

“The Marginalization of Long-Term Care in Canadian Federal Policy Making”

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Abstract

Although shifting demographics and changing gender patterns are placing pressure on governments across welfare states to develop new strategies to deal with the risks of dependency in old age, only some have expanded their welfare states to make long-term care policies a priority. This chapter considers the historical and continued reluctance of the Canadian government to develop national solutions to this increasingly important policy sector. While successive federal governments have been willing to spend the political capital necessary to uphold a public-sector ethos in hospital and physician care, they have been unwilling to do so for the long-term care sector. With reference to select Parliamentary and Senate debates, this paper draws attention to the efforts of a number of actors in the post-war period to elevate long-term care policy on the political agenda and the unwillingness of the federal government to broaden the health care system beyond the walls of hospitals and physicians' offices.

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

Since the 1990s, national governments in some welfare states, such as Japan, Germany, France and Spain, have begun to rethink their historical ambivalence towards long-term care. While aging itself is certainly not a new phenomenon, there are novel aspects about contemporary gender and demographic trends that have the potential to force policy makers to

rediscover long-term care. For one, welfare states are home to larger numbers of older people. By mid-century most affluent democracies will have seen their older populations double, and increases in life expectancy in the post-war period means that the number of frail seniors with complex care needs is now greater (Esping-Anderson 2009, 147, Pavolini and Ranci 2008). The increased demand for long-term care is thus one reason why there is a relative newness to this policy area and why dependency in old age is classified as a new risk. Additionally, while states have to rely on women's informal caregiving to accommodate aging populations, steady increases since the 1970s in women's labour market participation has made it more difficult for both women and the state to continue this practice (Bonoli 2007, Peng 2001, Esping-Anderson 2009).

This paper is concerned with explaining why a national strategy for developing long-term care services for seniors has failed to develop in Canada. Following Jacob Hacker's assertion that understanding contemporary trends requires that we "look at the development of health policy not as a series of discrete political struggles, but as an ongoing historical process in which past public policies and political battles shape what is possible in the future" (Hacker 1998, 127), the following pages incorporate an historical perspective. National health policy has been an ongoing historical process in which political battles have been waged over public health care delivered in hospitals and doctors' offices. While central government actors have been willing to spend the political capital necessary to uphold a public-sector ethos in these areas, they have been unwilling to do so for the long-term care sector. By breaking down federal government approaches to the sector into three phases, the following pages emphasize the low priority status of long-term care shared by federal policy makers in the post war period. The first phase, which I label as 'long-term care averse', spanned the 1945 to 1970 period. The need to develop national

solutions to observable problems in residential care was ignored by federal actors enamoured with designing a public health care system around hospital and curative medicine. The second phase, which can be referred to as 'long term care ad hoc-ism', applies to an approximately ten year window from the early 1970s to the early 1980s. It was characterized by piecemeal and, it would turn out, temporary, central government involvement. The 1980s and 1990s saw the return of an absent mandate. Through the exclusion of long-term care from the 1984 Canada Health Act as well as its marginalization in cost-sharing arrangements, federal governments of the period cemented the peripheral status of this form of care in the Canadian welfare state.

1945-1970 Long Term Care Aversion

While provincial governments have been responsible for health and welfare provisions since Confederation, with the exception of services for veterans and Aboriginal people, the federal government has used its spending powers to shape provincial policies in significant ways. Between 1945 and 1970, addressing problems in long-term care ranked low on the list of government priorities as issues of geriatric concern were overshadowed by the ambitions of political actors committed to a national health system centred on hospital and curative medicine. With reference to select parliamentary debates of the 1950s and 1960s and proceedings of the 1966 Senate Committee on Aging, the following draws attention to the efforts of a number of actors to elevate long-term care policy on the political agenda and the unwillingness of the federal government to broaden the health care system beyond the walls of hospitals and physicians' offices.

A number of opposition MPs in Ottawa were critical of the lack of consideration shown towards issues of aging in federal policy. Cooperative Commonwealth Federation (CCF) MP Herbert W. Herridge, for example, argued in Parliament in 1957 that the National Health and

Welfare department needed to do more to “study the problems of the aging, to develop wider understanding...to do something to improve the present situation” (Herridge 1957, 2749). The reality was that little information existed on the lives of Canada’s older people. CCF MP Stanley Knowles pointed out that although the welfare council of greater Winnipeg was addressing this issue on a local level through its Age and Opportunity report, the federal government was not taking the necessary steps to understand how seniors were doing on a national scale (Knowles 1956 2147). Progressive Conservative MP Alfred Johnson Brooks emphasized that “we are in many years behind other countries” when it comes to understand the housing needs of seniors (Brooks 1956, 3994), while another Conservative member noted “There does not seem to be the energy behind any move sufficient to meet that problem in an adequate way” (Green 1956, 3991).

The 1966 *Final Report of the Senate Committee on Aging* was also critical, noting that health policy was “preoccupied with maternal and child health to the exclusion of other age groups” (Senate of Canada 1966, 121). The Committee emphasized that during its hearings it was “reminded on all sides of the gaps and weaknesses in current facilities for meeting the health needs of older people” and of the “extreme shortage there is in Canada of facilities designed and equipped to meet the needs of long-term patients” (Senate of Canada, 1966 28, 32). While hospital grants had contributed to the expansion of hospitals across the country, the lack of attention to building up long-term care facilities was increasingly apparent by the mid-1960s. Although the federal government, through the Canada Mortgage and Housing Committee (CMHC), had been contributing money to non-hospital facilities to help cover capital costs through loans and subsidized mortgage rates since 1946, the reality was that not enough facilities had been created. The Committee noted that many older people with long term care needs were

ending up in hospitals because of a lack of nursing home beds, and in municipal homes for the aged (which were not originally designed to provide skilled nursing home care). “So desperate is the situation” the committee explained “that even nursing homes of such poor quality that according to the authorities they ‘should not be in operation’ have long waiting lists” (Ibid, 32). Because nursing homes were not included under the hospital insurance program, unless admitted as indigent, older people or their families were forced to pay the costs of this care at an average of \$8 to \$10 a day and “often much higher” (Ibid).

The Senate Committee noted that even more troubling than the shortage of long term care facilities was “the lack of clear policy” on long term care (Senate of Canada 1966 p.32). No attempt had been made by the federal government to determine the types of facilities needed to meet the care needs of an aging society, to determine the standards that care homes should meet, to come up with an arrangement to cover the substantive costs faced by older people and their families, or to determine whether or not the private sector should be involved in long term care provision (Ibid, 33). It argued that “By far the majority of nursing homes in Canada are proprietary” and that a “profit-making” ethos had come to dominate a field long ignored by Ottawa (Ibid, 111). While the federal government was committed to using its spending power to uphold conditions of public administration, comprehensiveness, universality, portability, and accessibility in hospitals and later medical care, a hands off approach characterized its relationship to seniors’ care. “There is entirely too little emphasis on aging and on the overall care of the chronically ill at the federal level”, the Committee argued (Senate of Canada 1966, 121). While Ottawa cost-shared hospital and physician care and ensured a level of national uniformity and strong public sector involvement, when it came to long-term care “lethargy” characterized the federal approach (Alexander 2002, 3).

1970s 'Long-Term Care Ad-Hocism'

In the 1970s, pressure did grow for more federal support for long-term care. One factor was the increased demand for beds resulting from women's changing labour market participation. In the 1960s, the female labour force rapidly expanded, increasing the need for more long-term care beds as more women found it increasingly difficult to balance caregiving duties for both their children and elderly parents (Ostry 2006, 192). The process of deinstitutionalization in mental hospitals which began in the 1960s was another factor. Closures of such facilities meant that many older patients with dementia and other psychiatric conditions ended up in general hospitals (Ibid, 192). While federal funding did help defray hospital costs, such facilities were expensive and demand exceeded the supply (Armstrong et al 2009, 22). The cost of hospital care was on the rise, a reflection in part from the increasing organization of the largely female care workers and their successful campaigns for wages that better reflected the work they performed (Ibid). Costs also increased because of sharp rises in the income of physicians, and from the growing costs of new technologies and drugs produced mainly from for-profit companies (Ibid). The cost of long-term patients was a concern, particularly as more people were living into old age, many with disabilities (Armstrong et al 2009, 22, Ostry 2006, 192). Throughout the 1970s, the cost of health care continued to increase at a rate faster than any other sector (Ostry 2006, 59). Moreover, as economic expansion was coming to an end with the sharp rise in oil prices in 1973, Canada, like most developed nations, experienced slow economic growth in combination with high inflation. Cost containment rose to the top of the political agenda (Ibid, 57).

By 1971, Ottawa had started negotiations with the provinces to transition from the system of conditional funding to block grants (Ostry 2006, 59). In 1977 changes were made to federal

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

The EPF included federal cash for a new program, the Extended Health Care Services (EHCS) program. The EHCS was a separate small block of funding for provinces to spend on extended health care, defined as services delivered outside of hospitals (Ibid, 60). Originally set at \$20 per capita in 1977-1978, the funds were put in place to encourage the provinces to shift their focus from expensive hospital and physician-based care delivery (Ibid). Opposition MPs had been pressing the Ministry of National Health and Welfare in the 1970s to enter into shared cost programs for nursing home and home care because “The care now is not adequate for our geriatric people” (Rynard 1976, 1352; 1974, 63). As one New Democrat MP pointed out, since the passage of Medicare in 1968, the federal government had refused to bring essential services within the mainstream of the Canadian health care system, nursing homes being a primary example (Rodriguez 1976, 11037). New Democrat David Orlikow criticized the federal

government for ignoring the nursing home sector and forcing the costs of long-term care onto the provinces, older people and their families, while it directed public funds to the hospital sector.

The federal government, he argued, showed a marked lack of “will” when it came to treating the nursing home sector with any sense of national priority (Orlikow 1976, 1305).

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

The provinces have been trying to persuade the federal government to join with them in instituting cost-shared programs for such services. A lot could be done in this country by the establishment of more nursing homes, the provision of home-care treatment, meals on wheels, more extended care units in hospitals...Those of us who through the years have talked about a new delivery system have been stressing the need for altering the focus on health care in this country. In the past we thought of the practice of medicine in terms of curative medicine and public health care, but many countries in the world now have switched their emphasis to preventative health programs...It is now eight years since we took the first step of establishing Medicare in this country. It was a forward step...However, we have taken few steps since to begin to change the health delivery system to any serious extent, and we are paying the price because the whole delivery system of merely curative medicine is expensive and will become increasingly expensive...What have we done about nursing homes? Some steps have been taken but they have been really meager (Douglas 1976, 14623).

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

While the ECHS funding did stimulate the development of more long-term care facilities in the provinces, and home care services, thereby addressing in some ways the gap in services that existed across the country (Alexander 2002, 18), the program did not signify a re-thinking of

Medicare in the manner which Douglas and others had argued was necessary. Unlike federal transfers for insured services, this portion of the EPF was mainly unconditional and it was short-lived. As Armstrong et al explain,

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

That it was never the federal government's intention to address long-term care through this program in a substantive way made clear early on. National Health and Welfare Minister Monique Begin, when pressed in Parliament about federal support for the sector, replied "each province is at a different stage in the development of extended health care service, and for that reason we could not impose upon all the provinces the minimum standards that were applicable under the hospital insurance and medical care programs (Begin 1978, 3114). Clearly, the political will that was shown in 1957 and 1968 to bring hospital and medical care into a national and publicly supported plan would not be spent on the long-term care sector.

The 1980s and Beyond

After the 1970s a great silence loomed over residential care in Ottawa. While the EHCS represented a brief recognition on the part of the federal government of the importance of directing public funds to residential care, beginning in 1986 the Progressive Conservative government in Ottawa took measures to limit EPF and EHCS growth and gradually clawed back federal health contributions (Alexander 2002, 19-20). From the perspective aging Canadians with long-term care needs, the EHCS should therefore be seen as a minor break in an otherwise highly stable pattern of federal non-involvement. Two actions by the federal government – the

introduction of the Canada Health Act 1984 and the Canada Health and Social Transfer 1996 – illustrated the marginalized position of long-term care in federal thinking.

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

While the Act ensured that Canadians would be entitled to similar levels of care provided in doctors' offices and hospitals across the country, once again, long-term care was left out of the mainstream of Canadian Medicare. The Act makes mention of "adult residential care service" and "nursing home intermediate service" as being part of "extended health care services", however the federal government did not declare regulations that would define such services, nor did it attach conditions to its funding of such services (CUPE 2009, 21). As such, long-term care was "defined out of the Canada Health Act" (Armstrong and Armstrong 2008, 46). The

exclusion of long-term care from the Canada Health Act has meant that the words public, comprehensive, universal, portable and accessible need not apply to the sector. Although for-profit companies had always been active in residential care in Canada, the designation of long-term care as merely an 'extended' service in this national legislative framework further opened the door to market principles in the sector. By defining long-term care out of the Canada Health Act, the federal government ensured that an area of care long relegated to the periphery of the nation's health care system would be forced to remain there. While the political will to enforce a new national program unpopular with the provinces and the medical community was demonstrated in the passing of the Act (Taylor, 1987), as with previous rounds of federal policy making, the will to expand the public focus of Canadian Medicare beyond hospitals and doctors' offices was not there.

And, as with previous rounds, arguments to make non-profit ownership of nursing homes part of any new national plan were presented to the federal government. The Canadian Medical Association, for example, in response to the announcement of federal plans to move forward with the Canada Health Act, commissioned the *Task Force on the Allocation of Health Care Resources* to make recommendations of its own. Released in 1984, the *Task Force* made aging a central part of its report and was highly critical of the growth of the for-profit nursing home industry and the lack of federal leadership to address it. It argued that, permitting nursing homes to be run for profit under a lenient system of legislation and an impotent system of inspection is a measure of societal negligence we can no longer allow to continue. When an institution becomes the only answer for the care of an elderly person, it must be one that is run on a principle of loving care, not one of tender, loving greed. It is recognized that within the uneven system that prevails, some provinces and some nursing homes serve the elderly better than others. In

comparison between old age homes run for profit and those run by non-profit ethnic or religious organizations, it is the latter that often exhibit a higher standard of care, food, rehabilitation, innovative recreational programs, and at the end of life, compassion, palliative care and respect for the individual (CMA, 1984, 36). The Task Force recommended that for-profit care homes be phased out. This is something that the United Seniors Citizens of Ontario was arguing. Its president, Joyce King, told the Globe and Mail in 1985, “we want to eliminate run-for-profit nursing homes” (cited in Steed 1985, 10).

Despite these, and similar concerns expressed throughout the previous decades, the federal government ignored long-term care in the Canada Health Act. While the Canada Health Act reaffirmed that care provided in hospitals and doctors’ offices was to be publicly funded and not for-profit, its silence on long-term care served to reaffirm the notion that for-profit ownership and delivery of care was permissible and that co-payments and user fees were perfectly acceptable. Moreover, because the Canada Health Act has served to structure national health care debates in such a way that “the public, the politicians and even the taxpayers see health care only within the acute care system context”, increasing privatization of long-term care has been able to occur largely under the radar and outside of the democratic process (MacLean and Greenwood-Klien 2002, 76).

As it turns out, “The 1984 Canada Health Act marked the end of positive social program intervention on the part of the federal government” (Armstrong et al 2009, 29-30). Thereafter, welfare state programs were more and more portrayed as threats to individual initiative and economic expansion (Ibid, 30). Inefficiency and ineffectiveness were terms that increasingly came to dominate government references to public programs. Federal and provincial governments concerned with rising debt and deficit cast social programs as the causes of

irresponsible government spending, even though “tax cuts and a faltering economy were more much more important causes” (Ibid, 30). The New Public Management philosophy rose to prominence, stressing “governments were to hand over as much as possible to be done by the for-profit sector, and any responsibilities that remained in government hands should be based on business principles” (Ibid, 30).

Between 1983 and 1993, the Mulroney Progressive Conservative government unilaterally changed the amount and nature of federal health care funding. This was continued under the Chretien Liberals in 1990s, who in the 1995 budget introduced the Canada Health and Social Transfer (CHST). The CHST rolled federal transfers for health care, post-secondary education and social assistance into a single block grant. The funding that had been previously reserved for extended health care services as part of the EPF was lost. As Marchildon argues, on the health care front, the CHST brought three significant changes (Marchildon 2004, 4). For one, it meant that the provinces would have to increasingly spend from their own coffers to maintain their public health care systems during a period in which they had been fighting debt and deficit problems of their own. Secondly, federal funding under the CHST would be episodic and unpredictable given that the escalator formula, which had tied increases in previous federal transfers to economic growth, was eliminated. Thirdly, it contributed to a highly acrimonious relationship between the federal and provincial governments in which discussions about the future of Canadian health care were dominated by dollars and cents. In this fractious climate, which lasted into the 2000s (albeit one that dissipated somewhat when federal funding was restored at the close of the 1990s), the possibility that any new shared-cost program could be introduced in which federal conditions were attached was virtually nil (Marchildon 2004).

While reforming the Canadian health care system in a meaningful way has been difficult under the best of circumstances, the “politics of blame avoidance” (Weaver 2004, Pierson 1996) made reform increasingly difficult. While all provinces in the late 1980s and early 1990s established task forces or commissions to investigate and give advice to policy makers on health care reform, nothing much came of these (Tuohy 1999, 97). On the seniors’ care front, “long-term residential care is largely invisible in Canadian policy debates” (Armstrong et al 2009, 12). The 2002 Royal Commission on the Future of Health Care in Canada made no recommendations to address residential long-term care. The reality is that “policy around nature and quality of LTC for the future is virtually absent from the political agenda” (Berta et al 2006, 176). The federal approach to facility-based long-term care in the 2000s, like in the 1960s, is characterized by an absent mandate.

Conclusion

Focusing on the issue of long-term residential care, the preceding pages have argued that the sector has long been relegated to the fringes of the Canadian welfare state. By breaking down federal government approaches to long-term care into three phases, it has been asserted that a lack of political will to elevate long-term care on the list of social policy priorities has characterized the post-war period. While national governments in some welfare states have begun to rethink their historical ambivalence towards long-term care by developing new public programs to address the unique care needs of seniors, long-term care remains a low priority on the Canadian federal agenda.

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