from the Ministry of Health to the Ministry of Community Services, where it could have more cost control elements introduced within it, including cost sharing mechanisms and "client participation" in funding (pg. III).

A close reading of the Price Waterhouse report shows that, though the authors clearly recognize the increasing demand for home care and associated need for the program to grow, they also portray an incessant focus on managing and controlling that growth. This provides a strong indication to the reader that the authors do not perceive Ontario's Home Care program as a cost-saving program in and of itself. Indeed, the report makes early mention of there being no conclusive empirical evidence of home care being a cost-effective alternative to institutional long-term care & hospital care and views its role in the province's health care system as being an essential backup and compliment to them (Price Waterhouse 1989, p.III). It is important to note that, thought the authors offer suggestions in the report on how to potentially improve the cost-effectiveness of Ontario's Home Care program, they do not ultimately argue that their suggested reforms will make the program cost-effective, only that the expected growth of the program might be more manageable. In broad terms, the report's authors portray the Home Care program as one whose growth had been left undermanaged and lacking in strategic direction. This is most evident in the final paragraph of the report's section overviewing the Home Care program, which notes that Home Care has developed via the "piecemeal introduction of new

service components" with no "overall strategic plan or framework for guiding these developments, assessing their appropriateness, or determining their effects on local programs" (Price Waterhouse, p. 10)

With the Price Waterhouse report on the Ontario Home Care program being so heavily focused on how to improve its cost-effectiveness, it is not surprising that the Liberal government that commissioned it subsequently became focused on cost-effectiveness in its reform strategy for Home Care. This can be further seen in content from the Premier's Council on Health Strategy's *From Vision To Action* document. In the document's section on community services development opportunities, there is a clear indication that the council does not see many community services as providing cost-effective alternatives to institutional care. The document notes that "there is only partial congruence between community service populations and institutional service populations. Many types of community services do not serve groups who would otherwise be in institutions" (Premier's Council on Health Strategy, 1989b, pg. 12). While the Home Care program is not specifically mentioned as an example of this point, this quote demonstrates the council's belief that investing in community services does not necessarily represent a means of introducing cost savings in institutional forms of care. Here again, the theme of necessity rather than intrinsic usefulness in terms of allowing for cost savings is maintained with regard to home care.

However, despite expressing this belief, the council still recommended an expansion of community service funding, suggesting it be doubled within a defined time period and that this

funding come primarily through the redirection of existing resources.[20] This represents a continued baseline acknowledgement from the Liberal government of the need to -eventually- shift the health system's emphasis from an institutional care reliance to a more community-based care model (Premier's Council on Health Strategy, 1989b). That said, by 1990, the Ontario government's previously intended trajectory of redirecting funding from institutional care to community services was already in the process of being gradually reversed.

What this section has demonstrated so far is that the Liberal government's initial approach to Home Care reform once they controlled a majority in the Legislative Assembly was part of a broad strategy to reform LTC policy, one which required a series of institutional changes to facilitate a substantial role for the bureaucracy in informing future directions of Ontario's health system reforms. Subsequent analyses conducted by the bureaucracy suggested that there was a need to shift the province's medical model of health to one which placed a greater emphasis on the social determinants of health and wellness. The Liberal government's decision to shift away from the medical model thus demonstrated the influence that the bureaucracy had on the ideas held by policy decisionmakers. In a sense, the Liberal government began Ontario's health reform journey in a similar fashion to Saskatchewan in terms of the ideological underpinnings of its reform strategy, which will be further demonstrated in the next chapter.

However, there was a key element of Ontario's decision to shift away from the medical model to the health promotion and illness prevention model that distinguished it from Saskatchewan.

[20] It is worth noting that the report does not actually define this time period for doubling the funding.

Specifically, the shift in Ontario was not built on a perception of community health services - namely the Home Care program – being inherently cost-effective alternatives to the institutional forms of care prominent in the medical model. Indeed, while the Price Waterhouse report recommended removing the social elements of the Home Care program from OHIP coverage to limit rising costs (and share them with the federal government through the Canada Assistance Plan), the Liberal government ultimately sought to go even further and cut out the Home Care program from OHIP coverage entirely and shift responsibility for all elements of the program to the MCSS.

The significance of the Liberal government's decision to ultimately pursue this strategy is twofold. The first is that they present evidence for my first hypothesis, in that home care in Ontario was not perceived as a vehicle for cost-savings in the province's health care system due to perceptions of its costs rising uncontrollably. The second is that they demonstrate the existence of a retrenchment agenda for home care policy in Ontario as far back as 1989. As the next section will demonstrate, the Liberal government's attempt to implement its LTC reform strategy represented the first instance of government commitment to home care policy retrenchment, with the long-term goal of transforming a medically insured service into a targeted one that the government would only have to partially fund.

Strategies for Change: From One-Stop Access to Service Access Organizations

In mid-1990, the Liberal government released its focused plan for reforming long-term care in the province, *Strategies for Change*. Though the plan still explicitly noted the Liberal government's intention to implement an incremental approach to LTC reform that would work

within the framework of the existing delivery system, there were a few key evolutions that had occurred since the publication of *A New Agenda*. The first was the inclusion of references to individualization, independence & consumer choice, and community living in the list of core principles associated with the reforms (MCSS et al., 1990). This change emphasized the importance of in-home support programs like Home Care and homemaker services to the Liberal government, as these programs worked to keep people in their home communities, where they would be able to have a greater degree of independence and choice in terms of the care they received. It has also been perceived as a potential response to disability activist mobilization in the late 1980's around consumer choice in terms of welfare support (Baranek, 2000).

The second evolution was in the proposed service delivery system. Building off the existing Home Care Program and Placement Coordination services and modeled similarly to the One-Stop Access pilot program, the Liberal government sought to introduce a Service Access Organization (SAO) in at least 38 regions (equivalent to the number of Home Care programs) across the province. These SAOs would provide a single, coordinated point of access for information and referral to community support services, specialized services, long-term care homes, and "In-Home Services", a term to referred to the integrated and consolidated bundle of in-home programs, including Home Care, Outreach Attendant Care, the Integrated Homemaker Program, Homemakers and Nurses Services, and the Home Support Program homemaking services. This grouping of professional services with personal support services through consolidation of In-Home Services represented another evolution of the Liberal government's LTC reform strategy, and the intention behind it was to make the existing system of services more responsive, integrated, and manageable (MCSS et al., 1990).

SAOs would also be responsible for negotiating contracts with community service providers through a formalized brokerage model to replace the informal contracting process that had existed up until that point. The informal contracting process had been seen as a "closed shop" that benefited existing providers, and the formal process that replaced it allowed new organizations to apply to be sponsoring agencies for service access, as well as preventing current direct providers of service to be the sponsoring agency (Baranek 2000). The intent here was to eliminate the perception of a potential conflict of interest associated with the management of Home Care programs by direct providers, such as the VON, who had held that role in a handful of regions.

These evolutions demonstrate an effort by the Liberal government to focus its LTC reform strategy on programs designed to keep people living independently in their homes. In addition to the integration and consolidation of In-Home Services, the government also outlined a series of caregiver support services out of recognition that 80 to 90 percent of the assistance given to those in need of daily personal support at the time was provided by informal caregivers. The Premier's Council also suggested transferring additional administrative authority to local communities, but that this should occur after a corporate restructuring within the government to integrate the Ministries of Health and Community & Social Services at the regional level (MCSS et al., 1990; Peat Marwick Stevenson & Kellogg, 1989). The primary mechanism for this was the creation of a decentralized, joint division between the Ministries called the Long-Term Care Division, from which one ADM would report to the Deputy Ministers of both Health and Community & Social Services. LTC programs from either ministry would be integrated within the structure of this new division and report to its ADM.

The new LTC division got to work with decentralizing LTC planning by establishing fourteen local offices, where staff would work with local organizations and District Health Councils (DHCs) to plan reform implementation. Though policy development and program management remained the responsibility of the joint division during this period, the long-term goal was to see these functions decentralized and responsibility for them transferred to the local offices. At this stage, however, the Liberal government's restructuring efforts for home and community care were less focused on the previously stated goals of improving accountability and accessibility and instead on controlling their costs as noted earlier. As former Health Minister Elinor Caplan noted in an interview, the increased scrutiny applied to home care funding was due to both the timing of recent cuts to provincial health funding as a result of the Mulroney government's changes to the federal funding formula for Established Programs Financing and an increasing awareness by the Liberal government of a recession being imminent [21]. Promoting a disease prevention and health promotion model over the medical had shifted from being the goal of health system reform to the justification for investing less into expensive medical programs, like the Home Care program.

The nature of the LTC reforms that occurred in the final years of the Peterson government demonstrate the presence of two key ideas being held by policy decisionmakers. The first was that cost-containment had become a top priority due to the external fiscal pressures imposed by federal funding cuts and recessionary circumstances. The second was the enduring notion that community service programs like Home Care did not necessarily represent an investment vehicle

[21] Elinor Caplan (former Ontario Minister of Health from 1985-1990) in conversation with the author, June 2022.

for cost-savings in other parts of the provincial health care system. Though the Liberal government initially experimented with expanding community care provision via the creation of the Integrated Homemaker Program, by the end of the 1980s, even relatively inexpensive community service programs were subject to the intense scrutiny for potential cost-savings.

The Home Care program thus became a target for cost-savings. The Price Waterhouse report brought attention to its rapidly rising costs, and also provided the government with a potential avenue to control costs within the program: transferring responsibility over it to the MCSS. Indeed, the relative influence of the Price Waterhouse report on the later stages of the Liberal government's LTC strategy demonstrates the dominance of more entrenched ideas regarding Home Care as a program experiencing wildly expanding costs over more recent, competing ideas of expanding home care provision as actually contributing to cost savings in healthcare. This is the first piece of evidence for my preliminary hypothesis in Ontario, as the ideas communicated in the Price Waterhouse report were based primarily on the authors' perceptions of the Home Care program's initial development and subsequent cost trajectory.

A key step in achieving cost savings in Home Care was integrating it with other community services. Establishing a regional integration mechanism (i.e. SAOs) was therefore an important step for the Liberal government. Indeed, as Baranek (2000) discovered through her interviews with government workers, regional integration of services was seen as the first move to the eventual integration of Ministry budgets. This meant that the Home Care program could be transferred from the Ministry of Health to the Ministry of Community and Social Services, where programs tended to use a user-fee, shared-cost model that relied more on volunteer labour and

less on professional, unionized workers like nurses with higher pay requirements. The program's budget could then eventually be transferred out of OHIP to a broader budget for all LTC community-based services, which would eventually be capped. Indeed, she notes in her thesis that: "the reallocation of funding from institutions to the community was essential to the overall goal of cost control and containment. Without an integration of the two divisions, the creations of a single budget envelope for LTC community and facility services would not be possible." (Baranek 2000, p. 77) Integration of the Ministry of Health and Ministry of Community and Social Services meant both budgets could be combined, and therefore have caps and other controls introduced to it. Furthermore, as the Price Waterhouse (1989) report noted, inter-ministry service integration would have potentially allowed for up to half of the Home Care program's costs being shouldered by the federal government.

As Harden (1999) notes, efforts to decentralize program administration represented a key element of the neoliberal trend in the province throughout the decade across parties that occurred alongside a prominence of debates concerning local control strategies for health care. His argument for the presence of these policy trends was that they served as a means for political elites to "preach the merits of local control and integration" but in practice rely on "fiscal centralism" to establish a reform agenda that would insulate the government from consequences of cutbacks and delegate them to community administrators (Harden 1999, pg. 1). Indeed, the Liberal government's inclusion of individualization, independence & consumer choice, and community living among the core principles in *Strategies for Change* could be interpreted as an attempt to justify its increased focus on budget integration and decentralization of LTC.

While the long-term plan for home care was never made explicit by the Liberal government, by the end of the 1980's its increasing focus on fiscal control was clear not just to the bureaucracy but also to the service providers. What had started as an easy relationship eventually became formalized through fiscal tensions. This change in relationship was exemplified by conflicts between the government and service providers regarding home care funding of both the Victorian Order of Nurses (VON) and Red Cross that began in Spring of 1988 and continued into early 1989. Both organizations were facing crises due to multi-million-dollar shortfalls in funding as a result of Health Minister Elinor Caplan's introduction of caps on funding for homemaker services to service providers. By winter of 1988, the issue had escalated substantially, and from December of that year to late January of 1989 dozens of petitions with thousands of signatories flowed into the Ontario legislature addressing the funding shortfall, and debate over how to respond to it raged, culminating in a protest outside of Queen's Park by Red Cross nurses. During this period (particularly amid the Queen's Park protest), home care was a daily topic of debate, even serving as a motivation for calls to have the Legislature pressure the government to schedule an emergency debate on January 9th, 1989. Debate on home care funding within the provincial parliament peaked on this date, and statements from the opposition indicated that the Liberal government had caved into the pressure by agreeing to provide a one-time funding top up to cover the Red Cross's $1.1 million deficit.

The public attention to the standoff between the Red Cross and provincial government and the ultimate decision of the Liberal government to absorb the debts at the heart of the conflict demonstrated the influence that the voluntary sector had on home care funding and policy, both in terms of it being the standard-bearer for service delivery and as a collection of powerful

interest groups. This influence would continue to be seen throughout the 1990s, as the NDP and Conservative governments attempted to navigate home care policy reform options that would avoid raising the ire of the organizations that had historically been the primary providers of care within communities.

Though the Liberals' plan for LTC reform was interrupted by their September 1990 election loss to the NDP, the Rae government would eventually follow through on elements of the Liberal LTC reform agenda, including the removal of Home Care from OHIP coverage. As the next section shows, the privatization of Home Care, often blamed on decisions made by the Harris Conservatives in the late 1990s, actually has its roots in decisions made by their predecessors. The LTC reform strategy initiated by the Liberals was one that – based on the reports generated by the Premier's Council on Health Strategy analyzed above – became increasingly focused on cost containment. Though the original vision of the Liberal government's health reform strategy was to develop a system that focused on health promotion and disease prevention to ensure that health services could be both accessible and equitable, the accountability and cost containment elements became more important as fiscal pressures on the province's health system ramped up at the end of the 1980s. With their unexpected rise to power, the NDP government found itself following a similar trajectory to the Liberals, with an early reform focus on accessibility and equity that shifted to prioritizing cost control measures as additional fiscal pressures materialized, along with the added pressure of mobilized interest group opposition. Indeed, the NDP went on to facilitate a substantial portion of the Liberal reform plan via the few policies it was able to implement throughout its governing tenure and ultimately open the door

for the movement of more care out of the public realm to the private one of user fees and copayments, as will be demonstrated later in the chapter.

The NDP's Redirection and Consumer Interest Group Coordination

The Liberal's plan for LTC represented a cornerstone of the election platform they brought into the snap election they called in Fall of 1990s. At this stage, the retrenchment goals for home care had been fully bundled into LTC reform portfolio. Community planning and implementation meetings slated to begin in September were cancelled as a result of Liberals' loss to the NDP. Though the Liberals were surprised to have lost the snap election that had been called by Premier David Peterson, who had hoped to obtain an easy majority victory, as Walkom (1994) notes, the NDP were even more surprised at their election victory, and came into power ill-prepared to assume the role of governing the province. They soon discovered that the province's finances were in dire straits, and the party's first two years in government were primarily focused on handling what ended up being the worst economic recession the province had experienced in decades.

With the surprise election of the NDP, LTC reform in Ontario was delayed due to a mix of factors. The most glaring one was the economic recession that had begun just months before the NDP government came into power. As Rae himself noted, the first two years of his tenure as Premier were primarily concerned with addressing the recession. Health system reforms were subsequently deprioritized in favour of other key policy issues that the party had a much clearer

vision on and were thus more capable of following through on, such as housing[22]. It was not until June of the following year that the Minister of Community and Social Services, Zanana Akande (1991), announced an investment of $440 million into community care programs, including home care, with a long-term investment of $647 million to be brought forward by 1996-1997. This funding commitment was the same as the one made by the previous Liberal Minister of Community and Social Services, Charles Beer in 1990. Indeed, the NDP's initial approach to LTC reform was largely a continuation of the work of their predecessors. Prior to the community care funding announcement, the only change that the NDP government had made to the LTC reform strategy was to involve the newly created Ministry of Citizenship, which assumed responsibility for older adults and those living with disabilities, as well as multicultural and anti-racism concerns.

Another reason for the NDP government's delay on LTC reform was that it had been an unfinished project of the Peterson government, whom the NDP had worked closely with under Bob Rae's leadership. The Liberals had only recently established their new framework for reform in *Strategies for Change* and, upon becoming Premier, Bob Rae had been requested by Elinor Caplan not to "mess with it" [23]. The work of the Premier's Council was also unfinished, with the final reports of both the Health Care System Committee and the Integration and Coordination Committee not being submitted until March of 1991.

[22] Bob Rae (former Premier of Ontario from 1990-1995) in discussion with the author, June 2022.
[23] *Ibid.*

The final reason for the NDP government's delay on LTC reform was the nature of their rise to power, in that the party itself did not expect to win the election, let alone attain a majority[24]. This in combination with the fact the NDP had never governed in the province before meant that the party was relatively unprepared to govern upon taking power. As Walkom (1994) notes, Rae was initially wary of bureaucrats who were seen as being able to "easily sabotage him". This distrust of the provincial bureaucracy made Rae reluctant to make significant policy changes early in his tenure and would go on to impact many of his future policy decisions. It also marked a clear divergence by the NDP government from its Liberal predecessors in terms of its approach to health reform, with Rae ultimately looking outside the bureaucracy for justification for its agenda rather than within it, as Peterson and Caplan had done before him via the implementation of the Premier's Council on Health Strategy.

The NDP government subsequently decided to conduct an internal review of the LTC reform plan before announcing its own goals. A key element of its plan was to develop a consultation paper which would seek further advice from previously ignored interest groups, particularly consumers, unions, and community support service providers. This paper, titled *Redirection of Long-Term Care and Support Services in Ontario: A Public Consultation Paper* was released in October of 1991 by the Ministries of Community and Social Services (MCSS), Health (MOH), and

[24] Thomas Walkom's (1994) book *Rae Days* notes that, on the night of the NDP's victory party, Rae was quoted in his victory speech as saying that the NDP "did not expect this result" (p. 34). Walkom goes on to note that Rae would later admit he had intended to resign from party leadership after the 1990 campaign.

Citizenship (MOC), and outlined the NDP's initial goals for LTC reform prior to beginning its extensive consultation process with interest groups and stakeholders (MCSS et al., 1991).

For the most part, the guiding principles and goals of the NDP's initial LTC reform strategy were similar to those of the Liberals. The main distinctions were increased emphasis on racial equity and enhanced worker protections, as well as a preference for non-profit providers of services. However, these distinctions would go on to inform many of their future decisions related to their reform trajectory. As for home care specifically, here again the NDP's initial strategy was to continue with the framework proposed by their Liberal predecessors, with the only substantial difference being the NDP's desire to ensure that there would continue to be no fees or copayments for necessary home care services in the province. As noted in the previous section, the long-term goal for the Liberal government's LTC reforms was to see Home Care program costs become diffused by transferring responsibility over it to the Ministry of Community Social Services, where it could be made eligible for CAP funding from the federal government and have the potential for client participation in funding. The NDP's initial desire to avoid introducing any copayments for essential home care services was indicative of their broader vision for LTC care reform, which was a return to emphasis on improving accessibility and equity, with an additional focus on racial and cultural dynamics as outlined in their *Redirection* document (MCSS et al., 1991). However, their later decision to follow through with the Liberals' plan of removing the Home Care program from OHIP would demonstrate a shift in reform priorities similar to that of their predecessors.

Service coordination within the NDP's initial reform plan was also comparable to that of the Liberals. The SAOs to be introduced in the province were relabeled as Service Coordination Agencies (SCAs) and the NDP planned to establish 40 rather than the original 38 planned by their predecessors. Much like SAOs, SCAs were intended to replace and consolidate the services of the Home Care Program and the Placement Coordination Services Program. Employees from each would transfer to the new SCAs, which would act as a one-stop access point for the same bundle of services that were to be coordinated through SAOs, including respite day programs, nursing home care, and the newly labeled "Health and Personal Support Programs", which represented the same group of services to be labeled as "In-Home Services" under the Liberal government (MCSS et al., 1991). There were to be no charges for Health and Personal Support Program services, unless those services were deemed as non-essential by SCA coordinators, in which case users would be expected to contribute to the service cost based on their ability to do so.

Beyond this, the LTC reform plan presented in the NDP's consultation paper noted an intention to shift funds from hospital care to community-based services, including an annual reallocation of $37.6 million from the hospital budget to LTC over the subsequent 5 years. Keeping with the NDP's attention to workers protection, the consultation paper indicated that the transfer of resources to the community sector would protect the interests of workers, with the extra financial resources being able to create new jobs in the community and in LTC homes. The government would assist workers in accessing these jobs through improved training programs and human resource planning (MCSS et al., 1991).

Recognizing that LTC workers were typically women – particularly female immigrants and visible minorities – the government's intent was also to adjust agency funding so that they would be able to provide more secure employment under improved working conditions (MCSS, MOH, and MOC 1991, p. 24). A key element in achieving this was extending pay equity requirements to the private sector and public sector workplaces that had not been previously covered, alongside increases to homemaker wages. Each health region in the province would be provided with a funding envelope for the provision of community-based services, which would be distributed by local offices under provincial guidelines and the assistance of local planning groups. The NDP government recognized that all communities could not be expected to have the same priorities for services, and so the government would establish criteria that would set a base level of funding for each service in each area (MCSS et al., 1991).

SCAs were in large part perceived by the government bureaucracy as being an extension of the Liberal model of SAOs, which is likely due in part to the fact that the bureaucracy itself had been given substantial leeway in developing the NDP government's approach outlined in its first consultation paper (Baranek, 2000). There was a strategic element embedded in releasing a public consultation as a starting point, however, as the NDP hoped to use it as a means of buying time to develop a model more reflective of its own values. Baranek (2000) notes that the consultation served to present the SCA model as a foil upon which community groups could reflect their own interests, which the NDP government anticipated would better align with its internal values since many of its own ministers had come from the sectors for which they sought to increase representation.

Indeed, upon recognizing that the NDP government had made an ideological commitment to community and citizen advocacy groups, many of these groups – who had lacked coordination and presence when it came to interest mobilization under the Liberal government – began to mobilize. In June 1991, the United Senior Citizens of Ontario (USCO), Ontario Coalition of Senior Citizens' Organizations (OCSCO) and Consumers' Association of Canada, Ontario (CAC) combined to form the Senior Citizens' Consumer Alliance for Long-Term Care Reform (SCCA), which was intended to serve as a single-purpose body with a limited mandate of conducting public hearings and responding to the NDP government on LTC reform.

With a focus on issues affecting older adults and their families, the SCCA formed a 12-member panel that met through summer and fall of 1991. They also sent out their own Public Hearings Paper to a mix of 6000 consumers, providers, and experts throughout Ontario outlining the questions they felt were most relevant to LTC reform (SCCA, 1992). Their own consultation period culminated in the June 1992 release of their *Consumer Report on Long-Term Care Reform* following a public policy conference with 600 attendees, and 16 days of public hearings in January of that year. As will be seen in the next section, this report heavily informed the NDP government's later proposed structure of multi-service agencies.

Another interest group alliance that would go on to play an important role in the NDP's LTC reform process formed at the end of the Liberal government and was comprised of the Association of Visiting Homemakers Ontario, the Ontario Home Support Association, and Meals-on-Wheels Ontario. These community support associations amalgamated to form the Ontario Community Support Association (OCSA) in April 1992. The OCSA believed that the NDP's

consultation process would not sufficiently address the needs of their sector, and rather than simply responding to the government's LTC redirection plan, decided to provide an alternative. The OCSA and SCCA both agreed that the existing brokerage model with provider agencies that had been left largely untouched by both the Liberal and NDP reform plans would not address a core issue related to community service delivery in the province: the lack of integration between case coordinators who conducted assessments and the actual providers of care.[25]

Taking advantage of financial assistance provided by the NDP government, the OCSA and SCCA coordinated on developing a model that would address the core issue they had identified with the SCA model that had been presented in the *Redirection* document. Specifically, the OCSA and SCAA argued that the agencies that coordinated care and managed individual cases (SCAs) did not employ any nurses or support workers. The actual care was outsourced by these agencies to the various providers; while the case managers that worked in care coordination were themselves mostly determining eligibility for care based on doctors' recommendations, making the role of case managers somewhat redundant. According to the ADM of the Joint LTC Division at the time (who went on to become Chair of the OCSA), case coordinators within SCAs were essentially functioning as an extra, unnecessary level of bureaucracy. The OCSA and SCCA thus proposed an alternative model for care coordination agencies that would allow them to also provide care rather than having to contract it out to community providers.[26]

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[25] Geoffrey Quirt (former Assistant Deputy Minister of Health and Executive Director of the Ontario Government's Long-Term Care Division) in discussion with the author, December 2021.
[26] *Ibid.*

Established providers of home and community care programs included in the umbrella of the SCA approach had little issue with the brokerage model. However, the SCCA consultation and the NDP government's subsequent focus on integrating and standardizing home and community care programs eventually became perceived as an intent to reduce the authority of the provider organizations[27]. The government's consultation period lasted five months and was completed by spring 1992. It was at this point that more noticeable shifts in the NDP government's reform strategy began to emerge. However, with it came backlash from interest groups, including those which had only recently mobilized to participate in the government's consultation.

As the next section will demonstrate, by allowing for such a broad range of stakeholder input into LTC reform, the NDP government introduced potential barriers to its own ability to implement its strategy. Consensus on the best path forward for LTC in the province was all but impossible to achieve, yet the government was seeking to adopt a strategy that would somehow be able to satisfy all vested interests. The conflict that emerged forced the government to further delay its reform strategy while it tried to adapt to changing interest group power dynamics. This situation demonstrates that interests aligned with legacy providers of home care – particularly non-profit organizations – represented a powerful group that could mobilize to significantly impact the political processes associated not just with reforms to home care, but also LTC as a whole.

[27] Joe McReynolds (former CEO of the Ontario Community Support Association) in discussion with the author, November, 2021.

Multi-Service Agencies and Interest Group Backlash

Shortly after completing the consultation process that followed the release of *Redirections*, the NDP made an unexpected change in its LTC reform strategy by switching leadership on the process from the Ministry of Community and Social Services to the Ministry of Health. With the NDP's previously noted intent to emphasize social services over medical services in the long-term care sector, this was a surprising move, and one justified by a range of considerations, including expediency, the capabilities of individual ministers, and shifting ideas regarding the nature of LTC (Baranek, 2000). Zanana Akande, the acting Minister of Community and Social Services at the time, was also under investigation before eventually resigning from cabinet due to concerns regarding her activities as a landlord, which likely contributed to the switch. Frances Lankin – who had recently been appointed as Minister of Health – was assigned to lead the LTC reform and the joint division on LTC reported to her as the process continued.

On May 25th, 1992, Lankin spoke at the OCSA's annual conference to discuss the findings of the government's consultation process, where she noted concerns from respondents with the lack of flexibility in the 14 existing LTC area offices, the financial viability of the not-for-profit community-based sector, and the perpetuation of the medical model of service delivery (Lankin, 1992a). She also specifically acknowledged the OCSA's recommendation for a multi-disciplinary, multi-service organization. The OCSA's model, which they labeled Comprehensive Community Care Organizations, had been recommended for a gradual implementation process beginning in 10 areas that were considered structurally ready for the concept (the jurisdictions which had previously been sites for the Liberals' one-stop access model were highlighted). However, the alliance's internal consultation with its membership did not include substantial involvement from

the Red Cross, despite it being the largest member of the OCSA. This was due to their preoccupation with the tainted blood crisis that was occurring at the same time. The Red Cross was unsupportive of the model suggested by the leadership of the OCSA, eventually forcing the association to withdraw its support (Baranek, 2000).

The SCCA also forwarded an advance copy of its own *Consumer Report on Long-Term Care Reform* (1992) to Frances Lankin, along with Marion Boyd, Minister of Community and Social Services, and Elaine Ziemba, Minister of Citizenship, on June 22, 1991. Here again critiques of the SCA model were presented, with an alternative model being recommended in the form of "Comprehensive Multi-Service Organizations (CMSO)", a concept which the SCCA credited the OCSA with developing (SCCA 1992). The CMSO model sought to amalgamate existing, not-for-profit home and community service providers through either merging their operations or establishing linkages among them while simultaneously allowing them to operate under their individual auspices. Key features of the model included the provision of in-home and community support services, responsiveness to the population demographics and geography, a multi-disciplinary assessment process, the integration of case management and service delivery, a consumer appeal process, the establishment of provincial standards of care/service, and a global budget and/or capitation funding model instead of brokerage.

In anticipation of possible objections from existing providers, the SCCA mentioned a desire to maintain the unique identity of organizations like the VON and Red Cross within the CMSO model, as well recommending that for-profit agencies be allowed to maintain but not increase their market share as changes to the sector were enacted. The SCCA also pushed for wage

equality between institutional and community workers and worker unionization and collective bargaining on a regional basis (SCCA 1992).

On July 6, 1992, Frances Lankin spoke at the SCCA policy conference to provide feedback on the government's consultation process, as well as speak to the alliance's report. There, she noted the government's agreement that a new model for service delivery was needed and that the CMSO model put forward by the OCSA and SCCA was under serious consideration. She also noted her agreement with the SCCA's suggestions that wages and working conditions of community workers required improvement, and that following through on this would improve both the quality of care and quality of work and family life of workers and consumers (Lankin, 1992b). This provided a strong indication of the NDP government's intention to pursue a home care reform strategy with the same goals put forward by previous approaches while also seeking to move away from the brokerage model of contacting out services.

The dynamic witnessed between the OCSA and SCCA and the Ontario government surrounding the CMSO model also suggests pressure from advocacy groups representing seniors and community support service workers. Indeed, as Baranek (2000) notes, the sector had seen an opportunity with the election of the NDP into government to find success in lobbying where it hadn't before, as there were many political staff – including Ministers associated with LTC reform – who had previously been members of community support associations. She also draws attention to a growing distrust of the provincial bureaucracy on the part of the NDP government, which will be discussed further below. The OCSA and SCCA subsequently positioned themselves well to promote the interests they represented during the government's consultation period on

LTC reform. However, this also suggests that the interest group influence observed in this instance was temporary and more a product of opportunism than a demonstration of tangible power being held by seniors' and community support service workers' advocacy groups. This will become more evident later in the chapter when investigating the influence of provider groups on LTC reforms.

With the foundation for the NDP government's new LTC strategy laid, Lankin began putting the pieces in place for the reform process over the rest of 1992. After officially announcing the government's commitment to developing Multi-Service Agencies (MSAs) in September, on November 26, 1992, she put forward the *Long-Term Care Statute Law Amendment Act* to amend several statutes affecting services within LTC homes. She also announced that a report on the community consultation process would be released in early 1993 indicating the policy directions for reform which would be followed by another report in spring of 1993 announcing the implementation framework (*Statement to the Legislature Re: Long Term Care*, 1992). Then, on December 2nd, she announced $133.5 of the $647.6 million expansion to homemaker services in 17 regions of the province deemed as underserved. Even more significant was her announcement that homemaker services were to be made available to consumers regardless of their need for professional health services, which meant that those services would be integrated with Home Care.

With the Home Care program being an OHIP entitlement at the time, this change would have represented a substantial expansion of the home support services provided through provincial funding. This day also saw Lankin elaborate slightly on the structure of MSAs, indicating that

these agencies would be “created from existing agencies such as home care, placement coordination services and a range of not-for-profit service delivery agencies” (MOH, 1992). However, following this last announcement on the intention to establish an MSA model, work on developing it reached a standstill. Much like other governments of the time in Canada – including the NDP government in Saskatchewan – the Rae government struggled with the growing recession and its associated effects throughout the early 1990s.

The effects of the recession were exacerbated by further cutbacks in funding from the federal government, and in 1993 the NDP government decided that spending its way out of the recession was no longer a tenable strategy (Walkom, 1994). Instead, they pivoted to debt and deficit control through the raising of revenues through taxation and asset sales and the reduction of expenditures in government ministries and programs, which made up their Expenditure Control Plan and the negotiation of the Social Contract, a controversial piece of legislation by the NDP which mandated that public-sector workers earning more than $30,000 take up to 12 unpaid days off per year. The blowback from public sector unions as a result of the Social Contract went on to dominate the government’s attention until the NDP lost power. Their approach to LTC reform – including the integration of Homemaker services and Home Care – also shifted in the months following the negotiation of the Social Contract.

The fiscal issues that the NDP government faced throughout this period - as well as their consequences on subsequent social policy decisions - have been well-documented (D. E. Abelson & Lusztig, 1996; Fanelli & Thomas, 2011; Maclean’s, 2018; Panitch & Swartz, 2008; Walkom, 1994). For LTC specifically, Baranek (2000) notes that the Social Contract served to bring

together many stakeholder groups involved in the LTC reform process which had never previously collaborated politically, most notably for-profit and non-profit home care providers, along with more powerful groups like the Ontario Medical Association (OMA) and Ontario Physician's Association (OPA). These powerful associations offered financial support to the cause of the non-profit and for-profit home care provider groups, who formed the Community Providers Coalition (CPC), based on their shared concerns about the NDP government's intentions to allow for the unionization of workers in LTC (Baranek, 2000). These meetings were credited with the subsequent formation of alliances within the LTC sector that would impede the implementation of MSAs.

That said, opposition from provider organizations like the Red Cross and VON – even supported as they were by powerful interest groups in healthcare like the OMA and OPA – represented only one facet of the challenges faced by the NDP government when it came to implementing MSAs. When asked directly about why the NDP failed to implement its proposed MSA infrastructure, in addition to the earlier noted combination of fiscal challenges and vested interests in the existing system, former Minister of Health Frances Lankin also mentioned the fact that the Liberals' brokerage model had only recently been developed and that moving to disrupt it was difficult.[28]

Baranek's (2000) research suggests that bureaucrats were divided on the best way forward for LTC reform, with some more supportive of the MSA model and others hesitant about it when contrasted with the SCA model that had been largely developed by bureaucrats themselves. This

[28] Frances Lankin (Former NDP Minister of Health from 1991-1993) in conversation with the author, April 2022.

internal conflict contributed to the frequent changes in leadership that occurred within the Ministry of Health while the NDP was in power, which Lankin also mentioned as contributing to delays on implementing the MSA model in our discussion.[29] Indeed, not only did the NDP government have three different Ministers of Health during its tenure, but also multiple Deputy Ministers, and the time necessary to get new leadership up to speed on major programmatic changes like the MSAs contributed to delays in implementation.

When asked specifically about the NDP government's inability to follow through with implementing the MSA model, former Premier Bob Rae also noted that the political culture within the bureaucracy of Ontario itself was skeptical of the NDP agenda as a result of the 42 consecutive years of Conservative governance that had preceded his tenure and that of David Peterson before him.[30] Here, Rae's distrust of the bureaucracy and its reception of the NDP's governing agenda echoes sentiments drawn attention to previously by Baranek (2000), as well as by Walkom (1994), who notes in his biography of Bob Rae that by 1993 the NDP government's sense of contempt for the bureaucracy was well established, perhaps most evidently by Rae's "quill pen" speech in January of that year.[31]

[29] Frances Lankin (Former NDP Minister of Health from 1991-1993) in conversation with the author, April 2022.
[30] Bob Rae (former Premier of Ontario from 1990-1995) in conversation with the author, June 2022.
[31] The "quill pen" speech refers to a talk given by Rae to University of Toronto business students in January 1993, wherein the premier began attacking the Ontario bureaucracy, saying the time had come "to shake up the civil service. It was inefficient, out-of-date. Bureaucrats working 'with quill pens' in the bowels of the government would have to shape up" (Walkom, 1994, p. 61)

The crux of the problem was that the New Democrats, lacking experience both in large organizations and government itself, were confounded and frustrated by the “intrinsic slowness” of bureaucracy (Walkom 1994). Bureaucrats, on the other hand, were struggling to adjust to the partisan swing in governance that had occurred with the NDP’s rise to power. One government official interviewed by Baranek (2000) suggested that, after having two changes in government after 42 years of stability: “it became very difficult for the bureaucrats to shift with whatever the ideology of the day is and the players of the day, and then the different ministers” (p. 119). The result of this was a substantial degree of interministerial conflict, which Rae himself noted as having contributed to the delay in action on LTC reform during his tenure as Premier.[32]

Despite the ongoing conflicts between the NDP government and the bureaucracy, the Ministries of Health, Community and Social Services, and Citizenship began releasing their "Partnership" documents on LTC reform in spring of 1993. These four documents – released in April, May, June, and September of that year – provided a policy framework, a local planning framework, an implementation framework, and guidelines for the establishment of MSAs, respectively. The policy framework document provided substantial clarity on exactly what the MSA model would entail. Making specific mention of the OCSA and SCCA’s rejection of the brokerage model outlined in the SCA, the document suggested that all in-home health and personal support services, as well as community support services would instead be delivered by one agency, the MSA.

[32] Bob Rae (former Premier of Ontario from 1990-1995) in conversation with the author, June 2022.

To access the services available within MSAs, physician referrals would no longer be required, nor would there be any charges for health and personal care services, homemaking services deemed essential, respite care services, adult day care, and support programs for family caregivers. Only community support services – including visiting homemakers, home support services, and Meals-on-Wheels – would involve charges, which would be based on one's ability to pay. Each MSA would be funded to provide a provincially defined minimum basket of services in their community. For workers, MSA would offer a means of regular employment rather than hourly contracts exclusively, as well as improved training and involvement in program, staffing, and budget planning. They would also look to address the succession rights of workers and give hiring priority to displaced hospital workers (MCSS et al., 1993a).

The Local Planning Framework focused on outlining the role of LTC committees and DHCs within the proposed system. The Implementation Framework document outlined the responsibilities of MSAs, indicating that MSAs were expected to not purchase more than 10% of its services from commercial or not-for-profit agencies by the end of 1995, with regions where these purchase levels were already at 10% would be frozen at that level. It also noted that the Integrated Homemaker Program (IHP) and Placement Coordination Services would be expanded (from 20 to 38 sites and 23 to 36 sites, respectively) and that not-for-profit health and personal support agencies would provide all services delivered by the new IHP sites and all new services within existing IHP sites, as well as all new growth in the Acute and Chronic Home Care Programs and the School Health Support Programs. A transition period from 1993 to 1995 to shift to a primarily not-for-profit delivery system for MSAs was outlined, with LTC area offices expected to establish a steering committee to help facilitate this shift in communities and registries to

established to assist displaced commercial agencies match with not-for-profit employers (MCSS et al., 1993b)

The final "Partnership" document released in September 1993, outlined guidelines for the establishment of MSAs. Each MSA was to be expected to operate at arm's length from the provincial government and be governed by a board of directors elected by a voting membership that would include representatives for consumers, family caregivers, volunteers, and other interested individuals. The document also discussed a transfer process for workers from existing services agencies to allow them to become employees of an MSA, noting that unions would need to be involved in various elements (MCSS et al., 1993c).

In August 1993, amidst the release of the "Partnerships" documents, the Director of LTC Policy released a draft manual for community-based services that were to be provided by MSAs. The manual provided a breakdown of the funding envelope, including the formula behind it which would be based on population and need factors and was to form the basis for allocating new community service funding to health districts. It also listed the mandatory collection of core services that the MSAs would be expected to provide. The manual made clear that, due to limited financial resources, eligibility for services would not necessarily guarantee that they would be delivered, and that there would be individuals who would be unable to receive some of the services they needed or go on a waiting list based on availability (LTC Policy Branch, 1993).

Though the NDP government would not bring in the strict eligibility criteria and maximum service limits of their successors in the Conservative government, MSA resources were to be limited, and the services provided by them were not considered entitlements. Most significantly,

it was here that the decision to transfer the budget for Home Care to the LTC Funding Envelope was made, therefore removing it from OHIP coverage. These decisions to incorporate the Home Care program into the funding envelope of LTC and eliminate guarantees of service delivery for all LTC programs demonstrate that elimination of the brokerage model was not the only distinction between MSAs and the SAOs they were to replace.

At this point, cost-control for LTC had officially become a core goal of reform for the NDP government, just as it had for their predecessors. The 'Keynesian deficit' approach of spending its way through the recession in its first two budgets was no longer a viable strategy, and the looming threat of a "debt wall" worried key figures within the NDP government, namely Bob Rae and Frances Lankin (Walkom, 1994). Creating a single, closed funding envelope for all services under the broad umbrella of LTC would allow the NDP government to ensure that costs within it could be capped.

The byproduct of this change was that it also allowed for home care funding to be even less prioritized through further austerity measures to the health care sector by successive governments less invested than the NDP were in the vision of improving home care accessibility and equity. Though the stated preference of the Conservative government that followed the NDP was to see non-institutional forms of care prioritized for funding over their institutional counterparts, the means by which they attempted to make this happen were flawed. As will be demonstrated later in the chapter, demand for Home Care services would far exceed the government's capacity to fund it due to efforts to move as many patients as possible out of hospitals and into community settings. The removal of the Home Care program from OHIP

coverage would also allow the provincial government to relinquish its responsibility to ensure program funding met local demand.

The Partnerships documents set the stage for Bill 173, the *Long Term Care Act* of 1994, to implement the NDP's LTC policies. MSAs were the centerpiece of this legislation, and the government's intention was to see the vast majority (80%, down from the 90% outlined as a goal the year prior) of home care service provision restricted to MSA employees, who were to be unionized workers employed by the province. This had become particularly contentious among interest groups and opposition MPPs.

In Parliament, health critics from opposition parties took a strong stance against the NDP approach to home care reform. Pushback from opposition members in the wake of Bill 173's initial announcement – which continued through its passage in parliament – was primarily couched in terms of concern regarding the future of for-profit and non-profit agencies under the so-called "80-20 rule", which referred to the intent of having unionized MSA employees provide no less than 80% of all services. Conservative MPP Cam Jackson, for example, was quoted in the Waterloo Region Record reacting to the NDP government's proposal that "the 80-20 rules will sound the death knell for agencies such as Red Cross, VON, as well as commercial home-care services" (Brennan, 1994).

The NDP government had previously attempted to put a positive spin on MSAs' replacement of the brokerage model by suggesting that the elimination of inter-agency competition would

incentivize those agencies to amalgamate with MSAs.[33] However, the glaring issue with this that the government was ignoring was that those agencies – be they for-profit or not-for profit – would ultimately cease to exist or no longer be offering those services; competition was a non-issue in comparison. The *Long Term Care Act* was also silent on the rights of employees in existing agencies, the transfer of employees to MSAs, and the status of collective agreements, which led to conflict between labour groups and management, and subsequently further delays to the implementation of the Act (Baranek, 2000).

From August to October of 1994, the NDP government's Standing Committee on Social Development held several public hearings across the province to listen to and accept submissions from various interest groups. The forced amalgamation of providers under the MSAs, alongside the labour concessions and 80-20 rule, evoked strong opposition, particularly from the providers themselves, most notably those from the not-for-profit sector. As the provincial Assistant Deputy Minister of Health at the time noted:

> The most influential backlash came from the VON and the Red Cross. And every opposition party – like the Conservatives, like the Liberals – say "what a travesty. A venerable organization like the VON is in our community for 200 years, and in one fell swoop these Socialists are knocking them out of business"… Certainly, the for-profit agencies thought they were being put out of business, but so did the VON, the Red Cross, St. Elizabeth… they were in strict opposition to somebody taking over their business.[34]

[33] Ministry of Health. *Redirection of Long-Term Care and Support Services in Ontario: Questions and Answers.* January, 1994.
[34] Geoffrey Quirt (former Assistant Deputy Minister of Health and Executive Director of the Ontario Government's Long-Term Care Division) in discussion with the author, December 2021.

This demonstrates the influence nonprofit home care providers had as detractors of the MSA model, giving the Conservatives and Liberals a common cause to rally behind together in opposition to the NDP. Another example of this was the Red Cross influencing the OCSA to switch its stance in less than 2 months from being generally supportive of the MSA model in mid-August (OCSA, 1994a) to revoking its support in early October (OCSA, 1994b). In that time, the Red Cross – the largest member organization within the OCSA – created substantial discord within the alliance and put pressure on the board to change its position on MSAs. The board's decision to revoke its support of MSAs ultimately led to the Chair of the OCSA's Policy Committee – who had been one of the of MSA model's original architects – resigning (Baranek, 2000).

The loss of OCSA's support made for bad optics for the NDP government, which had credited the association with developing the MSA model they were promoting. Non-profit sector representatives were generally skeptical of the NDP's claim that MSAs could serve as a means of reducing the bureaucratization of home care service delivery, as they would do so by integrating caregivers into the bureaucracy itself and classifying them as public employees (Baranek, 2000).

Beyond this perceived contradiction on the notion of bureaucratizing home care delivery, however, was the fear held by these agencies that their organizational role in care provision would be lost within the MSA model. As one Board member of St. Joseph's Villa at the time noted in an interview, the MSAs represented a threat to the "identity" of non-profit home care providers, as there was a fear that their role being reduced to simply providing employees to the agencies would limit their ability to maintain their core organizational values. It was also with some irony, however, that the interviewee noted a similar threat ended up emerging with the

creation of Community Care Access Centres (CCACs) under the Harris Conservatives, and that the relationship between the CCACs and the providers ended up being "antagonistic".[35]

The stance of the non-profit home care providers on the MSA model aligned with that of for-profit providers, and because of their shared concerns over its implementation in the *Long Term Care Act*, both groups mobilized to form the Community Providers Coalition. Over the course of the Standing Committee public consultation period, the Coalition expanded its membership to include additional provider groups as well as physician and hospital interests who shared its concerns about unionized workers in the MSA model, namely the Ontario Medical Association (OMA) and Ontario Hospital Association (OHA). Some consumer groups were also integrated, including religious groups like the Catholic Women's League. However, the majority of the Coalition members represented the interest groups that had become the most entrenched stakeholders in Home Care policy. This in turn demonstrates the influence of the policy legacies on the interest group population and power and the coordination efforts they were able to mobilize to maintain the status quo policies they benefited from. Ontario's early decision to have home care services provided by non-profit and for-profit providers in the community allowed them to become powerful stakeholders, as well as establishing an administrative framework built around the subcontracting process and transfer payment funding agreements, a framework that largely remains in place today. This provides evidence for my third hypothesis regarding the

[35] Michelle Cooper (former Board Member of St. Joseph's Villa) in conversation with the author, December 2021.

influence of policy legacies on the population of interest groups and their degree of influence on policy trajectories.

With a now-substantial resource backing from community agencies and medical interests, the Coalition began campaigning aggressively to oppose the legislation; issuing press releases, holding news conferences, hiring a consultant to advise them on media relations and legislative debate procedures, and writing to the Premier to request his personal intervention in the LTC reform process (Community Providers Coalition, 1994a, 1994b; P. J. Kehoe, personal communication, September 29, 1994; P. Rhodes, personal communication, October 25, 1994a, personal communication, October 25, 1994b). Following the government's tabling of amendments to Bill 173 concerning staff transfers in November of 1994, the Coalition received legal advice and issued a media release stating that MSAs would cause non-unionized workers to have less job security and that there would be fewer jobs within the new system of LTC delivery (Community Providers Coalition, 1994c). The announced amendments also prompted the Executive Director of the OCSA to step up its public opposition to Bill 173 (D. Stapleton, personal communication, November 16, 1994). When Bill 173 was eventually passed, the Coalition continued its activities under a new name: The Group for Long Term Care Reform, and further expanded its membership to include other interest groups in the field of Home Care, including the Alzheimer's Society of Ontario, Ontario Home Care Case Managers' Association, and the Ontario Home Care Medical Advisors. This continued opposition by entrenched stakeholders in home care to the MSA reforms proposed by the NDP government and the degree to which they delayed the implementation of those reforms was the prime example of interest group power over policy change discussed in the previous chapter.

The extent of the delays imposed by the opposition from these interest groups also further demonstrates their influence on home care policy relative to other stakeholders who were supportive of the NDP government's proposed reforms. Those supportive of the MSA model and *Long Term Care Act* were primarily consumer interests (particularly those representing seniors) and labour groups that were more ideologically compatible with and historically supportive of the NDP government's own ideology and policy interests. Labour groups became particularly influential on the government's LTC reform trajectory as it sought allies in the wake of its loss of support from the OCSA and attempted to placate the union vote as a result of the actions that had been taken with hospital restructuring and the Social Contract (Baranek, 2000).

However, as Baranek's (2000) research on this period found, providing assurances to the unions regarding LTC reform was a difficult task. Despite providing the Ontario Federation of Labour (OFL) with 2 years' worth of funding in the summer of 1994 to consult with labour groups on the implementation of MSAs, it was not until the Standing Committee hearings that labour groups began to exercise their influence. Their subsequent attempts to tinker with Bill 173 and press their concerns delayed its passage and implementation while also fueling the dissatisfaction of the formerly supportive interests embedded in the OCSA who were not aligned with labour groups on many human resource concerns, namely the unionization of MSA workers (Baranek 2000). These delays not only gave dissenting groups the opportunity to mobilize and launch a powerful counter-campaign fueled by resources provided by powerful interest groups, but also prevented the full implementation of the *Long Term Care Act* prior to the NDP's election loss to the Harris Conservatives.

The *Long Term Care Act* was eventually passed March 31st, 1995. The road to its passage was fraught with difficulties primarily associated with the recessionary events of the early 1990s and their effects on the NDP's governing strategy. Despite the years of work and consultation that went into developing the LTC reform strategy and the MSA model within it, the consensus that the NDP government had hoped to achieve prior to implementation never materialized. With such a broad range of interests to account for, the consultation period demonstrated that there was no reform strategy that would be able to please everyone affected by the government's reform strategy. The NDP ultimately decided to prioritize the interests of (most) consumer and labour groups in its finalized strategy, a decision which would end up resulting in substantial pushback from competing interests, and with that, further delays to implementation.

The NDP's LTC reform journey presented what was largely a continuation of the path taken by the Liberal government under David Peterson. The decision made by the NDP to pivot its strategy for home care from initially seeking to expand it to include homemaker and home support services to later seeking to introduce service caps and ultimately following through on the Liberal government's decision to remove the Home Care program from OHIP is evidence of this. At the time that the NDP government made this pivot, it had become increasingly preoccupied with identifying sources of cost-savings within the public sector, as demonstrated by Walkom (1994).

The NDP government's decision to scale back home care costs therefore demonstrated the same lack of confidence in home care as a vehicle for cost savings within the province's health care system that the Liberal government displayed. Though home care investment increased

substantially by the NDP government from 1990 to 1994, in 1995 home care expenditures decreased for the first time in over a decade (see Table 2 in the Appendix). Considering that home care spending would have been accounted for by the Rae government's budget prior to the NDP's election loss in June of that year, this decrease in funding indicates that the government's faith in home care as a reliable driver of cost reduction in the health system had faded. This reality suggests that, despite the NDP government's stated intention and initial efforts to expand the home care program in Ontario, the greater concern in the province's health system by 1995 was controlling costs, and home care was not exempt from the government's search for cost cutting opportunities as fiscal fears rose. This sequence of events also provides support for my first hypothesis, as the NDP government's policy decisions on home care ended up being an extension of their predecessor's approach. Specifically, removing the Home Care program from OHIP coverage was a strategy of the Liberal government clearly based upon a belief that the costs associated with the program needed to be controlled, and the NDP government's decisions to follow through with this suggests that decisionmakers in each party were ideologically aligned in this regard.

There is also some evidence to support my second hypothesis with the NDP government's shift in focus to the creation of MSAs as a vehicle for its LTC reform strategy. Much like the shift to SAOs made by the Liberal government before them, the NDP government's goals for MSAs were contextualized first and foremost in terms of value for money and consumer choice (MCSS et al., 1993a). This presents a pattern between the Liberal and NDP governments in terms of their reliance on their regionalized service delivery models to serve as mechanisms for offloading Home Care program costs. With policy decisionmakers skeptical of the notion of Home Care

serving as a cost-effective alternative to institutional forms of care as a result of the program's legacy arrangements as an OHIP entitlement with no population service caps, the reform strategies pursued by the Liberal and NDP governments appear to have emphasized implementing further cost controls onto Home Care. Though neither of these reform strategies were ultimately fully implemented, the Conservative government's approach to Home Care reform largely built on the strategies of their predecessors, as the next section will demonstrate.

The NDP's LTC reform journey also demonstrated the relevance of interest mobilization – particularly by the nonprofit sector in lobbying against the MSA – in contributing to the delays the NDP government faced in implementing its LTC reform agenda. The formation of alliances between stakeholders who had never previously cooperated – namely, provider organizations and the provincial medical and physician's associations – though tentative, constituted a substantial barrier to the NDP government's passage of the *Long Term Care Act*. This delay was sufficient to prevent the NDP from fully implementing its legislation prior to its 1995 election loss to the Conservatives.

The role of interest group mobilization in Ontario also provides evidence of my third hypothesis. Specifically, it is important to recognize that the prominent role that provider organizations had in resisting reforms to the status quo approach to home care delivery in Ontario was predicated on the entrenched legacy role those organizations had in providing home care across the province. This reality is most apparent when the influence of nonprofit provider organizations on home care is contrasted with that of groups representing seniors and community support service workers. These groups were able to experience a period of influence on home care policy reform

with the NDP government, making notable contributions to the development of the MSA model, but only prior to the pushback from nonprofit organizations. Since seniors' and community support service workers' groups lacked the privileged role in home care policy discourse provided to nonprofit organizations via the policy legacy which established their leadership role in service delivery, they were not able to maintain relevance in the home care policy discourse outside of the brief period where their ideational goals aligned with those of the NDP government.

As the next section will demonstrate, the barriers to reform faced by the NDP government would go on to inform the home care reform strategy brought forward by the Conservative government under Mike Harris as part of the "Common Sense Revolution". Coming into power as it did with a clear ideological agenda for reforming the province's health system that explicitly prioritized cost-control measures, the Conservative government was able to avoid the pitfalls of the Liberal and NDP governments when reforming home care. However, the Conservatives also benefited from the groundwork that had been laid by their predecessors, implementing a service delivery model very similar to the SAOs suggested by the Peterson Liberals, and leaving the *Long Term Care Act* that had been passed by the Rae Government largely untouched upon coming into power.

Ultimately, my analysis will show that the home care reforms implemented by the Conservative government represented a logical conclusion to a decade of incremental efforts by successive governments around measures of fiscal centralism. What the Liberal and NDP governments were hesitant to acknowledge early in their tenures the Conservatives were quick to embrace, which

was the notion that home care could only represent a mechanism for cost-saving in the Ontario health care system if its associated costs were both heavily managed and shared between the province and its users. This notion, which had first been brought forward by the Price Waterhouse report on the Home Care program commissioned two governments prior, had come full circle to be reflected in policy changes by an entirely different party in power. With it, however, came harsh lessons for home and community care providers, who quickly found themselves overwhelmed by a paradigm shift in the province's health system. This shift was characterized by an increasing reliance on home care providers to care for those with acute versus chronic care needs while also making them entirely accountable for the increased care costs associated with that shift in client demographics.

The "Common Sense" Ideology of the Harris Government – CCACs and Managed Competition

The majority of the Harris Conservatives' policy plans for their tenure in government can be found in the "Common Sense Revolution" booklet, the party's platform for the 1995 election. At 21 pages, the publication outlines the party's streamlined, five-point plan focused primarily on creating 725,000 new jobs. The densest point of this plan was the reduction of government spending. Indeed, one-third of the document details the various government services targeted for reforms, reductions, and restructuring. The section starts, however, by outlining priority services that would be protected from cutbacks in government spending. The first item listed is health care, and the bolded first line under this subheading declares: "We will not cut health care spending". It is followed shortly by another bolded declaration that the government "will be

aggressive about rooting out waste, abuse, health card fraud, mismanagement and duplication" (Progressive Conservative Party of Ontario, 1995).

This reference to mismanagement and duplication, while not necessarily a direct reference to the earlier-noted issues that existed in the province's home care program, certainly suggests that such issues would be flagged upon taking office. That said, while the Common Sense Revolution document gives a broad overview of the Conservative party's plans for health care, it does not go into any concrete detail on policy changes. However, based on my interviews with key decision makers in the Harris government, it was clear that the desire for accountability in the healthcare system was prominent, particularly regarding local health officials and their relationship with the Ministry of Health in terms of distributing and spending money as intended and budgeted for.[36]

This emphasis on accountability serves as a clear reflection of the acknowledgement among all parties of concerns regarding health funding distribution in the province, which was initially addressed by the Minister of Health in the Peterson Liberal government, Elinor Caplan. Indeed, Jim Wilson – the first Minister of Health for the Harris Conservatives – himself acknowledged Caplan's earlier work on the introduction of accountability mechanisms for health spending in the province.[37]

[36] Jim Wilson (Former Minister of Health 1995-1997), Cam Jackson (Former Minister responsible for Seniors [1996-1998] and Minister of Long-Term Care and Seniors [1998-1999]), and Mike Harris (Former Premier of Ontario from 1995-2002) in conversation with the author, January 2022.
[37] Jim Wilson (Former Minister of Health 1995-1997) in conversation with the author, January 2022.

Though the Conservatives lacked a clearly documented strategy for LTC reform prior to taking office, they entered government with a clear ideological vision of what policy changes should be implemented. After winning a majority of seats in Ontario's 36th Parliamentary election, Mike Harris was sworn in as the 22nd Premier on June 26, 1995. He appointed Jim Wilson, former Conservative health critic, as Minister of Health and gave him sole responsibility for Long Term Care, removing the Ministry of Citizenship and Ministry of Community and Social Services from the portfolio. The Conservative government quickly went to work with redirecting LTC reform, with Premier Harris first announcing his intention to halt the implementation of MSAs – an election promise – and revoke the 80-20 rule and labour adjustment provisions of Bill 173. His announcement also included hints about the sort of model his government found acceptable, most notably one that included a competitive process for funding allocation so that Ontarians could receive "the highest quality services for the best price" (Harris, 1995).

By this point in time, inequalities across the province in access to home care had become a significant issue for the Conservatives. An anecdote from Jim Wilson provides an illuminating example of this:

> I said to the [deputy minister] when I first became Minister, for example, I said, "why couldn't anybody get home care for the last 5 years in my riding?" And she's like "Well, they don't spend the money on home care we transferred to them. The last time we checked with the county of Simcoe, they admitted that the home care budget – the $1.5 million dollars that they had per year from the Ministry of Health – was spent on… the roads budget." So, they didn't have any money left for home care. And I found out county after county… there was a real problem back in those days, they wouldn't let you

audit another level of government, so… you would transfer money and hope to God they spent it on whatever they said.[38]

Wilson's perception of issues with home care policy in terms of local delivery informed his sense of urgency to introduce accountability mechanisms. Having learned from the experience of the NDP government before him, Wilson chose to avoid starting the reform project with a lengthy consultation process. Instead, private consulting firm ARA Consulting Group was hired to conduct meetings over 60 days with 65 invited representative organizations of the policy community, who would provide advice on coordinating the LTC system. Participating organizations were invited to discussion sessions that lasted 5 hours, and included groups representing people with disabilities, commercial and non-profit service providers, multicultural and francophone groups, and a variety of associations representing various LTC consumers, providers, and workers (see ARA Consulting Group 1995).

However, as Baranek notes in her thesis, this consultation was undertaken within a compressed time frame, with a shortened invitation list and a well-managed agenda, which – when combined with the institutional barrier the Minister created by hiring ARA Consulting and selecting the Parliamentary Assistant to lead the consultation – "allowed the Conservatives to orchestrate a report which supported the model they intended to develop and to move expeditiously" (Baranek 2000, p. 210) The Conservative government's subsequent decision to centralize all LTC reform within the Ministry of Health meant that interest groups better represented by the Ministry for Community and Social Services (i.e. labour groups and senior

[38] Jim Wilson (former Minister of Health 1995-1997) in discussion with the author, March 2022.

advocacy groups) were suddenly less able to lobby, only being able to do so now by writing to the Ministry of Health during the 60-day consultation period (MOH, 1995).

The Conservative government indicated their intention to move quickly on announcing their intended model by fall of 1995 after their truncated consultation process, which only included eight discussion sessions. Seven of these included representatives from various sectors (first providers, then users, then workers). The eighth session was for providers and consumers in the disability community, though workers in this group were not included. The resulting report made it clear right from the title ("Alternatives to the MSA") that there were limits to what the Conservative government would consider as an option for an LTC reform model. Four models were suggested, though the amalgamated MSA model favoured by seniors and labour groups previously promoted by the Rae government was buried within the report, with only passing mention made of it in the implementation section of the report as being an "integrated model" favoured in particular by "a few seniors' organizations and most labour groups" (ARA Consulting Group 1995, p. 14). This further demonstrates the relatively tangential influence that seniors' and community support service workers' interests had on LTC reform in Ontario and reinforces the point that their influence was largely determined by the degree of ideational alignment and sympathy assigned to them by the government of the day.

Three models were highlighted by the consultant report, one of which – the Municipal/Public Health Model – was similar to the existing brokerage system in the province. Another was the Federation/Partnership Model, which would establish a new, local, not-for-profit organization with a local community board of representatives of providers, consumers, and other community

groups. This organization would purchase services, administer contracts, maintain and manage the system, and coordinate assessments. Service providers in the model would be able to authorize services for consumers with easily addressable needs and for consumers who approached them directly (ARA Consulting Group, 1995).

The other model highlighted in the report was the Augmented Home Care/Managed Competition Model which would go on to become the one implemented by the government. It consisted of a single local authority that would merge Home Care and Placement Coordination services while also housing case management and assessment like in the Federated Model. Services would be purchased from approved providers, but no details were provided by consultants on the process associated with that. They only specified that consumers should be able to be involved in the decision related to their care providers to encourage competition and that quality standards could be used to do the same work and achieve high quality care. Implementation criteria from consultants were limited to a list including clear access points, accessibility, accountability, consumer & community involvement, consumer control & choice, a defined set of mandated services, and evaluation (ARA Consulting Group, 1995). The report ultimately made no specific recommendations regarding a particular model for reform beyond promoting alternatives to the MSA model (implied mainly by the title), demonstrating the lack of meaningful implementation planning put forward by the consulting group.

With the highly orchestrated consultation process complete, the Conservatives had a relatively free hand in creating a new community based LTC model. On January 25, 1996, Health Minister Jim Wilson announced the creation of 43 new facilities called Community Care Access Centres

(CCACs) which would amalgamate Home Care Programs and Placement Coordination Agencies. CCACs, like the Liberal and NDP systems they were replacing, were to serve as a simplified, one-stop shop for all LTC services including volunteer-based community services. According to a Board Orientation document circulated by the MOH in June 1996, CCACs would purchase services, supplies and equipment on the consumer's behalf. Service providers would be selected based on a new, "Managed Competition" process through a request-for-proposal (RFP) format. The process would be guided by provincial standards, and criteria would be developed and provided to assist CCACs with ensuring they would select service providers by taking into account both quality requirements and service cost (MOH, 1996)

Managed Competition was thus a phrase used to describe a revamped iteration of the brokerage model that was now to be more stringently "managed" by the provincial bureaucracy embedded within CCACs and have more "competition" through a more formalized RFP format that would place more pressure on legacy providers to demonstrate good performance by adhering to contracts they would negotiate with CCACs. A three-year transition period was provided to give non-profit and for-profit providers time to adapt and "become competitive" in the new model. CCACs were to be governed by independent, incorporated not-for-profit boards of directors made accountable to the MOH via service agreements. Boards would be composed of a mix of community LTC consumers and their caregivers and provide a balance of health and social services perspectives. They would not include service providers under contract with a CCAC (MOH, 1996).

Much of the intent behind the positioning of CCACs was to distance the model from the MSA approach put forward by the NDP. Indeed, when announcing the CCAC approach, Conservative Health Minister Jim Wilson noted that MSAs "would have eliminated choice, favored organized labor at the expense of volunteers and hurt the quality of care by driving long-standing provider organizations out of business. Our approach will keep volunteers in the system and ensures the needs of clients are emphasized at all times" (Wilson 1996). This demonstrates the enduring relevance of the nonprofit sector's influence on LTC policy, as the Conservative government clearly made a more concerted effort to appeal to the non-profit sector with its approach to home care reform than to groups representing seniors and workers within the sector. By systematically ignoring the interests of seniors and community support service labour while simultaneously attempting to demonstrate support for the interests of nonprofit providers, the Conservative government clearly expressed not only its own ideas regarding home care reform, but also the established interest group dynamics within the sector.

CCACs appeared to be more broadly intended to preserve the institutional status quo around home care, with the introduction of managed competition into the brokerage model being their only substantial innovation on previous changes proposed by the Rae and Peterson governments. Indeed, even as far as the NDP government's *Long Term Care* Act was concerned, outside of the MSAs, the 80-20 rule, and labour adjustment provisions within it, the Conservatives were generally satisfied with the rest of the Bill. Furthermore, as (Armstrong & Armstrong, 2006) note the Conservative government eventually quietly passed a number of regulations related to the *Long Term Care Act* after the 1999 election, including care limits and standardization policies for care provided by home care workers and Long-Term Care homes.

Choosing not to repeal the previous NDP government's LTC legislation allowed the Conservative government to avoid delays on implementing their preferred CCACs and Managed Competition Model. It also demonstrated their focus for home care reform was centered around accountability and cost control, as managed competition instituted a formal process which established enforceable budget targets and consequences associated with breaches of contract by service providers. By maintaining the brokerage model for contracting out home care services, the Conservative government showed its contentment with the existing service delivery structure (i.e. relying on non-profit and for-profit organizations in the community to provide services). By not repealing the *Long Term Care Act* passed by their NDP predecessors, the Conservatives were also tacitly acknowledging the lack of need for additional policy changes to improve accessibility to services.

Indeed, the *Long Term Care Act* provided a legislative framework for managing and delivering LTC community services and was largely kept intact by the Conservative government, apart from the elimination of MSAs. However, the Conservatives also made the deliberate decision not to officially replace CCACs as approved agencies for funding under the *Long Term Care Act* after removing MSAs from it. This decision became relevant later in the Conservative mandate, when a complaint brought by a consumer to the government regarding service denial was met with a response that CCACs – having never been designated as approval agencies – could not have their decisions appealed to by the Health Services Appeal Board as set out under the Bill of Rights within the *Long Term Care Act* (Provincial Auditor 1998).

This blatant instance of offloading responsibility for home care program outcomes onto more localized administrative bodies, alongside the removal of the program from OHIP by the previous NDP government and the intent by the Liberal government before them to introduce caps on Home Care program funding all provide support for my second hypothesis. This is because all the service delivery models – which were also regionalization mechanisms – platformed by each government in power during the study period were intended to be implemented with an underlying goal of rationing home care in the province. However, this implementation goal of rationing home care through reform is best demonstrated by the means through which CCACs were established by the Harris Conservatives, since they were the only model of home care administrative governance actually implemented in Ontario.

CCACs served two seemingly opposing functions for the Conservative government in terms of implementation. The first was to centralize home care governance under provincial control by making CCACs responsible for home care instead of public health boards. The second was to decentralize governance by strategically isolating CCAC decisions beyond the jurisdiction of the *Long Term Care Act* and the patient Bill of Rights associated with it. By doing this, the provincial government was simultaneously able to control home care funding by preventing it from being siphoned away into other public health programs while also being able to insulate itself from accountability associated with any decisions made by the CCACs, despite them operating at the behest of the government.

More broadly, the policy changes brought forward by the Conservative government were part of a clearly defined vision for the state's role in care provision that differed significantly from their

predecessors. As Jenson and Phillips (2000) note, according to the Conservatives, "the key to efficiency in the system is the discipline of the market". Indeed, the managed competition model brought market principles into the home care contracting process, which disadvantaged not-for-profit agencies by requiring them to behave more like for-profit agencies – which were inherently more market-oriented – to compete.

Though the 50-50 split between the for-profit and non-profit providers that had historically endured in Ontario remained relatively unchanged throughout the remainder of the Harris government's tenure in power, managed competition created a playing field that disadvantaged some previously well-established non-profit providers of home care in the province. A high-profile example of this was the Visiting Homemakers Association of Hamilton's filing for bankruptcy, which occurred under the Liberal government of Dalton McGuinty but was credited by a former Board member of the organization as being linked to the managed competition model.[39]

Broadly speaking, the home care sector became significantly more fragmented under the managed competition model. For-profit and not-for-profit providers had once cooperated under a shared vision, with each sector often helping the other by taking on caseloads or providing staff in the event of unexpected worker absences, but the need to compete in managed competition caused providers to become more secretive.[40] This was also the case when it came

[39] See O'Connor 2004.
[40] Juanita Gledhill (former Executive Director of Visiting Homemakers Association Health & Home Support Services) in conversation with the author, December 2021.

to interest mobilization in responding to the government's implementation of the model itself, as for-profit providers were generally in favour of managed competition while not-for-profits began to take issue with it. The reason for this, according to a representative of the non-profit sector, was the flexibility available to for-profit providers to adapt to changing caseloads. As she noted in an interview:

> "Historically, the for-profits had been in a position to cherry pick their clients… So, they could supplement with private pay, people that could afford to pay for additional services, they could choose whether to take the complex clients or not… We took everybody."[41]

As a result, the coalition of interests that the NDP had inadvertently fostered through its Social Contract (the CPC) had already begun to unravel as it became apparent that those within the Coalition had divergent goals within the Conservative government's health reform agenda. Those in the sector who did not approve of CCACs, and managed competition were therefore much less capable of mounting opposition to it, having lost access to the resources that had previously been plentiful within the CPC, most notably through the OMA and OPA. Though non-profit organizations did not end up being driven out entirely from the market-driven conditions of Home Care service provision in Ontario[42] their relative lack of capacity to effectively compete

[41] Juanita Gledhill (former Executive Director of Visiting Homemakers Association Health & Home Support Services) in conversation with the author, December 2021.

[42] As Shirlee Sharkey, Founder & former CEO of SE Health, noted to me during our conversation in January of 2022, her organization was able to effectively capitalize on the volatility introduced by managed competition and gain a foothold in what had previously been a relatively closed-off sector built on maintaining contracts with legacy providers.

with private actors in the Home Care market disproportionately impacted their involvement in the sector from the early 2000s onward [43].

Cost Control and the HSRC

Having quickly implemented its model for LTC reform, the Conservative government shifted its focus to cost containment of the hospital sector. It assigned Cam Jackson, Minister without Portfolio with responsibility for Senior Issues to oversee the implementation of CCACs while the Ministry of Health could focus on the work it was doing with the Hospital Services Restructuring Committee (HSRC). Established as an expert advisory panel for the government regarding decisions to make Ontario's health system more efficient, the HSRC sought to "rationalize" care provision in the province and establish "multi-institutional organizations with a single governance structure". A key element of this was attempting to bring a more "appropriate" balance of institutional and community-based care to the province, which included an expansion of home care and long-term care, with the goal of allowing hospitals to focus on the accommodation of acute care patients by discharging alternative level of care (ALC) patients from hospitals into long-term care homes and home care programs (HSRC 2000). According to the Commission's Legacy Report (2000), the reinvestment of savings taken from institutional restructuring efforts into home and community care options was a "critical" element of its long-term strategy for health system reform. After all, the goal of the HSRC was not to serve as a tool to allow the Conservative government to cut healthcare spending – indeed, the Conservative

[43] Joe McReynolds (former CEO of the Ontario Community Support Association) in discussion with the author, November, 2021.

party had campaigned on a promise to not cut a single dollar in total healthcare spending – but rather to provide guidance on where health system resources could be directed to maximize the system's cost-efficiency. As such, the commission's focus on hospitals as targets for cost-cutting measures and their legacy report's emphasis on the necessity of reinvesting all cost savings into home and community care programs demonstrates it had a clear goal of diverting health system resources from acute care into home and community care.

That said, the structuring of the HSRC's mandate – and the Conservative government's obligations to it – meant that the Committee could only make binding recommendations on decisions related to cost reductions, not on reinvestment. Home care was not meant to be a target for the Commission's cost-cutting recommendations, but a beneficiary of it through reinvestment. However, the Conservative government's subsequent focus on following through with cost-cutting measures without any clear agenda for reinvestment became concerning to the members of the HSRC.

In their book on the history of the HSRC, former commission members Duncan Sinclair, Mark Rochon, and Peggy Leatt (2005) noted a great deal of frustration felt by members regarding the government's perceived unwillingness to accept that short term funding was needed to increase the capacity of home care to support hospital restructuring (Sinclair et al., 2005). An announcement by the government on April 28th, 1998 that it would reinvest $2 billion in home care and facility based long-term care over its second tenure if reelected did eventually help to "ease the apprehension" of the HSRC and health sector that reinvestment might not actually happen (HSRC 2000, pg. 3).

However, the Commission remained concerned at the end of its mandate that "continued slowness in the pace of reinvestments will jeopardize successful restructuring and risk the loss or diminish the gains made toward the creation of a genuine health system" (HSRC 2000, pg. 3). As its former members note, the first two years of the Harris government's tenure were defined by a "determination to reduce spending as much and as rapidly as possible" (Sinclair, Rochon, and Leatt 2005, 116). It is perhaps unsurprising then that the government faced such pushback from both HSRC and opposition parties prior to their announcement of a reinvestment of funds acquired from hospital restructuring into home and facility based long-term care.

However, the HSRC also drew attention to a limitation in its own methodology for establishing the amount of home care reinvestment required via hospital restructuring in its 1998 report to the Ontario government. Specifically, the HSRC's definition of home care within its model for determining reinvestment guidelines was "limited to home care services provided after an acute impatient stay or same day surgery/procedure within 30 days of the procedures (i.e., post-acute home care)" (HSRC 1998). Individuals enrolled in a home care program for 180 days or longer were bundled into broader projections for long-term care (which focused primarily on LTC home beds investments), and roughly 30 per cent of all home care episodes noted at the time were not included at all within the HSRC's research. This was a reflection of the methodology used by the authors of the Institute for Clinical and Evaluative Studies (ICES) technical report commissioned by the HSRC to derive home care reinvestment options, which focused entirely on post-acute home care use from April 1, 1993 to March 31, 1996 (Cotye & Young, 1997).

This marked a substantial flaw within the HSRC's methodology for establishing a reinvestment benchmark for home care, one which implied that whatever amount was determined as a base line was substantially lower than what would likely have been needed for the home care sector. The HSRC's justification for its less-than-comprehensive analysis of home care was that its categorization of home care was made "in an attempt to expedite reinvestment into this sector during the first stage of health care restructuring to support changes to the hospital sector" (HSRC 1998, pg.v). However, this would end up being a costly oversight regarding the estimates for home care provision and the reinvestment benchmarks set by the commission.

As hospitals were amalgamated, there was a surge of home care needed in communities across Ontario by post-acute care patients beyond spring 1996 that could not have been captured in the ICES technical report due to its measurement timeline. These post-acute care patients – unlike the chronic care patients that had historically represented most home care recipients – required more labour and resource-intensive care. Therefore, as the number of these patients grew, so did the costs incurred by home care providers.

Here, evidence of the core issue with the Conservative government's health reform strategy emerges. As a result of their focus on getting ALC patients out of hospitals and the limitations of the HSRC's model for calculating home care investment, the Conservatives had drastically shifted the demographics of home care needs. This shift was one that made the average cost of care for a typical patient much higher, as post-acute care patients now made up a larger portion of home care recipients. According to Denise O'Connor, a home care policy researcher and former Board member of the Visiting Homemakers Association (VHA), home care went from having a 70/30%

split of chronic to post-acute clients to having a 70/30% split in the opposite direction.[44] Funding subsequently had to be adjusted to match that reality. However, since the reinvestment metrics calculated by the HSRC did not adequately account for the shift in patient demographics, the additional funding provided to home care providers within the new model by the Conservative government following its HSRC – recommended restructuring efforts to the hospital sector was inadequate.

Furthermore, the shift in patient demographics was not something the home care providers themselves could have predicted. As such, the estimates calculated for inclusion in request for proposals submitted to CCAC contract managers by those home care providers - which were based on the 70/30 split of chronic/acute care patients that had historically existed – were inaccurate. However, the Harris government had delegated all decision-making regarding the spending of home care dollars to the CCACs, and their enforcement of the managed competition model made community providers fully accountable for their own budgets. This meant that, when the increasing proportion of acute care patients that were funneled into home care via hospital restructuring began to be felt by home care providers, the appeals they made for additional funding to accommodate the increase in care load went to CCAC employees rather than the government itself. The CCAC employees, in turn, were able to point to the contracts that these providers had signed and essentially tell them to work within the budgets they had provided.

[44] Denise O'Connor (Visiting Homemaker Association Board Member from 1996-2002), in conversation with author, October 2021.

Here is where the negative long-term impact of removing Home Care from OHIP coverage can be observed. As was shown early in the chapter, at the end of the 1980s, provider organizations were able to leverage the legacy funding arrangements to pressure the government to meet service demands and top up budget shortfalls. However, with budgets in the post-OHIP system negotiated entirely between CCACs and provider organizations, the previously defined link between the government and service providers in terms of funding responsibility was diluted. With funding responsibility – and all incidental debt management – for the Home Care program offloaded from the Ministry of Health onto provider organizations, there was limited recourse for providers to find the funding necessary to adapt to the shift in balance of chronic vs. acute clients. As noted earlier, non-profit providers were particularly vulnerable in this situation. The reverse of the demographic split in care recipients in communities led to skyrocketing costs in care provision and eventually, as in the high-profile case of the Hamilton chapter of the Visiting Homemaker's Association, to bankruptcy (O'Connor, 2004).

With home care providers struggling under the increasing weight of consumer demand on top of capped budgets, many found themselves having to make substantial changes to their care provision model due to the shift in the government's expectation that home care be prioritized for those who were post-acute care patients in order to support hospital functionality. This expectation made the contracting process within the managed competition model untenable for many established providers of home care, particularly in the nonprofit sector, and it was eventually frozen in 2004 as a result of pressure from some of those providers, as noted by O'Connor (2005). This in effect reverted the brokerage model for home care back to the legacy

system that had been in place prior to the introduction of both the Conservatives' Managed Competition model and the NDP's *Long Term Care Act.*

CCACs were clearly different from the MSA model that the NDP would have introduced, but also largely represented a continuation of the status quo for home care administration. The duplication of administration that came with the brokerage model of contracting care provision out to separate community organizations continued, which meant an extra layer of bureaucracy remained integrated in the system, as did the relative breakdown of private vs. public provision of home care. The most notable area of continuity in practice, however, was the government's continued effort to distance itself from any responsibility associated with *managing* the home care system. Though the establishment of CCAC's successfully took control of home care funding decisions away from public health boards and into the purview of the Ministry of Health, responsibility for those decisions was still being delegated by the Ministry. Funding for home care was now going where it was intended, but when it came to questions related to outcomes, the government was quick to delegate responsibility to the bureaucrats within the CCACs they had recently established.

Indeed, between September 24th and December 17th, 1997, Conservative Ministers of Health responded to seven separate accusations by opposition members that the government was limiting home care services by indicating that care eligibility decisions were not the responsibility of the Ministry of Health. Jim Wilson was the first to do so, responding to concerns raised by Liberal MPP Gerard Kennedy and NDP MPP Howard Hampton by saying care decisions made both inside and outside the hospital were "medical" and ultimately "the responsibility of the

hospital," ("Home Care Availability Question" 1997; "Standards of Care Outside Hospitals" 1997). Cam Jackson later replicated this strategy in response to questions from five other MPs by shifting responsibility for decisions regarding the receipt of care to CCACs.

As this section has demonstrated, the HSRC's hospital restructuring agenda – along with the flawed metric for calculating the necessary home and community care reinvestments that were to be taken by the savings found from it – created the perfect storm to overwhelm the newly reformed home care program. Thanks to the removal of Home Care from OHIP and lack of accountability mechanisms for funding associated with the CCACs – as well as the government itself – within the *Long Term Care Act*, providers lacked any means of acquiring the funding necessary to adapt to drastic shifts in split between chronic and post-acute clients. The decision by three consecutive governments to emphasize home care cost control despite all coming into power with differing political ideologies effectively set up the home care program to fail while simultaneously offloading the costs of that failure onto care providers, along with their patients and employees.

The next section will drive home the connection between the events seen in Ontario's home care policy reform journey between the late 1980s and late 1990s and my three hypotheses. It will summarize how the period encapsulated the political trend in the province toward fiscal centralism identified by Harden (1999), as well as beginning to distinguish this trend from the one seen in Saskatchewan in the next chapter.

Discussion: Parsing Differences in Similarity

This chapter has demonstrated that the path to home care reform in Ontario in the 1990s was one defined primarily by inter-party congruence on the need to change the existing service delivery arrangements to make home care more accountable and cost-effective. Though the Liberal and NDP governments each initially held long-term goals for home care reform based around improving accessibility and equity, both found themselves pressured towards prioritizing short-term cost-saving . In the case of the Liberal government, this was due largely to the fiscal pressures of cutbacks made in 1986 by the federal government to Established Programs Financing for provinces and a looming economic recession, as validated by concerns raised by then-Health Minister Caplan herself during our interview[45]. In the case of the NDP, the recession that began in the months leading up to their rise to power would preoccupy their early governing years, eventually forcing them to make the shift to prioritizing cost-savings measures, namely the removal of Home Care from OHIP coverage.

The MSA model of service delivery the NDP subsequently worked to introduce still represented their long-term goals of improving accessibility and equity, one distinguished from the Liberal and Conservative model in its intent to see all home care provided by MSA workers, who were to be unionized employees of the state. As the next chapter will demonstrate, this model would have likely made home care in Ontario much more closely resemble the system implemented by Saskatchewan around the same time. However, its implementation was delayed by pressure

[45] Elinor Caplan (former Ontario Minister of Health from 1985-1990) in conversation with the author, June 2022.

from a coalition of interest groups led by non-profit providers but also supported by for-profit providers and other established health system interests, like the OMA and OPA, ultimately leading to its demise with the election of the Conservative government in 1995.

Having learned from the experiences of their predecessors and already settled on a clear ideological vision for reform, the Conservative government quickly enforced its own LTC agenda upon being elected, leading to the creation of CCACs and the managed competition model. The Conservative government's reforms to home care were in many ways a departure from the legacy model in terms of administration, particularly in that funding distribution was no longer determined by the quasi-municipal public health boards, but instead by bureaucrats within the CCACs.

However, the reforms also represented a continuation of the work of their predecessors, as CCACs largely resembled the SAOs the Liberal government had sought to introduce, which also would have seen home care funding distribution responsibilities more heavily regulated by the government. Indeed, the decision to wrestle control of home care governance away from quasi-municipal public health boards was likely one that would have been made by the end of the decade regardless of the party in power, much like the decision to remove Home Care from OHIP coverage.

In essence, CCAC's served as a buffer for government decision-making associated with access to home care. A similar strategy could be seen with the Conservative government's decision to give full authority to the HSRC to enforce decisions related to cost-savings in hospitals while maintaining full authority over reinvestment decisions related to those savings incurred. This

overarching approach to health reform appears to have been built on a series of blame avoidance strategies associated with the fiscal centralism approach discussed by Harden (1999), which began with prior decisions made by both the Liberal and NDP governments, further demonstrating its existence as a neoliberal trend of the 1990s.

More specific to my core hypotheses, the rationing of home care provision by CCACs reflected a perception held by all three political parties in government throughout the study period that home care costs had historically been rising precipitously and were in need of controls. This perception was quite distinct from the one held by the governments of Saskatchewan during the same period, as will be demonstrated in the next chapter. This supports my first hypothesis that the different reform trajectories for home care taken by Ontario and Saskatchewan were determined by perceptions of the costs associated with it.

Within the Conservative government's home care agenda, CCACs were heavily marketed as being an optimal solution to the patchwork system of home care that had existed historically. They promised consumer choice and the highest quality care for the best price and were positioned as a superior alternative to the MSA model that was to be introduced by their predecessors. The MSA model had similarly been touted as a means of improving consumer choice, quality of care, and cost savings in home care (and LTC more generally) by the NDP government, as had the SAOs brought forward by the Liberal government before them. This consistency in marketing behind the service delivery systems platformed by each of the governing parties further demonstrates not only the relative similarities between each party in

terms of their home care reform agendas, but also the role these service delivery systems playing in justifying those agendas.

Conclusion

Looking back at the trajectory for home care reform in Ontario, it's clear that portions of the blame for the faults with the system that emerged at the end of the reform period of the late 1990s can be distributed across all three governing three parties. Analyzing the home care reform strategies undertaken by the various political parties in Ontario is thus best described as an exercise of parsing differences in similarity, as the reform trajectory facilitated by each party was - for the most part - quite aligned, with the main differences between their respective reform strategies being in very specific elements of their service delivery models and the long-term goals associated with them. However, only the Conservative government under Mike Harris would stay in power long enough to see its reform strategy for home care ultimately implemented. That said, the groundwork laid by both the Liberal and NDP governments inadvertently paved the way for the Conservatives to pass on an increasing amount of home care costs onto consumers.

Despite the similarities that have been highlighted between the home care reform strategies of the three governing parties, the approaches to home care reform put forward by the models that weren't implemented - particularly the NDP's MSA model - remain an interesting consideration as a road not taken. However, the failure of the Rae government to implement its MSA model despite having five years in power with a majority government could also be seen as evidence of the approach being a road that was never really available. 30 years later, it is still not

clear how the NDP government would have been able to implement a systemic reform to home care that would have both absorbed the provider role and employment of formal caregivers from for-profit companies and non-profit organizations while also maintaining the latter group's involvement in the sector. Between this issue of feasibility and the lack of conviction from the Rae government regarding the notion that Home Care could be a cost-effective alternative to acute care, the MSA model might have never stood a chance against the institutional and ideational paradigms that had defined the Home Care program and the entrenched stakeholders that had maintained them since inception.

In acknowledging this, my analysis' focus on the role of policy legacies in the trajectory of home care in Ontario comes to different conclusions from previous analyses by Baranek (2000) and O'Connor (2005) regarding the role played by different governing parties over the course of the 1990s. Specifically, it demonstrates how retrenchment policies for home care were tabled by the Liberal government under Peterson based on concerns about the program's cost trajectory going into the 1990s. Though the NDP government went on to attempt a divergence from their predecessor's trajectory for the home care program, they eventually implemented the first steps of it before the election of the Harris Conservatives in 1995. This made following through on the home care retrenchment agenda a quick and easy matter for the Conservative government upon their rise to power. Home care retrenchment in Ontario is therefore best characterized not as having resulted from a rapid neoliberal shift initiated by the Harris Conservative government, but instead as the end result of an agenda focused on increasing government control over program expenditures by all three governments that came to power over the 1990s.

As the next chapter will demonstrate, the NDP government of Saskatchewan – which was able to maintain power for a much longer period than that of Rae and therefore had more time to implement its policy preferences – adopted a home care reform approach that largely mirrored that which was intended under Rae in Ontario. The approach to reform implemented in Saskatchewan contrasts significantly with the path ultimately taken in Ontario, and I will show how differing perceptions regarding the cost of home care were shaped largely by the difference in role played historically by the state in funding it. The final chapter will speak further to the significance of the impacts of these two provinces' divergent home care reform paths, particularly concerning the conditions for home care workers and service quality & access between them.

Exploring the Boundaries of Health Resource Reallocation: The Evolving role of Home Care in Saskatchewan

Much like Ontario, the trajectory for home care seen in Saskatchewan during the study period was largely influenced by ideas established by key policy actors in the early 1990s regarding home care's potential for serving as a cost-saving alternative to institutional care. As this chapter will demonstrate, these ideas were informed by policy legacies established through decisions made by previous governments, as was in the case in Ontario. However, these policy decisions manifested in a distinct health system trajectory for Saskatchewan that led to it entering the 1990s with a significant overabundance of acute care beds - the highest number per capita among the Canadian provinces - obtained through the excessive construction of rural hospitals in the 1980s. This occurred alongside the gradual overtaking of home care service provision by the Saskatchewan Department of Health from the non-profit sector. This trend of increasing

public stake in home care and support services led to a compacted population of interest groups in the home care policy space. Meanwhile, the rapid construction of rural hospitals in the 1970s and 1980s normalized their presence in small communities. This reality made the Romanow government's eventual decision to eliminate acute care provision within rural hospitals a sticking point for residents of the communities affected by that change, despite the fact those hospitals were otherwise underutilized.

These distinct factors in Saskatchewan combined with the nation-wide fiscal and administrative pressures in the mid-late 1990s led to a shift in priorities for health system reform in Saskatchewan characterized by an increasingly desperate search for cost savings. While the early 2000s saw an attempt to redirect health system resources in a direction more closely aligned with the NDP government's initial vision, by the time Lorne Calvert replaced Roy Romanow as Premier, the "Wellness" agenda that had served as the bedrock of the initial reforms of the early 1990s had largely dissipated, and with it went the attention to home care that had occurred with it.

This chapter is organized chronologically. The first section will demonstrate the policy legacies that were established for home care gradually from the late 1970s up until the election of the Romanow government in 1991. The second will unpack the ideological underpinnings of the NDP government's aggressive health reform agenda under Premier Roy Romanow in the early 1990s and outline its initial approach to home care within its "Wellness" agenda. The third will discuss the dynamics at play following the NDP's 1995 election win that contributed to a scaling back of the government's health reform agenda. These dynamics included cuts to provincial health

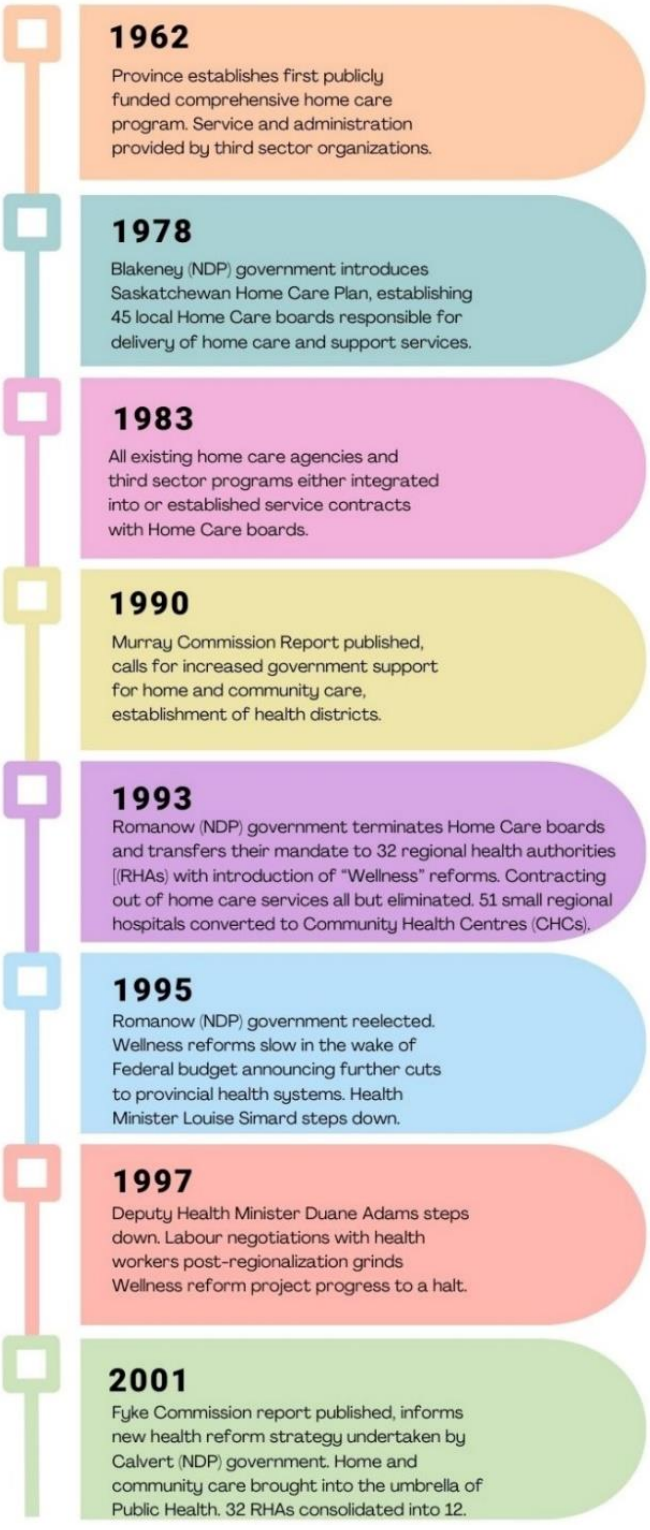
funding from the federal government in the 1995 federal budget, pushback from the public in response to the elimination of acute care provision in 51 rural hospitals, and the need to adapt to the new governance arrangements associated with regionalization reforms. The fourth section will discuss Saskatchewan health governance under Lorne Calvert in the wake of the publication of a high-profile provincial commission report by former Deputy Minister of Health and chair of the Saskatchewan Commission on Medicare, Kenneth Fyke. This report – dubbed the Fyke report – led to the creation of a final phase of health reform in the province, one that emphasized the expansion of primary health care services – of which home care was prioritized – and the amalgamation of the province's 32 DHAs into 12 Regional Health Authorities (RHAs). A discussion will follow on the distinct political legacies in Ontario and Saskatchewan, and how they have shaped the trajectories for home care's role in each province's health system.

Analyzing this period of political history in Saskatchewan, one might question why the study period I selected for the purpose of comparison of this province with Ontario does not focus on the changes made in the late 1970s and early 1980s and instead includes them as background policy legacies for the 1990s, where home care did not experience substantial policy changes. The main reason for this is that Saskatchewan's health reform period of the 1990s represents a timeframe where home care was seriously invested in by a provincial government perceiving it as a key target for resources transferred from institutional forms of care. In this sense, there is a more interesting contrast to make with Ontario in this study period than in the decade prior to it, because both provinces found themselves in a similar ideational space for health care where the need to reduce health systems' reliance on institutional forms of care was widely acknowledged. Looking at home care in Saskatchewan from the early 1990s to early 2000s, we can observe a

path to expanding home care as part of broader health system reforms defined initially by an ambitious strategy of centralization and resource redirection, followed by adaptation and reform atrophy in the wake of increasing fiscal and public pressures, and finally by a period of consolidated expansion driven by decisionmakers with less ambitious ideas for health system reform. The changes made to the province's health system during this final period – including those to home care – have remained largely intact today.

As the rest of the chapter will demonstrate, NDP governments in Saskatchewan established a legacy as key advocates and innovators in terms of expanding home and community care's role within health systems. By contrasting the Saskatchewan experience in home care policy reform with Ontario, there are important insights that can be gleaned regarding the relative influence of institutions, ideas, and interests in provincial health policy change. Specifically, the chapter will show that the distinct policy choices made in Saskatchewan regarding home care were influenced first and foremost by key decisions to absorb the service delivery role from nonprofit organizations and make it the exclusive responsibility of the Department of Health in the decade prior to the reform period initiated by the Romanow government. This policy legacy in turn fostered a unique ideational landscape for home care with the election of the NDP government in 1991, as well as narrowing the stakeholder environment to limit the range of competing interests and their coordination effects that could influence policy trajectories. The sequence of events for home care policy development in Saskatchewan is outlined in the timeline below.

TIMELINE OF HOME CARE IN SASKATCHEWAN



Home Care's Origins in Saskatchewan: The Growth and Decline in Non-Profit Provision

Home-based care services in Saskatchewan first emerged in the early 1900s with the Victorian Order of Nurses (VON), who were the sole provider of home nursing services in the province up until the development of formal home care programs in the 1960s. These early home care programs began as pilot projects that were locally developed and provided by the third sector, with little administrative involvement from government. However, these programs did receive funding from the public sector, including through National Health grants – namely the New Horizons program which to this day provides up to $25,000 in funding – to senior citizen groups like the Family Service Bureau of Regina to develop programs to improve the welfare of themselves and their communities[46] – and Local Initiative Grants provided by the Saskatchewan Department of Social Services (Lawson & Thériault, 1999; Pitsula, 1982). These programs were eventually integrated into a province-wide home care plan implemented from the late 1970s to the early 1980s, with the first provincially-governed home care program beginning to deliver services in 1980 and all district home care programs being operational by 1984 (Canadian Home Care Association, 1998).

In the 1970s, home care programs were expanded to include non-medical services such as homemaking, home maintenance, and meals on wheels. This largely occurred as a result of the efforts of the Alliance of Youth and the Elderly (AYE) in Saskatoon, which began as a summer works project in 1971 for university students in Saskatoon. The Alliance's initial mandate was to

[46] "Senior News", February 1983, Records of the Alliance of Youth and the Elderly, file Correspondence, Parks and Recreation Department, City of Saskatoon, Saskatchewan Archives Board, Saskatoon.

provide home maintenance – including minor household repairs, ironing, gardening, window and floor washing, snow removal, and grocery delivery – to older adults who were physically unable to carry out such tasks alone or with informal assistance. They eventually added other services in response to requests from their clients, including transportation, a telephone check-up for lonely and house-bound older adults, a personal care service that included haircuts, a referral and information service, and a weekly radio program run by and for older adults.[47] These services were provided free to clients who were unable to afford them, while some clients received them on a fee-for-service basis at the discretion of staff based on the client's ability to pay.[48] All revenue acquired from these fees was held in a trust that was reimbursed to the provincial government on a monthly basis.

Over time, the Alliance realized there was a need within the community for a permanent service organization for its care recipients who would otherwise be forced to enter the formalized LTC system (i.e., nursing homes), and lobbied the federal and provincial government accordingly for continued funding. After being funded by a grant from the federal government's Opportunities for Youth program in 1971, the AYE operated on funds from the Local Initiative Program in 1972 and 1973 before receiving permanent financing from the Saskatchewan Department of Social Services in 1974, at which time it also acquired a United Way grant.[49] By 1975, the AYE employed

[47] Alliance of Youth and Elderly Society: Budget Request For 1975-1976, file Correspondence, Continuing Care Division, Saskatchewan Archives Board, Saskatoon.
[48] *Ibid.*
[49] Report on the Activities of The Alliance of Youth and the Elderly to Mr. Zimmerman, 17 August 1971, AYE, file Correspondence, Patrick Lapointe, Continuing Care Division, Community Special Care Services Division, Department of Welfare, Saskatchewan Archives Board, Saskatoon, and Newsletter, 18 March 1974, AYE, Saskatchewan Archives Board, Regina.

8 people including 6 field staff but were still highly reliant on a large number of volunteers to provide the services they offered.[50] Across Saskatchewan, the Department of Social Services provided funding to 104 home care projects, including 36 homemaker projects, 47 meal service projects, and 21 Aids to Independent Living (i.e. home maintenance) projects by 1977, with the vast majority being operated by third sector agencies.[51]

In 1978, the Blakeney NDP government began a period of transition in administration of home care which marked the decline of third sector involvement in home care service delivery with the introduction of the Saskatchewan Home Care Plan. The first change this introduced was the establishment of 45 local Home Care boards which became directly responsible and received full funding for the delivery of homemaking, meals, nursing, and minor home maintenance services. Then, on May 5th, 1978 the Minister of Health announced that services from existing providers (such as the VON and the AYE) would be integrated into the system and coordinated by the Home Care boards.[52] These boards were structured as non-profit corporations and had the option to either contract with existing home care agencies in communities or directly provide home care services themselves. Lawson and Thériault (1999) suggest that the government at the time preferred the latter approach so as to reduce administrative costs and improve service

[50] Alliance of Youth and Elderly Society: Budget Request For 1975-1976, file Correspondence, Continuing Care Division, Saskatchewan Archives Board, Saskatoon.
[51] Memo Re. Home Care Proposal, 14 February 1977, R-1447 file 3.14, Department of Health Policy and Research and Management Services Branch, Deputy Ministers, Departments of Health and Social Services, Saskatchewan Archives Board, Regina.
[52] Saskatchewan Home Care, Ministers' Summary: 10, 26 March 1979, R-1447, file 3.14, Records of the Department of Health Policy and Research Management Services Branch, Saskatchewan Archives Board, Regina.

coordination. They further argue that a 1980 decision by the Department of Social Services to transfer its funding for the homemaking and Meals-on-Wheels programs in Saskatoon from the Family Services Bureau to the AYE was an indication of the Department's desire to see non-medical home care services provided by a single organization.

Over the course of 1980s and up until the 1993 decision by the Romanow government to forbid the contracting-out of home care services, the provincial government gradually took over the nonprofit sector's previously dominant role in home care provision. This was partially facilitated by creative accounting on the part of the Devine government to shift the responsibility for home care funding from the Department of Social Services to the Department of Health. Though this process of absorption of the nonprofit sector's role in delivery by the state for the most part occurred without substantial pushback from those organizations – certainly not to the extent seen in Ontario in the 1990s – there were some existing agencies, namely the VON, that attempted to combat the transition out of fear for their survival. This resistance was primarily mounted in Regina, where, in October 1980, the three nonprofit home care agencies – the Regina Family Service Bureau, the Senior Citizens Service, and the VON – united to devise an alternative home care administration and delivery model that would allow them to retain control of their services and continue to exist and operate in the city (Nurse, 1982). This model was presented to the Deputy Minister of Social Services at the time, Duane Adams, and accompanied by a moratorium request on the implementation of the 1978 Saskatchewan Home Care Plan in Regina. Though their efforts were unsuccessful in terms of preventing the implementation of the

provincial program plan in Regina, the Regina Home Care District Board did end up deciding to contract with the agencies up until 1993.[53]

Indeed, early in the establishment of the Saskatchewan Home Care Plan, many of the new Home Care District Boards decided to continue contracting out services to the third sector agencies which had historically provided them. Others, such as the AYE, joined the Saskatchewan Association for Non-Government Social Services Agencies (SANGSSA) during the interim period before being fully integrated into the Home Care District Boards.[54] However, over the 1980s, many Home Care District Boards gradually transitioned to directly providing services themselves to eliminate the duplication of administration (Lawson & Thériault, 1999).

That said, the implementation process of the Saskatchewan Home Care Plan for the most part managed to integrate the third sector agencies into the new model rather than cutting them outright.[55] For example, the Saskatoon Home Care District Board entered into contracts with existing agencies that would expire on March 31st, 1983, at which point the board would take on the service provision role. Some of the agencies in rural areas covered by the Saskatoon Board directly requested that the board assume responsibility for their services at the outset of the new agreement. Staff at the rest of the agencies were eventually all offered guaranteed

[53] "1995 Annual Report", Senior Citizens Service of Regina, 1987 Inc.
[54] Committee of Non-Government Organizations: Report on Activities and the Congress leading to the formation of the Saskatchewan Association of Non-Governmental Social Services Agencies, 1980, AYE, file Saskatchewan Association of Non-Governmental Social Services Agencies (SANGSSA), Saskatchewan Archive Board, Saskatoon.
[55] Home Care – Saskatoon, District No. 45 Inc. Annual Report, November 1982, AYE, file Home Care District #45, Saskatchewan Archive Board, Saskatoon.

employment with no loss of salary – apart from some managerial positions that were separately negotiated – by the Saskatoon Home Care District Board.[56] In a parallel example of the Home Care Board's retention of third sector human resources, part of the process of implementing the Saskatchewan Home Care Plan involved establishing a central home care directorate within the Department of Social Services to design, enforce, and supervise the implementation of program standards. Many of the newly hired development officers within this directorate were directly recruited from third sector home care agencies (Lawson & Thériault, 1999).

The transition of power from the third sector to the provincial government in the provision of home care services in Saskatchewan occurred in stark contrast to the public battle between nonprofit providers and the provincial government over the same issue in Ontario. There are a number of contributing factors that help to explain this phenomenon. The first is the reality that Saskatchewan has historically not been a place where home care providers could survive without external support. Emblematic of this is the fact that for-profit home care providers have historically failed to find success in the province, and only recently have found a foothold there due to service demand being unmet by the existing public sector services. Nonprofit providers of home care in the province, as Lawson and Thériault (1999) note, though the first providers of home care, have also been highly dependent on external funding sources, and even at the height of their activity were only able to afford to pay their workers a minimum wage. As such, the sector has always existed in a precarious state.

[56] Joe Bates, President, Home Care – Saskatoon District No. 45 Inc., 8 March 1982, AYE, file Home Care District #45, Saskatchewan Archive Board.

As a former Home Care Board Director-turned-Health-Department bureaucrat noted in an interview, changes announced in the 1978 Saskatchewan Home Care Plan were also hugely influential in explaining the transition from non-profit sector provision to government provision. This is because the plan not only came with additional government funding via the home care boards, but also made this funding be conditional upon the provision of services like homemaking and home maintenance, which had not previously been funded by the province.[57] This meant that non-profit organizations were put in a position of even greater reliance on the state in providing home care services, as they were already strained in terms of the human capital necessary to provide existing service. As a result, there was no incentive for the Home Care Boards to contract out services to nonprofit organizations in most regions, nor a strong case for non-profit providers to make to justify continuing the contracting process.[58] Considering this alongside the fact that existing non-profit providers of home care in the province were also offered guaranteed employment in the public sector throughout the transition process, it is not surprising that there was a lack of strong opposition from non-profit organizations to the Home Care Plan.

Another likely reason for less intense opposition to reform in contrast with Ontario was the lack of organized cooperation between non-profit organizations. Indeed, beyond the example mentioned earlier of three non-profit providers out of Regina collaborating to push an

[57] Roger Carriere, former Director of Home Services for Saskatoon Home Care Board and Director of Continuing Care & Rehab in the Saskatchewan Ministry of Health, in conversation with the author, January 2023.
[58] *Ibid.*

alternative home care delivery plan to their home care board, there is no other evidence of a collaborative resistance effort by non-profit providers against the Saskatchewan Home Care Plan from its outset in 1978 to the transition's culmination in 1993. Most interesting to observe was the lack of an organized resistance effort from 1983-1991, as the non-profit organizations might have had a greater opportunity to lobby Conservative Premier Grant Devine for an alternative to the Saskatchewan Home Care Plan of 1978. However, the Devine government did not appear to have a vested interest in home care. Indeed, as the next section will demonstrate, the Conservatives' health policies throughout the 1980s were primarily focused on acute care, with 10 rural hospitals being constructed during Devine's tenure as Premier.

The NDP government that succeeded the Devine Conservatives ultimately followed through on the transition process in 1993, which had been started by Premier Blakeney two governments prior with its extensive health system reforms from the late 1970s to early 1980s. After these reforms, contracting of home care services in the province was essentially forbidden. The only remaining non-profit home care providers were concentrated entirely in the northern, rural regions of Saskatchewan, where they collaborated with the two District Health Boards and one health authority established there, and thus accounted for a very small portion of the home care services provided in the province (Canadian Home Care Association, 1998).

This section provides evidence for two of my hypotheses. In the first case, it demonstrates that importance of early choices to establish government control over the funding and delivery of home care in Saskatchewan. This allowed the province's bureaucracy to contain costs throughout the tenure of the Devine Conservatives, and shaped Saskatchewan decision makers'

ideas about the role of home care in health care cost management. The comparative lack of control the Ontario government had going into the 1990s informed a perception held by decision makers that home care costs needed controlling, as demonstrated by the previous chapter. With the Saskatchewan government already in full control of home care costs, which also made up a smaller proportion of total provincial health spending going into the reform period, there was no onus for it to share the negative perception of the cost trends of program held by policy makers in Ontario. This would have made Saskatchewan's program implicitly more viable as an investment vehicle for health system cost savings, and indeed, home care investment in Saskatchewan increased at an even faster rate under the Romanow government between 1991 and 1995 than Ontario's did under the Rae government. This is consistent with my first hypothesis regarding the importance of policy legacies in influencing policymakers' ideas, as it is clear from the Romanow government's Wellness plan and its staunchest advocates that there were none of the concerns about home care cost trajectories in Saskatchewan that there were with Ontario, particularly under Peterson's Liberal government.

This section also provides evidence for my third hypothesis concerning the influence of policy legacies on the makeup of stakeholders and interest groups within the home care policy sphere, as Saskatchewan's decision to absorb the non-profit sector's role in home care provision and administration in the 1980s also served to eliminate a potential stakeholder that could oppose further consolidation of home care administration in the future. Indeed, by the time the Romanow government moved to ban the contracting of home care services for the majority of its district health boards in the early 1990s, most of the non-profit organizations that had been involved with home care delivery up until that point had either joined the Saskatchewan

Association for Non-Government Social Services Agencies, where they essentially operated as non-profit corporations in name only, or been fully integrated into the regional home care board they had previously contracted with (Lawson & Thériault, 1999). This meant that nonprofit organizations did not possess nearly the power necessary to resist home care policy reforms that effectively eliminated their role in service delivery as a result of that power having been gradually eroded throughout the 1980s. Non-profit organizations in Ontario, in contrast, were strongly situated within the brokerage system of contracting home care service delivery at the time a similar reform trajectory was proposed by Rae's NDP government, and subsequently were able to lobby effectively to ultimately prevent its implementation. Here again, we see a demonstration of the influence of home care policy legacies on the provincially distinct reform trajectories seen during the study period, this time through their impact on the interest groups and stakeholders involved in the policy arena.

Though home care ultimately received limited attention under the Devine government, with no major policy decisions occurring during the PC party's tenure in power, it is worth dedicating some brief attention to his legacy, which offers an important backdrop to the election of the NDP government under Roy Romanow in 1991. This will serve to contrast Saskatchewan's home care trajectory with Ontario, which saw an incremental series of reforms to home care introduced across three governments of different parties. Saskatchewan's experience provides a distinct contrast to this, with a broader health reform trajectory that was much more transformative, particularly in its early stages. This was in part due to the severity of the economic situation the NDP government inherited from its Conservative predecessors, but was also a result of the NDP's relentless critique while in opposition of the Devine government's health system agenda

throughout the 1980s, which made the implementation of a broad health reform by the NDP government in the 1990s a "political inevitability" (Loadman, 2010).

Though home care in Saskatchewan itself did not experience the sorts of direct policy changes seen in Ontario during the 1990s, it did see a greater expansion of its role and degree of government investment in its mandate within the NDP government's Wellness agenda, which emphasized home and community care investment and provision over that of acute care. Ontario, for all its investment in home care during the early 1990s by Bob Rae's NDP government, saw much of its targeted policy changes built around variations of "one-stop shopping" agencies for home care administration which were meant to function first and foremost as a means of introducing cost controls. The agencies that were finally implemented - CCACs - ultimately served to make it easier to redirect funding *from* home care, whereas Saskatchewan saw a focused, albeit relatively brief, effort made to reform its health system to ensure funding could be directed *toward* home care.

There were also some similarities between Ontario and Saskatchewan in terms of the fiscal pressures they had to navigate in their pursuit of health system reforms. However, those felt by the NDP government at the start of their tenure in power were even more pressing than those experienced by the Liberal and NDP governments in Ontario. To understand the context of these fiscal pressures, it is important to first address distinct political backdrop of the rise and fall of the Progressive Conservative government of the 1980s under Grant Devine's leadership and the impacts of policy decisions made during that period.

The Rise and Fall of Grant Devine and the Saskatchewan Conservatives

Grant Devine was elected as the Progressive Conservative Premier in 1982 as a political underdog with no prior experience in the legislature – he had twice previously tried and failed to win a riding of his own – in a sound victory that was surprising even to him. Indeed, this election victory marked the first and to date only time the party won a majority government in the province (Johnsrude, 1982). Devine's PC government was reelected in 1986, retaining majority status but losing the plurality of votes to the NDP. Over the course of its 9 years in power, the PC government gradually became a symbol of profligacy due to its fiscal record, posting 10 straight deficit budgets. Inheriting balanced books and seemingly strong economic conditions from the Blakeney government in 1982, Devine implemented several expensive initiatives that were seen as voter-friendly, like tax rebates and mortgage subsidies, and invested a significant amount of public money into costly megaprojects that ended up being net losses for taxpayers. At the same time, he eliminated the province's gas tax (eventually reintroducing it in 1987 with consumer rebates) and cut sales and incomes taxes (MacKinnon, 2003b). While Saskatchewan was not unique among the Canadian provinces in having a government that continued to increase spending despite mounting deficits, by the end of the 1980s it had become a "canary in the coal mine of deficit and debt", to quote former NDP finance minister Janice MacKinnon (2003b). Under Devine's leadership, Saskatchewan's debt grew from $3.5 billion to $12 billion.

Devine's aggressive spending patterns were maintained in the healthcare portfolio. As part of his effort to revitalize rural Saskatchewan communities, 10 new hospitals were constructed during his tenure, another costly health initiative part of his broader pattern of spending on large-scale public infrastructure, but also a continuation of a trend started by his NDP predecessor in Allan

Blakeney. Indeed, as Biggs (1991) notes: "the construction of health care facilities became the centerpiece of the Tory program in health care" (pg. 179). The Conservative government's 1983 budget was a prime example of this, which touted an almost $1 billion health budget (up by $250 million from the previous year), of which hospital construction and upgrades accounted for 25%.

Home care was also largely ignored during Devine's tenure in power. Although public home care expenditures increased by more than 24% in 1983, this was largely a result of this was largely a result of the government's creative accounting decision mentioned earlier, which came in the form of a transfer of $18,380,040 in grants and allowances for the program from the Department of Social Services to the Department of Health (Biggs, 1991). It then dropped by just under 3% in 1984 before rising again by just over 7% in 1985. It then rose by 17% in 1986, but this amount also included an emergency $700,000 that the government was forced to provide to meet program demand. Program expenditures dropped again in 1987 and 1988, before they began to rise more steadily from 1989-1993 (see Table 2 in the Appendix). User fees for the program were also increased by 66% in the 1987 budget, which, though accompanied by a subsidy that older adults could be eligible for via a means test, was part of a broader trend of privatization that occurred in health care under the Conservative government in Saskatchewan (Biggs, 1991).

Arguably the most significant health policy activity to occur under the Devine government was the establishment of the Saskatchewan Commission on Directions in Health Care – chaired by Robert G. Murray and often referred to as the Murray Commission – in July of 1988. However, establishing the commission was largely a deflection tactic for the Devine government in

response to its growing credibility problem with regard to its approach to healthcare. Indeed, the Devine government did not end up pursuing any health policy changes recommended by the Murray Commission's final report – the NDP government would go on to in their stead, as is discussed further in the next section – with the exception of consolidating hospital services in Saskatoon (Biggs, 1991). The Devine government's inaction on health care was part of a broader decline in governance by the Conservative party. As Eisler, (2022) notes, by time the PC government reached its final months in power, Devine appeared "rudderless and desperate", having introduced no budget in spring of 1991 and governing via special warrants to cabinet up until the October 1991 election, called at end of the government's fifth year in power and at the legal limit of its governing mandate. It would go on to be their NDP successors who pursued a reform agenda informed by the Commission, particularly in terms of attention to home and community care service investment, as will be demonstrated later in the next section.

Devine was similarly unwilling to put up a fight with the federal Mulroney government over the Established Program Financing (EPF) cuts that impacted health and education revenues in the 1986-1987 and 1989-1990 fiscal years (Graefe, 2002). The result of this was that health expenditures in the province rose while its funding sources continued to erode. The Devine government was aware of this but was either unable or unwilling to communicate to the public the financial stress it was facing due to the rising costs of health care, due largely to the fact that any attempt at cutting health services would lead to a flare of public protest (MacKinnon,

2003b).[59] Somewhat ironically, the flames of these public protests were fanned by the members of the NDP opposition, who were unknowingly creating untenable expectations regarding health system from the voting public that would go on to plague them when they would go on to govern (MacKinnon, 2003b). Eventually, in 1991 the Devine government was defeated by the NDP in a fashion much like their own victory the decade prior, reduced to ten seats in the legislature.

The legacy of Devine's leadership went on to hang a pall over the Saskatchewan PC party, most notably in the next election in 1995, where the PCs were further punished by the electorate as a result of legal action targeting 13 members of the former Premier's government, including Devine himself, for expense account fraud. The scheme in question, which defrauded taxpayers of more than $837,000, led to charges being laid just 2 months before the 1995 election, and was the biggest political scandal in Saskatchewan's history (Bergman & Eisler, 1996). It was ultimately one that the party was never able to recover from. Indeed, after winning only 5 seats in the 1995 election, the party all but disintegrated, with most former members and supporters – including then-leader Bill Boyd – leaving to form the Saskatchewan Party in 1997.

The political demise of the PC party offers an important backdrop to those unfamiliar with the political environment of Saskatchewan. As a province that has tended toward having a two-party system, the PC party's historic political scandal coming to a head in 1995 meant that the NDP ran

[59] The one notable exception to this was the Devine government's decision to terminate the Saskatchewan Dental Plan, which it followed through with in June of 1987 at the behest of the dental lobby, as noted by Steven Lewis (former CEO of HSURC from 1992-1999) in conversation with the author, January 2023.

essentially unopposed in an election that might otherwise have had a different result. Indeed, 1995 was a tumultuous year for the NDP as well. Though able to secure another majority victory, the NDP government faced plenty of opposition to its policy agenda, particularly when it came to health reform, as a result of its decision early in its first term in government to convert multiple rural hospitals into community health centres as part of its "Wellness" model (Adams, 2001). As will be discussed below, this public opposition to the NDP's health agenda contributed to decisions to scale back their reform ambitions in the late 1990s. Prior to that, however, the NDP government began its tenure with a well-defined ideological agenda, one that was largely informed by the Murray Commission that had been established by their political rivals in the Saskatchewan Conservatives.

The Murray Report and the Formation of the NDP Government's Vision of Health

Chaired by former head of the Medical Care Insurance Commission and Dean of the University of Saskatchewan's Department of Medicine, Dr. R.G. Murray, the Saskatchewan Commission on Directions in Healthcare was established out of recognition that there had been no attempt to make a comprehensive plan for Saskatchewan health services since the Sigerist Report of 1944. The Commission published its report in April of 1990 (hereafter referred to as the "Murray Report") after a twenty-one-month study of the province's health system involving public hearings in communities across Saskatchewan. The report was the final and most extensive of the many reports concerning Saskatchewan's health system made during the Devine

government's tenure in power[60], the latter efforts of which were written with the aim of convincing the public and health stakeholders to lessen demands for additional services and funding (Loadman, 2010). The report made 262 recommendations for reforms. Included among them were suggestions for the creation of 15 health service regions across the province led by an equivalent number of health councils to replace the 127 hospital boards, 133 nursing home boards, 108 ambulance boards, and 45 home care boards, as well as a proposal to fund new expenditures with tighter controls on medical practice and hospital admissions and an increased emphasis on community and supportive living services like home care (Saskatchewan Commission on Directions in Health Care, 1990).

Establishing these health regions, the report argued, would allow for a consolidation of system governance to reduce duplication of administration. More broadly, the report described the Saskatchewan health system as "open-ended, constantly expanding and lacking sufficient controls" and noted it lacked an emphasis on health promotion and illness prevention (Saskatchewan Commission on Directions in Health Care, 1990). The report also revealed that Saskatchewan had the most acute care beds per capita in the country by the end of the 1980s, largely the result of health spending having doubled over the course of that decade, most of which went to hospitals (Saskatchewan Commission on Directions in Health Care, 1990). One of its key recommendations was the consolidation of Saskatchewan's 134 hospitals – particularly

[60] Previous examples included the 1987 "Report on Enhancement of Regional Hospitals (Schwartz Report), which first suggested the closure of small, rural hospitals, 1989's "The Growth in Use of Health Services" report, verifying the need to curtail the dramatic growth seen in government health expenditures, and a report from Consensus Saskatchewan calling Saskatchewan's health system "inefficient, outdated and encumbered by escalating costs". (See Loadman 2010).

the myriad of underutilized rural hospitals – alongside a shift to home-based and community care to address the broad issue of the health system's affordability and effectiveness.

None of the views or suggestions for reform that were put forward by the Murray Commission were new or surprising. Much like Ontario and other provinces, issues of health system affordability and effectiveness were widespread, and the conclusions presented by similar studies across the country came to the same conclusions as those reached by the Murray Commission (Hurley et al., 1994; Loadman, 2010; O'Fee, 2001). Devine, however, was hesitant to take any significant action due to the negative response to the suggested reforms presented by rural communities, who were the prime target for hospital closures, reductions in health services, and losses of local jobs (Loadman, 2010). The NDP, in contrast, who had vigorously attacked the Devine government's inaction on health while in opposition, was primed to introduce health reforms upon their election in 1991. Having campaigned aggressively on a health reform approach built around concepts promoted by the Murray Commission like health promotion and population health– concepts also embraced by almost all health stakeholders in the province – the NDP government decision to implement a broad health reform strategy was not only politically strategic, but necessary (Loadman 2010).

Home care received significant attention within the Murray Commission report, as did support for family caregivers. Crucially, the report noted that the home care program was one of the province's most cost-effective health programs, and that it offered "an attractive alternative to costly institutionalization for residents requiring assistance to live independently" (Saskatchewan Commission on Directions in Health Care, 1990). This indicates that health policy experts in

Saskatchewan had a positive perception of home care in terms of it being a cost-effective alternative to institutional forms of care. Indeed, community-based services broadly were hailed as the "kingpin" of Saskatchewan's health system within the Murray report, promising value for money spent because their prime directive is to keep people healthy and provide the care people need in their homes or communities rather than in institutions (Saskatchewan Commission on Directions in Health Care, 1990). As the previous chapter suggested, policy experts in Ontario were not as convinced of this, instead expressing concern with a cost-effectiveness gap in the province's Home Care program. This provides evidence to support my first hypothesis and marks a key distinction between Saskatchewan and Ontario in terms of ideas held by those influencing health policy decisions in each province.

Another notable impression of home care brought up in the Murray report is the sole negative observation of the home care program lacking coordination due to the broader issue of community service segregation, which fragmented services and impaired accessibility. The report's recommended solution to this issue was integrating home care with other community-based services to maintain a continuity of care (Saskatchewan Commission on Directions in Health Care, 1990).

These ideas about home care in the Murray Commission report demonstrate key areas of congruence and divergence between policy experts in Saskatchewan and Ontario early in their reform periods. In terms of congruence, experts in each province acknowledged the need for increased integration of home care with other forms of care, as well as the notion that the medical elements of home care should not have any user fees associated with them. In terms of

divergence, however, there is a clear argument made in the Murray report that home care represents an “attractive alternative” to “costly institutionalization” (Saskatchewan Commission on Directions in Health Care, 1990). This impression of home care is quite distinct from the skepticism expressed by the Premier’s Council on Health Strategy in Ontario, which substantially influenced early health reform directions in the province, as was demonstrated in the previous chapter.

Another key distinction in how home care is discussed in the Murray Commission report in contrast with comparable sources in Ontario is its inclusion within the broader category of community-based services. Part of the reason for this is that Saskatchewan’s home care program has historically been technically distinct from home support and home maintenance programs, but all were considered important targets for increased resource allocation. As a result, placeholder terms like "community-based services" or "home-based health programs" are frequently referred to in place of home care – which more specifically refers to home nursing – more directly (see especially Saskatchewan Commission on Directions in Health Care 1990; Simard 1992; and Commission on Medicare 2001). All programs within this net, however, were directly targeted for increased funding commitments. Indeed, this can be seen as further evidence of ideational support for the home care program in Saskatchewan. As later sections of the chapter will show, much of the attention to home care by the NDP government was given in the form of reference to broader categories of “community health” or “public health” programs and/or services. Rather than being evidence of a disinterest in home care itself, however, it is more accurate to view this reality as evidence of the NDP government’s interest in increasing home care’s role within the Saskatchewan healthcare system, as community and/or public health

services are clearly highlighted as priorities for increased support within the government's Wellness agenda (Simard, 1992). Indeed, as the data in Table 2 in the Appendix demonstrates, home care went on to receive substantial funding increases in the first three years of the Romanow' government's tenure in power.

The Murray report generated a considerable amount of debate in the Saskatchewan Legislative Assembly (SLA) in the wake of its 1990 publication, particularly criticism of the Conservative government's home care budget by opposition members. Indeed, between April 2nd and June 7th of 1990, Dr. Murray's comments recommending home care and the fact that he was not consulted by the government on its latest health care budget was brought up 16 times in 4 sittings where the province's health budget was discussed.[61] Though the Conservative government touted its 9.5 percent increase in home care funding in the budget as a sign of its commitment to follow the recommendations of the Murray report, the fact that this increase amounted to less of an increase than that of the previous year (which was 14 percent) was criticized by opposition members. Criticism of the government's approach to home care would continue into the following year, with NDP health critic Louise Simard bringing attention to the increase in home care funding only being 6 percent in 1991, accompanied by an increase in home care fees of 15 percent, all while health care institutions were facing a $40 million shortfall in funding.[62]

[61] See SLA Hansard transcripts for April 2nd and 5th, May 4th, and June 7th (21st Legislature) on the Health Budget debates.
[62] See Louise Simard's comments in SLA Hansard transcripts for April 23rd and 25th, 1991 as well as May 6th of that same year (21st Legislature).

Ultimately, the NDP – and Louise Simard in particular, who had accompanied the Murray Commission in its province-wide consultation as the NDP's Health critic prior to becoming Minister of Health – would have the opportunity carry out much of the reform agenda put forward by the Murray Report when they won the Fall 1991 election. This election, which occurred just months after the report was published, saw the NDP win 55 of the 66 seats in the Saskatchewan Legislative assembly. With this resounding majority victory, achieved as the result of a campaign focused largely on health reform, there were strong expectations of the Romanow government to address the many issues with the province's healthcare system they had spoken so vehemently of.

However, the fiscal situation the incoming government found itself in following the decade of Conservative rule under Grant Devine limited its capacity to pursue expansionist policies for social services and the welfare state more broadly, the more typical modus operandi of the NDP. Emblematic of the situation was the province's bonds being downgraded to a BBB credit rating, making them worth little more than junk bonds, which represented a significant blow to the province's budgetary situation for the incoming NDP government (Adams, 2001; MacKinnon, 2003a; Mcintosh & Marchildon, 2009).

As Louise Simard, then Minister of Health, noted in an interview, Premier Romanow and his Cabinet found themselves in a position soon after coming to power of having to decide whether to cut or eliminate some health services entirely or pursue an aggressive, systematic reform

strategy to address the province's unprecedented debt.[63] The latter decision was ultimately made, and Simard subsequently instructed her Deputy Minister to communicate to all the hospital boards of the province that there would be no funding increases by the NDP government. In 1992, the government reduced the health care budget by 3.3%, with the cuts associated with the budget reduction primarily targeting acute care services.

The NDP government ultimately decided that establishing regional health authorities with the clout and authority necessary to coordinate care decisions between hospitals within each region would be the solution to rising acute care costs. Regional health authorities would also allow the government to reduce the health system's emphasis on acute care provision through integration of care delivery. To achieve this, they realized that the regional health authorities would also need to be responsible for other forms of care, and eventually all care providers – from acute care to continuing care – were asking to be incorporated within the administrative structure of regional health authorities. Simard noted that much of the ensuing framework was recommended by the Murray Commission, which underscores the degree to which the report influenced the health reform strategy the NDP government decided to pursue in the early 1990s.[64]

The NDP government's decision to transition away from prioritizing institutional care provision further reflected the Murray Commission report's role in informing the NDP's reform strategy, as

[63] Louise Simard (former Saskatchewan Minister of Health from 1991-1995), in conversation with the author, June 2022.
[64] *Ibid.*

the report's concern about the precipitous rise in acute care spending helped to further justify and reflect its views on how best to change the province's health system to make it more cost effective. Indeed, as Romanow's former deputy minister and architect of many of these reforms, Greg Marchildon, noted in a 2007 analysis of the province's health system evolution: "The key assumption underpinning the health reforms of the early 1990s was that cost-savings could be achieved by moving the system away from illness treatment… toward a variety of health promotion and disease prevention initiatives, home care and community-based care" (Marchildon & O'Fee, 2007).

Regionalizing Saskatchewan's health care system was also positioned by the Murray Commission as a means of improving the budgeting and funding processes associated with the province's health system to "contribute to a more effective use of resources" (Saskatchewan Commission on Directions in Health Care 1990, pg. 39). The dire financial straits that the province was facing when the NDP took power in 1991 meant that, though the process of establishing health regions was collaborative, the primary incentive underlying the structural changes to the province's health system via health regions was cost containment (Adams, 2001). Acute care provision was the primary target of this initial cost-cutting exercise, with spending in the province reduced by almost 20% between 1991-92. Spending did not reach 1991 levels again until 2000 (CIHI, 2000).

That said, there is also clear evidence to suggest that the NDP government did not consider its reform strategy to be a purely calculated pursuit of cost reductions. Health Department Minister Simard's Vision document, distributed in August 1992, is emblematic of this. The document served not only as an invitation to the people of Saskatchewan to participate in the health

reform consultation process, but also a means of outlining the challenges facing the province's health system and the "Wellness" approach that the government had been developing since the start of that year. The strategies associated with the Wellness approach outlined in the Vision document focus on pivoting the health system to focus on health promotion and disease prevention, enhancing community-based services, integrating and coordinating health services though establishing health districts, and making better use of existing health services by reassessing the role of hospitals and physicians, as well as increasing the system's emphasis on evaluation (Simard, 1992). Cost concerns are hardly raised within the document, with the lone exception being two mentions of the high operating costs of the many rural hospitals in the province with fewer than 10 acute-care beds.

Indeed, it was not lost on the government that its health reform strategy could not be entirely focused on retrenchment initiatives. As former Deputy Minister of Health Duane Adams (2001) notes: "while cost constraint was a necessary and legitimate goal for the government in the early and mid-1990s, that goal alone could not sustain public support indefinitely." This awareness of the need to maintain public support for the government agenda would continue to impact the Romanow government's decisions in the late-1990s, as will be demonstrated later in the chapter.

The contents of the NDP government's Vision document provide some tangential support for my first hypothesis emphasizing the role of policy legacies on policymakers' ideas regarding home care. The Wellness approach championed by Health Minister Louise Simard clearly emphasizes the value of integration and coordination of health services. Though home care is only explicitly mentioned twice in the Vision document, there is an implied emphasis on expanding support for

it via language promoting community-based services as an opportunity "to translate wellness into affordable services which may be brought closer to home" (Simard 1992, p. 18). This indicates a belief held by health decisionmakers in the NDP government that home care – alongside other community-based health services – represents an inexpensive way of improving population health. This in turn marks a clear distinction between policy decision makers in Saskatchewan and Ontario in terms of their ideas regarding home care. While home care in Ontario simply represented yet another increasingly expensive health system service in need of increased spending controls and rationing efforts, home care in Saskatchewan represented an investment vehicle as part of a broad reform plan to see the province's health system work towards emphasizing community-based service provision over acute care. As noted earlier, the lack of direct references to home care here should not be viewed as a lack of interest in the program by government, but rather an acknowledgement of its important role within the spectrum of community-based health services as an alternative to institutional health interventions. The emphasis on the importance of home care within Saskatchewan's Vision documents by their key architect, Louise Simard, is a testament to that fact. Though Simard's Vision for health went on to face ultimately insurmountable obstacles later in the 1990s, the early years of the Romanow government saw the rapid introduction of this radical reform agenda.

The aggressive push to shift away from institutional care provision to home and community care provision was further demonstrated by subsequent reform decisions made by the government. For NDP health minister Louise Simard, the most important element of achieving the objectives of the Wellness agenda was to implement a "one-way valve" that allowed for the movement of

funds from institutional care settings to community-based and promotion-prevention funding pools, but not vice-versa. This was seen by Simard as well as the former VP of Community Services in Saskatoon Health District, Shan Landry, as an important mechanism for preventing the natural, historical tendency for resource allocation within the health system to prioritize the downstream elements of care.[65] In practice, the valve was instituted within Saskatchewan Health regulations of RHA health spending, and its primary function was to allow any unutilized health funding allocated for institutional forms of care to be redirected for home and community care. However, the valve was not formally instituted, and instead implemented at Deputy Minister Duane Adams' discretion. Simard and Adams' successors in the Department of Health did not continue utilizing the valve, which was seen by Minister Simard as a significant blow to the NDP's original reform agenda.[66]

In addition to the above-noted changes that came with the *Health Districts Act*, 52 rural hospitals (all with fewer than 8 beds) stopped receiving funding for acute care services, with almost all being converted to Community Health Centres (CHCs), and one being closed entirely. Apart from the elimination of acute care service funding for the 51 newly labeled CHCs, provincial oversight of the centres in terms of service standardization was limited. Decisions

[65] Louise Simard (former Saskatchewan Minister of Health from 1991-1995), in conversation with the author, June 2022, and Shan Landry (former VP of Community Services in Saskatoon Health District), in email correspondence with the author, February 2023.
[66] Louise Simard (former Saskatchewan Minister of Health from 1991-1995), in conversation with the author, June 2022.

regarding service provision were left entirely in the hands of district health boards.[67] According to the guide to CHCs provided by the Saskatchewan Health Department, health boards were essentially free to provide whatever selection of services were deemed as required in the area they served, but could include primary care, counselling and mental health services, respite or day care services, and/or services for visiting health professionals, such as dentists, therapists, nutritionists, and speech pathologists (Saskatchewan Health, 1993). They were also to serve as the focal point for coordinating public health inspections and other community services, such as immunization, palliative care, breast cancer screening, baby clinics, breast cancer screening, blood pressure clinics, and local home care services (Simard, 1992).

Of course, central to the NDP government's reform agenda was the introduction of Regional Health Authorities. Indeed, as then-Deputy Minister of Health, Duane Adams noted in a book chapter on the health policy reforms of the 1990s, there were two stages to the government's health reforms. The first was a process of streamlining the existing "institutional" systems of delivery to eliminate service redundancies. The second was a reallocation of the system's scarce resources from costly illness care to community-based services and health promotion & disease prevention policies, i.e., primary care (Adams, 2001).

Here again, home care was not explicitly emphasized as an investment vehicle but was still indirectly highlighted as a priority for investment as part of primary care, community-based

[67] As health regions had not yet been fully established yet, the term "district health board" essentially served as a placeholder term for the boards that would eventually go on to govern Regional Health Authorities.

services, and home-based health programs in Saskatchewan. Regional health authorities were seen as being an "essential vehicle" for allowing the necessary reallocation of resources to be implemented (Marchildon, 2005b), as well as representing the core means of achieving the integration and co-ordination of health services aimed for in the Wellness strategy within the government's Vision document (Simard, 1992). However, the second stage of the government's health reform had not been fully achieved by the time Adams had stepped down from his role as Deputy Minister of Health. He and Simard were the core architects of the Wellness agenda, and their ideational alignment on health reform contributed to the speed with which the first phase of the Wellness strategy was able to be implemented. This is also why home care specifically did not see substantial, targeted reforms early in the Romanow government's reform efforts, as the structural changes that were undertaken in the first few years of the NDP's first term in power were already seen as moving too fast, which subsequently informed a slowing of the reform process (Adams, 2001). Losing both Simard and Adams in 1995 and 1997, respectively, thus dealt another significant blow to the Wellness agenda, since it had to proceed without either of its architects at the helm to steer reform efforts. That said, as spending data from that period demonstrates, home care did still see significant funding increases as a result of resource reallocation efforts prior to their departure (see Table 2 in the Appendix).

Regional Health Authorities were also implemented to allow the government to "move beyond being a passive insurer of public health services" while also being the organizations that "would actually manage that system", with an increase in monitoring of health outcomes via a greater emphasis on system evaluation, according to Marchildon et al. (2007). As they further note, the logic of this shift was that the increased reporting of health outcomes would in turn improve

accountability from the provider (RHAs) to the funder (the government). However, it was important for RHAs to find a balance between centralizing health system management and allowing for resource allocation based on locally acknowledged needs. RHAs were thus designed to operate at arm's-length from the provincial government, with service delivery centralized within them as regionally based bodies rather than in the single, central bureaucracy of the Ministry of Health.

Another key rationale behind the structural transition to RHAs was to have a mechanism to institute a population-needs based formula for resource distribution across the province. The goal in this was to establish global funding pools for healthcare and improve inter-district resource equity. As then-Deputy Minister of Health Duane Adams noted with regard to the needs-based funding system:

> "[it] supports a health outcomes approach to district program planning. It shifts attention away from the level of activity of health care providers, to the actual health of the population. This approach was intended to improve the equity among districts in their ability to address health needs. That is, health dollars were to be allocated where the needs were greatest. It encourages the provision of the appropriate services at the right time. It discourages the unnecessary institutionalization of citizens." (D. Adams 2001, pg. 282)

This stated goal of discouraging the use of institutional healthcare solutions via the introduction of a needs-based funding model within RHAs was further enforced through three additional financial transitions: moving money to follow citizens' use of services within the restructured system; reallocating money from historically overfunded to underfunded health regions; and allowing money only to move from institutional budget pools to community-based ones. It was in this third financial transition that the one-way funding valve mentioned earlier was instituted,

which mandated the transferring of surplus or unspent funds from institutional programs to community-based ones, but not vice versa. This change was particularly important for the expansion of home care in Saskatchewan, as it allowed for the program to have its funding protected from the "fiscally hungry" acute care institutions within the health system (Adams, 2001).

In terms of the Vision document's goal of expanding the health system's emphasis on monitoring health outcomes, the NDP government established the Health Services Utilization and Research Commission (HSURC) to assess outcomes associated with its health system agenda and identify other elements of the system in need of reform. Health policy experts' views on the HSURC were mixed. On the one hand, my interview with Ralph Nilson – a former member of the Saskatchewan Health Research Council and Saskatchewan Population Health and Research Unit (SPHERU) in the early 1990 – revealed that health data in Saskatchewan was "very robust" going into the 1990s, arguably even the "best in North America".[68] HSURC was initially established as a means of building on this strong legacy of health data collection and analysis and was seen by former Deputy Minister of Community & Social Services and Deputy Minister of Health, Con Hnutiak, as providing effective background when justifying investments in home care and other health services to the Treasury board.[69] It was also perceived as being "a major force in

[68] Ralph Nilson (former member of the Federal-Provincial-Territorial Committee on Population Health, Saskatchewan Health Research Council, Saskatchewan Population Health and Evaluations Research Unit (SPHERU)), in conversation with the author, August 2022.
[69] Con Hnutiak (former Deputy Minister of Community & Social Services from 1991-1996 and Deputy Minister of Health from 1996-1999), in conversation with the author, January 2023.

promoting positive change in the Saskatchewan health sector", including to the general public, according to (Adams, 2001).

However, the former CEO of HSURC, Steven Lewis stated during our interview that he felt the Commission's studies on home care were not that impactful and more generally that HSURC didn't really have much of an influence on health policy.[70] More specifically, Lewis noted that:

> HSURC was a creature of the 1990s, at the beginning of the knowledge translation era. Those were "linear thinking" times in my view – we assumed that all decision-makers were looking for, and took account of, would be high quality evidence. We know of course that this never was the case; it was a hypothesis, originating in the evidence-based medicine movement, long refuted by reality.[71]

However, scrutiny of HSURC's research timeline alongside the policy timeline throughout the study suggests that HSURC did at least have some influence on NDP government decision making. One example of this was the HSURC summary report on long-term care in Saskatchewan published in January of 1994, which argued that the province could provide more cost-effective long-term care if it "offered more community and home care services and used fewer institutional beds" (Health Services Utilization and Research Commission, 1994). The report specifically noted that Level 1 and Level 2 clients receiving care within long-term care homes could live independently with support from home care, and that clients from these groups who had not been assessed for home care services were "frequently admitted to institutional care before other care options [had] been considered" (Health Services Utilization and Research

[70] Steven Lewis (former CEO of HSURC from 1992-1999, as well as consultant and contributing author to the Fyke Commission report) in conversation with the author, January 2023.
[71] Steven Lewis (former CEO of HSURC from 1992-1999, as well as consultant and contributing author to the Fyke Commission report) in email correspondence with the author, May 2023.

Commission, 1994). The NDP government subsequently went on to discharge level 1 and level 2 clients from long-term care homes across the province, demonstrating the potential influence HSURC had on health policy decision making.[72]

Indeed, the research conducted by HSURC was not entirely without merit, as Lewis himself also suggested that a Commission study which demonstrated the widespread use of hospital beds for alternate level of care delivery "ended the debate about whether Saskatchewan had enough hospital beds".[73] In addition, one 2001 study published late in the Commission's mandate on the impact of rural hospital to CHC conversions in the province found that the loss of the hospitals did not adversely affect the health of residents in those communities, with some even seeing improved health outcomes through the alternative services provided by the CHCs (Liu et al., 2001). The results of this study were brought up in my conversations with multiple Health Department Ministers (specifically Louise Simard and Eric Cline)[74], and demonstrated the potential that HSURC had in serving as a means of communicating to the public that the conversion of rural hospitals into CHCs was not as destructive to rural health service provision as they had been led to believe previously.

[72] Care levels 1 and 2 refer to clients in need of supervisory or limited personal care, respectively, who primarily require supervision or a limited degree of assistance with household tasks. For reference, see the Saskatchewan Home Care Policy Manual (Saskatchewan Health, 2021).
[73] Steven Lewis (former CEO of HSURC from 1992-1999, as well as consultant and contributing author to the Fyke Commission report) in email correspondence with the author, May 2023.
[74] Louise Simard (former Saskatchewan Minister of Health from 1991-1995), in conversation with the author, June 2022. Eric Cline (former Saskatchewan Minister of Health from 1995-1997 and Finance Minister from 1997-2002), in conversation with the author, November 2022.

What is perhaps most interesting to observe about the implementation of the *Health Districts Act* in Saskatchewan is how distinct it was from the implementation of long-term care reform in Ontario, particularly in terms of the scope of what was targeted with each reform strategy. As was demonstrated in the previous chapter, the regionalization strategy implemented via CCACs by the Ontario Conservative government served an underlying objective of offloading responsibility for budgetary spending and – most importantly – individual program funding caps for home care specifically from the provincial government onto local administrative decision-making bodies. In contrast, RHAs in Saskatchewan were implemented to facilitate a broader increase in health system resources dedicated to home care and other community health services through a redirection of funding taken from acute care. While a similar strategy was originally promoted by the Conservative government through its establishment of the HSRC, it was not one that was implemented in practice, as home and community care programs in Ontario did not see nearly the increase in investment through the Harris government's approach that Saskatchewan saw under Romanow (see Tables 1 and 2 in the Appendix).

The NDP government in Saskatchewan also made the decision to follow through with the most publicly unpopular elements of its health reform strategy – namely, the conversion/closure of rural hospitals – prior to establishing RHAs to allow the regionalization strategy to remain politically viable. Blame avoidance was therefore clearly not a goal associated with the NDP government's regionalization strategy, as it made no effort to deflect responsibility for its least popular health reform decision onto other administrative bodies. In fact, as will be demonstrated later in the chapter, the NDP government's general lack of any focused attempt to deflect blame for the rural hospital conversions went on to inform their struggle to effectively

communicate the benefits of the Wellness approach to the Saskatchewan electorate. Indeed, the NDP generally found it difficult to sell a health reform strategy to the public predicated on making investments in community health programs and services like home care via divestments from acute care provision.

As Deputy Health Minister Duane Adams (2001) noted, the rural hospital conversions were intended as being the government's "black horse" of health reform, with RHAs being the "white horse". The fact that regionalization represented the "white horse" of the NDP's reform strategy demonstrates the strength of the belief by government decision makers that regionalization would be good for the health system not just fiscally, but also in terms of long-term health outcomes (Simard, 1992). This represents the crux of the distinction between Saskatchewan and Ontario's respective approaches to regionalization implementation. In Saskatchewan, regionalization clearly served as a means of shifting the health system's emphasis from hospital care to community care. In Ontario, regionalization mechanisms were introduced for home care specifically as part of a strategy to reassign responsibility and accountability for the program and introduce spending caps, as was demonstrated in the previous chapter.

Ultimately, the series of policy changes made by the NDP government in Saskatchewan throughout its first term in power gave a strong indication of its long-term intentions and the ambitious ideational agenda behind it. As noted previously, the 1992 health budget saw a 20% reduction in acute care spending, and this was accompanied by a broad decrease in health expenditures across the system. Between 1992 and 1995, the province would see its per capita health care expenditures drop considerably, as shown in Figure 1 below, and from 1990 to 1996,

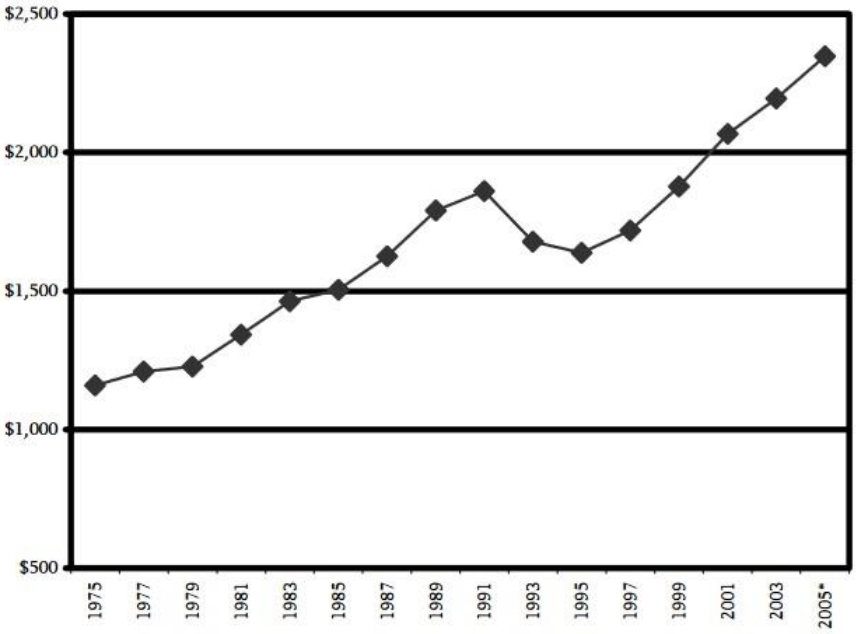
provincial health expenditure growth was essentially held flat (0.6%) while health sector inflation averaged around 2.1% annually over the same period (CIHI, 2000). This was largely achieved by cuts to acute care funding.

By 1995, hospitals accounted for 39 percent of total health care expenditures in the province, down from 42.1 percent in 1990. Hospital costs as a percentage of total health spending in the province remained well below 1990 levels though the NDP's tenure in power, while home care's proportion of the health budget increased as shown in Table 1 below[75]. While some credit for this trend can be given to the NDP government's emphasis on disease prevention and chronic disease management during this period, Marchildon and O'Fee (2007) also mention rapid

[75] Home Care is lumped in with the "Other Health Spending" category in this data, making it difficult to pin down exactly how much its growth contributed to the increases in this category.

technological change, progress in clinical practices, and improvements in overall population health as contributing factors to the relative decline in acute care spending in Saskatchewan.

Figure 2: Real Per Capita Provincial Government Health Care Expenditures (1997



Constant $'s)

Source: CIHI 2005

Table 1: Health Care Expenditure by Service Category, (%) of Total Expenditure, 1975-2005.

Provincial Government Health Expenditure, by Use of Funds, Saskatchewan
1975 to 2000 - Current Dollars

Year	Hospitals	Other Institutions	Physicians	Other Professionals	Drugs	Capital	Other Health Spending	Total
	(percentage distribution of $' 000,000)							
1975	58.6	6.7	17.4	2.3	2.8	2.8	9.6	100.0
1976	60.0	6.1	16.6	2.3	4.0	2.0	8.8	100.0
1977	60.0	5.9	16.4	2.5	4.2	2.2	8.8	100.0
1978	58.1	6.4	16.5	2.8	4.4	2.3	9.5	100.0
1979	55.2	8.4	15.9	2.7	4.4	3.4	10.0	100.0
1980	54.7	8.8	15.6	2.8	4.3	3.7	10.1	100.0
1981	51.3	12.2	15.7	2.9	4.3	3.3	10.2	100.0
1982	49.0	15.4	15.7	2.9	4.5	3.0	9.4	100.0
1983	48.1	16.6	15.6	3.0	4.9	2.3	9.5	100.0
1984	48.1	16.3	15.9	2.9	5.4	1.7	9.8	100.0
1985	46.7	15.9	15.9	2.9	5.9	3.2	9.6	100.0
1986	44.5	15.9	15.7	2.7	6.4	5.2	9.5	100.0
1987	43.9	16.6	15.9	2.7	5.2	6.0	9.8	100.0
1988	42.9	16.0	15.5	2.4	4.5	8.5	10.2	100.0
1989	42.1	15.4	15.6	2.2	4.9	9.8	10.0	100.0
1990	42.1	14.8	15.2	2.2	5.3	10.4	10.0	100.0
1991	43.1	15.2	15.8	2.3	5.5	7.5	10.5	100.0
1992	43.1	15.6	16.2	2.0	5.0	7.0	11.0	100.0
1993	44.6	16.5	16.4	1.5	3.7	4.7	12.5	100.0
1994	41.5	17.1	18.2	1.2	3.6	5.1	13.3	100.0
1995	39.0	16.7	18.5	1.1	4.0	5.0	15.6	100.0
1996	38.6	16.3	18.2	1.1	3.9	5.1	16.7	100.0
1997	37.0	15.6	18.3	1.1	3.8	7.1	17.1	100.0
1998	37.0	15.1	18.1	1.1	4.0	7.4	17.4	100.0
1999 f	37.1	15.0	17.7	1.2	4.3	7.9	17.0	100.0
2000 f	37.8	14.9	17.8	1.1	5.0	6.7	16.5	100.0

Source: (CIHI, 2000)

Meanwhile, public home care expenditures grew substantially during the NDP's first term in power, rising from just under $36 million (1.84% of total health expenditures) in 1991 to almost $63 million (3.55% of total health expenditures) in 1995 (see Table 2 in Appendix). The home care sector was also becoming a popular place to work during this period, thanks NDP government efforts to ensure all workers were unionized and home care representing an opportunity for nurses and other health workers to provide care outside of the hospital

environment.[76] This demonstrates that the redistribution of health system resources was occurring as promised over the course of the NDP's initial reform implementation period.

All told, government's early reforms on Saskatchewan's health system led to a substantial reduction in the province's number of acute care beds that was accompanied by declines in the demand for acute care, hospitalization rates, and average length of stay in hospital (CIHI, 2005). While the declines in hospitalization rates and average length of stay in hospital are not surprising in the wake of cuts to acute care funding, it is the accompanying reduction in demand for acute care which demonstrates that the NDP government's health reform strategy was succeeding. Had the reduction in acute care service funding been problematic, one would expect there to have been an increase in demand for acute care services to reflect the lack of infrastructure in place to meet demand. Instead, Saskatchewan was seeing the opposite effect occur, with hospital admissions decreasing in the 1990s (CIHI, 2005). This demonstrates that reallocating health system resources from acute care to community care could occur without leading to problems in terms of emergency service availability.

However, the NDP government's decision to shift the Saskatchewan health care system to a model based on wellness was not without controversy. As the next section will demonstrate, the ideology embedded within the Wellness agenda faced substantial criticism from the public, media, and political opposition in the mid-late 1990s as RHAs began running deficits and faced a

[76] John Nilson (former Minister of Health from 2001-2006) in conversation with the author, November 2022, and Pat Atkinson (former Minister of Health from 1998-2001), in conversation with the author, January 2023.

labor shortage in nurses and doctors (Mcintosh & Marchildon, 2009). This pushback came at a time when the Health Department was in the midst of renegotiating its employment contracts with workers across the newly reformed system. Increasing fiscal pressures caused by the federal government's further retreat from health funding were also a pressing concern. These forces combined to exhaust many of the key reformists within the Department of Health, including Minister Louise Simard and Deputy Minister Duane Adams, who left the government in 1995 and 1997, respectively. Their replacements were forced to cope with the combined impacts of public, financial, and administrative pressures that forced the NDP government to slow its reform trajectory and reverse some of its previous changes, including the removal of the one-way valve implemented by Minister Simard to ensure funding could not be diverted from community health services to institutional forms of care.

The circumstances that plagued the second term of the Romanow government also speak to broader issues associated with health reform strategies which seek to emphasize health promotion and illness prevention rather than the status quo illness response approach which emphasizes acute care in hospitals. While the cost-reduction justification of the NDP government's health reforms is important to acknowledge as a background for the Wellness approach, it is equally important to understand how the ideas embedded within the Wellness approach were received. Of particular interest was the response of the public, whose ideas of what constitutes a successful health system clashed with those of the experts and decision-makers in the NDP government, as will be discussed further below.

Post-Regionalization: The Slow Transition and Resulting Pushback to the Wellness Approach

Following the rapid series of reforms implemented by the NDP government as part of Health Minister Simard's Wellness agenda came a period of adaptation. Specifically, the implementation of RHAs brought with it significant administrative issues, particularly regarding healthcare human resources and their employment contracts with the province. Indeed, the transition from 127 hospital boards, 133 nursing home boards, 108 ambulance boards, and 45 home care boards down to 32 RHAs meant that the 538 collective bargaining units also had to be subsequently reorganized. To achieve this, the Health Labour Relations Reorganization Commission was put together in 1996. Chaired by Jim Dorsey, a politically independent litigator from British Columbia, the "Dorsey Commission" members went to work determining a new series of regulations that would govern the collective bargaining units that had been absorbed into the administrative structure of RHAs with the understanding that – as a neutral party unaligned with the Department of Health, NDP government or union representatives in Saskatchewan – its decisions would be binding. As Eric Cline, Minister of Health at the time, noted in an interview:

> The only way to do it was to have a commissioner who came in and said the way it would be. And I said to the Unions when we met with them to set it up that there would be no Court of Appeal. Like, if you want this Commission, we'll set up the Commission, but what the Commission says, we're going to do… and that was at [the Unions'] request.[77]

The restructuring of collective bargaining units was part of a broader administrative effort to organize human resources in the health sector. Home care workers, who were effectively all

[77] Eric Cline (former Saskatchewan Minister of Health from 1995-1997 and Finance Minister from 1997-2002), in conversation with the author, November 2022.

government employees and therefore part of a public sector union, were also involved in this. In January of 1997, the Dorsey Commission published its report, which amalgamated the 538 collective bargaining units that had existed in the province down to 45 and reduced the number of collective bargaining agreements from 25 to 10, with the goal of drastically reducing "incidents of rivalry, jurisdictional and representational disputes among unions and employees" (Health Labour Relations Reorganization Commission, 1997).

While the reduction in collective agreements across the health system made the Health Department's work to renegotiate new agreements with the unions much easier, it was still a process that – until it was completed – occupied much of the Health Department's attention after RHAs were established. It therefore represented a potential barrier to further health system reforms that might otherwise have been pursued during this period. This fact was confirmed not only by then Health Minister Eric Cline, but also by his Deputy Minister of Health, who noted that community health in general during his tenure was essentially a "black hole" and one of the last things on his mind due to competing concerns around the union negotiations alongside ongoing issues with blood services and health information technology.[78]

However, what is most interesting about the Dorsey Commission and the renegotiation of the collective bargaining agreements is what it tells us about interest mobilization from labour groups regarding health system regionalization. Though the *Health Districts Act* led to a

[78] Eric Cline (former Saskatchewan Minister of Health from 1995-1997 and Finance Minister from 1997-2002), in conversation with the author, November 2022, and Con Hnutiak (former Saskatchewan Deputy Minister of Health from 1996-1999), in conversation with the author, January 2023.

substantial amalgamation of administration and governance bodies, it was also implemented with an intent to ensure collective bargaining for all workers within the health system. This meant that labour groups had no structural grounds to lobby against the regionalization efforts. The most plausible explanation for this instance of union compromise is the evolution of centralized bargaining in Saskatchewan. This phenomenon is outlined within the Dorsey Commission report and is one that the home care sector representation is emblematic of. Specifically, home care workers had historically had their interests represented by non-profit provider organizations like the VON and AYE.

However, as noted near the start of this chapter, with the implementation of the Saskatchewan Home Care Plan in 1978, stakeholder interests were gradually aggregated in the sector, and eventually absorbed entirely into the public sector. In 1981, the Saskatchewan Home Care Association (SHCA) was founded, which went on to authorize the Saskatchewan Health-Care Association (SHA) to negotiate employment conditions with the province on its behalf alongside the Saskatchewan Government Employees Union (SGEU) and the Saskatchewan Union of Nurses (SUN). Then, on July 1, 1993, the SHCA, SHA, and Saskatchewan Association of Special Care Homes (SASCH) merged to form the Saskatchewan Association of Health Organizations (SAHO) (Health Labour Relations Reorganization Commission, 1997). By this point, all home care workers were employees of the province, and with this centralization of employer bargaining, home care worker interests – as well as their patients' – were effectively lumped in with those of special care homes and hospitals.

The result of this gradual amalgamation of home care stakeholder interests into the public sector meant that the capacity of those stakeholders to lobby against policy change was limited by the dilution of that sectors' interests within an advocacy organization (SAHO) representing interests that spanned across the entire healthcare sector, of which home care was still only a small part of. This in turn provides evidence for my hypothesis regarding the influence of policy legacies on interest group representation and power within the home care policy space, as it was the legacy of the provincial government's gradual integration of home care into the public sector from 1978 onward that determined the range of home care stakeholder interests in the policy space, as well as the capacity of these groups to react to the reforms of the 1990s. With home care interests so heavily diluted, by the time collective bargaining agreements were being renegotiated with the province in the mid-1990s there was no interest group left apart from the SAHO to lobby on the sector's behalf. Furthermore, with home care being an element of the NDP government's reform strategy that was both untargeted in terms of structural changes and actively benefitting in terms of resource allocation by the changes that had occurred, there was no tangible reason for SAHO to fight the government on its plan for home care. More broadly, with SAHO also needing to account for the interests of its SHA and SASCH members, it is not entirely surprising that there was such a willingness from the Association to conform to the interests of other unions.

The lack of pushback from stakeholders within the healthcare system against NDP government in the early stages of implementing its health reform agenda makes for a stark contrast with Bob Rae's experience as NDP premier in Ontario. Part of this can be attributed to strategic negotiations that the Saskatchewan government had with physicians and nurses in pursuing the

Wellness agenda. As Loadman (2010) notes, a deliberate attempt was made early in the reform process to minimize the impact of changes on physicians. A prime example of this was its decision to back away from attempts to shift physician renumeration away from the fee-for-service model, despite the government being keen to pursue alternative renumerations approaches. The SUN was also a key ally to the government throughout the early stages of reform, remaining supportive of the Wellness agenda based on its confidence that, despite layoffs across the system, there would still be jobs for nurses within the community-based alternatives to hospitals and long-term care homes that were being developed (Loadman 2010).

It is also important to acknowledge the unique political culture surrounding health policies that exists in Saskatchewan, particularly regarding the relationship between the NDP and professionals within the health sector. As Tom Mcintosh and Greg Marchildon note in their analysis of health reform in Saskatchewan from the early 1990s to the mid-2000s, the financial power of the health sector coupled with its constant struggle over the years in recruiting and retaining its workforce has historically meant that government-stakeholder relations in the province have been "a complicated balancing act between interest-promotion and turf-protection on the one hand and a desire to avoid mutually destructive behaviour on the other" (Mcintosh and Marchildon 2009, pg. 329). This tenuous balance of bargaining power between both parties is emblematic in the decision made by each to defer to an external commission to rule on the terms of new collective bargaining agreements following the implementation of the *Health Districts Act*.

By the mid-1990s, the Romanow government was also contending with significant public backlash in response to its decision to close or convert 52 rural hospitals into CHCs, as news media from the time demonstrates (see Canadian Press 1993; Henton 1996). Naturally, the most substantial backlash came from voters in rural communities that had lost their hospital, even though the vast majority of the hospitals had not been providing much care prior to their closure or conversion. Indeed, in my conversation with Steven Lewis, who was CEO of HSURC at the time, he mentioned that the loss of those hospitals was the "death knell of the NDP in rural Saskatchewan".[79] More broadly, the closure/conversion of rural hospitals in particular led to the public perceiving the government's wellness agenda as merely a smokescreen to make neoliberal austerity measures more palatable to voters (James, 1999; Mcintosh & Marchildon, 2009).

The nature of the public's reaction to the rural hospital 'closures' speaks to a broader issue regarding how the general public in Saskatchewan has historically understood the functioning of its healthcare system. As the negative response to the loss of rural hospitals in the province demonstrated, communities develop strong attachments to their hospitals as symbols of the health system working for them. Indeed, hospitals represent the most visible and tangible elements of the health system; they offer peace of mind to community residents that there exists a place where they can receive emergency care when necessary. The NDP government learned this the hard way with its attempts to sell the need for cutting acute care provision in

[79] Steven Lewis (former CEO of HSURC from 1992-1999, as well as consultant and contributing author to the Fyke Commission report) in conversation with the author, January 2023.

rural communities via the language embedded in the Wellness and Population Health approaches. They were ultimately not able to cut through the cynicism instilled in rural communities by the sense of loss that came with the hospital conversions.

Some of the blame for the public backlash to the decision regarding the rural hospitals can be placed on the NDP government itself for failing to effectively convey the message to the public that most of the hospitals were not, in fact, closing, but rather being repurposed to meet the actual care needs of surrounding communities. As former Health Minister Eric Cline mentioned in an interview:

> I would have to say that I think myself and everybody in the government really didn't handle that communication all that well, because we were unable to sell the concept of actually enhancing services and allowed that - to this day - of being described as being something where we were closing and taking away, which we really weren't. You know, a lot of money was being wasted… I've said to people I don't know why we said we were closing hospitals… Somehow, we failed there.[80]

Indeed, Cline noted that the CHCs which replaced rural hospitals were providing *more* care than their predecessors and only one was closed outright. Despite the fear in rural communities that the lack of acute care services would make them unsafe, the reality was that most residents in need of hospital care had historically been transported to urban hospitals to receive it anyway. One example Cline provided was of a hospital he visited that had the capacity to deliver babies but hadn't delivered one in 18 years.[81] Beyond this anecdotal example was the empirical evidence mentioned earlier that the hospital conversions undertaken by the NDP demonstrated

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[80] Eric Cline (former Saskatchewan Minister of Health from 1995-1997 and Finance Minister from 1997-2002), in conversation with the author, November 2022.
[81] *Ibid.*

no measurable negative impacts on the communities which experienced the conversions (Liu et al., 2001).

The Romanow government's inability to challenge the messaging that they were closing rural hospitals with more positive messaging associated with the CHCs that were replacing them was thus arguably their greatest political failure. In the end, the rural hospital to CHC conversions became the NDP government's black horse of health reform, one that couldn't be sufficiently counteracted via the white horse of regionalization in terms of swaying public opinion. The negative public reaction to the rural hospital conversion reform was also an unfortunate indicator to political decisionmakers that health system investments that targeted community health programs and services like home care were not effective means of demonstrating to voters that their government was effectively investing in health care, particularly when those investments were funded by divestments from acute care provision. As will be demonstrated later in the chapter, this did not bode well for home care, which became an even poorer cousin of the healthcare system in the wake of its failure in the eyes of the public to compensate for the cuts to acute care services by the NDP government.

Arguably the most impactful political development that hampered the NDP government's health reform strategy and its goals for improving the presence of home care was the 1995 federal budget by Finance Minister Paul Martin. It is hard to understate the effect that Martin's budget had not just on the Romanow government's capability to emphasize home and community care over institutional care, but also its ability to proceed with the wellness agenda more broadly. Indeed, the cuts to federal health transfers within Martin's budget could not have come at a

worse time for provinces pursuing health reform, as health care costs at the time were rising faster than provincial revenues. It was a budget that went on to redefine the relationship between provincial governments and the federal government within Canada's system of Federalism. As Saskatchewan's Finance Minister at the time, Janice MacKinnon, noted in her 2003 biography: "I, like many others, saw the 1995 budget as the end of Canada as we knew it" (MacKinnon 2003, p.228). She further notes how, in Ontario, NDP leader Bob Rae echoed this sentiment, and Saskatchewan Premier Roy Romanow attacked the budget as un-Canadian (MacKinnon, 2003a). It is perhaps unsurprising then that home care, the poor cousin of the health system, would find itself back in the position of being once again largely ignored by health decision-makers in government.

Indeed, the 1995 federal budget represented the final nail in the coffin for the continuation of Romanow government's original, ambitious reform agenda, which no longer had any real momentum left behind it. After having spent the previous five years eliminating additional spending on health care, the government was forced to make up for lost investments in hospitals, new technology, and nursing homes. By 1996, cabinet had become so exhausted by the constant political criticism it was receiving that it decided to add an additional $50 million when finalizing the year's health budget to prevent health districts from closing additional rural hospitals (Mcintosh & Marchildon, 2009). In 1997, the government found itself playing "catch-up" alongside other provinces with physicians and nurses by putting salary increases back on the trajectory they had been prior to the freeze which had accompanied the regionalization reforms (Marchildon, 2005a; Tuohy, 2002). Home care saw cuts in the form of reductions of service coverage during this period, with RHAs having home maintenance services eliminated as a

service requirement in 1996 (Lawson & Thériault, 1999). While there is no documented or reported rationale for this decision available, my interview with one of the Ministers of Health at the time, Pat Atkinson, highlighted the existence of concerns around how the bundle of services included in home care should be defined. With the establishment of RHAs and the centralization of home care delivery that came with them, there was a desire to see home care adopt a more standardized approach to service delivery.[82] With the shift to a provincially consistent package of services, the home support elements of home care that were more difficult to define as health-related ended up becoming a difficult service to pitch to Cabinet as relevant elements of the province's healthcare system.[83] Since home maintenance services were tougher to sell as a health-related service, it is likely this made them vulnerable to being cut with the implementation of RHAs and the continued financial difficulties faced by the NDP government in the late 1990s.

With opposition to the government's health reform mandate having grown rapidly, the Department of Health spent the majority of the late 1990s addressing more pressing, short-term issues rather than continuing to pursue long-term reform goals. Home care, as Steven Lewis noted in our interview, was subsequently "lost in the shuffle".[84] Unfortunately, it would go on to be largely ignored until the turn of the century, when the debate around health reform was

[82] Pat Atkinson (former Minister of Health from 1998-2001), in conversation with the author, January 2023.
[83] Judy Junor (former Minister responsible for Seniors from 1998-2007 and Co-Minister of Health from 1998-2001), in conversation with the author, December 2022.
[84] Steven Lewis (former CEO of HSURC from 1992-1999, as well as consultant and contributing author to the Fyke Commission report) in conversation with the author, January 2023.

revived in the wake of broader discussions across Canada regarding the future of Medicare. This is also reflected in the spending numbers, with the province's "Other Health Spending" actually decreasing in 1998, and seeing only small gains in 1999 and 2000 (see CIHI 2000a).

What is most notable about the findings of this section is the similarity in responses between Saskatchewan and Ontario as far as home care is concerned. Where the early 1990s displayed divergent reform paths defined by distinct impressions of home care investment as a means of cost saving, the mid-late 1990s saw both provinces pivot back toward the historically typical focus of desperately increasing acute care capacity to keep up with rising pressure on hospitals. As the next section will demonstrate, this tendency for governments to prioritize acute care funding, even when decision-makers express a desire not to do so, remains an unfortunate reality when it comes to health system governance. As the Romanow government's experience with health reform over the 1990s has shown above, there are few political rewards to be reaped from investing in programs like home care, as these services lack the public visibility that hospitals have as symbols of a working healthcare system. Addressing this issue would go on to remain a challenge for the NDP government under Calvert's leadership.

Romanow's Legacy, The Fyke Report, and the Bundling of Home Care into Primary Care

By the turn of the century, tensions between provincial governments and the federal government surrounding the future direction of Medicare in Canada had reached a climax. In Saskatchewan, Premier Roy Romanow saw the country as being at a pivotal fork in the road regarding public provision of health care. The 1997 report of the National Forum on Health - an advisory body commissioned and Chaired by Prime Minister Jean Chrétien in October 1994 to

suggest innovative approaches to improving the country's health system to the federal government – expressed its confidence that the health care system could be preserved through change without risking the existing emphasis on public delivery of services. The forum also argued that home care should represent an "integral part of publicly funded services", as well as making a series of recommendations for expanding home care that they believed would "not lead to a net increase in cost and should be funded by reallocation of savings from reductions in the institutional sector" (National Forum on Health, 1997).

The forum's suggestions, however, did not translate to health system change at the federal or provincial level, which is not surprising since they had been presented only two years after the federal government's 1995 budget had reduced federal transfers for health care. The provinces were being asked to do more with less, and in response, Premiers like Ralph Klein in Alberta and Mike Harris in Ontario began expressing negative sentiments regarding Medicare in Canada alongside a desire to experiment more with private funding and delivery of health services (Mcintosh & Marchildon, 2009). This political environment was increasingly concerning to Saskatchewan Premier Roy Romanow (2007), who after being refused a federal royal commission by Prime Minister Chrétien to insert national leadership into the conversation, decided to establish his own task force, both to seek advice on the next phase of health reform in Saskatchewan and also to influence the larger debate on Medicare's future (Mcintosh & Marchildon, 2009). This task force, named the Commission on Medicare and headed by Ken Fyke, was appointed by Premier Romanow in June 2000 and given a threefold mandate to: 1) identify the key challenges impacting Saskatchewan's healthcare system; 2) recommend an action plan for improving the delivery of health services in the province; and 3) investigate and

provide recommendations to future-proof the longevity of Medicare in the province (Commission on Medicare, 2001).

Appointing the Commission on Medicare essentially served as Romanow's send-off as Premier, as he resigned three months later, in September of 2000. In his exit speech, he drew attention to his motivation to enter provincial politics being the original Medicare debate that precipitated the Doctors' Strike of 1962 and expressed pride his own government's work to ensure the longevity of Medicare in Saskatchewan.[85] In February of 2001, Lorne Calvert succeeded Romanow as Premier of Saskatchewan. Two months later, Ken Fyke published the Commission for Medicare's final report: *Caring for Medicare*, (the Fyke Report).

The Fyke Report acknowledged the success of regionalization in integrating and coordinating many previously siloed services across the province's health care system while also noting that some of the "enormously ambitious goals" set by the NDP government almost a decade prior had not been achieved (Commission on Medicare, 2001). Building on reforms that had been made in the 1990s, the report argued that the 32 health districts and RHAs that had been previously established be collapsed down to 12 (plus the Athabasca region in the far north, which was and would continue to be operated by the province in partnership with the federal government and the Dene First Nations in the region), and that further closures or conversions of the 14 remaining smaller, rural hospitals be pursued. The Calvert government followed through with consolidating the health regions but chose not to go ahead with closures or

[85] Roy Romanow, text of news conference statement held at Legislative Building in Regina, SK, September 25, 2000.

conversions of rural hospitals, partly in response to further outcry from rural Saskatchewan (Mcintosh & Marchildon, 2009). It also established the Health Quality Council, which would be responsible for establishing and measuring benchmarks for quality within the health system (Commission on Medicare, 2001).

The cornerstone of the Fyke report was a series of recommendations focused primarily on the development of "an integrated system for the delivery of primary health services", defined as health services that "encompass preventative, promotive, curative, supportive, and rehabilitative and palliative services". (Commission on Medicare 2001, p.12). The Fyke report's focus on expanding primary care demonstrated a renewed focus by the government taken from the previous decade that pivoted the health system away from implicitly prioritizing acute care in hospitals and institutional long-term care and instead moved it back toward emphasizing health service provision at home and within communities. The report argued that the healthcare environment in Saskatchewan was changing, with rural populations shrinking, people living longer and elderly citizens wishing to stay in their communities. According to the authors, the changing environment demonstrated that "communities need the skills of nurses, physicians, social workers, emergency medical technicians and home care aides more than they need a hospital" (Commission on Medicare 2001, p. 10). This argument was the first of 24 mentions of home care within the Fyke report, which went on to argue that strengthening of home care and other community services would be "integral" to the effective implementation of Primary Health Service Networks.

Indeed, most of the report's discussion of home care was in the context of Primary Health Service Networks and Primary Health Teams, which were a cornerstone of the Fyke Commission's recommendations for health policy decision makers. However, it is also clear that the commission felt home care specifically was in need of more funding, made evident by the report's multiple mentions of the fact that Saskatchewan at the time was spending "considerably less" than other provinces on home care. The report also communicated the Commission's belief that there were many individuals in small hospitals at the time who would have been better served by home care through the use of anecdotes of Saskatchewan residents and reference to the fact that Saskatchewan residents use hospitals more than residents of other provinces (Commission on Medicare, 2001). These stances by the Fyke Commission largely indicate a continuation of the NDP government's thinking about home care's role in the Saskatchewan health care system that was first promoted under Romanow.

The NDP government published its action plan for health care, *Saskatchewan, Healthy People, a Healthy Province*, in December of 2001 to address the challenges within the system outlined by the Fyke report. The most substantial reform was the prioritization of primary health care via the establishment of Primary Health Care Networks (PHCNs) in all 12 of the consolidated RHAs, one per region. Core services within the PHCNs would include primary medical care, emergency medical services, mental health, addictions counselling, public health, special care homes, respite care, adult day care, palliative care, laboratory and x-ray services, therapy services, support for informal caregivers, and home care (Government of Saskatchewan, 2001). There was otherwise limited mention of home care within the Government's action plan.

For the most part, the NDP government's action plan drew upon the suggestions made in the Fyke report. Indeed, the Fyke report is explicitly mentioned in the plan's overview as being the main source of ideas and innovations. However, the plan also notes its departure from the Fyke report on the notion of pursuing "dramatic changes" that would "reduce access to hospital, emergency, or physician services" (Government of Saskatchewan, 2001). This represented a clear reference to the government's decision to not pursue the closure or conversion of the province's remaining rural hospitals as recommended by the Fyke report. More broadly, this statement was a clear signal that the NDP government had abandoned its previous goal to systematically divert acute care funding to home and community care.

The Calvert government's action plan diverged even further from the Fyke report in terms of its commitment to home care. Indeed, beyond its mention within the section of the plan elaborating on PHCNs, home care is largely absent from the plan, receiving only a passing mention in its section on improving hospital care and long-term care, with no mention of any additional commitments being made to it. This was an indication that the Calvert government had abandoned Romanow's previous strategy of redirecting resources from acute care provision to home and community care services within the system. Instead, it chose to focus on the expansion of primary care – of which home care was one element – *alongside* acute and long-term care.

My own interview with Ken Fyke reinforced my perception that the Calvert government's plan diverged from his views on home care. Indeed, though the former Commission chair made statements expressing his vision of home care being part of a primary care network – similar to

how it was portrayed in Calvert's plan – he emphasized that it represented an integral element of primary care. For example, he noted that home care "will solve many of the problems in an acute hospital and in the community", and that actions taken among many provinces to cut home care was frankly "the absolute stupidest thing to do, because if you have a good home support, home care program, you will relieve the pressures, you will make the hospitals more efficient, you will shorten the waitlist for surgery." [86]

Home care in Saskatchewan also continued to be viewed as a cost-effective alternative to institutional forms of care by health policy experts. Emblematic of this is the argument stated in the final report of a Home Care Program Review conducted by Hollander Analytical Services in 2006 that home care can be a cost-effective "as a means of delaying institutionalization for people with lower-level care needs, and as a substitute for residential care services for people with higher levels of needs for services." It also notes that there is evidence to suggest that "home care can function as a cost-effective alternative to residential care" and "perform a substitution function for hospital services" (Saskatchewan Health, Community Care Branch 2006, p. ii)

This demonstrates that home and community care, though not as directly emphasized as it was in the early years of the Romanow government's health reform agenda, still represented an important piece of the Saskatchewan health system in the eyes of experts within the province. It also appears to have remained important in the eyes of the government, even after the NDP lost

[86] Ken Fyke (Chair of the Saskatchewan Commission on Medicare in 2001), in conversation with the author, January 2023.

power to the Saskatchewan Party in 2007. Indeed, home and community care spending has continually risen in the past 15 years, albeit in an uneven manner, with year to year jumps as large as 28.4% in 2012 and as small as 1.8% in 2020 (CIHI, 2022a).

Discussion

This chapter has demonstrated that the health reform trajectory in Saskatchewan from the early 1990s to early 2000s was one that saw the most ambitious policy changes occurring in the early stages through strong mobilization around the notion that investing in home care represented a means of providing cost-savings to the healthcare system. With the Romanow government coming into power facing a historic deficit and healthcare being by far its biggest expense, a bold reform strategy for the health system was needed. The Wellness agenda introduced and championed by Health Minister Louise Simard represented first and foremost a necessity for the NDP government to regain control of its finances. Indeed, Dale Eisler notes in his 2022 book on Saskatchewan's political transformation over the past 70 years that there was "little doubt that the primary motivation for health care reform was the Romanow government's overarching goal of reaching a balanced budget" (Eisler 2022, p.155).

However, the focus on Wellness was also presented to the public as the final phase of Medicare's implementation promoted by its founder, Tommy Douglas himself. Indeed, the introduction to Louise Simard's 1992 vision document outlining the Wellness agenda begins with a quote from the 1982 film *Folks Call Me Tommy*, which reads: "When we began to plan Medicare, we pointed out that it would be in two phases. The first phase would be to remove the financial barrier between those giving the service and those receiving it. The second phase would be to

reorganize and revamp the whole delivery system – and of course, that's the big item. That's the thing we haven't done yet" (Simard, 1992). The government's decision to frame its Wellness model within the legacy of Tommy Douglas might have helped to prevent preliminary pushback from healthcare stakeholders and the general public. After all, who better to introduce ambitious reforms to Saskatchewan's healthcare system than the party which traced its roots to the system's founder? However, as was discussed earlier, the systemic centralization of collective bargaining of the health sector within the public sector likely also contributed to the lack of pushback, as the circumstances of the Dorsey Commission collective bargaining agreement negotiations of the late 1990s best demonstrates.

The reforms undertaken by the Romanow government (as well as the subsequent Calvert government) provide a couple of examples of how this balancing act worked in practice. One was the Saskatchewan Medical Association (SMA) and its tendency to avoid displays of open animosity towards government out of fear of potentially eroding the confidence of both the public and its own membership (as occurred in the wake of the 1962 doctor's strike). Mcintosh and Marchildon further note that:

> In the aftermath of the 1962 doctors' strike, despite the bitterness the strike engendered, the SMA eventually took on the mantle of one of Medicare's chief architects and has been a consistent defender of its principles and its preservation inside the province and within the medical community nationally. Similarly, virtually all of the major players within the system see themselves, at some level, as participating in the project initiated by Tommy Douglas and the CCF in the 1940s (Mcintosh and Marchildon 2009, pg.339)

Indeed, by the mid-1990s virtually all workers within the Saskatchewan healthcare system (with the exception of physicians) were directly employed by the province itself. As employment in the

health sector was concentrated within the public sector, so too was representation concentrated in collective bargaining negotiations. The amalgamation of interests (i.e., union representation) within hospitals, special care homes, and home care with the formation of SAHO was emblematic of this.

As a result, as far as interest representation in home care was concerned, the sector had to contend with its representation being bundled in with other sectors within SAHO. As for nonprofit organizations, which represented a powerful interest group that pushed back against home care reforms put forward by the Rae government in Ontario as discussed in the previous chapter, the gradual erosion of the sector's involvement in home care throughout the 1980s made it poorly situated to stand out as a stakeholder in home care provision. As was discussed early in this chapter, this process occurred as a result of the sector's reliance on the provincial government for funding and inability to expand its capacity for service provision to meet new requirements introduced in the late 1970s. This in turn left it with no real leverage to push back against the passage of the *Health Districts Act* by the NDP government in 1993, which eliminated its role in home care provision in the province almost entirely.

Clearly, health sector stakeholder relationships with the NDP government were quite distinct in Saskatchewan when compared with that of Bob Rae's government in Ontario. One might have suspected there to be more hostility expressed by the SMA in the face of acute care cutbacks included within the Romanow government's initial strategy with its Wellness approach. However, apart from pushing back on proposed changes to fee-for-service renumeration models, this was not to be seen. Mcintosh and Marchildon (2009) credit the legacy of Tommy Douglas

and his role in developing Canada's healthcare system as having contributed to the limited degree of pushback from stakeholders against the NDP government's reform agenda of the early 1990s. However, the health worker strikes of the mid-late-1990s heavily damaged the NDP government's relationships with SUN and unions representing other health workers who demonstrated during the period, which limits the applicability of the political culture argument to explaining the distinct responses by stakeholders in Ontario and Saskatchewan to home care reforms in each province.

Regardless, the most significant and damaging pushback against the Romanow government's wellness strategy came from the rural public in response to the conversion of 51 small rural hospitals to CHCs and the closure of one other. The pressure created on the government by this negative outcry was compounded by further cutbacks to provincial health funding by the federal government with Finance Minister Paul Martin's 1995 budget and the administrative hurdles – particularly the renegotiation of collective bargaining agreements – associated with establishing RHAs. These combined pressures ground the government's reform trajectory to a halt, and saw it forced it make up for years of funding freezes to acute care, drugs, and health technology in the late 1990s while also navigating changes in Health Ministry leadership with the departure of Minister Louise Simard and Deputy Minister Duane Adams in 1995 and 1997, respectively.

Then, in the midst of escalating conflict between the provincial and federal governments regarding the future of Medicare, Saskatchewan Premier Roy Romanow appointed Ken Fyke to Chair a Commission on Medicare to steer directions for future reforms to the province's health system. The task of implementing the reforms suggested by the Fyke Commission was then left

to Romanow's successor as Premier, Lorne Calvert. Calvert's action plan for Saskatchewan's health system, presented alongside his new Minister of Health, John Nilson, who went on to be the province's longest-serving Health Minister, in many ways represented a middle ground. In the first case it attempted to find compromise in the recommendations set forth by the Fyke report in avoiding further closure or conversions of rural hospitals while also introducing PHCTs, consolidating health regions, and establishing a Health Quality Council. It also more broadly served as a compromise between the aggressive transfer of resources from the institutional sector pursued by the Romanow government in the early 1990s and its desperate attempts to make up for those cuts to the institutional sector in the late 1990s. Calvert's action plan opted to avoid funding freezes for acute care services while also expanding non-institutional forms of care through an emphasis on primary health care, which in turn returned some degree of focus to home care in the province.

The trajectory of health reforms in Saskatchewan provides an interesting illustration of how home care tends to struggle to maintain relevance on government agendas, even in circumstances where it has strong ideational mobilization behind it. It took a dire fiscal crisis necessitating an overhaul of the provincial healthcare system for home care to become prominent on the NDP government's agenda in Saskatchewan. However, another fiscal crisis less than five years into the NDP's rise to power in the province served as a partial motivation for the government to scale back its agenda of prioritizing the funding of home and community care over institutional care. This demonstrates that, although there is evidence to support my hypothesis regarding home care's perception as a cost-effective alternative to acute care provision in Saskatchewan, the motivation to act on that perception of cost-effectiveness was

short-lived. In the end, the general public, unable to see the positive effects of the Wellness agenda on their health care system and preoccupied with the emotional loss associated with rural hospitals being "closed" stoked by cynical messaging from the NDP's political opposition, came to see the agenda underlying the NDP government's Wellness approach in a negative light.

As noted earlier, the NDP government itself is partly at fault for this due to its failure to effectively communicate the positive outcomes associated with the Wellness approach and appropriately conveying their messaging around the 52 rural hospitals primarily being converted to CHCs to counter the public's negative perception of the decision. However, it is also important to point out the disconnect that exists between the public's perception of how a good healthcare system works and how one works effectively in practice. Historically, the public's connection to healthcare in Saskatchewan has been emotionally tied to hospitals, particularly in rural communities. As (Lepnurm & Lepnurm, 2001) explain:

> For most small communities the hospital represents accumulated memories for the elders, and economic stature for the younger residents… While the elderly remember the value of past services received from the hospital, younger residents value the jobs that the hospital provided, more than its real capabilities. For many small communities, having a small hospital is not only a matter of local prestige, but also economic necessity (p. 1703)

To build an argument from this reality suggesting that the Romanow government was unsympathetic or unaware of the importance of the public's emotional reaction to policies would be shortsighted, as (Eisler, 2022) notes that Romanow frequently touted the three most important factors in politics as being "emotion, emotion, and emotion." A more realistic argument would be to suggest that the NDP government's capacity to extricate itself from a situation in which the public would respond negatively to its health reform agenda was doomed

to be limited. The reason for this is that home and community care services and their associated benefits to population health, unlike hospitals, are less visible to any given individual voter. As a result, despite the empirical evidence from HSURC and the Fyke report that the policy justifications and health outcomes of the conversion/closure of rural hospitals undertaken by the Romanow government were sound, the overwhelmingly negative emotional response from the public represented a more powerful influence on subsequent health policy decisions.

What the findings from this chapter ultimately demonstrate is that it is difficult to establish a set of circumstances that would allow governments to pursue a health reform strategy around expanding home care at the cost of reductions in acute care spending. At the same time, it also demonstrates that home care can struggle to find a place on provincial government agendas unless those governments find themselves in the midst of fiscal crises which necessitate more extreme policy measures that go beyond the typical patterns that prioritize attention to bolstering acute care. Even then, as the Ontario case demonstrates, it is still possible for home care to enter the government agenda in these circumstances as simply another target of cost-cutting efforts. Provincial home care programs thus appear to be in a Catch-22 in terms of their existence within the broader health systems they are a part of. They only seem to enter government agendas as programs worth investing additional resources into when they represent a potential means of cost-savings for acute care but are in turn vulnerable to facing cuts when pushback against the cuts to acute care necessary to fund the increased investment into them emerges.

This reality regarding the placement of home care on government policy agendas further demonstrates the importance of policy legacies in determining policy directions taken by governments. To reiterate the assumption underlying the analysis undertaken in this dissertation, policy legacies - which function as an extension of institutions - represent the primary independent variable within my application of the 3I framework. These legacies in turn influence the ideas held by policy decision makers on viable directions for reform, as well as determining who the prominent stakeholder interests in the policy sector are and their degree of power and influence on the reform directions pursued by decision makers. The assumptions underlying this framework have in turn been presented within my hypotheses regarding the distinct reform directions taken by governments in Ontario and Saskatchewan in the study period. The relative importance of Saskatchewan's home care policy legacies – specifically in terms of their influence on the NDP government's ideas of home care's potential as a cost-saving alternative to acute care and their impact on stakeholder mobilization within the health sector more broadly – therefore reinforces the core argument underlying my hypotheses that Institutions, Ideas, and Interests impact policy in a hierarchical fashion, with Institutions - represented by policy legacies - indirectly influencing home care reform trajectories via their influence on Ideas and Interests.

Studying home care policy development, however, also represents a unique means of understanding the broader political climate surrounding health care at a given moment in time. What has become increasingly clear through my investigation of home care policy reform in Ontario and Saskatchewan is that political sentiments regarding health care systems rarely correspond to how health care systems can effectively work in practice. Steven Lewis elaborated

on this idea in our interview noting that "home care is exactly the litmus test, the kind of program for [gauging] what political sentiment is at any particular time, and especially what… will people look for government to redress."[87]

In essence, governments who attempt to bolster home care seek to do so from a more holistic understanding of how the healthcare system can work effectively to keep people healthy in general, and not focus solely on illness treatment. In contrast, those who reduce support for home care maintain a historical status quo in provincial health system design prioritizing institutional forms of care, seeking to acquire short term political gain through adding acute or long-term care beds at the cost of the long-term sustainability of the province's health system. However, unfortunately for those who seek to bolster home care, such efforts do not tangibly link the voting public to their health care system the same way that commitments to hospitals and acute care providers do. The disconnect between the public and how health care works in practice is nicely summed up by a quote from former Minister of Health, Judy Junor, who noted in an interview that:

> Even Louise Simard and the Wellness model, people didn't buy that. They didn't care that you were looking... upstream, trying to prevent all this illness, which is where we need to go… They wanted to know that they could get their surgery done, they could get their emergency visit, they could see their doctor, that's what they wanted. And they wanted to see their hospital in their little town. They didn't care that nobody went to the hospital or nobody was ever in it, but they wanted to see it. And that was what they were focusing on and that's where they wanted government to spend their money.[88]

[87] Steven Lewis (former CEO of HSURC from 1992-1999, as well as consultant and contributing author to the Fyke Commission report) in conversation with the author, January 2023.
[88] Judy Junor (former Minister responsible for Seniors from 1998-2007 and Co-Minister of Health from 1998-2001), in conversation with the author, December 2022.

The next chapter will build on the comparative elements of my analysis and present concluding thoughts on what can be learned from Ontario and Saskatchewan's distinct experiences with home care policy change from the late 1980s to the early 2000s. It will also review and contrast the findings from my analyses of home care policy change in Ontario and Saskatchewan to assess the comparative evidence for my core hypotheses. It will draw attention to how the trajectories for home care within each province's health reform strategies informed dichotomies that exist between each province today regarding home care's situation within their respective health system. It will conclude with my thoughts on what elements of health reform strategies will be needed going forward to allow public home care programs to meet growing population demand while also reducing the increasing burden being faced by health care institutions that have been increasingly forced to compensate for gaps in home and community care coverage across Canada.

Conclusion: Institutions, Ideas, Interests, and Home Care as the "Poor Cousin" of Canadian Healthcare

This thesis has set out to investigate the cause of the distinct strategies for home care policy within the context of broader health system reforms that occurred in Ontario and Saskatchewan from the late 1980s to the early 2000s. It has demonstrated that appreciating the overlapping influences of institutions, ideas, and interests is necessary to have a holistic understanding of home care trajectories in each province across governments. Though this analysis does not argue that any one of the 3I pillars has exclusive explanatory power regarding policy outcomes, it does suggest the presence of a hierarchy of causal factors, with distinct home care policy legacies representing a key independent variable in determining the divergent trajectories for

home care observed in each province over the course of the study period. This is due to their role in establishing the population of the relevant stakeholder interest groups and their influence on the ideas held by policymakers regarding the potential for home care as a cost-saving investment vehicle in healthcare more broadly. Indeed, tracing the processes surrounding policy events that occurred in Ontario and Saskatchewan during the study period has demonstrated that distinct policy legacies in administration and service delivery established in each province prior to the study period influenced the ideas held by decision makers regarding home care's potential within broader health reform discussions. These policy legacies also established the policy arena within which the interest groups and stakeholders in home care policy could organize and influence policy in the two provinces.

In the case of Ontario, its key policy legacies were the historical reliance the subcontracting of home care service provision to community organizations, allowing them - especially those in the nonprofit sector - to become entrenched stakeholders, alongside the government's decision in 1982 to incorporate the home care program into OHIP when responsibility for it was transferred to the Ministry of Health. As chapter 3 demonstrated, this created a policy environment where program costs were seen by policy makers as rising precipitously and uncontrollably due to home care's status as an insured service, limiting its perceived viability as a cost-saving mechanism in Ontario's health system and leading to policy decisions that by and large involved retrenchment in home care policies during the study period, especially in the mid-late 1990s. At the same time, the dominant role of the nonprofit sector in service delivery established the nonprofit organizations involved as powerful stakeholders who could influence home care policy

trajectories, most notably in the case of the Rae NDP government's attempt at eliminating the contracting out of home care services entirely with its proposed MSA model in the early 1990s.

In the case of Saskatchewan, its key policy legacies were the 1978 Saskatchewan Home Care Plan by the Blakeney NDP government, which expanded home care in the province to include more home support services like basic home maintenance and snow removal while also implementing a means tested user fee for the program, and the 1982 decision by the Devine Conservative government to transfer all elements of home care – including the home support elements – from the Department of Social Services to the Department of Health. These two decisions established the state bureaucracy not only as the chief administrator of home care but also as the body involved in service delivery and employer of workers in the sector. This in turn allowed the government substantially more control over home care program costs prior to the reform period as well as narrowing the range of stakeholders involved in home care outside the purview of the state. The resulting impact of these decisions was that investing in home care was more easily viewed as a cost-saving opportunity by health policy decisionmakers in Saskatchewan's NDP government under Romanow in the 1990s, and stakeholders within the policy space were not able to push back against the subsequent Wellness agenda which emphasized investment in home care as cost-effective.

A key element of the distinct health policy reform strategies pursued by each province was the flexible opportunity for system restructuring offered by regionalization. In the case of Ontario, regionalization mechanisms were poised as a means of implementing home care retrenchment efforts by all three parties when they were in government, but ultimately carried out most

thoroughly by the Harris Conservative government via the introduction of CCACs. In the case of Saskatchewan, regionalization was posed as a "white horse" to facilitate expanding home care's role within the provinces' health system while simultaneously reducing its reliance on acute care received in institutional environments.

This chapter will revisit the institutions, ideas, and interests at play in determining each province's role for home care within broader health reform trajectories throughout the study period. Specifically, it will demonstrate how the dynamics discussed above contribute to our understanding of why home care reforms in Ontario ended up emphasizing retrenchment while those observed in Saskatchewan generally emphasized expansion over the course of the study period. To reflect the hierarchical structure of influence from the 3Is on home care programs in Ontario and Saskatchewan, I start by discussing the institutional forces of policy legacies observed, followed by their impacts on policymakers' ideas for home care, and then move on to a review of interest group and stakeholder mobilization in response to policy proposals put forward and the changes that were ultimately implemented in each province. After going over the limitations and discussing core insights from my research undertaking, I conclude the chapter by providing some takeaways to consider when it comes to reforming home and community care within provincial health systems in the wake of the COVID-19 pandemic, with consideration given to the parallels and distinctions between the fiscal crisis experienced by provincial governments of the 1990s and the health crisis that COVID-19 presented in 2019.

Institutions: Spending Legacies and the Fiscal Crunch of the 1990s

In Ontario and Saskatchewan, my analysis observed policy legacies of expansion and spending increases in both provinces' home care programs – as well as their health systems more broadly – from the mid-1970s up until the start of the study period in the late 1980s which represent an important backdrop for the early stages of health policy reform witnessed during the study period. As has been demonstrated in previous chapters, both Ontario and Saskatchewan entered the late 1980s with massive fiscal burdens due to a country-wide economic recession and scaling back of health transfers from the federal government. This set governments in both provinces on a desperate search for cost-savings in their respective health care systems, forcing them to look carefully at existing policy arrangements to determine where unnecessary or excessive expenditures existed. Of substantial concern for policymakers in both provinces was the historically disproportionate amount of funding being provided for costly acute care services (particularly within hospitals) over more cost-effective, preventative, long-term and continuing care services, particularly those provided in people's homes and communities. This put home care on the government agenda of both Ontario and Saskatchewan, albeit not at the same time. As noted in chapter 3, David Peterson's Liberal government in Ontario had already been interested in home care reform in the mid-1980s before accelerating its broader long-term care reform strategy in 1987 after obtaining a majority in the legislature. Saskatchewan, meanwhile, did not see its government look more closely at home care reform until Roy Romanow's NDP government was elected in 1991.

However, the policy legacies for home care established in each province provided different impressions to their respective governments regarding home care's potential as an opportunity

for cost savings. In the case of Ontario, an operational review of the province's home care program by Price Waterhouse (1989) highlighted the existence of a "cost-effectiveness gap" in the program. This report went on to establish a precedent for the government's understanding of the program as being a necessary expense rather than one that represented a cost-benefit to support its continued growth It also suggested a reform strategy based more around controlling the growth of home care costs than increasing access, noting concerns about the "open-ended" nature of the Home Care program as an insured service with OHIP that had experienced a 144% increase in per capita use from 1978-1986.

This cautious approach to home care policy reform was ultimately embraced by the Ontario Liberal government, who while suggesting an eventual doubling of the government's funding for home care, also actively pursued a strategy of offloading costs for it by transferring responsibility for it to the Ministry of Community & Social Services, where the program could be eliminated from OHIP coverage and have service caps introduced to it. The Liberal government's strategy also sought to employ cost sharing mechanisms with the federal government by making the Home Care program eligible for Canada Assistance Plan funding. While the implementation of this approach was halted with the NDP's rise to power in 1991, and funding for home care was increased for most of their time in power, the Rae government ultimately did not diverge substantially from the Liberal government's cautious approach to home care reform, even going as far as to follow through with eliminating the Home Care program from OHIP coverage and cutting its funding substantially before their election loss in 1995. The subsequent Conservative government further continued the trend of cost-containment in home care while perpetuating concerns about accountability in funding that had been raised by the Liberals two government

prior. After following through with the NDP's home care spending cuts in 1995, the Harris Conservatives' spending estimates for the two following years suggest that funding was increased substantially, but not at a rate anywhere near what was seen in the years prior to their election (Health Canada, 1998).

This demonstrates the long-term influence of the policy legacies of the Home Care program in Ontario, which allowed costs to rise at a rate that was perceived as unreasonable and in need of control by 1987. Indeed, the executive summary of the Price Waterhouse (1989) report makes specific mention of the home care program's increase in spending from $13.3 million in the 1975/1976 fiscal year to $245 million in the 1987/1988 fiscal year to demonstrate the need for "managed growth" of the program (pg. 2). This report informed concerns subsequently expressed by the Liberal government regarding the program's need for cost-controls. This in turn demonstrates the influence of existing institutions on the trajectory of home care in Ontario throughout the reform period.

Saskatchewan, on the other hand, though establishing a similarly strong legacy of increased support for home care in the decade leading up to the reform period, avoided the steeply rising costs in its program experienced by Ontario. As was demonstrated in chapter 4, public home care expenditures in Saskatchewan throughout the 1980s did not experience anywhere near the growth seen in Ontario, in some years even dropping, while in other years seeing growth largely influenced by clever accounting or emergency top-up spending on the part of the Devine government. The reason for this lack of growth in contrast with Ontario can be attributed to the greater control over home care expenditures available to the Saskatchewan government thanks

to introduction of the Saskatchewan Home Care Plan by the Blakeney NDP government in 1978, which established an increasingly strong role for the state in home care administration. This policy legacy, combined with Saskatchewan's home care program not being structed as a provincial health insurance entitlement, as was the case in Ontario, ultimately meant that the deficit-plagued Devine government was able to ration home care expenditures throughout the 1980s. More specifically, home care's status as a low priority for the Devine government's health agenda in Saskatchewan was easier to maintain in terms of resource allocation in comparison with Ontario, where home care's inclusion in OHIP meant that program costs would continue to rise alongside demand, which increased precipitously in the late 1980s.

By the time Romanow's NDP government came to power in 1991, though home care costs had risen substantially in Saskatchewan over the previous decade, they had done so at less than half the rate of Ontario (see Table 2 in the Appendix). In addition, the government had by that time already taken on a primary role not just in the funding of home care, but the direct employment of the caregivers that provided it. This reality meant that the NDP government was much better positioned to look to investing in home care as an opportunity for cost-savings rather than simply representing another rising cost within the broader provincial healthcare system.

The value of investing in home care in Saskatchewan was further reinforced by the Murray report, which presented home care as an "attractive alternative to costly institutionalization" (Saskatchewan Commission on Directions in Health Care, 1990). As discussed in Chapter 4, the Murray report went on to significantly inform Health Minister Louise Simard's Wellness agenda, which positioned increased investments in home and community care funded by reductions in

acute care funding at the forefront of its health reform strategy. Here again in Saskatchewan, we can see the influence of policy legacies on the ideas held by policymakers regarding home care, with previous decisions which allowed the provincial government to have a greater degree of control in both the funding and the administration of home care and subsequently more means by which to situate it as an investment vehicle for health system cost savings.

In both Ontario and Saskatchewan, NDP governments in the early 1990s sought to increase the role of home care in their provincial health systems while reducing their reliance on acute care delivered in hospitals. However, the strategies that were ultimately pursued in each province were informed by distinct home care policy legacies . In Ontario, the Price Waterhouse (1989) report made reference to the uncontrollably rising costs of home care as a justification for introducing cost-control and deferral mechanisms to the program. This report went on to inform the Premier's Council on Health Strategy's *From Vision To Action* report which argued it was "simplistic to think of community services primarily as a cost-effective alternative to institutional services" (Premier's Council on Health Strategy, 1989b). In Saskatchewan, the Murray report presented home and community care services as the "kingpin" of the province's health system that represented value for money due to its key role in keeping people out of costly institutions and in their own homes and communities (Saskatchewan Commission on Directions in Health Care, 1990). The report was described by Health Minister Louise Simard in an interview as being a key source of inspiration for the government's framework for regionalization in the *Health*

Districts Act, though her approach to implementation involved a more grassroots approach with significantly more community input.[89]

The rhetoric on home care in these reports – as well as the health system reform strategies they informed – demonstrates the strong influence of institutional elements in the form of policy legacies on early home care policy decisions in both Ontario and Saskatchewan. The distinct approaches undertaken in each province also represent evidence of my first hypothesis that provincially unique administrative and funding arrangements for home care influenced policy actors' perceptions regarding the potential of home care investment as a means for reducing health system costs. These ideas regarding home care went on to inform the health reform decisions – and policy mechanisms associated with them – that were undertaken in each province.

Ideas: The Difficulty in Diverging from the Hospital Dominance Paradigm

The ideas held by policy makers about home care in Ontario and Saskatchewan gradually evolved throughout each province's health system reform period. Both provinces' reform periods started at slightly different times – Ontario's being at the tail end of the 1980s and Saskatchewan's in the early 1990s – but also from very similar concerns about their respective healthcare systems. Specifically, governments in Ontario and Saskatchewan approached their health reform strategies with the understanding that their existing systems were unsustainable

[89] Louise Simard (former Saskatchewan Minister of Health from 1991-1995), in conversation with the author, June 2022.

in terms of both their total per capita costs and their balance of cost distribution between acute and nonacute care provision.

The Vision documents published by both the Ontario Liberal government under Peterson and the Saskatchewan NDP government under Romanow embraced what was at the time a new definition of health promoted by the World Health Organization. It was a definition that emphasized the social determinants of health, incorporating economic, environmental, and lifestyle factors. This new definition was promoted as a justification for shifting the focus of both provinces' health systems from illness treatment to illness prevention (Premier's Council on Health Strategy, 1989b; Simard, 1992).

The focus on illness prevention justified an increased focus by governments on home care, which had historically functioned as a mechanism of illness prevention by reducing people's reliance on hospitals for care needs that could be met by resources provided in their homes and communities. Both the Peterson government and the Rae government in Ontario, as well as the Romanow government in Saskatchewan, introduced policies which sought to expand home care services early in the reform period of both provinces. Of course, as the previous section on institutions highlighted, the approaches taken by governments in Ontario were less ambitious than that of Saskatchewan as far as home care expansion was concerned due to differing perceptions between each province's policy decisionmakers regarding the potential health system cost-savings that could be gained through home care investment.

However, as chapters 3 and 4 have demonstrated, much of the focus on home care by policy makers behind the scenes in Ontario and Saskatchewan was based on a desire to identify

opportunities for reducing health care costs. The perception of governments and policy experts in both provinces that their existing healthcare systems were unsustainable was part of a broader trend occurring in provinces across Canada over the course of the 1980s as health costs rose precipitously (Bickerton, 1999; Hurley et al., 1994). This perception was further solidified with the cuts to health funding transfers from the federal government in the 1986-1987 and 1989-1990 fiscal years, which precipitated broad health system retrenchment efforts in the early 1990s across provinces (Lazar et al., 2016). By 1995, pressures from health system stakeholders had begun to shift health reform directions away from further retrenchment efforts. However, the eventual dissolution of the Established Program Financing (EPF) program transfers in the federal government's 1995 budget further delayed efforts to make up for the cuts that had been made in previous years, particularly in Saskatchewan.

This retrenchment of home care in the mid-late 1990s could be seen in Ontario with the Rae government's decision to remove the Home Care program from OHIP as well as the Harris government's approach to introducing CCACs. This approach failed to scale the Home Care program enough to sufficiently keep up with growing costs associated with its rapidly increasing proportion of post-acute care clients. In Saskatchewan, the scaling back of home care's expansion was seen in the removal of the "one-way valve", which had been introduced by Health Minister Louise Simard early in her term to redirect health system funds from acute care to home and community care, and in the elimination of home maintenance from the publicly funded package of community services in 1997. As chapter 4 demonstrated, the removal of the "one-way valve" was seen by multiple policy actors in Saskatchewan as being a particularly significant step back from the ambitions of the Wellness agenda.

The late 1990s and early 2000s saw a resurgence in home care investment in both Ontario and Saskatchewan. However, in the case of Ontario, the investments made by the Harris Conservatives did not sufficiently make up for the ground lost by its retrenchment efforts undertaken in its first two years in government, as home care providers struggled to adapt to heightened care demands from a patient population that was increasingly made up of post-acute care cases. The situation was further exacerbated by the structure of CCAC regulations that insulated the provincial government from accountability for the increased funding demands that came from home care providers in the wake of the demographic shift in their patients. Saskatchewan, on the other hand, rebolstered its efforts to support home and community care provision by increasing its funding to primary care. This presumably increased the amount of funding allocated to home and community care[90], but did not achieve the gains in reducing the health system's emphasis on acute care funding that had been seen in the early years of the Romanow government.

The influence of home care policy legacies in Ontario and Saskatchewan on policymakers' ideas for home care within broader health care reform strategies can also be seen in each province's respective application of regionalization policy mechanisms. In the case of Ontario, the Liberals' Service Access Organizations, the NDP's Multi-Service Agencies, and the Conservatives' Community Care Access Centres all represented regionalization mechanisms intended to reform LTC administration primarily for the purpose of controlling home care program costs. As chapter

[90] Unfortunately, there is no concrete data on home care spending in Saskatchewan available to point to from the Calvert era to demonstrate the effects of health policy changes made in this period on the program.

3 demonstrated, each party's model also presented overlapping justifications of "one-stop shopping", improved coordination, and increased client access to LTC services as part of their rationale, but due to increasing fiscal pressures throughout the study period, cost control became an increasingly prioritized goal of health reforms in Ontario.

Evidence of this emphasis on cost control could be seen early in the reform period with the Liberal government's embracing of the home care reform strategy recommended by the Price Waterhouse (1989) report and its intent to see responsibility for the Home Care program transferred from the Ministry of Health to the Ministry of Community & Social Services so that controls could be introduced (Baranek, 2000). There was also evidence of the intention to offload responsibility for negative consequences associated with home care reforms in the Conservative government's implementation of CCACs, which included the decision not to incorporate CCACs into the framework of the *Long Term Care Act* introduced previously by the Rae government. This allowed the Conservative government to distance itself from concerns about home care raised by members of Opposition parties during question period in the Ontario Legislative Assembly and declare decisions regarding access to home care services as being the responsibility of hospital administrators. Even Rae's NDP government, for all its focus on unionizing the home care workforce and improving community access to home care with its MSA model, found itself following the lead of its Liberal predecessors to offload home care costs with its decision to remove the Home Care program from OHIP coverage.

Saskatchewan's experience with regionalization and home care, in contrast, was based on a clear perception held by policymakers within the NDP government that home care represented an

"attractive alternative" to institutional forms of care in hospitals and LTC homes (Saskatchewan Commission on Directions in Health Care, 1990). As Chapter 4 demonstrated, regionalization, and its emphasis on home and community care service provision, represented the "White Horse" of the government's approach to health reform, while it also took on responsibility for the decision which represented its "Black Horse": the elimination of acute care funding for 52 rural hospitals (Adams, 2001).

Ontario and Saskatchewan's approaches to regionalization were backed by their distinct ideological interpretations of home care's potential role in each province's respective visions for health system reforms, which were informed by their distinct policy legacies. This provides evidence for my second hypothesis regarding the impact of policy legacies on health reform strategies – i.e., regionalization mechanisms – in each province. In Ontario, Chapter 3 demonstrated the link between the Home Care program's legacy as a health program that was lacking in government controls needed to contain its precipitously rising costs and the broader LTC reform strategies pursued by multiple provincial governments. In Saskatchewan, Chapter 4 showed how RHAs served as a core mechanism of the Romanow government's health reform strategy, with the intent behind them demonstrated in Health Minister Simard's Vision document as a means of integrating the province's healthcare system and allow for less reliance on institutional forms of care in favour of increased support for home and community care services (Simard, 1992). This strategy was largely informed by the Murray report, which had only good things to say about home and community care services in Saskatchewan. Two government terms later, even the Fyke report could be seen echoing many of the sentiments of the Murray report, albeit through a more diluted lens with its focus on primary care services.

Overall, home care policy legacies established in the 1970s and 1980s in each province appear to have influenced not only decision makers' ideas of home care, but also the regionalization strategies – and home care's role within them – undertaken as part of the distinct approaches to health reform observed during the study period. However, these strategies faced obstacles to implementation, the most notable being the 1995 federal budget from the Chrétien government and Finance Minister Paul Martin, which served to exacerbate difficulties faced by provinces in continuing to fund their health systems.

The elimination of the EPF in the 1995 budget roughly coincided with a ramping up of pressure against government health reform agendas in both Ontario and Saskatchewan. In the case of Ontario, this pressure was primarily applied by interest groups, with non-profit providers of home care playing a particularly prominent role, which manifested in efforts to prevent the introduction of the NDP government's MSA model that were ultimately successful. In Saskatchewan, the most significant source of pressure against the NDP government's health reform agenda came from the public, particularly in rural communities which had seen their hospitals converted into community health centres, and in one case closed entirely. Interest groups, however, did not seek to mobilize against the Saskatchewan government's health reform agenda due an ongoing perception of the NDP government by key stakeholders as being the only viable party to ensure the province's healthcare system did not succumb entirely to retrenchment policies (Loadman 2010.) In the case of home care, as discussed in chapter 4, the shrinking of the stakeholder environment that gradually occurred with the Health Department's gradual absorption of the service delivery role within the home care program from 1978 to 1992 also meant that there were few stakeholders to push back against the NDP government's at all.

Thus, in both Ontario and Saskatchewan, we can see once again that home care policy legacies had an impact on interest group involvement in their respective health policy decision making processes.

Interests: The Power of Mobilization of the Non-Profit Sector and the General Public

As previous chapters have demonstrated, interest group influence on home care policy change in Ontario and Saskatchewan was also influenced by policy legacies. It was also shown to have largely occurred as a reaction to proposed reform frameworks in each province between 1993 and 1997. Interest group involvement in policy decision making was most evident in Ontario, where pressure from non-profit organizations was raised - and even encouraged by opposition parties - in response to the Rae government's proposed MSA model. Nonprofit organizations had established themselves as the legacy providers of home care as a result of the brokerage model of contracting home care provision to community organizations established early in the development of Ontario's Home Care program. When faced with a home care reform model that would put their status as legacy providers in jeopardy in the form of the NDP's MSAs, non-profit organizations like the VON and Red Cross mobilized to oppose them. In taking this stance, these non-profit organizations found ideologically aligned partners in for-profit care providers, as well as physician and hospital interest groups like the OMA and OPA who were concerned about government efforts to allow workers in long-term care to unionize. As the Assistant Deputy Minister of Health at the time noted in our interview, non-profit providers led the charge when it came to pushing back against the NDP government's proposed MSA model for home care

reform, and were strongly opposed to the government "taking over their business".[91] This interest group opposition went on to contribute to the NDP government's inability to fully implement their MSA model before their 1995 electoral defeat to the Harris Conservatives.

In Saskatchewan, interest group resistance to the NDP government's health reform agenda was limited when compared with the experience of their peers in Ontario. A significant contributor to this distinction was the centralization of employee bargaining in Saskatchewan's health system throughout the 1980s. Indeed, by the mid-1990s, all stakeholders in home care delivery outside the purview of the government had already been substantially crowded out through the implementation of the Saskatchewan Home Care Plan. The plan expanded the service mandate for home care in the province, which non-profit organizations – who had already historically been heavily reliant on state funding to provide home care – were unable to mount a meaningful resistance to. As a result, come the mid-1990s and the passage of the *Health Districts Act*, Saskatchewan's health system labour force was almost entirely employed by the province itself, which meant that virtually all bargaining had been centralized. This in turn limited the potential fragmentation of labour stakeholders during contract negotiations, with the health worker union representatives agreeing to allow the independent, externally appointed Dorsey Commission to unilaterally determine all new health system labour contracts demonstrating just how centralized the bargaining process had become.

[91] Geoffrey Quirt (former Assistant Deputy Minister of Health and Executive Director of the Ontario Government's Long-Term Care Division) in discussion with the author, December 2021.

As a former Health Department bureaucrat noted in an interview, it is also possible that the *Department of Health Act* – which transferred responsibility for home care and provided broad spending powers to the Health Department (Department of Health Act, 1979) – created circumstances around home care delivery that disincentivized the contracting of services to non-profit providers.[92] The Blakeney government's preference that its newly established Home Care District Boards be the direct provider of home care in the province is also hinted by (Lawson & Thériault, 1999). This would have subsequently limited the degree to which non-profit organizations were established within the home care space come the passage of the *Health Districts Act* in 1993 to push back against the legislation's moratorium on the contracting out of home care services by the province.

What this context for Ontario and Saskatchewan demonstrates is that the population of stakeholders and interests tied to home care and their capacity to participate in home care reform efforts in each province was also influence by policy legacies of the 1970s and 1980s, which provides evidence of my third hypothesis. In Ontario, nonprofit organizations were invited to collaborate with the provincial government to provide home care services as the province's Home Care program developed, which allowed nonprofits to solidify themselves as relevant stakeholders and levy pressure as an interest group to influence later policies that targeted home care. In Saskatchewan, non-state actors were gradually pushed out of the home care policy arena by both the Blakeney and Devine governments through the Saskatchewan Home

[92] Roger Carriere, former Director of Home Services for Saskatoon Home Care Board and Director of Continuing Care & Rehab in the Saskatchewan Ministry of Health, in conversation with the author, January 2023.

Care Plan and the *Department of Health Act*, which - in addition to providing cost control mechanisms through the introduction of means-tested user fees - combined to expand both the service delivery expectations of the province's home care program and the financial capacity of the state to provide those expanded services. The result was the NDP government under Romanow essentially being able to implement the home care expansion elements of its ambitious health reform agenda with limited pushback from entrenched health system interests. In both Ontario and Saskatchewan, home care policy legacies influenced which stakeholders and interest groups were able to be involved in policy reform efforts during the study period and the degree of influence they could have on said efforts.

Though interest group pressure on the Saskatchewan NDP government in response to its health reform agenda was fairly limited throughout the study period, there was notable pushback to it from the public, particularly rural communities. Most of this pushback was the result of the NDP government's decision to stop providing acute care service funding to 52 rural hospitals. Though all of the hospitals targeted by this decision had less than 8 beds and were generally underutilized, rural community members perceived their targeting by the NDP government as a sign that they did not care about the province's rural population. In addition, despite 51 of the 52 hospitals being converted into Community Health Centres rather than being shut down entirely, the NDP government did nothing to challenge the popular narrative that the hospitals

were being "closed". As former Health Minister Eric Cline mentioned in our interview, this was ultimately a public relations failure of the government.[93]

Indeed, even though a study by Saskatchewan's HSURC found that the rural hospital conversions had actually led to improved health outcomes in some of the communities targeted, with no negative outcomes reported (Liu et al., 2001), the NDP's commitment to this element of its health reform strategy became the "death knell" for the party's support in rural Saskatchewan.[94] The pushback also appeared to make the NDP government more hesitant to follow through on future rural hospital closures or conversions, despite recommendations for more by the Fyke Commission report to the Calvert government in 2001. This in turn made it difficult for the NDP government to follow through on the underlying goal of the Wellness agenda, which was to gradually redirect institutional care resources to home and community care services. Not being able to continue transferring resources from acute care to home and community care services subsequently made it difficult to continue increasing support for the latter.

Decisionmakers within the NDP government clearly believed that increasing investment in home care while divesting from acute care provision would lead not only to cost savings in the health system in the long run, but also to improvements in population health outcomes in the province. However, despite reports published by HSURC which provided positive assessments of the NDP government's health reform strategy, the Romanow government was not able to effectively

[93] Eric Cline (former Saskatchewan Minister of Health from 1995-1997 and Finance Minister from 1997-2002), in conversation with the author, November 2022.
[94] Steven Lewis (former CEO of HSURC from 1992-1999, as well as consultant and contributing author to the Fyke Commission report) in conversation with the author, January 2023.

communicate the success of its approach to the voting public, particularly in rural communities. Instead, many members of the public had come to perceive the Romanow government's health reform strategy as a poor attempt to mask a health agenda built on the neoliberal austerity the NDP was supposed to be fighting (James, 1999; Mcintosh & Marchildon, 2009).

Between the public pushback and increased fiscal pressure imposed by additional cuts to provincial health funding from the federal government in 1995, the NDP government found itself unable to continue justifying the pursuit of its original health reform goals. While the Calvert government reintroduced some degree of focus on home and community care service provision with its strategic emphasis on primary care, key elements of the NDP's original vision for health reform under Romanow were never brought back, including Simard's "one-way valve". All in all, these results demonstrate that considerations of interest group pressures in institutionalist analyses of policy change should also consider the impact of the voting public, at least in the case of relatively smaller jurisdictions like Saskatchewan. Indeed, as a geographically large province of less than 1 million people at the time when these health reforms were occurring, it is not unreasonable to suspect that elected officials would need to be more responsible to local needs than a similarly sized province with more than 10 million people like Ontario. Between the size/population ratio of electoral districts and the province's agricultural and resource-based economy, it is not necessarily surprising that public pressure, even outside of the context of a looming election, could substantially impact the policy agenda of a sitting government in Saskatchewan, even one motivated by a strong ideational drive.

Methodological Challenges

This analysis encountered many difficulties in terms of methodological implementation. Much of this was due to the period under investigation. Not only did I struggle to access many government documents related to home care governance, particularly in Saskatchewan, but I also faced many obstacles in the interview data collection process. Indeed, there were quite a few individuals I was unable to interview due to factors including them either having passed away, become unable to provide an interview due to illness, not having any identifiable contact information, or simply not being willing to give an interview due to a lack of recollection of the period I was investigating. As noted early in the dissertation, I also encountered difficulties with accessing provincial spending data for home care, as CIHI data on health spending among Canadian provinces did not separately report their home and community care funding allocation until 2013. While I was able to access public home care funding from 1975-1995, these amounts also included federal and municipal dollars allocated to home care, making the data somewhat distinct from the provincial funding I was most interested in.

Fortunately, the data I was able to collect provided a sufficiently clear picture of how home care funding had progressed throughout the majority of the study period and provided empirical support for my analysis of home care policy change in Ontario and Saskatchewan. The interviews I was able to conduct with experts and stakeholders involved with home care policy during the study period provided invaluable data, and I am deeply grateful for the time and detailed accounts of events that these individuals provided me. However, I also recognized that I was asking my interview subjects to recall events that had occurred decades prior, and thus I required access to means of verifying the accounts I was provided by my interviewees. In this

regard, I also benefited from ready access to government reports, documents, and press releases, as well as parliamentary debates and secondary literature such as biographies and memoirs through the McMaster library, all of which helped me to evaluate and contextualize claims and accounts provided to me by interviewees.

Contributions of this research

This analysis has offered an important contribution to the literature not only on home care policy reform, but on health policy reform in times of crisis more broadly. It also has important findings to contribute to the new institutionalist literature on subnational policy change. Specifically, the findings of my investigation of divergent home care policy trajectories in Ontario and Saskatchewan reiterate the centrality of policy legacies in shaping future policy paths, particularly through their influence on the ideas that define policy problems for decision makers, and their role in establishing the power that interest groups can have in preventing future policy change.

This comparative analysis of home care policy trajectories in Ontario and Saskatchewan also represented a novel contribution to the comparative literature on home care policy change in Canada more broadly, with the investigation of Saskatchewan being the most thorough to have been undertaken in any analysis of home care in Saskatchewan thus far. It has also represented a rare instance of a comparative health policy analysis involving Saskatchewan as a case and demonstrates the fascinating insights that can be gleaned from the province as a comparator due to its unique health system dynamics influenced by its history as the birthplace of Canadian Medicare.

As chapters 3 and 4 helped demonstrate, the context for home care policy change, as well as the directions that were ultimately pursued by governments throughout the study period, were determined first and foremost by the legacies that had been previously established within each province's program design. The most important finding was that key differences related to the source of program services delivered and the scope of services funded by the state went on to inform home care program cost trajectories over the years leading up to the reform period investigated in this analysis. These administrative differences led to Ontario and Saskatchewan entering the recessionary circumstances of the late 1980s with sufficiently distinct home care programs to provide unique contexts for analyses of each program by policy decisionmakers at the time. We are thus reminded that the institutional context established by policy legacies represents a pivotal, primary variable in determining the potential scope and direction of future reforms to any given program, reinforcing Hay's (2011) constructivist understanding of institutions and their role in contextualizing the ideas held by policy actors and the perceived interests.

Of course, though the institutional context provides a necessary starting point to allow for the possibility of policy change, it is ultimately actors that serve as agents of change and the ideas they hold about a given policy that define and implement any policy changes that do occur. The ideational motivations and momentum that such policy actors can build for reform efforts are thus also a key variable in understanding policy changes that are observed in any given example. In Ontario the underlying idea of a managed growth approach to home care was consistent throughout the tenure of three governments headed by otherwise ideologically distinct parties. As chapter 3 demonstrated, it was the durability of this perceived need to control home care

program costs above and beyond all other ideas about how to increase its role within Ontario's healthcare system that caused home care to be subject to the same retrenchment efforts experienced by other pillars of health within the province. The persistence of this idea also contributed to policies and programs built on alternative ideas – such as ideas regarding the need to expand in-home services with the Peterson government's Integrated Homemaker Program and ideas about unionizing the LTC workforce with the Rae government's Multi-Service Agencies – from becoming fully realized and entrenched themselves.

In chapter 4, Saskatchewan saw highly motivated health policy decisionmakers in Louise Simard and Duane Adams begin the NDP government's tenure in power by proposing and implementing an ambitious, comprehensive reform agenda for the entire province's health system that emphasized supporting the growth of home and community care programs through divestments in acute care. However, by 1995 the momentum behind the NDP government's ambitious health reform agenda had ground to a halt. Between the rural public's negative response to the perceived loss that came with the conversion of rural hospitals to community health centres, the additional fiscal pressures on health funding incurred by the elimination of the Established Programs Financing program by the federal government, and the stepping down of Louise Simard from her role as Health Minister, the Romanow government felt it necessary to scale back its health reform agenda. As a result, many of the gains made in home and community care over the government's first years in power were lost, and in 1997, Duane Adams followed Louise Simard in retiring from politics.

Though home care went on to find a bit of a resurgence in ideational relevance with the Calvert government's health action plan in the early 2000s, it would never again see the same level of growth it experienced between 1991 and 1995. Indeed, from the late 1990s to 2012, no governments were even bothering to track home care program spending, as the lack of data from that period demonstrates. Clearly then, even in Saskatchewan, where the institutional and ideational conditions were seemingly ripe for the implementation of comprehensive health reforms, they were still not sufficient to allow for changes to be implemented allowing home care more prominence within the province's health system.

As these events from Ontario and Saskatchewan demonstrate, ideas for reform, the agents that hold them, and the political contexts in which they operate are important determinants not only of the scale of change that can be achieved, but also of the potential for any change to occur. Both provinces saw an increased prevalence of ideas for home care reform promulgated throughout the study period by influential policy decisionmakers. Saskatchewan undoubtedly had the most driven supporters of home care in Louise Simard and Duane Adams, and the ideas they championed in the early 1990s were given additional momentum by the institutional and fiscal context they emerged from. The combined influence of the health system funding crisis and the ideas promoted in the Murray report allowed for comprehensive health reforms to be implemented by the NDP government where they could not by their peers in Ontario.

However, while positive ideas regarding home care allowed it to temporarily hold a relevant place in the Romanow government's health reform agenda, its return to being the poor cousin of the province's healthcare suggests that home care's enduring, legacy role as a peripheral

element of healthcare was too resistant to systemic changes. This demonstrates that, though ideas can be leveraged in the right circumstances to allow for the implementation of comprehensive reforms to institutions, it is much harder for the necessary circumstances to be established to allow for changes to widespread ideas, at least when it comes to health. When considered in terms of Carstensen and Schmidt's (2016) typology of ideational power, we observed change to home care policies by government actors leveraging the power over ideas (via majority government control mechanisms) and through ideas (via the ideational mechanisms inherent to regionalization strategies) related to home care's role in provincial health systems at large. However, we also observed a failure to see ideas that situated home care's role more centrally within provincial health systems become entrenched in either province, representative of a lack of power in those ideas themselves. This was a key finding and will likely continue to represent an important variable in future analyses of home care policy change and/or stability.

Of course, interests were also seen to represent a barrier to the implementation of home care reform agendas. This was most clearly the case in Ontario, where non-profit organizations who had established themselves as the legacy providers of home care services in the province lobbied extensively to prevent the NDP government from implementing reforms to home care (specifically MSAs) which would have supplanted their position in the sector. The success that nonprofit organizations had in ultimately preventing the full implementation of the NDP government's home care reform agenda, which opened the door to the Conservative government's implementation of CCACs, gives credence to Oliver's (2006) argument that

resistance from “concentrated interests” can contribute to political leaders adopting less ambitious policy reform strategies.

The contrast of Ontario with Saskatchewan provides further support for this argument, in that the absence of such concentrated interests to mobilize against the Romanow government’s Wellness agenda allowed for it to be implemented more successfully at first. Indeed, though health decision makers from the mid-late 1990s I interviewed primarily emphasized pushback from the general public as being the key source of opposition to the Wellness agenda, Loadman (2010) suggests that the Saskatchewan Medical Association (SMA), which represents physician interests in the province, had also become a source of opposition by 1995. Specifically, she argues that the SMA’s begrudging support of the Wellness agenda in its early stages was predicated on the government’s willingness to compromise on a key element of concern for physicians: changing the fee-for-service model. However, in late 1994, the government had begun increasing pressure on the SMA to cede ground on the possibility of opening the door to other forms of physician renumeration, which led to the Association becoming more publicly critical of the government’s treatment of physicians.

Ultimately, changes to the fee-for-service model of physician renumeration never came in Saskatchewan, giving further credence to the suggestion that, had the Health department not absorbed the non-profit sector’s role in home care service delivery, the NDP government might have experienced opposition from non-profit organizations to the Wellness agenda in similar vein to that which was seen in Ontario with the Rae government. After all, one element of the Wellness agenda was the formal transfer of the authority held by home care boards – which had

up until the 1990s still technically operated as non-profits – to regional health authorities, officially making all home care program workers employees of the province.

These findings related to the sequential influence of institutions, ideas, and interests on the home care policy reforms observed in Ontario and Saskatchewan further supports the constructivist understanding of New Institutionalism promoted by Colin Hay (2011), building especially upon Pierson's (1993, 2000) highlighting of the influence of early policy decisions on later ones. The 3I framework proposed in chapter 2 based upon the notion of ideational and interest-based variables being built off the groundwork laid by policy legacies makes sense when used to analyze how home care reform trajectories diverged in Ontario and Saskatchewan. This project's process tracing of home care policy change in Ontario and Saskatchewan has also demonstrated that ideas about home care held by policymakers tend to be constrained by cost concerns even when home care itself is seen as a potential mechanism for increasing cost savings in health care. What's more, the dominant paradigm within provincial health systems in Canada appears to be one which privileges the hospital and acute care provision over all else. This becomes particularly clear when looking at the burden of evidence necessary to justify spending in home care compared with acute care. Steven Lewis elaborated on this concept during our interview, noting:

> There's kind of an asymmetry… in terms of the evidence required to justify something… We build new hospitals, we do massive interventions, some of which are on a pretty flimsy evidence base. Nobody actually holds the very expensive part of the system as accountable for proving what its actually doing makes sense… In home care, any time

there is any suspicion that it may be somewhat superfluous… [you] say "Well, wait a minute, you shouldn't be spending money on that frivolity".[95]

According to Lewis, the burden of evidence to justify government spending on home care is further complicated by the difficulties associated with actually measuring its impacts, further noting:

How would you know if… a little bit of home care that you administered in 1990 deferred someone's admission to a nursing home in 1999? Well, you don't really… There's a plausible mechanism of action, and with some heroic methodological choreography you might be able to prove it, but it's harder.[96]

Combine this reality the fact that "soft" services like home care lack the "glamour and allure" of investments into elements of the health system tied to acute care, like health technology, and what emerges is a political culture around home care that prevents it from staying relevant.[97] In this sense, the 1990s represented a unique period where home care – which had otherwise been absent from political conversations on health care in Ontario and Saskatchewan – was actually able to find some traction among policymakers. In essence, it was an opportunity for home care to diverge from its most dominant policy legacy of playing second fiddle to acute care within provincial health systems.

However, another difficulty that has become apparent from this analysis is the fact that the same fiscal concerns and need to locate cost savings that put home care onto provincial government

[95] Steven Lewis (former CEO of HSURC from 1992-1999, as well as consultant and contributing author to the Fyke Commission report) in conversation with the author, January 2023.
[96] *Ibid.*
[97] *Ibid.*

agendas also appear to have been a contributing factor to home care's eventual displacement from government agendas. What the stories of home care policy development in Ontario and Saskatchewan show is that during fiscal crises, home care received the greatest attention in the form of investment in policy arenas where it was seen as an ideal alternative to acute care and hospital investment (i.e., in Saskatchewan under the tenure of the Romanow government). However, the story of Saskatchewan also shows that diverting acute care funding into home and community care programs can end up becoming a fruitless endeavour for provincial governments in terms of political outcomes. The reason for this is that local hospitals, regardless of the degree to which they are utilized, represent many communities' primary connection to the healthcare system.

The other key takeaway from this analysis of health reform in Ontario and Saskatchewan is that health reform is not something that can be achieved without the willingness to spend money to save money. Unfortunately, attempts to push for health reform being necessitated by budgetary crises means that the spending necessary to facilitate truly transformative reforms is that much harder to maintain, and as such, the status quo becomes even more difficult to shift from. As the stories from both provinces demonstrate, it is difficult to justify to the public shifting a health system's reliance on acute care to a reliance on home care when the most visible element of that shift is the disappearance of tangible institutions like hospitals.

The stories of home care policy development in Ontario and Saskatchewan, though initially ones I was interested in based on their differences, I have also come to realize are interesting in terms of their similarities. Specifically, both provinces saw home care enter government agendas for

the sake of ulterior health reform goals built largely upon a frantic search for cost-savings, either through home care investment or cost-containment. In neither province did I discover a concerted effort by policymakers to invest in home care for the sake of home care itself. I believe it is ultimately this sustained lack of interest in home care for the sake of home care by health policymakers in Canada that represents the core explanation for the sad state that home care programs across the country exist in today. Without a doubt, the most frequent refrain I heard from interviewees who were involved with home care reform in some way was that home care represented the "poor cousin" of healthcare. Looking forward, then, those who are earnestly interested in seeing home care programs in Canada thrive will first need to understand this mentality; why it exists and how to combat it.

Future Research Considerations

I believe there is a great opportunity for the empirical findings of this research to inform future studies on the provincial health policy changes that have begun occurring in the wake of the COVID-19 pandemic. Indeed, though the fiscal crises of the late 1980s and early-mid 1990s were different from the health crisis presented by the COVID-19 pandemic, there are significant overlaps that exist between them in terms of how they went on to impact provincial government health agendas, particularly regarding the health and wellbeing of older adults. Despite this, there has been a relative lack of attention to home care through the pandemic. As (Palmer et al., 2022) note despite there being "considerable" published research on the impact of the COVID-19 pandemic on long term care homes, published insights on home care are "quite limited". Though the research focus on long term care homes during the pandemic was to be expected in light of Canada's unfortunate status as having the highest rate of COVID-19 deaths in LTC

institutions worldwide, it is still surprising that home care would be largely ignored consider its role in LTC more broadly. It is also unfortunate observe this occurring despite the widespread awareness today of the same realities addressed by health experts and policymakers at the onset of this analysis' study period: that people would prefer to age at home and can be cared for more there more cost effectively than in long-term care homes or hospitals (Ireland & Kalata, 2021).

This analysis has demonstrated that there is even more insight to be gained by looking back at Canada's own political history to learn about policy changes that work to improve our healthcare system. More importantly, it has demonstrated the considerable barriers that exist to implementing health policy changes that diverge from the dominant paradigm in healthcare that privileges funding for acute care delivered in hospitals over community health services delivered closer to home. These barriers are primarily political, which means it is up to politicians and government bureaucrats to figure out how to steer the political culture around healthcare in Canada away from its historically entrenched focus on hospitals. Future comparative analyses of provincial health policy change should continue to investigate the hospital-centric approach to health reform that can be observed in Canada, as well as seek out instances where this trend was bucked for the purpose of analysis.

Across Canada, provinces have gradually decreased the hospital funding portion of their budgets over the past 30 years. However, this has not generally been accompanied by an increase in home and community care's portion of provincial health budgets (CIHI, 2022a). Home care has subsequently remained a marginalized element of healthcare systems across Canada, and while

there are plenty of explanations that have been offered for why that is, less is known about how this situation can be addressed. The case of home care policy development – and ultimately stagnation – in Canada is a prime example of the power of institutions in limiting the capacity for health policy change, even for agents of change with strong ideological motivations to counter the dominant paradigm in Canadian healthcare on hospitals and acute care. This thesis thus also demonstrates that putting home care back on government health policy agendas requires not only highly motivated and organized policy actors, but also strong ideational messaging and support from within the dominant health system institutions. The barriers to improving home care's current status as the 'poor cousin' of the Canadian healthcare system and up on governments' health reform agenda are high, but understanding how they were initially erected and have functioned historically provides an important first rung in the long climb over them.

Interviewee List

Interviewee name	Category of interviewee	Interview date	Format	Jurisdiction
Bob Rae	Politician	June 10, 2022	Virtual	Ontario
Brian Guest	Home Care Provider Org Administrator	December 2, 2021	Virtual	Ontario
Cam Jackson	Politician	February 16, 2022	Virtual	Ontario
Conrad Hnutiak	Civil Servant	January 4, 2023	Virtual	Saskatchewan
Denise O'Connor	Academic / Home Care Provider Org Administrator	October 19, 2021	Virtual	Ontario
David Peterson	Academic	June 13, 2022	Virtual	Ontario
Elinor Caplan	Politician	June 17, 2022	Virtual	Ontario
Frances Lankin	Politician	April 13, 2022	Virtual	Ontario
Geoffrey Quirt	Civil Servant	December 2, 2021	Virtual	Ontario
Greg Marchildon	Academic / Civil Servant	June 30, 2022	Virtual	Saskatchewan
Jane Aronson	Academic	October 27, 2021	Virtual	Ontario
Jim Wilson	Politician		Virtual	Ontario
Joe McReynolds	Community Association Executive / Advocate	October 26, 2022	Virtual	Ontario
John Nilson	Politician	November 28, 2022	Virtual	Saskatchewan
Juanita Gledhill	Home Care Provider Org Administrator	November 5, 2022	Virtual	Ontario
Judy Junor	Politician	December 5, 2022	Virtual	Saskatchewan
Ken Fyke	Civil Servant	January 4, 2023	Virtual	Saskatchewan
Louise Simard	Politician	November 21, 2022	Virtual	Saskatchewan
Michelle Cooper	Home Care Provider Org Administrator	November 24, 2021	Virtual	Ontario
Mike Harris	Politician	March 3, 2022	Virtual	Ontario
Murray Knuttila	Academic / Home Care Provider Org Administrator	September 27, 2022	Virtual	Saskatchewan
Patricia Atkinson	Civil Servant	December 3, 2022	Virtual	Saskatchewan
Ralph Nilson	Academic / Civil Servant	August 26, 2022	Virtual	Saskatchewan
Roger Carriere	Civil Servant	January 5, 2023	Virtual	Saskatchewan
Shan Landry	Home Care Provider Org Administrator / Civil Servant	January 2, 2023	Virtual	Saskatchewan
Shirley Sharkee	Home Care Provider Org Administrator	January 6, 2022	Virtual	Ontario
Steven Lewis	Civil Servant / Academic	January 12, 2023	Virtual	Saskatchewan
Sue VanderBent	Community Association Executive / Advocate	December 14, 2021	Virtual	Ontario

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Appendix: Public Home Care Data Charts & Tables

Table 2: Ontario Public Home Care Expenditures (1975-1995)

	Public Home Care Expenditures (millions of 1996 dollars) *	Annual Change in Spending (%)	Public Home Care % of Total Health Spending**
Year			
1975-76	$71.15	N/A	0.67%
1976-77	$68.46	-3.78%	0.60%
1977-78	$72.58	6.01%	0.65%
1978-79	$84.02	15.77%	0.73%
1979-80	$102.08	21.50%	0.93%
1980-81	$124.30	21.77%	1.09%
1981-82	$154.74	24.49%	1.29%
1982-83	$175.52	13.43%	1.39%
1983-84	$195.60	11.44%	1.46%
1984-85	$194.60	-0.51%	1.39%
1985-86	$269.28	38.38%	1.81%
1986-87	$337.01	25.15%	2.08%
1987-88	$397.84	18.05%	2.33%
1988-89	$448.66	12.77%	2.51%
1989-90	$461.78	2.92%	2.41%
1990-91	$538.22	16.55%	2.75%
1991-92	$627.46	16.58%	3.02%
1992-93	$690.70	10.08%	3.28%
1993-94	$867.20	25.55%	4.26%
1994-95	$980.49	13.06%	4.79%
1995-96	$896.85	-8.53%	4.48%

* Figures sourced from Health Canada (1998) "Public home care expenditures in Canada: 1975-76 to 1997-98", Ottawa, ON. Public Home Care Expenditure figures inflation adjusted to 1996 dollars and include all public sector funding from federal, provincial, and municipal governments, social security, and workers' compensation board funds.

**Includes all public sector spending on health services in Ontario.

Table 3: Saskatchewan Public Home Care Expenditures (1975-1995)

	Public Home Care Expenditures (millions of of 1996 dollars) *	Annual Change in Spending (%)	Public Home Care % of Total Health Spending**
Year			
1975-76	$8.03	N/A	0.75%
1976-77	$8.58	6.77%	0.72%
1977-78	$9.92	15.70%	0.81%
1978-79	$9.72	-2.08%	0.82%
1979-80	$15.71	61.73%	1.25%
1980-81	$18.04	14.83%	1.32%
1981-82	$25.88	43.44%	1.82%
1982-83	$22.54	-12.90%	1.44%
1983-84	$28.00	24.22%	1.72%
1984-85	$27.23	-2.76%	1.64%
1985-86	$29.17	7.13%	1.70%
1986-87	$34.30	17.59%	1.87%
1987-88	$32.87	-4.16%	1.85%
1988-89	$31.79	-3.30%	1.80%
1989-90	$34.19	7.56%	1.83%
1990-91	$35.91	5.03%	1.84%
1991-92	$36.60	1.92%	1.93%
1992-93	$39.78	8.69%	2.18%
1993-94	$46.15	16.01%	2.67%
1994-95	$60.78	31.69%	3.36%
1995-96	$62.87	3.44%	3.55%

* Figures sourced from Health Canada (1998) "Public home care expenditures in Canada: 1975-76 to 1997-98", Ottawa, ON. Public Home Care Expenditure figures inflation adjusted to 1996 dollars and include all public sector funding from federal, provincial, and municipal governments, social security, and workers' compensation board funds.

** Includes all public sector spending on health services in Saskatchewan.