Divergent Paths:

Ideas, Bureaucratic Rationality, and the Ownership Mix of the Public Nursing Home Systems of Ontario and British Columbia

Reza Hajivandi

Thesis submitted to the University of Ottawa

in partial Fulfillment of the requirements for the

Doctorate of Philosophy in Political Science

School of Political Studies

Faculty of Social Sciences

University of Ottawa

© Reza Hajivandi , Ottawa, Canada, 2026

Abstract

The ownership-mix of welfare-state services shapes care quality and regulatory costs, yet its formation remains undertheorized in welfare-state and non-profit scholarship. This dissertation examines why Ontario and British Columbia adopted opposing ownership-mix models for publicly funded nursing homes during the formative period of welfare-state modernization (1940s–1970s), despite shared liberal welfare institutions, conservative governments, federal funding opportunities, for-profit-dominated sectors, and despite Ontario's initially larger non-profit base. Prevailing social policy theories cannot explain the divergence, several predicting the reverse in at least one case.

Drawing on internal government archives, the study employs subnational comparative process-tracing within a framework integrating historical institutionalist, ideational, and Weberian theory, showing how distinct ideas and bureaucratic rationalities filtered a shared modernization objective into opposing policies. British Columbia's substantively rational 'caring bureaucracy' persistently advanced principled ideas of a high philosophy of care and framed poor care as moral failure, pressing a free-enterprise executive towards non-profit provision as the only means of reconciling care commitments with cost-efficiency. Ontario's instrumental-formal rationality privileged the causal belief that for-profit outsourcing under measurable physical standards and minimal care oversight would minimize regulatory, capital, and operational costs, a belief officials diligently operationalized, sometimes voicing concerns but deferring when overruled. This logic was reproduced across multiple windows of opportunity and entrenched through institutional layering and self-reinforcing feedback. Ontario promoted for-profit expansion, froze Homes for the Aged, and declined federal non-profit construction funding that British Columbia leveraged, alongside other measures, for non-profit nursing homes while restricting for-profit growth, culminating in a reform-resistant for-profit-dominated sector in Ontario and a non-profit-dominated one in British Columbia.

These findings date each province's ownership-mix foundations decades earlier than prevailing paradigmatic and leader-centred accounts, specify how ideas conditioned by bureaucratic rationality shape policy direction, and provide rare systemic evidence of both rationalities shaping policy formulation, extending care ethics beyond front-line administration.

ACKNOWLEDGEMENTS

First, I wish to express my deepest gratitude to Professor Jennifer Wallner for providing rigorous guidance and attentive and tailored support, which played a significant and enabling role in helping me maintain and advance the quality of my work at every stage of the dissertation, as well as for the generous funding, through the Jean-Luc Pépin Research Fellowship, that made my archival research in British Columbia possible. I would also like to thank the members of my thesis committee, Professors Luc Turgeon and André Lecours, for their thoughtful feedback on this project, and my external evaluators, Professors Eric Champagne and Peter Graefe, for engaging with my work.

Second, I would like to thank my loving parents, as well as my brother, who supported me in every way they could and spared no effort in doing so.

Third, I would like to thank Professors Daniel Stockemer and Dominique Arel in their roles as Supervisors of Doctoral Studies, for the assistance and support they provided in the program. I am also grateful to the staff of the University of Ottawa Library and the BC Archives for their efforts and assistance in locating and providing access to research materials.

Last, I was truly fortunate to pursue my doctoral studies in the School of Political Studies at the University of Ottawa, where I found a rich and critical academic and pedagogical culture. I am grateful to all the professors under whom I studied for the time they invested in me, both in the classroom and during office hours. These experiences helped me grow as a scholar and as a person.

LIST OF ABBREVIATIONS

Abbreviation	Definition
ANHIO	Associated Nursing Homes Incorporated Ontario
BC	British Columbia
BCHIS	British Columbia Hospital Insurance Service
CAP	Canada Assistance Plan
CCF	Co-operative Commonwealth Federation
CIHI	Canadian Institute for Health Information
CMHC	Canada Mortgage and Housing Corporation
CPT	Causal Process Tracing
CUPE	Canadian Union of Public Employees
EPF	Established Programs Financing Act
GNP	Gross National Product
HI	Historical Institutionalism
HIDS	Hospital Insurance and Diagnostic Services
LTC	Long-Term Care
MPP	Member of Provincial Parliament
NDP	New Democratic Party
NHA	National Housing Act
O. Reg.	Ontario Regulation
OAP	Old Age Pension
OANHSS	Ontario Association of Non-Profit Homes and Services for Seniors
OECD	Organisation for Economic Cooperation and Development
OHSC	Ontario Hospital Services Commission
OMA	Ontario Medical Association
OWC	Ontario Welfare Council
SEIU	Service Employees International Union
UAA	Unemployment Assistance Act

LIST OF TABLES

Table 1 Proprietary Groups or Chains of Special Care Facilities in Canada and the Provinces, 1974 141

Table 2 Number of Extended Care Beds and Private Hospital Beds, British Columbia, 1965–1974 216

Table 3 Number of Private Hospitals (Nursing Homes), British Columbia, 1945–1973 216

Table 4 Number of Intermediate Care Beds by Ownership, British Columbia, 1971–1983 235

Table 5 Number of Residential Care Beds by Ownership Type and by Jurisdiction, 1984–2010 252

LIST OF FIGURES

Figure 1 “Stringent Regulations as to Private Hospitals – Burden of Proof”, *Victoria Daily Times*, 1913 190

TABLE OF CONTENTS

Abstract ii
Acknowledgements iii
List of Abbreviations iv
List of Tables v
List of Figures vi

Chapter 1: Introduction 1

1.1 Presenting the Case Study: Ontario and British Columbia 1
1.2 Long-Term Care, Alternative Service Delivery, and the Significance of the Ownership-Mix in Canada's Liberal Welfare Regime 5
1.3 The Limitations of Prevailing Explanations and the Case for Historical Institutionalism 10
1.4 The Explanatory Power of Ideas as Independent Causal Forces 18
1.5 Bureaucratic Rationality as a Meso-Level Institutional Filter 19
1.6 Methodological Framework 22
1.7 The Central Argument 22
1.8 Empirical and Theoretical Contributions 24
1.9 Chapter Roadmap 26

Chapter 2: Literature Review 28

2.1 Introduction 28
2.2 Long-Term Care (LTC): A Weak Social Right 29
2.3 The Provision of LTC Across Welfare Regimes: Esping-Andersen's Contribution 36
2.4 Canada's Liberal Welfare Regime and the Long-Term Care Sector 39
2.5 Examining the Implications of Alternative Service Delivery Mechanisms in Canada's Public LTC System 45
2.6 Conclusion 49

Chapter 3: Theoretical and Methodological Framework 51

3.1 Theoretical Framework: Introduction 51
3.1.1 Historical Institutionalism 61
3.1.2 Ideas and Policy Change 68
3.1.3 The Modern Bureaucracy and Bureaucratic Rationality 70

3.1.3.1 The Modern Bureaucracy 70
3.1.3.2 Bureaucratic Rationality 71
3.1.3.3 The Logic of Instrumental-Formal Rationality 71
3.1.3.4 The Logic of Substantive Rationality 73
3.1.3.5 The Scholarly Divide 76
3.1.3.6 Identifying the Two Rationalities: Indicators of Discourse and Agency, and the Inference of Principles 78
3.2 Methodological Framework 82
3.2.1 Methodological Framework: Introduction 82
3.2.2 Method of Inference: Process Tracing 82
3.2.3 Case Selection 84
3.2.4 Method of Observation 87
3.3 Conclusion 89

Chapter 4: Municipal Governance, Provincial Reluctance, and the Entrenchment of For-Profit Nursing Homes in Ontario, 1940s–1960s **91**

4.1 Introduction 91
4.2 The For-Profit Path: The Emergence and Failure of Ontario's Municipally Organized Nursing Home Programme, 1940s–1950s 93
4.3 Provincial Intervention Without Provincial Responsibility: The 1958 Municipal Bylaw Scheme 105
4.4 Ontario's 1959 Temporarily Approved Nursing Homes for Chronic Care Programme 118
4.5 The Non-Profit Path Abandoned: Ontario's Homes for the Aged Programme, 1947–1972 124
4.6 Conclusion 134

Chapter 5: Ontario's Nursing Home Policy From the Late 1960s to the Early 1970s **136**

5.1 Introduction 136
5.2 The 1966 Nursing Homes Act and the Rise of For-Profit Chains 137
5.3 Ontario's Policy on Nursing Home Chains in the Early 1970s 147
5.4 Ontario's Policy on the Number of Nursing Home Beds and Its Impacts on the Public Nursing Home System 151
5.5 The 1972 Universal Nursing Home Program and the Ownership-Mix Question 165
5.6 Cost-Minimization as the Operative End of Policy 180
5.7 Conclusion 186

Chapter 6: Stringent Regulations and Strict Controls: The Emergence and Evolution of British Columbia's Nursing Home Regulations, 1913–1960s **189**
6.1 Introduction 189
6.2 Provincial Regulations in 1913 190
6.3 Conclusion 199

Chapter 7: From Regulation to Transformation: British Columbia's Shift to a Non-Profit Nursing Home System **201**

7.1 Introduction 201
7.2 The Emergence of Universal Extended Care Hospitals (Non-Profit Nursing Homes) in British Columbia 202
7.3 The Implementation of British Columbia's Universal Non-Profit Intermediate Care Nursing Home Program 218
7.4 Conclusion 237

Chapter 8: Application and Analysis: Ideas, Bureaucratic Rationality, and Institutions in Ontario and British Columbia **240**

8.1 Introduction 240
8.2 Windows of Opportunity, Political Authority and Will, and the Strategy of Layering 242
8.3 Application and Analysis—Ontario and BC: Causal Beliefs and Principled Ideas 245
8.3.1 The Role of Causal Beliefs in Ontario 245
8.3.2 The Role of Principled Ideas in BC 246
8.4 Application and Analysis—Ontario and BC: Ideas and Bureaucratic Rationality 248
8.4.1 Ontario's Instrumental-Formal Rationality 248
8.4.2 BC's Substantive Bureaucratic Rationality 256
8.5 Conclusion 261

Chapter 9: Conclusion **266**

9.1 Restating the Puzzle and the Central Argument 266
9.2 Summary of Empirical Findings 268
9.3 Contributions and Avenues of Future Research 271
9.4 Limitations 277
9.5 Conclusion 277

Bibliography **279**

Scholarly References 279
Policy and Institutional Reports 312
Government & Stakeholder Reports and Publications 314
Ontario Government & Stakeholder Reports and Publications 314
Ontario Legislative Records 315
British Columbia Government & Stakeholder Reports and Publications 315
Government of Québec 317
Government of Manitoba 317
Federal Government Reports 317
Archival Sources 319
Archival Sources, Ontario 319
Archival Sources, British Columbia 325
News and Magazine Articles 340
Ontario 340
British Columbia 344
Other Papers 346

Chapter 1: Introduction

1.1 Presenting the Case Study: Ontario and British Columbia

As two of Canada's wealthiest, most populous, and most developed provinces, Ontario and British Columbia embarked on modernizing their public nursing home systems from strikingly similar positions during the critical period of welfare state modernization examined in this dissertation, a period spanning from the 1940s to the 1970s. Both provinces operated under liberal welfare state regimes, featured nursing home sectors dominated by for-profit ownership, shared developmental conditions marked by urbanization and high per capita incomes, and possessed political contexts shaped by long-running conservative majorities (McInnis, 1966, 587; Acker, 1956, 367–368; Shoyama, 1966, 504; Green, 1971, 242–243; Johnson, 1973, 13). Each province also faced the same succession of federal funding initiatives constituting the windows of opportunity through which provincial nursing home policy was formulated. Crucially, both provinces also shared the same overarching political objective during this period: to address a growing shortage of public nursing home beds by establishing a modernized public nursing home system (Struthers, 1997; B.C. Department of Health and Welfare, 1954, 12/132). This objective was common to provincial governments across Canada during the postwar era, when a confluence of factors, including medical advances enabling longer life, the decline of family-based care provision as women's labour force participation increased, and generous federal cost-sharing programs, created both the need and the fiscal conditions for nursing home modernization (Guest, 1997; Sawyer & Stephenson, 2002; Forbes, Jackson, & Kraus, 1987). Yet, despite these commonalities, Ontario and British Columbia arrived at starkly divergent outcomes for the reform of their public nursing home ownership-mix. Ontario adopted a for-profit trajectory, initially buttressed by a provincially funded non-profit and municipally owned Homes for the Aged sector

that it later placed under a moratorium in order to sustain the rapid expansion of for-profit providers, whereas British Columbia staked a predominantly non-profit path through placing a moratorium on for-profit providers and adopting policies actively supporting non-profit development. Prevailing explanations of the welfare state, including partisan ideology (Castles, 1982; Huber & Stephens, 2001), neo-pluralism (McFarland, 2004; Johnson, 1999), public opinion (Burstein, 2003; Soroka & Wlezien, 2010), and power resources (Haddow, 2014; O'Connor & Olsen, 1998), fail to account for this divergence by failing to correctly predict the outcome in at least one, if not both, provinces. This points to an overlooked causal variable operating beneath the macro-level conditions these frameworks treat as fundamental. In addition, prevailing accounts in scholarship have attributed the prominent periods of reform in each province's nursing home ownership-mix to more recent periods, often relying on prevailing paradigms and party ideology to make their case. In Ontario, such studies have tended to link the province's for-profit dominance either to the austerity politics of the late 1960s, which paired policy centralization with decentralized delivery mechanisms as precursors to New Public Management (Evans & Fanelli, 2018, 131; Mishra, Laws, & Harding, 1988, 12, 123, 125), or to the ideological agenda of the Harris Conservatives in the 1990s (Evans, 2008, 151–152; Laws, 1987, 73, 168–170). Yet, as the empirical evidence in this dissertation demonstrates, Ontario was actively advancing a low-cost public nursing home system marked by weak care standards and reliance on for-profit providers decades earlier, long before neoliberalism or austerity existed as explicit political agendas. In British Columbia, scholarship has emphasized the onset of neoliberalisation in 1983 under the Bennett restraint program as the critical juncture for the province's social policy and ownership-mix, characterized by a shift toward private provision (Rekart, 1993, xi, 4, 32, 144; Prince, 1996, 254; Fuller, 2001, 287; Stinson, Pollak, & Cohen, 2005, 10–11). This emphasis gives insufficient

weight to the long and important history of state-voluntary sector relations in British Columbia prior to this period (Rekart, 1993, 4, 32, 144), and in particular to the finding of this dissertation that British Columbia's foundational commitment to a high-quality, non-profit nursing home ownership model was established decades earlier under Premier W.A.C. Bennett's ostensibly right-wing, free-enterprise Social Credit government (see also Meggs & Mickleburgh, 2015, 193).

When these two empirical realities are observed side by side, the explanatory shortcomings of both the prevailing theoretical frameworks and prevailing accounts become evident. If Ontario was operating on a cost-minimizing, pro-market footing long before the advent of neoliberal political paradigms, and British Columbia established a high-quality non-profit dominated public nursing home system under a conservative free-enterprise government, then neither the late-twentieth-century paradigmatic shifts relied upon by prevailing accounts, nor the partisan ideologies privileged by prevailing theoretical frameworks can adequately explain the divergence.

To resolve this puzzle, this dissertation employs historical institutionalism and process-tracing to problematize the role played by an actor often sidelined from the welfare-state literature, namely the bureaucracy. Drawing on extensive archival evidence, it argues that the divergent paths were driven by the interaction of ideas advanced by state actors with distinct bureaucratic rationalities filtering those ideas in each province.

In Ontario, the shared objective of addressing the nursing home bed shortage, filtered through what is understood here as instrumental-formal rationality, rested on the causal belief that outsourcing to for-profit providers governed through measurable physical standards and minimal care oversight would minimize regulatory, capital and operational costs, a belief diligently implemented by hierarchically bound officials, ultimately culminating in the establishment of a public nursing home system dominated by for-profit providers.

In British Columbia, by contrast, principled ideas rooted in a high philosophy of care, carried by a substantively rational bureaucracy which I conceptualize as a caring bureaucracy characterized by persistent advocacy, moral framing of policy failures, and resistance to cost-driven pressures, conditioned how the same objective was interpreted, with officials concluding that a non-profit ownership model was the only strategy capable of realizing their principled commitment, ultimately culminating in the establishment of a public nursing home system dominated by non-profit providers.

By isolating these causal mechanisms of ideational and bureaucratic rationality, this dissertation makes several empirical and theoretical contributions. Theoretically, it contributes to social policy and welfare-state scholarship by showing how bureaucratic rationality operates as a meso-level filter that mediates the causal force of micro-level ideational variables, and, in doing so, contributes to public administration by providing one of the only empirical demonstrations of how substantive rationality, operating through a caring bureaucracy, shapes the operation of a bureaucracy and the substance of its policy-making. By doing so, it also revalorises the state as a relatively autonomous site of policy formation. Methodologically, it reasserts the value of subnational comparison for uncovering causal mechanisms that national-level analyses within comparative politics tend to obscure (Snyder, 2001, 93–94, 103–104; Giraudy, Moncada, & Snyder, 2019, 5–6; Wallner, 2010; Wallner et al., 2020, 249, 265; Falleti, 2010, 20–21; Banting, 2005, 89–90, 115–116). Empirically, it corrects the historical timeline of Canadian long-term care, demonstrating that the institutional bases of each province's nursing home ownership-mix were entrenched decades earlier than prevailing scholarship indicates.

Finally, it contributes to the question of the ownership-mix in welfare-state and non-profit theory, a question both frameworks have tended to neglect, with welfare-state theory failing to

treat the ownership-mix as a distinct outcome to be explained in its own right and having often left it undifferentiated by conflating ownership types, and non-profit theory, while cognizant of the distinct consequences of ownership type in the welfare state, having theorized it only as a matter of institutional choice based on service type rather than as a process unfolding in the welfare state itself. By tracing how divergent ownership-mix trajectories take shape and become locked in, the dissertation offers one account of how such outcomes emerge and culminate in a path-dependent dynamic with profound implications for care quality and regulatory governance, implications the next chapter situates within the scholarly literature on long-term care and Canada's liberal welfare regime.

1.2 Long-Term Care, Alternative Service Delivery, and the Significance of the Ownership-Mix in Canada's Liberal Welfare Regime

In this study, nursing home care, also referred to as extended care and intermediate care, is the level of institutional care provided to those who are semi- or non-ambulatory and require regular nursing supervision. The boundaries or specifications that define nursing home care tend to be fluid, varying across and within jurisdictions, this being an outcome of the field's weak institutionalization and integration, as the literature review in Chapter 2 outlines in greater detail. As a sub-field of the long-term care (LTC) sector, nursing home care shares the same systemic weaknesses that have historically characterized LTC as a policy field, namely its weak institutionalization and poor integration, weaknesses that have left the field to a preponderance of private providers—a development that renders the ownership-mix among for-profit, non-profit, and publicly owned provision particularly consequential in a weakly institutionalized field such as LTC. These weaknesses come to take on an even greater salience in the nursing home field than in other LTC sub-sectors, owing to the high operating and capital costs that characterize this sub-sector (GR-0679, 1960, 12/27; GR-678, 1963, 14–15/25; GR-0419, 1967, 85–86/231; McFarland,

1948, 67–83, 110–137; Davies, 2003, 54–85), costs that have made governments and non-profits especially reluctant to enter and have left the field more heavily reliant still on for-profit operators able to enter and persist by skirting regulations and operating with minimal accountability (GR-0679, 1956, 23/34; GR-678, 1971, 5/10; GR-678, 1963, 14–15/25; Davies, 2003, 55–56, 63, 65, 70–71, 77–78, 84, 162–166; McFarland, 1948, 14–15, 53–55, 56–57, 117–124, 132–134; Morison, 1966, 6/12; Government of Québec, 1970, 17/31). For this reason, while this dissertation focuses specifically on nursing home care, the literature review surveys LTC as a whole, since these weaknesses underlie the ownership-mix question across the sector and are therefore best established at the field level, even as they give rise to an acute ownership-mix problem most sharply in the nursing home sub-sector, for the reasons just described.

In Canada, the welfare state is typically organized on the basis of public financing and delivery through private non-profit and for-profit providers. This reliance on a mixed economy of mostly private providers is a natural feature of Canada's liberal welfare regime, which aims to minimize the state's administrative and fiscal footprint, an arrangement that takes on heightened significance in the LTC field, given the sector's weak institutionalization and poor integration, to which the discussion now turns.

Weak institutionalization refers to the state's failure to assume clear, centralized responsibility for comprehensive, universal programs underpinned by secure and comprehensive funding, standardized rules, and professional delivery, a failure rooted in the patriarchal assignment of care to the family and the inherent difficulty of formalizing and measuring relational care, conditions that together prevented the emergence of the kind of robust public infrastructure that characterizes more strongly institutionalized policy fields such as health care, and that left the field to a greater preponderance of private actors (Pavolini & Ranci, 2013, 7; Ranci, 2002, 30;

Armstrong & Armstrong, 2019, 25; Österle, 2024, 193). Poor integration reflects the related absence of coordinated stakeholders with the capacity to advance coherent policy or defend the interests of care recipients (Estévez-Abe, 2025, 535–536), a vacuum that stands in sharp contrast to primary healthcare, where a powerful physician class has historically served as an institutional anchor capable of shaping policy in a coherent and institutionally sustained fashion (Tuohy, 1999, 10, 16–17; Tuohy, 2020; Baranek, Deber, & Williams, 2004, 4; Peters, 2001, 59, 196). Together, these conditions produce two reinforcing consequences. First, they result in weak oversight, given that no societal actor comparable to the physician class in healthcare has emerged to anchor the field, develop standards, or hold governments accountable (Ranci & Pavolini, 2015, 284; Tuohy, 2020; Baranek, Deber, & Williams, 2004, 24; Marier, 2021, 178). Second, they leave governments largely free to shape the ownership-mix and governance of the sector according to their own priorities, unconstrained by the kind of countervailing pressure that characterizes more strongly institutionalized policy fields like healthcare (Tuohy, 2020; Baranek, Deber, & Williams, 2004, 21, 24).

This combination of weak oversight and largely unchecked governmental discretion assumes an even greater salience in the nursing home sub-sector, where the high capital and operating costs of delivering nursing home care have produced a reluctance among governments and non-profits alike to enter the field. Non-profits have shied away even when government support was available, unless they were assured that funding levels would be sufficient to sustain an adequate level of care[1] (GR-0679, 1956, 23/34; GR-678, 1971, 5/10; GR-678, 1963, 14–15/25;

[1] Some non-profit groups, particularly religious orders such as the Sisters of Saint Ann in BC did enter the nursing home sector when sufficient government funding was available, viewing such work as part of their religious or charitable mission. However, as Davies (2003) documents, even these groups generally preferred to establish facilities for ambulatory rather than bed-care patients, given the higher capital and operating costs associated with the latter (Davies, 2003, 72–74, 78–79).

Davies, 2003, 55–56, 63, 65, 70–71, 77–78, 84, 162–166; McFarland, 1948, 14–15, 53–55, 56–57, 117–124, 132–134). This reluctance has in turn left the field open to for-profit operators, who, driven by the profit incentive inherent to this ownership type, enter and persist by taking advantage of the difficulty of formalizing and monitoring nursing home care to skirt regulations, exploit regulatory gaps, and operate with minimal accountability, maximizing profits at the expense of care quality, a pattern that results in lower staffing, poorer quality, and significantly more regulatory violations compared to non-profit and publicly owned provision (Ranci, 2002, 30; Armstrong & Armstrong, 2019, 25; Greve, 2018, 500; Pavolini & Ranci, 2013, 7; Comondore et al., 2009; Berta et al., 2006; Harrington, 2013; Harrington & Jacobsen, 2019; Harrington et al., 2020; Greb et al., 1994, 292–293; Patterson et al., 2023; Morison, 1966, 6/12; Government of Québec, 1970, 17/31; Davies, 2003, 70–71).

Transaction cost theory provides a systematic account of these behavioural differences, arguing that while for-profit providers are contracted on the basis of efficiency, government contracting with for-profit firms is viable only when services are simple, standardized, and easily monitored, since the structural incentive to maximize shareholder returns can otherwise lead operators to exploit the measurement difficulties inherent in complex care services, a problem that also results in high regulatory costs for governments (Prentice & Brudney, 2015, 88; Rademacher, 2011, 18–19). In the case of a complex service such as nursing home care, which is inherently difficult to measure and monitor, the labour-intensive character of the work further raises operating costs, heightening the pressure on for-profit providers to protect their profit margins—a pressure the profit-maximization incentive of this ownership type, presumed to generate efficiency, transforms into a drive to minimize staffing or avoid high-need residents (Brennan et al., 2012,

380, 386; Gilbert, 2002, 121–122; Tronto, 2019, 52), and one rendered particularly acute under government-subsidized rates, as the empirical evidence of this dissertation confirms.

In contrast, public and non-profit providers, constrained by the non-distribution principle and guided by mission-driven commitments, tend to deliver more reliable care even with less intensive government oversight, a phenomenon confirmed both in the scholarship (Prentice & Brudney, 2015, 80–81) and by the empirical evidence examined in this dissertation, where officials and reports identified for-profit facilities as generating higher regulatory costs and requiring more intensive and sustained oversight than non-profits due to their tendency to resist and skirt regulations (Struthers, 1997, 178; GR-2688, 1980, 138/139; B.C. Provincial Board of Health, 1915a, L8; The Globe and Mail, 1971; Ministry of Health, 1989, 89–99; Ontario Cabinet Office, 1991, 82–83/138).

The vulnerability posed by for-profit provision is compounded in liberal welfare regimes such as Canada, where the state's orientation toward minimizing its fiscal and administrative footprint leads to limited public investment, a preference for private providers, and a regulatory approach that privileges physical standards over care standards, making it easier for for-profit operators to enter and persist without needing to meet robust care requirements (Brennan et al., 2012, 380, 386–387; Gingrich, 2011, 180, 182–183; Pavolini & Ranci, 2013, 7). This is reflected in the study's own evidence, where officials in both provinces consistently identified for-profit nursing homes as sources of high regulatory costs and poor quality, with Ontario bureaucrats, operating under a regulatory regime characteristic of the liberal welfare-regime type, noting that effective oversight would require "a large staff and continual policing" (Struthers, 1997, 178), while in British Columbia, where the bureaucracy maintained stronger oversight over care quality, officials still

warned that "without an army of inspectors", for-profit operators could "easily ignore any attempts to raise standards" (GR-2688, 1980, 138/139).

Given the consequential nature of the ownership-mix for both care quality and regulatory governance in the nursing home field, the question of why Ontario and British Columbia adopted opposing ownership models becomes all the more pressing. Two provinces operating under the same liberal welfare regime, facing the same sequence of federal funding initiatives, and governed by ideologically comparable parties nevertheless arrived at starkly divergent ownership-mix outcomes—a puzzle that prevailing welfare state theories, as the following section demonstrates, are unable to resolve.

1.3 The Limitations of Prevailing Explanations and the Case for Historical Institutionalism

Prevailing welfare state accounts struggle to account for the divergence in outcome between BC and Ontario, with many generating hypotheses predicting the opposite pattern of policy development in at least one of the two provinces. This points to an overlooked causal variable operating beneath the shared structural conditions these frameworks treat as fundamental.

Explanations based on partisan ideology tend to predict that divergences in welfare state trajectories are driven by the ideological orientation of the governing party. While present-day scholarship, especially the "new politics of the welfare state" literature (Pierson, 1994), argues that the expected impact and direction of partisan differences have shifted in an age of permanent austerity and welfare retrenchment, the literature establishes that during the postwar era of welfare state expansion, the ideology of the governing party was a significant determinant of welfare state outcomes. According to this literature, parties of the Right held back welfare state expansion, whereas social democratic parties expanded the welfare state through the establishment of more comprehensive programs (Castles, 1982, 57–58, 71, 75–76; Huber & Stephens, 2001, 1–3, 17–

20). Applied to this study, this framework would predict that both provinces, governed by long-running, free-enterprise oriented conservative governments for nearly the entire formative period of welfare-state modernization, would converge on a similar path of reform. British Columbia was governed by Social Credit majorities for almost the entire period from 1952 to 1985, while Ontario was governed continuously by a Progressive Conservative party that maintained a majority for most of the period from 1943 to 1985. Given these partisan alignments, one would expect both provinces to tilt toward market mechanisms and minimal state intervention—a path that would entail the implementation of market-oriented policies that would facilitate the expansion of a for-profit ownership-mix. Yet the outcomes failed to converge. Ontario followed the predicted for-profit path, while British Columbia pursued a non-profit trajectory, rendering partisan ideology alone insufficient to explain the divergence.

Neo-pluralist accounts, which treat policy outcomes as a reflection of competition between interest groups (McFarland, 2004; Johnson, 1999), fare no better. According to these accounts, policy trajectories are structured by competition among organized interest groups, with outcomes reflecting the relative mobilization and strength of stakeholders in the policy arena (McFarland, 2004; Johnson, 1999, 34). Applied to this study, neo-pluralism would predict that Ontario, where a non-profit "Homes for the Aged" lobby emerged in 1919, decades before a for-profit lobby even formed in 1959 (OANHSS, 1991, 3/27), should have pursued a non-profit path, whereas BC, where a for-profit lobby emerged in 1957 (GR-0119, 1957, 46–48/82) while a non-profit lobby did not emerge until after the critical juncture of welfare state modernization (GR-2678, 1976, 71/84), should have pursued a for-profit path. Yet the very opposite outcome occurred, with Ontario pursuing a for-profit path and BC pursuing a non-profit path. What neo-pluralist frameworks fail to recognize is that the relative strength of these societal groups was prefigured by the state itself:

Ontario's regulatory structure enabled a powerful lobby to emerge from an expansive for-profit sector, while BC's regulatory structure severely constrained the growth of its for-profit sector, thereby preventing its lobby from ever transforming into a formidable political actor (The Province, 1959a; GR-0119, 1957, 46–48/82; The Vancouver Sun, 1959c).

Explanations centred on public opinion also fail to offer an adequate account of this divergence. The prevailing literature holds that sustained and salient public preferences tend to generate pressure for corrective policy reform, though the strength of this relationship is conditioned by institutional structure, issue salience, and the capacity of the political system to translate opinion into policy (Burstein, 2003; Soroka & Wlezien, 2010). These conditions were met in both provinces, with provincial governments being the dominant policy actor in this area, authority concentrated in the provincial executive, and while public opinion was against for-profits in both, it was even more salient and sustained in Ontario, owing to the province's regulatory structure underlying its bureaucracy that led to exceptionally poor quality care by for-profits (Greb et al., 1994, 292), whereas in BC it was less pronounced, reflecting the better quality of care produced by the persistent advocacy of a substantive provincial bureaucracy (GR-0119, 1958, 9–11; GR-0119, 1958, 12–14; GR-0119, 1958, 82/82; The Province, 1956; 1957; 1958; 1958a; 1959). Under such conditions, one would have expected policy reform to align with public opinion in both provinces, though even more so in Ontario. Yet, despite negative public opinion towards for-profits being especially salient in Ontario, the province maintained and accelerated its pursuit of a for-profit ownership-mix, whereas BC, where public criticism of for-profits was comparatively less pronounced, adopted a non-profit ownership-mix.

Most significantly, Ontario has long favoured a strictly cost-driven approach to long-term care, yet much of the welfare state retrenchment literature links this tendency to more recent

events, such as the emergence of austerity in the late 1960s or to explanations centred on individual leadership, like the ideological agenda of Mike Harris (e.g., Evans, 2008, 151–152; Laws, 1987, 73, 168–170; 1988; 1989; Rea, 1985, 238; Mishra, Laws, & Harding, 1988, 12, 123, 125; Roberts, 1994, 108–109; Evans & Fanelli, 2018, 131; Gabel, Clemens, & LeRoy, 2004, 35). However, there was no explicit austerity agenda or ideological figures like Mike Harris in power during the critical period of public nursing home expansion and modernization under examination here. Nevertheless, from 1948 to 1972, Ontario adopted a strictly cost-driven model that enabled the rapid growth of for-profit providers in its public nursing home system. Similarly, much of the BC scholarship attributes the critical juncture of the province's nursing home ownership-mix to the 1980s, citing macro-level factors such as party ideology and neoliberalism as the main drivers (Rekart, 1993, xi, 4, 32, 144; Prince, 1996, 254; Fuller, 2001, 287; Stinson, Pollak, & Cohen, 2005, 10–11). Yet, as demonstrated in this dissertation, BC's commitment to a non-profit ownership model was established decades earlier under a conservative free-enterprise government (see also Meggs & Mickleburgh, 2015, 193).

Power resources theory holds limited relevance for the Canadian context, where federalism fragments class-based political influence while reinforcing regional, religious, and linguistic identities (Orloff, 1993, 54–55; Haddow, 1993, 11–19; Jenson, 1990). While labour and leftist parties have had a greater impact on the Canadian welfare state than their counterparts in other liberal regimes, thanks in part to the existence of leftist parties as third parties at the federal and provincial levels, as Chapter 2 demonstrates, their influence has not been as structurally embedded as in the social democratic contexts where the theory's predictions hold most strongly, and in the case of the long-term care sector specifically, organized labour did not become a significant

political force until the early 1970s, well after the formative policy decisions examined in this dissertation had been made (Canadian Union of Public Employees, 1984; Angel, 1985, ii, 25).

A further dimension of the puzzle that prevailing explanations cannot account for comes from the pre-existing institutional arrangements in each province. Prior to the establishment of their modern welfare states, Ontario possessed a significantly larger non-profit rest home sector compared to BC, where such institutions were historically few in number (GR-3975, 1984, 16/49; Davies, 2003, 66; Canada Dominion Bureau of Statistics, 1931, 21–22). Even during the establishment of their modern welfare states, Ontario initially leapfrogged ahead of BC by building over 11,000 non-profit nursing home and residential care beds in its Homes for the Aged program from the end of the 1940s to the early 1960s (Department of Social and Family Services, 1972, 13–14/16), while BC did not begin investing in the establishment of non-profit nursing homes until the mid-1960s. Path dependence would therefore predict that Ontario, having developed a substantial non-profit and municipal Homes for the Aged sector alongside its for-profit dominated nursing home sector early in the formative period, would be more likely to consolidate a non-profit trajectory, while BC, lacking such a base, would face greater difficulty doing so. Yet the opposite occurred. BC transitioned to a non-profit ownership model while Ontario abandoned its non-profit sector in favour of for-profit expansion, an outcome that points to the operation of factors capable of overriding pre-existing institutional arrangements.

Given the inability of explanations centred on societal actors, including neo-pluralist, public opinion, and power resources accounts, to explain the divergent outcome, the analysis turns to considering state-centred and ideational approaches, which may offer partial relevance insofar as they identify ideas as possessing independent causal power and problematize the state as a partially autonomous policy actor whose bureaucrats shape policy through their own expertise and

assessments rather than merely responding to societal pressures (Campbell, 2002, 21; Chou, 2014, 29–30; Heclo, 1974; Peters, 2001, 223). However, this requires further qualification, since not all state-centred explanations can account for the divergent outcome observed here.

In particular, state capacity frameworks fail to offer an explanation, given that both provinces possessed a comparable state capacity. While BC's provincial government assumed direct responsibility for social services earlier than Ontario's, where municipal development preceded provincial development and the provincial government avoided direct engagement with the for-profit dominated nursing home sector for decades, limiting its early intervention to the Homes for the Aged program (Crawford, 1954; Cassidy, 1945, 41–42; Davies, 2002, 59; B.C. Newspaper Archives, 1897, 15/136; Brady, 1947, 278; Social Welfare Branch of the Department of Health and Welfare, 1948, P 8), this difference reflects the timing of provincial engagement and BC's comparatively greater degree of centralization rather than a differential in governing capacity, since Ontario's provincial state had ample capacity to restructure the nursing home sector both prior to the 1960s, when it chose not to directly intervene in the for-profit dominated portion of the field, and once it chose to directly intervene between the late 1960s and 1970s, it simply exercised that capacity in a market-oriented direction. Nor does the Heclo (1974) and Skocpol (Skocpol & Amenta, 1986; Evans, Rueschemeyer, & Skocpol, 1985) hypothesis, a specific variant of the state capacity thesis, that bureaucratic autonomy is greatest where bureaucracies were established before full democratization differentiate the two provinces, since there are no marked differences between the provinces in terms of the sequence of their bureaucratization and democratization (Crawford, 1954; Hodgetts, 1995).

Hence, since both provinces possessed comparable state capacity, the source of the divergence may reside not in the capacity of the state but in the ideas that state actors advanced

and the institutional rationality of the bureaucracy through which those ideas were filtered and acted upon. In this respect, as stated above, ideational and state-centred approaches may offer partial relevance, insofar as they identify ideas as possessing independent causal power and problematize the state as a partially autonomous policy actor (Campbell, 2002, 21; Chou, 2014, 29–30), thus making it possible to attribute the adoption of divergent policy paths in each province to the selection of different ideas by state actors. However, what they cannot do is explain why opposing ideas came to prevail in two provinces within the same federation, each governed by ideologically similar parties during an era of welfare state expansion.

The analysis therefore necessitates a framework that can explain how variations in ideas and bureaucratic orientations, under shared macro-level conditions, interact over time to produce divergent institutional trajectories. Historical institutionalism (HI) is aptly suited for this task, given its capacity to theorize how variations in micro-level factors, such as actors' distinct ideas and decisions, interact with mid-level institutional conditions, including distinct bureaucratic rationalities, and become amplified through windows of opportunity and entrenched through path-dependent processes, culminating in starkly divergent policy outcomes (Pierson, 1995; 1996, 153, 175; Béland & Waddan, 2012; Hall & Taylor, 1996; Roux, 2018, 299–300; Lecours, 2005; Tuohy, 1999, 112–113). As Bryant (2016) observes, HI functions as "a middle-level theory about the evolution of health systems" in which "ideas and knowledge are seen as driving policy responses" rather than structural conditions alone (78). However, HI lacks an account of the precise mechanism by which a window of opportunity is translated into policy (Tuohy, 2018b, 6; Smyrl & Genieys, 2016, 7–8; Steinmo, 2008, 129). To address this gap, this dissertation draws on Tuohy's refinement of HI, which demonstrates that the potential for reform to proceed from a window of opportunity depends on whether governing actors possess the political authority and political will

to overcome vetoes and push for reform (Tuohy, 1999, 6, 12). Both provinces satisfied these conditions.

Tuohy then specifies that the magnitude and direction of change that follow from a window of opportunity depends on the internal logic of a policy sector as resting on the configuration of actors and institutional instruments that structure how actors respond to opportunities (Tuohy, 1999, 7–8, 11–12). In Canadian long-term care, state hierarchy constitutes the dominant structural force within the internal logic of the public nursing home system, endowing provincial governments with exceptional decision-making authority and shaping the direction of change (Tuohy, 2020; Marier, 2021, 161; Baranek, Deber, & Williams, 2004, 21, 24). However, while Tuohy's (1999) account largely succeeds in demonstrating the mechanism through which change occurs following the emergence of a window of opportunity, including how to account for the magnitude and direction of change, it falls short in explaining why a particular instrument is selected to impart a specific direction of change in the first place. Tuohy would attribute this selection to the broader agenda of the governing party, arguing that the policy idea chosen from available alternatives is chosen based on its fit with that agenda (Tuohy, 1999, 13). Yet in the units under study here, both governments shared broadly similar agendas based on a commitment to free enterprise and welfare-state expansion, thereby rendering Tuohy's framework inadequate for explaining the divergence under investigation. This shortcoming stems from Tuohy's insufficient attention to the role that bureaucrats and actors other than parties play in the policy process, and from the way her framework, when applied, removes the autonomous role ideas play in that process by reducing them to the governing party's broader agenda, despite her own epistemological premise that ideas carry an independent causal force (Tuohy, 1999, 12). This dissertation addresses these gaps by problematizing ideas as causal forces independent of material

and power interests and by problematizing the distinct bureaucratic rationalities through which ideas were filtered, selected, and either persistently advanced or accepted without sustained resistance when overruled by hierarchical superiors. Hence, this dissertation does not reject Tuohy's framework but extends its explanatory scope by specifying the mechanism through which state hierarchical authority, the dominant structural force within the internal logic of Canada's public nursing home system, is exercised in opposing directions according to the distinct beliefs advanced by bureaucrats and the distinct bureaucratic rationalities through which those beliefs are filtered.

1.4 The Explanatory Power of Ideas as Independent Causal Forces

To address the first of these gaps, namely the inability of Tuohy's framework to explain why distinct policy options come to be preferred by state actors in provinces with broadly similar governmental agendas, this dissertation turns to ideational theory. Ideas are not mere derivatives of political agendas or reflections of material interests but independent variables that define "the universe of possibilities for action" (Goldstein & Keohane, 1993, 8). The divergent ownership-mix outcomes observed in Ontario and British Columbia were fundamentally shaped by the distinct ideas that bureaucrats carried into successive windows of opportunity (Campbell, 2002, 21; Chou, 2014, 29–30; Kingdon, 2013, 125).

As Chapter 3 develops in detail, the ideational scholarship distinguishes principled beliefs, understood as value-based or normative ideas that define which policy ends are legitimate, from causal beliefs, understood as cognitive ideas expressing cause-and-effect relationships that serve as strategies for achieving specific objectives (Goldstein & Keohane, 1993, 9–10; Blyth, 1997, 240). Due to their normative orientation, principled beliefs possess a resilience that makes them especially consequential in social policy domains, which tend to raise fundamental debates about

goals that are vulnerable to attacks on the legitimacy of state action (Sikkink, 1997, 229; White et al., 2015, 403).

In Ontario, the policy process was shaped by causal beliefs that prevailed when the shared political objective of a modernized public nursing home system was filtered through instrumental-formal rationality, with officials reducing the governance of nursing home provision to its most easily measurable and least costly dimension, i.e., physical infrastructure standards, while implementing only minimal care standards coupled with weak oversight over care quality, with no principled beliefs operating to constrain the range of such acceptable causal strategies. In British Columbia, by contrast, the principled belief that public nursing home care ought to be grounded in a high philosophy of care constrained the range of acceptable causal strategies by subordinating cost and technical considerations to ethical imperatives, leading bureaucrats to press the government in favour of a non-profit ownership-mix.

1.5 Bureaucratic Rationality as a Meso-Level Institutional Filter

While ideational frameworks demonstrate how different ideational variants can result in the selection of distinct policy options, they remain unable to explain why one ideational variant came to prevail in each province rather than another, since officials in both provinces had access to both principled and causal ideas. Understanding this requires moving from the content of ideas to the distinct forms of bureaucratic rationality under which they were filtered, selected, and either persistently advanced or accepted without sustained resistance when overruled by hierarchical superiors, i.e., from ideational theory to the institutional framework of bureaucratic rationality (Chou, 2014, 34; Schmidt, 2012, 91; Braun, 1999, 22).

Public administration scholarship identifies two modes of rationality that differentiate bureaucracies, namely instrumental-formal and substantive rationality, with each having a

markedly distinct impact on how bureaucracies analyse policy problems, evaluate available options, and develop solutions (Bartels, 2009, 449; Schreurs, 2002, 279; Monteiro & Adler, 2022, 433). Instrumental-formal rationality is means-oriented and indifferent to the substantive merit of overarching ends, assuming that policy goals are received from political superiors and are to be achieved through the most efficient means by applying universal rules and procedures. This constrains bureaucratic agency by leaving little room for discretion or critical deliberation, as the procedural method is presumed to guarantee the optimal outcome, positioning officials as obedient implementers whose role is to carry out political directives without evaluating their human consequences. Hence, while officials may raise objections, the expectation is that they obey the hierarchy if overruled, since the method's objectivity is presumed to guarantee the optimal outcome, with any personal discretion or deviation from the bureaucratic procedure seen as redundant, if not undermining the effective, efficient, and impartial operation of the modern bureaucracy. In contrast, substantive rationality is value-based and end-goal oriented, inviting deliberation about which policy paths best align with normative commitments and empowering bureaucrats as active participants in policy formulation. Unlike their counterparts under instrumental-formal rationality, officials operating under substantive rationality persistently defend principled positions and resist orders from above when those orders conflict with their substantive objectives.

Scholars of public administration diverge over the role each form of rationality should play in a bureaucracy. The critical school, including care ethics scholars, argues that both substantive and instrumental-formal rationality are needed for a bureaucracy to function effectively and efficiently, thereby avoiding entrapment within the iron cage, whereas the classical or mainstream

approach holds that an effective and efficient bureaucracy must be governed by instrumental-formal rationality alone and sees substantive rationality as a threat to its operation.

The empirical evidence of this dissertation lends strong support to the critical school of public administration, having found that when substantive rationality directs instrumental-formal rationality rather than being displaced by it, the result is a substantive orientation in which the procedural rigour and efficiency of the latter are guided by the ethical deliberation of the former. This does not mean that instrumental-formal procedures are abandoned or that fiscal and procedural considerations become irrelevant. On the contrary, the bureaucracy continues to operate within budgetary constraints, to conduct routine inspections, to apply standardized rules, and to pursue cost-effectiveness. What distinguishes this substantive orientation is that these procedural and instrumental means are treated as means in the service of substantive ends, such as a high philosophy of care, rather than as ends in themselves. Consequently, when it comes to evaluating policy choices that result in a tension between human and fiscal costs, the substantive orientation empowers officials to prioritize care first while still operating within procedural and fiscal constraints. This dissertation defines the institutional translation of this substantive orientation as a caring bureaucracy, under which officials persistently advocate for principled positions across successive windows of opportunity, frame policy failures as moral imperatives requiring governmental action, and resist cost-driven pressures even when fiscal considerations become politically important (Frederickson et al., 2011, 3–4; Stivers, 1995, 527–528; Stensöta, 2010).

It is this mid-level institutional filter, namely bureaucratic rationality, that, as Chapters 3 and 8 demonstrate, resolves the central puzzle, explaining how distinct ideas were filtered and carried forward in each province by conditioning how officials interpreted policy problems,

weighed available ideas, and either persistently advocated for those ideas or served as obedient implementers who accepted outcomes consistent with procedural logic.

1.6 Methodological Framework

While HI helps make theoretical sense of the role that micro-level ideational variables and mid-level institutional factors play in shaping these divergent outcomes, process-tracing provides the methodology required to uncover and frame their empirical form.

Process-tracing was selected because the research question is outcome-oriented rather than variable-oriented, requiring a methodology capable of reconstructing the causal process that produced a particular outcome rather than testing the effect of a single independent variable (Blatter & Haverland, 2012, 24, 112; Beach & Rohlfing, 2018, 12). In this light, process-tracing aligns well with the theoretical framework of HI, as it is aptly suited to reconstruct the sequential and temporal dimensions of policy formation by drawing on dense within-case evidence and multiple observations.

This dissertation relies mainly on governmental archival records as the principal source of evidence for the process-tracing approach. The use of these records stems from their confidential and unfiltered character, which provides access to the "confessions" or internal and frank deliberations, assessments, and justifications of officials that are essential for uncovering the causal mechanisms that prevailing accounts have been unable to identify (Blatter & Haverland, 2012, 117–118; Friedrich, 2022, 466).

1.7 The Central Argument

Having established the theoretical and methodological basis for this investigation, I now present my central argument. In both provinces under study, the governing party possessed the political authority and political will required to pursue reform, a condition established by each

party's legislative majority and a political climate that made welfare state expansion an important objective, respectively. In Ontario, the shared political objective of establishing a modernized public nursing home system was filtered through a bureaucracy governed by instrumental-formal rationality, an orientation that treated procedural compliance and cost-minimization as the operative ends of policy, positioning officials as obedient executors procedurally bound to finding the most efficient means for achieving their assigned political directive, leaving them neither inclined nor empowered to entertain substantive alternatives or to weigh the human consequences of the decisions they implemented. The resulting causal belief was that outsourcing to for-profit providers, governed through reliance on measurable physical standards and minimal care monitoring, represented the most cost-efficient strategy for realizing that objective. Consequently, for-profit nursing homes, including for-profit chains, emerged as the products of the causal beliefs advanced through this instrumental-formal rational process. In contrast, in British Columbia, a caring bureaucracy, characterized by substantive rationality, granted officials greater discretion and enabled them to retain sight of their public purpose. Rather than merely executing directives from a pro-free-enterprise political executive, these officials independently formulated and persistently advanced the case for a non-profit ownership model, using principled ideas rooted in a high philosophy of care to push for this alternative across successive windows of opportunity.

These divergent approaches, underpinned by a strategy of institutional layering in each province, created self-reinforcing feedback processes that progressively locked in the initial divergence. In Ontario, weak and minimally enforced care standards enabled the for-profit sector to grow large, politically organized, and increasingly resistant to reform. In British Columbia, stringent regulations from 1913 kept the for-profit sector small and politically weak, making it

increasingly easier for officials to impose restrictions and eventually transition to non-profit dominance.

Hence, while both provinces faced identical windows of opportunity during the critical period of welfare state modernization and both possessed sufficient political authority and political will to pursue reform, each province filtered these federal opportunities through the interaction of distinct ideas advanced by bureaucrats with distinct bureaucratic rationalities. It was this interaction that conditioned how policy problems were interpreted, which policy instruments were selected, and whether bureaucrats were empowered to advocate for particular ownership models or constrained to accept outcomes consistent with procedural logic.

1.8 Empirical and Theoretical Contributions

This dissertation contributes to scholarship in several ways.

First, the dissertation reasserts the scholarly value of subnational comparison for uncovering causal mechanisms that national-level analyses within comparative politics tend to obscure (Snyder, 2001, 93–94, 103–104; Giraudy, Moncada, & Snyder, 2019, 5–6; Wallner, 2010; Wallner et al., 2020, 249, 265; Falleti, 2010, 20–21; Banting, 2005, 89–90, 115–116). It does so by showing that forces operating beneath the national level can play a decisive role in shaping policy outcomes, particularly in federal systems like Canada where subnational governments hold genuine regulatory and jurisdictional authority over major areas of social policy.

Second, by specifying a mechanism through which a window of opportunity is translated into a particular direction of reform, the dissertation addresses a shortcoming in Tuohy's model of policy change, thereby building on her refinement of historical institutionalism and contributing to the undertheorized question of how policy is made following the opening of a window of opportunity. Whereas Tuohy ties the selection among available options to the governing party's

broader agenda and the prevailing paradigm, surrendering, at the point of selection, the autonomous role her own framework grants ideas in defining the menu of options, this dissertation shows that ideas can shape the direction of reform as genuine forces independent of partisan and paradigmatic agendas through their interaction with distinct bureaucratic rationalities. In developing this account, the dissertation also contributes to public administration scholarship by building on Stivers' (1995; 2000) work on care-centred public administration, translating her reconstruction of substantive rationality as a historical alternative to the instrumental-formal model into one of the only empirical demonstrations of how substantive rationality shapes the real-life operation of a bureaucracy at a systemic level, including the substance of its policy-making. Taken together, these contributions revalorise the state as a relatively autonomous site of policy formation whose institutional characteristics have direct causal consequences for welfare state outcomes (Evans, Rueschemeyer, & Skocpol, 1985; Carpenter, 2001), thereby reaffirming the value of state-centred explanation against society-centred accounts of policy change that prevailed across the postwar decades of welfare-state scholarship (Skocpol, 2008; Jessop, 2001).

Third, the dissertation contributes to Canadian long-term care scholarship, a field that continues to suffer from a shortage of comprehensive and comparative studies on this topic (Greb et al., 1994, 280; Havens, 1995, 246) by providing one of the few comprehensive, comparative, archival studies of provincial nursing home policy during the formative period of welfare state modernization. In doing so, it also corrects the historical timeline of the field. Whereas prevailing accounts attribute each province's nursing home ownership-mix to late-twentieth-century developments, including austerity, neoliberalism, or the agendas of particular leaders, this dissertation demonstrates that the institutional bases of Ontario's for-profit dominance and British Columbia's non-profit commitment were laid through competing bureaucratic rationalities and

distinct ideas decades earlier, establishing path-dependent legacies that continue to shape the quality of care received by the most vulnerable members of Canadian society today.

Fourth, by providing one framework that demonstrates how and why divergent welfare-state ownership-mix trajectories take shape, this study addresses shortcomings in both welfare state and non-profit scholarship. Welfare-state explanations have tended to neglect the ownership-mix as a distinct conceptual entity worth examining in its own right, while also conflating ownership types by lumping commercial and voluntary providers together as private provision. Non-profit theory, though cognizant of the distinct consequences of ownership type for state regulations and the quality of welfare state programs, has taken up the contracting relationship mainly as a question of which type of provider a government should choose for a given kind of service, rather than as a process that unfolds within the welfare state over time (Salamon, 1987, 15; Gidron, Salamon, & Kramer, 1992; Rekart, 1993, 147; Panet & Trebilcock, 1998, 22–23).

1.9 Chapter Roadmap

Chapter 2 lays the conceptual basis by situating long-term care as a weak social right within Esping-Andersen's welfare regime framework and examining, through transaction cost theory, the implications this weakness carries for the ownership-mix of long-term care programs, with particular attention to the salience the ownership-mix question attains within Canada's liberal welfare regime (Esping-Andersen, 1990; 1999; Prentice & Brudney, 2015; Salamon, 1987). Chapter 3 connects the theoretical frameworks of historical institutionalism, ideational theory, and bureaucratic rationality while specifying how process-tracing lays the empirical groundwork. Chapters 4 and 5 reconstruct the Ontario case, tracing how instrumental-formal rationality filtered the same federal opportunities through a cost-minimization logic, deploying informal instruments that generated market-based incentives, including relaxed facility-size restrictions and a regulatory

approach privileging physical standards over care quality, that helped facilitate the rapid and unchecked expansion of for-profit chains while advancing policies, including a moratorium, to suppress the non-profit Homes for the Aged program. Chapters 6 and 7 empirically construct the British Columbia case, tracing how BC's caring bureaucracy filtered those same federal opportunities through a principled commitment to a high philosophy of care, deploying anti-market incentives, including stringent care regulations, small facility size restrictions, prohibition of chains, and construction moratoriums on for-profit facilities, while actively promoting non-profit development through successive strategies of institutional layering. Chapter 8 grounds both cases in the theoretical frameworks, making explicit the causal mechanisms and showing how the interaction of distinct principled and causal beliefs, filtered through competing bureaucratic rationalities during identical windows of opportunity, produced the observed divergence in ownership-mix. Chapter 9 concludes by providing a summary analysis of the central argument and findings, outlining the study's theoretical and empirical contributions, and presenting avenues for future research.

Chapter 2: Literature Review

2.1 Introduction

Chapter 1 established that prevailing welfare state explanations cannot account for the divergent ownership-mix outcomes in Ontario and British Columbia's nursing home sector. This chapter situates that empirical puzzle within the broader scholarship on long-term care, establishing why the question of the ownership-mix, which remains undertheorized in welfare state and non-profit scholarship, is particularly consequential in the LTC sector, and why this consequentiality becomes still more acute in Canada's liberal welfare regime. The chapter argues that this significance arises from LTC's weak institutionalization and poor integration as a policy field—conditions that make the ownership-mix a consequential variable by leaving the sector's regulation and provision vulnerable to governmental discretion and to the behaviour of providers, particularly for-profit operators. This vulnerability is heightened still further in the nursing home sub-sector, where the high capital and operating costs of nursing home care make governments and non-profits especially reluctant to enter, leaving the field disproportionately open to for-profit provision. Drawing on Esping-Andersen's welfare regime framework, the chapter demonstrates that while the challenges afflicting LTC persist across all regime types, they prove particularly acute in liberal and conservative regimes. Situating Canada's public long-term care sector within this framework, it shows how the liberal regime's preference for private provision and its orientation toward minimizing administrative and fiscal costs heighten the salience of the ownership-mix question in this regime type, and more acutely still in the nursing home sub-sector, while also identifying the features that distinguish Canada's welfare regime from archetypal liberal regimes such as the United States. These departures, attributable in part to the role of leftist third parties within Canada's federal structure, have tempered but not displaced the liberal regime's

preference for market-based provision and minimal state intervention, a preference that, given LTC's institutional weaknesses, renders the ownership-mix question particularly consequential in the Canadian LTC sector. The chapter then turns to the consequential question of ownership type itself, drawing on transaction cost theory to provide a systematic account of why for-profit provision of complex care services such as nursing home care carries particularly significant implications for regulatory costs and care quality, implications well established in the scholarship and confirmed, as the empirical chapters of this dissertation demonstrate, in both provinces.

Together, this literature demonstrates that LTC's weak institutionalization, Canada's liberal welfare regime, and the structural incentives of for-profit providers make the ownership-mix a consequential policy outcome in Canada. What it cannot do, however, is account for why two provinces governed by conservative, free-enterprise oriented parties, operating under the same welfare regime type, and sharing broadly comparable socioeconomic conditions pursued opposing policy paths on this consequential question. The source of this divergence must therefore reside in variables that operate beneath the shared structural conditions these frameworks treat as fundamental, a gap that Chapter 3 addresses by introducing the theoretical frameworks of historical institutionalism, ideational theory, and bureaucratic rationality.

2.2 Long-Term Care (LTC): A Weak Social Right

Following the European Union, this dissertation defines LTC as "the range of services and assistance for people who, as a result of mental and/or physical frailty and/or disability over an extended period of time, depend on help with daily living activities and/or are in need of some permanent nursing" (European Commission, 2018, 46). This broad conceptual definition is appropriate for the purposes of this chapter, which surveys LTC as a policy field whose

shortcomings give the ownership-mix question salience across the sector as a whole, even as that salience becomes particularly acute in the nursing home sub-sector.

Despite serving society's most vulnerable, public long-term care (LTC) remains a weak social right across many countries, including Canada, underpinned by programs with patchy availability that are rationed based on fiscal capacity rather than need, characterized by poor quality, and delivered under weak and poorly enforced standards by a workforce that is typically underpaid, undertrained, and overworked (Ranci & Pavolini, 2015, 271; Armstrong et al., 2020, 5; Mahon, 2008; Pavolini & Ranci, 2013, 8; Gingrich, 2011, 178).

These shortcomings stem from LTC's weak institutionalization since its emergence as a distinct social risk between the 1940s and 1990s (Österle & Rothgang, 2012, 326–337; Rothgang, 2010, 436–437; Marchildon, 2021, 186; Österle, 2024, 191–194; Pavolini & Ranci, 2013, 9), a period when medical advances and women's increased labour force participation made family-based care increasingly unsustainable (Österle, 2010, 465; Morel, 2006; Bonoli, 2005; Marier, 2021, 178; Pavolini & Ranci, 2013, 6–7; Rothgang, 2010, 436–437; Greve, 2018, 498).

Weak institutionalization refers to the state's failure to assume clear, centralized responsibility for comprehensive, universal LTC programs underpinned by secure funding, standardized rules, and professional delivery, with no other actor, including professionals, unions, or non-profits, emerging to fill this gap or shield the field from retrenchment and arbitrary cutbacks (Titmuss, 1958; Zijderveld, 2018, 12; Esping-Andersen, 1989, 20; Wilensky & Lebeaux, 1965).

This institutional void is compounded by poor integration, reflecting the absence of coordinated stakeholders with the capacity to advance coherent policy or defend the interests of care recipients (Garritzmann, Häusermann, & Palier, 2023; Pavolini & Ranci, 2013, 9–10; Estévez-Abe, 2025, 535–536).

Several interacting factors are responsible for the sector's weak institutionalization and integration. These include the frailty of LTC service recipients, which limits their capacity to mobilize as a collective political force to advance their interests (Ranci & Pavolini, 2015, 284; Weissert, 2008; Baranek, Deber, & Williams, 2004, 24; Moses, 1982; Office of the Chief Science Advisor, 2020; Marier, 2021, 178). Moreover, this population, composed largely of frail elderly, is often dependent on guardians, particularly adult children, who themselves lack the time or resources to advocate effectively on their behalf (Chou, 2002, 294, 296). The interests of frail LTC users are further marginalized by those of the non-frail elderly and non-frail persons with disabilities (Baranek, Deber, & Williams, 2004, 149), a population whose priorities not only diverge from those of frail LTC users but, as Pavolini and Ranci (2013) and Ranci and Pavolini (2013) have pointed out, are advanced by their stronger political mobilization capacities. These capacities have at times even surpassed those of trade unions and community organizations, a dynamic attributable in part to the alignment of the demands of the non-frail elderly with the fiscal-conservative and New Public Management agendas of contemporary governments (Pavolini & Ranci, 2013, 13; Ranci & Pavolini, 2013, 276, 285–291, 299, 309, 311).

In addition, unlike primary healthcare, where a powerful physician class historically served as an institutional anchor, the LTC field lacks any comparable actor, thereby further reinforcing its weak institutionalization and integration (Tuohy, 1999, 10, 16–17; Tuohy, 2020; Baranek, Deber, & Williams, 2004, 4; Peters, 2001, 59, 196). Moreover, the LTC field remains highly fragmented across families, informal caregivers, for-profit and non-profit providers, and multiple levels of government, fostering what scholars call "organizational fragmentation" (Ranci & Rostgaard, 2025, 7–8), a condition that undermines coherent governance and enables governments to shape the LTC agenda according to their own priorities, largely without challenge (Ranci & Rostgaard,

2025, 7–8; Greve, 2018, 503; Marier, 2021, 161, 167, 170, 172, 178, 195; Baranek, Deber, & Williams, 2004, 21, 24; Guzmán, Santos, & Savall, 2024, 1854). The care workforce itself, while having made demands for better conditions and care provision, remains weakly organized relative to professional groups such as physicians and teachers, further attenuating the field's capacity for coordinated advocacy (Gingrich, 2011, 178).

Further undermining institutionalization are definitional challenges, where, unlike healthcare policy, there exists a wide gulf or lack of alignment between conceptual and administrative or legal definitions of long-term care (European Commission & Social Protection Committee, 2021, 27, 56; OECD, 2020, 5, 24; OECD, 2011; World Health Organization, 2024; Ariaans, Linden, & Wendt, 2021; Gonzalez-Aquines et al., 2024, 415; Kalavrezou et al., 2025, 44–45; Barreira et al., 2023, 8).

Compared to conceptual definitions, administrative definitions of LTC tend to cover a narrow set of services and vary across and within jurisdictions (Alexander, 1996, 1; Hollander, 2002, 101–102; National Institute on Ageing, 2019, 21–29). Not only does this complicate efforts aimed at making cross-national and intra-national comparisons of LTC policy, it undermines the coherence and institutional integration of LTC as a policy field by carving it along jurisdictional, sectoral, and funding lines, thereby hindering efforts to develop the field in a comprehensive and coherent way (National Institute on Ageing, 2019; Lai, 2024; Béland & Arweiler, 1996; Wu, Ramesh, & Howlett, 2015; Theobald & Hampel, 2013, 117; OECD, 2011, 47). In Canada, no single definition of LTC exists, as this policy falls under provincial rather than federal jurisdiction, resulting in definitions that vary across provinces and even among federal and provincial agencies (e.g., CIHI, n.d.; Office of the Veterans Ombudsman, 2017).

Compounding these definitional issues are the inherent challenges involved in standardizing and measuring LTC (Armstrong & Armstrong, 2019, 6–7, 25; OECD, 2005, 12–13, 68, 70; Browne & Welch, 2002, 118; Elwell, 1984, 78, 80, 83; O'Brien, Saxberg, & Smith, 1983, 345–346; Baum, 1999, 572; Pavolini & Ranci, 2013, 7; Rodriquez, 2014, 56; Rodrigues, 2017, 325–340; Kane, 2003; Aase et al., 2021; Rantz et al., 2000; Nakrem et al., 2009; Sangl et al., 2005; James, 1987, 400; Ferguson, 1995, 118; Ullmann, 1987, 235, 239; Sheridan, White, & Fairchild, 1992, 334; Ghatak, 2021, 239–240). Since social care is a vital part of LTC provision, over and above its medical care component, and because care provision is a deeply interpersonal and relational activity centred on dignity, trust, and daily social support, it is not as easily amenable to quantification as primary healthcare, where the medical orientation of service delivery has enabled the development of effective measurement and monitoring procedures, thereby allowing for standardized protocols, robust regulation, and strong state oversight (Brennan et al., 2012, 380; Ranci, 2002, 30; Armstrong & Armstrong, 2019, 25; Pfau-Effinger & Rostgaard, 2011, 2; Greve, 2018, 499–500; Pavolini & Ranci, 2013, 7; Österle, 2024, 193; Van Slyke, 2003, 297–298). These measurement challenges not only undermine efforts to achieve institutional integration in LTC but also make it easier for governments to justify poor governance through vague regulations, weak enforcement, and reliance on unreliable delivery models, whether through for-profit providers with questionable practices or a poorly supported formal and informal workforce (Gingrich, 2011, 180, 183; Greve, 2017, 1–3; Greve, 2018, 499; OECD, 2005, 12–13; Ranci, 2002, 31).

Cultural attitudes that assign care to the family, and particularly to women, have similarly contributed to LTC's weak institutionalization and its status as a weak social right by situating care as a domain of private familial obligation rather than public responsibility (Leira, 1992; Hancock

& Moore, 1999, 265; Kremer, 2007, 241; Benoit & Hallgrímsdóttir, 2011; Pavolini & Ranci, 2013, 7; Baumol, 1996; Rothgang, 2010, 436–437; Sassoon, 1987, 171–184; Balbo, 1987, 50).

Underlying the residual status of LTC is the patriarchal character of the welfare state (Orloff, 1993), which alongside the difficulties of formalizing care and cultural attitudes that continue to assign care to the family, particularly to women, has made it easier for governments to avoid taking central responsibility for the sector's development, instead treating LTC as a familial responsibility (Pavolini & Ranci, 2013, 7; Baumol, 1996; Leira, 1992; Rothgang, 2010, 436–437).

Together, these structural factors underlying LTC's weak institutionalization and integration have produced a set of persistent consequences for how LTC is governed, funded, and delivered. They have contributed to making LTC a low-priority, residual domain, delegated to local authorities and private actors by central governments (Vabo, 2010, 343–344; Marier & Séguin, 2015, 339–340; Pavolini & Ranci, 2013, 7), with intervention proceeding in an uncoordinated, piecemeal, and reactive manner across multiple levels of government, with decisions driven by "immediate political or financial problems" rather than long-term, transparent planning (OECD, 2005, 12–13; Cercel, 2021, 341; Österle & Rothgang, 2012, 329/895; OECD, 2011, 13; OECD, 2013a; Ranci, 2002, 31).

Moreover, even as LTC morphed into a social risk due to socio-economic developments that made it impossible for LTC provision to be left entirely to the family (Morel, 2006; Ranci & Pavolini, 2015, 282), governments have responded ambivalently, partly because LTC's emergence as a social risk coincided with an era of fiscal austerity (Ranci & Pavolini, 2015, 282; Theobald & Hampel, 2013; Mätzke & Wiß, 2017, 126; Pavolini & Ranci, 2013, 3–4, 6–9, 15; Morel, 2006). The result has been what scholars term "restricted universalism", which entails modest public investment paired with weak standards, fragmented delivery, and continued reliance on families

who remain involved either because public programs are inadequate or because policy actively reinforces their involvement through low subsidies, dependence on informal caregivers including migrant care workers, and reliance on a low-wage care workforce (Leira & Saraceno, 2004; Österle & Rothgang, 2012, 328/895; Pavolini & Ranci, 2013, 8–10; Ranci & Pavolini, 2015, 282; Béland & Lemay, 2002, 45; OECD, 2011, 19, 25; Greve, 2018, 503). Consequently, private actors, including families, informal labour, and for-profit and non-profit providers, have remained central to LTC delivery. This can be particularly problematic given the sector's weak institutionalization, which tends to result in poorer oversight and fragmented accountability, conditions that, as the final section of this chapter demonstrates through the lens of transaction cost theory, have significant implications for the quality of care delivered by different provider types, particularly for-profit operators. This problem is especially acute in the nursing home sub-sector, where the high capital and operating costs of delivering nursing home care have made governments and non-profits especially reluctant to enter the field, leaving it disproportionately reliant on for-profit providers able to operate with minimal accountability (GR-0679, 1956, 23/34; GR-678, 1971, 5/10; GR-678, 1963, 14–15/25; Davies, 2003, 55–56, 63, 65, 70–71, 77–78, 84, 162–166; McFarland, 1948, 14–15, 53–55, 56–57, 117–124, 132–134).

While LTC's weak institutionalization and integration render it a structurally fragile social right across all welfare states, the consequences of this weakness, once examined through Esping-Andersen's welfare regime framework, prove particularly acute in liberal and conservative regimes, as the following sections detail (Pavolini & Ranci, 2013, 8–10; Pfau-Effinger & Rostgaard, 2011, 2; CIHI, 2018, 30–36; Ranci & Pavolini, 2015, 278; Österle, 2024, 191–194; Marchildon, 2021, 186; Gingrich, 2011, 180–183).

2.3 The Provision of LTC Across Welfare Regimes: Esping-Andersen's Contribution

Various LTC-specific welfare typologies have been developed in scholarship, often drawing on Esping-Andersen's model while seeking to address its shortcomings (Ranci & Rostgaard, 2025, 11; Ariaans, Linden, & Wendt, 2021, 609–610; Jensen, 2008, 151–152; Grages, 2025, 7; Österle & Rothgang, 2012, 328/895), including his initial analytical neglect of care services, non-profit actors, and gendered dynamics in the welfare state (Anttonen & Sipilä, 1996; Kuhnle & Selle, 1992; Warburton & Jeppsson Grassman, 2011, 181; Strauss & Trommer, 2018, 314; Bartlett & Blackman, 2001, 30). Yet these alternatives face serious limitations of their own, stemming from a methodological approach that relies on qualitative and quantitative empirical data to develop LTC typologies without a robust pre-existing theoretical framework (van Damme, Spijker, & Pavlopoulos, 2025, 20; Bambra, 2007). Not only does this render them incapable of explaining why LTC systems differ or how they evolve over time (van Damme, Spijker, & Pavlopoulos, 2025, 20), but their models have also been criticized for failing to capture the complexities of LTC regimes. Some rely on spending data, which, as Esping-Andersen has argued, is a poor proxy for understanding welfare states (Huber et al., 2009; Riedel & Kraus, 2011; Lamura, 2007; Jensen, 2008), while others employ too many or too few variables to develop their typologies, with those incorporating too many variables often producing a large number of regime variants that make it difficult to identify broad common patterns or develop predictive theories, and those using too few tending to miss critical aspects of LTC regimes that fall outside their narrow empirical scope (van Damme & Spijker, 2023, 3). This shortcoming is expected, for as Esping-Andersen has argued, neither empirical nor quantitative research alone can capture the complexities of welfare states, whose emergence stems from the intricate interplay of historical legacies, political coalitions, and political agency resulting in distinct organizational logics that

differentiate each welfare regime (Esping-Andersen, 1999, 138). In contrast, Esping-Andersen's framework offers a historically grounded, institutionally sensitive approach that identifies the dominant logics structuring welfare provision (Esping-Andersen, 1999, 88, 138; Esping-Andersen, 1990, 28–29). This makes it particularly well-suited for problematizing all dimensions of welfare regimes, including the analysis of how regime type shapes ownership patterns and service delivery models in long-term care, even if real-world cases inevitably deviate from ideal-types, a deviation that, as Esping-Andersen has argued, is to be expected and does not undermine the overall organizational logic of the welfare state in question (Esping-Andersen, 1999, 88, 138; Esping-Andersen, 1990, 28). Hence, and for this reason, many scholars continue to favour Esping-Andersen's model over LTC-specific typologies, using it to interpret and analyse patterns in LTC governance across welfare states (Grages, 2025, 7; Österle & Rothgang, 2012, 328/895; Warburton & Jeppsson Grassman, 2011, 181).

Esping-Andersen adopts a historical institutionalist (HI) approach to welfare state formation, showing how three distinct regime types—social democratic, conservative/corporatist, and liberal—emerged during windows of opportunity shaped by different patterns of working-class mobilization and class coalitions, as well as distinct state legacies, resulting in welfare regimes that differ fundamentally in terms of decommodification, stratification, defamilisation, and the corresponding balance of state, market, and family in welfare provision (Esping-Andersen, 1990, 16–20; Esping-Andersen, 1999, 40, 45–52).

Social democratic regimes arose where strong, solidaristic labour movements forged hegemonic coalitions with the middle class, convincing them of the benefits of universal welfare state programs (Hoekstra, 2010, 11). In these regimes, the state assumes the primary role in welfare provision, overtaking both market and family as the guarantor of social rights, providing generous

transfers and programs that enable individuals to live independently of market and family, resulting in high decommodification and defamilization and low stratification. While high decommodification has reduced women's dependence on the patriarchal family in these regimes (Mahon, 1997, 383), women still remain culturally and socially positioned as primary caregivers, whether paid or unpaid (OECD, 2011).

Conservative regimes developed where working-class organizations were "isolated", allowing pre-existing corporatist and familial institutions rooted in status-based entitlements and traditional gender roles to shape welfare state development (Hoekstra, 2010, 11; Béland & Mahon, 2023, 31). These regimes therefore advance generous benefits and programs to a specific 'insider' population based on corporatist arrangements and centre social reproduction on policies that reinforce the patriarchal family underpinned by the male breadwinner and female homemaker, with the state only intervening to help the 'outsider' population once the family's capacity to provide welfare is exhausted, albeit through means-tested rather than generous benefits (Perna & Moreno, 2025, 26; Shaver, 2019, 87).

Liberal regimes emerged where leftist forces were divided along sectional or business-union lines and the new middle classes could already sustain themselves adequately through the market, resulting in a residual welfare state oriented toward minimal, stigmatizing means-tested state support and poor quality programs that end up reinforcing individuals' reliance on the labour market for their welfare needs through the sale of their labour (Béland & Mahon, 2023, 31; Hoekstra, 2010, 11; Esping-Andersen, 1990, 25–26, 33). The state therefore assumes the smallest role and the market the largest role in welfare provision in these regimes. While nominally gender-neutral, these regime-types end up reinforcing women's unpaid caregiving by treating care as a

private affair, hence leaving the family, and women in particular, as key providers of unpaid welfare services (Mahon, 1997, 383).

The consequential nature of the ownership-mix is particularly pronounced in liberal and conservative regimes, a pattern established by the institutional design of these welfare regime types, which either directly or indirectly assigns responsibility for care to the family and market-based forms of provision, reinforced by minimal state intervention and comparatively low public investment in the LTC sector, tendencies that in liberal regimes are further compounded by a regulatory approach privileging measurable physical standards over robust care standards and their substantive oversight (Estévez-Abe, 2025, 535–536; Jenson, 2021/2025, 365–366; Pavolini & Ranci, 2013, 7; Leira, 1992; Rothgang, 2010, 436–437; Grages, Eggers, & Pfau-Effinger, 2021; Vicente et al., 2022; OECD, 2023; Pfau-Effinger & Theobald, 2025, 255–258; Engster, 2015, 125; Shaver, 2019, 87; Perna & Moreno, 2025, 26). The next section situates the public LTC sector within the context of Canada's liberal welfare regime, showing why the sector's weak institutionalization and ownership-mix gain particular salience in this regime type, thus helping problematize the consequential nature of the ownership-mix underlying the provincial divergence examined in this dissertation.

2.4 Canada's Liberal Welfare Regime and the Long-Term Care Sector

Canada's welfare state, including its public long-term care (LTC) sector, broadly resembles Esping-Andersen's liberal welfare regime variant, characterized by policies, regulations, ideas, and institutional preferences that aim to keep state involvement in public LTC minimal and residual, albeit with temporal variations that distinguish it from archetypal liberal regimes like the United States (Jenson, 2021/2025; Béland & Mahon, 2014, 249; Mahon, 1997, 396; 2008; Haddow & Klassen, 2006, 38–39). Nevertheless, LTC remains treated as a scarce resource in Canada, marked

by fragmented availability and poor quality, and delivered through programs that are inaccessible and inadequate due to supply shortages, over-rationing, and eligibility policies that restrict access to those with the highest needs (Jenson, 2021/2025; Mahon, 2008; Shapiro, 1994, 334; Toronto Star, 2017; Saskatchewan Population Health and Evaluation Research Unit, 2017, 11, 26).

Although eligibility for public nursing home care across Canadian provinces is universal on the basis of medical need, with care and nursing costs covered, these programs include an income-tested user co-payment on accommodation costs that reaches up to 22 percent of total costs, of which private insurance covers approximately 1 percent and individuals the remainder, while government funding covers the remaining 78 percent of public nursing home costs (Library of Parliament, 2025; Canadian Association for Long Term Care, 2024; Statistics Canada, 2024; Statistics Canada, 2022). When private nursing home care is included, total private spending rises to approximately 30 percent of overall nursing home costs, indicating that only a small segment of the population can afford private options.

Given the unavailability, inadequacy, and poor quality of public long-term care programs, and the fact that market-based options remain unaffordable, a significant portion of long-term care in Canada is provided by or through the family, most typically as unpaid care by females who are members or friends of the family—a figure whose value was pinned at 97 billion dollars of unpaid care in 2024 (Eales et al., 2022; Canadian Centre for Caregiving Excellence, 2022; Fast et al., 2024; Statistics Canada, 2024; Fairstone, 2025).

Welfare state services, including public LTC programs, are typically delivered through a mixed economy across most provinces, with preference tilted towards private non-profit and for-profit agencies in line with the orientation of liberal welfare regimes to keep the state lean (Greb et al., 1994; Shapiro, 1994, 349–351; Shapiro, 2000, 440–441, 2001; Brennan et al., 2012, 380,

386–387). The makeup of this mixed economy tends to vary by province due to provincial government policy decisions and other contextual factors (Armstrong et al., 2009, 25, 37; The Leader Post, 1972, 48–49/104; Hospital Administration in Canada, 1971, 3–4/9; CUPE, 1980, 6/27; Associated Nursing Homes Incorporated Ontario, 1970, 67).

Assessing the effectiveness of LTC policy and the quality of LTC programs remains challenging, as this area generally suffers from data limitations and a lack of comprehensive comparative research, including among OECD countries (Österle, 2011, 461; Österle, 2017, 1–3; Pavolini & Ranci, 2013, 6–7; Pieper, Sixsmith, & Vaarama, 2008, 153–154; Carrera et al., 2013, 50–51; Rocard, Sillitti, & Llena-Nozal, 2021, 51; Cabin et al., 2014, 1464; MacAdam, 2004, 397). This difficulty is particularly acute in Canada, where long-term care falls under provincial jurisdiction and where government data remains scarce and comprehensive comparative studies of Canadian LTC policy few, a gap this dissertation seeks to address (Fletcher, 1986, 7–8, 10, 27; Hirdes, 2002, 76; CMHC, 1983b, 1; Shapiro, 1994, 330, 345; Health Services Restructuring Commission, 1997; Havens, 1995, 246; Tarman, 1990; Greb et al., 1994, 280; Kane & Kane, 1985b; CHA, 2009, 71; O'Connor, 2005; Laxer, 2014, 74–75). Most existing research remains focused on surface-level similarities, obscuring underlying provincial differences in history and structure that make each province's LTC system unique.

Despite these shortcomings, scholars and policymakers acknowledge that Canada's public LTC system suffers from historical neglect (Hall, 1964, 831–832; Canadian Medical Association, 2016, 4; Agnew, 1974, 203; Ontario Nurses' Association, 1984), with this having resulted in systemic shortcomings and failures (Braedley, 2025; Report of the Special Committee of the Senate on Aging, 1966, 32; Canadian Medical Association, 1984, 7–8, 32–38; Ontario Nurses' Association, 1984). Nevertheless, overly broad generalization about the quality of LTC programs

should be avoided due to potential variations in quality among provinces and provider ownership type, differences that are documented in this dissertation and which were also made evident in the recent COVID-19 pandemic (Braedley, 2025; Marier, 2021, 202).

One persistent source of shortcomings in the quality of public LTC programs in Canada has been linked to the ownership type of providers delivering these services (Brennan et al., 2012, 386; Marier, 2021, 161; Shapiro, 1994, 349; Greb et al., 1994, 292–293; Comondore et al., 2009, 2/35; Berta et al., 2006, 175, 189–190; Pitters, 1995; Tarman, 1990, 31–33; Bos, Boselie, & Trappenburg, 2017, 353; Callahan & McNiven, 1988, 13; Pinch, 2002, 25; Brenton, 1985), with for-profit operators frequently associated with lower quality care and weaker regulatory compliance compared to their non-profit counterparts (Marier, 2021, 147; Berta et al., 2006; Brennan et al., 2012, 386), a phenomenon this dissertation found prevalent in Ontario and British Columbia's public nursing home sectors during the period under study, and one also evident in other jurisdictions historically and today. For this reason, the benefits and drawbacks of a mixed economy, including and particularly the involvement of for-profits in the public nursing home system continues to remain as salient and fiercely debated as it was a century ago (Banerjee & Armstrong, 2015, 8; McGregor & Ronald, 2011; Armstrong et al., 2009; Harrington & Jacobsen, 2019, 182, 184; Baum, 1999; Tarman, 1988; 1990; Strauss, 2021, 3; Comondore et al., 2009; Harrington et al., 2020; Harrington & Jacobsen, 2019; GR-2585, 1964, 44/62, 46/62; Ontario Hospital Services Commission, 1971d, 3/9, 5/9, 8–9/9; 1969, 8/22; Morison, 1966; Government of Québec, 1970, 20/31; Armstrong, 2002, 5, 8; Associated Nursing Homes Incorporated Ontario, 1970, 67/129; GR–880057–0091, 1975, 53/107; Kane & Kane, 1985b, 111; Shapiro, 1997).

A number of scholars have attributed such shortcomings in LTC policy to its exclusion from the Canada Health Act and the medicalization bias inherent in Canada's healthcare system.

While valid, this diagnosis overlooks a deeper cause, namely Canada's liberal regime logic, which keeps public programs lean in order to reinforce reliance on the market (Marier, 2021, 145, 161, 195). Hence, those who advocate for designating long-term care as a medically necessary service under the Canada Health Act conflate the exception with the rule, since universal healthcare constitutes a historically contingent exception within Canada's liberal welfare regime, one that is not easily replicable to other sectors of the welfare state (Maioni & Marmor, 2019, 152–166/233; Béland & Mahon, 2023, 26; Maioni, 1998).

Nonetheless, meaningful improvements in LTC policy have emerged through pressure from influential actors, including bureaucrats in British Columbia, as demonstrated in this dissertation, as well as unions and leftist parties, which, despite lacking the systemic influence of their counterparts in social democratic regimes (Bakker & Scott, 1997, 298; Banting & Myles, 2013, 6; Obinger, Castles, & Leibfried, 2005, 23), have leveraged their position as third parties within Canada's decentralized Westminster parliamentary system to advance reforms that have enabled certain areas of Canadian social policy to diverge from an archetypal liberal welfare regime like the United States (Béland, Marchildon, & Prince, 2019, 124; Maioni & Marmor, 2019, 166/233; Maioni, 1998, 8–11; Béland, Marchildon, & Ianni, 2020, 161; Orloff, 1993, 54; Haddow & Klassen, 2006, 39), whether in pensions (Orloff, 1993, 54; Guest, 1997), healthcare (Maioni, 1998; Rosenthal, 1999), income inequality (Eidlin, 2015; Zuberi, 2006), or long-term care (CUPE, 1982, 1–11; CUPE, 1984; Canadian Labour Congress, 2020; Kane et al., 1998, 300). Moreover, unlike in the United States, eligibility for these programs in Canada is often universal rather than tied to employment or subject to a means-test, with Canadian unions[2] also playing a formidable role in advancing a dual agenda of improving both worker wages and care conditions in healthcare

[2] Albeit, the emergence and influence of unions in Canadian LTC remains a relatively recent development, emerging only in the 1970s following the formation of modern provincial LTC systems (CUPE, 1984).

and long-term care (Armstrong et al., 2009, 22; Armstrong & Armstrong, 2019; CUPE, 1982, 1–11; CUPE, 1984; Hospital Employees' Union, 2009; 2012; Crouch & Keune, 2005; Mahon, 1997; 2008). These dynamics have led scholars such as Pontusson (2005, 38–39, 58, 148–150) and Haddow and Klassen (2006, 39) to characterize Canada as the most egalitarian liberal market economy, distinguished by a comparatively more efficient use of taxes to invest in more generous transfers and programs aimed at mitigating the high levels of inequality typically associated with liberal market regimes.

As stated above, the commitment of liberal welfare regimes to a mixed economy helps explain why Canada's welfare state tends to rely on private for-profit and non-profit providers to deliver public welfare programs, a preference rooted in the goal of maintaining a lean state with a minimal administrative and fiscal footprint (Callahan & McNiven, 1988, 13; Pinch, 2002, 25; Brenton, 1985, 2–6). It is precisely this reliance on private providers that makes the question of the ownership-mix a particularly consequential one in Canada's welfare state. This is especially so in a weakly institutionalized welfare sector such as LTC, where fragmented governance and poor integration leave the field vulnerable to the behavioural divergence between ownership types, a vulnerability further compounded by the orientation of liberal welfare regimes toward low public investment and minimal substantive regulation of care quality, with regulatory frameworks focused on physical and procedural compliance rather than the quality of care delivered (Brennan et al., 2012, 380, 386–387; Gingrich, 2011, 180, 182–183; Pavolini & Ranci, 2013, 7). In contrast, social democratic regimes have historically favoured publicly owned organizations, reflecting strong labour and leftist influence. Even these regimes, however, have faced growing pressure to adopt market-oriented reforms in recent decades, including engaging in partnerships with for-

profit actors in their welfare states (Ranci & Pavolini, 2013). It is to this question that the review now turns through the lens of transaction cost theory.

2.5 Examining the Implications of Alternative Service Delivery Mechanisms in Canada's Public LTC System

The use of alternative delivery mechanisms, specifically, for-profit and non-profit providers, in the provision of welfare state programs carries significant implications for regulatory costs and service quality. This distinction is especially consequential in complex, human-intensive services such as nursing home care, where outcomes are difficult to measure and monitor (Salamon, 1987, 15; Panet & Trebilcock, 1998; Brennan et al., 2012; Gilbert, 2002). Yet the frameworks most expected to address this question suffer from theoretical shortcomings, as "both welfare state and non-profit scholarship have paid little attention to alternative delivery arrangements" (Salamon, 1987, 15; see also Rekart, 1993, 147; Graefe, 2004). Welfare state theories often adopt a dirigiste or overly state-centred view of the welfare state, presenting government as a monolithic entity and giving the "misleading impression… of no separation between the financing and the delivery of public services" (Gidron, Salamon, & Kramer, 1992, xii–xiii, 2), a problem compounded by their tendency to conflate non-profit and for-profit providers as 'private actors', despite the significantly different regulatory and quality implications of each ownership type for welfare state programs. Non-profit theory, meanwhile, tends to treat the state and non-profits as isolated actors, leaving little room for the reality of welfare state-contracted service provision by private providers, and where it does take up the contracting relationship, it treats it mainly as a question of which type of provider a government should choose for a given kind of service, rather than as a process that unfolds within the welfare state over time (Salamon, 1987, 6, 15, 44; Gidron, Salamon, & Kramer, 1992, 75; Panet & Trebilcock, 1998, 22–23). As a result, neither framework adequately accounts for the nature of the relationship between

governments and private providers within the welfare state (Salamon, 1987, 6, 15, 44; Gidron, Salamon, & Kramer, 1992, 28, 75; Rekart, 1993, 147).

Transaction cost theory remains the sole approach that provides a systematic account of these implications. It argues that government contracting with for-profit firms is viable only when services are simple, standardized, and easily monitored, such as garbage collection or street maintenance, because for-profits possess a structural incentive to maximize shareholder returns, which can lead them to skirt or resist contractual obligations, a risk that can be managed at reasonable cost only when violations are easy to detect (Prentice & Brudney, 2015, 88; Rademacher, 2011, 18–19; Gingrich, 2011, 7). In this light, the rationale for contracting with for-profit providers is based on the assumption that market competition and access to private capital will result in cost efficiencies and reduce the fiscal burden on government, advantages that may in fact hold when services are simple and outputs are easy to measure. In contrast, complex services like nursing home care are inherently difficult to measure and monitor, and their labour-intensive character further raises operating costs, heightening the pressure on for-profit providers to protect their profit margins—a pressure the profit-maximization incentive of this ownership type, presumed to generate efficiency, transforms into a drive to exploit regulatory gaps, minimize staffing, or avoid high-need residents (Brennan et al., 2012, 380, 386; Gilbert, 2002, 121–122; Tronto, 2019, 52), and one rendered particularly acute under government-subsidized rates, as the empirical evidence of this dissertation confirms. This combination of inherent complexity and opportunistic behaviour makes effective government oversight extremely costly and often ineffective, making presumed efficiency gains illusory and often resulting in poor quality programs (Brennan et al., 2012, 380; Bendick, 1984, 166; Boston, 2016, 37/446; Chou, 2002, 295; Brooks, Liebman, & Schelling, 1984, 347; Prentice & Brudney, 2015, 78, 88, 91). The presumption of for-

profit efficiency is further undermined by the absence of real competitive market conditions in publicly contracted nursing home care, where government-set reimbursement rates, limited provider pools, high barriers to entry, and the inability of frail residents to exercise meaningful consumer choice produce quasi-market conditions that negate the efficiency rationale on which for-profit contracting depends (Barron & West, 2017; Brennan et al., 2012, 379–381; Corlet Walker et al., 2022). Regardless of these regulatory and efficiency challenges, however, as the subsequent empirical chapters will demonstrate, a provincial government may effectively circumvent the predicted regulatory costs by declining to rigorously monitor or enforce care standards, instead restricting its oversight to easily measurable physical requirements, an approach that maintains low administrative costs for government-contracted for-profit nursing home provision at a significant expense to the well-being of residents, a pattern that becomes especially prevalent in liberal welfare regimes given their preference for private provision and for minimizing the state's administrative and fiscal footprint (Brennan et al., 2012, 380; Gingrich, 2011, 180, 182–183).

By contrast, the same risks do not extend to non-profit and publicly owned providers, since both are constrained by the non-distribution principle, which prohibits the appropriation of profits for private gain and requires any surpluses to be reinvested into service delivery. Moreover, these organizations are typically oriented toward social value creation or addressing human needs rather than profit maximization (Prentice & Brudney, 2015, 81; Rademacher, 2011, 18; Guzmán, Santos, & Savall, 2024, 1858). These characteristics align their objectives closely with public goals, reducing the risk of opportunism and lowering the need for intensive oversight. In addition, they often provide better working conditions compared to for-profits, a difference that is argued to contribute to higher-quality services (Banerjee & Armstrong, 2015, 14; Armstrong, Armstrong, & Choiniere, 2024; Harrington, 2013, 231–233). This is not to suggest that malfeasance cannot occur

under non-profit or public provision, but rather that both the incentive and the capacity to do so are comparatively more constrained under these ownership types. Consequently, governments can partner with non-profits to deliver complex services without incurring high regulatory costs, in spite of the fact that such services are difficult to measure and monitor (Greve, 2007, 37; Browne & Welch, 2002, 22; Witesman & Fernandez, 2013, 689; Prentice & Brudney, 2015, 76, 78, 80–81, 88, 91; Macinati & Young, 2024, 158; Young, 2000, 156; Witesman, 2024, 372). As a result, government relationships with non-profits often take on a relational or informal character, grounded in trust and altruism rather than strict contractual enforcement (Prentice & Brudney, 2015, 80–81; Ranci, 2002, 31; Boston, 1994; Boston, 2016; Verhoest, 2016; Van de Walle, 2016; Newman, 2016, 304/446, 331/446; Gregory, 2016; Williamson, 1985, 72; Greve, 2007, 32; Ontario Cabinet Office, 1991, 82–83/138).

Empirical evidence from this dissertation extensively supports these theoretical predictions. In both Ontario and British Columbia, officials consistently identified for-profit nursing homes as sources of high regulatory costs and poor quality. Ontario bureaucrats noted that effective oversight "would require a large staff and continual policing" (Struthers, 1997, 178), while BC officials warned that "without an army of inspectors… [for-profits] can easily ignore any attempts to raise standards" (GR-2688, 1980, 138/139). Both provinces observed that for-profit operators engaged in cherry-picking, admitting lighter-care residents while avoiding those with greater needs (B.C. Newspaper Archives, 1956, 266/375; GR-0117, 1964, 13/24; Office on Aging Branch, 1974, 55/58; Co-ordinating Committee Extended Care Health Insurance, 1972, 2/46; Ontario Council of Health, 1977, 51/97; Task Force on Long-Term Care and Facilities, 1974, 31/67). In contrast, concerns about non-profit providers were minimal, as reflected in the regulatory approach of both provinces, underpinned by a minimalist approach to the monitoring

and regulation of non-profits on the one hand, and concern over the regulatory costs of for-profits on the other.

These results extend beyond Ontario and BC alone. For example, in 1968, officials in Alberta temporarily suspended for-profit participation in its public nursing home program due to quality failures (Ontario Hospital Services Commission, 1970; Ontario Hospital Services Commission, 1971a; Technical Committee on Nursing Homes, 1969; GR–880057–0091, 1975, 53/107). A Manitoba Department of Health report prepared for the Canadian Conference on Aging described the proprietary nursing home as "the most notorious" form of institutional care, characterized by facilities that were "greatly over-crowded almost of economic necessity" where "neglect and ignorance were quite common" (Morison, 1966, 6/12). Québec officials, meanwhile, described for-profit facilities as delivering particularly poor care, remarking that "an incalculable number of civil servants" would be needed to regulate them effectively (Government of Québec, 1970, 17/31).

2.6 Conclusion

The literature surveyed in this chapter establishes the terrain on which the dissertation's central puzzle takes shape, demonstrating that LTC's weak institutionalization and poor integration leave the sector acutely exposed to governmental discretion and to the behaviour of providers, a vulnerability further compounded in the nursing home sub-field by the high capital and operating costs of nursing home care, which deter non-profit and public entry in the absence of sufficient government funding and thereby ease the entry of for-profit providers, who, as transaction cost theory predicts and this dissertation's empirical chapters confirm, exploit the measurement difficulties inherent in government-contracted complex care services to skirt regulations and deliver substandard care, a dynamic exacerbated by the structural features of Canada's liberal

welfare regime, where low public investment, reliance on private provision, and weak substantive care oversight further facilitate for-profit entry and enable these operators to persist and maximize profits with minimal accountability. What this literature cannot do, however, is account for why two provinces governed by conservative, free-enterprise oriented parties, operating under the same welfare regime type, and sharing broadly comparable socioeconomic conditions pursued opposing policy paths on this consequential question. The source of this divergence must therefore reside in variables that operate beneath the shared structural conditions these frameworks treat as fundamental. Chapter 3 takes up this task, introducing the theoretical frameworks of historical institutionalism, ideational theory, and bureaucratic rationality that together provide the analytical apparatus for explaining the meso-level and micro-level factors that produced the divergent ownership-mix outcomes in Ontario and British Columbia.

Chapter 3: Theoretical and Methodological Framework

3.1 Theoretical Framework: Introduction

As two of Canada's wealthiest, most populous, and most developed provinces, Ontario and British Columbia embarked on modernizing their public nursing home systems from strikingly similar positions during the critical period of welfare state modernization examined in this dissertation, a period spanning from the 1940s to the 1970s. Both provinces operated under liberal welfare state regimes, featured nursing home sectors dominated by for-profit ownership, shared developmental conditions marked by urbanization and high per capita incomes, and possessed political contexts shaped by long-running conservative majorities (McInnis, 1966, 587; Acker, 1956, 367–368; Shoyama, 1966, 504; Green, 1971, 242–243; Johnson, 1973, 13). Despite these commonalities, they arrived at starkly divergent paths in public nursing home ownership. Ontario adopted a for-profit trajectory, initially buttressed by a provincially funded non-profit and municipally owned "Homes for the Aged" sector that it later abandoned to sustain the rapid expansion of for-profit providers, whereas British Columbia staked a predominantly non-profit path. Traditional accounts of the welfare state struggle to account for this divergence.

Approaches emphasizing partisan ideology, which attribute divergences in welfare state trajectories to the ideological orientation of the governing party, fail to account for the contrasting outcomes observed in British Columbia and Ontario. While present-day scholarship, especially the "new politics of the welfare state" literature (Pierson, 1994), argues that the expected impact and direction of partisan differences have shifted in an age of permanent austerity and welfare retrenchment, the literature establishes that during the postwar era of welfare state expansion, the ideology of the governing party was a significant determinant of welfare state outcomes. According to this literature, parties of the Right held back welfare state expansion, whereas social

democratic parties expanded the welfare state through the establishment of more comprehensive programs (Castles, 1982, 57–58, 71, 75–76; Huber & Stephens, 2001, 1–3, 17–20). Applied to this study, this framework would predict that both provinces, governed by long-running, free-enterprise oriented conservative majorities during the critical junctures of nursing home sector modernization, would converge on a similar path of reform. British Columbia was governed by Social Credit majorities for almost the entire period from 1952 to 1985, while Ontario was governed continuously by a Progressive Conservative party that maintained a majority for most of the period from 1943 to 1985. Given these partisan alignments, one would expect both provinces to tilt toward market mechanisms and minimal state intervention—a path that would entail the implementation of market-oriented policies that would facilitate the expansion of a for-profit ownership-mix. Yet the outcomes failed to converge. Ontario followed the predicted for-profit path, while British Columbia pursued a non-profit trajectory, rendering partisan ideology alone insufficient to explain the divergence.

Explanations centred on public opinion also fail to offer an adequate account of this divergence. The prevailing literature holds that sustained and salient public preferences tend to generate pressure for corrective policy reform, though the strength of this relationship is conditioned by institutional structure, issue salience, and the capacity of the political system to translate opinion into policy (Burstein, 2003; Soroka & Wlezien, 2010). These conditions were met in both provinces, with provincial governments being the dominant policy actor in this area, authority concentrated in the provincial executive, and while public opinion was against for-profits in both, it was even more salient and sustained in Ontario, owing to the province's regulatory structure underlying its bureaucracy that led to exceptionally poor quality care by for-profits (Greb et al., 1994, 292), whereas in BC it was less pronounced, reflecting the better quality of care

produced by the persistent advocacy of a substantive provincial bureaucracy (GR-0119, 1958, 9–11/82; GR-0119, 1958, 12–14/82; GR-0119, 1958, 82/82; The Province, 1956; 1957; 1958; 1959). Under such conditions, one would have expected policy reform to align with public opinion in both provinces, though even more so in Ontario. Yet, despite negative public opinion towards for-profits being especially salient in Ontario, the province maintained and accelerated its pursuit of a for-profit ownership-mix, whereas BC, where public criticism of for-profits was comparatively less pronounced, adopted a non-profit one.

Neo-pluralist accounts, which treat policy outcomes as a reflection of competition between interest groups (McFarland, 2004; Johnson, 1999), fare no better. According to these accounts, policy trajectories are structured by competition among organized interest groups, with outcomes reflecting the relative mobilization and strength of stakeholders in the policy arena (McFarland, 2004; Johnson, 1999, 34). Applied to this study, neo-pluralism would predict that Ontario, where a non-profit "Homes for the Aged" lobby emerged in 1919, decades before a for-profit lobby even formed in 1959, should have pursued a non-profit path (OANHSS, 1991, 3/27), whereas BC, where a for-profit lobby emerged in 1957 (GR-0119, 1957, 46–48/82) while a non-profit lobby did not emerge until after the critical juncture of welfare state modernization (GR-2678, 1976, 71/84) should have pursued a for-profit path. Yet the very opposite outcome occurred, with Ontario pursuing a for-profit path and BC a non-profit one. What neo-pluralist frameworks fail to recognize is that the relative strength of these societal groups was prefigured by the state itself: Ontario's regulatory structure enabled a powerful lobby to emerge from an expansive for-profit sector, while BC's regulatory structure severely constrained the growth of its for-profit sector, thereby preventing its lobby from ever transforming into a formidable political actor.

Most significantly, Ontario has long favoured a strictly cost-driven approach to long-term care, yet much of the welfare state retrenchment literature links this tendency to more recent events, such as the emergence of austerity in the late 1960s or to explanations centred on individual leadership, like the ideological agenda of Mike Harris (Evans, 2008, 151–152; Laws, 1987, 73, 168–170; 1988; 1989; Rea, 1985, 238; Mishra, Laws, & Harding, 1988, 12, 123, 125; Roberts, 1994, 108–109; Evans & Fanelli, 2018, 131; Gabel, Clemens, & LeRoy, 2004, 35). However, there was no explicit austerity agenda or ideological figures like Mike Harris in power during the critical period of public nursing home expansion and modernization under examination here. Nevertheless, from 1948 to 1972, Ontario adopted a strictly cost-driven model that enabled the rapid growth of for-profit providers in its public nursing home system. Similarly, much of the BC scholarship attributes the critical juncture in the province's nursing home ownership-mix to the 1980s, citing macro-level factors such as party ideology and neoliberalism as the main drivers (Rekart, 1993, xi, 4, 32, 144; Prince, 1996, 254; Fuller, 2001, 287; Stinson, Pollak, & Cohen, 2005, 10–11). Yet, as demonstrated in this dissertation, BC's commitment to a non-profit ownership model was established decades earlier under a conservative free-enterprise government (see also Meggs & Mickleburgh, 2015, 193). This scholarship suffers from a further analytical limitation. By framing the 1980s shift as a generic move toward "private provision" (Rekart, 1993), it conflates the commercial and voluntary sectors into a single category despite their markedly contrasting regulatory and quality implications for government contracting, a conflation that is also contradicted by the literature's own evidence, which shows that the 1980s expansion in BC was overwhelmingly directed toward non-profit contracting rather than for-profit growth.

Power resources theory also fares poorly. First, this theory is more suited for explaining macro-level welfare regime differences, such as the emergence of social democratic and

conservative regimes, than micro-level variations like ownership-mix in long-term care. It also holds limited relevance for the Canadian context, as Canadian federalism fragments and subdues class-based political influence while reinforcing regional, religious, and linguistic identities (Orloff, 1993, 54–55; Haddow, 1993, 11–19; Jenson, 1990). Hence, even though BC had a strong and militant union movement during the period under investigation, there were no formal institutional linkages between the unions and the CCF Party (Co-operative Commonwealth Federation), a key requirement of the power resources model. Moreover, the CCF was not even in power during this period (Isitt, 2011, 98; Bossert, 2021, 35, 36; Haddow & Klassen, 2006, 51; Banting & Myles, 2013, 6). In addition, organized labour in the long-term care and nursing home sectors did not become a significant political force until the early 1970s, well after the formative decisions shaping each province's welfare state had been made (CUPE, 1984; Angel, 1985, ii, 25; SEIU, 2025). This is not to deny the important role that unions and leftist parties have played in eking out a progressive edge in certain parts of Canada's welfare state, including but not limited to universal healthcare, a role made possible in part by the existence of leftist parties as third parties at the federal and provincial levels. Rather, it is to emphasize that their influence has not been as structurally embedded or system-wide as in social democratic contexts like Sweden, where labour's integration into the state apparatus fundamentally shaped welfare institutions (Mahon, 1997, 396; Olsen, 1998).

A further dimension of the puzzle that prevailing explanations cannot account for comes from the pre-existing institutional arrangements in each province. Prior to the establishment of their modern welfare states, Ontario possessed a significantly larger non-profit rest home sector compared to BC, where such institutions were historically few in number (GR-3975, 1984, 16/49; Davies, 2003, 66; Canada Dominion Bureau of Statistics, 1931, 21–22). Even during the

establishment of their modern welfare states, Ontario initially leapfrogged ahead of BC by building over 11,000 non-profit nursing home and residential care beds in its Homes for the Aged program from the end of the 1940s to the early 1960s (Department of Social and Family Services, 1972, 13–14/16), while BC did not begin investing in the establishment of non-profit nursing homes until the mid-1960s. Path dependence would therefore predict that Ontario, having developed a substantial non-profit and municipal Homes for the Aged sector alongside its for-profit dominated nursing home sector early in the formative period, would be more likely to consolidate a non-profit trajectory, while BC, lacking such a base, would face greater difficulty doing so. Yet the opposite occurred. BC transitioned to a non-profit ownership model while Ontario abandoned its non-profit sector in favour of for-profit expansion, an outcome that points to the operation of factors capable of overriding pre-existing institutional arrangements.

Given the inability of explanations centred on societal actors, including neo-pluralist, public opinion, and power resources accounts, to explain the divergent outcome, the analysis turns to considering state-centred and ideational approaches, which may offer partial relevance insofar as they identify ideas as possessing independent causal power and problematize the state as a partially autonomous policy actor whose bureaucrats shape policy through their own expertise and assessments rather than merely responding to societal pressures (Campbell, 2002, 21; Chou, 2014, 29–30; Heclo, 1974; Peters, 2001, 223). Together, these perspectives suggest that state actors and ideas can help shape divergent outcomes in otherwise similar settings. However, this partial relevance requires qualification, since not all state-centred explanations can account for the divergent outcome observed here.

In particular, state capacity frameworks fail to offer an adequate explanation, given that both provinces possessed comparable degrees of state capacity. While BC's provincial government

assumed direct responsibility for social services earlier than Ontario's, where municipal development preceded provincial development and the provincial government avoided direct engagement with the for-profit dominated nursing home sector for decades, limiting its early intervention to the Homes for the Aged program (Crawford, 1954; Cassidy, 1945, 41–42; Davies, 2002, 59; Social Welfare Branch of the Department of Health and Welfare, 1948, P 8), this difference reflects the timing of provincial engagement and BC's comparatively greater degree of centralization rather than a differential in governing capacity, since Ontario's provincial state had ample capacity to restructure the nursing home sector throughout this period, yet prior to the 1960s it first chose not to intervene at all and then chose to intervene only indirectly, and once it chose to intervene directly in the mid-1960s and 1970s it simply exercised that capacity in a market-oriented direction. Nor does the Heclo (1974) and Skocpol (Skocpol & Amenta, 1986; Evans, Rueschemeyer, & Skocpol, 1985) hypothesis, a specific variant of the state capacity thesis holding that bureaucratic autonomy is greatest where professional bureaucracies were established before full democratization, account for the divergent outcome, since if the sequence of bureaucratization and democratization had differed between the two provinces, it could offer a basis for why bureaucrats in one province were better positioned to act as more autonomous policy actors. Yet no such difference is evident in analyses of the administrative history of each province (Crawford, 1954; Hodgetts, 1995).

Taken together, these shortcomings fall into two groups. The first concerns explanatory adequacy. Partisan ideology, public opinion, neo-pluralism, power resources, and state capacity each fail to generate the observed divergence, and several predict the opposite pattern in at least one province.

The second concerns timing. Paradigm-based and leader-centred accounts also fail to explain the divergence, albeit their failure operates at a more basic level. Given that these accounts are built around late-twentieth-century developments, namely austerity, neoliberalism, or the agendas of particular political leaders, they look for the decisive shift in that period and misdate the critical juncture by several decades. This misdating arises because, lacking an account of how an ownership-mix is built and entrenched as a process within the welfare state, the prevailing accounts of each province's social policy attribute each province's nursing home sector ownership-mix trajectory to the recent, paradigm-driven and partisan reforms of the 1980s and 1990s, mistaking the moment a path became politically salient for the moment it was actually established, which this dissertation found to have taken place decades earlier. In these accounts, then, the theoretical gap and the dating error are one and the same problem. A related shortcoming, operating at the conceptual rather than temporal level, is the tendency in some of these accounts to treat commercial and voluntary provision as interchangeable, despite their markedly different implications for regulatory costs and care quality.

Stepping back from these paradigm-based and leader-centred accounts to the rival explanations as a whole, one finds that they share a common problem. The macro-level structural factors on which they all rest cannot, on their own, account for the divergence, which suggests the explanatory variable lies at a level beneath the structural conditions these accounts treat as fundamental.

This points us elsewhere. If the divergence cannot be explained by the macro-level conditions these accounts share, then the candidate factors are the ideas that state actors advanced and the institutional rationalities through which those ideas were filtered. Yet neither ideational nor state-centred frameworks can, on their own, adequately explain why ideas took opposing forms

in two provinces within the same federation, each governed by ideologically similar right-wing parties during an era of welfare state expansion.

Compared to the explanations explored above, historical institutionalism (HI) provides the most effective account for explaining this divergence. This is due to HI's ability to demonstrate how regions within the same federation that share nearly identical starting points, broadly similar developmental conditions, and comparable political institutions can reach starkly divergent policy outcomes even when faced with the same opportunities for reform. This strength stems from HI's capacity to theorize how small, early variations in micro-level factors, such as actors' distinct ideas and decisions as well as localized events, interact with mid-level institutional factors like distinct bureaucratic rationalities, interactions that are then amplified and entrenched through windows of opportunity, path-dependent processes, and the sequencing of policy choices, culminating in starkly divergent policy outcomes. Hence, HI can effectively incorporate explanatory mechanisms from ideational and state-centred approaches within its broader explanatory framework. As Bryant (2016) states, for example, HI serves as "a middle-level theory about the evolution of health systems. Ideas and knowledge are seen as driving policy responses" (78), rather than structural conditions.

However, HI suffers from certain shortcomings, including its inability to provide a precise account of the process or mechanism by which an opportunity for reform is translated into policy following a window of opportunity (Tuohy, 2018b, 6; Luk, 2016, 6–8; Smyrl & Genieys, 2016, 7–8; Cohn, 2001, 50; Steinmo, 2008, 129). To address this gap, this dissertation draws on Tuohy's refinement of HI, which demonstrates how conditions in the broader political arena that operate independently of the specific policy domain—namely, the political authority and political will of governing actors—shape actors' strategic judgments about the viability of reform during windows

of opportunity, affecting both whether actors seize these opportunities and the magnitude and direction of change that follows (Tuohy, 1999, 12, 34; Tuohy, 2018b, 72). Yet Tuohy's account also faces limitations. While it effectively explains the 'how' of divergence, showing, for instance, how Ontario and British Columbia adopted contrasting regulatory paths that yielded a for-profit ownership model in one province and a non-profit one in the other, it cannot explain why each province selected opposing regulatory logics in the first place. Tuohy would attribute these distinct choices, or the 'why', to each government's broader agenda. However, the agendas of both governments were broadly similar in that they were both committed to free enterprise and the expansion of public nursing home care. To be sure, both provinces' conservative governments shared preferences for fiscal restraint and minimal state expansion, preferences that shaped the basic constraints through which nursing home policy was formulated. However, it is precisely at this point that Tuohy's framework reaches its limit, i.e., precisely because these fiscal and partisan preferences were common to both provinces, they constitute a constant rather than a variable capable of explaining the divergent outcome. This shortcoming stems from Tuohy's limited attention to the role that state actors other than the governing party play in the policy process, particularly state bureaucrats, and from the way her framework, when applied, reduces the autonomous role ideas play in the policy process by tying them to the governing party's broader agenda and the prevailing paradigm, even though the epistemological basis of her framework casts ideas as carrying an independent causal force. To address this gap, the dissertation turns to an ideational-institutional model that centres on bureaucrats' principled and causal beliefs, mediated by distinct institutional models of bureaucratic rationality. It investigates whether bureaucrats' principled and causal ideas, mediated by the distinct models of bureaucratic rationality in each province, informed their interpretation of policy problems and guided their agency in ways that

ultimately drove each province toward opposing policy paths, with Ontario adopting a public nursing home system centred on for-profit ownership and British Columbia adopting one centred on non-profit provision.

3.1.1 Historical Institutionalism

In this dissertation, historical institutionalism (HI) is used as the theoretical framework to investigate how and why the policy paths of the ownership-mix of nursing home facilities in Ontario and British Columbia diverged in opposing directions despite the fact that both provinces faced comparable pressures and shared broadly similar macro-level conditions and opportunities for reform. HI is particularly effective in explaining this divergence due to its ability to look beyond broader structural features and conditions that remain common across both settings, to show how significant policy divergence can nevertheless occur as a result of the interaction of early, contingent variations in micro-level factors, such as actors' ideas and decisions, as well as local events, such as elections or scandals, with mid-level institutional conditions, including distinct bureaucratic rationalities, to tip policy trajectories in radically divergent directions (Pierson, 1995; Béland & Waddan, 2012; Roux, 2018, 299–300; Brejning, 2016, 15, 22; Luk, 2014, 17; Hall & Taylor, 1996; Kenny, 2007; Lecours, 2005; Béland & Lecours, 2023).

While institutional design and configurations matter for shaping outcomes in HI, as a framework HI valorizes the importance of history and is focused on problematizing institutions as stable, historically shaped structures that retain considerable stability and resilience but are also prone to change in rare moments of 'windows of opportunity'. According to HI, the stability and resilience of institutions or policies serves both to constrain and to enable agency through their historical or path-dependent legacies, legacies which emerge from early and contingent variations such as the distinct ideas and bureaucratic rationalities described above, whose interaction

produces a new institutional logic that, once established, becomes self-reinforcing and entrenched, shaping the direction of policy development for years to come (Lecours, 2005; Béland & Lecours, 2023; Stefes, 2019; Tuohy, 1999, 112–113; Pierson, 1996, 153, 175; Luk, 2020, 16; Skocpol & Amenta, 1986; Weir & Skocpol, 1985; Rueschemeyer & Skocpol, 1996). Institutions acquire this entrenchment through the positive feedback or increasing returns that they derive over time from their new policy path. As these returns accumulate, they progressively raise the cost of path-departing reform, generating exit costs so high that institutions tend to either follow or revert to their established path against pressures of path-departing change (Pierson, 1996, 153, 175; Turgeon, 2014). It is this self-reinforcing dynamic that gives institutions and policies their stability and resilience.

While HI emphasizes the stability and endurance of institutions and policies, it also offers an account of how they may change. To account for institutional or policy change, HI presents a framework of mechanisms that can disrupt the very process of path-dependence or entrenchment that makes institutions and policies stable in the first place. According to HI, change occurs through windows of opportunity, which can be triggered by a confluence of factors, including crises and political opportunities that temporarily lower institutional constraints, enabling actors to introduce new ideas and policies (Remuss, 2018, 169; Collier & Munck, 2022, 8–9; Bernhard, 2015, 978). It is only in such moments, when institutional constraints temporarily loosen, that contingent and contextual factors, including ideas and human agency, can push the policy path in a new direction, with significant change occurring either abruptly in a ‘big bang’ fashion or gradually through incremental path-departing reforms that culminate in major transformation (Wallner, 2014; Hall, 2020; Häusermann, 2009, 44–45; Streeck & Thelen, 2005; Mahoney & Thelen, 2010; Hogan, 2006, 660; Collier & Munck, 2022, 15–16; Smyrl & Genieys, 2016, 7–8).

There is ongoing debate in HI scholarship regarding the outcomes of windows of opportunity. Some scholars associate windows of opportunity only with instant major change that follows pressure from powerful external forces or events, while treating gradual change as an entirely separate process (Collier & Collier, 1991; Capoccia & Kelemen, 2007; Hogan, 2006, 660). Others hold that change need not rely on external shocks at all, arguing that major transformation can also build up gradually and from within, through incremental reforms that accumulate over time to reshape the prevailing institutional logic (Häusermann, 2009, 44–45; Streeck & Thelen, 2005; Mahoney & Thelen, 2010). This dissertation draws on both insights without adopting either position in full. In line with Tuohy, it holds that major change is set in motion by a window of opportunity opened by a confluence of external factors. Yet, unlike accounts that tie such windows exclusively to instant transformation, it shows that the major change which follows can unfold slowly and incrementally rather than all at once (Collier & Munck, 2022, 1, 15–16; Koppenborg, 2023, 17; Smyrl & Genieys, 2016, 7–8). It is precisely this combination produced by an externally forced opening followed by gradual, path-departing reform, that the present study observes in both provinces. In each case, the provincial government adopted a gradual strategy of path-departing change, underpinned by layering, to implement major reform following the opening of a window of opportunity. Layering involves "the introduction of new rules on top of or alongside existing ones" (Mahoney & Thelen, 2010, 16; see also Turgeon, 2010). Layering "therefore involves making amendments, revisions, or additions to existing rules" (Béland, 2016, 138) that can result in substantial policy changes over time since "amendments [can] alter the logic of the institution or compromise the stable reproduction of the original core" (Mahoney & Thelen, 2010, 16–17; see also Streeck & Thelen, 2005, 31).

While historical institutionalism (HI) provides a convincing account of why otherwise stable institutions may suddenly become open to change, it often fails to explain the process or mechanism by which change may proceed, or even occur, following the emergence of a window of opportunity (Luk, 2016, 6–8; Smyrl & Genieys, 2016, 7–8; Cohn, 2001, 50; Steinmo, 2008, 129; Luk, 2014, 10–15; Greener, 2002a, 163; 2002b; 2004; Béland, 2007; Peters, 1999, 68–70). In this respect, some HI accounts are criticized for using tautological reasoning, inferring the existence of a window of opportunity solely from the fact that major change occurred, even though windows do not always lead to reform (Tuohy, 2018b, 6). This shortcoming leaves HI unable to explain why actors sometimes fail to seize opportunities, why reform attempts sometimes fail, and why significant change sometimes proceeds gradually rather than abruptly. To address these gaps, this dissertation will take from Tuohy's model of policy change. As Tuohy (1999) observes, the mere opening of a window does not guarantee change. Rather, successful reform depends on whether governing actors possess the political authority and will to act. Political authority or capacity, according to Tuohy (1999, 6), refers to "a favorable set of institutional and electoral conditions" that allows actors which can accumulate sufficient authority to "overcome vetoes" and achieve change, while political will is the significance that a policy holds for the government's broader agenda to prioritize the policy over others and pursue change (12). This contribution by Tuohy is therefore important, not only because it demonstrates when actors may seize on windows of opportunity, but because it demonstrates that seizing windows has nothing to do with the policy area itself, i.e., no matter how extreme a crisis or the pressure for change within the policy area, change will not occur unless conditions in the broader political arena, defined by sufficient political authority and political will, exist to bring about reform (Tuohy, 1999, 6). For example, a province

may possess the political authority to act on a federal funding opportunity but refrain from doing so due to a lack of political will.

However, a proper model of policy change also needs to account for the degree of change, which, according to Tuohy, necessitates paying attention to the internal or "accidental" logic of the specific policy area as defined by the balance of actors, such as the state, private finance, and professional groups, and institutional instruments of social control, including hierarchy, market mechanisms, and collegiality, which structure and incentivize the behaviour of actors (Tuohy, 1999, 7–8, 11–12, 15; Tuohy, 1999a, 122). In Canadian long-term care, state hierarchy constitutes the dominant structural force within the internal logic of the public nursing home system, endowing provincial governments with exceptional decision-making authority unconstrained by the kind of professional countervailing power that characterizes the physician-dominated healthcare sector (Tuohy, 2020; Marier, 2021, 161; Baranek, Deber, & Williams, 2004, 21, 24).

According to Tuohy, during the emergence of windows of opportunity, actors that constitute the policy's internal logic will have to compete and negotiate to reach some kind of agreement or compromise that satisfies their preferences, with the magnitude of change being determined by the "durability of forces and the fit between the change proposed and internal logic of the system" (Allen, 2012, 284; Tuohy, 1999, 11–12). Hence, change is a product of both human agency and institutional legacies. One aspect of change that Tuohy's model does not explicitly take into account is the impact that institutional legacies outside the internal logic of the policy area may have on the degree of change. Thus, even though provincial governments in Canada enjoy significant hierarchical powers as the sole actors in the internal logic of the public LTC system, external actors, i.e., those outside the internal logic of the system may nevertheless wield significant influence, thereby impacting the degree of change in the process. As the subsequent

empirical chapters demonstrate, this dynamic was evident in Ontario on several occasions, where the for-profit nursing home lobby, having grown powerful as a direct result of the provincial government's earlier policies, worked to block or temper subsequent reform efforts.

Apart from explaining the magnitude of change, Tuohy's model also accounts for the direction of change. This, Tuohy explains, depends on the balance of institutional instruments, which not only structure incentives and shape how actors respond to opportunities but also define the direction of change. Furthermore, Tuohy (1999) prioritizes instruments over and above actors, arguing that shifts in instruments are likely to impart much more radical changes than change in the balance of actors (10–11). For Tuohy, hierarchical mechanisms are more formidable than market- or collegial-based arrangements in enabling major reform (Tuohy, 1999, 14–15; Allen, 2012, 284).

Of particular relevance for this dissertation are market-based instruments, which, when deployed, lead actors to orient their behaviour around market signals. Most importantly, Tuohy shows that market-based incentives can emerge even in the absence of private financial actors or formal market instruments. Governments or states may use hierarchical authority to introduce market-oriented tools, such as internal markets or managed competition, or, even without such tools, generate powerful market-based incentives by implementing policies and adopting a regulatory stance that privileges measurable physical standards over care oversight, an approach that rewards economies of scale, cost-cutting, and profit-driven behaviour (Tuohy, 1999, viii, 128, 241, 159–160, 242, 245; Tuohy, 2018b, 40–42, 574–575). States may also use their hierarchical authority to enforce an anti-market logic through strong substantive standards covering care quality and structural constraints on market behaviour, backed by strict enforcement and active

monitoring, thereby discouraging private investment by aligning actor behaviour with non-market incentives.

However, while the notion of internal logic helps explain the magnitude of change and why reform proceeds in a specific direction, it cannot explain why certain instruments or policy options come to be preferred by state actors in the first place. For example, what leads a state to advance market-based incentives? To account for this, Tuohy would point to the government's broader agenda, arguing that the policy idea selected from available alternatives is chosen based on its fit with that agenda (Tuohy, 1999, 13). Yet this explanation fails to account for the divergent outcomes examined here, since the broader agendas of both provincial governments were nearly identical, both shaped by a commitment to free enterprise and welfare-state expansion. And while British Columbia's Social Credit was known for having a pragmatic and interventionist style, this preference for interventionism on the part of the political executive was directed mainly toward economic infrastructure development projects and extended to specific welfare state sectors, including acute-care hospitals and postsecondary education, only insofar as these served the government's economic-development objectives (McDonald, 2021, 246–250, 317–318; Helliwell, 2010, 61, 67–72; Marchildon & O'Byrne, 2012, 207–208; Mitchell, 1983, 246–250, 355–358; Meggs & Mickleburgh, 2015, 21, 193). The literature is clear that the Bennett executive, including the Premier himself as well as his ministers of health and welfare, was strongly opposed to welfare-state expansion, particularly spending on public elderly institutional programs (Moran, 1992, 39–40, 54, 58; Davies, 2003, 161; Mitchell, 1983, 355–358; Blake, Carty, & Erickson, 1991, 9). Hence, state interventionism alone cannot explain British Columbia's rejection of for-profit provision, given that the Bennett government was, in the first place, opposed to spending on public elderly care and since an economically interventionist government could, in any case, equally have

channelled its activism into a market-oriented nursing home model. The failure of the partisan-agenda approach thereby points to a shortcoming in Tuohy's framework, a shortcoming that stems from the fact that even though Tuohy herself treats ideas as independent forces capable of shaping the direction of reform in their own right (1999, 12), her framework ultimately surrenders that autonomy by tying their selection to the governing party's broader agenda and the prevailing paradigm. To address this gap, the dissertation turns to an ideational-institutional model that centres on bureaucrats' principled and causal beliefs, mediated by distinct institutional models of bureaucratic rationality. These rationalities conditioned how officials interpreted the purpose of nursing home care and the roles they assumed, enabling BC bureaucrats to act as assertive advocates who drew on principled ideas rooted in a moral imperative of a high philosophy of care to advance a non-profit ownership-mix, while their Ontario counterparts, operating as obedient implementers under instrumental-formal rationality, drew upon causal beliefs rooted in the cost-minimization this rationality demanded, privileging physical standards over care quality and leaving a for-profit model as the default outcome.

3.1.2 Ideas and Policy Change

The ideational scholarship underscores the important role ideas play in shaping policy as independent variables that define "the universe of possibilities for action" (Goldstein & Keohane, 1993, 8), demonstrating that policy and politics are not simply products of power and self-interest (Campbell, 2002, 21; Chou, 2014, 29–30; Kingdon, 2013, 125). The question is no longer whether ideas matter, but how they shape policy outcomes (Van Kersbergen & Vis, 2014, 108–112; Sanders, 2008, 41; Dukelow, 2016, 72; Rayner, 2015, 68; Fontaine, 2015, 3; Béland & Lecours, 2023). While windows of opportunity create ideational openings by loosening institutional constraints, ideas do not enter the policy sphere on their own, but require actors, such as

bureaucrats, to introduce and advocate for them as viable solutions (Chou, 2014, 34; Bucken-Knapp, Karlsson Schaffer, & Strömbäck, 2012, 171; Pautz, 2020, 10; Blyth, 1997, 240).

Within this literature, two types of ideas are especially relevant for explaining policy divergence: principled beliefs and causal beliefs (Meibauer, 2025, 35; Tannenwald, 2005, 16). Principled beliefs are value-based or normative ideas that "specify criteria for distinguishing right from wrong and just from unjust", thereby defining which policy ends are legitimate (Widmaier, 2016, 16; Drezner, 2000, 739; Poletti, 2012, 27; Campbell, 2002, 23–24). An example is the view that public services should be grounded in a high philosophy of care. Since they are rooted in ethical commitments rather than empirical claims, principled beliefs are less susceptible to falsification and exhibit greater stability over time (Sikkink, 1997, 229; Goldstein & Keohane, 1993, 9). This resilience helps explain why governments sometimes maintain policies despite weak evidentiary support, as seen in Latin America's enduring commitment to import-substitution industrialization, justified more by the principled beliefs in Latin American nationalism and sovereignty than by measurable outcomes (Sikkink, 1997, 229–230; Campbell, 2002, 23–24).

Principled beliefs are especially influential in social policy domains, which invite value-based debate rather than purely technical reasoning. As White et al. (2015) note, "social policy investments… raise fundamental and principled debates about goals" and are "vulnerable to attacks on the legitimacy of state action", allowing ethical arguments to prevail over efficiency-based ones (403).

Principled beliefs can give rise to causal beliefs (Blyth, 1997, 240; Widmaier, 2016, 16), which operate at a lower level of generality and express means-end or cause-effect relationships aimed at solving concrete problems (Goldstein & Keohane, 1993, 10). If principled beliefs provide "principled roadmaps" about "what's right", causal beliefs offer "causal roadmaps" about "what

works" (Blyth, 1997, 240). For instance, the proposition that non-profit provision leads to higher-quality care is a causal belief that gains normative force when linked to a principled commitment to ethical care. Together, these beliefs form programmatic frameworks that guide policy elites in formulating actionable strategies (Berman, 1998, 21).

Ideas facilitate policy change through several pathways (Philpott, 1996, 186). They serve as roadmaps under uncertainty (Chou, 2014, 32), function as coordination mechanisms among actors (Goldstein & Keohane, 1993, 7–8), and become institutionalized within organizations as taken-for-granted assumptions (Philpott, 1996, 187–189; Goldstein & Keohane, 1993, 7–8).

In conclusion, as the foregoing discussion illustrates, institutions do not change on their own; they require both ideas and actors, such as bureaucrats, to bring them into the policy process and advance them as solutions (Schmidt, 2012, 91; Braun, 1999, 22).

3.1.3 The Modern Bureaucracy and Bureaucratic Rationality

3.1.3.1 The Modern Bureaucracy

As the preceding discussion illustrates, ideas require institutional carriers to enter the policy process, and bureaucrats constitute the principal carriers in the case study examined here. However, demonstrating that bureaucrats carry ideas into the policy process does not explain why bureaucrats in each province carried distinct ideas, nor why some were empowered to advocate persistently while others acquiesced to predetermined outcomes. Answering these questions requires moving from ideas to the institutional conditions of the bureaucracies themselves, i.e., to the bureaucratic rationalities that shaped how officials interpreted problems, evaluated options, and perceived their own roles in the policy process.

The important role the bureaucracy plays in shaping policy was brought to light by state-centred theorists in the 1970s who criticized prevailing theories of social policy for ignoring the

state as a partially autonomous and formidable policy actor while valorizing other factors such as party ideology and societal groups as the primary shapers and influencers of policy outcomes (Peters & Pierre, 2012, 2–3; Pfiffner, 1987, 60; Schmidt, 1996, 26; Heclo, 1988, 40; Vincent, 2013, 46–48; Evans, Rueschemeyer, & Skocpol, 1985). State bureaucrats, they argued, played a key role in the policy process by detecting policy issues in advance and proposing solutions based on their own intellectual effort through their own expertise (Peters, 2001, 223) or by adapting or reworking ideas drawn from their country's past, other jurisdictions, or existing ideational and institutional legacies (Heclo, 1974). Hence, they concluded that policy outcomes were not merely products of external interests but were significantly shaped by the ideas and autonomous actions of state bureaucrats.

3.1.3.2 Bureaucratic Rationality

Although bureaucracies clearly play a fundamental role in shaping policy, the nature of their influence is shaped by their operative rationality. As the public administration literature notes, despite sharing basic structural features such as hierarchy, formal rules, and merit-based staffing, bureaucracies can be differentiated by their practice of two distinct modes of rationality, namely instrumental-formal and substantive rationality, with each type having a markedly distinct impact on policy formulation and administrative practice (Bartels, 2009, 449; Hummel, 1994; Hatch & Cunliffe, 2013, 25; Schreurs, 2002, 279; Torgerson, 2011, 70; Netelenbos, 2016, 48; Gregory, 2017, 227–228).

3.1.3.3 The Logic of Instrumental-Formal Rationality

Instrumental-formal rationality involves adherence to technical calculations and universal rules and procedures to ensure the most efficient achievement of assigned political directives with maximum impartiality, objectivity, and predictability (Kalberg, 1980; Bologh, 1990, 98, 99, 107–

108; Heller, 2009, 188–189). This makes it a purely means- or method-oriented form of rationality that is indifferent to the substantive or moral merit of the ends, since the optimal outcome is already guaranteed in advance through the application of universal rules and procedures to the assigned political directive (Torgerson, 2011, 58–59, 64; Berman, 1990, 151; Ritzer, 1996, 244; Orsini, 2024, 192; Delaunay & Gouveia, 2023; Todorovic, 2016, 20–21; Elster, 2000). Consequently, questioning the end goal or appraising its legitimacy becomes unnecessary and even forbidden, not only because the optimal end is already guaranteed by the method, but because any value-based appraisal is considered subjective and a threat to the method's objective, value-free basis (Ritzer, 1996, 246; Morrison, 2006, 287, 380; Bartels, 2009, 460; Gronow, 1988, 325–326; Torgerson, 2011, 65). This severely constrains bureaucratic agency, leaving little room for discretion and debate, as the correct outcome is already fixed in advance and any personal input or critical reflection is treated as a violation of the method's objective nature (Berman, 1990, 154–155; Monteiro & Adler, 2022, 433; Torgerson, 2011, 59, 68; Levine, 1981). Decision-making becomes highly centralized, reserved for political superiors (Monteiro & Adler, 2022, 433; Bartels, 2009, 461), while bureaucrats come to assume a subordinate and impersonal role, their main obligation being to obey orders and serve the method "irrespective of its relation to organizational objectives" (Albrow, 1970, 65). Hence, they are reduced to mere handmaidens of the procedure, their own faculties and understandings systematically excluded from the policy process. Decisions are not made by bureaucratic interpretation but are pre-determined and judged according to objective criteria of "measurement, calculation, and quantification" (Todorovic, 2016, 20). While bureaucrats may still express concerns over policy matters, they are expected to carry out their orders if their objections are overruled (Bartels, 2009, 459–460; Monteiro & Adler, 2022, 435). As Monteiro & Adler (2022) point out, "Deliberation on the ends of action is here reserved for actors

at the top of the hierarchy of authority: subordinates take those ends as given by authoritative command, and they understand their task as pursuing the most rational and efficient way of realizing those ends" (433). It is this hierarchical constraint on deliberation that the Ontario empirical chapters will demonstrate in action (Bartels, 2009, 460).

This procedural subservience produces what Weber termed the "iron cage"—a bureaucracy obsessed with perfecting internal routines, focused on how to act and maximize efficiency rather than why or for whom (Weber, 1922/1978; Pierucci, 2000, 146). In this state, the organization narrows its mandate to what can be counted and measured, sidelining considerations such as care quality or human well-being that do not lend themselves to quantification, and prioritizing the perfection of its own procedures over the needs of the people it is meant to serve (Gregory, 2017; Tronto, 2019; Grey, 2013, 140; Gronow, 1988, 326; Frederickson, 2010, 31). This loss of purpose, in which the procedure becomes an end in itself, whereby adherence to rules and measurable outputs displaces the substantive outcomes those rules were meant to serve, is the organizational mechanism through which the iron cage takes hold, and is what the public administration scholarship terms goal displacement (Merton, 1968, 253; Bohte & Meier, 2000, 173–174; Peeters, 2020, 580–581; Mokoagow et al., 2026).

3.1.3.4 The Logic of Substantive Rationality

In contrast to instrumental-formal rationality, substantive rationality is value-based and end-goal oriented, with outcomes judged according to an ethical system, such as a philosophy of high-quality care (Morrison, 2006, 287, 353; Ritzer, 1996, 244; Langer, 2022, 2; Kalberg, 2012, 31). As TenHouten (2012) explains, "Substantive rationality's principal emphasis, then, is on chosen ends which also govern and constrain one's choice of means. In this sense, substantive rationality radically differs from instrumental [or formal] rationality, where means [or the universal

method] represent the principal focus" (15; see also Ritzer, 1996, 244; Orsini, 2024, 192; Delaunay & Gouveia, 2023).

Grounded in ethical ends, substantive rationality invites deliberation about which policy paths best align with normative commitments, an inquiry that, as Hatch and Cunliffe (2013) note, demands that "the ends need to be questioned" (25; see also Monteiro & Adler, 2022, 432; Letiche, 2008, 31; Bartels, 2009, 461; Hatch & Cunliffe, 2013, 25). This opens the policy process to multiple perspectives and creative solutions derived from bureaucratic judgment, thereby helping to dismantle the bureaucracy's rigid proceduralism (Monteiro & Adler, 2022, 432; Torgerson, 2011, 58–60, 66, 68). In the process, bureaucrats' roles shift from subordinate executors of procedure and orders from above to assertive advocates who exercise discretion, analytical capacity, and agency rooted in a sense of public duty to shape policy outcomes.

Crucially, substantive rationality does not abandon procedural rigour or cost-efficiency concerns but subordinates them to ethical imperatives (Abrahamsson, 1993). Furthermore, it accommodates uncertainty, context, and particularity, valuing experiential knowledge alongside standardized rules and procedures. Thus, whereas instrumental-formal rationality demands indifference in order to protect neutrality, substantive rationality embraces attentiveness, sensitivity, and principled commitment (Tribe, 1973, 627; Brubaker, 1984; Berman, 1990, 152, 154–155; Waerness, 1984, 195–198). In so doing, substantive rationality provides the institutional basis for care-oriented outcomes. As Tronto (2019) and Waerness (1984, 195) have argued, care is not merely a private matter but a political practice that requires attentiveness, discretion, and emotion, qualities that are systematically excluded by instrumental-formal rationality's procedural indifference but enabled by substantive rationality's orientation toward ethical ends. In the context of social policy, this orientation naturally invites evaluation of policy options against the well-

being of service recipients rather than against fiscal imperatives alone (Hatch & Cunliffe, 2013, 25).

When substantive rationality directs instrumental-formal rationality rather than being displaced by it, the result is a substantive orientation in which the procedural rigour and efficiency of the latter are guided by the ethical deliberation of the former. This does not mean that instrumental-formal procedures are abandoned or that fiscal and procedural considerations become irrelevant. On the contrary, the bureaucracy continues to operate within budgetary constraints, to conduct routine inspections, to apply standardized rules, and to pursue cost-effectiveness. What distinguishes this substantive orientation is that these procedural and instrumental means are treated as means in the service of substantive ends, such as a high philosophy of care, rather than as ends in themselves, as is the case under instrumental-formal rationality, which tends to leave no room for substantive ends, treating value-based judgement as a subjective interference with the procedure's objectivity (Ritzer, 1996, 246; Bartels, 2009, 460). Consequently, when it comes to evaluating policy choices that result in a tension between human and fiscal costs, the substantive orientation empowers officials to prioritize care first while still operating within procedural and fiscal constraints. It is this alignment between substantive rationality and the relational basis of care that this dissertation captures through the concept of the caring bureaucracy, a bureaucracy that does not disregard costs or procedures but evaluates them against the principled ends they are meant to serve, enabling officials to retain sight of their public purpose, exercise discretion in evaluating policy options against principled ends, and act as assertive advocates rather than obedient implementers.

3.1.3.5 The Scholarly Divide

The scholarship on bureaucratic rationality is divided between mainstream and critical approaches (Schreurs, 2002, 279–281; Berman, 1990, 154; Grey, 2013, 130–131, 140). Mainstream scholars hold that bureaucracies should operate on an instrumental-formal basis alone, both to enable the bureaucracy to achieve its tasks with maximum efficiency and predictability and to dissociate bureaucrats' personal discretion from the administrative process to uphold the politics–administration dichotomy. They therefore reject substantive rationality as a threat to that dichotomy and to the impartiality of the bureaucratic process on the grounds that the value-based debate, personal interests, and discretion it introduces would slow or corrupt the bureaucracy's operation (Morrison, 2006, 381; Cockerham, 2015, 127; Adewale, 2017, 6–7). By contrast, critical scholars, including Max Weber, argue that though instrumental-formal rationality often dominates, effective bureaucracies require both instrumental-formal and substantive rationality to remain connected to ethical ends and public purpose (Torgerson, 2011, 71; Hatch & Cunliffe, 2013, 24–25; Schreurs, 2002, 279–280; Mannheim, 1940; Harmon, 1981; Denhardt, 1981; Hummel, 1994). One example that illustrates just how distinctly these different bureaucratic orientations can shape the nature of policy outcomes can be drawn from the early twentieth-century contrast between the substantively-oriented Settlement Women and the instrumentally-oriented Bureau Men in Chicago (Stivers, 1993; 1995; 2000; Farmer, 1995; Box, 2005; Fischer, 1990; Marcuse, 1964; Rothstein, 1998; Olsen, 2006). In 1917, a debate ensued over the poor state of Chicago's garbage collection services, where the streets were left a "foul mess" as a result of the city's inadequate service provision (Wayman, Alexander, & Shields, 2022, 303–304). The Settlement Women, guided by a substantive bureaucratic orientation, reached the conclusion that public ownership "would better serve the health and welfare of the city than private ownership", while the Bureau Men, guided by

an instrumental-formal orientation, concluded that the interests of the city would be best served by "maximizing private profit and minimizing government involvement" (Stivers, 1995, 527–528; Wayman, Alexander, & Shields, 2022, 303–304). These divergent conclusions were also reflected in the distinct research strategies each movement employed. The Settlement Women adopted a critical, hands-on, and experiential approach that involved conducting research on garbage collection methods in Europe, producing "understanding directly relevant to action" (McSwite, 2004, 414; Stivers, 2000, 95–96; Burnier, 2022, 62), while the Bureau Men relied on consultants who affirmed private profit as inherently efficient (Stivers, 1995, 527–528). Crucially, the Settlement Women did not reject scientific administration. Rather, they complemented objective analysis, grounded in the critical comparison of different policy options, with value-guided inquiry to ensure outcomes aligned with the public interest, a combination that enabled more responsive and effective policy conclusions (McSwite, 2004, 414; Stivers, 2000, 95–96; Burnier, 2022, 62; Waerness, 1984). The bureaucratic model practiced by the Settlement Women can thus be understood as a caring bureaucracy, one in which instrumental-formal procedures were placed at the service of principled ends, with cost-efficiency and procedural rigour treated as means rather than as ends in themselves. Similar models have been documented in the scholarship, including in the New Public Administration (Frederickson, 2005; Frederickson et al., 2011, 3–4; Lindquist, 2025; Dong, 2016, 181–183) and feminist public administration (Findlay, 2015; Ashcraft, 2001; Eisenstein, 1990; 1991; 1995; 1996; Hart, 1992), where value-guided reasoning was institutionalized alongside procedural rigor. As the empirical chapters will demonstrate, the divergence between Ontario's instrumental-formal orientation and British Columbia's substantive orientation echoes this early twentieth-century divide: the same question of whether public

services should be delivered through for-profit or non-profit provision was resolved through the same competing rationalities that differentiated the Bureau Men from the Settlement Women.

3.1.3.6 Identifying the Two Rationalities: Indicators of Discourse and Agency, and the Inference of Principles

Having distinguished instrumental-formal from substantive rationality at the conceptual and theoretical levels, this section specifies how each form of rationality manifests itself in the empirical record. This is done in order to clearly distinguish what counts as evidence of each type of rationality, thereby allowing the analysis to map which rational form was operative in each province. Accordingly, both rationalities leave observable empirical manifestations of two kinds, namely in how officials talk about and justify policy problems and solutions, and in the nature of the agency they exercise when they act.

Discursively, instrumental-formal rationality is indicated by language that frames the policy problem in terms of cost, efficiency, procedure, and measurable output, with substantive considerations marginalized or absent, and the overarching end treated as given by the procedure rather than as a matter for evaluation. Officials operating under this form of rationality discuss nursing home provision through the vocabulary of per-diem rates, capital expenses, dollar value, and the avoidance of administrative burden. A characteristic discursive marker is the dismissal or reframing of care quality through the justification that any care is preferable to no care, a formulation that accepts a low threshold of adequacy as an acceptable endpoint rather than a problem to be solved. A corollary marker is the treatment of qualitatively distinct programs as interchangeable once they are measured solely in terms of bed capacity and cost, such that differences in the quality of care they deliver are rendered invisible. Substantive rationality, by contrast, is indicated by language that frames the policy problem in moral or principled terms, that subordinates cost and procedure to an ethical end such as a high philosophy of care, and that treats

the overarching end as something to be questioned, defended, and acted upon on principled grounds, even where this departs from the solution dictated by the bureaucratic procedure. Officials operating under this form of rationality frame substandard care as a moral failure implicating the government's own integrity, describe the exploitation of vulnerable patients as a problem the state is obligated to correct, and insist that the case for a given ownership model rest on care quality rather than cost savings alone.

In practical terms, instrumental-formal rationality is indicated by an administrative effort concentrated on what is most easily measured and least costly to monitor, by the privileging of physical standards over the substantive quality of care, and by the avoidance of policy options that would commit the state to direct capital expenditures and ongoing operational-deficit costs, opting instead for the least costly available route. Crucially, it is also indicated by a particular pattern of agency. Officials may raise objections, but tend to do so in a defeatist voice and are expected to defer once overruled. Substantive rationality, by contrast, is indicated by an administrative effort directed toward the realization of a principled end despite fiscal and political costs and pressures, by the imposition and active enforcement of high standards covering both physical infrastructure and care quality, and by a contrasting pattern of agency in which officials, rather than backing down, persist in advocating a preferred option across successive windows of opportunity and resist directives from above when those directives conflict with their substantive objective.

A particular indicator of instrumental-formal rationality warranting separate treatment, one on which much of the Ontario analysis rests, is the documented failure of officials to act on extensive and well-known evidence of harm, not because that evidence was absent or unavailable to them, but because the form of rationality through which they worked screened out the human consequences of policy as falling outside the scope of what the procedure was equipped to register

as relevant. This failure is not a personal or moral failing on the part of individual officials, but a structural tendency that Weber himself anticipated in his account of the iron cage, since instrumental-formal rationality, bound to the orthodox pursuit of a procedure presumed to deliver the most efficient means to a given end, tends to leave no room for substantive ends or human needs, as these cannot be expressed in the procedure's own terms of countable measurement, calculation, and cost (Bartels, 2009, 451). This exclusion of substantive ends is not incidental but an inherent by-product of the procedure's claim to superiority, since the certainty, predictability, and consistency prized in formal rationality depend on reducing problems to what can be counted and calculated. This same claim, resting on the procedure's presumed universality and objectivity, also renders substantive judgement both unneeded, since the procedure is already presumed to deliver the best result, and illegitimate, since any exercise of discretion is treated as a subjective interference with that objectivity (Morrison, 2006, 380; Ritzer, 1996, 246; Bartels, 2009, 460). It is in this way that, under instrumental-formal rationality, the procedure becomes an end in itself, resulting in a process of goal displacement where adherence to rules and measurable outputs supplants the substantive outcomes those rules were meant to serve, leaving the bureaucracy diligent, competent, and active yet unresponsive to the human consequences its own policies produce (Merton, 1968, 253; Bohte & Meier, 2000, 173–174; Peeters, 2020, 580–581; Gittell & Douglass, 2012, 713). Identifying this displacement requires showing two things together. First, that evidence of harm was available to officials and acknowledged by them. And second, that officials nonetheless declined to treat that harm as a reason for corrective action, treating it instead as lying outside the parameters of the instrumental-formal rational procedure, where concerns over cost-minimization and the orthodox pursuit of procedure itself took priority, and where substantive concerns were rendered incompatible with, if not actively undermining, the procedure and its

corresponding results. Where both conditions are met, as the Ontario chapters repeatedly demonstrate, this failure serves not as evidence of mere ignorance or individual shortcoming but as evidence of the governing role of instrumental-formal rationality, since it is ultimately the bureaucratic rationality, and not the diligence of officials, that determines which considerations register as relevant and which do not.

A final qualification concerns the identification of a principle itself, since a principle, unlike a regulation, does not appear as a single, explicit instance in the archival record. It must therefore be inferred, and the inference can be considered accurate when it rests on a repeated pattern in what officials said and what they did, sustained across time. A single observation would not be enough, since an official using the language of care, or a single decision that happens to favour a non-profit option, could each be explained on other grounds, whether administrative, fiscal, rhetorical, or simply idiosyncratic to one official or one moment in time. What the archival record provides instead is a consistent pattern, with officials taking a repeated principled stance and formulating and advancing policy on that basis across successive windows of opportunity, confirmed in the confidential confessions of officials, where the frankness of the internal record reduces the likelihood that the language of care was merely political rhetoric. It is this sustained advocacy of the principled position, rather than any single instance, that warrants the inference. The same standard applies to instrumental-formal rationality. Language that privileges rates, expenses, and dollar value over the quality of care is more readily discernible in a single document and less likely to be mere rhetoric, since officials had little to gain from appearing indifferent to care. But it is only the repetition of that orientation across successive windows of opportunity that shows it to be the operative rationality, rather than a passing consideration.

3.2 Methodological Framework

3.2.1 Methodological Framework: Introduction

Prevailing explanations of the welfare state fall short of explaining the puzzling outcome found in this case study, as the key variables these explanations emphasize are either shared by the two provinces, and therefore cannot explain their divergence, or differ between them but fail to predict the outcome correctly. For this reason, the study employs process tracing as its core methodology, a within-case rather than cross-case method of causal inference that is capable of uncovering explanatory variables by reconstructing the complex, historically embedded causal process that led to the distinct outcome in each case. As process tracing depends on dense within-case evidence and multiple observations to accurately uncover the complexity of the historical process, the study adopts a case-study research design which, in contrast to large-N studies, allows for the complexity and number of within-case observations that process tracing requires (Checkel, 2015, 96; George & Bennett, 2005, 13, 19, 21; Blatter & Haverland, 2014, 19; Bennett, 2004). The next section elaborates the inferential logic of process tracing in detail.

3.2.2 Method of Inference: Process Tracing

Process tracing is a within-case method of causal inference that entails the "intensive analysis of the development of a sequence of events over time" in order to demonstrate the intervening causal-process connecting the initial condition or independent variable(s) (IVs) to the outcome or dependent variable (DV) (Levy, 2008; Collier, 1991). The choice to use process tracing is based on the research design, goals, and objectives of this dissertation.

First, the research question being posed is outcome-oriented or Y-centred rather than variable-oriented or X-centred (Blatter & Haverland, 2012, 24, 112; Beach & Rohlfing, 2018, 12). In other words, the primary objective is to determine how a particular outcome (Y) has come about,

rather than whether a particular factor (X) makes a difference (Y), or what impact X has on Y. Process tracing is the most appropriate methodology for addressing these types of research questions as it is a research methodology that is 'process' oriented rather than 'variable oriented'. In other words, the central aim of process tracing is to demonstrate the causal process that leads to an outcome by problematizing the outcome on the basis of a combination and interaction of multiple causal factors under particular sequential and temporal configurations (Hall, 2003, 385; Blatter & Haverland, 2012, 84), rather than on the basis of a single independent variable that alone has caused the dependent variable. In addition, process tracing is friendly to the collection and utilization of numerous forms of empirical observations at different levels and dimensions, from the individual level to the societal level, or from the local level to the national level (Blatter & Haverland, 2012, 81, 87, 109; see also Reilly, 2010). This makes process tracing a good fit with the research objective of this dissertation, which is to examine causal complexity by engaging in deep within-case analysis in order to collect a plethora of empirical observations to uncover how a multitude of real-world mechanisms and events interacted together over time to lead to the outcome of interest.

The empirical observations collected and analysed in process tracing can be categorized into three types: the comprehensive storyline, smoking gun, and confessions (Blatter & Haverland, 2012, 118; 2014). As Blatter and Haverland (2012) state, "ideally, a full-fledged explanation based on CPT [Causal Process Tracing] should include all three kinds of empirical evidence" (118). Storylines present the bigger picture of the causal process by revealing the major causal factors and critical moments that play out and shape the causal process, while confessions are aimed at understanding the motivations, perceptions, and reactions of major actors involved in the causal process in respect to the major structural events of the 'storyline' (King, Keohane, & Verba, 1994,

226–227; Blatter & Haverland, 2012, 117–118). Smoking-gun tests demonstrate the existence of a phenomenon in a less certain or direct sense, more so by pointing to the existence of a phenomenon in a hint-like manner rather than directly or explicitly (Collier, 2011; Goertz & Mahoney, 2012, 95–96; Beach & Pedersen, 2016; 2019; Blatter & Haverland, 2012, 110, 115–116, 117).

As a process-oriented inferential approach, process tracing also aligns well with the historical institutional theoretical framework adopted in this dissertation, which is itself a processual approach that involves an examination of how certain processes such as path-dependence or path-breaking change occur over time (Halperin & Heath, 2020, 269–270; Blatter & Haverland, 2014, 2; Jaramillo, 2020, 114–115; Ghalehdar, 2022, 440–441). Similar to process-tracing methodology, historical institutionalism can tackle complexity as it is a multi-causal rather than mono-causal theory which pays attention to the interaction of multiple factors at multiple ontological levels, and also takes into account time, history and context as it pertains to the macro, mid-range, and micro-level factors in question (see also Champagne, 2013, 46).

3.2.3 Case Selection

In process tracing, case selection does not play as systematic or central a role as it does in other research methods, such as small-N covariational studies (Blatter & Haverland, 2012, 99). In addition, given that process tracing is a within-case methodology, the number of cases (Ns) does not lead to more accurate causal inference as may be the case with the 'comparative method'. Instead, the primary objective of case-selection in process tracing is to ensure that extensive, diverse, and accessible information is available for the cases selected (Blatter & Haverland, 2012, 81, 106; Rohlfing, 2012, 160). This is a crucial requirement for process tracing, as this methodology depends more on the case than theory, thus requiring dense and rich information. Or

as Blatter and Haverland (2012) point out, "the cogency of CPT relies on the ability of the researcher to assemble many empirical details, to have a profound knowledge and understanding of the development of structural factors, and/or to attain deep insights into the perceptions and motivation of major actors" (102). In addition, "diverse observations" are required "to produce 'comprehensive storylines' […] and 'confessions' which form the empirical basis for drawing causal inferences" (Blatter & Haverland, 2012, 20).

This case study was chosen taking into consideration that a multiplicity of diverse and extensive information would be available and accessible through governmental archives and newspaper and stakeholder reports. In addition, the fact that these events occurred several decades ago enhances information accessibility by increasing the likelihood that previously confidential government documents have been declassified or could be accessed through freedom of information requests.

While the availability of dense information forms the main basis for case selection in process tracing, research goals may also guide this choice, including a case's social importance or its practical and theoretical relevance (Blatter & Haverland, 2012, 27, 90, 137, 154). This case study was also selected because it meets these criteria. It concerns a social policy area that has historically been marked by severe shortcomings, regulatory failures, and substandard care (World Health Organization, 2002, 5; OECD, 2013a; 2005, 3, 13, 65–77; 2013b, 1; 2011, 13, 15; Langins et al., 2020, 7; Akhtar-Danesh et al., 2022, 1), especially in Canada as demonstrated by the recent COVID-19 pandemic (Wong et al., 2021; CIHI, 2020, 2; Badone, 2021, 389; Estabrooks et al., 2020, 654; Combden et al., 2022, 59; Rocard, Sillitti, & Llena-Nozal, 2021, 131; OECD, 2021, 3; Armstrong & Armstrong, 2019, 5). The divergent policy outcomes observed across two provinces offer practical relevance for policymakers and stakeholders by showing that meaningful

improvements are possible even in a domain long characterized by persistent quality and regulatory challenges. At the same time, the case yields theoretical insights by demonstrating that two provinces within the same national context which share a host of institutional similarities as well as a greater number of socioeconomic similarities with each other than with other provinces can ultimately follow starkly divergent policy paths with respect to the ownership-mix of their nursing home systems.

Although this dissertation selects two broadly similar provinces, a design choice that resembles a most similar systems approach, this was not done to complement the research with co-variational analysis in the conventional sense. Rather, the similarity between the two cases constituted the initial analytical puzzle that inspired their selection in the first place, and it is precisely this puzzle that makes the research compelling both substantively and as a dissertation project. Moreover, the primary objective of the study here is to rely on process-tracing to uncover the causal-process effecting the outcome from which to then determine the independent variables, rather than to use a most similar-systems design to detect the independent variables. Using the comparative method in this way is in line with both process-tracing methodology as well as the historical institutionalist (HI) approach to studying politics, where comparison is often used as a heuristic device or exploratory tool to guide research while process-tracing has often served as HI's core methodology (Boychuk, 2016, 752; Hall, 2003, 395–398; Hall, 2006; Fioretos, Falleti, & Sheingate, 2016, 8, 18; Mahoney, 2007, 134; Blatter & Haverland, 2014, 61; Waldner, 2015, 126; Fontaine, 2020, 291; Bartlett & Vavrus, 2016, 16; Pahl-Wostl, Basurto, & Villamayor-Tomas, 2021, 288; Blatter & Haverland, 2012, 33–34; George & Bennett, 2005, IX; Møller, 2013, 693).

3.2.4 Method of Observation

The method of observation used in this dissertation will consist of extensive archival, web-based, as well as library-based research of government documents, newspaper reports, special magazines, and stakeholder reports and studies that provide relevant and direct information about the major mechanisms and events surrounding the research question or those "that were generated during the policymaking process under examination" (George & Bennett, 2005, 6–7, 99; Jacobs, 2015, 53; Blatter & Haverland, 2012, 106, 188; Beach & Pedersen, 2019, 216, 213–222).

The study will place special emphasis on obtaining observations that provide detailed accounts of the views, ideas, and explanations of senior bureaucratic officials and ministers overseeing health and social policy, particularly as they pertain to the formulation of nursing home policy. The reason emphasis is being placed on collecting observations on senior bureaucrats is because they constitute the key informants that tend to be the most directly and actively involved in the policy decision-making process, including through the policy-making advice and guidance they provide to ministers.

This dissertation also places special emphasis on data from governmental archival sources as these records have the potential to offer unbiased and unfiltered information due to their confidential nature and the fact that they capture officials' 'frank' views behind closed doors. Such records therefore allow for obtaining 'confessions' from officials, which are crucial forms of empirical evidence for process tracing (Friedrich, 2022, 466; Ghalehdar, 2022, 442; Blatter & Haverland, 2012, 118). This is critical for process tracing, a methodology that aims to make conclusions from a multiplicity of observations that provide significant amounts of detail, small and large, in order to uncover the causal complexity behind the outcome in question. This makes it essential that the information obtained is as genuine and free of bias as possible (Blatter &

Haverland, 2012, 105–106). Archival government records are also particularly valuable for detecting the kind of gradual, under-the-radar policy shifts that, while not well-publicized by government if they were publicized at all, ended up having a major impact over time in each province.

The views, reactions, and influence of other stakeholders, including key interest groups and civil society organizations will also be gauged through a combination of archival government documents, online newspaper research, and stakeholder publications and reports. However, the amount of such information is expected to vary between the two provinces due to contextual differences. For example, the Ontario government's failure to intervene and address long-standing issues in the nursing home system encouraged a stronger societal reaction compared to BC, where stringent provincial regulations and controls covering both physical and care standards not only lowered the levels of stakeholder and popular discontent, but also limited the power of the province's for-profit nursing home lobby (Greb et al., 1994, 292).

Much of the analytical weight, however, will rest on the motivations and actions of the provincial government. As established in the theoretical overview, the government constitutes the dominant structural force in the internal logic of the nursing home system in Canada, and this endows it with significant decision-making authority at the expense of other stakeholder groups.

The dissertation will also rely on other observational methods, such as Hansard records and publicly accessible government reports. However, since such sources of data tend to be more focused on explaining major and instant changes in policy than they are in demonstrating gradual 'under the radar' policy shifts that culminate in major transformation over time, they may play a smaller role in the dissertation project.

In conclusion, the large majority of the sources of observation for this dissertation come

from government archival records, followed by historical newspapers and government and stakeholder reports, respectively.

3.3 Conclusion

In sum, this dissertation employs process tracing as its core methodology, supported by the theoretical lenses of historical institutionalism, bureaucratic rationality, and ideational theory to uncover how and why two otherwise similar provinces arrived at divergent ownership-mixes in their public nursing home sectors. Process tracing enables a detailed reconstruction of the causal sequence leading to each outcome, while historical institutionalism helps theorize how major policy change can occur through critical junctures and gradual forms of change.

At the same time, the concepts of bureaucratic rationality, together with ideational factors, provide the analytical tools to explain how bureaucratic actors, operating within distinct rationalities, shaped policy trajectories in ways that prevailing welfare state theories could not anticipate. This integrated approach allows for a nuanced, empirically grounded explanation of policy divergence rooted in process, institutional context, and the ideas and agency of bureaucratic actors.

More precisely, the theoretical model operates as follows. Historical institutionalism provides the foundational framework, demonstrating how identical structural conditions and shared windows of opportunity can produce divergent outcomes when filtered through distinct institutional conditions. Ideational theory specifies the content of the divergence, distinguishing between the causal beliefs that dominated Ontario's cost-minimization approach and the principled beliefs that drove BC's non-profit orientation. Bureaucratic rationality provides the mid-level mechanism that connects these two levels, explaining how distinct ideas were filtered and carried forward in each province by specifying how the institutional conditions of each

bureaucracy conditioned how officials interpreted and weighted options from among the range of available ideas, and whether they were empowered to exercise discretion as persistent advocates or constrained to accept outcomes consistent with procedural logic. It is the interaction of these three components, operating across successive windows of opportunity, that the empirical chapters that follow aim to demonstrate.

Chapter 4: Municipal Governance, Provincial Reluctance, and the Entrenchment of For-Profit Nursing Homes in Ontario, 1940s–1960s

4.1 Introduction

As the theoretical framework predicts, under instrumental-formal rationality, officials will pursue the bureaucratic procedure in an orthodox fashion as both the means and end of administration, filtering the shared political objective of a modernized public nursing home system primarily through a cost-minimization lens, one that leads them to treat direct regulatory and administrative responsibility as an avoidable expense rather than a public obligation. Bound by this instrumental-formal rational orientation, officials retain agency as executors of the procedure but lack both the principled basis and the institutional empowerment to challenge the status quo as agents of public duty when confronted with the issue of the rapid and unchecked expansion of for-profit nursing homes and the substandard care provided in these facilities.

This chapter traces these developments across the emergence and evolution of Ontario's nursing home policy from the early 1940s to the late 1960s, showing how, during this period, an emergent, pressing need for public nursing home care prompted a series of municipal and provincial initiatives that generated a two-tiered and uncoordinated approach in the field. Within this uncoordinated framework, two parallel public programs emerged: a for-profit dominated, municipally administered and funded means-tested public nursing home program marked by substandard care and symbolic regulations, and a municipal and charitable Homes for the Aged program providing multiple levels of care, including nursing home care, that targeted welfare patients but was also open to those of higher means on an ability-to-pay basis, which the province initiated and developed with generous funding before ultimately abandoning it.

Crucially, provincial absence and action throughout this period were governed by an instrumental-formal rationality under which procedural compliance and cost-minimization

operated as ends in themselves, displacing substantive deliberation over care quality. Filtered through this rationality, the political directive of addressing the nursing home bed shortage was interpreted through causal beliefs that led the province first to abstain from intervention and, when forced to act, to implement policies designed to intervene in the sector in the most cost-efficient manner possible while evading direct oversight and control—an approach that facilitated the rapid expansion of a for-profit nursing home sector within a public system governed and funded by municipalities and marked by substandard care and the absence of substantive oversight.

To demonstrate how the province's bureaucratic logic locked in the for-profit trajectory over its non-profit alternative, this chapter proceeds in four stages. First, it provides an analysis of the regulatory vacuum and subsequent symbolic governance that characterized the municipal era, tracing how an emergent, pressing local need for public nursing home care, coupled with a completely absent provincial role, forced municipalities to intervene on their own by relying on local property taxes to enter into funding partnerships with for-profit nursing homes. This ineffective municipal regulatory regime ultimately facilitated the rapid expansion of a municipally-governed and funded for-profit dominated public nursing home system characterized by substandard care and the absence of substantive oversight. Second, the chapter illustrates that when public pressure eventually forced provincial intervention in the late 1950s, the provincial government merely reinforced municipal responsibility, refusing to assume direct regulatory control by citing the prohibitive administrative costs of oversight as the reason. Instead, the province advanced financial support to municipalities strictly tied to the adoption of provincially devised municipal bylaws, privileging easily measurable physical standards over care quality while deliberately failing to sanction municipal non-compliance either through enforcement or the withdrawal of funding. Third, the chapter examines how, when the 1958 federal-provincial

Hospital Insurance and Diagnostic Services program opened a further window of opportunity, the province addressed a chronic care bed shortage by again deferring to the cheapest available means, securing a temporary exemption from the program's exclusion of for-profit providers to establish the 1959 Temporarily Approved Nursing Homes for Chronic Care programme despite the well-documented poor care in these facilities, and retaining it for fifteen years even as most for-profit homes failed to meet the standards required under federal guidelines, with some dropped from the program. Finally, the chapter contrasts this trajectory with the provincially funded municipal and non-profit Homes for the Aged program. While this program demonstrated the state's capacity to successfully prioritize non-market approaches to social policy, the provincial government ultimately abandoned these efforts, identifying for-profit expansion as the least costly means of establishing a modernized system, since for-profit provision spared the province the up-front capital contribution and the ongoing operating-deficit liabilities that non-profit and municipal provision would have entailed.

4.2 The For-Profit Path: The Emergence and Failure of Ontario's Municipally Organized Nursing Home Programme, 1940s–1950s

This section traces the emergence and evolution of Ontario's municipally-organized public nursing home system from the early 1940s to the late 1950s, demonstrating how the absence of any provincial role, set against a pressing shortage of public nursing home beds, forced intervention by a municipal level of government that lacked the capacity and the will to adequately fund and regulate the sector, thereby producing a regulatory regime that was symbolic in character and unable to check the expansion of substandard for-profit provision.

Prior to the 1940s, Ontario had no dedicated public nursing home program, and institutional accommodation of any kind for the bedridden elderly remained critically scarce. Those requiring care were scattered across county Houses of Refuge, alongside a small, unregulated private

boarding-home sector that had begun to emerge in the 1930s which some municipalities subsidized on an ad-hoc basis (Struthers, 1997, 171–173; Scully, 1985, 23). Others, with nowhere else to go, filled acute-care hospital beds at per-diem rates shared by municipal and provincial governments but condemned by hospitals as inadequate, a situation that produced a hospital bed shortage that would eventually force municipalities into nursing home partnerships in the 1940s (The Globe, 1934; The Globe and Mail, 1944; Struthers, 1997, 173). Toronto, the city most affected by a shortage of accommodation for those requiring nursing home care that had led to overcrowded hospitals, became the first municipality to offer a public nursing home program in 1941, when it started providing a subsidy of 40 dollars per month to what were predominantly small and independent for-profit nursing homes to care for welfare-eligible patients requiring nursing home care (Struthers, 1997, 173–174; Lundman, 1975, 25/103). This funding was not, however, accompanied by any regulations at either the provincial or municipal levels. As a result, there was a rapid expansion of for-profit providers throughout the city in an unregulated environment. Between 1941 and 1947, Toronto's municipal nursing home program grew from 30 patients in several nursing homes to over 600 patients, cutting the average length of hospital stays in half in the process (Struthers, 1997, 174, 176, 178, 181, 186).

However, this rapid, unregulated growth came at a high cost to patient well-being, as for-profit nursing homes quickly developed a poor reputation among government officials and the public alike due to their provision of low-quality care and inadequate living conditions (Struthers, 1997, 174–175, 178–179). The earliest and most scathing evidence of this systemic failure emerged from a 1944 provincial Old Age Pension (OAP) Commission investigation. The OAP report documented extreme mortality rates, including the deaths of "thirty-six old age pensioners… over a two-year period at one Toronto nursing home, a death rate almost triple that

of the much larger Queen Elizabeth Hospital for Incurables." The investigation uncovered widespread illness, with nearly all residents suffering from "severe colds" or "pneumonia", alongside physical abuse, with patients exhibiting signs of violence ranging from "black eyes and a badly swollen face" to a "bad bruise on the left temple" and "blood… oozing [from a] stocking… from the knee to the ankle" (as quoted in Struthers, 1997, 175). Notably, prior to 1947, city officials largely justified ignoring these horrifying conditions on the grounds that in the absence of "bylaws to force improvements", "any drastic action might… only add to our troubles", and that given "the shortage of institutional accommodation for this type of care, [the elderly] would probably be left on the street" (Struthers, 1997, 175–176).

Amidst the continued fallout from these horrific findings, and ongoing reports of substandard care that the mayor of Toronto denounced as "disgraceful" (Toronto Daily Star, 1947; 1948; Struthers, 1997, 174–175), the city was finally forced to act, introducing mandatory licensing bylaws for all nursing homes in July 1947 (Globe and Mail, 1947a; Toronto Daily Star, 1947a; Struthers, 1997, 175–176). However, as a municipal government, it is not clear that the City of Toronto possessed the capacity to effectively oversee and enforce supervision of for-profit nursing homes. As a result, municipal regulations quickly turned out to be largely symbolic, doing little to satisfy relevant stakeholders who witnessed a continuation of the same poor conditions. Based on the initial findings from the health inspections carried out under the newly introduced bylaw later that same year, Mrs. Jean Good of the Toronto Welfare Council's Old Age Division publicly exposed the persistent continuation of systemic deficiencies in these facilities. She noted that conditions remained "terribly overcrowded", pointing to a failure to separate senile and non-senile cases, poor quality food and care, and crammed rooms with no sitting space and little to no space between beds, which forced patients to often remain in bed (Toronto Daily Star, 1947). Two

subsequent reports further confirmed the continuation of substandard care and the symbolic nature of municipal regulation, with one report published in 1948 demonstrating that the city had failed to effectively protect the elderly from substandard care in for-profit nursing homes (Toronto Daily Star, 1948), and the provincial government's own Ontario Health Survey concluding in the same period that for-profit nursing home facilities were simply "unfit for safe nursing care", with only a minority providing adequate service (Ontario Health Survey, 1950, 46, 167).

While municipal reliance on for-profit nursing homes had initially begun as a temporary stopgap to relieve the wartime shortage of hospital beds, this rationale quickly shifted into defensive rhetoric even as the sector's record of substandard care became well-known, with officials continually assuring a concerned public that the partnership with the for-profit sector remained strictly temporary and would end once sufficient non-profit options became available (Struthers, 1997, 174–175, 186). As the subsequent sections demonstrate, however, what was introduced as an expedient stopgap became progressively entrenched as the costs of reversing course increased as prevailing conditions and successive policy decisions facilitated the for-profit sector's continued growth, a dynamic consistent with the process of path-dependence theorized by historical institutionalism.

A description of dynamics in Toronto serves to capture these developments and the challenges facing the municipal public nursing home system. Following complaints and accounts of 'atrocious conditions' in the city's for-profit nursing homes (The Globe and Mail, 1952; The Globe and Mail, 1952a), together with a Toronto Welfare Council report that documented similar findings and set out a proposed code of improved nursing home standards, city officials were forced to consider new bylaws in 1952 (Toronto Daily Star, 1952). As the Secretary of the Welfare Council's Health Division, Frances Pearle, had argued in a brief to the Toronto Board of Health,

more “safeguards for the operation” of for-profit homes were needed “to ensure at least minimum standards of nursing care”, since as “experience has shown” some for-profit providers prioritize their profits over providing adequate care (The Globe and Mail, 1952). The Toronto Welfare Council’s proposed code was praised in the Toronto Daily Star for bringing much needed improvements to an out-of-date licensing framework that had failed to cover any of the “essentials of human care” (Toronto Daily Star, 1953). In contrast to the old code, which privileged physical standards over care standards and omitted critical areas entirely, the new code comprehensively addressed the essentials, including “minimum standards for personnel; classification of patients and the home’s facilities to provide the necessary care; relationship between the home, physicians and welfare resources; food service, bathing and toilet facilities, laundry, heating, nursing and other elements of personal care; and maintenance of proper records” (Toronto Daily Star, 1953; see also Toronto Daily Star, 1953a; The Globe and Mail, 1952a).

Despite concurring with the Welfare Council’s assessments, the Toronto Department of Health refused to implement the minimum standards, arguing they were too “rigid” and unenforceable amid a nursing home bed shortage that gave for-profit operators leverage to demand higher rates before agreeing to revised bylaws (The Globe and Mail, 1952; Toronto Daily Star, 1952). In response, Mrs. J-A Wilson, President of the Toronto Welfare Council, acknowledged that enforcing standards was difficult in a context of scarcity, and that effective enforcement required alternative accommodation for residents displaced from substandard facilities. Yet she insisted that “‘poor care’ is not an adequate substitution for ‘no care,’” rejecting the notion that substandard conditions should be tolerated or justified simply because options were limited (The Globe and Mail, 1952). The Toronto Welfare Council was not the only stakeholder to rebuke what amounted to a ‘poor care is better than no care’ attitude on the part of government. The recently published

Ontario Health Survey had already raised a similar point, arguing that there was no point in freeing nursing home patients from hospital beds if it meant that they would be "consigned to a bed in some of the unclean, crowded, depressing 'nursing homes' visited in the course of this survey" (Ontario Health Survey, 1950, 162).

Amidst the continued absence of provincial intervention, this uncoordinated and ineffective pattern of municipal governance soon spread across the province, as other municipalities were forced to enact their own legislation to respond to the substandard care provided in local for-profit facilities. In 1954, Ottawa became the second city to pass a nursing home bylaw (Ottawa Citizen, 1954), acting just one year after the city's Assistant Medical Officer of Health presented the Ottawa Board of Health with a study which revealed that the city's nursing homes lacked adequate care and cleanliness and were severely overcrowded. In response to these findings, the Board immediately set up a special committee to draft new bylaws governing all nursing homes (The Evening Citizen, 1953).

By 1957, twelve municipalities had passed nursing home bylaws. However, licensing measures ended up effecting little change in the sector. For example, in 1959, five years after Ottawa had implemented its municipal nursing home bylaw, the city's Medical Officer Dr. R. A. Kennedy and Social Service Commissioner H. P. Goodfellow argued that apart from a scarce number of "shining examples" of for-profit nursing homes, the rest are "neither willing nor equipped to give anything approaching adequate bed care" (The Ottawa Citizen, 1959). However, by this point it had become widely acknowledged among stakeholders, including public officials, that the poor quality of care in for-profit nursing homes did not simply and only emerge from their tendency to prioritize profits over the quality of care or from the weak substance of the bylaws, but also from an under-capacitated municipal authority that was unable to govern and organize the

sector effectively (Tarman, 1990, 51). For example, a Toronto Daily Star (1953a) article labelled Toronto's licensing system for boarding and nursing homes "superficial", while Struthers (1997) has called it "little more than a symbolic gesture" (176). This was also conceded by provincial welfare authorities themselves, who by the late 1950s concluded that municipal licenses were issued without any substantive criteria, with oversight frequently delegated to local administrative staff or politicians who possessed little to no understanding of resident care, while these nursing homes operated largely as basic boarding facilities devoid of skilled nursing personnel (Struthers, 1997, 176). Local officials were well aware of these shortcomings, conceding five years after Toronto's 1947 bylaw came into effect that it had become an "embarrassing situation", yet they argued that there was little they could do to "enforce compliance in the absence of alternative accommodation for the elderly or clear definitions to distinguish boarding house care from nursing home care. Hospitals and homes for the aged already had waiting lists in the hundreds" (Struthers, 1997, 175–176).

The aforementioned Ontario Health Survey had been emphatic and clear in blaming the problems on poor for-profit operations and the absence of any real or viable regulatory system in place to administer this sector, with the report pointing to numerous shortcomings in municipal governance, including the absence of a working definition of what counted as a nursing home, a near-complete absence of patient records and facility registries, and a lack of either the desire or the capacity on the part of municipalities to enforce existing bylaws (Ontario Health Survey, 1950, 47/465, 57/465, 173/465, 175, 177–178; see also The Globe and Mail, 1965b). These shortcomings had resulted in multiple severe regulatory failures. For instance, the absence of a clear definition of a nursing home and nursing home registry, coupled with an apathetic municipal authority had meant, as was pointed out in an Ontario Welfare Council report, that "the medical officer [of health]

often did not know and was not advised by anyone of nursing homes that were being operated" (Ontario Welfare Council, 1959, 19/50; see also The Globe and Mail, 1959). These systemic regulatory failures were reflected by the fact that "a large number of unregistered institutions, known by a variety of names such as nursing homes, rest homes, convalescent homes and maternity homes" were providing nursing home care "without license, inspection, or compliance with the regulations of the Ontario Department of Health" (Ontario Health Survey, 1950, 175/465). Summing up these failures, the survey had pointed out that there was "a lack of supervision which permits" poor conditions to exist in nursing homes and that "on the basis of the survey's findings, it is evident that there is no properly organized effort, at any level, to supervise and inspect these homes adequately" (Ontario Health Survey, 1950, 177–178).

The failures of municipalities to effectively supervise and inspect nursing home facilities were also reflected in the attitude of local Medical Officers of Health, who typically felt that any level of care, no matter how poor, was better than no care at all. As Struthers (1997) points out, "Local Medical Officers of Health seemed 'generally [to] show little or no interest in a Nursing Home,' provincial welfare officials conceded by the end of the 1950s" (176). This indifference stemmed from several interrelated sources: the weakness of existing bylaws made it difficult to impose penalties or close substandard facilities (Chatelaine Magazine, 1965, 4/5); inspectors' primary focus on communicable diseases led them to deprioritize nursing home regulations; and the chronic shortage of nursing home beds left officials with few alternatives, since calling out poor care and living conditions could mean shifting nursing home patients to hospitals which would come at significantly greater cost to the government (The Globe and Mail, 1959a; Struthers, 1997, 176).

The symbolic nature of municipal licensing also stemmed from the fact that municipalities were not prioritizing the development of substantive regulations in the first place, being more concerned with protecting their budgets and real estate values from being negatively impacted by nursing home licensing (Toronto Daily Star, 1948, 1948a, 1948b, 1948c, 1949) than with ensuring that nursing homes provided adequate care (Globe and Mail, 1965n; CMHC, 1982). This pattern was acknowledged in the 1959 Conference on Nursing Homes, where the provincial government was asked whether anything could be done to discourage "budget conscious municipal authorities" from sending "indigent patients to nursing homes with lowest rates regardless of standard care provided" (Ontario Welfare Council, 1959, 31/50). Even the for-profit nursing home lobby itself acknowledged this pattern. In 1961, the Associated Nursing Homes of Ontario argued that municipalities more often than not overlooked substandard conditions in for-profit nursing homes due to what they described as the "necessity of stretching the public dollar as far as it will go"—a characterization with which Ontario's Minister of Health Matthew Dymond agreed (as quoted in Struthers, 1997, 179).

The symbolic character of municipal licensing was further compounded by the patchy and fragmented regulatory system that existed across the province (Tarman, 1990, 52), which took several forms. First, the system of municipal nursing home bylaws in Ontario was permissive rather than mandatory, meaning that not all municipalities adopted them, and in those municipalities that did adopt bylaws, the regulations often applied only to nursing homes receiving welfare patients (Ontario Welfare Council, 1965, 30/85; The Globe and Mail, 1965d, 1965e, 1965n, 1966). Where bylaws did exist, they varied substantially across jurisdictions in their substance, interpretation, and enforcement (Ontario Welfare Council, 1965, 27–28/85; Globe and Mail, 1965a, 1965b, 1965c). Political considerations further hampered regulatory efforts, with

enforcement becoming “somewhat more casual” where operators were “close friends of the inspecting officer” (The Globe and Mail, 1965b; see also Struthers, 1997, 178; Bacher, 1985, 87–88), or where proximity to the municipal clerk or local council allowed nursing homes to operate outside the rules (Toronto Daily Star, 1964).

The persistence of these regulatory shortcomings was confirmed at the 1957 First Ontario Conference on Aging, which identified the same failures in municipal governance that the Ontario Health Survey had documented over seven years earlier, including the continued absence of a definition for what constituted a nursing home, the lack of clearly defined responsibilities among governing authorities, and the general want of information about which facilities were licensed and what standards were expected (First Ontario Conference on Aging, 1957, 96/118).

The weak regulatory capacity of municipal government is also confirmed in the academic literature, which identifies the lack of interest, expertise, and resources of municipalities as central reasons for their inability to effectively plan, regulate, and administer major areas of social policy (Daly, 2015, 40; Struthers, 1997, 175–176, 178). Municipalities are also more vulnerable to capture by vested interests, a dynamic that early twentieth-century urban reformers described as “corrupt and plutocratic” and a “denial of democracy” (Novak, 2022, 50; see also Bacher, 1985, 530). For example, just one instance of this dynamic was evident in Toronto’s housing sector in the years following the First World War, where, as Bacher (1985) has shown, the Toronto Housing Commission, a municipal body responsible for administering a provincial housing program, was captured by real estate companies, mortgage lenders, and large commercial interests, the very groups opposed to the legislation it was meant to implement (87–88). Such tendencies are made further salient by the structural fiscal constraints of the municipal level of government in Ontario,

which, as research shows, relies heavily on property taxes and has limited access to other revenue sources (Good, 2024, 47; Kitchen & Slack, 2016, 2; Horak, 1998, 7).

The regulatory shortcomings were further exacerbated by the domination of for-profit providers, which, as various public officials, stakeholders, and studies had acknowledged, provided substandard care and tended to resist and skirt regulations, making them difficult and costly to regulate (Toronto Daily Star, 1947; 1948; 1952; The Globe and Mail, 1952; The Ottawa Citizen, 1959; Struthers, 1997, 174–175, 178; Ontario Health Survey, 1950). As one government official would point out years later, whereas authorities could "insist on standards" for non-profit Homes for the Aged, they "don't have the same leverage with nursing homes" since "their purpose is to make a profit, and there are only two areas in which they can substantially cut costs. One is on food and the other is on the quality of staff" (The Globe and Mail, 1971). As the remainder of the analysis on Ontario will demonstrate, symbolic municipal regulations not only reinforced this substandard care but also facilitated the unchecked growth of the for-profit sector by allowing it to operate largely free from regulatory constraints. This grim reality was acknowledged by senior officials themselves, with Ontario's Minister of Health labelling the conditions in the majority of for-profit nursing homes in 1959 as "dreadful", describing them as overcrowded, providing poor care, and staffed by insufficient and poorly trained personnel, and concluding that "....we have...to decide what responsibility, if any, we have to these people" (as quoted in Struthers, 1997, 178–179).

Given the extensive problems associated with the municipal administration of nursing homes in Ontario, the question arises as to why responsibility for the sector had come to rest on municipal rather than provincial shoulders in the first place, as ultimately it had been the total absence of any provincial responsibility that had not only forced municipal intervention beginning

in the 1940s, but left local officials with little choice but to form a temporary partnership with the for-profit sector despite their awareness of the substandard care these facilities typically provided. The consideration of alternatives, such as a non-profit nursing home program was simply a non-option for municipalities, as they lacked the resources and expertise necessary to support the construction and operation of such large-scale projects without provincial assistance (The Ottawa Citizen, 1959; McFarland, 1948, 121). Indeed, and in this light, what officials and stakeholders had by now come to acknowledge was not merely the inability of municipal licensing to effectively govern the sector, but the consequent need for provincial regulations, with multiple studies, including the 1950 Ontario Health Survey, concluding that provincial regulations were needed (Ontario Health Survey, 1950, 173; see also Baum, 1999, 547; Toronto Daily Star, 1948a; Toronto Daily Star, 1952a). For example, Archie Laidlaw, an Ottawa Liberal MPP, pointed out that the absence of a provincial role in the municipally licensed and funded nursing home field was indicative of a "great gap in our social welfare services", arguing that to free hospital beds from nursing home cases provincial intervention was required (Ottawa Citizen, 1959). A 1982 CMHC report on Ontario's adult residential care sector reflected this historical reality, concluding that without "financial and consultative assistance" from the province, municipalities would not be in a position to undertake meaningful licensing, regulation, or inspection of such facilities (CMHC, 1982, 12/66).

The question arises, therefore, as to why the provincial government repeatedly failed to intervene despite its capacity to do so and its awareness of the symbolic nature of municipal regulations and the regulatory and quality challenges associated with for-profit nursing homes. The answer, as this dissertation argues, lies in the instrumental-formal rationality of the province's bureaucracy, which when tasked with the political directive of addressing a severe nursing home

bed shortage, filtered this objective through a strict cost-minimization framework that came to rest on the causal belief that the most efficient means of expanding capacity was to rely entirely on municipal-for-profit partnership, thereby completely absolving the province of direct administrative and capital costs. Furthermore, seeing their function as hierarchically obedient executors of procedure, provincial officials calculated that assuming direct jurisdiction would burden the province with the high transaction costs of directly monitoring and enforcing care standards in a for-profit sector that was costly to regulate and prone to evading regulation. Consequently, provincial non-intervention functioned as a deliberate institutional strategy: by deliberately leaving fiscal and regulatory responsibility to incapable municipalities and up-front capital costs to for-profit operators, the province successfully stimulated the growth of a public nursing home sector at virtually no direct cost to the provincial treasury. As the subsequent sections demonstrate, even when public and stakeholder pressure eventually forced the province to intervene in the late 1950s, its interventions were designed to reinforce this cost-evading strategy through reinforcing municipal responsibility rather than assuming direct control of the sector itself, and to do so in a way that would minimize its fiscal and administrative commitments rather than improve care standards.

4.3 Provincial Intervention Without Provincial Responsibility: The 1958 Municipal Bylaw Scheme

In 1958 the province intervened in the nursing home sector for the first time. Yet rather than assuming direct jurisdiction, it devised a strategy to preserve its jurisdictional separation by offering, for the first time, to subsidize municipalities for the costs of the public nursing home sector on the condition that they adopt the province's recommended municipal nursing home bylaws, an approach well in line with its instrumental-formal rationality that allowed it to avoid the administrative burden of direct oversight. As the Director of the General Welfare Assistance

Branch of the Department of Public Welfare pointed out, the purpose of these bylaws was to bring nursing homes "to a higher standard", with the province offering to subsidize up to either 80 percent or 80 dollars of the monthly costs for each welfare-eligible patient (Ontario Welfare Council, 1959, 9/50).

The emergence of this provincial scheme was not accidental. It took place following the opening of a window of opportunity triggered by the federal government's passing of the Unemployment Assistance Act (UAA), which offered to relieve provinces of 50 percent of the costs of those who were unemployed and lacked access to unemployment insurance (Department of Public Welfare, 1958a; Struthers, 1997, 177; Social Development Services Division, 1970, 16–17/17). This federal cost-sharing measure extended to the blind, disabled, aged, and those living in homes for special care such as nursing homes (Federal Department of National Health and Welfare, 1957, 127–128/1037).

Administered by the Department of Public Welfare under the General Welfare Assistance Act, this 1958 scheme represented the first instance of provincial funding for nursing homes (Tarman, 1990, 51; The Globe and Mail, 1958). Most tellingly, however, it exemplified the bureaucracy's active, calculated effort to stimulate nursing home capacity while successfully evading the immense transaction costs associated with direct regulatory responsibility over for-profit nursing homes—a cost-evading logic that had led the provincial government to consistently ignore calls for provincial regulations and administration of the sector. For instance, the Ontario Hospital Services Commission (OHSC) had refused to attend the 1957 First Ontario Conference on Aging to answer questions about provincial nursing home regulations despite the repeated requests and pleas of conference organizers (First Ontario Conference on Aging, 1957, 96, 108/118). Similarly, as Struthers (1997) explains, in 1958 provincial officials in the Public Welfare

Department had "rejected any suggestions that the province should undertake this responsibility [of regulating nursing homes] itself, arguing such a task 'would require a large staff and continual policing'" (178). Ontario's Deputy Minister of Welfare, James Band, echoed this framing when he characterized the regulation of the nursing home sector as a "herculean task" (as quoted in Struthers, 1997, 178–179). Together, these characterizations capture instrumental-formal rationality at work, where direct regulatory oversight of the for-profit sector was rejected not on ideological grounds, but because the administrative costs of provincial enforcement were treated as acceptable grounds for inaction, irrespective of the significant consequences this would have on care quality.

This explicit effort to avoid the high costs associated with the regulation of for-profit nursing homes not only justified the province's evasion of direct responsibility, but it is also what had directly shaped the substance of the 1958 provincially devised municipal bylaws. Operating under this same instrumental-formal rationality, the provincial government established these guidelines to privilege easily measurable physical standards over complex, qualitative care standards. Since physical standards serve more as a fixed, identifiable checklist, they allow the state to project an illusion of strict oversight without committing to the intensive human resources and financial investment required to monitor care in for-profit facilities in a substantive fashion. In contrast, advancing municipal nursing home bylaws encompassing substantive care standards would have required greater provincial subsidies to support higher standards, increased the administrative burden of provincial oversight by requiring closer monitoring of municipal enforcement, and ultimately raised the risk that the provincial government would have to take direct regulatory control from the symbolic municipal authority over nursing homes. The decision to reinforce municipal responsibility with physically-oriented bylaws rather than assuming direct

regulatory responsibility was thus not a policy misjudgment, but a calculated institutional strategy in which the bureaucratic procedure served the pursuit of cost-minimization at the expense of care quality.

Predictably, this provincially devised municipal bylaw scheme, built on an inherently ineffective municipal authority and standards that privileged physical infrastructure over care quality, facilitated the opening of a number of new for-profit facilities, with proprietors possessing "no previous experience and few qualifications…applying for licensing" and thereby further entrenching the for-profit sector in Ontario's public nursing home system (Ontario Welfare Council, 1965, 11/85; Ontario Ministry of Community and Social Services, 1984, 18/20; The Globe and Mail, 1959; Toronto Daily Star, 1958). However, the new system of provincially-devised municipal nursing home bylaws failed to bring any improvements, since as numerous studies, reports, and stakeholders had previously pointed out—including from within the government itself—the substandard conditions in for-profit facilities could not be effectively addressed under municipal authority, and the solution lay in provincial regulations. As a result, calls for provincial regulations only intensified (Tarman, 1990, 53–56).

York County was just one stakeholder that had begun advocating for provincial regulations in 1958 (Globe and Mail, 1958a). York County Council's call for provincial licensing had come against a case of negligence in a nursing home where despite inspections and warnings that the home was inadequate for nursing home care, municipal authorities had failed to intervene (Globe and Mail, 1958a). A legal case had been launched against the respective nursing home, although the owners were freed without charge due to what the case's Magistrate described as the absence of nursing home regulations of the kind that existed to protect animals from cruelty in the criminal

code, regulations which would have made it possible for the Magistrate to charge the nursing home or protect its inhabitants (Globe and Mail, 1958a; 1958c; Toronto Daily Star, 1958a).

Some of the other early advocates of provincial regulations included the Ontario Welfare Council (OWC), the Associated Nursing Homes Incorporated of Ontario (ANHIO), the First Ontario Conference on Aging, and local Medical Officers of Health (First Ontario Conference on Aging, 1957, 108/118; The Globe and Mail, 1959; 1959a; 1965b; Daly, 2015, 40). The OWC and ANHIO pursued provincial regulations based on different motivations (Daly, 2015, 40). Whereas the OWC sought provincial standards modelled on the Homes for the Aged Act (The Globe and Mail, 1965e) as a means of improving care quality, the ANHIO sought them to legitimise its role and secure access to public patients under an anticipated provincially-insured nursing home plan by pressing for regulations that would drive out smaller "unscrupulous" operators while resisting any standards that would threaten its profit margins, a strategy reflected in its successive responses, which included criticizing the 1964 amended bylaws for having been introduced without consideration of "whether they were feasible or enforceable" (The Globe and Mail, 1965b), cautioning the government "against imposing too high standards on their field overnight" (The Globe and Mail, 1965d), and, once regulations were in place, quickly pressing for higher per-diem rates so that nursing homes could operate in line with provincial standards (The Globe and Mail, 1966a). That even the for-profit lobby was pressing for provincial regulations, albeit to serve its own commercial interests, highlights the extent to which the provincial government's cost-avoidance had displaced the substantive purpose of regulation, with the province unwilling to assume direct responsibility even as the industry it was meant to oversee was demanding it.

Another key stakeholder urging provincial regulations was Ontario's Minister of Health, Matthew Dymond, who in 1961 had warned Premier Frost that nursing homes were "in such

dreadful condition...that I have feared for many months a virtual explosion.... [T]hey should be licensed by a central body, preferably the Department of Health...and...licensing should only be granted after certain minimal standards have been met" (as quoted in Struthers, 1997, 179). Yet the Premier rejected the Minister's proposal for provincial regulations, telling Dymond that he "did not want to be involved in this at all" (as quoted in Struthers, 1997, 179). Dymond later renewed his warning to Frost's successor, Premier Robarts, cautioning that "only good fortune has protected us from serious calamity" (as quoted in Struthers, 1997, 179), yet Robarts also remained unconvinced and authorized only a study of nursing homes in 1963 (Struthers, 1997, 179).

This refusal was reaffirmed in 1964, when the provincial government once again responded to calls for provincial regulations without assuming direct regulatory control, instead choosing to amend the 1958 provincially devised municipal bylaws under the General Welfare Assistance Act by increasing municipal funding from $80.00 to $140.00 a month and adding minor "account and record-keeping" rules to municipal bylaws (Ontario Welfare Council, 1965, 11/85; The Globe and Mail, 1965g; 1965m; 1965d). Yet, like its intervention in 1958, this move was a creature of instrumental-formal rationality, helping the province create the appearance that it was taking greater responsibility while in fact preserving the same ineffective municipal licensing system, with amended bylaws that added easily countable regulations while leaving care standards virtually unchanged.

The 1964 amended bylaws did differ from their 1958 predecessor in one notable respect, however. Whereas the 1958 bylaws had tied provincial funding to the existence of a municipal bylaw containing certain minimum standards but had given the province no mechanism to verify or enforce compliance, the 1964 amendments included a verification mechanism empowering the provincial Director to demand inspections, and a fiscal conditionality that for the first time

empowered the province to withhold its 80 percent subsidy from a municipality if the provincial Director was not satisfied that a nursing home was in compliance with the bylaw under which it was licensed (O. Reg. 140/58; O. Reg. 338/64[3]). Yet within three weeks of the new regulation taking effect, the province made clear that it had no real intention of actually using these enforcement mechanisms. This was reflected in the shifting stance the Minister of Welfare adopted towards the enforcement mechanism over the course of three days in January 1965, first announcing that the province would "get tough" with nursing homes, then telling reporters that the new rules were "merely a guideline" that "would be policed by the municipalities rather than the province" and that "the province would continue to pay grants even if it didn't like a home's operation", and then walking the position back the following day under public criticism by stating that grants would be cut off from badly-operated homes (Toronto Daily Star, 1965). This shifting public stance did not represent mere indecisiveness but reflected an institutional logic in which the province claimed a regulatory role in rhetoric while avoiding the administrative costs of monitoring and enforcement, irrespective of the impact this would have on the quality of care. The province had thus written enforcement powers into law through the 1964 amendment and then immediately disavowed using them. Enforcement of standards on nursing homes themselves remained municipal, as it had been since 1958, and the province continued to disburse subsidies regardless of compliance. These regulatory issues were further compounded by the fact that municipal regulations only applied to homes that received government funding, leaving unlicensed homes and those serving only private patients outside regulations (The Globe and Mail, 1965n). Kent County's Medical Officer of Health Dr. Cunningham had criticized the 1964 amendments for this very reason, stating that they "in no way prevent unscrupulous operators from running shabby

[3] See Clause 7 and 8 of the regulations.

nursing homes"—a gap that provincial regulations were expected to close by making licenses mandatory for all homes (Tarman, 1990, 52; The Globe and Mail, 1965d, 1965e).

By this point, the continued absence of provincial regulatory responsibility had become increasingly difficult to justify on any substantive grounds (Baum, 1999, 547). When asked about provincial licensing of nursing homes in 1965, Minister of Welfare Louis P. Cécile responded that he was "against spur-of-the-moment acts" (Globe and Mail, 1965p), while Dr. C. Keith Stuart, the medical director of the province's Department of Public Welfare, suggested that while funding responsibility for nursing homes should rest with the provincial and municipal levels of government, their administration and oversight should be left to the local community (The Globe and Mail, 1965z). Yet, facing ongoing pressure and having exhausted its justifications, the provincial government was finally forced from rhetoric to action by a systemic shock generated by the Ontario Legislature's Select Committee on Aging hearings of 1964–1965, which exposed appalling conditions in for-profit nursing homes (Struthers, 2017, 294), and by the testimony before the Senate of Canada's Special Committee on Aging, where those testifying from the province's non-profit nursing home sector charged that provincial subsidies were merely "financing public psychological slums" in which people "sit… and rot by the thousands" (as quoted in Struthers, 2017, 294), testimony that, Struthers (2017) argues, "created a firestorm of negative newspaper coverage that pushed the provincial government" toward reform (294). The Senate committee itself concluded that conditions in nursing homes were "downright disgraceful" (as quoted in Struthers, 1997, 180).

Press coverage had been quick to identify the underlying problem, launching a sustained campaign of criticism against the government's continued refusal to assume direct regulatory responsibility and condemning the province for sidestepping the issue through stopgap measures

that merely reinforced the very municipal authority already identified as a root problem. One Globe and Mail article singled out the province as the only one in the country without provincial licensing, regulations, and inspections, criticizing it for "evad[ing its] real responsibility in the matter" by advancing "sound regulations for the operation of such homes and wholly inadequate machinery to enforce them", and pointing out that "Good regulations are meaningless unless they are enforced" (Globe and Mail, 1965n). A subsequent piece noted that no other legislative item in Ontario's history had been "so frequently demanded, so obviously needed, and so resolutely denied" (Globe and Mail, 1965c), and yet another captured the widening gap between public concern and provincial inaction, observing that despite "widespread agreement about the most direct way to attack the problem: by bringing the nursing homes under provincial supervision", the provincial government "still insists on leaving nursing homes under the control of unenthusiastic local authorities" (Globe and Mail, 1965p). Other articles made similar remarks, accusing the government of "toy[ing] with the problem" through piecemeal amendments to municipal regulations rather than assuming provincial responsibility, and of failing in one of its "first responsibilities: the protection of those... incapable of protecting themselves" (Globe and Mail, 1964; Globe and Mail, 1965m). Notably, even the ANHIO joined these calls, pointing out that it was "difficult to comprehend why a province progressive in so many areas is content to leave the licensing and regulatory requirements... to, in many instances, uninformed [municipal] elected officials" (Globe and Mail, 1965c).

Underlying these calls for provincial action was the ongoing reality of substandard conditions in for-profit nursing homes, with accounts from various stakeholders, including the ANHIO (Journal of the Canadian Hospital Association, 1964, 4/4; Baum, 1999, 547), indicating that "the quality of care in many–possibly most–nursing homes, leaves much to be desired" (The

Globe and Mail, 1965a). The Ontario Welfare Council (1965) documented that 165 of 425 nursing homes provided inadequate care (The Globe and Mail, 1965c; see also The Globe and Mail, 1965m; Ontario Welfare Council, 1965; Struthers, 1997, 180), including arrangements in which friends of operators "use their names to be used as nurses on call just to satisfy municipal regulations", while actual nurses were called only in emergencies and often unpaid (The Globe and Mail, 1965e). A Chatelaine Magazine investigation painted a similar picture, describing Ontario's nursing homes as "a living script for Dickens' Oliver Twist", documenting a decade of ignored fire-safety warnings and fabricated nurse registries alongside widespread abuse, neglect, and inadequate nutrition (Chatelaine Magazine, 1965). Other stakeholders echoed these findings more bluntly, with the Toronto and District Labour Council's Welfare Services Committee labelling the sector's homes "poor's death houses" (The Globe and Mail, 1965k). Most revealingly, Dr. John B. Neilson, the Chairman of the Ontario Hospital Services Commission, who had described many of the sector's facilities as substandard fire traps (The Globe and Mail, 1965g), told the Select Committee that "we would much sooner be out of this thing completely, as soon as we can.... [F]rom what I have seen of nursing homes and I have seen a lot of them, I hope that if I become chronically ill, somebody will not put me in one" (as quoted in Struthers, 1997, 179–180).

Following this ongoing wave of sustained and extensive pressure to enact provincial regulations, the provincial government launched an inter-departmental study on provincial nursing home regulations in 1965 (Globe and Mail, 1965h; Globe and Mail, 1965d), before finally passing the first provincial Nursing Homes Act in 1966, to be administered by the Department of Health (Department of Health, 1970). The move was widely welcomed, though many stakeholders thought it had taken too long (The Ottawa Citizen, 1966a; Toronto Daily Star, 1966; The Ottawa Citizen, 1966). Yet, consistent with its instrumental-formal orientation, the 1966 Act failed to

transfer full regulatory responsibility from municipalities to the province, with the Department of Health only assuming licensing responsibility while monitoring and enforcement duties under the Nursing Homes Act remained assigned to municipalities, and means-tested funding remained the responsibility of the Department of Public Welfare, renamed the Department of Social and Family Services in 1966 (Deber & Williams, 1995, 300; Baum, 1999, 547; Tarman, 1990, 57; The Globe and Mail, 1966). Effectively, then, the provincial government's 1966 Nursing Homes Act was very similar to its 1958 and 1964 provincially devised municipal nursing home bylaw schemes under the Department of Public Welfare in that it essentially left the monitoring and enforcement of regulations to municipalities. The only difference was that all nursing homes in the province would now fall under the same mandatory 'provincial' regulations licensed by the Department of Health (The Globe and Mail, 1967; The Globe and Mail, 1966). This decision had puzzled officials within the Department of Municipal Affairs itself. For instance, in an internal memorandum sent to Deputy Minister of Municipal Affairs W. H. Palmer, a senior official in the department questioned the legislation's purpose, pointing out that they had thought that the whole "effect of this exercise was that the Department of Health was to take over entirely in this situation and we were to move out", as the Department of Municipal Affairs itself had felt "there should not be a divided jurisdiction" that kept regulatory responsibility in municipal hands, while further pointing out that they did "not know just what supervision is provided by the Department of Health" of for-profit homes, which according to officials remained a central concern for the government due to their substandard conditions (Ontario Department of Municipal Affairs, 1969, 40–41/58). Hence, as with earlier provincial measures, the 1966 Act proved insufficient to improve the quality of public nursing home care in Ontario. As a 1969 Department of Health Report acknowledged, "there is still a great number of unsuitable" (114/148) for-profit facilities, thereby confirming what

stakeholders had raised repeatedly: that the root of the problem lay in the inability of municipalities to adequately administer, control, and plan the sector. That 'provincial' regulations and planning would be ineffective without greater and more effective provincial involvement and direction was reflected in the words of Dr. Richard Potter, then a Progressive Conservative backbench MPP and later Minister without Portfolio from November 1971 and Minister of Health from February 1972, who told Ontario's for-profit nursing home lobby, the ANHIO, in a speech in 1970 that:

> 43 per cent of nursing homes still have only provisional licenses and there is indication that regulations are not being enforced uniformly. The task of handling inspections and licensing on a uniform and effective basis could be made manageable by certain actions not heretofore taken, e.g., having training conferences of Medical Officers of Health, arranging formal orientation and training for nursing home inspectors, and providing more consultative help from the central Department of Health or its regional offices. (Associated Nursing Homes Incorporated Ontario, 1970, 68/129)

By 1968, evidence of the Act's failure to improve substandard conditions continued to accumulate, with Ontario's Chief of the Department of Health's Medical Rehabilitation and Chronic Care Section, Dr. J. C. Allison, confirming that substandard care by for-profit nursing homes remained a key concern (Globe and Mail, 1968). Moreover, the issue stemmed not only from the provincial government's decision to leave municipalities with the responsibility of enforcing and monitoring provincial regulations, but also from the minimalist nature of the 1966 provincial regulations themselves. While the new standards served as a major paradigmatic change for the nursing home sector, this reflected the outdated state of Ontario's public nursing home system more than the robustness of the newly unveiled standards, which exceeded prevailing conditions to such a degree that no nursing home was initially granted a permanent license

(Lundman, 1975, 77). In fact, the one area in which the new Act had excelled was in physical standards requirements—not unexpectedly so given the province's instrumental-formal orientation, under which physical standards were preferred for being both easier to measure and cheaper to administer than care-oriented standards. As Hospital Administration in Canada observed at the time, "in dealing with the nursing home building, the regulations appear to be more comprehensive and stringent. They deal extensively with space allocation, sleeping accommodation and toilet arrangements" (as quoted in Lundman, 1975, 78). Care-oriented standards, by contrast, remained comparatively weak. Indeed, even the for-profit nursing home lobby itself, the Associated Nursing Homes of Ontario, had argued that the Act's care standards were insufficient, calling for approximately two hours of care from a Registered Nurse per week per patient, compared to the Act's requirement of only one Registered Nurse on duty for twelve hours per week (Lundman, 1975, 78). In this manner, the new provincial Act shared the same shortcomings as its municipal predecessor: a bias towards physical standards and a neglect of care standards. However, unlike the municipal governance of the sector whose failure to implement an act that balanced both physical and care standards stemmed from the incapacity and ineffectiveness of municipal authority itself, the provincial government's failure to implement a Nursing Homes Act that would privilege both physical and care standards, as well as its decision to leave enforcement and monitoring responsibility for provincial regulations in the hands of municipalities, was reflective of an instrumental-formal orientation in which procedural rules served the pursuit of cost-minimization as the end of nursing home policy, structurally excluding principled considerations from the evaluation of regulatory options.

4.4 Ontario's 1959 Temporarily Approved Nursing Homes for Chronic Care Programme

In 1959, Ontario introduced the Nursing Homes Temporarily Approved for Chronic Care program to address what it described as a shortage of chronic care beds that had resulted in a backlog in acute care hospitals (Task Force on Long-term Care, 1974, 1, 7–8/21; Toronto Daily Star, 1961; Globe and Mail, 1965a). The timing of the program was not accidental. Similar to the 1958 provincially funded municipal bylaw nursing home program that had emerged on the back of the Federal Unemployment Assistance Act (UAA), the 1959 Nursing Homes Temporarily Approved for Chronic Care program emerged in a window of opportunity opened by the 1958 federal-provincial Hospital Insurance and Diagnostic Services program, under which the federal government shared 50 percent of the operational costs of universally-insured provincial hospital and diagnostic services (HIDS) with provinces (Struthers, 1997, 177–178). Unlike the province's provincially-subsidized, municipally regulated means-tested nursing home program, the Temporarily Approved Nursing Homes for Chronic Care program was provincially regulated and universally insured. The programme's universal coverage derived from its inclusion under the federal-provincial Hospital Insurance and Diagnostic Services Act, whose conditions required universal eligibility and prohibited means-testing. Although HIDS expressly excluded for-profit operations from federal funding, Ontario secured a temporary exemption for for-profit participation until sufficient public chronic care hospital beds were available (Lossing, 1960, 305; Toronto Daily Star, 1966; Task Force on Long-term Care, 1974, 7–8/21), much as BC had overcome the same exclusion to obtain permanent coverage for its non-profit Extended Care programme by demonstrating that its facilities met the chronic care standards required under federal guidelines. However, unlike BC, Ontario's Temporarily Approved Nursing Homes for Chronic Care Program faced serious difficulties from the day it was established because the

Ontario Hospital Services Commission (OHSC) was unable to find for-profit nursing homes that could meet or maintain the required standards set by the federal government for eligibility in the universal hospital insurance program. For instance, as stated in the Toronto Daily Star (1959), all 100 private nursing homes initially surveyed had failed to qualify for the plan. In yet another edition of the Toronto Daily Star (1959a), it was pointed out that attempts to address the shortage of chronic care beds through temporarily approved nursing homes had so far failed to yield fruition, for "though there are many private nursing homes in the province, [of approximately 300 nursing homes] only 29 of them have so far qualified as homes under the scheme."

Despite these challenges, Ontario's Temporarily Approved Nursing Homes for Chronic Care Programme initially showed an impressive rate of growth, increasing its tally to a total of over 950 beds by 1964. However, by the last years of the program's operation the number of beds had receded to 500 beds as more publicly built and operated chronic care beds became available and as some for-profit homes were dropped from the program due to their failure to meet or maintain the required federal standards to remain in the program (Lundman, 1975, 19–20/103; Department of Health, 1969, 114/148; Statistics Canada, 1964, 39–57; Statistics Canada, 1971, 30–67; The Globe and Mail, 1967c). As a report released by the Department of Health in 1969 pointed out, "it is recognized that there is still a great number of unsuitable facilities currently used for nursing homes, but every effort is being made by the Chronic Care Section to up-grade the standards of these [nursing] homes, or drop them from the programme" (114/148).

The substandard nature of the program, which led to the widespread disqualification of participating homes, was made particularly evident in the remarks of BC officials who had visited Ontario to examine the program's operation (GR-0498, 1976, 26/54). For example, BC's Assistant Deputy Minister of Hospital Insurance L. F. Detwiller had described the degree of chronic care

provided in Ontario for-profit nursing homes as "very limited" and "marginal…even under the Federal Government's interpretation of the treatment", while also noting that "certainly it would not fall within the scope of the type of chronic care that is envisaged by British Columbia" (GR-678, 1960, 2–5/18). In addition, in a meeting among senior bureaucrats of B.C's Department of Hospital Insurance Service, Detwiller had made further criticisms of Ontario's program (GR-2653, 1960, 6–8/8), arguing that nursing homes serving as temporary chronic care facilities in Ontario were "providing essentially a custodial care and there is no active treatment in the sense that we know it. Occupational and physiotherapy facilities are lacking and it would appear that there is little control over the activities of these institutions" (7/8).

Yet if from the viewpoint of BC officials Ontario's strategy represented a misstep, from the perspective of Ontario officials, the decision to partner with for-profit nursing homes to address the chronic care bed shortage was a carefully calculated decision driven by the bureaucracy's instrumental-formal rational orientation. This divergence in judgement reflected the distinct rationalities operating in each bureaucracy. In British Columbia, officials directed instrumental-formal procedures such as cost comparison toward a substantive commitment to care quality, exercising the discretion to depart from the course the procedure alone would dictate. In Ontario, officials pursued the procedure in an orthodox fashion, and cost-minimization followed as its result, with the human consequences of that calculation falling outside what the procedure could register. Tasked with the responsibility to address acute hospital backlogs through recently introduced HIDS subsidies, Ontario officials advanced the causal belief that outsourcing chronic care to existing for-profit facilities represented the most cost-efficient strategy available. As the data demonstrated, this approach cost the government merely $6.50 per day, compared to the $18.00 required for publicly operated facilities (The Globe and Mail, 1964b). And even though the

relative cost difference between the two programs had substantially narrowed by 1969, with the daily cost in publicly funded for-profit facilities rising from $6.50 to $9.50 and that of publicly owned and operated chronic care facilities increasing from $18.00 to $19.18, the absolute difference in their cost, as reflected in the substantially lower cost of for-profit facilities compared to publicly owned facilities, still amounted to significant cost savings for the government (Ontario Department of Treasury and Economics, 1969, 36–37/58).

As the foregoing discussion has shown, however, despite its substantially lower costs, Ontario's strategy predictably yielded care of consistently poor quality. For a bureaucracy governed by instrumental-formal rationality, the orthodox pursuit of the procedure, i.e., finding the cheapest path to the assigned political objective, was nevertheless what counted as policy success. Consequently, shortcomings in program quality failed to register as policy failures requiring intervention, with discretionary efforts to improve patient care viewed as active interference with the orthodox pursuit of the bureaucratic procedure, leading officials to resolutely ignore the human toll of the program and remain subservient to the cost-minimization directive. Insofar as efforts were made to improve conditions in facilities, these were driven almost entirely by the necessity for satisfying mandatory federal HIDS standards tied to funding, rather than by any genuine concern on the part of the provincial bureaucracy for patient well-being. This instrumental-formal orientation was made evident not only by the unconcerned attitude senior public officials displayed toward substandard living conditions in for-profit nursing homes, but by the frustration they directed at medical professionals who prioritized patient well-being over the orthodox pursuit of the procedure. For instance, as Struthers (1997, 184) notes, OHSC bureaucrats expressed great displeasure with doctors who often refused to discharge patients from hospitals to nursing homes because of concerns about the poor quality of care in those facilities. The Commission complained

that elderly patients were occupying hospital beds costing $20 daily when nursing home beds cost $7 daily, "simply because it was a convenient place for them to be and simply because somebody was able to pay for it" (as quoted in Struthers, 1997, 184). This reduction of patient well-being to a purely mathematical calculation of daily bed rates—a framework practically devoid of any substantive concerns about the quality of care—was echoed by Dr. C. K. Stuart, the province's Chief Medical Consultant of the Welfare Department, who in 1965 stated:

> I could take you to a place where eight or nine people live and you would say the place fell far short in some ways. Yet the operator is doing a good job in a poor physical plant. I'm not denying there is a problem—well, take food for example. Some operators cut corners a bit on food, but what they serve is better than most of these people would get living alone in a single room somewhere where they might not bother to cook for themselves. (as quoted in the Globe and Mail, 1965a)

Dr. Stuart's justification, that substandard care was preferable to no care at all, reflects the governing role of instrumental-formal rationality in Ontario's policy process. That an official could reduce the evaluation of a nursing home to the condition of its physical infrastructure while dismissing qualitative shortcomings such as poor nutrition as acceptable compromises reveals both the absence of any principled commitment to care quality and an orientation in which measurable physical conditions served as the primary basis for evaluating policy adequacy, leaving no principled basis from which to question whether the care being delivered met any substantive quality standard. In addition, any attempt to exercise personal discretion by advocating for improved care was viewed not as the work of dedicated agents, but as an administrative obstacle interfering with the objectivity of the bureaucratic procedure. In this way, Ontario's provincial bureaucracy reached, through the iron cage of its own instrumental-formal rationality, the same

'poor care is better than no care' attitude that its municipal counterpart had arrived at through its inherent incapacity.

In conclusion, although Ontario's universally-insured temporary chronic care nursing home program was ultimately not successful owing to the constant difficulties the province faced in finding for-profit facilities that could meet or maintain the standards set by the federal government, it would still benefit the for-profit nursing home sector by supporting the sector's entrenchment in the province's ownership-mix of nursing homes at the expense of the non-profit Homes for the Aged sector which was not made privy to participation in the program. Moreover, while the program was touted as being temporary, it remained in existence for fifteen years, until 1974-75, when its 635 beds were released for use by extended care patients (Department of Health, 1973b, 45; Statistics Canada, 1973, 5, 29; Statistics Canada, 1974, 7, 33). As the foregoing two sections established, while Ontario had multiple policy options available during each of the windows of opportunity that opened under the 1956 Federal Unemployment Assistance Act and 1957 Federal Hospital and Diagnostic Insurance Act, it chose the path of an ownership-mix based on partnership with the for-profit sector for both the provincially-subsidized municipal nursing home program it implemented in 1958 and the Temporarily Approved Nursing Homes for Chronic Care programme it implemented in 1959. However, Ontario could have just as likely taken advantage of these two recently unveiled federal-provincial cost-sharing initiatives to carve a policy-path based on non-profit sector growth. For instance, Ontario could have enlisted some of the beds from its non-profit Homes for the Aged program to provide either chronic care or advanced-level nursing home care under the Federal Hospital and Diagnostic services program. Alternatively, it could have tapped into the funding available under the National Health Grants and Federal Hospital and Diagnostic Insurance programs to subsidize the construction and operation

of an entirely new advanced-level non-profit nursing home program as BC had done. However, the provincial government's instrumental-formal orientation led it to identify partnership with the for-profit nursing home sector as the most efficient means of addressing the chronic care shortage, despite the substandard and relatively scant amount of care that these facilities typically provided. In so doing, it helped to further the institutionalization and power of the for-profit nursing home sector in the province's public nursing home system.

4.5 The Non-Profit Path Abandoned: Ontario's Homes for the Aged Programme, 1947–1972

In 1947, around the same period that municipalities entered into a partnership with for-profit nursing homes to provide nursing home care for social assistance recipients, the Ontario provincial government embarked on a modernization project that involved transforming the province's municipally and charitably operated Homes for the Aged sector from a set of institutions which had previously functioned primarily as a refuge for ambulatory individuals facing poverty, into a system focused on providing institutional care for the elderly, particularly non-ambulatory older adults (Department of Public Welfare, 1955–56, 55–56; Department of Public Welfare, 1957–1958, 15/59; Department of Public Welfare, 1958, 17/53; Ontario Ministry of Community and Social Services, 1984, 3–4/20).

This initiative had emerged in response to broader social and technological shifts, including modern medical advancements that enabled people to live longer, often into non-ambulatory old age, as well as changing family structures affecting the role of women in the family who were no longer able to dedicate all their time to providing unpaid care to the sick and elderly in their families (Social Planning Council of Metropolitan Toronto, 1963, 7/91). Homes for the Aged also witnessed a decline in their traditional clientele, namely ambulatory residents who no longer depended on these facilities for survival thanks to the emergence of new social measures and

programs including Old Age Pensions and special housing projects that helped them maintain their independence and remain in the community (Social Planning Council of Metropolitan Toronto, 1963, 11/91). The main exception to this trend were women, who remained reliant on homes for the aged for economic reasons due to the patriarchal structure of the modern state (Social Planning Council of Metropolitan Toronto, 1963, 22/91, 24/91).

The new Homes for the Aged program provided three categories of service. The first was normal or ambulatory care, a category that was, however, being increasingly phased out. The second was special care for the mentally incompetent who were ineligible for admission to mental facilities under The Mental Hospitals Act. The third was nursing home or bed care, which represented the fastest growing category of the three (Department of Public Welfare, 1956, 85; Forbes, Jackson, & Kraus, 1987, 26; Halpern, Phillips, & Grasse, 2022, 35–36; White, 2016, 19–20; CMHC, 1983a, 4–5). Providing these services required new modern facilities, as existing buildings lacked the necessary physical design and safety standards. As a result, the provincial government embarked on a major construction program, providing municipalities and charitable organizations with generous capital and operational subsidies to build and operate modernized Homes for the Aged to be regulated under the Homes for the Aged Act and the Charitable Institutions Act, respectively (Ontario Ministry of Community and Social Services, 1984, 11/20).

Funding for these two ownership types was not initially equal, however. Municipal homes enjoyed significantly more generous provincial subsidies than charitable institutions starting in 1949, receiving 50 percent coverage for both their capital and operational costs from the province (Dominion Bureau of Statistics, 1949, 321/1326; Forbes, Jackson, & Kraus, 1987, 11). By contrast, charitable institutions were not privy to any capital funding until 1952, when they became eligible for a $1,000 flat grant per bed (Charitable Institutions Amendment Act, 1952), while their

operational subsidies were limited to a marginal fixed daily rate of 10 cents until 1956 (Charitable Institutions Act, 1937). This difference helped municipal homes enjoy a significantly faster rate of growth compared to non-profits until 1956 and 1958, when the provincial government significantly increased capital and operational funding for charitable organizations. This move brought charitable homes on par with municipal homes by offering them 50 percent capital subsidies, and in 1958, transferring them from an $8 flat rate to 75 percent coverage of their maintenance costs, placing their operational subsidies even over and above municipal homes (Charitable Institutions Act, 1956; Charitable Institutions Amendment Act, 1958). This generous increase was made largely possible by the influx of federal funding that emerged under the 1956 Federal Unemployment Assistance Act (Department of Public Welfare, 1956–1957, 14; 1957–1958, 3, 7/59; Ontario Ministry of Community and Social Services, 1984, 14–16/20; Kane & Kane, 1985b, 72; Dominion Bureau of Statistics, 1959, 280, 298/1308). Apart from these provincial subsidies, user fees made up the remainder of the funding for these Homes. Unlike the municipal public nursing home program, where subsidies were strictly limited to the poor, the Homes for the Aged program admitted individuals across the income spectrum, charging each resident according to their ability to pay, so that those of greater means paid correspondingly more for their care. In fact, full-paying residents were actively accommodated, eventually making up 50 percent of municipal home populations and nearly 70 percent of residents in charitable institutions (Ontario Ministry of Community and Social Services, 1984, 11/20, 16/20).

This funding model, under which public and non-profit homes drew on direct capital assistance and operational subsidies, differed in two respects from the way the province subsidized for-profit nursing homes. On the capital side, municipal and charitable homes were eligible for direct capital assistance under the Homes for the Aged Act and the Charitable Institutions Act, with

the province covering half the capital cost of municipal homes and offering a generous per-bed grant for charitable homes, whereas for-profit nursing homes received no such direct assistance and instead financed their own capital, recovering it over time through the same per-diem they received for their operating costs, a portion of that rate taking their capital costs into account, rather than through a direct up-front provincial grant (Ministry of Health, 1971, 6/14, 10/14). On the operational side, while the province paid nursing homes this same per-diem and Homes for the Aged "up to the same per-diem rate", that ceiling was only the starting point for the municipal and non-profit sectors, since the province further committed to sharing the operating deficits of municipal and charitable homes, the latter receiving deficit assistance only in emergency situations or for "short-term problems", a liability that did not apply to for-profit nursing homes, which were paid the flat per-diem and nothing more (Ontario Hospital Services Commission, 1972, 2–4/15; Ontario Financial Consulting Services Branch, 1971, 3/23, 8/23; Tarman, 1990, 45; Ministry of Health and Ministry of Community and Social Services, 1991, 10/20). This higher cost of public and non-profit provision did not reflect a poorer use of public funds, since the higher per-diems and operating costs of municipal and charitable homes purchased more staffing, a greater space allocation per resident, and a fuller range of services than for-profit nursing homes provided, with average daily staff costs in municipal homes also being above those in nursing homes (OANHSS, 1996, 1–3/28).

Overall, thanks to generous provincial subsidies, Ontario's Homes for the Aged program witnessed explosive growth. Between 1948 and 1970, the number of beds in municipal Homes for the Aged grew from 2,998 to 15,922 (Department of Social and Family Services, 1972, Table 22; Association of Municipalities of Ontario, 2011, 10–11), while charitable home accommodation increased from approximately 3,000 beds in 1950 to 8,363 beds by 1970 (Department of Social

and Family Services, 1972, 14/16). The program also garnered significant praise from both the public and officials regarding its high quality of care. In fact, so extensive was the Homes for the Aged sector's growth and so high its reputation, that the Ontario Ministry of Community and Social Services (1984) later labelled it "a system of institutional care that was unsurpassed in North America and probably in the world" (10/20; see also Department of Public Welfare, 1966, 51–54/148). According to the Ontario Association of Homes for the Aged (1971), Ontario was "one of the few jurisdictions in North America in which the beds in homes for the aged outnumber those found in proprietary nursing care institutions" (11/20).

In this regard, Ontario shared a notable commonality with British Columbia, whose non-profit Extended Care programme was also recognized as one of the highest quality nursing home programs in the country. Yet, these programs differed in two fundamental respects. First, while both were highly reputable, they were supported through distinct federal funding regimes. As BC's program was medically advanced and maintained strong care standards, officials had managed to secure funding under the federal HIDS Act, whose universal conditionality resulted in the program providing full coverage to anyone regardless of income (The Toronto Daily Star, 1966; Lossing, 1960, 305; Kane & Kane, 1985b, 61–62). On the other hand, Ontario's Homes for the Aged program, while noted for its distinctively high quality of care (Ontario Homes for the Aged Branch, 1969, 134/148), was targeted primarily at welfare patients, with those of higher means also accepted on an ability to pay basis, a set of conditions that followed directly from the program's place under federal social assistance cost-sharing—first under the 1956 Unemployment Assistance Act and later under the 1966 Canada Assistance Plan—which tied federal cost-sharing to a needs test rather than extending coverage universally.

The distinct federal funding mechanism surrounding each program was arguably a byproduct of their historical timing. Ontario's non-profit program emerged early in 1948, well before the advent of universal health programs, whereas BC's non-profit nursing home program emerged in 1965. Yet, what makes this periodization so remarkable is that by 1965 Ontario had successfully constructed a massive, internationally recognized non-profit infrastructure (Ontario Association of Homes for the Aged, 1971, 11), and yet, the province ended up pursuing a strictly for-profit path in the years ahead. Conversely, British Columbia, which had in fact possessed only a marginal non-profit nursing home infrastructure alongside a large for-profit infrastructure until 1965 (Davies, 2003, 66), ultimately embarked on a predominantly non-profit path from this period onward. This phenomenon demonstrates how differences in bureaucratic orientation and ideas can override the power of pre-existing institutional legacies.

Ultimately, despite the high quality and historically impressive growth of Ontario's Homes for the Aged program, its expansion was abruptly upended in 1972 when, following the launch of Ontario's new Extended Care universal public nursing home program, the provincial government decided to place both the Homes for the Aged and for-profit nursing home sector under a moratorium, justifying its decisions on the basis of austerity measures that it argued it had been forced to implement in response to an economic crisis (Ontario Ministry of Community and Social Services, 1984, 13–14, 17/20; Task Force on Long-Term Care, 1974a, 10–11/21). However, the freeze on the for-profit nursing home sector did not last for very long and was quickly lifted and replaced with a population needs-based model of expansion following strong protests from the for-profit nursing home industry (Journal of the Canadian Hospital Association, 1971, 52–53; Lundman, 1975, 53/103, 86/103; Ministry of Health, 1974a; Ministry of Health, 1972c, 5–6/22, 15/22; Task Force on Long-Term Care, 1974a, 10/21). In announcing this policy shift, the Minister

of Health noted that the "integration of [for-profit] nursing homes" into the new Extended Care Program would be more "effective and economical than our present arrangement" (Ontario Hospital Services Commission, 1971b, 5/161). In contrast, the Homes for the Aged sector remained under a moratorium for roughly a decade until 1981.

The impact of the freeze on the Homes for the Aged sector was dramatic (Social Planning Council, 1984, 31). Over a ten-year period from 1973 to 1983, the number of extended care beds in municipal and charitable Homes for the Aged grew by only 856, bringing the total to roughly 13,104 nursing home beds in Homes for the Aged by 1983 (Ministry of Community and Social Services Statistical Supplement, 1973, 24, 31; Ministry of Health, 1976b, 12; Kane & Kane, 1985b, 86; Ministry of Health, 1982, 38; Social Planning Council, 1984, 31, 110). This stagnant growth was noted in a report by the Canada Mortgage and Housing Corporation (1983a), which pointed out that "there has been a minimal increase in the total number of beds in Municipal Homes for the Aged and Charitable Institutions since 1976" (9/68).

In contrast, the growth of the number of beds in for-profit nursing homes, while constrained by the population needs-based expansion model that had been placed on the industry under the province's austerity measures, was more impressive, with the number of beds increasing by a total of 6,710 between 1973 and 1983, bringing the total number of for-profit nursing home beds to roughly 29,215 by 1983 (Ministry of Health, 1972c; Ministry of Health, 1982; Kane & Kane, 1985b, 85; Social Planning Council, 1984, 31, 110; Pinch, 2002, 37). Indeed, as a report by the Canada Mortgage and Housing Corporation (1983a) pointed out, "500 new for-profit nursing home beds" had been licensed yearly since 1976 (9/68).

The province's stated rationale for lifting the freeze on for-profit facilities while maintaining it on Homes for the Aged was based on the claim that the government could not bear

the heavy capital costs associated with municipal and charitable construction in light of austerity measures (Department of Social and Family Services, 1969, 124–125/148; Technical Committee on Nursing Homes, 1969, 78/148). However, this justification was contradicted by a federal window of opportunity that had opened in 1969, when the federal government, through the Central Mortgage and Housing Corporation (CMHC), introduced an initiative designed to assist provinces with the capital costs of non-profit and state-owned facilities (CMHC, 1983b; Cabinet Committee on Nursing Homes & Technical Committee, 1969, 60/148). Archival records reveal that multiple internal government committees recognized this opportunity and recommended that the province utilize CMHC funding to expand its non-profit Homes for the Aged sector whilst also reducing its capital costs. At a meeting of the Technical Committee on Nursing Homes in October 1969, for instance, Chairman Lawrence Crawford argued that "the provision of extended care services below the hospital level and in the field of domiciliary care, would best be handled by a majority of facilities under non-profit auspices", warning that without this proviso there would be "a never-ending pressure on the Government from proprietary operators to meet increased rates in order that they might maintain an adequate profit level" (Technical Committee on Nursing Homes, 1969, 78/148; Ontario Homes for the Aged Branch, 1969, 134/148; Co-ordinating Committee Extended Care Health Insurance, 1971b, 82/161). Yet the provincial government ultimately ignored these internal recommendations, choosing not to take advantage of the CMHC program to build more Homes for the Aged facilities.

Understanding this refusal requires looking at how each ownership type was funded. As stated above, the province subsidized a significant portion of the up-front capital costs of Homes for the Aged along with their operating deficits, neither of which it provided to for-profit nursing homes, which received only a per-diem up to a ceiling for their operating costs and also recovered

their capital costs through the same per-diem subsidy. Since CMHC funding covered only capital costs, it still left the province with the operating-deficit liability that public and non-profit provision involved, rendering it reluctant to use the federal-subsidy measures to expand its Homes for the Aged program, a reluctance well in line with its instrumental-formal rationality, under which the heightened costs imposed by that operating-deficit liability rendered expansion of the Homes for the Aged sector unacceptable at a time of restraint, even where the up-front capital cost was federally subsidized.

As a natural extension of its instrumental-formal orientation, Ontario's bureaucracy went even further, implementing restrictive policies on top of the moratorium to suppress non-profit Homes for the Aged and secure the expansion of for-profit facilities without competition from a non-profit and publicly owned alternative. Consequently, while the absolute freeze on the Homes for the Aged sector was eventually lifted in 1981, government reports and documents from the early 1970s made it clear that further expansion of the sector would no longer be permitted. For example, a 1973 Department of Health Submission to Cabinet had called for:

> (2) Controls [to] be exerted on the numbers of extended care beds provided in Homes for the Aged in view of legislated age limitations placed on admissions, and the effect that over-supply of beds in these facilities could have on the [for-profit] nursing home industry and on the total health care delivery system.
>
> (3) High priority be given to establishing the need for nursing homes/extended care beds in line with studies of need for beds in active treatment, psychiatric, chronic and convalescent hospitals. (Department of Health, 1973b, 36, 42/48)

It was in this light that the government implemented various measures to actively restrict the expansion of the Homes for the Aged sector. For example, when Ontario launched its provincial

nursing home insurance program in 1972, officials initially permitted a ratio of 60 percent nursing home beds in municipal homes and 40 percent in charitable homes (Office on Aging Branch, 1974, 55/58; Ontario Program Co-ordination Branch, 1972, 1). By the 1980s, however, this allowance had become significantly reduced, with each home for the aged in Ontario becoming "restricted regarding the proportion of its total beds that can be at the extended care level, according to a formula that averages out to approximately 40% of its total beds" (Forbes, Jackson, & Kraus, 1987, 28; see also Sub-Committee on Nursing Home Care, 1974, 26/28). In addition, to further ensure that Homes for the Aged would not be able to match the growth of the for-profit nursing home sector, Ontario's provincial government set a nursing home bed ratio of 2.5 per 1000 of the population for nursing homes and 1.0 per 1000 for Homes for the Aged (Department of Health, 1973b, 36/48; Management Board of Cabinet, 1973, 33/48). It was for these reasons, therefore, that even after the freeze on the homes for the aged was lifted in 1981, the program experienced no further growth, with its size having "remained constant" (Ontario Cabinet Office, 1991, 81/138). In fact, the government's initial plans in the early 1970s had been to exclude the Homes for the Aged sector from the province's universal nursing home Extended Care Program altogether. However, a shortage of sufficient for-profit nursing home beds left the provincial government with little choice but to include Homes for the Aged in the Extended Care program (Department of Health, 1973a, 4/5; Ministry of Health, 1989, 117/174; Ontario Association of Homes for the Aged, 1981, 13/183). Hence, despite the program's impressive growth, popularity, and the provincial government's own admission of its "consistently high standards" since its emergence in the late 1940s, its fate was effectively sealed in 1972, when the provincial government's instrumental-formal orientation led it to implement a moratorium on the sector (Ontario Homes for the Aged Branch, 1969, 133/148; The Globe and Mail, 1981; CMHC, 1983b, 25/108), defaulting instead to

for-profit sector expansion as the least costly means of meeting demand without assuming the up-front capital contribution and ongoing operating-deficit liability that non-profit and municipal provision placed upon the province.

4.6 Conclusion

The evidence laid out in this chapter confirms the theoretical predictions of this dissertation, demonstrating that under instrumental-formal rationality, Ontario's provincial government consistently filtered the shared political objective of a modernized public nursing home system through a lens in which bureaucratic procedure served the pursuit of cost-minimization as its operative end. By treating the direct regulation and administration of nursing home care as a cost-liability to be evaded rather than a public duty, the province initially took no action, thereby forcing municipalities to intervene on their own, and, when eventually pressured to act, adopted interventions designed to evade direct administrative and regulatory responsibility while incurring the least possible cost. These included the 1958 and 1964 provincially devised municipal bylaws that privileged measurable physical standards over care standards and the 1966 Nursing Homes Act that devolved enforcement to the same municipal authorities whose incapacity had long been identified as a root cause of the sector's failures, with substantive considerations of care quality systematically excluded from the evaluation of policy options.

The same logic governed the province's preference for for-profit partnership over non-profit expansion in both the 1959 Temporarily Approved Nursing Homes for Chronic Care programme and the abandonment of the Homes for the Aged programme in the early 1970s. In each case, this preference was driven by the causal belief that for-profit partnership offered the most efficient means of avoiding the capital and operational commitments that non-profit and publicly owned alternatives would have entailed, commitments that persisted even where, as with

federal CMHC funding from 1969 onward, the immediate capital costs were federally subsidized, since for-profit capital was recovered through the per-diem rather than met by a direct provincial capital subsidy, and for-profit operators carried no provincial commitment to the coverage of their operational deficits.

What this chapter has shown, then, is not a series of isolated policy choices but a sustained institutional logic in which bureaucratic procedure consistently selected the cheapest available course of action at each successive juncture, with no serious consideration given to care quality, a logic that, by leaving the sector in the hands of incapable municipal authorities, facilitated the early expansion and progressive entrenchment of the for-profit nursing home sector long before the province assumed direct control.

Chapter 5: Ontario's Nursing Home Policy From the Late 1960s to the Early 1970s

5.1 Introduction

In line with the empirical demonstration of Chapter 4, this chapter traces how the same instrumental-formal rationality that led Ontario's provincial government to avoid direct regulatory and administrative responsibility for three decades continued to govern policymaking as the province gradually assumed direct jurisdiction over the nursing home sector in the mid-1960s. Whereas the province had previously adopted strategies designed to evade direct responsibility and minimize costs by forcing interventions onto incapable municipal authorities and advancing an inexpensive municipal bylaw system that privileged physical standards over care standards, its eventual assumption of formal control represented not a departure from this logic, but its extension and intensification. Driven by the exact same underlying cost-driven trajectory, the province generated outcomes strikingly similar to those of the municipal era—namely, the rapid and substantively unchecked expansion and entrenchment of for-profit nursing homes, particularly corporate chains.

This chapter demonstrates how this instrumental approach was operationalized through a regulatory framework underpinned by low, uniform per-diem rates, relaxed size restrictions, and strictly enforced regulations that privileged physical infrastructure upgrades, irrespective of what this meant for the quality of care delivered to residents. This framework worked to the disadvantage of smaller, independent for-profit operators, who were forced to close or sell their facilities because their small size denied them the economies of scale needed to afford physical upgrades under low reimbursement rates. Conversely, large for-profit chains were able to thrive and expand by leveraging their scale to meet upgraded physical standards requirements and operate profitably under low reimbursement rates, while minimal care standards and relaxed size

restrictions helped protect their profit margins. To further secure the expansion of the for-profit sector and to evade the operating-deficit liabilities that public and non-profit provision entailed, the province, having already declined to access federal CMHC capital funding for non-profit and public nursing homes when it became available in 1969, imposed a construction moratorium on its municipal and non-profit Homes for the Aged programme in 1972 citing a period of fiscal restraint as the reason, and even after lifting the freeze, imposed additional restrictive measures to ensure that the programme would not compete with for-profit expansion. In doing so, the bureaucracy effectively insulated expanding nursing home chains from the proliferation of the socially trusted non-profit and public Homes for the Aged programme.

Together, these measures enabled the for-profit nursing home sector to progressively entrench itself in the province's public system, ultimately locking the province into a path-dependent dynamic of its own making. Consequently, the provincial bureaucracy found it increasingly difficult to attempt even marginal deviations from its cost-driven trajectory, with any attempt to introduce minor improvements to care standards—such as those proposed in the 1972 Nursing Homes Act—immediately confronted with overwhelming institutional resistance from a well-entrenched for-profit industry whose very dominance the state's own policies had helped establish.

5.2 The 1966 Nursing Homes Act and the Rise of For-Profit Chains

Although the provincial government signaled a new willingness to intervene directly in the for-profit dominated public nursing home sector with the implementation of the 1966 Nursing Homes Act, this intervention was immediately undermined by its decision to delegate the monitoring and enforcement of provincial regulations to municipalities. In so doing, the province reaffirmed its commitment to a strictly cost-driven, substantively minimal regulatory approach,

one that not only failed to improve care quality but facilitated the expansion of for-profit nursing homes, including for-profit chains in particular. Furthermore, as Chapter 4 demonstrated, the regulatory environment that had governed the sector under municipal authority, and which had been further reinforced through provincial policies, already privileged physical standards over care quality, with municipal bylaws focusing on premises, safety, and location while having little to say about the actual care being provided. This upcoming section demonstrates that the province's post-1966 policies continued this qualitatively minimalist yet procedurally rigorous orientation, consistently prioritizing cost savings and administrative efficiency over ethics and care standards while paying marginal attention to the quality of nursing home provision. This orientation was evident in a set of specific provincial measures that, as the following discussion demonstrates, accelerated the rapid expansion of for-profit nursing home chains at the expense of smaller for-profit operators.

Until the early to mid-1960s, Ontario's nursing home sector was made up of small and mainly independent family-owned operations of former residential homes that had been converted into nursing homes housing between twenty to thirty patients (Lundman, 1975, 32; A. E. Ames & Co. Limited, 1972, 10/28; Ministry of Health, 1992, 13/90; Ministry of Health, 1992a, 79/90; Journal of the Canadian Hospital Association, 1964, 4/4). This composition began to change after the passage of the Nursing Homes Act in 1966, when the provincial government implemented a policy regime that introduced strictly enforced upgraded physical infrastructure requirements while maintaining weak care standards alongside a low per-diem rate. This framework disadvantaged small for-profit operators, which, unlike chain operations, lacked the economies of scale needed to afford the physical upgrades under the low per-diem, while enabling large for-profit chains to thrive by leveraging their scale to meet upgraded physical standards requirements

and operate profitably under low reimbursement rates, with minimal care standards and relaxed size restrictions protecting their profit margins (Baum, 1999, 544, 548, 551; Lundman, 1975, 77–80, 85; Toronto Daily Star, 1969; Ministry of Health, 1971a, 13/25; Ministry of Health, 1992, 13/90; Ministry of Health, 1992a, 79/90; The Toronto Star, 1972; A. E. Ames & Co. Limited, 1972, 11/28; Associated Nursing Homes Incorporated Ontario, 1970c, 1–2/129; Canadian Union of Public Employees, 1982, 6/17; Ministry of Health, 1974c, 58–59/65; Ministry of Health, 1974, 2/10; Tarman, 1988, 61–62; 1990, 60–62). Although smaller nursing homes tried various strategies to maintain their operational viability under the new regulatory regime, such as increasing their bed capacity (Tarman, 1988, 62; 1990, 60–62), many were unsuccessful and forced to close, exit the sector, or were acquired by emerging for-profit chains, with facilities of fewer than fifty to seventy-five beds finding it particularly difficult to remain viable (Ministry of Health, 1972a, 9/11; Ontario Special Health Services Branch, 1972, 7/25; Associated Nursing Homes Incorporated Ontario, 1970c, 1/129; Baum, 1999, 548, 571; Hospital Administration in Canada, 1971, 2/9; Ministry of Health, 1971a, 13/25; Ontario Special Health Services Branch, 1972, 2/25; Tarman, 1990, 58–60; Ministry of Health, 1974a, 4/5; Ministry of Health, 1974c, 58–59/65; Ministry of Health, 1974, 2/10). Overall, as Baum (1999) explains, the Nursing Homes Act "restricted competition to homes able to afford the new regulations, increasing the closure rate of smaller homes….[while]….the lower per-diem subsidy made it difficult for many independent homes to afford licensing standards" (547; see also Ontario Secretariat for Social Development, 1974, 2/5).

The decision to implement a regulatory regime centred on a low per-diem rate and standards that privileged physical infrastructure over care quality was consistent with the province's instrumental-formal orientation, which filtered the shared political objective of a modernized public nursing home system primarily through a cost-minimization lens. As Baum

(1999) indicates, "nursing-home chains might be viewed as 'white knights' that made it feasible for the industry to continue to operate under severe austerity measures imposed by provincial authorities" (571). In fact, Baum (1999) has gone so far as to argue that low per-diem rates had "forced for-profit nursing homes to apply controversial methods to provide services and make a profit, and they appear also to have fostered the rise of nursing-home chains" (549). Similarly, Struthers (1997) has argued that from 1966 and onward, Ontario's nursing home policies "cemented an uneasy partnership between private enterprise and the Department of Health to ensure that profitability could be reconciled with Ontario's burgeoning fiscal priorities as well as with the long-term care needs of the elderly" (180). Driven by the province's instrumental-formal rationality, this cost-minimizing regulatory regime successfully stimulated the rapid growth of chains, so much so that by 1974 Ontario accounted for nearly half of the proprietary groups or chains of special care facilities recorded in Canada and more than half of their beds (see Table 1).

It was not merely the implementation of a regulatory regime underpinned by a low per-diem rate and the strictly enforced privileging of physical upgrades over care standards that helped facilitate the expansion of chains, but also chains' own expectation that provincial regulation would advance their image in the eyes of a public that had become disillusioned with the poor quality of care that these facilities provided, thereby raising their confidence to invest in Ontario's public nursing home sector (Lundman, 1975, 40/103; Hospital Administration in Canada, 1971, 2/9; Struthers, 1997, 187). The for-profit nursing home industry had been well aware of its reputational problem, and it was precisely this poor reputation that prompted the Ontario Medical Association (OMA) to recommend in 1965 that one way to create public confidence in for-profit nursing homes was by having a "doctor sitting on the board of an incorporated nursing home" (The Globe and Mail, 1965g). It was for this same reason that the industry began advocating for a provincial regulatory regime, believing that the mere presence of provincial oversight would lend the sector a new-found legitimacy in place of the weak and apathetic municipal structure that had so far governed it (Baum, 1999, 547–548; Struthers, 1997, 178, 187; Tarman, 1990, 53–54, 58).

Table 1
Proprietary Groups or Chains of Special Care Facilities in Canada and the Provinces, 1974

Province	Number	Beds
Newfoundland	**1**	**10**
Prince Edward Island	—	—
Nova Scotia	**11**	**526**
New Brunswick	**3**	**37**
Quebec	—	—
Ontario	**75**	**7,109**
Manitoba	**14**	**1,330**
Saskatchewan	**5**	**640**
Alberta	**20**	**1,943**
British Columbia	**35**	**1,477**
Yukon	—	—
North West Territories	—	—
Canada	**164**	**13,072**

Note. Adapted from: Tarman (1990, 60).

As the sector had argued as early as 1961, municipal regulation was so "unduly influenced by… political considerations and personal favouritism" that legitimate for-profit operators struggled to distinguish themselves from unscrupulous ones (Struthers, 1997, 179). Struthers (1997) adds that the ANHIO argued that because welfare cases comprised "more than half of the patients in nursing homes", municipalities more often than not "overlooked substandard conditions because of the necessity of stretching the public dollar as far as it will go" (as quoted in Struthers, 1997, 179). Struthers (1997) characterizes the pre-1966 terrain in similar terms, noting that the absence of an effective regulatory regime had attracted "the unscrupulous, the undercapitalized, and the unskilled" into the business, leaving a "small-scale, low-profit, and publicly suspect business that had grave difficulty staking a legitimate claim as a health care enterprise" (187). These shortcomings were also reflected in the words of Mr. McKay, the President of Extendicare Nursing Home chain, who in 1971 had argued that improving the sector's image "will depend to a great extent on two factors: credibility and performance" (Hospital Administration in Canada, 1971). Hence, and for this very reason, the for-profit nursing home industry had every reason to desire provincial licensing, believing it would allow them to be accepted as a credible and integral player in the public system by the government and public alike (Struthers, 1997, 180, 187; Baum, 1999, 547; Lundman, 1975, 33; Ontario Special Health Services Branch, 1972, 7/25; Ministry of Health, 1972a, 9/11; Tarman, 1990, 53–54, 58). Consequently, the mere anticipation of the pending legislation in the 1960s triggered significant investment by the for-profit sector, leading to the establishment of chains even prior to the passage of provincial licensing (Ministry of Health, 1972a, 9/11). The subsequent passage of the Act in 1966 received strong endorsement from the for-profit lobby (Struthers, 2017, 293–294), with a study commissioned by the Extendicare Nursing Home chain noting that improved "standards of care and expanded utilization" were

raising the public image of for-profit nursing homes "as larger numbers of the medical profession and the general public become aware of the upgraded level of health care [as had been expected to emerge with the introduction of provincial regulations]" (A. E. Ames & Co. Limited, 1972, 11/28).

Following the passage of the 1966 Act, for-profit investment continued to further increase in pace, this time based on the sector's anticipation that a universally subsidized nursing home program would follow now that provincial regulations had been instituted (Tarman, 1990, 53; Ministry of Health, 1972a, 9/11). Indeed, the rapid expansion that Ontario's for-profit nursing home industry witnessed prior to the emergence of a nursing home insurance plan in 1972 was nothing short of remarkable, with operators aggressively increasing the number of beds from "8,500 to 18,200" between 1966 and 1969, "an explosive 114 percent growth" (Struthers, 1997, 180). The rapid growth that some of the individual nursing home chains experienced was also impressive, such as Extendicare's share, which increased from 150 to 200 nursing home beds in 1969 to 2,069 beds by July 1972 (Lundman, 1975, 33). The rate of expansion of the for-profit nursing home industry was so impressive, that as Struthers (1997, 181) observes, by the end of the 1960s the majority of Ontario's nursing home operators had entered the business within the previous six years. As Baum (1999) points out, most of these newly built beds would stay "half empty until April 1972" (Baum, 1999, 547), when nursing home coverage was added to the province's health insurance program (Baum, 1999, 547; The Nursing Homes Act, 1972; Ontario Budget, 1981, 12). Albeit, as Ontario's Deputy Minister of Health Dr. K. C. Charron had pointed out in 1969, this growth had taken place without any controls or "rhyme or reason", with new for-profit operators permeating the market and building facilities "before we knew anything about it" (as quoted in Struthers, 1997, 180–181) and without being "functionally equated to the health

system" in terms of "location, size and standards" (Cabinet Committee on Nursing Homes, 1969, 36/148).

The absence of any vetting of new for-profit nursing homes on the basis of care capacity under Ontario's provincial government, combined with the bureaucracy's near-exclusive reliance on physical regulatory audits over care standards, had helped fuel the sector's growth, and this was reflected in the enthusiastic attitude for-profit chains displayed about their regulatory prospects in the province. A local publication from one Ontario chain, for instance, pointed out that while in "most countries of the world a business with Leisure World's short history would still be struggling for recognition", including, for example, in countries like Switzerland where "the average Swiss corporation must endure a half century of scepticism before cautious financiers are convinced the company has earned recognition", "in Canada the attitude is different. Here an onlooker would more likely examine Leisure World's relatively fresh origins—then be impressed by the impressive strides the company has taken since its inception" (Leisure World News, 1972, 5/15).

The positive perception of nursing home chains was in fact mirrored by the government's own position, which actively welcomed the entry of chains into the public nursing home system, as provincial officials boasted in 1969 about "three very large groups of people from outside the province, representative of substantial financial resources all expressed most active interest" in the public nursing home sector (as quoted in Lundman, 1975, 79). This unrestrained willingness on the part of the provincial government to form a full-fledged partnership with for-profit nursing home chains had not gone unnoticed in other provinces. For example, in a letter sent by Donald Cox, B.C's Deputy Minister of Hospital Insurance, to Eric Martin, B.C's Health Minister in 1965, Cox stated that he was "really more concerned with the startling indication of profits as shown on the statements of Ontario [nursing home] projects" (B.C Ministry of Health Service and Hospital

Insurance, 1965, 15). As Cox goes on to point out, "There can be little wonder that many statements are being made regarding exploitation of the sick in proprietary institutions of the type proposed" (B.C Ministry of Health Service and Hospital Insurance, 1965, 15–16). Just three years after, in 1968, a nursing home owner from Ontario told the Inspector of B.C's Hospital Services Division that the "Ontario Hospital Commission was most anxious to see private enterprise in this [nursing home] field and that Mortgage Companies appear to be willing to lend money" (B.C. Department of Social Welfare, 1968, 74/101).

On the one hand, the eagerness on the part of the provincial government to integrate the for-profit industry into the public nursing home system was the direct product of its instrumental-formal orientation. Filtering the nursing home bed shortage through this rationality, officials formed the causal belief that the most efficient response was to implement a regulatory regime characterized by low per-diem rates and standards that privileged physical infrastructure and disregarded care quality (Struthers, 1997, 180; Baum, 1999, 571; Tarman, 1990, 59–65; Laws, 1987, 313–314). However, and in addition, politics also served as a lynchpin in institutionalizing the relationship between these two actors, with an NDP Communique (1983) pointing out that "many major nursing home companies, which have grabbed an ever-increasing share of the licenses, are managed by former senior officials of the Ministry of Health". Tarman (1990, 68–69) also provides a long and extensive list of government officials who went on to work for the for-profit nursing home industry after serving in government. One example of a key official from the Ministry of Health to join the for-profit nursing home industry is Gary J. Chatfield, who served as the president of Medex Nursing Homes Limited until 1969, before he was appointed to the role of Co-ordinator of the Extended Care Program for the provincial Ministry of Health. In 1976, he became the Assistant Deputy Minister of Institutional Health Services, and following the end of

his tenure with the Ontario provincial government he served as Deputy Minister of Hospitals in Alberta for several years before assuming the presidency of Extendicare nursing home chain (The Toronto Star, 1972a; Associated Nursing Homes Incorporated Ontario, 1973, 88/129; B.C Hospital Consultation Division, 1969, 104/130; News from the Field, 1976; Co-ordinating Committee Extended Care Health Insurance, 1971, 56/161; Chatfield, 2022). Interestingly, Medex Nursing Homes, where Chatfield had served as president prior to joining Ontario's Ministry of Health, was bought by Extendicare in 1973, just one year after Ontario had unveiled its universal Extended Care nursing home program, with Chatfield serving as the program's Co-ordinator (The Globe and Mail, 1973). The foregoing analysis suggests that from the mid-1960s and onward, Ontario's partnership with the nursing home sector was well on its way into becoming institutionally entrenched (Struthers, 1997, 186–187).

However, not all stakeholders and public officials were comfortable with what appeared to be a rapid and substantively unconstrained growth of for-profit nursing home chains in the province, with warning signs starting to emerge that if the provincial government did not implement structural controls on the sector's growth, it would become difficult to reverse the trend of for-profit domination in Ontario's nursing home sector. The Ontario Welfare Council (1965) was just one of the groups that had expressed such a concern, noting that more effective legislation to protect the safety and well-being of nursing home residents was urgently needed in light of "plans under way to establish a number of very large commercial nursing homes accommodating up to 200 or more residents" (34/85). Meanwhile, as S. W. Martin, the Chairman of the Ontario Hospital Services Commission stated in 1969, "private capital has been moving into the nursing home area and the Government should get this matter under control quickly or it would be difficult to negotiate costs with these homes" (Cabinet Committee on Nursing Homes, 1969, 38/148). Dr.

Holling, Ontario's Consultant for Chronic Care, delivered a similar warning, protesting that for-profit chains "were laying plans to actively develop large nursing home facilities in certain large urban centers in Ontario without reference to the Rehabilitation and Chronic Care Section", criticizing the government for allowing this to happen "without consideration of community needs except in the opinion of the promoters" (Ontario Special Health Services Branch, 1969, 24/25). Last, but not least, in 1965 the Chairman of Ontario's Select Committee on Health had urged the government to rein in the rapid and unplanned growth of chains, "because once these organizations are established, it would be an entrenched group maintaining their independence" (as quoted in Tarman, 1990, 56).

Perhaps what the words of the Ontario Welfare Council (1965), the Ontario Hospital Services Commission Chairman (1969), the Chairman of the Select Committee on Health (1965), and the Consultant of the province's Chronic Care Program (1969) all serve to make clear is that Ontario's public nursing home system was not treated very differently under provincial rule than it had been during municipal rule. For-profit chain operations were simply entering the sector in the name of investment, facilitated by a provincial government that almost entirely abdicated planning and control oriented toward care quality. But this was not due to a lack of governing capacity, as had been the case when the sector was under municipal oversight. Rather, it reflected the province's instrumental-formal orientation, which heavily prioritized cost-containment over the social dimensions of the public nursing home program.

5.3 Ontario's Policy on Nursing Home Chains in the Early 1970s

As the previous section demonstrated, starting in the mid-1960s, Ontario's provincial government implemented a regulatory structure that enabled the swift and rapid expansion of for-profit nursing home chains at the expense of smaller for-profit nursing homes in the province.

However, the effects of this rapid and unplanned growth of nursing home beds in the hands of a few large nursing home chains had concerned public officials, who feared that it would not only foreclose alternative policy paths but also lead to monopolistic control with serious implications for the province's public nursing home system. The most frequently cited risk was the concentration of a significant number of beds in the hands of one or a few companies. Officials had argued that this would undermine the government's bargaining power with the for-profit sector, making it difficult to enforce standards, set fair rates, or relocate patients when a chain closed, refused admissions, or engaged in disputes with the government (Ministry of Health, 1972a, 10–11/11; Cabinet Committee on Social Development, 1973, 3–7/7). For instance, as Jean M. Ciceri, the Co-ordinator of the Nursing Home Inspection Program had stated in 1974, "my main concerns about Extendicare are that increase in the number of operations will tend to make for less central control, a decline in standards and an impersonal non-Home attitude" (Ontario Personal Care Standards Division, 1974, 3/4). Yet, in the same letter, Ms. Ciceri had almost gone so far as to praise Extendicare, noting that they provided an "acceptable" or "good operation", that she was appreciative both about the fact that Extendicare accepted patients that required heavier levels of care and that Extendicare's president, Mr. McKay, was a member of the Ministry of Health and "has done much to further good inter-agency relationships and understandings" (Ontario Personal Care Standards Division, 1974, 3/4). Nevertheless, it was precisely due to such concerns centred around regulatory costs and quality issues that the provincial government had considered regulating the sector's growth in the early 1970s, with Ontario's Cabinet Committee on Social Development (1972) calling for the further expansion of chains to "be discouraged, with preference being given to projects sponsored by local groups" (10–11). A year later, in 1973, the

Department of Health considered the issue of imposing structural controls on the growth of nursing home chains. The stated purpose of such controls was:

> To minimize a potential for conflict and to maintain adequate control over selected nursing home companies to insure compliance with legislated standards of care, type of service offered to recipients of extended Health Care benefits, acceptance of payment rates and company admission policies. Simultaneously to prevent a potential for sizeable and serious disruption of service to large numbers of nursing home residents should these companies cease to continue operations as licensed nursing homes. (Department of Health, 1973, 4/7)

However, the Department of Health (1973) ultimately recommended against the placement of controls, arguing that while the unchecked expansion of chains could pose a grave threat for both government and public interest alike, the placement of controls on a nursing home sector that was already so immense and powerful could lead to the very same problems that the government was trying to avoid in the first place, namely the very disruption it sought to prevent, since chain operations "have a large investment in the field and can be subject to great hardship in any dispute with government which would result in closing large numbers of nursing home beds", and that "with current standards, these facilities will be difficult to convert to other uses" (7/7). Hence, the Department concluded that "unless circumstances not now existent dictate a change, we should retain the current administrative process to control the "chain" facilities without resorting to specific legislated and, therefore, arbitrary control over size of nursing home companies" (Department of Health, 1973, 7/7).

The Cabinet Committee on Social Development (1973) concurred with the Ministry of Health's position on the issue and recommended against the placement of controls on chains, arguing that while it was indeed "concern[ed] over the possibility of monopolistic control by large

nursing home chains…[it] agreed that the Ministry of Health should continue its current administrative procedures for control of chain-operated facilities without resorting to specific legislated and, therefore, arbitrary control over the size of nursing home companies" (Department of Health, 1973, 4/7). In equating regulatory legislation with arbitrariness, the Committee's position reveals the extent to which instrumental-formal rationality governed the Department's evaluation of its policy options, rendering invisible policy alternatives not pre-determined by the instrumental-formal procedure itself.

The Department of Health's recommendation against the placement of controls, and the Cabinet Committee's acceptance of that recommendation, illustrate how the provincial government's earlier cost-driven regulatory decisions, rooted in instrumental-formal rationality, had set in motion a self-reinforcing dynamic that it could no longer easily reverse. The same instrumental-formal rationality that had enabled the for-profit sector's unchecked expansion from the mid-1960s onward, through a regulatory regime characterized by low per-diem rates, minimal care standards, and relaxed size restrictions, had now produced an actor so large and politically powerful that the sector could no longer be regulated without significant disruption, with the government's own capacity to impose controls effectively curtailed. That officials explicitly acknowledged the risks of monopolistic control yet concluded that legislative intervention would itself cause the disruption they sought to prevent confirms a phenomenon consistent with the increasing returns mechanism theorized by historical institutionalism, in which early contingent decisions generate feedback effects that reinforce the initial path and raise the costs of reversal with each successive iteration (Pierson, 1995; 1996, 153, 175). In this respect, the recommendation against controls was not simply a policy decision but the institutional consequence of a trajectory set in motion by the province's own prior choices, choices themselves rooted in an instrumental-

formal rationality that treated procedural compliance and cost-minimization as the operative ends of policy, and that progressively locked in the for-profit ownership-mix. The effects of this approach and its role in facilitating the rapid expansion of the for-profit industry are neatly captured in the growth of chain ownership over a fourteen-year period. In 1973, chains, defined as companies owning three or more facilities, controlled 9,521 or 36 percent of total licensed nursing home beds in Ontario (Department of Health, 1973, 5/7). By 1987, chain ownership of beds had increased to 63 percent, or 18,890 of the province's 29,991 nursing home beds (Tarman, 1987, 44). Ultimately then, the provincial state's instrumental-formal orientation led it to embrace the for-profit nursing home sector as the most efficient means of addressing the bed shortage, while disregarding the substandard care these facilities provided. In doing so, it progressively helped engineer the permanent entrenchment of for-profit dominance in Ontario.

5.4 Ontario's Policy on the Number of Nursing Home Beds and Its Impacts on the Public Nursing Home System

Ontario had no strict legislative or regulatory limits on the number of beds allowed in for-profit nursing homes (Ministry of Health, 1974, 2/10; Department of Health, 1969a, 1/23). Just how many beds a for-profit nursing home was allowed depended on which official you asked, with each official providing a different figure that ranged from 150 to 300 beds (Ministry of Health, 1974, 2/10; Ministry of Health, 1974b, 40/65; Department of Health, 1969a, 1/23; The Globe and Mail, 1965z; Ontario Personal Care Standards Division, 1974, 1/4). Insofar as officials showed concerns pertaining to the relationship between nursing home size and the quality of nursing home care, this concern was limited to the institutional atmosphere in large nursing homes (Ontario Personal Care Standards Division, 1974, 1/4; Ministry of Health, 1974, 2/10; Ministry of Health, 1974b, 40/65). However, in this respect officials still retained a permissive attitude, and merely warned that large nursing homes should strive to avoid an institutional atmosphere rather than

forbidding their establishment in the first place (Ministry of Health, 1974, 2/10; Ministry of Health, 1974b, 40/65; The Globe and Mail, 1965z). This puts Ontario in stark contrast to provinces such as BC, where strict limits surrounding the number of beds in nursing homes were not only stipulated through stringently-enforced regulations but also assessed in terms of their relationship to the quality of care provided in nursing homes, rather than their institutional atmosphere alone. In Ontario, by contrast, the number of beds was shaped not by such regulatory limits or quality concerns but by officials' cost-viability considerations, including the province's low per-diem rate and minimal regulations that privileged physical standards over care standards, conditions that encouraged the construction of large nursing home chains while making it difficult for independent and smaller facilities with fewer than fifty to seventy-five beds to survive (Toronto Daily Star, 1971d; Toronto Daily Star, 1971c; Toronto Daily Star, 1967a; The Toronto Star, 1972d; The Ottawa Citizen, 1972d; Associated Nursing Homes Incorporated Ontario, 1970, 66/129; Ministry of Health, 1974a, 4/5; Baum, 1999, 548, 551; Ministry of Health, 1974c, 58–59/65; Lundman, 1975, 45/103; Ministry of Health, 1974, 2/10). This approach to the question of facility size was a direct expression of the province's instrumental-formal rationality. The formal dimension of that rationality privileges what is most easily quantified, which in the province's regulatory context meant that size was treated as a matter of countable beds and measurable per-diem economics to assess the economic viability of facilities. The instrumental dimension, meanwhile, oriented the bureaucracy toward cost-minimization as the operative end of policy, with the result that economic viability, rather than care quality, became the criterion by which bed numbers were evaluated. What is more, by confining the quality question to institutional atmosphere, a matter that rests on the operator's own approach rather than on any regulatory standard, the province effectively absolved itself of any regulatory obligation to specify or enforce a standard of care tied to facility

size, and thereby avoided the administrative costs that such implementation and enforcement would have entailed.

Yet not all officials were satisfied with Ontario's permissive policy towards the number of beds in nursing homes. For instance, the Consultant of the Chronic Care division, Dr. S. A. Holling, was critical of the fact that "no action was taken with respect to size...", reiterating that "a minimum and maximum occupancy should be recognized by legislation. It is doubtful if the control of location in itself is sufficient authority to regulate the size of nursing homes" (Department of Health, 1969a, 1/23).

To some degree, the province's permissive approach, which, alongside its low per-diem rate and regulations privileging physical upgrades, had contributed to the growth and expansion of large chain nursing homes, could be framed in positive terms, as the image of these new large-sized facilities capable of achieving upgraded physical standards could counteract the general perception of the smaller 'unscrupulous' operators in the province who had been providing substandard care at the tax-payer's expense, but were now being driven out by the larger operators (Hospital Administration in Canada, 1971, 2/9; Struthers, 1997, 179, 187; Ontario Welfare Council, 1965, 11/85; The Globe and Mail, 1967b; The Globe and Mail, 1971b; The Globe and Mail, 1965z). However, it was not at all evident that the large for-profit operators actually provided or were even able to or willing to provide a higher quality of care than smaller operators, given that the quality of nursing home care is not limited to physical and safety standards alone (Associated Nursing Homes Incorporated Ontario, 1970c, 7/129). The limited government information that did touch on the issue suggested that the chains were creating no fewer difficulties than independent operators, with a 1973 Cabinet Committee document concluding that there was "no significant evidence that 'chain' operated facilities are creating problems relating to the

Extended Health Care Program that are not occurring with independent facilities" (Cabinet Committee on Social Development, 1973, 7/7). It was precisely this recognition that prompted some government bureaucrats, taking note of the rapid expansion of for-profit chains, to question why the province had permitted these facilities to proliferate despite the absence of any evidence that they had brought about substantive improvements in the quality of care. For instance, in 1969, Ontario's director of the Homes for the Aged branch, Lawrence Crawford, had criticized Ontario's Minister of Health Matthew Dymond over his excitement about nursing homes' physical upgrades while ignoring their failure to carry out similar improvements in their caring standards, questioning why these operations had been permitted to proliferate despite failing to produce meaningful increases in the level and quality of care being offered (Ontario Homes for the Aged Branch, 1969a, 147–148/148). Furthermore, according to the director, "neither the nursing Homes in this Province nor those any where else in North America have done anything creditable by and large—except achieve a temporary bullishness on the N.Y. Stock Exchange" (Ontario Homes for the Aged Branch, 1969a, 147–148/148). A position paper prepared by the provincial government's Family Benefits Branch in 1969 raised similar points, arguing that Ontario's Government was now facing the same conundrum as its American counterpart, i.e., the realization that it was "inherently impossible for even the most altruistic nursing home proprietors to provide registered nursing service, routine medical care, rehabilitation and recreational activity and still, make even a small profit" (Department of Social and Family Services, 1969b, 28/58; see also Associated Nursing Homes Incorporated Ontario, 1970, 65/129). Provincial officials raised similar concerns about the inadequacy of nutritional provisions and meal preparation in for-profit facilities (Associated Nursing Homes Incorporated Ontario, 1970, 65/129; see also Ontario Homes for the Aged Branch, 1969a, 147–148). This suggests that while wider exits, sprinklers, and qualified management staff

to oversee employees' care of patients is important and should be welcomed, the actual care delivered, including sufficient staff-to-patient ratios, the duration of care hours per-patient, healthy diets, and social programs such as rehabilitation and physiotherapy are also important and need to be taken into consideration when it comes to assessing the quality of care delivered in nursing homes (Associated Nursing Homes Incorporated Ontario, 1970c, 7–8).

Other stakeholders, including the for-profit industry itself, raised similar concerns about the quality of care in nursing home chains compared to that provided by independent and smaller operators, implicitly challenging the government's assumption that chain expansion would yield superior care. For instance, in 1971, W. I. Taylor, a medical doctor serving as the Executive Director of the Ontario for-profit nursing home lobby had questioned the very assumption that larger for-profit operations provided better or more professional care than small nursing homes, noting that there was no "evidence that large homes can and do just because of their bigness, provide better personal and nursing care in a homelike atmosphere….There are advantages and disadvantages in the operation of both large and small homes" and that such an assumption was therefore "distinctly erroneous" (The Globe and Mail, 1971a). In a publication by the Journal of Hospital Administration in Canada (1971, 2/9), W. I. Taylor had made similar remarks, arguing that "both small and large homes are needed now and will be required in the future if community needs are to be well met" (Hospital Administration in Canada, 1971, 2/9).

In the meantime, the aggressive closure of smaller nursing homes, including those that offered decent care, by a provincial government intent on enforcing its low-cost regulatory regime had started to raise concern among various stakeholders (Journal of the Canadian Hospital Association, 1971, 52). For instance, MPP E. R. Good had raised concern over the rapidly changing situation that was reflected by the closure of "many smaller homes, and the concentration on larger

establishments" in Ontario over the past few years, pointing out that "the upgrading of standards was no doubt necessary, but many of us at the time felt that small nursing homes were being closed down more because of the fact that they couldn't provide 70 sq ft per bed, rather than being accredited on the amount of care that was given patients" (Ontario Legislative Assembly, 1975). In fact, in 1969, a nursing home owner had found himself in just such a predicament when provincial officials forced the closure of his small converted nursing home despite the fact that it had been providing high quality care according to the relatives of the patients of the nursing home (The Ottawa Citizen, 1969). In a statement provided to the Ottawa Citizen (1969), David Foulkes, the owner of the nursing home, is said to have stated that he was surprised to find that the Ministry of Health's sole emphasis on improvement was "on the physical building, rather than patient care, and communication between the health unit and myself was still vague" (The Ottawa Citizen, 1969). Ontario's Chief of the Department of Health's Medical Rehabilitation and Chronic Care Section, J. C. Allison, had also expressed dismay at the fact that small nursing homes providing high quality care were being closed on the basis of not meeting physical standards alone. As pointed out in the Globe and Mail (1968), "there is a regret, he [Dr. Allison] said, that some small homes that provide tender loving care cannot meet the standards". Even by 1999 this situation remained unchanged, with the provincial government retaining its desire to see the expansion of chains while remaining adamant about the closure of smaller nursing homes irrespective of the quality of care that these homes provided (Toronto Star, 1999).

The closure of smaller for-profit nursing homes also reveals a less obvious but significant dimension of Ontario's instrumental-formal orientation, namely, that while the province's bureaucracy was lax in enforcing the rules pertaining to care quality, even as its care standards were weak to begin with, it could be stringent and active where stringency served cost-

minimization ends. The same bureaucracy that left care standards weak and largely undefined was strict and unrelenting in its enforcement of physical standards against smaller operators, and this strictness was not incidental but a structural feature of Ontario's regulatory regime, with low per-diem rates and easily measurable physical requirements operating together to systematically disadvantage operators whose closure would, in turn, ease the province's administrative and fiscal burden by transferring beds to chains capable of meeting upgraded physical requirements at scale. This selective stringency demonstrates that Ontario's bureaucracy was not a passive observer of for-profit expansion and entrenchment but an active curator of it, with provincial officials diligently enforcing a specific regulatory regime, just as British Columbia's officials, as the following two chapters will demonstrate, diligently enforced theirs. What separated the two provinces was not the activeness of the bureaucracy but the ends to which that activeness was directed, since while Ontario's bureaucracy actively secured cost-minimization through structural disadvantages imposed on smaller operators that, in effect, cleared the field for chain expansion, British Columbia's bureaucracy actively aimed to maintain a higher quality of care through structural constraints on for-profit market behaviour, as Chapters 6 and 7 will show.

One area where for-profit nursing homes fared particularly poorly was in their failure to provide essential social programs, including activation measures, emotional and spiritual programs, and rehabilitation and physiotherapy. These programs play an important role in nursing home care because residents are not expected to recover and therefore require such services to remain healthy and fulfilled (Ministry of Health and Ministry of Community and Social Services, 1991, 8/20).

Marginal holistic programming by nursing homes was a problem that provincial officials and other stakeholders were well aware of and had warned about ahead of time (The Globe and

Mail, 1970; Associated Nursing Homes Incorporated Ontario, 1970c, 9–10/129; Associated Nursing Homes Incorporated Ontario, 1970, 65/129; Ontario Homes for the Aged Branch, 1969a, 147–148). For example, in 1965, the Ontario Welfare Council had argued that "for-profit operators understood too little about the therapeutic value of recreation" (The Globe and Mail, 1965e), while in 1967 Ontario's Select Committee on Aging had argued that "proprietary nursing homes be required to provide the same rehabilitation and re-activational services that public care institutions are required to provide" (Ontario Select Committee on Aging, 1967, 14/25; see also Cabinet Committee on Nursing Homes, 1967, 3/5). The nursing home lobby, too, was well aware of the crucial role that social programs played in the provision of nursing home care and had openly acknowledged the failure of for-profit nursing homes in this area (Associated Nursing Homes Incorporated Ontario, 1971, 8/30). However, the lobby had attributed this failure to limited funding and demanded a significant increase in public funding for nursing homes to provide these measures (Associated Nursing Homes Incorporated Ontario, 1971, 8/30). While the provincial government was willing to increase funding for for-profit nursing homes so that they could provide activation-based programs, the two sides could not come to an agreement over 'how' extra funding for these measures should be paid to nursing homes.

The main disagreement was over the funding model that would be used to increase the funding of for-profit nursing homes. For-profit nursing homes had been traditionally reimbursed by the province through the per-diem model of funding which involved paying a fixed uniform rate to all nursing homes based on yearly negotiations between the government and ANHIO over the government's estimate of the capital costs, reasonable return on investment, and care costs of nursing homes. However, provincial officials had argued that they would only agree to increase the funding of nursing homes if nursing homes agreed to switch from the per-diem funding model

to the global budgeting model that was used for homes for the aged. Unlike the per-diem model of funding, the global budgeting model linked funding to the actual money that facilities spent on care provisions and other expenses and would have required for-profit nursing homes to share their full accounts with the government—a requirement that was meant to ensure that facilities were not receiving or asking for more money than they needed (The Globe and Mail, 1971; The Toronto Star, 1972; Sub-committee on Nursing Home Care, 1974, 26/28; Ministry of Health, 1971, 6/14, 10/14). However, the for-profit nursing home lobby, which had historically rejected any funding model that required nursing homes to share their full financial accounts with government, was swift to reject the government's request (Associated Nursing Homes Incorporated Ontario, 1970d, 51/129; Ontario Hospital Services Commission, 1970b, 6/10). In turn, the provincial government rejected nursing homes' requests for funding increases for social programs, since the lobby's refusal to share its accounts left the government with no means of verifying that the additional funding would be used for care rather than diverted to profits (Ontario Legislative Assembly, 1972, 143, 153/1292).

This issue was not helped by the fact that a number of testimonies made at the Select Committee on Aging in 1965 had mentioned that for-profit nursing homes often lied about their financial statements (The Ottawa Citizen, 1965). In fact, even under the current per-diem funding model the provincial government was using to fund nursing homes, there were criticisms made by public officials from outside and within Ontario that given the provincial government's late entry into the field and the virtual absence of any viable data from municipalities which had previously governed the field, the provincial government lacked adequate knowledge over various matters pertaining to policy surrounding for-profit nursing homes (Struthers, 1997, 180; Department of Health, 1969, 142/148), and that this had allowed what had become "an increasingly militant" for-

profit industry to use its expansive size and the "burgeoning demand for long-term care" to its advantage by extracting more funding from the government than it required (Struthers, 1997, 181). Alberta officials, too, had conceded this point about Ontario, noting that while "[the] Alberta system has been careful to avoid setting the per-diem rates too high", there was "a lot of trouble in Ontario as regards the setting of rates of payments to nursing homes", with for-profit operators providing "factually incorrect arguments as regards the amount of money required" (Ontario Hospital Services Commission, 1971c, 5/16). Moreover, as provincial officials themselves admitted, they were unable to determine whether the incessant requests for ever higher per-diem rates from the for-profit nursing home industry were "impelled by a real economic necessity or merely a desire for higher profits" (as quoted in Struthers, 1997, 182).

For these reasons, and given the unwillingness of for-profit nursing homes to share their full financial accounts with the government, the government remained unwilling to accede to their demands that their rates be raised further in order that they provide social and activation programs, with Ontario's Minister of Health, Matthew Dymond, having argued in 1969 that "the problem of establishing fair price for services in nursing homes requires study" (Department of Health, 1969, 142/148). As a result, the per-diem model remained the main method of funding for nursing homes, while the absence of social programs continued to be a trend in for-profit nursing homes (Associated Nursing Homes Incorporated Ontario, 1970c, 9–10/129; Associated Nursing Homes Incorporated Ontario, 1970, 65/129). Even by 1996, the lack of social care services in publicly funded for-profit nursing homes still remained a major problem in Ontario's nursing home system (Ontario Nursing Home Association, 1996, 3/3).

The foregoing analysis underscores the difficulties associated with the regulation of for-profit nursing homes, which, as the discussion above serves to make clear, not only openly tied the

level of care they were willing to provide to their for-profit logic and tended to resist and skirt regulations, but were also staunchly unwilling to share their accounts with government. However, what the analysis above also points to is the historical unwillingness of the provincial government to shift the Nursing Homes Act from its central focus on physical standards to one that balances both physical and care standards, and, as the for-profit sector the province's own policies had cultivated grew large and politically organized, its increasing inability to do so. This failure is consistent with instrumental-formal rationality governing the province's approach to nursing home policy, an orientation that left the province's public nursing home system virtually devoid of a philosophy of care and that, upon the province's assumption of partial regulatory responsibility in 1966, led officials intent on keeping costs as low as possible to implement a regime combining a low per-diem rate and relaxed size restrictions with strictly enforced physical upgrade requirements and weak care oversight, thereby privileging physical standards over care quality and disregarding the adverse impact this unbalanced approach would have on patient well-being. As expected, this regulatory regime led to the emergence of large chain-owned nursing homes that, by virtue of their access to economies of scale, were able to meet the increased physical standards required by regulations under the same uniform low per-diem rate that the government paid to all nursing homes, thereby outcompeting smaller and independent for-profit homes that lacked the financial capacity to do so. In fact, some of the care standards in the act were so weak that the for-profit nursing home lobby had to ask for them to be raised (Lundman, 1975, 85/103; Tarman, 1990, 57–58; Lai, 2020, 102–103; Ontario Homes for the Aged Branch, 1969a, 147–148; Department of Social and Family Services, 1969b, 28/58; Associated Nursing Homes Incorporated Ontario, 1970c, 9–10/129).

The failure of the provincial government to establish nursing home regulations that balanced physical and care standards is reminiscent of the same problem that Ontario's nursing home system had faced under municipal regulations. For instance, as it was pointed out by Toronto's Municipal Department of Health in 1952, municipal nursing home bylaws were only focused on "the premises, safety, and location", while having "little to say about standards of care" (The Globe and Mail, 1952a; see also Tarman, 1990, 47). And as it was pointed out by the Toronto Daily Star (1953), "The present [municipal] by-laws cover only the physical aspects, i.e., fire hazards, sanitation and safety. They do not cover any of the essentials of human care." However, whereas municipal failures stemmed from insufficient resources and expertise, the provincial government's failure was a deliberate institutional choice that disregarded the adverse impact this unbalanced approach would have on the quality of publicly regulated nursing home care. This failure resulted in criticisms from various stakeholders, including from within the bureaucracy, such as Dr. Barbara Blake, director of the Standards Committee (Co-ordinating Committee Extended Care Health Insurance, 1971d), who maintained that care standards were also important but were "insufficiently emphasized" (Blake, 1972, 8; Tarman, 1987, 95). These criticisms persisted into the 1980s. In 1985, the Concerned Friends of Ontario Citizens, an Ontario grassroots group calling for better conditions in for-profit nursing homes, criticized the Nursing Homes Act for its obsession with detailed physical standards such as "the thickness of fire doors or record-keeping" while noting its failure to say "very much in regards to the care of residents", arguing that physical and care standards were both important (TLC Villa, 1985, 2/2; Concerned Friends of Ontario Citizens in Care Facilities, 1985; Lai, 2020, 102–103).

An over-emphasis on physical standards over care standards is not the only problem that Ontario's Nursing Homes Act has historically suffered from, however. Even when care standards

have been included in the Act, they have been left undefined or too vague to have any real substance, impact, or meaning. For instance, during its second reading in parliament, the 1966 provincial legislation on nursing homes faced "opposition objections" that it was "too vague and left too much to be outlined in the regulations passed by the Cabinet" (The Ottawa Citizen, 1966b). These failures remained intact even by 1984, with the Concerned Friends of Ontario Citizens in Care Facilities (1984) criticizing the Act on the same grounds, faulting it for failing to define basic terms such as "basic care" and "special services", for omitting any "minimum criteria for hiring staff", and for providing no directives "by which staff who are unwilling or unable to adequately fulfill their obligations to residents can be disciplined or dismissed". The group also described the province's for-profit nursing home inspection system as "ineffective", and argued that alongside inadequate legislation pertaining to care standards this would result in "serious problems" for the care of patients (Concerned Friends of Ontario Citizens in Care Facilities, 1985). Verna Staffler, President of the Ontario Association of Registered Nursing Assistants had made a similar argument in 1985, arguing that a lack of emphasis on the quality of care and clarity pertaining to care standards in the act was "frightening", noting, for example, that fancy terms such as "comfort care" were left undefined and that the act failed to say anything about the quality of meals (Toronto Star, 1985a, 8/20). Last, but not least, a 1983 report by the Registered Nurses' Home Association of Ontario (1983) had criticized Ontario's nursing home regulations for allowing for the "revocation of licenses only as related to physical conditions [such as] the number of nursing stations per floor]" rather than also revoking licenses due to the poor quality of care and lack of social programs in nursing homes (2/5). As the report stated, are not "high quality physical care and high quality psychological and social care" also important, arguing in turn that "both are important [and]..both

should be subject to enforceable standards, otherwise, quality of life has no concrete meaning" (Registered Nurses' Home Association of Ontario, 1983, 2/5).

Both the vagueness and weakness of care standards in Ontario's nursing home regulations would come to haunt the province in 1985 in the same way that they had in 1958, when a magistrate threw out a case of significant abuse and neglect in an Ontario nursing home since the poor state of municipal regulations for nursing homes in the province had made it difficult for the magistrate to lay charges on the owners of the nursing home (The Globe and Mail, 1958). In 1985, a similar issue would recur, but this time under provincial regulations, with the magistrate of the case, Judge Steele, arguing that the nursing home accused of providing substandard care could not be charged for violations due to the fact that the "Nursing Home Act omnibus regulation safeguarding the health and safety of residents" was "too vague to be enforced" and that the Act also diffused blame to staff rather than the nursing home or its owners (Toronto Star, 1985c).

What the foregoing analysis serves to demonstrate is that nothing was done over the years to improve the Nursing Homes Act despite the negative impact that the vagueness and inadequacy of care standards in the Act had had on the quality of nursing home care over the previous decades. This was also confirmed in a 1991 Cabinet Report by the Ministry of Health and Ministry of Community and Social Services, where it was argued that although the act specifies a requirement of "1.3 hours of nursing and personal-care per resident per day…[it remains] silent on other service levels, such as raw food expenditures" (Ministry of Health and Ministry of Community and Social Services, 1991, 6/20). Even by the year 2020 there appears to have been little to no improvement in the act pertaining to its clarity and substance regarding care standards (Toronto Star, 2020). Overall, Ontario's prioritization of cost-minimization over care quality, an orientation

underpinned by instrumental-formal rationality, has left many perverse impacts on the province's public nursing home system that remain intact today.

5.5 The 1972 Universal Nursing Home Program and the Ownership-Mix Question

By the end of the 1960s, Ontario's public nursing home system had become structurally dependent on the for-profit sector. As Dr. Richard Potter, a Progressive Conservative backbench MPP for Quinte who would become Minister of Health in 1972, stated in a speech in 1970, "private enterprise is responsible for almost 100 per cent of all nursing homes in the Province of Ontario…it can be seen how significant a role private effort has played in contributing to facilities for overall care in the Province" (Associated Nursing Homes Incorporated Ontario, 1970, 65/129; see also The Globe and Mail, 1972c). Although Dr. Potter's figure described nursing homes as an institutional category and did not extend to the municipal and charitable Homes for the Aged sector, which, as Chapter 4 demonstrated, possessed a substantial non-profit and public base of extended care beds, what it captured was the position that the province's own policy approach had brought about, namely reliance on for-profit operators to meet the demand for nursing home care.

Bureaucrats were well aware of the regulatory, political, and quality of care risks that this reliance entailed. A Department of Social and Family Services (1969b) report pointed to the emergence of "considerable friction" between a militant and expansive for-profit nursing home sector and the provincial government over such matters (28/58). This friction was nowhere more apparent than in the evolving views of Ontario's Minister of Health, Matthew B. Dymond, whose frustration with the for-profit nursing home industry had grown over time. Despite having initially believed that for-profit operators appeared to be doing a good job following the enactment of provincial regulations in 1966, Dymond's views had quickly shifted by 1967, when he noted that as soon as provincial licensing via municipal enforcement had come into effect, "they have

constituted themselves a pressure group to beat the Government over the head" (as quoted in Struthers, 1997, 181). Two years later, in 1969, Dymond confirmed that he was "worried about the private entrepreneur, but not about" nursing home care provided in municipal facilities (Cabinet Committee on Nursing Homes, 1969a, 74/148). In the same year, Dymond had become even more regretful about for-profit nursing homes, arguing that "they are concerned about one thing only, making as much money as possible and giving as little as possible in return to the patients.... [T]he sooner this is gotten into on a public basis, the sooner we will be able to provide good quality health care for this segment of our population" (as quoted in Struthers, 1997, 181).

Ironically, the solution Dymond arrived at was to recommend that the government extend provincial health insurance to nursing home care, a measure that, in a sector composed predominantly of for-profit providers (Struthers, 1997, 184–185), could only work to entrench the very operators whose conduct he had come to detest. This was not surprising, for it reflected the very instrumental-formal rationality that conditioned Dymond's approach to reform, an approach in which his case rested not on a principled commitment to care quality but on the efficiency gains he expected reform to produce, namely that, as he argued, without provincial coverage, beds would not be used economically across the health system, and the "modernization and expansion of nursing home facilities" and the attraction of "more efficient operators into the industry" would not occur (Struthers, 1997, 185–186). Increased spending on nursing homes would, he calculated, be offset by reduced demand for more expensive hospital beds, a purely cost-oriented argument that treated the problem as one of financial optimization alone, with care standards receiving no explicit acknowledgement. Hence, that a senior official critical of for-profit provision could, at the decisive moment, envision only a procedural-cost solution, namely higher per-diem rates channeled through a public insurance plan, rather than a principled alternative such as the non-

profit model British Columbia was building in the same period, is a measure of how comprehensively instrumental-formal rationality governed the evaluation of policy options in Ontario, even among officials who had directly witnessed and acknowledged the negative consequences of the province's cost-driven approach, including the poor quality of care provided by for-profit operations in particular.

Indeed, for-profit nursing homes were constantly asking for increases to their rates (Daly, 2015, 41), and yet they had remained unwilling to share their financial records with the government. It was in light of these issues that some officials advocated for greater non-profit involvement, including Dymond himself, who stated that "it would be a big help if organizations such as the Salvation Army were able to get into the field of nursing homes" (Cabinet Committee on Nursing Homes, 1969a, 72–73/148), and Minister of Social Services John Yaremko, who advocated for a non-profit nursing home sector as a viable alternative to the low-quality and costly for-profit nursing homes that were overtaking Homes for the Aged facilities in other Canadian provinces and the U.S. (Ontario Homes for the Aged Branch, 1969, 132–133/148; see also Ontario Welfare Council, 1959, 3/50).

Between 1969 and 1972, Ontario faced two distinct windows of opportunity that bore directly on the ownership-mix of its public nursing home system and that offered a means of acting on the concerns officials had acknowledged regarding the system's dependence on for-profit provision.

The first had emerged in 1969, when the federal government, through the Central Mortgage and Housing Corporation, announced that it was making capital subsidies available to assist provinces with the construction costs of non-profit and municipal Homes for the Aged, the first time such assistance had been extended to nursing home construction, with CMHC funding having

been previously restricted to senior self-contained apartments. This was an important development, particularly given the rapidly growing and entrenching for-profit nursing home sector, since it would have allowed the province to build on or add to its pre-existing expansive non-profit and municipal Homes for the Aged sector and thereby lessen what statements and reports from within the government had already identified as a risky overreliance on the for-profit sector. The importance of this possibility was reflected in a report published by the Department of Social and Family Services (1969) in the same year:

> In the distant future, it may be that the broad alternatives open to the provincial Government are these—(1) to continue to purchase services from private operators, at a rate set by the market price, or by negotiation, or by price control; (2) to build some type of public nursing homes either wholly or partially to replace private nursing homes (The public homes could be built and operated by non-profit organisations, publicly supported, or directly by governments, municipal or provincial). (123/148)

The second window emerged in 1972 with the passage of the province's universal nursing home insurance plan, known as Extended Care, which made massive provincial subsidies available for public nursing home provision (Struthers, 1997, 186), with the province free to direct those subsidies toward the publicly funded nursing home beds in the for-profit dominated nursing home sector, toward the non-profit and municipal Homes for the Aged sectors, or some combination of the two. The newly unveiled universal nursing home insurance plan would be regulated under the new Nursing Homes Act of 1972, which, compared to the 1966 Nursing Homes Act, saw the Ministry of Health undertake full regulatory and funding responsibility for the public nursing home program that had heretofore been enforced by the municipal level and subsidized by the Department of Social and Family Services (Halpern, Phillips, & Grasse, 2022, 66), while the non-

profit and municipal Homes for the Aged sector would remain regulated and subsidized by the Department of Social and Family Services (renamed the Ministry of Community and Social Services in 1972) under the Homes for the Aged and Rest Homes Act and the Charitable Institutions Act (Ontario Council of Health, 1977, 29; Department of Social and Family Services, 1969, 124/148).

Hence, the provincial government had major political and policy considerations to take into account in this period. It could either use the windows of opportunity that had emerged in 1969 and 1972, namely the federal CMHC funding for non-profit and municipal construction and the introduction of universal nursing home insurance to lessen its risky overreliance on the for-profit sector by investing in the non-profit sector while implementing structural controls on the growth of for-profit nursing home beds, or it could maintain its minimalist approach to care regulation, enabling the sector's continued expansion and further entrenchment.

Ontario's response to these opportunities ultimately proved decisive. With the launch of its universal nursing home insurance program in 1972, the province refused the federal CMHC funding for non-profit and municipal construction that had emerged in 1969 while channelling its new provincial subsidies primarily toward the for-profit sector, thereby choosing to build on and expand its partnership with that sector. Consistent with the two conditions specified in Chapter 3, the risks of dependence on for-profit provision were acknowledged across the bureaucracy, yet could not become operative, because a procedure whose function was to reach the given end of addressing the bed shortage at the lowest cost contained nothing that could raise the response above the lowest defensible cost, or allow such risks to register as a failure, given that it treated the value judgement, discretion, and persistence required to act on them as subjective interference, incompatible with its objectivity and, by extension, the hierarchy.

The 1972 nursing home insurance program emerged in a period of restraint that had led to a freeze being placed on bed construction in both the Homes for the Aged and for-profit nursing home sectors. However, soon after the program was launched, the provincial government moved to lift and replace the freeze on the for-profit sector with a population-needs-based model of expansion while maintaining the freeze on Homes for the Aged for nearly a decade. The decision to lift the moratorium on the for-profit nursing home sector came in response to significant backlash from the for-profit industry (Department of Health, 1973, 7/7). As pointed out in the Journal of the Canadian Hospital Association (1971), when Ontario's Minister of Health A. B. Lawrence was asked about the "problems faced by nursing home owners who were in the process of developing new facilities with a large commitment of money and who stand to lose their investment because of the building freeze", he stated that "My department is ready and willing to hear and approve facilities already in the stages of development, and the association would be a good vehicle to work out these problems with my department." In the same publication, the Minister also admitted that while he had felt remorseful about the media leak pertaining to the freeze, the freeze had helped "in developing some controls and perhaps was politically expedient." Yet the province's imposition of a population-needs-based expansion model on the for-profit sector also reflected its instrumental-formal rational orientation. For the first time in its history, the province imposed stricter regulations that controlled the rapid and unplanned growth of for-profit nursing homes—but not for the sake of care quality or coordinated planning. Rather, this control was imposed in the name of austerity, demonstrating that even when the province exercised structural controls on the for-profit nursing home sector, it did so to advance cost-minimization rather than principled ends.

Having lifted the moratorium on the for-profit nursing home sector following the backlash it had faced, the province continued to maintain the moratorium on the non-profit and municipal Homes for the Aged sector, citing the capital costs of Homes for the Aged and the restraint measures it had imposed as the reason (Department of Social and Family Services, 1969, 124–125/148; see also Struthers, 1997, 182; Lundman, 1975, 53/103, 86/103; Journal of the Canadian Hospital Association, 1971, 52–53; Laws, 1987, 313; Ontario Hospital Services Commission, 1971b, 5/161; Ministry of Health, 1972c, 5/22, 7/22; Toronto Star, 1972a). Prior to the imposition of the moratorium on Homes for the Aged, the objective of the government had been to exclude the sector from the new 1972 Nursing Home Program altogether. However, after being unable to secure a sufficient number of for-profit nursing home beds, the provincial government was left with no choice but to allow the inclusion of Homes for the Aged beds in the nursing home program on a temporary basis until sufficient for-profit nursing home beds were available (Department of Health, 1973a, 4/5; Ministry of Health, 1989, 117/174; Ontario Association of Homes for the Aged, 1981, 13/183). At the same time, to ensure that the Homes for the Aged program would not threaten the prospects of the for-profit nursing home sector, the provincial government implemented various measures to control and curb its growth. As these measures have already been discussed in the Homes for the Aged section of the previous chapter, they will only be discussed briefly here.

Beyond the nearly decade-long construction moratorium itself, the provincial government implemented additional measures to ensure that the Homes for the Aged program would not threaten the growth and survival of the for-profit nursing home sector (Department of Health, 1973b, 36/48, 42/48; Department of Health, 1973a, 4/5; Sub-committee on Nursing Home Care, 1974, 26/28; Forbes, Jackson, & Kraus, 1987, 28). These included limiting the role of the Homes for the Aged program to providing nursing home care to existing residents who became too frail

over time and needed to be transferred from a residential bed to a nursing home bed within the same facility (Ontario Association of Homes for the Aged, 1981, 13/183; The Community Information Centre of Metropolitan Toronto, 1983, 10/37; Task Force on Long-Term Services and Facilities, 1974b, 43/67; 1974e, 58/67; Task Force on Long-Term Services And Facilities, 1973, 8/28), capping the ratio of nursing home beds in Homes for the Aged to no more than 40 percent of total beds (Forbes, Jackson, & Kraus, 1987, 28; Sub-committee on Nursing Home Care, 1974, 26/28), and imposing a nursing home bed ratio of 1.0 per 1000 for homes for the aged and 2.5 per 1000 on for-profit nursing homes (Department of Health, 1973b, 36/48; Management Board of Cabinet, 1973, 33/48). Attempts to further increase the population per bed ratio of for-profit nursing homes received pushback from some government officials who had become concerned with what they saw as the government's obsession with for-profit nursing home sector growth (Management Board of Cabinet, 1973, 34/48), a concern echoed in internal calls to encourage non-profit organizations precisely to balance the "preponderance of private enterprise in this field" (Sub-committee on Nursing Home Care, 1974a, 21/28) and in the recognition that Ontario's direction was out of step with that of other provinces, which, as one official pointed out, were heading toward a public and non-profit ownership-mix model (Task Force on Long-Term Services and Facilities, 1974a, 14/67).

Yet even as the province was actively suppressing the non-profit alternative, the for-profit sector it had been cultivating was proving increasingly resistant to regulatory control. In this light, the lifting of the construction freeze was not the only area in which the provincial government softened its approach after facing intense pressure from the for-profit nursing home sector. Having become cognizant of the weaknesses present in the 1966 Nursing Homes Act which had been criticized on the basis that it had much to say about physical standards but little about care

standards, the provincial government had tried to strengthen the care standards in the act upon introducing the 1972 Nursing Homes Act (Tarman, 1990, 58–59). However, the for-profit nursing home industry, while having been "relatively pleased" with the standards that had accompanied Ontario's 1966 Nursing Homes Act, severely criticized and attacked the government's amendments to the 1972 Nursing Homes Act which aimed to tighten and strengthen regulations (Journal of the Canadian Hospital Association, 1971, 52–53; Lundman, 1975, 25, 86–87/103; Tarman, 1990, 66–67, 90; The Globe and Mail, 1972), arguing that the government's amendments pertaining to the quantity of staffing, services, and care were too stringent and prescriptive, and that they should either be lowered or dropped (Associated Nursing Homes Incorporated Ontario, 1970a, 13–14/129; Associated Nursing Homes Incorporated Ontario, 1970d, 41–42/129; Toronto Star, 1972; Toronto Star, 1972c; Globe and Mail, 1969i; The Globe and Mail, 1969j). The lobby's criticisms were also reflected in a 1972 Globe and Mail article titled "New rules for Ontario nursing homes termed impossible", where it was stated that while the new nursing home operators embraced the higher physical and safety requirements of the proposed amendments, they were not as pleased with the improved care standards that were included in the new regulations (Globe and Mail, 1972).

Even though the provincial government had publicly announced that it would not give in to the demands of nursing homes to lower care regulations, it eventually did following a meeting with the ANHIO in 1971 (Journal of the Canadian Hospital Association, 1971; The Globe and Mail, 1972c). In giving in to the for-profit sector's demands to lower standards, the provincial government had decided that as long as for-profit nursing homes provided 'adequate' services, it would not enforce the 1972 Nursing Homes Act too strictly or harshly. As Dr. Potter, by then Ontario's Minister of Health, stated in 1973 during a meeting with Ontario's nursing home

inspectors, “in our determination to upgrade the quality of nursing Homes, we must be careful to prevent making them sterile, unfriendly, regimented prisons for the elderly into which, in the name of society and health, we incarcerate the old or unwell” (Associated Nursing Homes Incorporated Ontario, 1973, 87/129). This led to celebrations on the part of the ANHIO which began boasting about the fact that the “harassment” of for-profit nursing homes by the Ministry “through unnecessarily strict enforcement of Regulations will cease”, “that the Ministry will no longer tolerate literal application of the regulations that work unneeded hardships on Homes giving good care”, “that Homes that cannot meet all the regulations by an economically feasible route, but that are meeting basic requirements of good care with adequate staffing, will not be forced to close”, and that “inspectors will use understanding and compassion when applying regulations” (Associated Nursing Homes Incorporated Ontario, 1973, 87/129). What the above picture suggests is that in its aim to prioritize cost-minimization over care standards, the provincial government had put itself in a position where a sizable for-profit nursing home sector that the government’s own lax policies had served to create was now resisting the provincial government’s own demands on the basis that government regulations were too stringent, a resistance that the government proved unable to withstand.

The provincial government’s abandonment of its own regulatory amendments under pressure from the for-profit lobby constitutes a second instance of the self-reinforcing feedback dynamic identified above in Section 5.3. Whereas the earlier instance demonstrated that the government could no longer impose structural controls on the sector’s growth, this one showed that it could no longer enforce even its own care standards against a sector whose size and political organization were the direct products of the government’s prior choices made under a narrowly cost-driven regulatory logic. This represented a significant development underpinned by the fact

that the government had moved from being unable to regulate the sector's size to being unable to regulate the sector's behaviour.

Despite the immense power that the for-profit sector had come to wield, Ontario's provincial government still had one last opportunity to stake out an alternative policy path when it implemented a universal nursing home insurance plan in 1972, namely by drawing on capital subsidies made available through the federal CMHC program to lift the freeze on the Homes for the Aged sector and to construct new facilities or add new non-profit nursing home beds. In fact, several reports and committees from the provincial government had advocated for the use of the CMHC program as a way to "greatly" reduce reliance on the province's own capital aid grant program for subsidizing the construction costs of non-profit and municipal Homes for the Aged (Technical Committee on Nursing Homes, 1969, 78/148; Ontario Homes for the Aged Branch, 1969, 134/148; Cabinet Committee On Nursing Homes & Technical Committee, 1969, 60/148; Co-ordinating Committee Extended Care Health Insurance, 1971b, 82/161; CMHC, 1983b, 25/108; Sub-committee on Nursing Home Care, 1974, 25/28). Yet as noted above and as laid out in detail in Section 4.5, the province declined to do so. The province's own public justification for the moratorium had been that capital expenditures were the cost the province could most readily control (Department of Social and Family Services, 1969, 124–125/148), a logic that led the province to halt capital construction on Homes for the Aged as a cost-limiting measure it attributed to a period of fiscal restraint (Ministry of Health, 1976, 2/11; Peel Community Services, 1976, 8–9/11; Ministry of Health, 1976a, 5/11; Ministry of Health, 1976c, 5/12). And yet that same rationale should have made CMHC funding, which would have relieved precisely that capital burden, all the more attractive. That the province nonetheless declined to access CMHC subsidies suggests that the up-front capital cost could not have been the true obstacle. What for-profit provision

allowed the province to avoid, therefore, was not the immediate capital expenditure that CMHC would largely have covered for non-profit and municipal Homes for the Aged, but the operating deficit liability that those programs entailed and which CMHC funding did nothing to relieve. And even had the CMHC program been absent, the provincial government's justification that economic challenges and restraint were the reasons for the permanent moratorium on non-profit and municipal Homes for the Aged cannot be too readily accepted, for British Columbia too faced fiscal challenges in 1978 when it launched its universal intermediate care program, yet worked to ensure a successful and high quality program by shielding it from the province's restraint measures. This is not to deny that provinces facing similar pressures may legitimately respond in different ways, but rather to suggest that Ontario's citing of restraint, alongside its unwillingness to use CMHC funding to expand its non-profit program, was an outcome of its instrumental-formal rational approach, which, in preferring the most cost-minimal path, treated the ongoing operating deficit costs that public and non-profit provision placed upon the province as more costly than a for-profit model whose capital was recovered through the per-diem and which carried no comparable operational deficit component.

Ontario also had another non-profit nursing home program at this time called the Rest Homes program. Established under the 1966 Rest Homes Act, the purpose of the Rest Homes program was to respond to the shortage of nursing home beds for advanced-level nursing-home patients that for-profit nursing homes were refusing to admit on the basis that they were not being sufficiently reimbursed by the provincial government for their care (Ontario Homes for the Aged Branch, 1969a, 147/148; Department of Health, 1969, 104/148; Department of Social and Family Services, 1969, 124/148; Struthers, 1997, 181). These patients could not be admitted to Homes for the Aged either, which were operating at capacity. However, much like the Homes for the Aged

program, the Rest Homes program had also faced an austerity-induced moratorium since its inception, with the province's own public explanation for this postponement being that "capital expenditures is one of the few major costs that can be deliberately and closely controlled", and that capital expenditures had therefore "been markedly reduced", resulting in "a postponement of much prospective building" of Rest Homes (Department of Social and Family Services, 1969, 124–125/148). The same report acknowledged that if the province offered the usual 50 percent capital subsidy to every project, "the Rest Home, within a few years, would likely form a substantial proportion of the facilities available for Nursing Home Care" (Department of Social and Family Services, 1969, 124–125/148), while a separate report from the same Department in the same year had recommended the use of CMHC capital subsidies to expand this sector (Ontario Homes for the Aged Branch, 1969, 134/148; see also Struthers, 1997, 182). The provincial government nevertheless refused to take advantage of the CMHC funding for this program, with Minister of Health Dymond noting that "it would seem inadvisable to encourage at this time not only competition with the private sector, but also with another department of government" (Department of Health, 1969, 104–105/148), a decision underpinned by its instrumental-formal orientation, since doing so would commit the province to the same operating-deficit liability that had blocked the expansion of the Homes for the Aged program, a liability its cost-minimization logic identified as unacceptable. Moreover, while internal committees did recommend the program's use, officials who raised this alternative did not remain persistent when their recommendations were set aside, a pattern consistent with the hierarchical constraints on bureaucratic agency under instrumental-formal rationality documented throughout this chapter. Ultimately, Ontario only built two Rest Homes—both predating CMHC funding—while only building one Home for the Aged facility using CMHC funding before dropping both programs to

secure the expansion of the for-profit nursing home sector (CMHC, 1983b, 20; CMHC, 1983a, 4–5; Struthers, 1997; Department of Social and Family Services, 1969, 124–125/148).

At this point the province's refusal to use CMHC funding to build a Rest Homes program can no longer be attributed solely to the provincial bureaucracy's instrumental-formal orientation, but also to the path-dependence that this form of bureaucratic rationality had helped generate, which, by facilitating the entrenchment of a large and politically organized for-profit sector, served as a further constraint on the province's capacity to consider alternatives to for-profit growth, with evidence from the Rest Homes program demonstrating that politics likely influenced the government's decision to curb the program's growth, particularly after the for-profit lobby had launched a fierce attack against the program soon after its implementation. The ANHIO had claimed that publicly subsidized competition placed its members at an inequitable disadvantage and served as a waste of tax dollars, especially when "private enterprise is eager to fill the need" (as quoted in Struthers, 1997, 182). As Struthers (1997, 182) notes, Ontario's health department officials were for the most part in agreement with the for-profit sector's position. This was partly due to the fact that provincial officials judged alternatives unnecessary, because, as they had argued by 1969, with 14,000 for-profit beds already established in the province "it would be impractical and unjustified to eliminate private enterprise in favour of charitable non-profit or Governmental agency operations", and that, therefore, so long as for-profit facilities were able to "provide a satisfactory level of service...then it would not seem necessary for Government to enter this field" (as quoted in Struthers, 1997, 182). Hence, once again, the provincial government moved to entrench its reliance on the for-profit sector, an outcome driven not merely by the instrumental-formal rationality that left bureaucrats less persistent in their advocacy for the Rest Homes program, but by the province's inability to overcome the well-entrenched for-profit sector its own

policies had created. What this confirms is that the province's stated justification of austerity for maintaining the freeze on both Homes for the Aged and the Rest Homes program, despite the availability of CMHC funding, was less a matter of fiscal necessity than a consequence of the path-dependence and instrumental-formal orientation that had consistently identified for-profit provision as the least costly means of meeting demand, irrespective of the consequences for care quality.

In conclusion, by the time Ontario assumed full regulatory control of the nursing home sector and implemented a provincial nursing home insurance program in 1972, the purpose of the for-profit nursing home sector had transformed from the 'temporary partnership role' officials in the 1940s and 1950s had promised it would assume, to becoming an integral part of the province's nursing home system whose position would be secured by government legislation and directives (CMHC, 1983a, 9/68; Task Force on Long-Term Services and Facilities, 1974d, 46/67; Cabinet Committee on Social Development, 1972, 2/11; Department of Health, 1973b, 36/48, 42/48). The tables had now effectively turned. Whereas in the 1940s and 1950s it had been assumed that the partnership with for-profits was a temporary phenomenon until more Homes for the Aged could be built, and that therefore the non-profit Homes for the Aged sector would eventually come to overtake the sector's ownership-mix through a process of layering, the provincial government had now ensured precisely the opposite, namely that the for-profit sector would displace the non-profit sector through the same institutional mechanism, a mechanism driven by the province's instrumental-formal rationality and the path-dependence it had generated (Struthers, 1997, 186–187).

Ontario had therefore missed yet another opportunity to cultivate a different or more balanced policy approach to the ownership-mix of publicly funded nursing home facilities. Unlike

provinces such as BC which eagerly took advantage of the federal government's CMHC funding measure to finance the construction of many intermediate-care nursing homes, Ontario moved on as if the federal capital assistance program did not even exist. In so doing, Ontario's provincial government ensured that the for-profit nursing home sector would continue its incessant expansion while consolidating rapidly under corporate chains, with Struthers (1997, 186) pointing out that under "the impetus of health insurance coverage, from 1972 onwards" the for-profit sector transformed itself from an industry made of small homes "of less than twenty beds" to one made up of corporate chains operating facilities of one hundred to two hundred beds and "earning up to 15 percent rates of return for investors[,] and dedicated, as Matthew Dymond [, Ontario's Minister of Health, had] argued, 'to one purpose, and one purpose only, to make money for the shareholders'" (as quoted in Struthers, 1997, 186).

5.6 Cost-Minimization as the Operative End of Policy

The specific policy decisions traced across this chapter represent the concrete expression of ideas mediated by an underlying institutional rationality, one which meant that even after assuming direct control of the publicly funded for-profit nursing home sector from municipalities in the mid-1960s, Ontario's provincial government continued to govern the sector through a regulatory approach characterized by a low per-diem rate alongside minimal care oversight and standards that privileged physical infrastructure over care quality, with reference to care standards either entirely absent or serving as rhetoric. Unlike municipalities, however, this stance did not stem from a lack of resources or expertise but from an instrumental-formal rationality that treated procedural compliance and cost-minimization as the operative ends of nursing home policy, this resulting in the development of a public nursing home system dominated by for-profit providers and underpinned by the virtual absence of any philosophy of care, including substantive care

standards. As has been shown, provincial standards were initially so low that even the for-profit nursing home lobby had to repeatedly ask for them to be raised to a basic minimum (Lundman, 1975, 86/103; Baum, 1999, 547–548; Struthers, 1997, 179, 187; Tarman, 1990, 53–54, 58). Conversely, when the provincial government later sought to improve care standards beyond a basic minimum, it faced the stiff resistance of its own creation, namely a powerful for-profit sector which was structurally incentivized to maximize profits for shareholders with marginal incentives to assure the quality of care (Struthers, 1997, 181–182).

The Ontario bureaucracy's obsession with cost savings and efficiency is starkly captured in a 1969 Government Report prepared for the Cabinet Committee on Nursing Homes and Technical Committee, which pointed out that:

> In each of the proposed levels of care categories the Province would achieve the maximum return on our dollar by building wherever possible lower per unit cost facilities, rather than "holding" people in high cost per unit accommodation, and would further achieve, wherever possible, a maximum return through Federal contributions or the "use" of immediate Federal capital investment through loans. (Cabinet Committee on Nursing Homes & Technical Committee, 1969, 59/148)

The same report's three stated objectives for the Extended Care Program centred entirely on cost-efficiency and utility—avoiding "inappropriate utilization" of care types, maximizing the potential of federal funding, and "the question of the maximum dollar value being obtained for your Provincial capital investment"—with virtually no discussion of care quality (Cabinet Committee on Nursing Homes & Technical Committee, 1969, 59/148). Lundman's (1975, 78) observation that "between the 1966 Act and the 1972 Act, most concern was over the financing of nursing home care" confirms this broader pattern, reflecting the extent to which fiscal concerns

dominated deliberation over care standards during the period. Cost considerations also took priority over care standards at a December 23, 1971 meeting of the Co-ordinating Committee for implementation of the Extended Care Health Insurance. Although the Standards Committee, under the direction of Dr. Barbara Blake (Co-ordinating Committee Extended Care Health Insurance, 1971d), had recommended better care standards, including an improved ratio of professional nursing personnel and "round-the-clock qualified nursing care available in nursing homes", a recommendation with which all involved departments had agreed, the minutes noted that "any such arrangement would result in substantial cost increases", with the Deputy Minister of Health, Dr. K. C. Charron, urging that standards first be considered "from the economic and practical aspects" and suggesting "Registered Nurses on the day shift, and Registered Nursing Assistants on the two night shifts as an alternative to 24 hour R.N. service." Hence, the Co-ordinating Committee decided it could not accept the improved standards "at this time." While it did not dispute that they were desirable, it placed them on hold, recommending that their costing first be assessed by its Finance Committee (Co-ordinating Committee Extended Care Health Insurance, 1971, 51/161). This meeting serves as yet another illustration of the two markers that, as Chapter 3 explains, indicate instrumental-formal rationality at work: the need for improved care standards was acknowledged across the departments involved, yet that acknowledgement was not treated as a reason for corrective action, with their adoption instead made contingent on cost. As with other voices within the bureaucracy that called for improved care standards, the Standards Committee's recommendation was recognized but did not prevail over cost considerations.

But such concerns have not simply taken priority over the standards of care of the public nursing home system; they have also led the government to ignore the positive attributes of the existing system, making it seem as if these attributes do not exist. For example, one positive aspect

of Ontario's public nursing home system has been the Homes for the Aged program, where the quality of nursing home care has often been hailed as being higher than the quality of care provided in for-profit nursing homes. Rather than acknowledging the Homes for the Aged sector as an important and valuable part of the program, officials have often focused on whether and why the Homes for the Aged program is costing more than the province's for-profit dominated nursing home program. For instance, in 1969, the province's Minister of Health Matthew Dymond expressed his alarm at the higher cost of the Homes for the Aged program compared to for-profit nursing homes, leading him to conclude that "we had better take a long look at the two programmes" (Department of Health, 1969, 141/148). Even when the program's quality was acknowledged, it was subordinated to fiscal considerations (Task Force on Long-Term Care, 1974a, 11/21), as one participant in a government Task Force on Long-Term Care meeting stated that one "can't divorce finances from any discussion" in relation to Homes for the Aged (Task Force on Long-Term Care, 1974a, 12/21), while in another meeting a member rationalized the program's expansion on the basis of cost-saving, noting that home "Administrators would cut their costs in all sincerity" if it were expanded (Task Force on Long-Term Services and Facilities, 1974a, 14/67).

Officials also treated the care provided across settings as broadly interchangeable, with Dr. Laird, a member of the Technical Committee, noting at a Joint Meeting of the Cabinet Committee on Nursing Homes and of the Technical Committee on Nursing Homes in October 1969 that "many people in nursing homes getting domiciliary care, get the same kind of care as in Homes for Aged" (Cabinet Committee on Nursing Homes, 1969, 37/148), and with Minister of Health Dymond making a similar remark in his comparison between the Rest Homes and nursing home programs, pointing out that "there is an overlapping of function in the area of Rest Homes with that of nursing

homes under the Department of Health, and no difference can be seen between the type of patient cared for in the Rest Home... and that in our nursing homes" (Department of Health, 1969, 104/148). In these ways, officials echoed the arguments that the for-profit nursing home lobby had historically made, i.e., that the Homes for the Aged program and nursing home program should be given equal funding because they both serve the same function. That officials found these arguments persuasive reflects the instrumental-formal orientation through which they evaluated the two programs: by measuring both solely in terms of bed capacity and cost, qualitative differences in care were made invisible (Associated Nursing Homes Incorporated Ontario, 1970d, 35/129; Associated Nursing Homes Incorporated Ontario, 1972, 95/129). Furthermore, such discussions ignored two well-known aspects of the municipal and charitable Homes for the Aged program. First, they ignored the better quality care that these facilities were generally known for (Ontario Hospital Services Commission, 1969, 5, 8; Ontario Nursing Home Association, 1984, 46/46; Task Force on Long-Term Care, 1974a, 11/21). Second, even if municipal Homes for the Aged cost more, this was due to the fact they provided more services including social care services that were often not available in for-profit nursing homes (Concerned Friends of Ontario Citizens in Care Facilities, 1985, 18/29, 20/29; OANHSS, 1996b, 1–2/28; Toronto Star, 1985; City of Toronto, 2001, 8/10; City of Toronto, 2009, 9/13).

Even when concerns over costs were not explicitly stated, any discussion over care standards doubled down on the most minimal measures possible. For example, in a 1971 meeting of the Co-ordinating Committee Extended Care Health Insurance, members generally agreed that one should accept lower standards rather than "build them up", since the program was only just being initiated (Co-ordinating Committee Extended Care Health Insurance, 1971c, 145/161). The same logic ran through the recommendations of the Task Force on Long-Term Care in 1974, which

made cost-efficiency the explicit standard governing all its proposals, including its recommendation to develop Co-ordination Services across the province as the means to ensure that "the health dollar is being used most efficiently" (Task Force on Long-Term Care, 1974f, 61–65/67), thereby leaving the needs of residents behind a measure of cost-efficiency.

Not everyone inside government was aligned with this purely cost-driven approach. Several officials had voiced strong criticism over the fact that the province had continued to formulate its nursing home policy on the basis of cost-saving priorities alone, without paying sufficient or any attention to the humane or social elements of these policies. A member of the Co-ordinating Committee Extended Care Health Insurance argued in 1972 that the standards of care in for-profit nursing homes should not be "in any way…less than those in the Homes for the Aged", and further expressed concern over the fact that the 1972 nursing home program was being organized exclusively from a "financial and functional" point of view "without consideration of the rights of the patient" (Co-ordinating Committee Extended Care Health Insurance, 1972, 29/46). In addition, in a 1974 meeting of the Task Force on Long-Term Services and Facilities, one member had argued for the need for a "philosophy of care" for the program, while another member similarly argued that "financial implications" should not be dictating policy for rehabilitation programs in nursing homes, and yet another member argued that not only the concerns of for-profit facilities, but also those of their patients, should be taken into account by the Ministry (Task Force on Long-Term Services and Facilities, 1974b, 42/67; 1974d, 45/67, 46/67). Yet such voices remained marginal. The prevailing instrumental-formal orientation conditioned how their positions were received and weighed, ensuring that cost-minimization continued to serve as the operative end of policy across each successive window of opportunity.

5.7 Conclusion

What the evidence presented in each section of this chapter serves to demonstrate is that the systemic exclusion of substantive care standards from the policy process in Ontario was not a simple policy failure or a result of misjudgment, but the underlying product of an instrumental-formal bureaucratic rationality under which the orthodox pursuit of the procedure and the cost-minimization it produced governed the evaluation of policy options, marginalizing care quality in the process. This orientation conditioned every major policy decision the provincial government made across the period under examination, including its implementation of a regulatory regime characterized by a low per-diem rate, relaxed size restrictions, and standards that privileged physical infrastructure over care quality, a regime that drove smaller operators out of business while enabling large for-profit chains to thrive, its deliberate suppression of the municipal and non-profit Homes for the Aged and Rest Homes programmes to evade the operating-deficit liabilities that public and non-profit provision entailed and to secure the expansion of for-profit chains, and its swift retreat from its regulatory duties the instant it faced pushback from the for-profit chain sector its own policies had empowered.

Moreover, this orientation not only produced poor policy outcomes, but also generated a self-reinforcing dynamic that made those outcomes progressively harder to reverse. By the time the provincial government finally assumed full regulatory control of the sector in 1972, the province's decades of governing the sector under a cost-minimization logic had allowed a powerful and sizable for-profit nursing home sector to emerge and entrench itself, one that strongly resisted the very improvements the government now attempted to introduce. As a result, not only did the provincial government fail to enact stringent and clear regulations that would balance both care and physical standards when it implemented the 1972 Nursing Homes Act, but when it attempted

to introduce minor improvements, it was met with a monopoly power of its own making: a well-entrenched for-profit nursing home sector that, driven by an inherently self-reinforcing commercial logic, took advantage of the province's cost-driven framework to push for further funding increases while resisting stricter care regulations (Daly, 2015), ultimately forcing the province to abandon its own regulatory amendments.

Indeed, as Baum (1999) and Ingram and Baum (1997) have argued, the provincial government led a process that made it so dependent on a powerful and expansive for-profit nursing home chain sector lacking any competition that it was rendered unable and afraid to pursue alternative policy options or make inspection reports public, since it believed that "further regulatory limits on nursing-home profitability would exacerbate the bed shortage" (1999, 548) and "destroy the very people the law is intended to protect" (Ingram & Baum, 1997, 70). While the industry's own lobbyist, Richard O'Donnell, claimed in 1983 that "the core of the problem is that the present [long-term care] system was never planned; it has simply evolved" (as quoted in Daly, 2015, 29), this chapter has demonstrated that this evolution was in fact the direct, path-dependent consequence of the state's regulatory approach, governed by cost-minimization and the marginalization of substantive care considerations.

The following two chapters turn to British Columbia, which encountered the same sequence of federal funding opportunities examined here but filtered them through a fundamentally different bureaucratic orientation. Whereas Ontario's instrumental-formal bureaucracy treated cost-minimization as the operative end of policy, first declining to assume direct responsibility for the sector and, once it did intervene, implementing policies devoid of substantive concern for care quality, thereby laying the groundwork for the expansion and entrenchment of for-profit nursing homes, including powerful corporate chains, British

Columbia's caring bureaucracy, as Chapters 6 and 7 demonstrate, drew on principled ideas rooted in a high philosophy of care to pursue a layering process in the opposite direction, transforming its ownership-mix toward non-profit dominance.

Chapter 6: Stringent Regulations and Strict Controls: The Emergence and Evolution of British Columbia's Nursing Home Regulations, 1913–1960s

6.1 Introduction

The preceding chapters documented how Ontario's bureaucracy, operating within an instrumental-formal rational framework, worked diligently to facilitate the growth of a for-profit dominated nursing home system on the causal belief that this would minimize the costs of reform, first taking no action and later, upon intervening, advancing policies devoid of substantive concern for care quality, whether by upholding a symbolic municipal authority that privileged physical over care standards or by replicating similar policies upon taking control of the sector. Against this backdrop, the analysis now turns to the British Columbia case, where a fundamentally different bureaucratic orientation led to the opposite trajectory. That orientation, as the theoretical framework specifies, found institutional expression in a caring bureaucracy, one that enables officials to approach policy objectives on the basis of principled ideas, empowering them to frame substandard care as a moral problem requiring corrective action. This chapter provides the first empirical demonstration of these implications, tracing the origins and evolution of BC's nursing home policy from 1913 through the early 1960s and showing how the substantive orientation of the province's bureaucracy enabled officials to develop a regulatory approach grounded in their principled commitment to a high philosophy of care. Prompted by persistent complaints about substandard conditions and their own consistent framing of these failures as moral problems, officials built a stringent system of provincial oversight covering both physical and care standards that effectively controlled for-profit growth and, through key legislative reforms and active monitoring, fostered measurable improvements in care quality. As this chapter reveals, officials continually discovered that for-profit nursing homes persistently skirted regulations, requiring constant and resource intensive monitoring just to maintain minimum standards. In stark contrast,

officials recognized that non-profit and state-owned facilities required far less intervention, maintaining superior care standards without requiring intensive oversight and persistent enforcement—a pattern consistent with the transaction cost predictions outlined in Chapter 2. The stark disparity between the mounting regulatory costs of for-profit providers and the bureaucracy's principled commitment to a high philosophy of care set the stage for BC's eventual departure from a for-profit ownership model, and its ultimate transition toward a non-profit one.

6.2 Provincial Regulations in 1913

Prior to 1913, British Columbia's nursing home sector, composed almost entirely of for-profit operations known as "private hospitals" (B.C.H.I.S., 1957, Y8; B.C.H.I.S. Annual Report, 1963, H13; GR-2653, 1968, 26/97), operated in an unregulated environment, free from any controls, monitoring, or oversight. However, amidst ongoing complaints about substandard care in these facilities, the provincial government introduced a system of robust provincial regulations through the Hospital Amendment Act of 1913 (Latham & Pazdro, 1984; Converse, 1998, 105; B.C. Hospital Amendment Act, 1913; B.C.H.I.S Annual Report, 1960, W 22; GR-2653, 1970, 8/79). The caption of a 1913 *Victoria Daily Times* paper captured this shift, reading: "Stringent Regulations as to Private Hospitals – Burden of Proof" (Figure 1).

The Act established a range of standards to ensure adequate care, including the mandatory use of a detailed patient registry available during inspections, proper equipment, and qualified staff, with a superintendent who was either a licensed medical practitioner or a trained graduate nurse required to be on-site at all times (B.C. Hospital Amendment Act, 1913).

The new regulations also established a system of oversight and control over the sector by making it mandatory for nursing homes to be open for inspections at all times, imposing heavy fines for violations, empowering the provincial secretary to close non-compliant facilities without

Figure 1

Stringent Regulations as to Private Hospitals – Burden of Proof


HOSPITALS ACT
HAS BEEN PREPARED

MAKES PROVISION FOR UNIVERSITY INSTRUCTION

Stringent Regulations as to Private Hospitals—Burden of Proof

Note. From Victoria Daily Times, 1913

judicial review, requiring government approval for the transfer of licenses, and implementing a rigorous application-vetting process that obligated licensee applicants to provide "comprehensive descriptions" in their applications (Victoria Daily Times, 1913; B.C. Newspaper Archives, 1913a, 83; 1913b, 219/219). Credit for these reforms is attributed to Dr. Henry Esson Young, a young physician "remembered as the father of public health" in BC who, following his election to the Atlin Electoral District in 1903 and his re-election in 1907 was appointed to serve as BC's provincial Minister of Education and Provincial Secretary from 1907 to 1915 and subsequently as the Secretary of the Provincial Board of Health from 1916 until his death in 1939 (B.C. Newspaper Archives, 1907, 47/195; McDonald, 2021, 72; Amyot & Defries, 1958, 504; Cassidy, 1945, 41–42; Daily Province, 1916; Davies, 2002, 69; Reid, 1998).

As evidenced by inspection reports, these regulations not only improved the quality of care, but also served as powerful mechanisms to control the unchecked growth of the for-profit nursing home sector (B.C Provincial Board of Health, 1915a, L8; B.C Provincial Board of Health, 1917a, G 15; B.C Provincial Board of Health, 1919a, B 14; B.C Provincial Board of Health, 1931a, P 17; B.C. Provincial Board of Health, 1915b, I 6; B.C. Newspaper Archives, 1916, 105/222; Vancouver Sun, 1948; B.C.H.I.S., 1956, AA 13-AA 14; B.C.H.I.S., 1957, Y 18; GR-0698, 1950, 46/50). For example, within its first year, the new Act enabled officials to shut down "twelve to fifteen" substandard nursing homes (Latham & Pazdro, 1984; B.C. Provincial Board of Health, 1913b, U81; B.C. Provincial Board of Health, 1913a, F 15). BC's inspector of Hospitals, Dr. Henry Esson

Young, prided himself on this fact, pointing out that for-profit nursing homes lent themselves to many abuses, and that by taking the initiative to appoint himself as the Inspector of Hospitals, he was able to "correct a great deal of abuse" by not only closing poorly performing for-profit nursing homes but insisting on "trained attendants, trained nurses, and…proper safeguards for the protection of patients" (B.C Provincial Board of Health, 1913b, U81). Dr. Young's self-appointment and his framing of for-profit nursing homes as sites of abuse rather than mere regulatory problems underscore the substantive rational orientation that would come to define BC's bureaucratic approach to nursing home governance, an orientation in which officials retained sight of their public purpose and acted as assertive advocates rather than subordinate administrators.

The closure of substandard facilities continued in subsequent years. A 1915 Board of Health report highlighted that the department had focused on "the elimination of many so-called private hospitals" (B.C. Provincial Board of Health, 1915a, L8). Beyond closures, officials also controlled the sector's size and quality by carefully vetting licensee applicants and not granting applications to those that "lacked necessary qualifications on the part of the applicant or [due] to the premises not being suitable" (B.C. Provincial Board of Health, 1917a, G 15). Improvements in the safety standards and operations of for-profit nursing homes also followed from the stringent regulations (BC Provincial Board of Health, 1915b, I 6; BC Provincial Board of Health, 1917a, G 15). While acknowledging the improvements achieved in for-profit nursing home operations under a stringent regulatory system and strict controls (B.C Provincial Board of Health, 1915b, I 6; B.C Provincial Board of Health, 1917a, G 15; B.C. Newspaper Archives, 1916, 105/222), public officials found that these providers were still frequently committing violations and required constant monitoring and enforcement to ensure their compliance with regulations and standards

(B.C Provincial Board of Health, 1916a, H 17; B.C Provincial Board of Health, 1917a, G 15; B.C Provincial Board of Health, 1919a, B 14, B 15). This was particularly the case with the larger for-profit nursing homes. As Dr. Henry Esson Young stated in 1915 in his capacity as Provincial Secretary, "it has become apparent that some further amendments to the [Hospital] Act pertaining to the operation of private hospitals are needed to prevent the almost exclusive employment of non-graduate or inexperienced nurses in the larger private hospitals" (B.C. Provincial Board of Health, 1915a, L8). For these reasons, officials made for-profit facilities the main target of their inspections and regulatory efforts (B.C. Provincial Board of Health, 1915a, L8; B.C. Provincial Board of Health, 1915b, I 18; B.C. Provincial Board of Health, 1916a, H 16; B.C. Provincial Board of Health, 1918a, A 18; B.C. Provincial Board of Health, 1919a, B 14, B 15).

In contrast, officials were less concerned with government and charitable-owned homes, which they generally found provided adequate care and suffered from the least violations—even during harsh operating conditions such as the First World War (B.C. Provincial Board of Health, 1916a, H 17; B.C. Provincial Board of Health, 1915b, I 18; B.C. Provincial Board of Health, 1917a, G 15; B.C. Provincial Board of Health, 1918a, A 19; B.C. Provincial Board of Health, 1919a, B 14, B 15). Officials also boasted that they rarely conducted inspections in government-owned facilities as these facilities were already effectively self-managed by their boards of directors (B.C. Provincial Board of Health, 1915b, I 18; B.C. Provincial Board of Health, 1916a, H 16; B.C. Provincial Board of Health, 1917a, G 15).

Throughout the period covered in this chapter, the state funded nursing home care only for welfare patients (GR-0119, 1956, 70/82; GR-2578, 1965, 194/231; GR-2653, 1969, 19/130; GR-2653, 1968, 10/97; Victoria Times, 1967; GR-2653, 1967, 65/80, 75/80; GR-2653, 1969, 20/130; GR-136, 1967, 10/55; GR-2675, n.d., 20/20). Prior to 1947, the funding of this care rested on a

jurisdictional division determined by where the welfare recipient resided: the provincial government covered the costs of those living in unorganized territory, that is, areas of the province without municipal government, by typically placing them in provincial institutions or, where space was unavailable, in licensed private hospitals; municipalities, by contrast, funded the care of welfare cases resident within their own boundary, contracting with for-profit private hospitals on a per-diem basis (Social Welfare Branch of the Department of Health and Welfare, 1948, P 25; Goldenberg, 1947, X 91; McFarland, 1948, 59–60; Social Welfare Branch of the Department of Health and Welfare, 1945, R 58–R 59). This fragmented system was replaced in April 1947 by a joint provincial-municipal cost-sharing formula administered through the Social Welfare Branch, an arrangement that, by resolving a long-standing dispute between the province and municipalities over funding responsibility for the publicly funded nursing home care provided to welfare patients, expanded the public funding available for such care and resulted in the expansion of the for-profit sector (Social Welfare Branch of the Department of Health and Welfare, 1948, P 26, P 41; Goldenberg, 1947, X 91; McFarland, 1948, 74; Davies, 2003, 165).

By the 1950s, more stringent and extensive regulations had been introduced in B.C.'s nursing home system with the aim of controlling the development and quality of care in for-profit nursing homes. These regulations and practices stemmed from officials' objective of establishing a nursing home system based on high standards, as well as their negative experience with what they found to be a for-profit nursing home sector that provided substandard care and was resistant to regulations. Reflecting their dedication to maintaining effective standards, BC officials carried out routine, frequent, and detailed inspections that focused on both physical and care standards in for-profit nursing homes (B.C.H.I.S., 1955, Z 15). Active guidance and assistance were also provided to for-profit nursing homes under BC's inspection system to help improve the quality of

care and establish higher levels of service in for-profit nursing homes, including the creation of diversional and recreational programs (B.C.H.I.S., 1953, NN 14; B.C.H.I.S., 1954, CC 12; B.C.H.I.S., 1955, Z 15).

Additional measures were implemented to control development and the quality of care, including limiting the number of beds in for-profit facilities to a maximum of 30 (GR-678, 1956, 36/64; GR-0119, 1957, 21/28; GR-0119, 1955, 4/33). Officials had adopted small size restrictions for nursing homes for several reasons, reflecting principled attention to the quality and standard of care in the province's nursing home system.

First, officials had found that since for-profit nursing homes typically provided substandard care and were frequently violating regulations, such violations would be easier to detect and monitor in small for-profit nursing home operations than in large for-profit operations (GR-380, 1955, 12/25).

Second, officials had discovered that they were often unable to enforce standards in for-profit nursing homes, and in the event it became necessary to close a facility that was providing inadequate care and refusing to abide by regulations, this would be much more difficult to accomplish with a larger nursing home since it would also be difficult to find alternative venues for transferring patients at once (GR-380, 1955, 12/25).

Officials also contended that compared to large facilities, a smaller size facility such as 30 beds would allow for a homelike atmosphere and for the operator to know all the patients while also allowing officials to "secure an intimate picture of exactly what is being done" and to "make certain that a good quality of care is maintained and that patients are not exploited" (GR-2653, 1968, 46/130; GR-380, 1955, 12/25). In addition, having small for-profit nursing homes would prevent for-profit operators from controlling large blocks of beds, which officials acknowledged

would completely undermine their ability to exercise any meaningful control over a sector that provided substandard care and was difficult, if not impossible, to regulate (GR-2653, 1968, 46/130).

Although officials allowed for the maximum number of beds in for-profit nursing homes to increase over time, often in response to a shortage of beds and pressure from for-profit providers who argued that larger sizes were needed to sustain adequate profit levels (GR-2653, 1967, 8-9/39; GR-2653, 1967, 16/39; GR-2675, 1966, 16/20; GR-2653, 1967, 7/80; GR-2653, 1967, 75/80; GR-136, 1967, 10/55), these increases were kept extremely limited in light of officials' concerns for ensuring the high standards of the nursing home system. For instance, in 1955 the number of beds allowed in for-profit nursing homes was increased from 30 to 50 beds, with officials refusing to allow more beds due to concerns that this would undermine the quality of care provided in nursing homes (GR-678, 1956, 35/64[i]; GR-0119, 1958, 12/28; GR-0119, 1957, 18/28; GR-0119, 1957, 20-21/28; GR-380, 1955, 12/25). In recommending the 50-bed maximum, BCHIS Commissioner, D.M. Cox, had noted that while "the necessary supervision could be given to private hospitals of upwards to 50 beds without too much difficulty", he remained "extremely apprehensive of what would happen if a large private hospital got into the hands of an unreliable operator" (GR-380, 1955, 12/25). British Columbia ultimately increased the maximum number of beds allowed in for-profit nursing homes to 75, with this size restriction never being increased further, as officials were convinced that they would be unable to maintain a satisfactory service in larger proprietary institutions (GR-2653, 1968, 41/97; see also GR-2653, 1968, 24/97). Officials continued to maintain this limit even after private hospitals stated that they would no longer accept welfare patients because a 75-bed limit was eating into their profit levels and that they therefore needed to admit private patients to increase their profits (GR-128, 1966, 15/76; GR-2653, 1968, 24/97).

Consistent with their objective of operating the nursing home sector in accordance with high ethical standards, BC's provincial government also introduced standards prohibiting absentee landlords and foreign ownership of nursing homes, including a requirement that the majority of the equity in any nursing home come from the province and that its owners hold Canadian citizenship (GR-3578, 1969, 14-15/29), and restricting any individual or family from owning or holding a stake in more than two private hospitals, a measure that effectively prevented the establishment of nursing home chains (B.C.H.I.S., 1966; GR-365, 1969, 8/9; GR-0119, 1958, 11; GR-0119, 1958, 12/28). These restrictions became formalized with the establishment of private hospital standards in 1966 (GR-2653, 1967, 12/39; GR-2653, 1971, 18/146; GR-364, 1969, 3/36). However, some of these measures predated this time and were being enforced as early as the late 1950s due to officials' concerns that absentee control and the establishment of for-profit nursing home chains would cause the provincial government to lose its ability to maintain adequate oversight of a for-profit nursing home sector characterized by substandard care and weak regulatory compliance (GR-0119, 1958, 11/28; GR-0119, 1958, 12/28; GR-2653, 1963, 26/29; GR-2661, 1973, 24/48).

Apart from sparing no regulatory and enforcement efforts to ensure that nursing homes were operating in accordance with standards, the focus of B.C officials for much of the remainder of the early second half of the 20th century was to improve the quality of the public nursing home system by addressing shortcomings in regulations that had made it difficult to hold places which provided substandard nursing home care or violated the Hospital Act accountable (GR-078, 1955, 78/92). As a 1955 BCHIS report had pointed out, "none of the amendments" since the Hospital Act's passage in 1902 was in the form of "a full scale revision" (GR-078, 1955, 78/92). Hence, it was "now deemed necessary and advisable to completely overhaul the Act to make it applicable

to present day conditions" (GR-078, 1955, 78/92). Improvements sought included closing loopholes through tightening "licensing provisions for private hospitals", improving procedures for "revoking private hospital licenses to cover situations where the standard of care or the building or its furnishings and equipment have been allowed to deteriorate", stronger mechanisms "for securing reports and returns from private hospitals", and revamping procedures to put an end to the operation of places that were masquerading as private hospitals (GR-078, 1955, 78/92). To address these issues which affected for-profit nursing homes in particular (GR-078, 1955, 78/92), officials had come to recognize that they needed to take a multi-pronged approach which addressed not only the deficiencies present in the Hospital Act, but also the definitional ambiguities surrounding the term 'nursing home' and the flaws in the Welfare Institutions Licensing Act governing residential care facilities. This was due to two reasons.

First, definitional ambiguities over the term 'nursing home' had made it easier for unlicensed nursing homes and residential care facilities posing as nursing homes to deny allegations that they were providing nursing home care (GR-0119, 1958, 9–11/82; GR–0119, 1955, 12–13/33; GR-0698, 1953, 14/50; GR-0698, 1954, 24–30/164; GR-078, 1955, 78/92; GR-0119, 1957, 7–8/82; GR-0119, 1959, 3–4/82; GR-0119, 1958, 12–14/82; GR-0678, 1953, 7–12/50; GR-911, 1939, 44–45/58; GR-3938, 1952, 6/12; GR-3938, 1951, 10/12; GR-3938, 1951, 12/12; GR-0678, 1950, 48–50/50; GR-0678, 1953, 4/50).

Second, regulatory efforts involving residential care facilities were further complicated by the limited scope of the 1937 Welfare Institutions Licensing Act. Because the Act applied exclusively to facilities receiving government funding, for-profit rest homes operating without public subsidies were exempt from regulation entirely. This exemption enabled a number of these

unlicensed operators to deliver severely substandard care while masquerading as legitimate nursing homes and evading provincial oversight.

Bureaucrats had known and pushed for the resolution of these issues for years, and while other regulatory weaknesses had been addressed in the intervening period, legislative efforts to close these two specific loopholes had repeatedly stalled in the legislature, acting as a major source of frustration and concern among officials (GR-0119, 1958, 9/82; The Vancouver Sun, 1959; GR-0119, 1959, 3/82; GR-0119, 1958, 10/82; GR-0119, 1957, 39/82; GR-0119, 1958, 82/82; GR-078, 1955, 78/92; GR-3938, 1955, 5; GR-0119, 1957, 7–8/82; GR-0119, 1959, 3–4/82). The poor quality of care provided by these evasive for-profit facilities also received some media coverage in British Columbia, though such coverage was far less prevalent than in Ontario, likely reflecting the extremely weak regulatory environment in that province, which permitted for-profit facilities to operate without meaningful oversight of care quality (GR-0119, 1958, 9–11; GR-0119, 1958, 12–14; GR-0119, 1958, 82/82; The Province, 1957a; The Province, 1957b; The Province, 1958). These gaps were finally overcome in 1961, when relevant amendments expanded the Welfare Institutions Licensing Act's regulatory oversight to encompass all residential care facilities, regardless of whether they received government funding (Vancouver Sun, 1961; GR-0698, 1959, 84/164; The Province, 1959; B.C.H.I.S. Annual Report, 1961, R 28; B.C. Department of Social Welfare, 1962, K87-K88; GR-0119, 1958, 9–11/82; GR-0119, 1958, 12–14/82).

6.3 Conclusion

The evidence presented in this chapter demonstrates the first observable implications of British Columbia's caring bureaucracy in action, showing how from the establishment of stringent provincial regulations in 1913 to the legislative reforms of the early 1960s, BC officials, guided by substantive rationality, advanced principled ideas and persistently pursued corrective reforms

and actions aimed at improving the quality of care in for-profit nursing homes, framing substandard care as a moral problem demanding state intervention rather than a costly administrative expense to be evaded.

While these persistent regulatory efforts led to measurable improvements in the quality of care in for-profit facilities, their impact ultimately remained limited, especially when placed against officials' aim of establishing a public nursing home system grounded in a high philosophy of care, since as the evidence illustrates, despite persistent and active monitoring and strict enforcement, for-profit facilities continually resisted regulations, creating sustained quality of care issues while imposing significantly higher administrative and regulatory costs on the provincial government than their non-profit counterparts.

As Chapter 7 will demonstrate, it was precisely this combination of persistent bureaucratic advocacy for a high philosophy of care and the recognition that even robust regulation could not reconcile this objective with for-profit provision that would drive officials to look beyond mere regulation and pursue a fundamental transformation of the province's public nursing home system toward a non-profit model.

Chapter 7: From Regulation to Transformation: British Columbia's Shift to a Non-Profit Nursing Home System

7.1 Introduction

The preceding chapter traced BC officials' persistent efforts to regulate the for-profit sector through stringent controls and legislative reform from 1913 through the early 1960s. This chapter examines a parallel and ultimately more consequential sequence, namely, officials' growing conviction that even stringent regulation could not reconcile for-profit provision with a high philosophy of care, a realization that led bureaucrats' subsequent efforts to transform the ownership-mix itself. In this light, the archival evidence presented shows how BC officials' substantive orientation moved beyond regulatory reform to drive a fundamental transformation of the province's nursing home ownership-mix, with officials persistently advocating for a non-profit model across successive windows of opportunity based on their causal belief that this path would enable them to realize a public nursing home system with a high philosophy of care.

This evidence aligns with the study's theoretical framework, which specifies that a caring bureaucracy enables officials to evaluate and persistently advance causal beliefs on the basis of principled ideas rooted in a high philosophy of care, empowering them to treat policy failures as moral problems, to hold to their positions before political superiors across successive windows of opportunity, and to resist cost-driven pressures even when fiscal concerns become politically prominent.

This chapter analyses how the provincial government translated this principled idea into policy by imposing a moratorium on for-profit nursing homes in 1965, and subsequently on for-profit intermediate care nursing homes in 1971, while simultaneously leveraging emerging federal windows of opportunity to actively promote the growth of extended care and intermediate care non-profit facilities, thus helping transform the province's public nursing home ownership-mix

from a system dominated by for-profit providers to one primarily led by non-profit organizations. As the archival record demonstrates, BC officials advocated for this non-profit transition with a persistence and principled conviction that directly shaped the direction of reform. Even though federal and provincial funding constraints structurally hampered the pace of this non-profit expansion throughout this period, preventing officials from fully realizing their vision as rapidly and comprehensively as they desired, bureaucrats' persistent push for funding mechanisms along with their refusal to default back to cheap, for-profit alternatives, including through lifting or relaxing the moratorium on the for-profit sector, confirms the resilience of a bureaucracy fundamentally anchored in substantive rationality.

7.2 The Emergence of Universal Extended Care Hospitals (Non-Profit Nursing Homes) in British Columbia

As outlined in the preceding chapter, B.C.'s provincial government gradually established a robust system of regulation and enforcement over the for-profit nursing home sector beginning in 1913, one that had led to some visible improvements in the quality of care provided in publicly funded for-profit nursing homes. However, by the late 1940s and early 1950s, officials in B.C. had reached the conclusion that operating a public nursing home system in accordance with a philosophy of care based on strong standards was simply irreconcilable with an ownership-mix made up of for-profit providers (GR-136, 1967, 42/101). This was due to several reasons.

First, while provincial regulations and controls over for-profit nursing homes since 1913 had led to visible improvements in their quality of care, these improvements fell short of officials' expectations, which were tied to establishing a public nursing home system based on high standards. The inherent and irreconcilable challenges involved in establishing a for-profit nursing home sector aligned with a high philosophy of care were reflected in a research paper on nursing home standards forwarded by Edith Pringle, the Inspector of Hospitals of the B.C.H.I.S., to D. M.

Cox, the Assistant Commissioner of the B.C.H.I.S., in 1953 (GR-678, 1953, 27–30/52; Kinnaman, 1953). The paper pointed out that the profit motive of for-profit nursing homes rendered them incompatible with providing effective care, as these facilities typically complied with required standards only during official inspections but neglected them in inspectors' absence, and that the imperative to maximize profits led operators to extract maximum revenue from patients through multiple charges and unfair rates rather than caring for them in a "genuine" and "friendly, professional manner" (GR-678, 1953, 27–30/52; Kinnaman, 1953).

Over time, the regulatory difficulties officials faced over for-profit facilities were compounded by a growing shortage of nursing home beds in the province—a shortage that, given the small size of the non-profit nursing home sector and the scarcity of state institutions, had left the provincial government heavily dependent on for-profit nursing homes, which in turn exploited the scarcity by demanding higher rates (McFarland, 1948, 14–15, 55–57; Davies, 2003, 162). This dependence was deepened still further by two developments. First, the Hospital Clearance Program, introduced in 1937–38 to relieve the congestion in British Columbia hospitals caused by patients requiring nursing home care who lacked suitable accommodation, authorized their transfer into private nursing homes, channelling a growing stream of public funds to for-profit operators and fuelling the sector's growth in the process (Social Welfare Branch of the Department of Health and Welfare, 1948, P 20; Davies, 2003, 162, 165–166). Yet the program could only partially relieve the backlog, because the availability of nursing home beds remained outstripped by the number of patients requiring placement (Social Welfare Branch of the Department of Health and Welfare, 1948, P 20). The joint provincial-municipal cost-sharing reform introduced in 1947 deepened this dependence even further by expanding the public funding available for nursing home care, funding that flowed predominantly to private hospitals, thereby helping the sector expand further in the

process (McFarland, 1948, 74; Davies, 2003, 165). The consequences of this growing dependence were not lost on officials. As E. P. Pringle, Inspector of Hospitals for the BCHIS, observed in a 1953 report, "due to a shortage of beds for such cases and particularly in the City of Vancouver a situation has been created where the private hospitals are calling the tune as to 'price' but not service…" (GR-678, 1953, 23–24/34), with a number of private hospitals refusing welfare patients unless the provincial government provided them with significantly higher subsidies (The Vancouver Sun, 1952; The Vancouver Sun, 1955; GR-0119, 1957, 52–55; Davies, 2003, 166). With few alternative public options available, the provincial government often had little choice but to agree (McFarland, 1948, 14–15, 56–57).

Officials were concerned about for-profit nursing homes not only because of quality problems and high administrative and regulatory costs, but also because of the long-term operational costs imposed on the public purse by their capital structure. This concern was raised by K. G. Wiper, Administrative Officer of the BCHIS, who informed Minister of Health Eric Martin that "allowance would have to be made for interest due on borrowed capital (which the Federal Government presently won't share in) plus a reasonable return on the capital cost of the private hospital property", and that this would lead to "considerable difficulty… in setting satisfactory rates of payment for privately-owned nursing homes" (GR-2585, 1963, 49/62). That BC officials evaluated the ownership-mix question not only on the grounds of care quality but also on the basis of long-term cost implications reflects the critical, multifaceted analysis that their principled orientation produced—an orientation under which officials applied the instrumental-formal procedure of cost comparison not as an end in itself, but as a means of testing each policy option against their principled commitment to a high philosophy of care. Conducted in this way, that analysis led them not to abandon efficiency concerns, but to apply them critically, thereby

helping them recognize that for-profit homes were not as cost-efficient as they initially appeared once their high regulatory costs and rising long-term operational expenses were taken into account—an approach that was largely absent in Ontario, where officials accepted the for-profit model as the low-cost default without subjecting it to the same critical, multifaceted analysis that BC officials applied.

Apart from these concerns, BC officials were also troubled by the financial exploitation of private patients by private hospitals (GR-2653, 1968, 24–25/97). In a letter to the Minister of Health, Eric Martin, BC's Hospital Commissioner, D. M. Cox, noted that he had warned the Health Minister on numerous occasions about the "great tendency of proprietary hospitals to charge paying patients very high rates", that "it is an unfortunate situation if care of the helpless sick is to be condoned and encouraged by the Government as a suitable field for profits on investments", and that the government's policy of encouraging the growth of for-profit providers was seriously harming its "otherwise fine record...in the health field" (GR-678, 1963, 14–15/25; see also GR-0178, 1950, 46/50; GR-0419, 1963, 18–19/20). That officials' concerns extended beyond the public purse to the treatment of private paying patients, patients for whom the state bore no direct financial responsibility, underscores the principled, substantive foundation of their orientation, namely that the exploitation of the "helpless sick" was framed not as a matter outside the state's agenda, but as a moral problem implicating the government's own integrity, consistent with the high philosophy of care that guided BC's caring bureaucracy.

Altogether, these challenges, including the persistent quality failures, escalating regulatory costs, and financial exploitation of patients, led BC officials to pressure the government to prioritize policy options centred on non-profit nursing homes, which they found not only provided superior care, but were also less costly to regulate and offered greater long-term value by delivering

higher quality at a more sustainable cost, especially when administered in accordance with strong caring standards (GR-0178, 1950, 46/50; GR-0119, 1959, 76/82; GR-0119, 1958, 12/82; GR-0119, 1958, 61/82; GR-0119, 1958, 66/82; GR-0119, 1958, 79/82; GR-0119, 1958, 81/82). For instance, in 1950, D. M. Cox, the Assistant Commissioner of the B.C.H.I.S, had noted in a letter to A.W.E. Pitkethley, the Manager of the Hospital Construction Division at the B.C.H.I.S that the provincial government was considering a non-profit nursing home program since setting and controlling standards and rates for this sector was an achievable task, much unlike what officials had found to be the case with the for-profit nursing home sector (GR-0178, 1950, 46/50).

The overall lower regulatory costs of the non-profit sector was also emphasized by Edith Pringle, the B.C.H.I.S. inspector of hospitals, who had expressed her support for a publicly operated nursing home care program in a 1953 letter to B.C.'s Assistant Commissioner of B.C.H.I.S., Donald Cox, arguing that non-profit facilities could be regulated far more effectively, whereas "we cannot control private enterprise in this regard too greatly" (GR-678, 1953, 18–19). E. Pringle further elaborated her case for a non-profit nursing home program in a 1953 report titled "The Need for Chronic Diseases Hospitals", where she advocated for the construction of municipally operated nursing homes as an effective solution to the cost, regulatory, and quality issues that were plaguing publicly funded for-profit nursing home facilities (GR-678, 1953, 22–24/34).

Amidst ongoing calls by bureaucrats for the establishment of a public nursing home system based on non-profit ownership, a window of opportunity emerged in 1958. This window of opportunity was marked by the advent of the Federal-Provincial Hospital Insurance Plan which established a 50/50 cost-sharing agreement for hospital care expenses between the provincial and federal governments. Generous increases were also made to the federal hospital construction grants

under the 1948 National Health Grant in the same year (Gelber, 1959, 261). The opening of this window of opportunity created an occasion for bureaucrats to further their calls to the government for the establishment of a non-profit nursing home program by urging the provincial government to seek coverage for such a program under the new federal-provincial cost-shared hospital insurance plan (GR-0119, 1959, 76/82; GR-0119, 1958, 12/82; GR-0119, 1958, 61/82; GR-0119, 1958, 66/82; GR-0119, 1958, 79/82; GR-0119, 1958, 81/82). For instance, in 1958, J. W. Mainguy, the B.C.H.I.S. Manager of the Hospital Consultation and Inspection Division informed D. M. Cox, the Commissioner of B.C.H.I.S. about the list of reasons he had provided to the provincial government as to why a non-profit ownership model was preferred over a for-profit one, arguing, for example, that unlike for-profits, non-profit nursing homes enjoyed "continuity of operation…[whereas for-profits] are changing hands quite often" (GR-678, 1958, 24/25).

Bureaucrats' calls for a non-profit nursing home program gained further leverage amidst increasing tensions between the provincial government and the for-profit nursing home sector over the subsidy rates the provincial government paid to for-profit nursing homes for welfare patients. These tensions came to a head in 1959 when several private operators started refusing welfare patients unless the government raised their rates to match those paid by private patients. With no alternatives for placing welfare patients requiring nursing home care, the provincial government agreed to immediately raise its daily subsidy rate from $5.50 to $6.50, just short of the $7.00 demanded by private hospitals (The Province, 1959; The Vancouver Sun, 1959; The Province, 1959a; The Province, 1959b; The Vancouver Sun, 1959a; The Vancouver Sun, 1959b). In the same year, B.C.'s Commissioner of Hospital Insurance Services, D. M. Cox, and James W. Mainguy, the B.C.H.I.S. Manager of the Hospital Consultation and Inspection Division again repeated their

calls for a non-profit nursing home program, arguing that the need for such a program was long overdue (GR-0119, 1959, 76; GR-0119, 1958, 81/82).

In 1960, the provincial government finally took the initial steps towards establishing a non-profit nursing home program by announcing construction grants that covered 50 percent of capital costs and a portion of equipment costs for non-profit nursing homes under the province's hospital construction program while also conducting surveys to determine the required number of nursing home beds (The Vancouver Sun, 1960; Victoria Times, 1960). Government subsidies for the operation of non-profit nursing homes would be limited to welfare patients until the program achieved universal coverage under the federal-provincial hospital insurance program, a policy that, as a senior bureaucrat later noted, Minister of Health Eric Martin would only approve if recommended by the Hall Commission (GR-2653, 1964, 14–15; GR-2653, 1964, 88, 92/146; GR-2585, 1963, 48–50/62; see also House of Commons, 1964, 7895, 7899).

In 1961, the provincial government revised its initial funding model, reducing capital subsidies for non-profit nursing homes from 50 percent to 33 percent while also narrowing the range of equipment eligible for grants (Order-in-council #283; B.C.H.I.S. Annual Report, 1961, R 25; GR-0419, 1964, 3/19). The change originated in July 1960, when, on the Premier's instruction, the draft Order was withdrawn so that nursing home grants could be brought in line with those for Elderly Citizens' Housing (GR-0679, 1960, 12/27; GR-0679, 1960, 14–15/27). The province's Deputy Minister of Hospital Insurance, D. M. Cox, was quick to criticize the decision, arguing in a 1960 letter to the Minister of Health, Eric Martin, that the reduced funding levels were inconsistent with the province's vision for nursing homes and would significantly diminish the program's appeal to prospective non-profit sponsors, since the broader range of equipment that nursing homes required, including medical-grade equipment, made them considerably costlier to

build and operate than custodial facilities (GR-0679, 1960, 12/27). Cox went so far as to draft a submission for the Minister to put directly to the Premier, urging that construction grants be restored to 50 percent or, at a minimum, that equipment grants be retained (GR-0679, 1960, 14–15/27). The government, however, rejected these concerns and formalized the reduced scale in February 1961, a decision Cox would again sharply criticize in a 1963 letter to Eric Martin, arguing that the government's policies, including a grant scale of one-third for construction and no support for most equipment encouraged proprietary operations while discouraging non-profit ones, thereby creating room for the continued growth of an exploitative for-profit sector (GR-678, 1963, 14/25). In the same letter, Cox went on to further warn the Health Minister that he was "certain that the time will come when there will be very general criticism of the policies which you require to be followed, and I do not know of any effective answer that can be given to such criticisms" (GR-678, 1963, 14/25).

In addition to their concerns about inadequate capital subsidies, BC bureaucrats had also raised concerns over a conditional measure present in the funding model stemming from the Federal Hospital Insurance and Diagnostic Act that prohibited organizations from using operational subsidies from the Hospital Insurance Service or the associated revenue to repay borrowed capital costs (GR-0419, 1967, 85/231; Lindenfield, 1963, 223; Lindenfield, 1959, 158; Gelber, 1959, 261; Rosenfeld, 1969, 54; GR-0419, 1965, 157/231; Order In Council-283; 1961; GR-2653, 1967, 15/17; GR-2653, 1963, 110/146). Having experienced similar situations in the past, provincial officials were well aware that they served to actively discourage non-profit organizations' participation in the program (GR-0679, 1956, 23/34; GR-0419, 1967, 85/231). As K. G. Wiper, the Administrative Assistant of the B.C.H.I.S had pointed out, "it may be extremely difficult to persuade private groups or municipalities to construct suitable facilities unless they are

given a guarantee that operating deficits will be met by the Government" (GR-0679, 1956, 23/34). Non-profit organizations were also quick to express their concerns, arguing that they could not participate in such a costly program without a sustainable means to repay their capital borrowings, as being barred from drawing on their operational subsidies to repay capital debt would leave them financially vulnerable (GR-2653, 1963, 97/146; GR-678, 1971, 5/10; GR-2653, 1963, 101/146; GR-2653, 1963, 102–103/146; GR-2653, 1964, 88/146).

In an effort to alleviate this issue, B.C.'s Commissioner of the B.C.H.I.S., D. M. Cox once again lobbied the government in 1963, this time arguing that raising capital subsidies would leave non-profit groups responsible for a smaller portion of their share of capital costs, thereby reducing their concerns about being prohibited from using their operational grants and revenues to repay their capital borrowings (GR-2653, 1963, 97/146).

Meanwhile, concerns about regulatory challenges and quality of care issues in for-profit nursing homes had continued, with officials continuing to document persistent quality and regulatory compliance issues (GR-0117, 1964, 13/24). For instance, Dr. Fahrni, the Consultant of the Chronic Care division of the B.C.H.I.S. "was definite in the opinion that general hospitals should have custodial units and he much preferred this arrangement to the proprietary operation. In fact he was critical of the lack of treatment facilities and treatment programs being undertaken in these [private hospital] institutions" (GR-678, 1963, 6/7; see also GR-678, 1963, 3-5/7). In addition, officials were also concerned about the cost-based selectivity that for-profit nursing homes showed in admitting lighter-care patients over heavy care patients (GR-0117, 1964, 13/24). The problem of for-profit nursing homes refusing to admit social assistance patients on the basis that government rates were insufficient showed no signs of abating either (GR-128, 1966, 15/76; GR-2653, 1968, 24/97). Amid such concerns, bureaucrats continued their calls for a non-profit

nursing home program, emphasizing the potential improvements in standards and reduced regulatory costs that could be realized with a public nursing home system based on a non-profit rather than for-profit ownership model (GR-0419, 1963, 18–19/20; GR-2585, 1963, 49/62).

Officials also highlighted additional advantages of a non-profit ownership model. For instance, as D. M. Cox, Deputy Minister of the BCHIS, had noted in a letter to the Minister of Health, Eric Martin, in 1965, size restrictions such as the 75-bed limit imposed on for-profit nursing homes would not be necessary for non-profit operations (GR-0419, 1965, 185/231). This view was consistent with Cox's long-standing position that facility size restrictions were necessitated by the regulatory difficulties posed by for-profit operators, whose larger operations made it "increasingly more difficult to make certain that a good quality of care is maintained and that patients are not exploited" (GR-380, 1955, 12/25), and with his broader conviction that for-profit provision was incompatible with the government's fiscal and care objectives, since the per-diem rate would have to absorb costs for "depreciation, interest, profit, and taxes, none of which is taken into account" in non-profit institutions, while public funds would be spent "unnecessarily on profits, interest, etc." rather than on the care of patients (GR-0419, 1965, 185/231; GR-0419, 1965, 116/231).

To further their case and reassure the Minister of Health, Eric Martin, who had grown troubled about the potential costs of a non-profit nursing home program, including the challenges involved in extending federal-hospital insurance for its establishment and whether the province might realize greater savings by relying on for-profit rather than non-profit providers, K. G. Wiper, Administrative Officer of the B.C.H.I.S., wrote a letter to the Minister in 1963, noting that "everyone at the BCHIS was convinced that non-profit nursing homes could provide a better

standard of patient care at a lower cost than the profit-seeking establishments, because their final goals would be so completely different" (GR-2585, 1963, 48–49/62).

Although BC officials may have shown occasional differences over the cost-differences between non-profit and for-profit nursing homes, they were broadly unanimous in their view that non-profits invested significantly more in patient care and delivered higher-quality services compared to for-profit facilities at comparable or lower cost. This point was echoed by A. J. Lyle, the Finance Manager of the B.C.H.I.S who stated that while he was "not convinced that" better quality care could be provided by non-profit nursing homes at a lower cost than for-profit homes due to non-profits' tendency to provide higher quality food and employ more staff over time, "I feel that our arguments in favour of non-profit nursing homes should be based on adequate care for the patients rather than suggest a savings in operating costs" (GR-2585, 1963, 47/62). Official Lyle's insistence on grounding the case for non-profit provision in principled rather than fiscal terms illustrates how principled beliefs functioned as a coordination mechanism among BC bureaucrats, ensuring unanimity around a non-profit model by subordinating cost considerations to ethical imperatives.

Overall, what the above demonstrates is that BC officials' determination to align the nursing home system with a high philosophy of care led them to critically and carefully evaluate and discuss all available policy options or pathways, ultimately concluding, on multiple grounds, that non-profit and publicly owned options were ethically and functionally superior to for-profit options.

Officials' persistent advocacy finally bore fruit in 1965 when, following the program's successful integration into the federal-provincial hospital insurance plan, the provincial government re-announced the non-profit nursing home program on a universal basis, a move that

came even though the Hall Commission had omitted nursing home care from its recommendations for universal and comprehensive federal cost-sharing (Hall, 1964, 19–20, 411, 608; House of Commons, 1964, 7895, 7899; Hastings, 1966, 108; GR-2653, 1964, 14-15; GR-2653, 1964, 88, 92/146; GR-2585, 1963, 48–50/62). That the program was approved despite the Minister's earlier condition that he would only extend such coverage on the Commission's recommendation shows that the persistent and principled advocacy of BC's bureaucrats had overcome the Minister's resistance, an outcome consistent with the substantive rational orientation of the province's bureaucracy. Unlike the province's existing means-tested nursing home program, which was administered through the Social Welfare Branch and funded the care of welfare patients in a for-profit dominated nursing home sector, the new Extended Care programme was delivered exclusively through non-profit and provincially owned facilities, was universally accessible based on medical need alone, and was funded under the federal-provincial Hospital Insurance and Diagnostic Services Act, whose conditions required universal eligibility and restricted user charges to a means-tested nominal co-pay of $1.00 that the government later raised to $4.00, with funding administered through the Department of Health Services and Hospital Insurance (GR-0679, 1966, 10–11/45; GR-2653, 1968, 26–28/97). Following its launch, funding for the program was significantly increased to cover half of the capital costs, one-third of equipment and renovation costs, and all operating costs for any government or non-profit organization interested in purchasing or building a nursing home (GR-128, 1965, 54–56/80; GR-0679, 1965, 7/15; GR-136, 1967, 64–66/101; GR-2653, 1966, 44/66; GR-0679, 1970, 3/45; GR-0419, 1965, 157/231). Additionally, a federal grant of $2,000 per bed was provided (GR-2661, 1968, 6/7). Under this arrangement, non-profit and public facilities shared their full accounts with the provincial government to have their operating deficits covered under a global-budgeting model, whereas the

province's means-tested programme delivered through for-profit nursing homes remained wedded to a capped per-diem rate—a dual funding structure that also characterized nursing-home policy in Ontario, where non-profit and for-profit providers were similarly subsidized through distinct funding mechanisms (Angel, 1985, 21, 98; Hollander, 1999, 85; Levenick, 1986; Kane & Kane, 1985b, 163).

In the same year the Extended Hospital Care program was launched, the government also placed a permanent construction moratorium on the for-profit nursing home sector (GR-2653, 1967, 4; GR-2653, 1967, 41-43/43; GR-3578, 1969, 12-13/29; GR-3578, 1969, 14–15/29). By imposing the moratorium, the government aimed to eventually revoke the licenses of all for-profit nursing homes, the majority of which would then be closed, while the small minority that met modern standards could either be purchased by non-profit organizations or receive licenses to provide intermediate-level nursing home care (GR-2653, 1967, 17/39; GR-2677, 1969, 43-45; GR-2677, 1968, 92–94; GR-2653, 1967, 55, 63/121; GR-3578, 1969, 12-13; GR-3578, 1969, 14–15/29; GR-880057-0091, 1974, 84, 168/308; GR-2653, 1968, 41/97; GR-136, 1967, 10–11/55; GR-2653, 1969, 15/130; GR-2653, 1968, 27/97; GR-078, 1967, 8/20; GR-2653, 1967, 41-43/43; GR-0419, 1965, 116–118/231; GR-89, 1974, 85/153). In tandem with the newly launched Extended Care non-profit nursing home program, the moratorium on for-profits would help ensure a successful transition from a for-profit to a non-profit ownership-mix (GR-3578, 1969, 14–15/29). Officials were optimistic about this shift as they believed that compared to for-profits, non-profit providers prioritized the quality of care above profits and could be regulated with less intensive oversight (GR-2653, 1967, 4). This shift would occur 'gradually' as sufficient non-profit nursing home beds were built to absorb the existing nursing home patients in for-profit nursing homes. Based on a survey the government had carried out in 1964, it was expected that 60 to 70 percent

of existing patients in for-profit nursing homes would qualify for advanced-level nursing home care in the Extended Care Program delivered through non-profit nursing home facilities, whereas the remaining 30 to 40 percent would qualify for intermediate-level nursing home care, which was typically provided in private boarding homes that had special government approval to provide this type of care (GR-0698, 1965, 5/29). However, the provincial government faced great challenges in realizing the transition from a for-profit ownership-mix to a non-profit one. Even though the new funding package offered to non-profit operators was more comprehensive and generous than previous ones, the uptake of the program by non-profit organizations still remained significantly less than what was needed to adequately expand the program to meet public need and terminate all for-profit nursing home operations (GR-2653, 1969, 8/130; GR-2653, 1970, 39/79; GR-2653, 1970, 42/45; GR-2653, 1972, 56/104; GR-135, 1967, 70/70; GR-380, 1970, 67/80; GR-2653, 1969, 118/130). The low uptake of the program by non-profit organizations stemmed from the same issue that had concerned officials earlier, namely the provision in the Federal Hospital Insurance and Diagnostic Services Act that prohibited the use of operating grants or revenue generated from those grants to repay capital borrowings (GR-136, 1967, 65/101; GR-678, 1971, 5/10). Furthermore, as BC's Minister of Health, R. R. Loffmark pointed out in 1971, the restrictions in the Federal Hospital Insurance and Diagnostic Services Act led many non-profit organizations to go into the "construction of residential boarding homes" instead, where it was possible to obtain construction funds from the Elderly Citizens Housing Aid Act (GR-678, 1971, 5/10).

The slowdown in the construction of extended care facilities, coupled with the moratorium on the construction of for-profit nursing homes resulted in a backlog of nursing home patients being sent to acute care hospitals and special boarding homes (GR-2653, 1967, 87–88; GR-2653,

1967, 43–45). It also intensified the pressure officials faced to allow existing private hospitals to expand beyond the 75-bed limit. However, officials had insisted that they would not agree with increasing the maximum number of beds allowed in for-profit nursing homes as this would undermine their desire to operate the nursing home system in accordance with a high philosophy of care (GR-2653, 1968, 24–25/97). As E. Nordlund, the Registered Nurse of the Hospital Consultation Division had stated in a letter to J. Bainbridge, the Manager of the Hospital Consultation Division of the B.C.H.I.S., despite ongoing bed shortages, "restrictions" of increases in the number of private hospital beds should be enforced, as "we have a moral responsibility for the standard of care given to all patients (private and social welfare)" and that placing more "beds into inadequate hospital facilities is contrary to our philosophy of care which we are endeavoring to establish and maintain" and "would not improve the health programme, particularly for extended care patients" (GR-2653, 1968, 24–25/97).

While the B.C.H.I.S. had tried to alleviate the situation by recommending that construction grants be increased to cover all capital costs for a temporary period, this recommendation was not adopted by the provincial government (GR-2653, 1967, 88; GR-2653, 1967, 4/43; GR-0419, 1966, 115/231). As would be expected, this resulted in a continued lack of interest and participation by non-profits in the program. However, guided by substantive rationality and their principled commitment to a high philosophy of care, BC officials refused to default to cheap, for-profit alternatives, instead pressing the provincial government to build or purchase most extended-care facilities itself, an approach that, as this chapter demonstrates, ultimately proved successful (GR-2653, 1972, 3/9; GR-0117, 1974, 94-95/146; GR-2653, 1973, 104/144; GR-4201, 1974, 72). The challenges the government faced in stimulating the construction of non-profit hospitals are illustrated by Tables 2 and 3.

Table 2
Number of Extended Care Beds and Private Hospital Beds, British Columbia, 1965–1974

Year	Number of Extended Care Beds (Non-Profit Nursing Home beds)	Number of Private Hospital Beds (For-Profit Nursing Home Beds)
1965	~650–700	~3300
1966	1038	3256
1967	1038	3233
1968	1190	3150
1969	~1500	3133
1970	1797	3145
1971	N/A	3114
1972	2104	2988
1973	N/A	2822
1974	3398	2711

Table 3
Number of Private Hospitals (Nursing Homes), British Columbia, 1945–1973

Year	Number of Private Hospitals	Number of Private Hospital Beds
1973	53	2822
1972	57	2979
1971	62	3114
1970	64	3154
1969	65	3133
1968	66	3154
1967	66	3093
1966	70	3233
1965	72	3349
1964	74	3312
1963	66	2674
1962	64	2411
1961	60	2105
1960	55	1898
1959	54	1806
1958	54	1759
1957	54	1704
1956	52	1410
1953	44	1224
1945	N/A	661

As shown in Table 2, it was not until approximately 1974 that the number of beds in extended care facilities exceeded the number of for-profit nursing home beds. This long timeline suggests that federal funding conditions constrained the capacity of BC's bureaucracy to pursue its principled commitment to a high philosophy of care. The restrictions in the Federal Hospital Insurance and Diagnostic Services Act, which prohibited non-profit organizations from using operational subsidies to repay capital borrowings, were the primary cause of this low uptake. That officials continued to press for a non-profit model despite these structural constraints, rather than reverting to the existing for-profit sector as the path of least

resistance, constitutes a clear instance of the substantive rational orientation of BC's bureaucracy, with officials viewing it as their public duty to advance a high-quality nursing home system despite facing persistent administrative and funding obstacles.

Albeit, this progress proved too slow to accommodate the backlog of patients requiring extended care services, a backlog created both by the large proportion of for-profit nursing home residents who qualified for extended-care transfer once the moratorium took effect and by the simultaneous rise in demand for public nursing home care among those not already in for-profit facilities (GR-136, 1967, 64–65; GR-2653, 1967, 4/43). The slow development of the Extended Care programme thus weakened the impact of the moratorium on the for-profit sector, as the government was forced to repeatedly delay its plans to revoke private hospital licences (see Table 3; GR-2653, 1970, 39/79; GR-2653, 1969, 8/130).

In conclusion, while the activism of bureaucrats and the opening of a window of opportunity marked by the emergence of the universal federal-provincial Hospital Cost-Sharing Program in 1958 finally enabled British Columbia to move toward its goal of establishing a high quality public nursing home program based on a non-profit ownership model, this goal was frustrated by the very federal measure that had enabled it in the first place, as the rigid conditions in the federal funding agreement ended up discouraging many non-profit organizations from participating in the Extended Care programme.

7.3 The Implementation of British Columbia's Universal Non-Profit Intermediate Care Nursing Home Program

Following the implementation of the extended care nursing home program, British Columbia's provincial government turned its attention to introducing an intermediate-level nursing home program, determined to address what officials had come to regard as the most acute bed shortage across the province's institutional care system.

As a specific variant of long-term institutional care, “intermediate care” is provided to people who are semi-ambulatory and require “regular review by a physician” and some care that can be provided by staff including “practical nurses, aides, and orderlies” under the supervision of a nurse whose presence is required every day but not on a 24-hour basis (GR-4650, 1992, 20–21/60). Intermediate care patients are not eligible for extended nursing home care as they require a level of nursing home care that is lower than that given in extended care hospitals, but higher than what is provided in boarding homes (GR-2653, 1969, 10/21; GR-2677, 1971, 67/96; GR-2921, 1972, 6–7; B.C Public Health Services Annual Report, 1973, 22/60; B.C Ministry of Human Resources, 1976, 99/116; GR-2647, 1972, 16/102; Daily Colonist, 1971, 78/102; GR-6768, 1975, 18/28).

While this type of care has a long history of existence in British Columbia, it was not officially recognized and defined until the introduction of Adult Care Regulations under the Community Care Facility Act in 1977 (GR-2678, 1977, 5/7; B.C Ministry of Health, 1977, 25/160; GR-2665, 1979, 31/36; GR-2720, 1949, 4/13; GR-3975, 1985, 88/157; GR-2653, 1968, 26–28/97). Prior to 1977, intermediate care was known by various names, including semi-nursing home care, personal care, intensive personal care, special care, and supervised boarding care. It was available for welfare patients, and provided in boarding homes that had special approval from the provincial government who paid these homes higher subsidies for public intermediate care patients than it did for regular boarding patients (GR-136, 1967, 66/101; GR-2653, 1968, 26–28/97; GR-2653, 1968, 37-39/97).

A number of government committee reports released in the mid to late 1960s had begun identifying an increasing need for intermediate care in “recent years”, with some reports identifying intermediate care as the level of institutional long-term care with the most “critical

shortage" (GR-136, 1967, 66/101; GR-0678, 1968, 13/20). Owing in part to this shortage, a number of patients requiring intermediate care were being accommodated in private hospitals instead, with a 1964 provincial survey finding that approximately 30 percent of patients in private hospitals were being provided with intermediate care (GR-2653, 1969, 104/130; GR-2653, 1968, 20/54; GR-2585, 1964, 23–25/62). In this light, the initiative was also driven by expectations of the cost-savings it would help generate by transferring intermediate care patients from private hospitals to specialized beds in boarding homes, although officials later came to the realization that operating an intermediate care nursing home program with high standards did not make it significantly less costly than nursing home care provided in non-profit extended care facilities and for-profit private hospitals.

To address the "critical shortage" of intermediate care beds, officials had begun expressing interest in a non-profit intermediate care program as early as the late 1950s and were eager to unveil such a program by the mid-1960s (GR-136, 1967, 18/101; GR-136, 1967, 4/55; GR-136, 1967, 51/55; GR-2665, 1968, 40/93; GR-2653, 1968, 20/121). Their expressed desire for an intermediate care program based on a non-profit ownership model was driven by the same factors that had led government officials to prefer a non-profit ownership model for the Extended Care programme, i.e., the regulatory difficulties and quality concerns they had historically faced with both the for-profit nursing home and rest home sectors. These persistent issues showed no signs of improvement, leaving officials well aware of the challenges they could encounter with a for-profit ownership model. For instance, in a letter to J. W. Mainguy, the Director of the Hospital Consultation division in 1967, J. Bainbridge, the Manager of the Hospital Consultation division had criticized for-profit nursing homes for always demanding ever higher welfare rates while service quality always remained poor, as evidenced by a lack of nutritious food, insufficient and

unqualified staff, a lack of diversional programs, and inadequate service quality (GR-678, 1967, 3–4). In the same letter, J. Bainbridge had gone on to state that the government could not regulate minimum standards in for-profit nursing homes due to their economic circumstances, arguing that "the standard of care is dangerously low in many nursing homes; complaints from patients and relatives are received with increasing frequency, and our efforts to improve conditions are, in most cases, nugatory" (GR-678, 1967, 3–4). Similar, if not identical challenges were found in the for-profit boarding home sector, with Minister Without Portfolio P. Dawson noting in a letter to Premier W. A. C. Bennett that insufficient government grants for non-profit rest homes had stunted their growth, leaving for-profit operators without meaningful competition and enabling them to provide substandard care and to "attain the initiative and embarrass the government by their exorbitant demands and their exorbitant prices for maintenance of helpless individuals" (GR-746, 1971, 11–12/17).

These criticisms were confirmed by other officials and government reports, with the general conclusion being that unlike non-profit providers, for-profit providers in the nursing and boarding home sectors tended to resist higher standards by demanding higher rates or otherwise threatening to close down, lower their standards, or refuse welfare patients (GR-136, 1967, 42/101; GR-2653, 1969, 44/79; GR-365, 1969, 10/21; GR-128, 1966, 15/76; GR-128, 1966, 3/76; GR-2675, 1968, 13/20). For these reasons, BC bureaucrats believed that a non-profit policy was to be supported, since as stated in a 1967 Community Care Services Committee meeting, "many of our problems in licensing and the maintenance of standards in private hospitals and boarding homes can only be resolved by the eventual replacement of proprietary institutions by those operated by non-profit organizations" (GR-2653, 1967, 88/121). Such concerns were well-founded after all. For instance, as an investigation carried out by the BC Attorney-General's department in 1973 had

found, Neil B. Cook, a Vancouver lawyer and nursing home operator, had got around BC's two-hospital ownership limit by having associates hold shares on his behalf, giving him undisclosed interests in at least four facilities (GR-2661, 1973, 26-29/48; GR-2661, 1973, 31/48; GR-2661, 1974, 33/48). The case illustrated a pattern familiar to BC officials throughout the period under examination, namely that for-profit operators tended to resist and circumvent regulations even under BC's strict enforcement regime, just as their counterparts did in Ontario, thereby confirming officials' earlier conclusion that effective governance of the sector could not rely on enforcement alone but required a fundamental shift in the ownership-mix itself.

Further reinforcing officials' desires to support a non-profit nursing home policy was the absence of official standards for intermediate care homes, which, combined with for-profit operators' inherent incentive to minimize compliance, made it even harder to ensure that adequate care was being provided (GR-2653, 1968, 11/17; GR-2647, 1971, 39/102; GR-2651, 1977, 34/121). As BCHIS Deputy Minister, Donald Cox, had stated in a letter to the Minister of Health Eric Martin in 1968, he was unable to recommend the approval of for-profit intermediate care home operations due to the fact that the extreme eagerness they had shown about entering the field was closely related to the absence of formal licensing and standards, an absence that would allow them to skirt regulations and provide lower quality care. In addition, D. M. Cox had argued that beyond quality concerns, for-profit operations would demand ever higher capital debt charges (GR-2653, 1968, 11/17).

All these factors together placed BC officials well on their way in their push for a policy that would transition the province towards a non-profit ownership-based public intermediate care nursing home sector. However, in their quest for realizing this policy model, BC bureaucrats encountered two significant challenges.

One challenge involved finding a means to define and standardize intermediate care in a way that effectively set this type of care apart from the nursing home care provided in extended care and private hospitals (Daily Colonist, 1971, 78/102; GR-2647, 1972, 22; GR-2647, 1971, 38/102; GR-2647, 1971, 34/102; GR-2677, 1974, 29/57).

Another challenge officials had encountered was finding a provincial funding package that could provide subsidies for such a program. While officials had considered the provincial Elderly Citizens' Housing Aid Act, this policy was designed and restricted for residential-type constructions and for elderly with strictly ambulatory needs, with its maximum payment rates also restricted to a level that was insufficient for subsidizing intermediate care (GR-136, 1967, 42/101; GR-2677, 1971, 67/96; GR-746, 1971, 8/17; GR-136, 1967, 4, 14/55; GR-0678, 1969, 4/31). The Act also faced frequent funding shortages which in turn contributed to a shortage of boarding homes (GR-136, 1967, 4, 14/55; GR-136, 1967, 42/101). Hence, these financial limitations and constraints limited the Act's capacity to meet even its own basic objectives, let alone support more resource intensive initiatives such as an intermediate care program, where infrastructure and care costs were far more expensive than what the Act was designed to accommodate (GR-0678, 1968, 12/20; GR-136, 1968, 5–6/27; GR-0678, 1969, 4/31; GR-2677, 1968, 58/96; GR-2677, 1968, 66/96; GR-136, 1967, 42/101).

In seeking funding, officials also encountered the same obstacle that they had encountered at the provincial level when they sought funding at the federal level: the absence of existing funding mechanisms for intermediate-level nursing home care. Most federal programs were divided between those supporting custodial or ambulatory care and those funding medical or hospital care, with no category for semi-nursing home care. Although the Canada Assistance Plan (CAP) subsidized care costs for such facilities, it excluded construction expenses. The Federal

Hospital Insurance and Diagnostic Services Act and National Health Grants were also not suitable for funding an intermediate care program, as their funding was restricted to programs that provided care for those with strictly non-ambulatory needs and therefore could not be used to fund a program like intermediate care, which was designed specifically for those with semi-ambulatory needs. Finally, capital funding through the Central Mortgage and Housing Corporation (CMHC) was unavailable, as CMHC support was limited to residential-type construction (GR-0678, 1967, 15/20). These challenges were summed up by J. A. Sadler, the Assistant Deputy Minister of Social Welfare, who stated that no funding model was available for intermediate care homes, as they fell neither "within the present interpretation of the Elderly Citizens' Housing Aid Act and as they are not hospitals they do not fall under the B.C.H.I.S. grant system" (GR-2677, 1968, 58/96).

Despite the significant challenges they faced in securing funding for an intermediate care program, public officials remained steadfast in their efforts to find a solution. This commitment stemmed from what officials viewed as their public duty to build a high-quality program based on a non-profit ownership model to address the substandard quality and "critical shortage" of intermediate care accommodations in the province (GR-0678, 1968, 13/20; GR-2647, 1971, 39/102). Numerous non-profit organizations had also expressed interest in participating in an intermediate program, which officials used to further reinforce their case for such a program by urging the government to make funding available either by raising the limits of the Elderly Citizens' Housing Aid Act or through a special warrant (GR-136, 1967, 4, 14/55; GR-136, 1967, 51/55; GR-2665, 1971, 18/93; GR-2677, 1971, 67/96; GR-0678, 1968, 11–12/20; GR-0678, 1968, 13/20; GR-0678, 1967, 14/20; GR-136, 1967, 42/101). For instance, J. A. Sadler, the Assistant Deputy Minister of Social Welfare, had "strongly recommended" in a letter to E. R. Rickinson, the Deputy Minister of Social Welfare in 1968 that the government secure grants for the "half-a-dozen

non profit organizations willing and ready to build intermediate care facilities" to address the critical shortage of space and its associated complications (GR-2677, 1968, 58/96). BC's Cabinet had also expressed support for an intermediate care program, one based preferably on a non-profit route (GR-2653, 1967, 35/121). Other organizations, such as the United Church of Canada, Association of Women Electors, and the B.C Christian Institute had also called for a non-profit intermediate care program (GR-2677, 1970, 33/96; GR-2653, 1973, 17/79; GR-2665, 1971, 16/93). However, officials' efforts were ultimately to no avail, with only several facilities constructed, including one facility through the Elderly Citizens Housing Aid Act as a pilot, and another through a special warrant (GR-2649, 1967, 28/55; GR-0678, 1969, 3–4/31). By 1968, efforts to develop intermediate care facilities had come to a standstill. As BC's Assistant Deputy Minister of Social Welfare pointed out in 1968, officials had become "severely embarrassed" by encouraging non-profit groups to construct intermediate care homes only for the government to refuse to budge or provide any funding on the basis that "no grant formula for this group" existed (GR-135, 1968, 17/70).

Amidst the struggles provincial officials faced securing funding for a non-profit intermediate care program, a window of opportunity emerged in 1969. This window of opportunity was marked by the introduction of federal funding for the construction of non-profit and publicly owned nursing homes, with funding administered through the Canada Mortgage and Housing Corporation (CMHC) under section 15.1 of the National Housing Act (NHA) (B.C. Department of Human Resources, 1976, 9–15/48; GR-2678, 1977, 10/31). As Andrew Rose, B.C's Inspector of Hospitals of the B.C.H.I.S had stated in 1969, whereas previously the CMHC only provided grants to non-profits for constructing "Senior Citizen self-contained units (apartments)", now

CMHC is trying to identify the standards of intermediate care in BC to provide loans to non-profits for this type of construction (GR-0416, 1969, 56/93).

British Columbia's provincial government acted swiftly on this opportunity, amending the Elderly Citizens' Housing Aid Act in 1970 to include funding for intermediate care facilities. This was followed by the introduction of a non-profit intermediate care program for welfare patients one year later (GR-2665, 1971, 18/93; B.C. Public Health Services, 1973, 22/60; GR-2921, 1972, 7/31; GR-678, 1974, 6/39; GR-678, 1974, 7/39; GR-746, 1972, 3/17; GR-746, 1971, 24/29; GR-2678, 1975, 11/19; GR-2678, 1971, 14; GR-2678, 1971, 15–17; GR-2678, 1975, 11–12/19).

Under the newly initiated program, non-profit organizations were eligible to have 35 percent of their construction costs covered through a government grant, one-half through a long-term CMHC loan that was repayable from operating revenue, and were responsible for covering the remaining 15 percent of construction costs themselves (GR-746, 1971, 5/17; GR-2653, 1971, 5/146). As licensing standards were yet to be developed for intermediate care homes, all intermediate care facilities were licensed as personal care homes, which are ordinarily licensed to provide boarding home care under lay or non-professional supervision (GR-2698, 1973, 5/7; GR-746, 1973, 17; GR-2677, 1977, 3/57). As a step towards creating standards, in 1971 the provincial government outlined plans to launch a pilot program of four government-operated intermediate care facilities in order to "test out the validity and practical application of our defined criteria" (GR-746, 1973, 20/32).

Despite finally succeeding in establishing a non-profit intermediate care program, officials found themselves disappointed by the low uptake of the program by non-profit organizations who were discouraged from participating in the program due to concerns that they would not survive on government-subsidized rates (GR-2921, 1972, 7/31; GR-746, 1972, 3/29). To address this issue,

officials increased operational funding for non-profits and reduced their share of capital costs from 15 percent to 10 percent in 1972, eventually eliminating the requirement entirely by 1975 (GR-2649, 1975, 92/212; GR-2678, 1975, 11/19; GR-2678, 1975, 12/19; GR-2653, 1972, 9/104). These measures proved successful, leading to a "substantial increase in sponsor activity under the Elderly Citizens' Housing Aid Act" (GR-2649, 1975, 92/212).

In the same year the provincial government had implemented the non-profit intermediate care nursing home program, it also imposed a 'quiet' or 'implied' moratorium on the development of for-profit intermediate care projects (GR-2649, 1975, 162/212). This decision aligned with the government's objective of establishing a nursing home system grounded in a high philosophy of care by securing the long-term growth and entrenchment of the non-profit intermediate care nursing home sector within the province's ownership-mix of boarding homes.

Unlike the explicit 1965 moratorium on for-profit nursing homes, this policy was subtle and never formally stated publicly. The 'implied' or 'quiet' nature of the moratorium is evident in the policy's articulation across government statements, discussions among officials, engagements with stakeholders, and coverage in newspaper reports. For instance, in 1972, BC's Minister of Health Dennis Cocke had implied the existence of the quiet moratorium very indirectly by cautioning for-profit operations about investing in the field, arguing that although the government did not wish to eliminate for-profit rest homes or close those that met standards, that for-profits tended to provide substandard care, and that the government was also considering providing grants for the construction of publicly owned and non-profit owned homes (GR-2647, 1972, 3/102).

However, the 'implied' nature of the policy had unintended consequences and created confusion among stakeholders. A government report had critiqued this ambiguity, arguing that because the policy was never clearly enunciated or accompanied by dedicated funding, regional

authorities failed to incorporate non-profit intermediate care facilities into their planning, leaving the private sector and non-profit societies to develop such facilities on their own initiative. After all, as the report had pointed out, given that the policy of both the previous conservative Social Credit party in power and current NDP government was to "phase out the private sector" and shift the ownership of extended care and intermediate care facilities to a non-profit model, "Is it not time that this be announced as a definite, rather than an implied, policy?" (GR-89, 1974, 24/191).

The lack of a clearly communicated policy change also left some for-profit operators unaware and unprepared, as they were unexpectedly informed about the moratorium without any advance notice. In letters sent to the Minister of Health by two for-profit operators, one operator had expressed shock about suddenly and unexpectedly learning about the restriction (GR-2698, 1974, 40–41) while another, objecting to being grouped with substandard operators, pleaded with the Minister not to apply the prohibition to all private operators and to instead recognize a distinct category of "Personal Care under nursing supervision" for compliant private facilities, arguing that "it is undoubtedly true that some Rest Homes and Private Hospitals are lacking in care, services and standards of facilities, and those operators who consistently fail to improve their standards should be ruthlessly eliminated in fairness to those who maintain high levels of care" (GR-2698, 1973, 5/7).

Media reports also reflected the confusion and ambiguity generated by the implied nature of the ban. For instance, a report in the Vancouver Sun highlighted the "uncertain" future of for-profit rest homes, stating that the government should clearly "make a point of saying there is no plot to force private operators out of the business although they are well aware that the two Cabinet ministers mostly concerned have said there is no role for profit in the care of the sick and the elderly" (The Vancouver Sun, 1975).

Altogether, the government's multi-pronged approach, which followed a layering process underpinned by a 'quiet' construction moratorium on for-profit rest homes and a program to stimulate the growth of non-profit intermediate care homes, proved successful in stimulating an impressive rate of growth in the non-profit sector within just a few years, so much so that by 1975 the number of non-profit intermediate care beds had surpassed the number of for-profit intermediate care beds (see Table 4). The success of B.C.'s strategy in stimulating the growth of non-profit beds was highlighted in various government and media reports (GR-2677, n.d., 33; GR-2677, 1974, 40/99; B.C. Department of Health, 1976, J 81). For example, a Vancouver Sun (1975) article had pointed out that the non-profit intermediate program initiated by the previous provincial government was now finally "gathering momentum", resulting in for-profit nursing homes closing down "at the rate of one a week", while larger non-profit intermediate care facilities were opening in increasing numbers.

Despite these successes, officials found they still lacked adequate resources to expand the program sufficiently to meet public need (GR-746, 1972, 3–5/29; GR-2649, 1975, 144–145; GR-2649, 1975, 89–90; The Province, 1974; The Vancouver Sun, 1975a; The Province, 1973; The Vancouver Sun, 1971; The Province, 1970), finding that they faced obstacles similar to those they had encountered when attempting to expand the intermediate program in the 1960s, including the absence of a federal measure to support the development of an intermediate care program capable of meeting public need. Existing federal programs all had significant limitations. The Central Mortgage and Housing Corporation (CMHC) program, despite playing an instrumental role in stimulating the growth of non-profit intermediate care homes, provided construction subsidies only and was therefore insufficient on its own to fund the development of a more comprehensive non-profit intermediate care program (GR-89, 1975, 25, 28–29). The federal-provincial hospital

insurance program applied only to programs offering a level of care above intermediate care (GR-89, 1975, 50/67; GR-89, 1975, 53/67). The Canada Assistance Plan (CAP) was restricted to means-tested patients, and officials warned that implementing a universal long-term care program with a uniform co-payment would cause the province to lose a significant portion of CAP funding, potentially resulting in astronomically higher costs (GR-89, 1975, 12–13; GR-89, 1975, 53/67). Given officials' inability to find viable funding mechanisms, intermediate care remained the sector of institutional care with the most critical shortage, just as it had been in the 1960s (GR-2653, 1966, 10/146; GR-2653, 1966, 13/146; GR-2665, 1971, 18/93; B.C. Public Health, 1973, 22/60; GR-880057-0091, 1976, 7/108; The Vancouver Sun, 1973; GR-880057-0091, 1975, 67/107; The Province, 1976). This shortage was further exacerbated by the moratorium on the for-profit nursing home sector, with officials forced to place welfare patients requiring intermediate care in acute care hospitals (The Sun, 1971a; The Vancouver Sun, 1971b; GR-2677, n.d., 33). Officials believed that the most effective way to overcome this issue would be through a universal program with federal assistance, as it would enable the development of a comprehensive long-term care program, including an intermediate care program capable of meeting public need (GR-880057-0091, 1976, 21; The Province, 1973; The Province, 1974; The Vancouver Sun, 1975a; GR-89, 1975, 25–26; GR-89, 1975, 27–29; The Vancouver Sun, 1971; The Province, 1970). These points were reiterated by the province's Minister of Health, Ralph Loffmark in 1971, according to an article in the Vancouver Sun:

> He [Minister of Health Loffmark] told the house that he and other provincial health ministers are considering a proposal that Ottawa share in the cost of operating intermediate care facilities on the same basis that it does acute care hospitals and medicare. 'Nothing

> short of a shared-cost program will enable this to go ahead,' he [Loffmark] stated. (The Vancouver Sun, 1971)

These challenges in leveraging available federal programs to fund the development of an adequate intermediate care program had led to divisions within the B.C. bureaucracy. Some reports recommended implementing a universal long-term care program while others advocated for means-testing all long-term care programs, including those that were already being administered on a universal basis (GR-746, 1972, 4–5/29; The Province, 1974; GR-880057-0091, 1976, 16–17/107; GR-89, 1975, 25; GR-89, 1975, 41–42). One major government report had called this division the "key obstacle", noting that:

> Discussions of the problem to date have always broken down over the difficulties of financing this type of programme under the current Federal/Provincial cost-sharing agreements. There has been a failure in the past to define the "key obstacle" that has inhibited the resolution of the major problems and face it squarely. This must be carried out now as this, related to Provincial Government imposed restrictions, not only prevents the development of a long term care programme but also blocks the entry into the Treasury of millions of dollars annually for existing programmes for long term care. (GR-89, 1975, 29)

Ultimately, BC's Cabinet came out in support of a universal long-term care program (GR-89, 1975, 62–64). However, this decision may have been based on the understanding that B.C could make a special arrangement with the federal government, which as a few other provinces had also done, made it possible to implement a universal long-term care program without losing any federal money than if BC had subjected all its long-term care programs to a means-test for cost-sharing through the CAP (GR-89, 1975, 37/67; GR-89, 1975, 51/67; GR-880057-0091, 1975,

20/53). As an additional source of revenue, the provincial government also considered raising the co-pay of the extended-care program above the current rate of $4.00 per day, using the generated revenue to offset the cost of an intermediate care program (GR-4201, 1975, 13/53).

Although the provincial government had finally settled on a strategy for securing federal funding for a long-term care program, this strategy lost relevance when a window of opportunity emerged in the province, spurred by the federal government's restraint policies. This window of opportunity was marked by the replacement of federal-provincial healthcare cost-sharing with the Established Programs Financing Act (EPF) in 1977. Under EPF, federal healthcare transfers were no longer tied to provincial spending on a 50–50 matching basis but were instead linked to provincial population growth and structured according to federal economic conditions and policy, specifically through two mechanisms: the transfer of tax points, regulated according to the tax base, and per capita cash grants, regulated according to GNP. While this led to a reduction in overall federal healthcare transfers, the benefit it provided to provinces was that they were no longer restricted to spending federal healthcare funds exclusively on physician and hospital care services, but could now allocate federal healthcare funding to other areas of the healthcare system, including long-term care (Ostry, 2006, 63). Included in the EPF was a $20 per capita transfer known as the Extended Health Care Services of the EPF Act, which the federal government had designated for "intermediate care services, adult residential care services, converted mental hospitals, home care services and ambulatory health services" (CMHC, 1983b, 8/108; see also Evans & Stoddart, 1986, 33). The provincial government swiftly seized this opportunity, and together with the extra revenue it would collect by raising the co-pay of extended care from $4.00 to $6.50, it used the new federal EPF transfer to secure funding to establish a new universal long-term care personal and intermediate care program in 1978 (GR-2649, 1977, 57/156; B.C. Ministry

of Health, 1980, 19/238; Chappell & Hollander, 2013, 80). Eligibility for the new long-term care program was based on care needs only and included a co-pay of $6.50 that would be subsidized or waived for welfare patients. As stated in the Annual Report of the B.C Ministry of Health (B.C. Ministry of Health, 1977), "with the Federal Government's general trend to move from shared-cost programs to block funding….. Services such as personal care, intermediate care, health aspects of home care, and some ambulatory services were considered appropriate uses for these funds. The sum was set at $20 per capita per year" (15).

Although BC launched its intermediate nursing home program during a period of significant economic difficulties, a period when restraint measures were implemented on numerous social programs, BC's provincial government worked to ensure the program's successful launch and development by exempting it from any restraint measures (GR-2649, 1978, 70/143; GR-3975, 1982, 22, 25–45; GR-3975, 1982, 18/45; GR-3975, 1982, 5/30).

B.C.'s intermediate care program was also established with high standards. As one government report pointed out, "the Adult Care Regulations establish relatively high standards and spell these standards out in considerable detail. The Act and regulations acknowledge that the standards they contain are somewhat higher than 'minimum' standards" (GR-3975, 1985, 22/137). In fact, the standards were so high that officials sometimes questioned their necessity and affordability (GR-880057-0091, 1974, 72–73/108; GR-3975, 1985, 76/137; GR-2677, 1974, 29/57). As one government report had argued:

> There is clear evidence that the current [Community Care Facility Act] regulations are creating problems because they set standards which are somewhat higher than "minimum" standards. For example, the high level of the current standards (combined with an inability

to be flexible in administering them) threatens to hamper needed program development in the Long Term Care Program. (GR-3975, 1985, 26/137)

Not just other public officials, but the for-profit sector, too, lobbied the government to lower required standards, with Extendicare, one of Canada's largest nursing home chains, writing to the provincial government to argue that BC's construction standards were unnecessarily higher than Ontario's and urging the province to consider lowering them to a comparable level (GR-2677-1, 1979, 13/15; GR-2665, 1970, 24/93).

Under the new universal intermediate care program, provincial policy concerning the ownership-mix continued to remain firmly rooted in a non-profit model (GR-2690, 1981, 62/149; GR-3975, 1983, 17; GR-3975, 1982, 27–30; GR-0117, 1977, 37/146; GR-3975, 1983, 25/124). While existing for-profit providers were allowed to participate, the provincial government maintained an unspoken policy of not approving new for-profit intermediate care projects (GR-0117, 1977, 37/146). As J. Bainbridge, B.C's Assistant Deputy Minister of Support Services pointed out in 1980, "we are quietly pursuing a policy of not encouraging private development of any kind, except where circumstances force us or where there have been previous commitments" (GR-2688, 1980, 138/139). The provincial government's motivation to stick to a non-profit ownership model for intermediate care facilities thus remained unchanged, rooted in the substandard care and regulatory challenges that persisted in the for-profit sector. For example, one report attributed the prohibition on for-profits as being due to their tendency to "maximize profit by minimizing service, particularly staff, under a flat rate system" (GR-2688, 1980, 138/139), while another report had found that for-profits provided the "poorest quality of care" compared to other ownership types (GR-3975, 1983, 25/124). In addition, the province's Assistant Deputy Minister of Support services, J. Bainbridge, pointed to the difficulties involved in enforcing

standards on the for-profit sector as "private operators will maximize profit by minimizing expense" through hiring insufficient and inadequately trained staff, and that "without an army of inspectors, and with very little 'bite' in the Act, operators such as Mr. Cook can easily ignore any attempts to raise standards" (GR-2688, 1980, 138/139).

Overall, British Columbia's unwritten policy of not approving for-profit intermediate care projects, coupled with its active promotion of the development of non-profit facilities, proved remarkably successful in shifting the ownership-mix of intermediate care nursing home facilities towards a non-profit dominated model (see Table 4), a success evidenced in multiple government reports (GR-3975, 1982, 8/45; GR-2690, 1983, 19/28; GR-2690, 1981, 125/149). As Table 4 illustrates, the number of non-profit beds had surpassed the number of for-profit beds by 1975, following the moratorium on for-profits and the federal CMHC construction program introduced a few years earlier, with the gap widening further by 1978. This trajectory demonstrates how the interaction of persistent bureaucratic advocacy with successive windows of opportunity, namely the 1969 CMHC funding program, which supplied the capital subsidies that supported the construction of both state-owned and state-contracted non-profit nursing homes (CMHC, 1983b, 17; GR-3997, 1986, 22/89), and the 1977 EPF Act, which enabled the province to overcome the conditions attached to previous federal healthcare transfers and place the care on a universal footing, helped produce a public intermediate care program based on a non-profit ownership-mix capable of meeting public need, thereby achieving the objective of officials who had persistently pressed for a non-profit model since the late 1950s despite the absence of adequate funding mechanisms for much of that period.[4]

[4] It should be noted that BC's Extended Care nursing home programme was already receiving funding under the Federal Hospital Insurance and Diagnostic Services Act, but this was an exception to the Act's conditions, which ordinarily restricted federal cost-sharing to physician and hospital care. BC's Extended Care programme qualified because its standards equated to the level of care provided in chronic care facilities. The EPF removed these

Table 4
Number of Intermediate Care Beds by Ownership, British Columbia, 1971–1983

Year	Non-profit			For-profit		
	Existing	Under Construction / Proposed	Total	Existing	Under Construction / Proposed	Total
1971	1,714		1,714	4,533		4,533
1974	3,443	2,621	6,064	6,559	488	7,047
1975	5,178	1,439	6,617	6,193	256	6,449
1976	6,559	346	6,905	6,242	553	6,795
1977	7,137		7,137	6,033		6,033
1978	8,745		8,745	4,444		4,444
1983	7,728		7,728	4,673		4,673

In the early 1980s, however, the federal government began to draw down its CMHC capital funding stream for nursing homes, forcing BC to reconsider its traditional reliance on this ownership type for building and expanding its intermediate care nursing home sector (GR-3997, 1986, 22/89). Yet even as this development took place, BC's bureaucracy declined to abandon its principled commitments. Guided by its substantive orientation and belief in a high philosophy of care, it refused to default to for-profit provision, insisting instead that for-profit operators be approved only where they could match the quality of non-profit and publicly owned providers, and treating their development otherwise as a last resort, to be encouraged "if and only if we cannot meet the Province's critical new and replacement bed needs by other means" (GR-2690, 1983, 19/28). That provincial officials held to this position even as federal capital funding for non-profit nursing home construction was drawing down confirms that their commitment to care quality was not dictated by funding conditions but operated as an end in itself, reflecting the substantive rational orientation that had guided BC's bureaucracy throughout the period.

restrictions, enabling provinces to allocate federal healthcare transfers to a broader range of long-term care programmes, including intermediate-level nursing home care.

7.4 Conclusion

British Columbia's efforts to address the poor quality of care in for-profit nursing homes commenced with the establishment of stringent provincial regulations in 1913. However, following decades of regulatory challenges in which for-profit providers consistently skirted rules and minimized care, BC officials observed that non-profit and publicly owned facilities delivered superior care at substantially lower regulatory transaction costs. By the early 1950s, BC's bureaucracy concluded that establishing a system anchored in a high philosophy of care was structurally incompatible with for-profit dominance. Guided by substantive rationality, officials persistently advocated for a transition to a non-profit ownership model, driven by the causal belief that this was the only strategy capable of realizing their principled commitment.

This transition was initially frustrated by the absence of coherent federal and provincial funding mechanisms. Yet, leveraging successive windows of opportunity, from the Federal Hospital Insurance and Diagnostic Services Act in 1958 to federal CMHC funding in 1969 and the Established Programs Financing Act in 1978, the province's bureaucracy pursued a sustained strategy of institutional layering that gradually and systematically transformed the ownership-mix of the province's public nursing home system from one made up predominantly of for-profit providers until 1965 (GR-2653, 1968, 26/97; GR-2653, 1967, 41-43/43) to one dominated by non-profit providers. When federal conditions deterred non-profit participation, the province responded by building and purchasing extended care facilities itself under the same federal funding measure that had discouraged non-profit participation, and by increasing provincial capital subsidies for intermediate care until non-profit uptake accelerated. Even when faced with provincial austerity measures, bureaucrats refused to default to cheap, for-profit alternatives, exempting the non-profit

nursing home program from restraint rather than abandoning their principled objective of a public nursing home system based on a high philosophy of care.

What this chapter has shown, then, is not a series of ad-hoc policy decisions, but the sustained operation of a substantive rationality in which a caring bureaucracy resisted cost-driven pressures even when fiscal considerations became politically important, while leveraging successive windows of opportunity to help advance a public nursing home system based on a high philosophy of care. The underlying basis of this bureaucratic commitment had been well captured in a 1965 BCHIS report, *The Extension of B.C. Hospital Insurance Service Coverage to Nursing Home Patients*, which, even before the Extended Care programme was implemented, had already declared that "B.C.H.I.S. is not anxious to extend coverage to substandard arrangements, and the following requirements are set out in the hope of achieving suitable treatment for all patients requiring nursing home care" (GR-678, 1965, 4/7; see also The Province, 1957). This trajectory stands in stark contrast to Ontario, which as Chapters 4 and 5 demonstrated, encountered the exact same sequence of federal funding opportunities but filtered them through a fundamentally different bureaucratic orientation. Whereas BC's caring bureaucracy layered a non-profit alternative to realize its principled commitment to a high philosophy of care, Ontario's instrumental-formal bureaucracy pursued a layering process in the opposite direction, one that treated cost-minimization as the operative end of policy, first by declining to assume direct responsibility for the sector and, once it did intervene, by implementing policies devoid of substantive concern for care quality, thereby laying the groundwork for the expansion and entrenchment of for-profit nursing homes, including powerful corporate chains.

Chapter 8 now situates these dynamics within the theoretical framework of bureaucratic rationality and ideational theory, demonstrating how the interaction of distinct bureaucratic

rationalities with distinct ideational forms produced the divergent outcomes observed in each province, namely the establishment of a for-profit nursing home ownership-mix in Ontario and a non-profit ownership-mix in British Columbia.

Chapter 8: Application and Analysis: Ideas, Bureaucratic Rationality, and Institutions in Ontario and British Columbia

8.1 Introduction

Having presented the empirical record in Chapters 4 through 7, this chapter applies the theoretical framework from Chapter 3 to both cases, making explicit the causal mechanisms through which the interaction of distinct ideas with distinct bureaucratic rationalities during identical windows of opportunity produced the observed divergence in ownership-mix. The chapter proceeds in three analytical parts. Section 8.2 examines how both provinces possessed sufficient political authority and political will, encountered multiple windows of opportunity, and adopted gradual processes of layering to reform and transform their ownership-mix. Sections 8.3 and 8.4 then demonstrate how distinct ideas advanced by bureaucrats interacted with distinct bureaucratic rationalities to drive each province's divergent policy trajectory.

The empirical chapters have confirmed the expectations specified by the theoretical framework. In Ontario, officials filtered the shared political objective of a modernized public nursing home system primarily through a cost-minimization lens, treating provincial regulations as an avoidable expense and initially taking no action to address the shortage of nursing home beds, thereby forcing the emergence of a municipally governed for-profit dominated public nursing home system marked by symbolic regulations and substandard care, a regime the province worked to uphold when first pressed to act in order to avoid the costs of its own direct involvement. Even when finally forced to intervene, provincial officials implemented policies designed to minimize administrative and fiscal commitments rather than improve care standards, devolving enforcement to the same municipal authorities whose incapacity had been identified as a root cause of failure, and enacting a regulatory regime that privileged easily measurable physical standards over care quality, a combination that drove smaller operators out of business while enabling large for-profit

chains to thrive. While officials raised concerns at times, noting the substandard conditions in for-profit facilities and calling for policies that would align the sector's development with population need, they did not persist when overruled, often accepting outcomes consistent with procedural logic rather than exercising discretion to weigh the human consequences of the decisions they implemented. Each of these patterns points to the governing role of instrumental-formal rationality, under which the bureaucratic procedure operated as both means and end of administration, prioritizing cost-minimization over substantive care quality and enabling the for-profit sector to grow large and politically organized across successive windows of opportunity, progressively raising the cost of reversal and locking the province into a for-profit dominated ownership-mix its own policies had created.

In British Columbia, by contrast, officials persistently advocated for principled ideas across successive windows of opportunity, framed substandard care in for-profit facilities as a moral problem requiring governmental action, resisted directives from political superiors when those directives conflicted with their substantive objectives, and maintained their advocacy despite structural challenges brought about by federal and provincial funding and economic conditions. Crucially, they did not abandon procedural and efficiency concerns but assessed them against their principled objectives. Each of these behaviours constitutes an observable implication of the concept of caring bureaucracy introduced in Chapter 3, under which substantively oriented officials, guided by a principled commitment to the idea of a high philosophy of care, saw it as their public duty to deploy stringent regulations, bed size restrictions, and moratoriums on the for-profit nursing home sector, measures that kept the for-profit sector small and politically weak, enabling them, through persistent advocacy across successive windows of opportunity, to shift the province's ownership-mix to non-profit dominance.

The following sections demonstrate how these distinct bureaucratic rationalities, operating on the same federal opportunities, interacted with distinct ideational types to generate the divergent ownership-mix trajectories that constitute this dissertation's central empirical puzzle.

8.2 Windows of Opportunity, Political Authority and Will, and the Strategy of Layering

As illustrated in the theoretical overview, while policy change is invariably shaped by ideas and requires institutional carriers such as bureaucrats to insert those ideas into the policy process, major reform is not possible without the emergence of a window of opportunity.

In both Ontario and British Columbia, such windows opened during formative periods of welfare state expansion, when a confluence of factors, including a public crisis in nursing home care and generous federal funding opportunities aimed at assisting provinces with the modernization costs of their welfare states lowered institutional constraints and created windows of opportunity.

These windows emerged at politically opportune moments, when both provinces possessed sufficient political authority to pursue reform, with Ontario governed continuously by Progressive Conservatives who held a legislative majority for most of the period from 1943 to 1985, and British Columbia governed by Social Credit majorities almost uninterruptedly from 1952 to 1985.

Broader political, societal, and ideological conditions provided both provinces with the political will needed to pursue reform during this period. As the Canadian welfare state scholarship has documented, the postwar era was characterized by a confluence of factors that incentivized provincial welfare state expansion across the country, including the perceived competitive threat of the CCF's rise, a Keynesian consensus favouring state investment in social programs, widespread public expectations for postwar social reconstruction, and, most importantly, the view that welfare state expansion was vital to maintaining provincial economic competitiveness within

a federal system in which provinces competed for investment, population, and political legitimacy (Banting, 1987; 2005; Guest, 1997; Maioni, 1998; Simeon & Robinson, 1990). These conditions were shared equally by both Ontario and British Columbia and therefore explain why both provinces were willing to pursue welfare state reform, but they cannot account for the divergent direction that reform took in each province. This thesis argues that policy divergence emerged from the distinct ideas and bureaucratic rationalities through which each province filtered these shared opportunities.

When implementing reform, both provinces adopted a gradual strategy of path-departing change known as layering which involved gradually closing one sector while simultaneously building another on top of it. A gradual approach was preferred over big bang reform due to the significant financial and political risks involved. Unlike hospital and physician care, nursing home care received only marginal and fragmented federal funding, often restricted to social assistance recipients, making it financially risky for provincial governments to build a comprehensive system at once, thereby increasing their preference for incremental change. Attempting major policy change also carried significant political risks, including creating potential gaps in bed capacity. In fact, both provinces encountered this challenge, with BC having to delay the closure of for-profit nursing homes due to insufficient non-profit extended care beds, while Ontario abandoned plans to dismantle its Homes for the Aged sector because for-profit facilities were already at capacity and unable to absorb the impending shortfall. Layering thus allowed each province to transition toward a new ownership-mix in a financially and politically sustainable manner, albeit in radically different directions.

In Ontario, layering worked through a series of measures that gradually cemented the for-profit ownership-mix while suppressing non-profit alternatives. These measures included the

placement of a moratorium on the Homes for the Aged sector for nearly a decade, the restriction of Homes for the Aged nursing home beds to existing residents who became too frail over time and needed to be transferred from residential beds to nursing home beds, capping the ratio of nursing home beds in homes for the aged to no more than 40 percent of total beds, bed ratio restrictions that capped Homes for the Aged at 1.0 per 1000 of the population while setting for-profit nursing homes at 2.5 per 1000, and a regulatory regime that combined a low per-diem rate and relaxed size restrictions with strictly enforced physical upgrade requirements to systematically disadvantage smaller for-profit operators while enabling large for-profit chains to thrive. Each of these measures was layered onto the existing public nursing home system, ultimately ensuring a transition to an ownership-mix overwhelmingly dominated by for-profit providers.

In British Columbia, layering worked in the opposite direction through a series of measures that, taken together, gradually shifted the system away from for-profit dominance by restricting the for-profit sector's growth while building a non-profit alternative alongside it. These measures included the permanent construction moratorium on for-profit nursing homes and the leveraging of the Federal Hospital Insurance and Diagnostic Services Act as the window for launching the universal non-profit Extended Care programme in 1965, the leveraging of federal CMHC construction funding for non-profit intermediate care nursing homes beginning in 1969, the quiet moratorium on for-profit intermediate care projects in 1971, and the establishment of the universal non-profit intermediate care programme in 1978 following the emergence of the Federal Established Programs Financing Act. Each measure was layered on top of or alongside existing rules, and their combined effect over time, as Tables 2, 3, and 4 in the empirical chapters illustrate, was to produce a decisive shift from for-profit to non-profit dominance in both the extended and intermediate care sectors.

8.3 Application and Analysis—Ontario and BC: Causal Beliefs and Principled Ideas

8.3.1 The Role of Causal Beliefs in Ontario

In Ontario, the policy process was guided by causal beliefs that treated cost-minimization and non-formal market mechanisms as the most effective means of organizing nursing home provision (Task Force on Long-Term Care, 1974a, 12/21), with no principled beliefs centred on the well-being of residents operating to constrain the range of acceptable causal strategies. These beliefs had become institutionalized through recurrent official reasoning that any care is better than no care, a stance that lowered the threshold for accepting a for-profit dominated public nursing home system marked by substandard care, weak care standards, and poor oversight of care quality (Globe and Mail, 1965a; Struthers, 1997, 175–176). As demonstrated in Chapter 5, the priorities that Ontario officials articulated in their own policy documents confirm this orientation, with the province's three central objectives for the Extended Care Program centring on avoiding inappropriate utilization, maximizing federal funding, and ensuring maximum dollar value for provincial capital investment, with virtually no discussion of care quality (Cabinet Committee on Nursing Homes & Technical Committee, 1969, 59/148; Lundman, 1975, 85/103). That this cost-driven orientation constituted the governing logic through which all policy options were assessed is further confirmed by the Co-ordinating Committee's rejection of proposed improved standards in 1971 on the grounds that they first needed to be analysed by the Ministry of Finance (Co-ordinating Committee Extended Care Health Insurance, 1971, 51/161).

Hence, unlike in BC, where principled commitments to care quality directed procedural and cost considerations, the ideas that prevailed in Ontario's policy process were causal beliefs centred on procedural compliance and cost-minimization alone, with every reform, whether on regulations, facility size, or per-diem rates, evaluated through this lens at the expense of care

quality considerations. As Chapters 4 and 5 demonstrated, this framework led officials to evaluate facility size in terms of financial viability rather than care quality, to set the per-diem rate at a level that drove smaller for-profit operators out of business while enabling chains to thrive, and to close facilities that provided adequate care but could not meet costly physical upgrade requirements—a pattern that Lawrence Crawford, the Director of Ontario's Homes for the Aged Branch had criticized when he questioned why for-profit operations had been "permitted to proliferate despite failing to produce meaningful increases in the level and quality of care being offered" (Ontario Homes for the Aged Branch, 1969a, 147–148).

This cost-minimization approach was also consistent with the provincial government's earlier reluctance to intervene and directly regulate the sector, a reluctance documented across successive periods in Chapter 4, where officials failed to take any action, or when they did, refused to take direct control of the sector, citing the regulatory costs they would incur as the justification.

8.3.2 The Role of Principled Ideas in BC

In stark contrast to Ontario, BC bureaucrats persistently advanced the principled idea that a public nursing home system ought to be grounded in a high philosophy of care, with this principled commitment driving the nature of reform. For this to occur, they advanced the causal idea that a non-profit, rather than for-profit ownership-mix would serve to best ensure the effective and efficient provision of high quality care. The role of principled ideas in advancing a non-profit ownership model in BC is therefore noteworthy, because as stated in the theoretical framework, these types of ideas operate at a higher level of generality and help define the ends of policy, thereby serving to constrain the nature and range of acceptable causal strategies or beliefs. In BC, this meant that cost and technical considerations remained subordinated to principled or ethical commitments, with debates about the ownership-mix primarily revolving around care quality and

citizen well-being rather than cost-efficiency alone. While instrumental and rational-technical arguments about costs were also present, they played a role that was complementary to the substantive objectives being sought, serving to strengthen political support for a non-profit ownership-mix on the basis that a for-profit model imposed significant long-term regulatory and capital costs that would be difficult to control, especially if the goal was to operate for-profit nursing homes in accordance with a high philosophy of care (GR-0419, 1963, 18–19/20; GR-2585, 1963, 48–49/62; GR-0178, 1950, 46/50; GR-2653, 1968, 11/17).

The impact of principled ideas in BC was further reinforced by the fact that the provision of public nursing home care entails making social policy investments, making this area more prone to critique on the basis of ethically-centred principled arguments compared to other technical areas of policy. As the archival evidence in Chapters 6 and 7 demonstrates, BC bureaucrats repeatedly cautioned the provincial government that its partnership with the for-profit sector was exposing it to the charge that vulnerable citizens were being exploited as a result of government policy (GR-678, 1963, 14/25; GR-0178, 1950, 46/50; GR-0119, 1958, 9/82; GR-365, 1969, 10/21; GR-0419, 1965, 116–118/231; GR-678, 1964, 2/16).

Principled ideas also served as a focal point of coordination for BC bureaucrats, helping to ensure unanimity in favour of a non-profit ownership model. As the remarks of BC's BCHIS Finance Manager in Chapter 7 illustrated, even officials who were not fully convinced that non-profit provision would cost less than for-profit provision insisted that the case for non-profit nursing homes should rest on their capacity to deliver high quality care rather than on cost savings alone (GR-2585, 1963, 47; GR-2585, 1963, 48–50/62), thereby subordinating fiscal considerations to the principled commitment that unified the bureaucracy.

Thus, even though both provinces had the power to choose, they chose differently due to the fact that their bureaucrats interpreted the purpose of nursing home care through distinct ideational frameworks, with Ontario officials relying on instrumental causal beliefs that framed it as a cost problem to be solved by the procedure alone and BC officials drawing on principled beliefs that framed care as a moral imperative.

However, since officials in both provinces had access to both principled and causal ideas, the account offered so far does not explain why one ideational variant came to prevail in each case. As the next section argues, it was the institutional context, specifically the distinct bureaucratic rationalities through which ideas were filtered in each province that conditioned how officials weighed and deployed the ideas available to them, including how they interpreted policy problems and the kinds of roles they assumed, with officials in Ontario acting as obedient implementers bound by procedure and those in British Columbia as assertive advocates who acted on the basis of principled beliefs and a sense of public duty to fulfil their substantive mandate.

8.4 Application and Analysis—Ontario and BC: Ideas and Bureaucratic Rationality

8.4.1 Ontario's Instrumental-Formal Rationality

While ideas were central to policy reform in both provinces, they were filtered through distinct bureaucratic rationalities that served as interpretive guides for how officials interpreted problems, evaluated policy options, and implemented reforms, thereby conditioning how officials weighed and deployed available ideas both through their interpretive function and through the agential roles assigned to bureaucrats, specifically, whether bureaucrats would accept outcomes without sustained resistance or actively advocate to shape policy outcomes. Thus, in Ontario, instrumental-formal rationality positioned officials as agents bound by cost-driven procedures and priorities, which left them less inclined and less empowered to challenge the status quo, whereas

in British Columbia, substantive rationality empowered them as assertive agents who actively intervened to advance ethical care standards which they also deemed to be a public duty.

As outlined in the theoretical framework, a bureaucracy's operative orientation is shaped by whether substantive rationality directs instrumental-formal rationality or is displaced by it. Instrumental-formal rationality is means-oriented and focused on achieving outcomes with maximum efficiency through adherence to universal rules and procedures, while substantive rationality is value-based and end-goal oriented, with outcomes judged according to an ethical system such as a high philosophy of care. In Ontario, instrumental-formal rationality governed the bureaucracy and, when applied to the shared political objective of a modernized public nursing home system, actively oriented the bureaucracy toward cost-minimization and the displacement of ethical deliberation over care quality by fiscal imperatives. Under this rationality, policy problems were understood as matters of calculation and measurement, with considerations that could not be expressed in those terms falling outside the bureaucracy's register. This was the product of an instrumental-formal procedure that was treated as both the means and end of administration, with the expectation that filtering political directives through it would yield the optimal solution, rendering critical and independent bureaucratic judgement unnecessary and indeed unwelcome. Conversely, in British Columbia substantive rationality directed instrumental-formal rationality, placing procedural and efficiency-driven priorities in the service of ethical imperatives.

The Ontario case illustrates what happens when instrumental-formal rationality governs. Archival records reveal a bureaucracy so extensively shaped by instrumental-formal rationality that procedural compliance, cost calculation (Lundman, 1975, 85/103), cost-minimization, technical details, and the operational elements of programs became its operative ends, with care quality and human well-being not only falling outside the scope of its operative instrumental-

formal rationality but treated as actively interfering with and undermining the effectiveness and objectivity of the instrumental-formal procedure, whose ultimate purpose is to ensure the most efficient and predictable results. Within this context, officials adopted a market-oriented logic for governing the public nursing home system, drawing on the causal belief, advanced through their instrumental-formal orientation, that a low per-diem rate and a regulatory regime that privileged strictly enforced physical standards over care quality would result in the greatest cost savings for the government in delivering nursing home care. This regulatory architecture reflected both dimensions of the province's instrumental-formal rationality. The formal dimension demanded objective, quantifiable rules, which led officials to privilege easily measurable physical standards over care quality, a relational and social element that does not allow for easy measurement or quantification. The instrumental dimension demanded the least costly means of achieving the political objective, which led officials not only to adopt a low per-diem rate but to keep care standards minimal, so that oversight could be restricted to easily administered physical inspections rather than the resource intensive monitoring and higher subsidies that a system based on substantive care standards would have required. Together, these two dimensions reinforced each other, ensuring that care quality was marginalized in the province's regulatory framework and costs were kept low. The government reinforced this model through relaxed restrictions on for-profit facility size and a per-diem rate set so low that it effectively drove smaller for-profit operators out of business, while for-profit nursing home chains, possessing access to economies of scale, were able to build large nursing homes and thrive by taking advantage of the relaxed size restrictions and well-enforced physical upgrade requirements that only they could afford under the low reimbursement rate, all while minimal care standards protected their profit margins. Baum's (1999) research article, "The Rise of Chain Nursing Homes in Ontario", demonstrates how Ontario's

provincial government introduced strong market-based signals without deploying any formal market-oriented instruments, driving both the rapid rise of nursing home chains and the displacement of smaller operators, a process analysed in detail in Sections 5.2 to 5.4.

This orientation was reflected in bureaucratic practice. For instance, officials prioritized transferring patients from hospitals to low-cost nursing homes (Struthers, 1997, 184; Globe and Mail, 1965a), justifying the practice based on their view that any care is better than no care (Struthers, 1997, 175–176; Globe and Mail, 1965a). Although some officials raised concerns, such as a 1972 committee member who questioned why the program was designed exclusively from a "financial and functional" perspective "without consideration of the rights of the patient", such objections were rare, consistently ignored, and not persistent (Co-ordinating Committee Extended Care Health Insurance, 1972, 29/46).

Furthermore, senior officials who recognized the negative impact of unchecked for-profit growth on the public nursing home system's organization and quality of care expressed their concerns cautiously and indirectly. Their restraint did not stem from indifference, however, but from the prevailing institutional logic, namely, that instrumental-formal rationality frames policy outcomes as the product of an objective procedure that is presumed to guarantee the most efficient outcome and is not to be interfered with. Therefore, in this context, persistent advocacy came to be viewed negatively, not as leadership but as a violation of the procedure's objectivity and effectiveness, an interference that undermined its capacity to produce the most efficient results with certainty and predictability, a constraint that rendered sustained principled resistance institutionally illegitimate regardless of its substantive merit. While instrumental-formal rationality allows and even encourages bureaucrats to raise objections, the expectation is that they must not persist in doing so and must back down if their demands are rejected (Weber, 1922/1978,

1404; Weber, 1919/1994, 330–331; Bartels, 2009, 459; Monteiro & Adler, 2022, 433; Du Gay, 2000, 78). Numerous observations cited in Chapters 4 and 5 demonstrate this behaviour (Ontario Special Health Services Branch, 1969, 24/25; Cabinet Committee on Nursing Homes, 1969, 38/148; Cabinet Committee on Nursing Homes, 1969a, 72–73/148; Technical Committee on Nursing Homes, 1969; Struthers, 1997, 181; Globe and Mail, 1965n; Toronto Daily Star, 1965; Ontario Personal Care Standards Division, 1974, 3/4). The specific instances cited in Chapters 4 and 5, including Deputy Minister of Health Charron's observation that nursing homes had expanded "without rhyme or reason" (Cabinet Committee on Nursing Homes, 1969, 36/148), and Minister Dymond's acknowledgement that for-profit homes were dedicated to "one purpose only, to make money" (as quoted in Struthers, 1997, 186), both follow this same pattern, where concerns were pointed out but were abandoned when overruled rather than being persistently pursued within and across successive windows of opportunity.

The governing role of instrumental-formal rationality also meant that policy-making in Ontario proceeded without the kind of comprehensive, critical evaluation of available options that characterized British Columbia's approach, as officials assumed, rather than established through any careful weighing of alternatives, that large for-profit chains would deliver adequate care by virtue of their capacity to meet upgraded physical standards, an assumption that the empirical information presented in Chapter 5 demonstrated to be unfounded (The Globe and Mail, 1971a; Hospital Administration in Canada, 1971, 2/9).

The persistence of Ontario's instrumental-formal orientation is evident not only in the formative period of the welfare state analysed in this dissertation but in how the province would continue to govern the sector in the decades that followed, as Daly's (2015) study of nursing home policy in Ontario illustrates. Table 5, adapted from Daly's (2015) study, captures this phenomenon,

demonstrating that between 1984/1985 and 2009/2010 every other province shown substantially expanded its provincial ownership of long-term care beds, with British Columbia growing from 421 to 7,518 beds, Alberta from none to 6,147, and Manitoba from 185 to 3,669, while the national total rose from 3,764 to 25,236. Ontario was the sole province that moved in the opposite direction, reducing its provincially owned beds from 868 to 311. This trajectory represents a clear continuation of the province's instrumental-formal orientation and its path-dependent legacy, in which the procedural logic of cost-minimization that had governed the formative period continued to preclude direct provincial investment in publicly owned nursing home beds long after that period had ended, even as British Columbia and other provinces moved decisively in the opposite direction.

Table 5

Number of Residential Care Beds by Ownership Type and by Jurisdiction 1984–2010

		Proprietary	Nonprofit Religious	Nonprofit Lay	Municipal	Provincial
Canada	1984/1985	61100	13863	25104	28029	3764
	2009/2010	94482	15616	30292	19030	25236
	% Growth	54.6%	12.9%	20.7%	-32.1%	570.5%
Ontario	1984/1985	32810	4250	6013	17785	868
	2009/2010	53587	4953	13220	17014	311
	% Growth	63.2%	16.5%	119.9%	-4.3%	-64.2%
Alberta	1984/1985	3606	1414	778	2875	0
	2009/2010	6831	3042	2777	0	6147
	% Growth	89.4%	115.1%	256.9%	-100%	-
BC	1984/1985	6995	1217	10159	76	421
	2009/2010	10313	2429	6593	0	7518
	% Growth	47.4%	99.6%	-35.1%	-100%	1685.7%
Manitoba	1984/1985	2716	2058	2680	969	185
	2009/2010	2629	1795	1589	0	3669
	% Growth	-3.2%	-12.8%	-40.7%	-100.0%	1883.2%

Note. Adapted from Daly (2015, 36)

Of course, Ontario's provincial government did invest in publicly owned and non-profit nursing homes during the formative period through the municipal and non-profit Homes for the Aged programme, a program it would later abandon in favour of for-profit expansion. As Chapter 4 demonstrated, this abandonment reflected the instrumental-formal rationality under which any policy committing the province to an ongoing operating-deficit liability was treated as incompatible with cost-minimization, even where federal subsidies were available to offset the immediate capital costs. The figure for municipal beds in Table 5, while comparatively higher in Ontario than elsewhere, is the remnant of that earlier program, frozen at roughly the level it had reached when the moratorium was imposed in 1972. And while figures indicate that the number of non-profit nursing home beds in Ontario grew at a faster rate than in British Columbia from the mid-1980s to 2010, this increase was far smaller than the concurrent expansion of for-profit nursing home beds in Ontario, as well as the significant growth of provincially owned beds in British Columbia over the same period, further affirming British Columbia's commitment to investment in publicly owned nursing homes.

No single policy decision more clearly illustrates the divergence between the two provinces' bureaucratic rationalities than their contrasting responses to the federal CMHC construction funding programme introduced in 1969. This programme offered provinces subsidies specifically designated for the construction of non-profit and publicly owned nursing homes. As Chapter 7 demonstrated, British Columbia swiftly seized on this opportunity and used CMHC funding as a central pillar of its non-profit intermediate care expansion strategy, amending the Elderly Citizens' Housing Aid Act in 1970 to include funding for intermediate care facilities and introducing a non-profit intermediate care programme one year later. By 1975, non-profit intermediate care beds had surpassed for-profit beds, and by 1978, the gap had widened decisively.

This response was consistent with the persistent advocacy of BC's caring bureaucracy, which had advocated for a non-profit model since the late 1950s and recognized the CMHC programme as the instrument through which its principled objectives could finally be realized in the intermediate care sector.

Ontario, by contrast, only built two Rest Homes—both predating CMHC funding—while only building one Home for the Aged facility using CMHC funding before dropping both programmes to secure the expansion of the for-profit nursing home sector (CMHC, 1983b, 20; CMHC, 1983a, 4–5; Struthers, 1997; Department of Social and Family Services, 1969, 124–125/148). This decision cannot be attributed to fiscal restraint measures, measures that had led the province to impose a freeze on capital funding for the Homes for the Aged based on the rationale that capital costs were the costs the province could most readily control, since the express purpose of the federal CMHC programme was to relieve provinces of those very costs. Nor can it be attributed to the absence of internal advocacy, since several government bodies had strongly recommended the program's use (Technical Committee on Nursing Homes, 1969, 78/148; Ontario Homes for the Aged Branch, 1969, 134/148; Co-ordinating Committee Extended Care Health Insurance, 1971b, 82/161; Department of Social and Family Services, 1969, 124–125/148). Nor can it be explained by partisan ideology, since British Columbia's Social Credit government operated under an equally, if not more, conservative ideological orientation and yet actively leveraged the same federal funding program. Nor, finally, can it be explained as a result of policy failure underlined by "misjudgement" and "indecisive state planning" on the part of state planners, as Struthers (1997, 186–187) appears to suggest, since the recommendations were repeated by multiple committees across several years. While Struthers does correctly document the role of for-profit lobby pressure in pushing the province to abandon the Rest Homes programme (Struthers,

1997, 182), this lobby pressure does not constitute an alternative explanation to the analytical framework developed here but rather reinforces it, since it was precisely an instrumental-formal orientation that both allowed a large, powerful for-profit sector to emerge and entrench itself and left Ontario officials without the principled basis from which to resist such pressures, a basis whose presence in British Columbia's caring bureaucracy is documented in Chapters 6 and 7. What accounts for Ontario's non-response, therefore, is neither a fiscal nor a political constraint but an institutional one: the procedural framework through which Ontario officials evaluated policy options identified the non-profit alternative as unacceptable because it would have committed the province to the ongoing operating-deficit sharing that public and non-profit provision involved, together with an expanded administrative role, even though the up-front construction costs were federally subsidized. That Ontario simultaneously suppressed its successful municipal and non-profit Homes for the Aged programme despite the availability of federal capital funding constitutes the clearest instance in the archival record of the iron cage, under which the bureaucracy's instrumental-formal orientation rendered an available and advantageous policy instrument unacceptable, even as British Columbia was actively using the same programme to transform its ownership-mix.

8.4.2 BC's Substantive Bureaucratic Rationality

Whereas Ontario's bureaucracy operated under an instrumental-formal rationality that actively oriented the bureaucracy toward cost-minimization and procedural compliance as the operative ends of policy, British Columbia's bureaucracy was characterized by substantive rationality, which, as made evident in Chapters 6 and 7, was reflected in its use of state hierarchy to deploy powerful anti-market incentives in order to institute a public nursing home system based on the principled idea of a high philosophy of care. These incentives took the form of strict

enforcement and active monitoring, prohibition of nursing home chains and external capital investment, strong physical and care regulations, restrictions on the size of for-profit nursing homes that were never increased beyond seventy-five beds, along with a low per-diem rate for for-profit facilities. Together, these factors combined to create a powerful anti-market logic in BC, serving as a strong discouragement for investment and expansion by the for-profit nursing home sector, which, despite persistent attempts to convince the government to remove or ease such measures, was unable to do so (GR-2677–1, 1979, 13/15; GR-2665, 1970, 24/93).

This substantive orientation enabled officials to retain sight of their public purpose and advance principled ideas through assertive advocacy, persistently pressing their case on political superiors and resisting directives from above when those directives conflicted with their substantive objective. Guided by a substantive commitment to care quality, they resisted market-oriented approaches and any de-prioritization of care quality in favour of costs, even when it was fiscally and administratively expeditious to do so. This was reflected in their decisions, which as detailed in Chapters 6 and 7, included resisting pressures to expand for-profit bed capacity during shortages and refusing to fund substandard facilities or lower standards in favour of costs, all in the name of quality (GR-2653, 1968, 24–25/97; GR-365, 1969, 10/21; GR-2653, 1968, 11/17; GR-678, 1965, 4/7). Perhaps most strikingly, as Chapter 7 demonstrated, when BC launched its universal intermediate care program during a period of significant economic difficulties in the late 1970s, the provincial government exempted the program from the restraint measures it had imposed on other social programs (GR-2649, 1978, 70/143; GR-3975, 1982, 22, 25–45; GR-3975, 1982, 18/45; GR-3975, 1982, 5/30). This decision is incomprehensible under instrumental-formal rationality, which would predict that a cost-driven bureaucracy would subject all programs to fiscal discipline regardless of their substantive purpose. That BC's government selectively protected the

non-profit nursing home program from the restraint measures that it applied to other social programs constitutes direct evidence that the commitment of BC's caring bureaucracy to principled ideas had practical implications and was not merely symbolic. This is also reflected in the fact that officials established standards for the intermediate care program that were so high that some stakeholders, including other officials, questioned their necessity and the financial burden they placed on the government (GR-880057-0091, 1974, 72–73/108; GR-3975, 1985, 76/137; GR-2677, 1974, 29/57; GR-3975, 1985, 26/137; GR-678, 1965, 4/7; GR-2653, 1968, 26/97; GR-2690, 1983, 15/28), a further indication that substantive rationality oriented the bureaucracy toward ethical ends even when this generated fiscal and political tension.

In hindsight, this orientation helps explain why, as Golant (2001) stated in his overview of long-term care in Canada, for-profit developers in BC are "especially frustrated" with the BC government's "unwillingness" to establish a viable role for the for-profit institutional nursing home sector in BC and "pessimistic" about changing the "antibusiness climate in the province" (57, 78).

Crucially, BC's caring bureaucracy did not reject instrumental-formal rationality but directed it to substantive ends, employing routine and thorough inspections of both physical and caring standards, strict bed-size restrictions on for-profit facilities, and cost-benefit analyses of non-profit versus for-profit regulatory costs as tools in the service of their principled philosophy of care rather than as ends in themselves. A particularly clear illustration of this orientation is found in a 1963 memorandum from BCHIS Deputy Minister Donald Cox to Health Minister Eric Martin, in which Cox protested the Minister's decision to approve a private hospital licence in Prince George on the basis of political pressure rather than the official review procedure. Cox's objection was not a procedural complaint about the violation of bureaucratic routine. Rather, he framed the review procedure itself as instituted "for the protection of the patients", with patient welfare as "of

primary importance", and asked the Minister to clarify whether "safeguarding future patients should be our primary concern" (GR-678, 1963, 3–6/25). The procedure mattered to Cox because it operationalized a substantive end. When the substantive end was bypassed, the procedure could no longer fulfil its purpose.

This orientation, in which procedural rigour was placed in the service of substantive ends, had defined the BC bureaucracy from early on, as Donald Cox, Deputy Minister of the B.C.H.I.S., had noted upon joining the province's service in 1950, recalling that:

> When I came to British Columbia in 1950 I was greatly impressed by the effective control over the operation of nursing home type accommodation... I soon learned that this difference was based on a strong and effective application of the requirements of the Hospital Act, and that a particularly important feature was a searching and impartial review of every application... to ensure that applicants are treated fairly, but that no situation is created whereby an applicant might be given a means of pressuring the Government into approving his application, or of building beyond requirements and thereby creating the hazard of sub-marginal operations (GR-678, 1963, 3–4/25)

Cox's account is telling, for it casts the bureaucracy's procedural rigour, namely its impartial vetting and its insistence on the Hospital Act's requirements, not as an end in itself but as the means through which patients were protected and exploitation forestalled, the very orientation that would later lead BC officials to favour a non-profit ownership model.

It was precisely this orientation, in which substantive ends directed instrumental-formal means, that BC's ultimate transition from for-profit to non-profit provision came to satisfy on both counts, namely that it fulfilled the substantive commitment to care quality that had driven officials' advocacy since the late 1940s while also resolving the mounting regulatory and long-term cost

burden that for-profit provision had imposed, a burden that, once the substantially higher regulatory costs and the long-term capital and operational costs of for-profit homes were taken into account, made that ownership model less economical than it first appeared and thereby placed it in tension with the instrumental-formal requirement of administering the system in a cost-efficient manner. That the non-profit model served both ethical and administrative ends simultaneously demonstrates the integrated character of BC's caring bureaucracy, in which substantive rationality directed the policy decision while instrumental-formal considerations reinforced it. In Ontario, by contrast, instrumental-formal rationality governed, producing a system in which efficiency was pursued at the direct expense of care quality rather than in its service.

The substantive basis of British Columbia's bureaucracy also empowered officials to conduct thorough and critical examinations of all policy options, since substantive rationality, by virtue of its orientation toward moral ends rather than procedural means invites evaluating choices against principled ends. This allowed bureaucrats to engage in more creative and reflective analysis, as they were not confined to rigid formal procedures alone, but could direct procedural tools with their professional judgment, technical expertise, principled ideas, and creativity to shape policy outcomes. For example, this critical approach helped bureaucrats in BC recognize and emphasize that for-profit models would incur rising long-term costs due to interest on "borrowed capital", complicating government efforts to control reimbursement rates, an insight that appeared to be entirely absent in Ontario (GR-2585, 1963, 49/62; see also GR-0178, 1950, 46/50).

BC's substantive bureaucratic orientation also strengthened bureaucratic agency by empowering bureaucrats to direct the policy process rather than merely carry out political directives handed down from above. This highlights a crucial divergence in bureaucratic agency between the two provinces: whereas Ontario officials operated within an institutional rationality

that made them subservient to the procedure, constraining them to find the most efficient means of achieving given political objectives irrespective of the impact this would have on the quality of care and to defer to the hierarchy if their concerns were overruled, BC officials drew on their substantive orientation to independently shape the policy direction, driven by a profound sense of public duty to advance a non-profit ownership model that would serve both care quality and cost-efficiency, and to assertively resist their political superiors when state directives threatened their substantive objective of a high philosophy of care—going so far as to directly warn ministers that failure to reform would render the government complicit in the exploitation of vulnerable citizens by for-profit providers (GR-0119, 1958, 9/82; GR-678, 1963, 14/25; GR-0419, 1965, 185/231; GR-746, 1971, 11–12/17; GR-2677, 1968, 58/96).

8.5 Conclusion

A central argument of this dissertation, and one of its principal contributions to the scholarly literature on Canadian long-term care, is that the absence of a provincial role in Ontario's public nursing home system during the formative period was not a policy vacuum but the institutional product of instrumental-formal rationality. Under this orientation, the shared political objective of a modernized public nursing home system was filtered through a procedural logic in which concerns over administrative and operational costs marginalized substantive deliberation over care quality, leading the provincial government to delay intervention in order to avoid the regulatory and operational costs of direct involvement and effectively forcing municipalities to assume responsibility for the sector for decades. This orientation, reflected in a provincial approach to social policy largely devoid of a 'social' component, did not merely shape the province's initial non-intervention but conditioned every subsequent decision examined in Chapters 4 and 5, from the 1958 provincially devised municipal bylaw scheme through the 1972 nursing home insurance

program. Here a crucial analytical distinction must be noted between the sources of regulatory failure at the municipal and provincial levels in Ontario. Whereas in the case of municipal regulations, it was a weak and under-capacitated municipal authority that was responsible for the regulatory failures of Ontario's nursing home system, in the case of provincial regulations, it was an instrumental-formal rationality that structurally devalued principled considerations in the evaluation of policy options, leading the province to reproduce and reinforce municipal failure rather than correct it. The province did not lack the capacity to regulate. What it lacked was the substantive rationality that would have made regulation a public duty rather than an avoidable expense.

The contrast with British Columbia is therefore not a contrast of capacity but of bureaucratic orientation. In British Columbia, a caring bureaucracy, underpinned by substantive rationality, enabled officials to retain sight of their public purpose and advance principled ideas rooted in a high philosophy of care. Whereas Ontario's officials treated regulation as an avoidable expense, BC's officials treated it as a public duty, establishing stringent provincial regulations from 1913 onward and persistently strengthening them in response to the regulatory failures they documented in the for-profit sector. Over successive windows of opportunity, this substantive orientation drove a sustained process of institutional layering that gradually shifted the ownership-mix from for-profit to non-profit dominance. These measures included the permanent construction moratorium on for-profit nursing homes and the leveraging of the Federal Hospital Insurance and Diagnostic Services Act as the window for launching the universal non-profit Extended Care programme in 1965, the leveraging of federal CMHC construction funding for non-profit intermediate care nursing homes beginning in 1969, the quiet moratorium on for-profit intermediate care projects in 1971, and the establishment of the universal non-profit intermediate

care programme in 1978 following the emergence of the Federal Established Programs Financing Act. Each measure was layered on top of or alongside existing rules, and their combined effect over time, as Tables 2, 3, and 4 in the empirical chapters illustrate, was to produce a decisive shift from for-profit to non-profit dominance in both the extended and intermediate care sectors. Ontario's trajectory ran in the opposite direction, with layering measures that gradually cemented the for-profit ownership-mix while suppressing non-profit alternatives. These included the placement of a moratorium on the Homes for the Aged sector for nearly a decade, the restriction of Homes for the Aged nursing home beds to existing residents who became too frail over time and needed to be transferred from residential beds to nursing home beds, capping the ratio of nursing home beds in homes for the aged to no more than 40 percent of total beds, bed-ratio restrictions that capped Homes for the Aged at 1.0 per 1000 of the population while setting for-profit nursing homes at 2.5 per 1000, and a regulatory regime that combined a low per-diem rate and relaxed size restrictions with strictly enforced physical upgrade requirements to systematically disadvantage smaller for-profit operators while enabling large for-profit chains to thrive. Each of these measures was layered onto the existing public nursing home system, ultimately ensuring a transition to an ownership-mix overwhelmingly dominated by for-profit providers.

A clear pattern emerges from the evidence presented in both cases. In each province, the same regulatory logic reproduced itself across six successive windows of opportunity over three decades, a consistency that makes it difficult to attribute the divergence to isolated political calculations or contingent events. After all, if the divergence had resulted from a one time political decision, one would not expect it to show up consistently across windows. Nor can prevailing welfare state accounts explain this pattern. For instance, if the outcome had resulted from partisan ideology, one would expect the two provinces to have ended up in a similar place given that both

were governed by broadly similar conservative parties. This suggests that the causal variable lies beneath the level these accounts treat as fundamental, pointing instead to the state as a relatively autonomous site of policy formation where the ideas and institutional rationalities of bureaucratic actors carry independent causal force. This focus on state actors and institutions gains a special salience in the LTC field in particular, because as explained in Chapter 2, provincial governments constitute the dominant structural force within the internal logic of Canada's public nursing home system, a configuration that endows them with exceptional decision-making authority unconstrained by the kind of professional countervailing power that characterizes the physician dominated healthcare sector (Tuohy, 1999; 2020; Baranek, Deber, & Williams, 2004, 21, 24).

As this dissertation has shown through a process-tracing methodology grounded in historical institutionalism, this divergence stems from the interaction of distinct ideas with distinct bureaucratic rationalities as the driving mechanism, an interaction that structured how officials interpreted challenges and whether they acted persistently on their convictions. This dynamic helps explain why British Columbia institutionalized a non-profit nursing home system grounded in a high philosophy of care, while Ontario, whose instrumental-formal orientation filtered the shared political objective of a modernized public nursing home system through a cost-minimization lens, embraced the notion that 'any care is better than no care' to justify a regulatory approach centred on physical standards and minimal care oversight, setting in motion a path-dependent trajectory in which for-profit expansion and lobbying progressively raised the political and administrative costs of reversal.

These findings also resolve a long-standing empirical blind spot in Canadian scholarship on the formative period of each province's nursing home ownership-mix. By misperiodising the main critical junctures to the late-twentieth-century austerity paradigms in Ontario and to the 1983

restraint program in British Columbia (Evans, 2008; Laws, 1987; Rekart, 1993; Prince, 1996; Fuller, 2001), and by lumping the commercial and voluntary sectors into one category as 'private provision', thereby obscuring the distinction BC bureaucrats drew between these two sectors when advancing a non-profit model while restricting for-profit growth, prevailing accounts have insufficiently engaged with the meso-level causal mechanisms that this dissertation has identified. Tellingly, this same scholarship documents that the 1980s expansion in BC was directed overwhelmingly toward the non-profit sector, even as it characterizes this expansion merely as part of a privatization agenda driven by neoliberalism or conservative ideology (Rekart, 1993, 56, 73, 89; Clément, 2019, 301), an outcome that, as this dissertation has demonstrated, was in fact the product of the path-dependent force of substantive bureaucratic rationality and principled ideas that had emerged decades earlier. Neither neoliberalism nor partisan ideology, therefore, set the institutional logic governing each province's ownership-mix—that logic had already been locked in through the persistent advocacy of substantively rational bureaucrats in British Columbia and the obedient procedural compliance of instrumentally rational bureaucrats in Ontario decades before explicit market-oriented agendas emerged in government politics.

Chapter 9: Conclusion

This chapter draws the dissertation together. It restates the puzzle and the central argument, summarizes the empirical findings, sets out the contributions, identifies the study's limitations, and outlines avenues for future research. The chapter closes by stepping back from these items to state what the comparison of Ontario and British Columbia reveals about the relationship between bureaucratic rationality, ideas, and policy, and about its consequences both for the functioning of the state bureaucracy and the people it is meant to serve.

9.1 Restating the Puzzle and the Central Argument

This dissertation began with a puzzle that prevailing welfare-state accounts cannot resolve. Ontario and British Columbia entered the formative period of welfare-state modernization, a period spanning from the 1940s to the 1970s, attempting to tackle an acute nursing home bed shortage from comparable developmental starting points. Both were among Canada's wealthiest, most populous, and most urbanized provinces, and in both cases these starting conditions were set within broadly similar macro-institutional arrangements, including liberal welfare and market regimes, for-profit dominated nursing home sectors, rule by long-running, free-enterprise conservative majorities for nearly the entirety of that period, and the same sequence of federal cost-sharing windows of opportunity. Despite these commonalities, their reform paths diverged, with Ontario pursuing a strictly for-profit path for its public nursing home ownership-mix and BC a primarily non-profit one.

Prevailing explanations fail to account for this divergence, and several predict the opposite of what occurred in at least one province. Partisan accounts predict convergence under the two provinces' shared conservative rule, neo-pluralism predicts that Ontario, whose non-profit lobby emerged decades before the for-profit lobby, should have been more likely to consolidate a non-

profit path, path-dependence would have pointed in the same direction given the substantial non-profit institutional base the province built early in the formative period, and public opinion approaches would expect Ontario, where pushback against for-profit care was more severe, to have been the likelier of the two to abandon its pursuit of a for-profit ownership model. Power resources theory carries limited purchase in a federal context that fragments class-based influence, and state capacity cannot differentiate provinces that both possessed ample capacity to act. The failure of these explanations points to a causal variable operating beneath the macro-level conditions they treat as fundamental. This dissertation found that this causal variable lies in the interaction of distinct ideas with distinct bureaucratic rationalities.

In Ontario, the shared objective of establishing a modernized public nursing home system was filtered through a bureaucracy governed by instrumental-formal rationality, such that cost-minimization became the operative end of policy, positioning officials as obedient executors of the procedure bound to finding the most efficient means to their assigned directive, thus leaving them neither inclined nor empowered to weigh the human consequences of the decisions they implemented. The resulting causal belief, that a for-profit ownership model governed by measurable physical standards and minimal care oversight was the most cost-efficient route available to the province, produced a public nursing home sector dominated by for-profit providers and, over time, by for-profit chains.

In British Columbia, by contrast, a caring bureaucracy, underpinned by substantive rationality, granted officials the discretion to retain sight of their public purpose. Rather than merely executing directives from a pro-free-enterprise political executive, they drew on principled ideas rooted in a high philosophy of care to advance a non-profit model across successive windows of opportunity, concluding it was the only strategy capable of realizing their commitment. This

decision did not come at the expense of cost considerations, with officials carefully evaluating multiple options and settling on the one that reconciled cost-efficiency with their principled commitment.

Through process-tracing, the dissertation found that this divergence could not be reduced to a single decision, the role of a particular official, or a period of fiscal pressure or prosperity, since the same regulatory logic reproduced itself across six successive windows over three decades. It is this patterned and persistent reproduction of the same distinct regulatory dynamic, across changing officials, shifting fiscal conditions and prevailing policy paradigms, and successive federal opportunities, that marks the divergence as the work of two distinct bureaucratic rationalities rather than of partisan design, despite both provinces operating under free enterprise governments, both in Ontario, where a market-oriented regulatory logic persisted through an era of welfare state expansion, and in British Columbia, where officials advanced a non-market regulatory path against decades of conservative free-enterprise rule and the fiscal austerity of the late 1970s.

9.2 Summary of Empirical Findings

The empirical chapters traced how each province's bureaucratic rationality, interacting with the ideas its officials advanced, culminated in opposing ownership-mix trajectories across an identical sequence of federal windows, trajectories that path-dependent dynamics then entrenched.

Ontario's trajectory rested on instrumental-formal rationality, its nursing home system having originated in the absence of any provincial role, leaving municipalities, which lacked the capacity to govern the sector, no choice but to enter into a partnership with for-profit operators under a regulatory regime that was symbolic, a regime the province sought to uphold when first pressed to act in order to avoid the costs of its own direct involvement. Even when finally forced

to assume direct responsibility, the same cost-minimizing, procedurally bound instrumental-formal rationality continued to govern the province's interventions, as reflected in the 1966 Nursing Homes Act, under which the province devolved enforcement back to the same municipal authorities whose incapacity had been seen as a root problem. From the mid-1960s, the province operationalized that same rationality through a regime combining a low per-diem rate, relaxed size restrictions, and strictly enforced physical upgrade requirements, a combination that drove small for-profit operators out of business while enabling large chains to use their economies of scale to afford the upgrades under the low rate and thrive, their margins protected by minimal care standards that left care quality correspondingly poor. Ontario's bureaucracy was therefore no less active than British Columbia's, but its planning was directed toward cost-minimization rather than care, a contrast made evident by the two provinces' responses to the 1969 federal CMHC construction funding programme for non-profit and publicly owned nursing homes, which Ontario declined while freezing its own non-profit sector, since expanding non-profit provision would have committed it to ongoing operational deficit liabilities its instrumental-formal rationality treated as unacceptable, even though the programme would have relieved it of the large immediate capital costs it had complained of as a constraint. The result was a for-profit sector that grew large, organized, and increasingly resistant to reform, to the point that the province could neither impose structural controls on its growth nor enforce its own care standard amendments against the industry its policies had created.

British Columbia's trajectory began not with a decision to build a non-profit sector but to regulate a for-profit one. From 1913, officials confronted substandard conditions in for-profit private hospitals through a stringent regime of licensing, inspection, and enforcement, an experience that led them by the early 1950s to conclude that a for-profit ownership-mix was

irreconcilable with their high philosophy of care, since for-profit operators continued to skirt regulations and required constant oversight to meet even minimum standards, whereas non-profit and publicly owned facilities delivered superior care without comparable monitoring. Unlike Ontario, where officials made decisions with an eye primarily to costs, BC officials reached their conclusion on multiple grounds simultaneously, recognizing that for-profit provision was not necessarily inexpensive once its higher regulatory and increasing long-term costs were taken into account, and that the profit motive exposed both public funds and vulnerable patients to exploitation the government could not adequately police. They then advanced their case for a non-profit system with a principled persistence across successive windows from the 1950s onward, beginning with a permanent construction moratorium on for-profit nursing homes and a universal non-profit Extended Care programme in 1965, and culminating with a moratorium on for-profit intermediate care facilities and the establishment of a universal non-profit intermediate care program in 1978, ultimately achieving a decisive shift to non-profit dominance despite persistent funding obstacles and without ever reverting to the cheap for-profit alternative—even amid the fiscal restraint of the late 1970s. This refusal to abandon their objectives amidst funding obstacles and fiscal pressures is the clearest behavioural signature of a bureaucracy anchored in substantive rationality. This same orientation, expressed through regulations that prohibited nursing home chains and absentee and external ownership and strictly enforced strong physical and care standards, kept the for-profit sector small and politically weak, making each successive restriction easier to impose and the eventual transition to non-profit dominance possible.

In both provinces, then, the formative decisions did not merely set a direction but progressively raised the cost of reversing it, locking in the divergence through the path-dependent dynamics the study's analytical framework anticipated.

9.3 Contributions and Avenues of Future Research

The contributions of this dissertation are theoretical, empirical, methodological, and normative, as set out below.

One contribution addresses a shortcoming in historical institutionalism, which, while apt at explaining when reform becomes possible through windows of opportunity, leaves underspecified the mechanism through which change follows from such windows. To address this shortcoming, this dissertation builds on Tuohy's framework, which, while having advanced the field by specifying political will, political authority, the internal logic of a policy sector, and ideas as variables governing how change follows from a window, falls short in explaining the direction of policy change. While Tuohy treats the prevailing climate of policy ideas as a force that defines the options a window opens onto (1999, 12), in explaining which option is selected she surrenders that autonomy by making the choice a function of the governing party's agenda and prevailing paradigm, rather than treating ideas as independent forces capable of shaping the direction of reform. Yet the comparison shows this cannot be the whole story, since each government selected different options despite sharing broadly similar agendas, including a commitment to free enterprise and welfare-state expansion. This dissertation locates the missing variable in the interaction of the distinct ideas officials advanced with the distinct bureaucratic rationalities through which those ideas were filtered, an interaction in which each rationality conditioned how officials advanced ideas rather than producing outcomes in their absence. It is this interaction, operating beneath partisan agenda and paradigms, that determined which of the options a window opened onto each province selected. In advancing this mechanism, the dissertation offers a theoretical rather than merely case-bound contribution, since the mechanism rests on two features of bureaucratic policy making that are not reducible to the particular conditions of either province:

the ideas bureaucrats advanced and the distinct bureaucratic rationalities through which those ideas were filtered.

By developing an account of how bureaucratic rationality filters ideas into policy, the dissertation contributes to public administration scholarship by building on Stivers' (1995; 2000) reconstruction of substantive rationality as a historical alternative to the instrumental-formal model and translating it into one of the few empirical studies of how the two forms of rationality shape the operation of a bureaucracy at a systemic level over time, including the substance of its policy-making. It also contributes to care ethics scholarship in public administration, where most empirical studies have remained concerned with front-line level bureaucrats' interaction with the public (Urban, 2020, 294, 296, 298–299). Yet for bureaucracies to play a fuller role in building a caring society, care ethics must also extend to the higher levels where policy research and formulation take place (Stensöta, 2010, 295; 2015, 185; Urban, 2020, 294, 296, 298–299), a gap this dissertation addresses.

The dissertation also reaffirms the value of state-centred explanation of social policy against the society-centred accounts that prevailed across the postwar decades of welfare-state scholarship by demonstrating that the state is not a passive arena for societal contestation but a relatively autonomous site of policy formation whose institutional features carry direct causal consequences for welfare-state outcomes (Evans, Rueschemeyer, & Skocpol, 1985; Carpenter, 2001). In doing so it also corrects the field's historical timeline, showing that the institutional bases of each province's nursing home ownership-mix were laid decades earlier than prevailing accounts recognize.

Methodologically and empirically, the dissertation demonstrates the value of subnational comparison, which, by holding regime type, partisan orientation, developmental level, and the

sequence of federal funding constant, brings into view the meso-level variables that national comparison can leave obscured behind the macro-level differences between countries (Snyder, 2001, 93–94, 103–104; Giraudy, Moncada, & Snyder, 2019, 5–6; Wallner, 2010; Wallner et al., 2020, 249, 265; Falleti, 2010, 20–21; Banting, 2005, 89–90, 115–116). It also adds to the small body of subnational comparative research in comparative politics, and to the even smaller body of comprehensive comparative studies of Canadian long-term care, where most analyses focus on surface-level commonalities among provincial programs rather than the deeper structural differences that set each province's long-term care system apart. Alongside this scant literature, the dissertation offers an archival, process-traced account of provincial nursing home policy during the formative period of welfare-state modernization.

The dissertation further offers, by tracing how divergent ownership-mix trajectories take shape and become locked in, a focused account of how such outcomes emerge as path-dependent processes within the welfare state, contributing to a question of the ownership-mix that welfare-state and non-profit scholarship have both tended to neglect. Welfare-state explanations often advance a dirigiste view that gives the "misleading impression… of no separation between the financing and the delivery of public services" (Gidron, Salamon, & Kramer, 1992, xii–xiii, 2), and also tend to leave the ownership-mix undifferentiated by lumping commercial and voluntary providers together as private provision (Gidron, Salamon, & Kramer, 1992; Salamon, 1987), thus serving to obscure the very ideational and administrative factors within the state that this dissertation shows drove the choice between non-profit and for-profit provision. Non-profit theory, though cognizant of the distinct consequences of ownership type, has treated the state and non-profits as isolated actors, and where it has taken up the contracting relationship at all, it has framed it as a one-off question of which provider to choose for a given service rather than as a process

that unfolds within the welfare state over time (Salamon, 1987; Panet & Trebilcock, 1998; Rekart, 1993). This dissertation, by contrast, shows the provider mix to be the outcome of just such a process, one in which the state's bureaucratic rationality interacts with the ideas of its bureaucrats to actively shape which providers emerge and become entrenched.

Finally, the dissertation carries a normative implication that follows from its empirical findings. The comparison of the two provinces shows that the form of rationality through which a bureaucracy works has direct consequences for the people a public system is meant to serve. Where instrumental-formal rationality governed, as in Ontario, cost and procedure became the ends of policy, and the well-being of residents fell outside what the bureaucracy was equipped to treat as relevant. Where substantive rationality formed the orientation of the bureaucracy, as in British Columbia, instrumental-formal rationality was not abandoned but directed to the service of principled ends, with officials treating cost-efficiency and procedural rigour as important while keeping sight of their public purpose and weighing the human costs of policy against its fiscal costs. What this comparison therefore suggests is not that fiscal objectives and procedural rules are to be set aside in favour of concerns over quality, but that a bureaucracy pursuing them alone, without the guidance of ethical objectives, is likely to produce substandard care, while a bureaucracy that pursues cost objectives in the service of ethical ones can remain efficient, impartial, and ethical towards the people it is mandated to serve, with British Columbia serving as a clear demonstration of such a case. The comparison thus supports the critical stream of public administration, which argues that both forms of rationality must operate together if a bureaucracy is to carry out its tasks effectively and in line with its public duty (Stivers, 1995, 527–528; Stivers, 2000, 95–96; McSwite, 2004, 414; Burnier, 2022, 62; Burnier, 2003; Bourgault, 2017, 204, 208; Jos & Hines, 1993, 386; Urban, 2020; Stensöta, 2010; Engster, 2020, 627, 631), while specifying

the form this takes, namely substantive rationality directing instrumental-formal rationality, and counters the mainstream view that the two forms are incompatible and that, for effective functioning, a bureaucracy should be governed by instrumental-formal rationality alone. This finding also carries clear theoretical implications, for it shows that bureaucratic rationality operates not as a neutral administrative phenomenon but as a determinative force that shapes the substance and direction of policy. The form it takes shapes which policy options become visible, which harms or reforms register as actionable, and whether officials are empowered to act as ethical servants of the public or constrained to function as executors of a procedure that treats human consequences as externalities. These implications are not abstract. They are written into the regulatory architecture that governs the care received by the most vulnerable members of society, and their consequences persist today. The COVID-19 pandemic made this evident, with Ontario suffering some of the country's worst failures owing to its preponderance of for-profit facilities, while its government has continued to shield those same operators from public accountability despite substantial evidence and stakeholder complaints (Stevens, 2020; Raveendran, 2025). By contrast, British Columbia, where non-profit and state-owned homes together account for a substantial majority of beds, recorded far lower death rates and was cited as having responded far more effectively to the pandemic (Stevens, 2020).

Several avenues for future research, together with the normative implications that motivate them, follow from these findings.

The first concerns the origins of the bureaucratic rationalities themselves, which this study does not investigate. Such work would carry practical implications, since understanding the origins of bureaucratic rationality may show whether substantive rationality can be deliberately cultivated, a matter of particular relevance for bureaucracies in which instrumental-formal rationality governs,

producing the well-known iron cage and its attendant regulatory and ethical consequences for both the functioning of the state and its treatment of citizens. This has particularly grave implications for Ontario. It shows that the province's failure to implement stronger care standards does not stem merely from the resistance and path-departing costs of the expansive, entrenched for-profit nursing home sector its own policies created, but also from its instrumental-formal orientation, which registers costs as a priority over care standards, thereby making the high regulatory costs of the for-profit sector that concerned BC a non-issue for Ontario, a province that, as this dissertation has shown, neither seeks to implement strong care standards nor to enforce them strictly.

A corollary of this is that where path-dependence and bureaucratic orientation reinforce one another, policy problems become correspondingly difficult to address. This argument carries significant normative implications, for it means that Ontario's ongoing quality of care problems are not resolvable by advancing policy reforms or investing more money alone but by addressing the governing role of instrumental-formal rationality in the province's bureaucracy. In other words, it requires breaking through the iron cage by building into the bureaucracy itself the substantive orientation that was present in British Columbia and absent in Ontario: a commitment to care not as a residual consideration but as the end that procedure exists to serve.

This raises yet further implications that could be researched, such as the role public and stakeholder pressure, electoral accountability, or more broadly democracy can play in either inducing policy change or breaking Ontario's iron-cage bureaucracy, and why they have thus far failed to do so, especially in light of the fact that the province's public nursing home system continues to demonstrate the same substandard quality that has historically plagued it, quality shortcomings that appear to be a product of deliberate policy-making rather than accidental events or government error, and that persist despite ongoing public and stakeholder pressure for reform.

9.4 Limitations

The central limitation of the study follows from the nature of one of its explanatory variables, bureaucratic rationality, which does not manifest itself in the archival record as a single, directly observable fact but must be inferred from a sustained pattern in what officials said and did over time. The study has sought to make that inference as accurate as possible by grounding it in repeated and consistent evidence drawn from confidential records, where officials were more likely to set down their candid views, and by tracing the same orientation across successive windows in each province, so that the pattern, rather than any single observation, carries the weight of the claim.

9.5 Conclusion

By applying a process-tracing methodology within a historical institutionalist framework, this dissertation found that the interaction of distinct ideas with distinct bureaucratic rationalities produced the divergent ownership-mix trajectories in Ontario and British Columbia, independent of partisan ideology, prevailing paradigms, and other contingent factors. In reaching this finding, the study also showed that the institutional bases of each province's nursing home ownership-mix were laid decades earlier than prevailing scholarship recognizes, not by the partisan agendas or austerity paradigms of the late twentieth century to which those accounts attribute each province's trajectory, but in the formative postwar decades, when the challenges and opportunities that prompted both provinces to modernize their nursing home systems were filtered through their distinct bureaucratic orientations and the ideas their officials advanced. In British Columbia, a caring bureaucracy that kept the instrumental-formal procedure in the service of principled ends produced a public nursing home system based on non-profit ownership, one anchored in a high philosophy of care, whereas in Ontario, where instrumental-formal rationality governed, cost-

minimization and procedural compliance became the operative ends of policy itself, producing a system dominated by for-profit ownership and marked by substandard care. What the comparison of the two provinces ultimately reveals is that bureaucratic rationality is not a neutral administrative phenomenon but a force that reaches into the most intimate corners of public life, and whose consequences are borne, for better or worse, by the people the state is meant to serve.

Bibliography

Scholarly References

Aase, I., Ree, E., Johannessen, T., Strømme, T., Ullebust, B., Holen-Rabbersvik, E., & Wiig, S. (2021). Talking about quality: How 'quality' is conceptualized in nursing homes and homecare. *BMC Health Services Research*, *21*, Article 185.

Abrahamsson, B. (1993). *The logic of organizations*. Sage.

Acker, M. S. (1956). How much health service do Canadians receive? *Canadian Journal of Public Health*, *47*(9), 365–377.

Adams, G. B., & Balfour, D. L. (2009). *Unmasking administrative evil* (3rd ed.). M.E. Sharpe.

Adewale, A. (2017). Does bureaucracy stifle moral agency? *International Journal of Public Administration in the Digital Age*, *4*(2), 1–13.

Agnew, G. H. (1974). *Canadian hospitals, 1920 to 1970: A dramatic half century*. University of Toronto Press.

Akhtar-Danesh, N., Baumann, A., Crea-Arsenio, M., & Antonipillai, V. (2022). COVID-19 excess mortality among long-term care residents in Ontario, Canada. *PLOS ONE*, *17*(1), Article e0262807.

Albo, G., & Evans, B. M. (Eds.). (2019). *Divided province: Ontario politics in the age of neoliberalism*. McGill-Queen's University Press.

Albrow, M. (1970). *Bureaucracy*. Bloomsbury Publishing.

Alexander, T. (1996). The history and financing of the long-term care systems. In E. Sawyer & M. Stephenson (Eds.), *Continuing the care: The issues and challenges for long-term care* (pp. 1–43). CHA Press.

Allen, P. (2012). Accidental logics: Carolyn Hughes Tuohy's analysis of the English National Health Service internal market of the 1990s. In M. Exworthy, S. Peckham, & M. Powell (Eds.), *Shaping health policy: Case study methods and analysis* (pp. 279–290). Policy Press.

Amyot, G., & Defries, R. (1958). The British Columbia Department of Health and Welfare. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique*, *49*(12), 503–515.

Angel, E. S. (1985). *In search of parity: The Hospital Employees' Union in the British Columbia long term care industry* [Doctoral dissertation, University of British Columbia].

Anttonen, A., & Sipilä, J. (1996). European social care services: Is it possible to identify models? *Journal of European Social Policy*, *6*(2), 87–100.

Ariaans, M., Linden, P., & Wendt, C. (2021). Worlds of long-term care: A typology of OECD countries. *Health Policy*, *125*(5), 609–617.

Armstrong, P. (2002). *Wasting away: The undermining of Canadian health care* (rev. ed.). Oxford University Press.

Armstrong, P., & Armstrong, H. (2009). Precarious employment in the health-care sector. In L. F. Vosko, M. MacDonald, & I. Campbell (Eds.), *Gender and the contours of precarious employment* (pp. 270–284). Routledge.

Armstrong, P., & Armstrong, H. (Eds.). (2019). *The privatization of care: The case of nursing homes*. Routledge.

Armstrong, P., Armstrong, H., & Choiniere, J. (Eds.). (2024). *The labour crisis in long term care*. Edward Elgar Publishing.

Armstrong, P., Armstrong, H., Choiniere, J., Lowndes, R., & Struthers, J. (2020). *Re-imagining long-term residential care in the COVID-19 crisis*. CCPA.

Armstrong, P., Armstrong, H., MacDonald, M., & Doupe, M. (2019). Privatization of long-term residential care in Canada. In *The privatization of care* (pp. 87–101). Routledge.

Armstrong, P., Banerjee, A., Szebehely, M., Armstrong, H., Daly, T., & Lafrance, S. (2009). *They deserve better. The long-term care experience in Canada and Scandinavia*. Canadian Centre for Policy Alternatives.

Ascoli, U., & Ranci, C. (2002). The context of new social policies in Europe. In U. Ascoli & C. Ranci (Eds.), *Dilemmas of the welfare mix: The new structure of welfare in an era of privatization* (pp. 1–24). Springer.

Ashcraft, K. (2001). Organized dissonance: Feminist bureaucracy as hybrid form. *Academy of Management Journal*, *44*(6), 1301–1322.

Baccaro, L., Blyth, M., & Pontusson, J. (Eds.). (2022). *Diminishing returns: The new politics of growth and stagnation*. Oxford University Press.

Bacher, J. C. (1985). *Keeping to the private market: The evolution of Canadian housing policy: 1900–1949* [Doctoral dissertation, McMaster University]. MacSphere.

Badone, E. (2021). From cruddiness to catastrophe: COVID-19 and long-term care in Ontario. *Medical Anthropology*, *40*(5), 389–403.

Baekgaard, M., Mortensen, P. B., & Seeberg, H. B. (2018). The bureaucracy and the policy agenda. *Journal of Public Administration Research and Theory*, *28*(2), 239–253.

Bakker, I., & Scott, K. (1997). From the postwar to the post-liberal Keynesian welfare state. In W. Clement (Ed.), *Understanding Canada: Building on the new Canadian political economy* (pp. 286–310). McGill-Queen's University Press.

Balbo, L. (1987). Crazy quilts: Rethinking the welfare state debate from a woman's point of view. In A. S. Sassoon (Ed.), *Women and the state: The shifting boundaries of public and private* (pp. 45–71). Hutchinson.

Bambra, C. (2004). The worlds of welfare: Illusory and gender-blind? *Social Policy and Society*, *3*(3), 201–212.

Bambra, C. (2007). Defamilisation and welfare state regimes: a cluster analysis. *International Journal of social welfare*, *16*(4), 326-338.

Banerjee, A., & Armstrong, P. (2015). Centring care: Explaining regulatory tensions in residential care for older persons. *Studies in Political Economy*, *95*(1), 7–28.

Banting, K. (1987). *The welfare state and Canadian federalism* (2nd ed.). McGill-Queen's University Press.

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

Banting, K., & Myles, J. (Eds.). (2013). *Inequality and the fading of redistributive politics*. UBC Press.

Baranek, P. M., Deber, R. B., & Williams, A. P. (1999). Policy trade-offs in 'home care': The Ontario example. *Canadian Public Administration*, *42*(1), 69–92.

Baranek, P. M., Deber, R. B., & Williams, A. P. (2004). *Almost home: Reforming home and community care in Ontario*. University of Toronto Press.

Barreira, L. F., Paiva, A., Araújo, B., & Campos, M. J. (2023). Challenges to systems of long-term care. *IJERPH*, *20*(3), 1698.

Barron, D. N., & West, E. (2017). The quasi-market for adult residential care in the UK: Do for-profit, not-for-profit or public sector residential care and nursing homes provide better quality care? *Social Science & Medicine*, *179*, 137–146.

Bartels, K. P. (2009). The disregard for Weber's Herrschaft: The relevance of Weber's ideal type of bureaucracy for the modern study of public administration. *Administrative Theory & Praxis*, *31*(4), 447–478.

Bartlett, H., & Blackman, T. (2001). Models of care. In T. Blackman, S. Brodhurst, & J. Convery (Eds.), *Social care and social exclusion: A comparative study of older people's care in Europe* (pp. 27–41). Palgrave Macmillan.

Bartlett, L., & Vavrus, F. (2016). *Rethinking case study research: A comparative approach*. Routledge.

Baum, J. A. (1999). The rise of chain nursing homes in Ontario, 1971–1996. *Social Forces*, *78*(2), 543–584.

Baumol, W. J. (1996). Children of performing arts, the economic dilemma: The climbing costs of health care and education. *Journal of Cultural Economics*, *20*, 183–206.

Beach, D., & Pedersen, R. B. (2016). *Causal case study methods: Foundations and guidelines for comparing, matching, and tracing*. University of Michigan Press.

Beach, D., & Pedersen, R. B. (2019). *Process-tracing methods: Foundations and guidelines*. University of Michigan Press.

Beach, D., & Rohlfing, I. (2018). Integrating cross-case analyses and process tracing in set-theoretic research: Strategies and parameters of debate. *Sociological Methods & Research*, *47*(1), 3–36.

Beetham, D. (1996). *Bureaucracy*. University of Minnesota Press.

Béland, D. (2007). Ideas and institutional change in social security: Conversion, layering, and policy drift. *Social Science Quarterly*, *88*(1), 20–38.

Béland, D. (2016). Ideas and institutions in social policy research. *Social Policy & Administration*, *50*(6), 734–750.

Béland, D., & Lecours, A. (2023). Ideas, federalism and policy feedback: An institutionalist approach. *Territory, Politics, Governance*, *11*(2), 377–393.

Béland, D., & Mahon, R. (2014). *Analysing social policy concepts and language: Comparative and transnational perspectives*. Policy Press.

Béland, D., & Mahon, R. (2023). *Advanced introduction to social policy*. Edward Elgar Publishing.

Béland, D., & Waddan, A. (2012). *The politics of policy change: Welfare, Medicare, and Social Security reform in the United States*. Georgetown University Press.

Béland, D., Marchildon, G. P., & Ianni, R. M. (2020). *Federalism and the response to COVID-19: A comparative analysis*. McGill-Queen's University Press.

Béland, D., Marchildon, G. P., & Prince, M. J. (2019). *Universality and social policy in Canada*. University of Toronto Press.

Béland, D., Marchildon, G. P., & Prince, M. J. (2020). Understanding universality within a liberal welfare regime: The case of universal social programs in Canada. *Social Inclusion*, *8*(1), 124–132.

Béland, D., Rocco, P., & Waddan, A. (2016). Reassessing policy drift: Social policy change in the United States. *Social Policy & Administration*, *50*(2), 201–218.

Béland, F., & Arweiler, D. (1996). Conceptual framework for development of long-term care policy 1: Constitutive elements. *Canadian Journal on Aging*, *15*(4), 649–681.

Béland, F., & Lemay, A. (2002). The issues in long-term care policy. In E. Sawyer & M. Stephenson (Eds.), *Continuing the care: The issues and challenges for long-term care* (rev. ed., pp. 45–76). CHA Press.

Bendick, M. (1984). Privatization of public services: Recent experience. In H. Brooks, L. Liebman, & C. Schelling (Eds.), *Public-private partnership: New opportunities for meeting social needs* (pp. 153–171). Ballinger.

Bennett, A. (2004). Case study methods: Design, use, and comparative advantages. In D. F. Sprinz & Y. Wolinsky-Nahmias (Eds.), *Models, numbers, and cases: Methods for studying international relations* (pp. 19–55). University of Michigan Press.

Benoit, C., & Hallgrímsdóttir, H. (Eds.). (2011). *Valuing care work: Comparative perspectives*. University of Toronto Press.

Berman, B. J. (1990). Perfecting the machine: Instrumental rationality and the bureaucratic ideologies of the state. *World Futures: Journal of General Evolution*, *28*(1–4), 141–161.

Berman, S. (1998). *The social democratic moment: Ideas and politics in the making of interwar Europe*. Harvard University Press.

Bernhard, M. (2015). Chronic instability and the limits of path dependence. *Perspectives on Politics*, *13*(4), 976–991.

Berta, W., Laporte, A., & Valdmanis, V. (2005). Observations on institutional long-term care in Ontario: 1996–2002. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, *24*(1), 71–84.

Berta, W., Laporte, A., Zarnett, D., Valdmanis, V., & Anderson, G. (2006). A pan-Canadian perspective on institutional long-term care. *Health Policy*, *79*(2–3), 175–194.

Blake, D. E. (1996). The politics of polarization: Parties and elections in British Columbia. In R. K. Carty (Ed.), *Politics, policy, and government in British Columbia* (pp. 67–84). UBC Press.

Blake, D. E., & Carty, R. K. (1995). Partisan realignment in British Columbia: The case of the Provincial Liberal Party. *BC Studies: The British Columbian Quarterly*, *108*, 61–74.

Blake, D. E., Carty, R. K., & Erickson, L. (1991). *Grassroots politicians: Party activists in British Columbia*. UBC Press.

Blatter, J., & Haverland, M. (2012). *Designing case studies: Explanatory approaches in small-N research*. Palgrave Macmillan.

Blatter, J., & Haverland, M. (2014). Case studies and (causal-) process tracing. In I. Engeli & C. Rothmayr Allison (Eds.), *Comparative policy studies: Conceptual and methodological challenges* (pp. 1–27). Palgrave Macmillan.

Blyth, M. M. (1997). 'Any more bright ideas?' The ideational turn of comparative political economy. *Comparative Politics*, *29*(2), 229–250.

Bohte, J., & Meier, K. J. (2000). Goal displacement: Assessing the motivation for organizational cheating. *Public Administration Review*, *60*(2), 173–182.

Bologh, R. W. (1990). *Love or greatness: Max Weber and masculine thinking–A feminist inquiry*. Unwin Hyman.

Bonoli, G. (2005). The politics of the new social policies: Providing coverage against new social risks in mature welfare states. *Policy & Politics*, *33*(3), 431–449.

Bos, A., Boselie, P., & Trappenburg, M. (2017). Financial performance, employee well-being, and client well-being in for-profit and not-for-profit nursing homes: A systematic review. *Health Care Management Review*, *42*(4), 352–368.

Bossert, C. F. (2021). *Power, alliances, and redistribution: The politics of social protection for low-income earners in Argentina, 1943–2015*. Verlag Barbara Budrich.

Boston, J. (1994). Purchasing policy advice: The limits to contracting out. *Governance*, *7*(1), 1–30.

Boston, J. (2016). Basic NPM ideas and their development. In T. Christensen & P. Lægreid (Eds.), *The Ashgate research companion to new public management* (pp. 17–32). Routledge.

Boucock, C. (2000). *In the grip of freedom: Law and modernity in Max Weber*. University of Toronto Press.

Bourgault, S. (2017). Prolegomena to a caring bureaucracy. *European Journal of Women's Studies*, *24*(3), 202–217.

Box, R. C. (2005). *Critical social theory in public administration*. M.E. Sharpe.

Boychuk, G. W. (2016). "Studying public policy": Historical institutionalism and the comparative method. *Canadian Journal of Political Science*, *49*(4), 743–761.

Brady, A. (1947). *Democracy in the Dominions: A comparative study in institutions*. University of Toronto Press.

Braedley, S. (2025). Long-term care policy in Canada. In D. Béland, R. Mahon, & A. Smith (Eds.), *The Oxford handbook of social policy in Canada*. Oxford University Press.

Braun, D. (1999). Interests or ideas? An overview of ideational concepts in public policy research. In D. Braun & A. Busch (Eds.), *Public policy and political ideas* (pp. 11–29). Edward Elgar Publishing.

Brejning, J. (2016). *Corporate social responsibility and the welfare state: The historical and contemporary role of CSR in the mixed economy of welfare*. Routledge.

Brennan, D., Cass, B., Himmelweit, S., & Szebehely, M. (2012). The marketisation of care: Rationales and consequences in Nordic and liberal care regimes. *Journal of European Social Policy*, *22*(4), 377–391.

Brenton, M. (1985). *The voluntary sector in British social services*. Longman.

Brooks, H., Liebman, L., & Schelling, C. (Eds.). (1984). *Public-private partnership: New opportunities for meeting social needs*. Ballinger.

Browne, P. L., & Welch, D. (2002). In the shadow of the market: Ontario's social economy in the age of neoliberalism. In Y. Vaillancourt & L. Tremblay (Eds.), *Social economy: Health and welfare in four Canadian provinces* (pp. 101–134). Fernwood Books.

Brubaker, R. (1984). *The limits of rationality: An essay on the social and moral thought of Max Weber*. Routledge.

Bryant, T. (2016). *Health care in Canada* (2nd ed.). Canadian Scholars' Press.

Bucken-Knapp, G., Karlsson Schaffer, J., & Persson Strömbäck, K. (2012). Security, equality, and the clash of ideas: Sweden's evolving anti-trafficking policy. *Human Rights Review*, *13*(2), 167–185.

Burnier, D. (2003). Other voices/other rooms: Towards a care-centered public administration. *Administrative Theory & Praxis*, *25*(4), 529–544.

Burnier, D. (2008). Erased history: Frances Perkins and the emergence of care-centered public administration. *Administration & Society*, *40*(4), 403–422.

Burnier, D. (2009). The shock of recognition: Reflections on bureau men, settlement women. *Administrative Theory & Praxis*, *31*(4), 586–589.

Burnier, D. (2022). The long road of administrative memory: Jane Addams, Frances Perkins and care-centered public administration. In E. M. Witesman & C. Wise (Eds.), *Handbook on gender and public administration* (pp. 53–68). Edward Elgar Publishing.

Burstein, P. (2003). The impact of public opinion on public policy: A review and an agenda. *Political Research Quarterly*, *56*(1), 29–40.

Cabin, W., Himmelstein, D. U., Siman, M. L., & Woolhandler, S. (2014). For-profit Medicare home health agencies' costs appear higher and quality appears lower compared to nonprofit agencies. *Health Affairs*, *33*(8), 1460–1465.

Caetano, P. J. da Costa, Toma, S., Kemple, T., & Mendes, M. M. (2023). Beyond Weber. *Intersections: East European Journal of Society and Politics*, *9*(3), 1–9.

Callahan, M., & McNiven, C. (1988). British Columbia. In J. S. Ismael & Y. Vaillancourt (Eds.), *Privatization and provincial social services in Canada: Policy, administration and service delivery* (pp. 13–39). University of Alberta Press.

Campbell, J. L. (1998). Institutional analysis and the role of ideas in political economy. *Theory and Society*, *27*(3), 377–409.

Campbell, J. L. (2002). Ideas, politics, and public policy. *Annual Review of Sociology*, *28*(1), 21–38.

Capoccia, G., & Kelemen, R. D. (2007). The study of critical junctures: Theory, narrative, and counterfactuals in historical institutionalism. *World Politics*, *59*(3), 341–369.

Carpenter, D. P. (2001). *The forging of bureaucratic autonomy: Reputations, networks, and policy innovation in executive agencies, 1862–1928*. Princeton University Press.

Carrera, F., Pavolini, E., Ranci, C., & Sabbatini, A. (2013). Long-term care systems in comparative perspective: Care needs, informal and formal coverage, and social impacts in European countries. In C. Ranci & E. Pavolini (Eds.), *Reforms in long-term care policies in Europe: Investigating institutional change and social impacts* (pp. 23–52). Springer.

Cassidy, H. M. (1945). *Public health and welfare reorganization: The postwar problem in the Canadian provinces*. Ryerson Press.

Castles, F. G. (Ed.). (1982). *The impact of parties: Politics and policies in democratic capitalist states*. Sage Publications.

Cercel, A. L. (2021). A good life in old age? Monitoring and improving quality in long-term care. *Revista Universitară de Sociologie*, *17*(2), 341–350.

Champagne, É. (2013). Les programmes d'infrastructures municipales du gouvernement fédéral: une analyse de la gouvernance multiniveau au Canada. *Télescope*, *19*(1), 43–61.

Chappell, N. L., & Hollander, M. J. (2013). *Aging in Canada*. Oxford University Press.

Checkel, J. T. (2015). Mechanisms, process, and the study of international institutions. In A. Bennett & J. T. Checkel (Eds.), *Process tracing: From metaphor to analytic tool* (pp. 74–97). Cambridge University Press.

Chou, M. H. (2014). The evolution of the European Research Area as an idea in European integration. In M. H. Chou & A. Gornitzka (Eds.), *Building the knowledge economy in Europe* (pp. 27–50). Edward Elgar Publishing.

Chou, S. Y. (2002). Asymmetric information, ownership and quality of care: An empirical analysis of nursing homes. *Journal of Health Economics*, *21*(2), 293–311.

Clément, D. (2019). How the state shaped the nonprofit sector: Public funding in British Columbia. *Canadian Review of Sociology/Revue canadienne de sociologie*, *56*(3), 299–328.

Cloutier-Fisher, D., & Joseph, A. E. (2000). Long-term care restructuring in rural Ontario: Retrieving community service user and provider narratives. *Social Science & Medicine*, *50*(7–8), 1037–1045.

Cockerham, W. C. (2015). Max Weber: Bureaucracy, formal rationality and the modern hospital. In W. C. Cockerham, R. Dingwall, & S. Quah (Eds.), *The Palgrave handbook of social theory in health, illness and medicine* (pp. 124–138). Palgrave Macmillan.

Cohn, D. (2001). Policy legacies and the potential for radical surgery on health-care systems. *Canadian Public Administration*, *44*(4), 503–509.

Collier, D. (1991). The comparative method: Two decades of change. In D. Rustow & K. Erikson (Eds.), *Comparative political dynamics* (pp. 7–31). HarperCollins.

Collier, D. (2011). Understanding process tracing. *PS: Political Science & Politics*, *44*(4), 823–830.

Collier, D., & Munck, G. L. (Eds.). (2022). *Critical junctures and historical legacies: Insights and methods for comparative social science*. Bloomsbury Publishing.

Collier, R. B., & Collier, D. (1991). *Shaping the political arena: Critical junctures, the labor movement, and regime dynamics in Latin America*. Princeton University Press.

Combden, S., Forward, A., & Sarkar, A. (2022). COVID-19 pandemic responses of Canada and US. *IJHPM*, *37*(1), 50–65.

Comondore, V. R., Devereaux, P. J., Zhou, Q., Stone, S. B., Busse, J. W., Ravindran, N. C., & Guyatt, G. H. (2009). Quality of care in for-profit and not-for-profit nursing homes: Systematic review and meta-analysis. *BMJ*, *339*, Article b2732.

Converse, C. (1998). *Mainstays: Women who shaped BC*. Horsdal & Schubart.

Corlet Walker, C., Druckman, A., & Jackson, T. (2022). A critique of the marketisation of long-term residential and nursing home care. *The Lancet Healthy Longevity*, *3*(4), e298–e306.

Crawford, K. G. (1954). *Canadian municipal government*. University of Toronto Press.

Crouch, C., & Keune, M. (2005). Making use of institutional diversity in Hungary and the United Kingdom. In W. Streeck & K. Thelen (Eds.), *Beyond continuity: Institutional change in advanced political economies* (pp. 83–102). Oxford University Press.

Daly, T. (2015). Dancing the two-step in Ontario's long-term care sector: Deterrence regulation = consolidation. *Studies in Political Economy*, *95*(1), 29–58.

Davies, M. J. (1994). *Institutionalizing old age: Residential accommodation for the elderly in British Columbia, 1920–1960* [Doctoral dissertation, University of British Columbia]. UBC Circle.

Davies, M. J. (2002). Competent professionals and modern methods: State medicine in British Columbia during the 1930s. *Bulletin of the History of Medicine*, *76*(1), 56–83.

Davies, M. J. (2003). *Into the house of old: A history of residential care in British Columbia*. McGill-Queen's University Press.

Deber, R. B., & Williams, A. P. (1995). *Policy trade-offs in home care*. HSRU, University of Toronto.

Delaunay, C., & Gouveia, L. (2023). Acknowledging the plural Weberian rationalities in clinical embryology: When moral values, habits, and/or affection prevail beyond efficiency. *Intersections: East European Journal of Society and Politics*, *9*(3), 54–72.

Denhardt, R. B. (1981). *In the shadow of organization*. University Press of Kansas.

Dong, L. (2016). *Public administration theories: Instrumental and value rationalities*. Palgrave Macmillan.

Drezner, D. W. (2000). Ideas, bureaucratic politics, and the crafting of foreign policy. *American Journal of Political Science*, *44*(4), 733–749.

Du Gay, P. (2000). *In praise of bureaucracy: Weber-organization-ethics*. SAGE.

Dukelow, F. (2016). 'Pushing against an open door': Reinforcing the neo-liberal policy paradigm in Ireland and the impact of EU intrusion. In C. de la Porte & E. Heins (Eds.), *The sovereign debt crisis, the EU and welfare state reform* (pp. 69–93). Palgrave Macmillan.

Eidlin, B. (2015). Continuity or change? Rethinking left party formation in Canada. In C. de Leon, M. Desai, & C. Tuğal (Eds.), *Building blocs: How parties organize society* (pp. 61–86). Stanford University Press.

Eisenstein, H. (1990). Femocrats, official feminism and the uses of power. In S. Watson (Ed.), *Playing the state: Australian feminist interventions* (pp. 87–104). Verso.

Eisenstein, H. (1991). Speaking for women? Voices from the Australian femocrat experiment. *Australian Feminist Studies*, *6*(14), 29–42.

Eisenstein, H. (1995). The Australian femocratic experiment: A feminist case for bureaucracy. In M. M. Ferree & P. Y. Martin (Eds.), *Feminist organizations: Harvest of the new women's movement* (pp. 69–83). Temple University Press.

Eisenstein, H. (1996). *Inside agitators: Australian femocrats and the state*. Temple University Press.

Elster, J. (2000). Rationality, economy, and society. In S. Turner (Ed.), *The Cambridge companion to Weber* (pp. 19–41). Cambridge University Press.

Elwell, F. (1984). The effects of ownership on institutional services. *The Gerontologist*, *24*(1), 77–83.

Engster, D. (2015). *Justice, care, and the welfare state*. Oxford University Press.

Engster, D. (2020). A public ethics of care for policy implementation. *American Journal of Political Science*, *64*(3), 621–633.

Esping-Andersen, G. (1989). The three political economies of the welfare state. *Canadian Review of Sociology/Revue canadienne de sociologie*, *26*(1), 10–36.

Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. Polity Press.

Esping-Andersen, G. (1999). *Social foundations of postindustrial economies*. Oxford University Press.

Estabrooks, C. A., Straus, S. E., Flood, C. M., Keefe, J., Armstrong, P., Donner, G. J., & Wolfson, M. C. (2020). Restoring trust: COVID-19 and the future of long-term care in Canada. *Facets*, *5*(1), 651–691.

Estévez-Abe, M. (2025). Long-term care systems and their pandemic preparedness: Lessons from COVID-19. In C. Ranci & T. Rostgaard (Eds.), *Research handbook on social care policy*. Edward Elgar Publishing.

Evans, B. M. (2008). *From Pragmatism To Neoliberalism* [Doctoral dissertation, York University].

Evans, B. M., & Fanelli, C. (Eds.). (2018). *The public sector in an age of austerity: Perspectives from Canada's provinces and territories*. McGill-Queen's University Press.

Evans, P. B., Rueschemeyer, D., & Skocpol, T. (Eds.). (1985). *Bringing the state back in*. Cambridge University Press.

Evans, R. G., & Stoddart, G. L. (Eds.). (1986). *Medicare at maturity: Achievements, lessons & challenges*. University of Calgary Press.

Falleti, T. G. (2010). *Decentralization and subnational politics in Latin America*. Cambridge University Press.

Farmer, D. J. (1995). *The language of public administration: Bureaucracy, modernity, and postmodernity*. University of Alabama Press.

Fast, J., Duncan, K. A., Keating, N. C., & Kim, C. (2024). Valuing the contributions of family caregivers to the care economy. *Journal of Family and Economic Issues*, *45*(2), 236–249.

Ferguson, G. (1995). Homecare. In E. Sawyer & M. Stephenson (Eds.), *Continuing the care: The issues and challenges for long term care* (pp. 115–134). CHA Press.

Findlay, T. (2015). *Femocratic administration: Gender, governance, and democracy in Ontario*. University of Toronto Press.

Fioretos, O., Falleti, T. G., & Sheingate, A. (2016). Historical institutionalism in political science. In O. Fioretos, T. G. Falleti, & A. Sheingate (Eds.), *The Oxford handbook of historical institutionalism* (pp. 3–30). Oxford University Press.

Fischer, F. (1990). *Technocracy and the politics of expertise*. Sage Publications.

Fletcher, M., Sawyer, E., & Stephenson, M. (2003). Continuing the care. *The Canadian Nurse*, *99*(1), 15.

Fletcher, S. (1986). *Cost and financing of long term care in Canada*. Dept. of National Health and Welfare.

Fontaine, G. (2015, July 1-4). *Ideas and institutions in policy change: The post-oil era paradigm* [Paper presentation]. 2nd International Conference on Public Policy, Milan, Italy. https://www.ippapublicpolicy.org/file/paper/1434309363.pdf

Fontaine, G. (2020). Process tracing for comparative policy analysis: A realist approach. In B. G. Peters & G. Fontaine (Eds.), *Handbook of research methods and applications in comparative policy analysis* (pp. 277–295). Edward Elgar Publishing.

Forbes, W. F., Jackson, J. A., & Kraus, A. S. (1987). *Institutionalization of the elderly in Canada*. Butterworths.

Frederickson, H. G. (1980). *New public administration*. University of Alabama Press.

Frederickson, H. G. (1997). *The spirit of public administration*. Jossey-Bass.

Frederickson, H. G. (2005). The state of social equity in American public administration. *National Civic Review*, *94*(4), 31–38.

Frederickson, H. G. (2010). *Social equity and public administration*. M. E. Sharpe.

Frederickson, H. G., Lambright, W. H., Moynihan, D. P., Piotrowski, S., Guy, M. E., Newman, M. A., & Wright, B. E. (2011). *The future of public administration around the world: The Minnowbrook perspective*. Georgetown University Press.

Friedrich, A. K. (2022). Archival research. In K. Dunn & M. S. Shapiro (Eds.), *Routledge handbook of foreign policy analysis methods* (pp. 463–481). Routledge.

Fuller, C. (2001). The information gap: The impact of health care reform on British Columbia women. In P. Armstrong, C. Amaratunga, J. Bernier, K. Grant, A. Pederson, & K. Willson (Eds.), *Exposing privatization: Women and health care reform in Canada* (pp. 287–315). Garamond Press.

Garritzmann, J. L., Häusermann, S., & Palier, B. (2023). Social investments in the knowledge economy: The politics of inclusive, stratified, and targeted reforms across the globe. *Social Policy & Administration*, *57*(1), 87–101.

Gelber, S. M. (1959). Hospital insurance in Canada. *International Labour Review*, *79*(3), 244–272.

George, A., & Bennett, A. (2005). *Case studies and theory development in the social sciences*. MIT Press.

Ghalehdar, P. (2022). Historical analysis. In K. Dunn & M. S. Shapiro (Eds.), *Routledge handbook of foreign policy analysis methods* (pp. 435–449). Routledge.

Ghatak, M. (2021). Economic theories of the social sector: From nonprofits to social enterprise. In R. O. Herman (Ed.), *The nature of the nonprofit sector* (pp. 238–248). Routledge.

Gidron, B., Salamon, L. M., & Kramer, R. M. (1992). *Government and the third sector: Emerging relationships in welfare states*. Jossey-Bass.

Gilbert, N. (2002). *Transformation of the welfare state: The silent surrender of public responsibility*. Oxford University Press.

Gingrich, J. R. (2011). *Making markets in the welfare state: The politics of varying market reforms*. Cambridge University Press.

Giraudy, A., Moncada, E., & Snyder, R. (2019). Subnational research in comparative politics: Substantive, theoretical, and methodological contributions. In A. Giraudy, E. Moncada, & R. Snyder (Eds.), *Inside countries: Subnational research in comparative politics* (pp. 3–54). Cambridge University Press.

Gittell, J. H., & Douglass, A. (2012). Relational bureaucracy: Structuring reciprocal relationships into roles. *Academy of Management Review*, *37*(4), 709–733.

Goertz, G., & Mahoney, J. (2012). *A tale of two cultures: Qualitative and quantitative research in the social sciences*. Princeton University Press.

Goldstein, J., & Keohane, R. O. (Eds.). (1993). *Ideas and foreign policy: Beliefs, institutions, and political change*. Cornell University Press.

Gonzalez-Aquines, A., Singh, S., Krol-Jankowska, A. G., & Koziel, A. (2024). Defining long-term care in European Union countries: A review of policy documents. *Journal of Long-Term Care*, *2024*, 414–423. https://doi.org/10.31389/jltc.333

Good, K. R. (2024). Situating the constitutional, legal, and historical foundations of Canadian municipal government. In K. R. Good & J. Nelles (Eds.), *Canadian urban governance in comparative perspective* (pp. 33–71). University of Toronto Press.

Graefe, P. (2004). Personal services in the post-industrial economy: Adding nonprofits to the welfare mix. *Social Policy & Administration*, *38*(5), 456–469.

Grages, C. (2025). Understanding gaps in the provision of long-term care for older people across Europe. *Social Policy & Administration*.

Greb, J., Chambers, L. W., Gafni, A., Goeree, R., & Labelle, R. (1994). Interprovincial comparisons of public and private sector long-term care facilities for the elderly in Canada. *Canadian Public Policy/Analyse de Politiques*, *20*(3), 278–296.

Green, A. G. (1971). *Regional aspects of Canada's economic growth*. University of Toronto Press.

Greener, I. (2002a). Understanding NHS reform: The policy-transfer, social learning, and path-dependency perspectives. *Governance*, *15*(2), 161–183.

Greener, I. (2002b). Theorising path-dependency: How does history come to matter in organisations? *Management Decision*, *40*(6), 614–619.

Greener, I. (2004). *Theorising path dependence: How does history come to matter in organisations, and what can we do about it?* University of Edinburgh.

Gregory, R. (2016). Normativity and NPM: A need for some theoretical coherence. In T. Christensen & P. Lægreid (Eds.), *The Ashgate research companion to new public management* (pp. 375-388). Routledge.

Gregory, R. (2017). New public management and the ghost of Max Weber: Exorcized or still haunting? In T. Christensen & P. Lægreid (Eds.), *Transcending new public management* (pp. 221–277). Routledge.

Greve, B. (2017). *Long-term care for the elderly in Europe: Development and prospects*. Routledge.

Greve, B. (2018). Long-term care. In B. Greve (Ed.), *Routledge handbook of the welfare state* (pp. 498–507). Routledge.

Greve, C. (2007). *Contracting for public services*. Routledge.

Grey, C. (2013). *A very short, fairly interesting and reasonably cheap book about studying organizations*. Sage.

Gronow, J. (1988). The element of irrationality: Max Weber's diagnosis of modern culture. *Acta Sociologica*, *31*(4), 319–331.

Guest, D. (1997). *The emergence of social security in Canada* (3rd ed.). UBC Press.

Guidi, M. (2016). *Competition policy enforcement in EU member states: What is independence for?* Springer.

Guzmán, C., Santos, F. J., & Savall, T. (2024). How to explain social innovation in elderly care services: The role of for-profit and non-profit social enterprises. *International Entrepreneurship and Management Journal*, *20*(3), 1849–1877.

Habermas, J. (1984). *The theory of communicative action: Vol. 1. Reason and the rationalization of society* (T. McCarthy, Trans.). Beacon Press.

Habermas, J. (1987). *The theory of communicative action: Vol. 2. Lifeworld and system: A critique of functionalist reason* (T. McCarthy, Trans.). Beacon Press.

Haddow, R. (2014). Power resources and the Canadian welfare state: Unions, partisanship and interprovincial differences in inequality and poverty reduction. *Canadian Journal of Political Science/Revue canadienne de science politique*, *47*(4), 717–739.

Haddow, R. S. (1993). *Poverty reform in Canada, 1958–1978: State and class influences on policy making*. McGill-Queen's University Press.

Haddow, R. S., & Klassen, T. R. (2006). *Partisanship, globalization, and Canadian labour market policy: Four provinces in comparative perspective*. University of Toronto Press.

Hall, M. H., & Banting, K. G. (1999). *The nonprofit sector in Canada: An introduction*. Queen's University, School of Policy Studies.

Hall, P. A. (2003). Aligning ontology and methodology in comparative research. In J. Mahoney & D. Rueschemeyer (Eds.), *Comparative historical analysis in the social sciences* (pp. 373–404). Cambridge University Press.

Hall, P. A. (2006). Systematic process analysis: When and how to use it. *European Management Review*, *3*(1), 24–31.

Hall, P. A. (2020). The electoral politics of growth regimes. *Perspectives on Politics*, *18*(1), 185–199.

Hall, P. A., & Taylor, R. C. R. (1996). Political science and the three new institutionalisms. *Political Studies*, *44*(5), 936–957.

Halperin, S., & Heath, O. (2020). *Political research: Methods and practical skills* (3rd ed.). Oxford University Press.

Halpern, L., Phillips, S. D., & Grasse, N. J. (2022). Non-profit long-term care in Ontario: How financially robust is the system? *Canadian Public Policy*, *48*(s2), 64–80.

Hancock, L., & Moore, S. (1999). Caring and the state. In L. Hancock (Ed.), *Health policy in the market state* (pp. 265–287). South Wind Production.

Harmon, M. M. (1981). *Action theory for public administration*. Longman.

Harrington, C. (2013). Understanding the relationship of nursing home ownership and quality in the United States. In M. Szebehely (Ed.), *Marketisation in Nordic eldercare* (pp. 229–240). Stockholm University.

Harrington, C., & Jacobsen, F. F. (2019). Nurse staffing in nursing homes in industrialized countries. In P. Armstrong & H. Armstrong (Eds.), *The privatization of care* (pp. 177–195). Routledge.

Harrington, C., Ross, L., Chapman, S., Halifax, E., Spurlock, B., & Bakerjian, D. (2020). Nurse staffing and coronavirus infections in California nursing homes. *Policy, Politics, & Nursing Practice*, *21*(3), 174–186.

Hart, V. (1992). Feminism and bureaucracy: The minimum wage experiment in the District of Columbia. *Journal of American Studies*, *26*(1), 1–22.

Hastings, J. E. (1966). The Report of the Royal Commission on Health Services—Implications for Public Health. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique*, *57*(3), 106-116.

Hatch, M. J., & Cunliffe, A. L. (2013). *Organization theory: Modern, symbolic and postmodern perspectives* (3rd ed.). Oxford University Press.

Häusermann, S. (2009). Policy flexibility vs. policy inertia: Coalitional dynamics in German pension reform. In G. Capano & M. Howlett (Eds.), *European and North American policy change: Drivers and dynamics* (pp. 43–62). Routledge.

Haveman, H. A., & Kluttz, D. N. (2016). Bureaucracy. In *The Palgrave encyclopedia of strategic management* (pp. 1–4). Palgrave Macmillan.

Havens, B. (1995). Long-term care diversity within the care continuum. *Canadian Journal on Aging*, *14*(2), 245–262.

Hawkesworth, M., & Kogan, M. (Eds.). (2013). *Encyclopedia of government and politics* (2-vol. set). Routledge.

Heclo, H. (1974). *Modern social politics in Britain and Sweden: From relief to income maintenance*. Yale University Press.

Heclo, H. (1988). The in-and-outer system: A critical assessment. *Political Science Quarterly*, *103*(1), 37–56.

Heller, M. G. (2009). *Capitalism, institutions, and economic development*. Routledge.

Helliwell, J. (2010). A province defined: An analysis of the political ideology of the 1952–1972 Social Credit government of British Columbia. *On Politics*, *4*(1), 61–75.

Hirdes, J. P. (2002). Long-term care funding in Canada: A policy mosaic. *Journal of Aging & Social Policy*, *13*(2–3), 69–81.

Hodgetts, J. E. (1995). *From arm's length to hands on: The formative years of Ontario's public service, 1867–1940*. University of Toronto Press.

Hoekstra, J. S. C. M. (2010). *Divergence in European welfare and housing systems*. IOS Press.

Hogan, J. (2006). Remoulding the critical junctures approach. *Canadian Journal of Political Science*, *39*(3), 657–679.

Hollander, M. J. (1999). *The cost-effectiveness of community based long term care services for the elderly compared to residential care: A British Columbia perspective* [Doctoral dissertation].

Hollander, M. J. (2002). The continuum of care: An integrated system of service delivery. In E. Sawyer & M. Stephenson (Eds.), *Continuing the care: The issues and challenges for long-term care* (pp. 57–70). CHA Press.

Horak, M. (1998). *The power of local identity: C4LD and the anti-amalgamation mobilization in Toronto*. Centre for Urban and Community Studies, University of Toronto.

Huber, E., & Stephens, J. D. (2001). *Development and crisis of the welfare state: Parties and policies in global markets*. University of Chicago Press.

Hummel, R. P. (1994). *The bureaucratic experience: A critique of life in the modern organisation*. St. Martin's Press.

Hummel, R. P. (2008). *The bureaucratic experience: The post-modern challenge* (5th ed.). M.E. Sharpe.

Ianni Segatto, C., Béland, D., & Marchildon, G. P. (2020). Federalism, physicians, and public policy: A comparison of health care reform in Canada and Brazil. *Journal of Comparative Policy Analysis: Research and Practice*, *22*(3), 250–265.

Ingram, P., & Baum, J. A. C. (1997). Chain affiliation and the failure of Manhattan hotels, 1898–1980. *Administrative Science Quarterly*, *42*(1), 68–102.

Irving, A. (1987). The development of a provincial welfare state: British Columbia 1900–1939. In A. Moscovitch & J. Albert (Eds.), *The benevolent state: The growth of welfare in Canada* (pp. 155–174). Garamond Press.

Isitt, B. (2011). *Militant minority: British Columbia workers and the rise of a New Left, 1948–1972*. University of Toronto Press.

Jacobs, A. M. (2015). Process tracing the effects of ideas. In A. Bennett & J. T. Checkel (Eds.), *Process tracing: From metaphor to analytic tool* (pp. 41–73). Cambridge University Press.

James, E. (1987). The nonprofit sector in comparative perspective. In W. W. Powell (Ed.), *The nonprofit sector: A research handbook* (pp. 397–415). Yale University Press.

Jaramillo, G. (2020). Comparing historical cases: Advances in comparative historical research. In B. G. Peters & G. Fontaine (Eds.), *Handbook of research methods and applications in comparative policy analysis* (pp. 113–133). Edward Elgar Publishing.

Jensen, C. (2008). Worlds of welfare services and transfers. *Journal of European Social Policy*, *18*(2), 151–162.

Jenson, J. (1990). Representations in crisis: The roots of Canada's permeable Fordism. *Canadian Journal of Political Science*, *23*(4), 653–684.

Jenson, J. (2021/2025). Care for older people in Canada's resilient liberal welfare regime. In C. Ranci & T. Rostgaard (Eds.), *Research handbook on social care policy* (pp. 363–379). Edward Elgar Publishing.

Jessop, B. (2001). Bringing the state back in (yet again): Reviews, revisions, rejections, and redirections. *International Review of Sociology/Revue internationale de sociologie*, *11*(2), 149–173.

Johnson, H. T. (1973). *Urbanization and economic growth in Canada, 1851–1971*. University of Toronto Press.

Johnson, N. (1999). *Mixed economies of welfare: A comparative perspective*. Routledge.

Jones, B. D. (1994). *Reconceiving decision-making in democratic politics: Attention, choice, and public policy*. University of Chicago Press.

Jos, P. H., & Hines, S. M., Jr. (1993). Care, justice, and public administration. *Administration & Society*, *25*(3), 373–392.

Kalberg, S. (1980). Max Weber's types of rationality: Cornerstones for the analysis of rationalization processes in history. *American Journal of Sociology*, *85*(5), 1145–1179.

Kalberg, S. (2012). *Max Weber's comparative-historical sociology today*. Routledge.

Kalberg, S. (2021). *Max Weber's sociology of civilizations: A reconstruction*. Routledge.

Kane, R. A. (2003). Definition, measurement, and correlates of quality of life in nursing homes: Toward a reasonable practice, research, and policy agenda. *The Gerontologist*, *43*, 28–36.

Kane, R. A., & Kane, R. L. (1985a). The feasibility of universal long-term-care benefits: Ideas from Canada. *New England Journal of Medicine*, *312*(21), 1357–1364.

Kane, R. A., Kane, R. L., & Ladd, R. C. (1998). *The heart of long-term care*. Oxford University Press.

Kane, R. L., & Kane, R. A. (1985b). *A will and a way: What the United States can learn from Canada about caring for the elderly*. Columbia University Press.

Kelly, C., Dansereau, L., FitzGerald, M., Lee, Y., & Williams, A. (2023). Inequities in access to directly-funded home care in Canada: A privilege only afforded to some. *BMC Health Services Research*, *23*(1), Article 51.

Kenny, M. (2007). Gender, institutions and power: A critical review. *Politics*, *27*(2), 91–100.

King, G., Keohane, R. O., & Verba, S. (1994). *Designing social inquiry: Scientific inference in qualitative research*. Princeton University Press.

Kingdon, J. W. (2013). *Agendas, alternatives, and public policies* (2nd ed.). Pearson Education.

Kinnaman, J. H. (1953). Standards of care in nursing homes. *American Journal of Public Health*, *43*(8), 1020–1022.

Kitchen, H., & Slack, E. (2016). *More tax sources for Canada's largest cities: Why, what, and how?* Institute on Municipal Finance and Governance.

Koop, R. (2020). *Canadian government and politics*. Broadview Press.

Koppenborg, F. (2023). *Japan's nuclear disaster and the politics of safety governance*. Cornell University Press.

Kremer, M. (2007). *How welfare states care: Culture, gender and parenting in Europe*. Amsterdam University Press.

Kuhnle, S., & Selle, P. (Eds.). (1992). *Government and voluntary organizations: A relational perspective*. Avebury.

Lai, P. (2024). How enforcement shapes compliance with legal rules: The case of long-term care homes in Ontario. *Canadian Journal of Law and Society*, *39*(1), 110–131.

Lai, P. L. (2020). *Disability's encounter with legislation and governance: Long-term care homes in Ontario* [Doctoral dissertation, York University].

Lamura, G. (2007). Italy's familistic approach to elderly care and the new role of migrant home care workers. In V. Burau, H. Theobald, & R. H. Blank (Eds.), *Governing home care: A cross national comparison* (pp. 171–189). Edward Elgar Publishing.

Lancaster, C. (2008). *Foreign aid: Diplomacy, development, domestic politics*. University of Chicago Press.

Langer, J. (2022). Bureaucracy and the imaginal realm: Max Weber, rationality and the substantive basis of public administration. *Perspectives on Public Management and Governance*, *5*(2), 122–134.

Langins, M., Curry, N., Lorenz-Dant, K., Comas-Herrera, A., Rajan, S., & World Health Organization. (2020). The COVID-19 pandemic and long-term care: What can we learn from the first wave about how to protect care homes? *Eurohealth*, *26*(2), 77–82.

Latham, J. B., & Pazdro, R. J. (1984). Residential care. *Canadian Journal on Aging*, *3*(3), 115–125.

Laws, G. (1987). *Restructuring, privatisation and the local welfare state* (Doctoral dissertation, McMaster University).

Laws, G. (1988). Privatisation and the local welfare state: the case of Toronto's social services. *Transactions of the institute of British Geographers*, 433-448.

Laws, G. (1989). Privatization and dependency on the local welfare state. In J. Wolch & M. Dear (Eds.), *The power of geography: How territory shapes social life* (pp. 238–257). Routledge.

Laxer, K. E. (2014). *Mapping the division of labour in long-term residential care across jurisdictions* [Unpublished manuscript]. York University.

Lecours, A. (Ed.). (2005). *New institutionalism: Theory and analysis*. University of Toronto Press.

Leira, A. (1992). *Welfare states and working mothers: The Scandinavian experience*. Cambridge University Press.

Leira, A., & Saraceno, C. (2004). Care: Actors, relationships and contexts. In B. Hobson, J. Lewis, & B. Siim (Eds.), *Contested concepts in gender and social politics* (pp. 55–83). Edward Elgar Publishing.

Letiche, H. (2008). *Making healthcare care: Managing via simple guiding principles*. IAP.

Levenick, K. L. (1986). *Measuring effectiveness in long-term care facilities in British Columbia* [Doctoral dissertation, University of British Columbia].

Levine, D. P. (1981). Rationality and freedom: Weber and beyond. *Sociological Inquiry*, *51*(1), 5–25.

Levy, J. S. (2008). Case studies: Types, designs, and logics of inference. *Conflict Management and Peace Science*, *25*(1), 1–18.

Lindenfield, R. G. (1959). Hospital insurance in Canada. *Social Service Review*, *33*(2), 148–160.

Lindenfield, R. G. (1963). *The hospital insurance and diagnostic services act* (Doctoral dissertation, University of Chicago).

Lindquist, E. (2025). Social equity and the "new public administration" in Canada. In J. A. Chouinard & S. Thiessen (Eds.), *Transforming public administration in Canada: An exploration of social equity in research, practice, and teaching* (pp. 243–268). Emerald Publishing.

Lossing, E. H. (1960). The Federal-Provincial Hospital Insurance and Diagnostic Services program. *Canadian Journal of Public Health*, *51*, 302–308.

Luk, S. C. Y. (2014). *Health insurance reforms in Asia*. Routledge.

Luk, S. C. Y. (2016). *Financing healthcare in China: Towards universal health insurance*. Routledge.

Luk, S. C. Y. (2020). *Ageing, long-term care insurance and healthcare finance in Asia*. Routledge.

Lundman, S. B. (1975). *An economic analysis of the nursing home industry of Ontario* [Doctoral dissertation, McGill University].

Lundquist, L. J. (1980). *The hare and the tortoise: Clean air policies in the United States and Sweden*. University of Michigan Press.

MacAdam, M. (2004). Examining home care in other countries: The policy issues. *Home Health Care Management & Practice*, *16*(5), 393–404.

Macinati, M. S., & Young, S. H. (2024). Contracting out social care services to for-profit and not-for-profit organizations in Italy: Social categorization and governance choices. *Public Money & Management*, *44*(2), 156–164.

Mahon, R. (1997). Child care in Canada and Sweden: Policy and politics. *Social Politics: International Studies in Gender, State & Society*, *4*(3), 382–418.

Mahon, R. (2008). Varieties of liberalism: Canadian social policy from the 'golden age' to the present. *Social Policy & Administration*, *42*(4), 342–361.

Mahoney, J. (2007). Qualitative methodology and comparative politics. *Comparative Political Studies*, *40*(2), 122–144.

Mahoney, J., & Thelen, K. (2010). A theory of gradual institutional change. In J. Mahoney & K. Thelen (Eds.), *Explaining institutional change: Ambiguity, agency, and power* (pp. 1–37). Cambridge University Press.

Maioni, A. (1998). *Parting at the crossroads: The emergence of health insurance in the United States and Canada*. Princeton University Press.

Maioni, A., & Marmor, T. R. (2019). Healthcare. In P. J. Quirk (Ed.), *The United States and Canada: How two democracies differ and why it matters*. Oxford University Press.

Mannheim, K. (1940). *Man and society in an age of reconstruction: Studies in modern social structure*. Harcourt, Brace & Company.

Marchildon, G. P. (2021). Social democratic solidarity and the welfare state: Health care and single-tier universality in Sweden and Canada. *Canadian Bulletin of Medical History*, *38*(1), 177–196.

Marchildon, G. P., & O'Byrne, N. C. (2009). From Bennettcare to Medicare: The morphing of Medicare care insurance in British Columbia. *Canadian Bulletin of Medical History*, *26*(2), 453–475.

Marchildon, G. P., & O'Byrne, N. C. (2012). From Bennettcare to Medicare: The morphing of medical care insurance in British Columbia. In G. P. Marchildon (Ed.), *Making Medicare: New perspectives on the history of Medicare in Canada* (pp. 207–228). University of Toronto Press.

Marcuse, H. (1964). *One-dimensional man: Studies in the ideology of advanced industrial society*. Beacon Press.

Marier, P. (2021). *The four lenses of population aging: Planning for the future in Canada's provinces*. University of Toronto Press.

Marier, P., & Séguin, A. M. (2015). Aging and social assistance in the provinces. In D. Béland & P.-M. Daigneault (Eds.), *Welfare reform in Canada: Provincial social assistance in comparative perspective* (pp. 339–352). University of Toronto Press.

Mätzke, M., & Wiß, T. (2017). Paradoxical decisions in German long-term care: Expansion of benefits as a cost-containment strategy. In B. Greve (Ed.), *Long-term care for the elderly in Europe* (pp. 140–158). Routledge.

McDonald, R. A. (2021). *A long way to paradise: A new history of British Columbia politics*. UBC Press.

McFarland, A. S. (2004). *Neopluralism: The evolution of political process theory*. Johns Hopkins University Press.

McFarland, W. D. (1948). *The care of the chronically ill: A survey of the existing facilities and needs of Vancouver* [Doctoral dissertation, University of British Columbia].

McInnis, R. M. (1966). Regional income differentials in Canada, 1911–1961. *The Journal of Economic History*, *26*(4), 586–588.

McPhee, M. E. (1977). *Health care of health: The development of the elements of a plan to address the health needs of the elderly in British Columbia* [Doctoral dissertation, University of British Columbia].

McSwite, O. C. (2004). Creating reality through administrative practice: A psychoanalytic reading of Camilla Stivers' Bureau Men, Settlement Women. *Administration & Society*, *36*(4), 406–426.

Meggs, G., & Mickleburgh, R. (2015). *The art of the impossible: Dave Barrett and the NDP in power, 1972–1975*. Harbour Publishing.

Meibauer, G. (2025). No-fly zones in US foreign policy: Past, present and future. In G. Meibauer (Ed.), *The no-fly zone in US foreign policy* (pp. 135–152). Bristol University Press.

Merton, R. K. (1968). *Social theory and social structure*. Simon and Schuster.

Mishra, R., Laws, G., & Harding, P. (1988). Ontario. In J. S. Ismael & Y. Vaillancourt (Eds.), *Privatization and provincial social services in Canada: Policy, administration and service delivery* (pp. 119–139). University of Alberta Press.

Mitchell, D. (1983). *WAC Bennett and the rise of British Columbia*. Douglas & McIntyre.

Mokoagow, M. S., Sukmana, O., & Yumitro, G. (2026). Max Weber's social action and rationality: An analysis of bureaucracy and rationalization processes in modern organizations. *International Journal of Economics Management and Social Science*, *9*(1), 445–457.

Møller, J. (2013). When one might not see the wood for the trees: The 'historical turn' in democratization studies, critical junctures, and cross-case comparisons. *Democratization*, *20*(4), 693–715.

Monteiro, P., & Adler, P. S. (2022). Bureaucracy for the 21st century: Clarifying and expanding our view of bureaucratic organization. *Academy of Management Annals*, *16*(2), 427–475.

Moran, B. (1992). *A little rebellion*. Arsenal Pulp Press.

Morel, N. (2006). Providing coverage against new social risks in Bismarckian welfare states: The case of long-term care. In K. Armingeon & G. Bonoli (Eds.), *Politics of post-industrial welfare states: Adapting post-war welfare states to new social risks* (pp. 227–247). Routledge.

Morrison, K. (2006). *Marx, Durkheim, Weber: Formations of modern social thought* (2nd ed.). Sage.

Moses, D. V. (1982). Nursing advocacy for the frail elderly. *Journal of Gerontological Nursing*, *8*(3), 144–145.

Myles, J., & Pierson, P. (1997). Friedman's revenge: The reform of "liberal" welfare states in Canada and the United States. *Politics & Society*, *25*(4), 443–472.

Nakrem, S., Vinsnes, A. G., Harkless, G. E., Paulsen, B., & Seim, A. (2009). Nursing sensitive quality indicators for nursing home care: International review of literature, policy and practice. *International Journal of Nursing Studies*, *46*(6), 848–857.

Nekola, M., & Kohoutek, J. (2017). Policy formulation as policy work: Developing options for government. In M. Howlett & I. Mukherjee (Eds.), *Handbook of policy formulation* (pp. 39–62). Edward Elgar Publishing.

Netelenbos, B. (2016). *Political legitimacy beyond Weber: An analytical framework*. Palgrave Macmillan.

Newman, J. (2016). Serving the public? Users, consumers and the limits of NPM. In T. Christensen & P. Lægreid (Eds.), *The Ashgate research companion to new public management*. Routledge.

Novak, W. J. (2022). *New democracy: The creation of the modern American state*. Harvard University Press.

O'Brien, J., Saxberg, B. O., & Smith, H. L. (1983). For-profit or not-for-profit nursing homes: Does it matter? *The Gerontologist*, *23*(4), 341–348.

O'Connor, D. (2005). Almost home: Reforming home and community care in Ontario [Review of the book *Almost home: Reforming home and community care in Ontario*, by P. M. Baranek, R. B. Deber, & A. P. Williams]. *Canadian Public Administration*, *48*(4), 588–591.

O'Connor, J. S., & Olsen, G. M. (1998). *Power resource theory and the welfare state: A critical approach*. University of Toronto Press.

Obinger, H., Castles, F. G., & Leibfried, S. (2005). Introduction: Federalism and the welfare state. In H. Obinger, S. Leibfried, & F. G. Castles (Eds.), *Federalism and the welfare state: New world and European experiences* (pp. 1–50). Cambridge University Press.

Olsen, G. M. (1998). *Locating the Canadian welfare state: Family policy and health care in Canada, Sweden, and the United States*. University of Toronto Press.

Olsen, J. P. (2006). Maybe it is time to rediscover bureaucracy. *Journal of Public Administration Research and Theory*, *16*(1), 1–24.

Olsen, W. K. (2022). *Systematic mixed-methods research for social scientists*. Palgrave Macmillan.

Orloff, A. S. (1993). *The politics of pensions: A comparative analysis of Britain, Canada, and the United States, 1880–1940*. University of Wisconsin Press.

Orsini, A. (2024). *Sociological theory: From Comte to postcolonialism*. Springer Nature.

Osborne, S. P. (2016). Public Governance and Public Services: A 'Brave New World' or New Wine in Old Bottles? In T. Christensen & P. Lægreid (Eds.), *The Ashgate research companion to new public management* (pp. 417-430). Routledge.

Österle, A. (2010). Long-term care in Central and South-Eastern Europe: Challenges and perspectives in addressing a 'new' social risk. *Social Policy & Administration*, *44*(4), 461–480.

Österle, A. (2011). Long-term care in Central and South-Eastern Europe: Challenges and perspectives in addressing a 'new' social risk. In J. Costa-Font (Ed.), *Reforming long-term care in Europe* (pp. 103–122). Wiley-Blackwell.

Österle, A. (2017). *Equity choices and long-term care policies in Europe: Allocating resources and burdens in Austria, Italy, the Netherlands and the United Kingdom*. Routledge.

Österle, A. (2024). Long-term care. In M. Powell, T. I. Agartan, & D. Béland (Eds.), *Research handbook on health care policy* (pp. 191–207). Edward Elgar Publishing.

Österle, A., & Rothgang, H. (2012). Long-term care. In F. G. Castles, S. Leibfried, J. Lewis, H. Obinger, & C. Pierson (Eds.), *The Oxford handbook of the welfare state* (pp. 326–336). Oxford University Press.

Ostry, A. S. (2006). *Change and continuity in Canada's health care system*. CHA Press.

Pahl-Wostl, C., Basurto, X., & Villamayor-Tomas, S. (2021). Comparative case study analysis. In *The Routledge handbook of research methods for social-ecological systems* (pp. 282–294). Routledge.

Panet, P. D. L., & Trebilcock, M. J. (1998). Contracting-out social services. *Canadian Public Administration*, *41*(1), 21–50.

Park, D. C., & Wood, J. D. (1992). Poor relief and the county house of refuge system in Ontario, 1880–1911. *Journal of Historical Geography*, *18*(4), 439–455.

Patterson, P. B., Weinberg, T., McRae, S., Pollack, C., & Dutton, D. (2023). Long-term care staffing policies pre-COVID-19 and pandemic responses: A case comparison of Ontario and British Columbia. *Canadian Public Policy*, *49*(1), 94–113.

Pautz, H. (2020). Think tanks and policymaking. In W. R. Thompson (Ed.), *Oxford research encyclopedia of politics*. Oxford University Press.

Pavolini, E., & Ranci, C. (2013). Reforms in long-term care policies in Europe: An introduction. In C. Ranci & E. Pavolini (Eds.), *Reforms in long-term care policies in Europe: Investigating institutional change and social impacts* (pp. 3–22). Springer.

Peeters, R. (2020). The political economy of administrative burdens: A theoretical framework for analyzing the organizational origins of administrative burdens. *Administration & Society*, *52*(4), 566–592.

Perna, R., & Moreno, L. (2025). Welfare regimes and long-term care in the 'Old Continent'. In *Long-term care and older people in Western Europe* (pp. 24–34). Policy Press.

Peters, B. G. (1999). *Institutional theory in political science: The new institutionalism*. Edward Elgar Publishing.

Peters, B. G. (2001). *The politics of bureaucracy* (5th ed.). Routledge.

Peters, B. G., & Pierre, J. (Eds.). (2012). *The SAGE Handbook of Public Administration*. SAGE.

Pfau-Effinger, B., & Rostgaard, T. (2011). Introduction: Tensions related to care in European welfare states. In B. Pfau-Effinger & T. Rostgaard (Eds.), *Care between work and welfare in European societies* (pp. 1–14). Palgrave Macmillan.

Pfau-Effinger, B., & Rostgaard, T. (2011a). Welfare-state change, the strengthening of economic principles, and new tensions in relation to care. *Nordic Journal of Social Research*, *2*(1), 1–6.

Pfau-Effinger, B., & Theobald, H. (2025). The changing relationship between formal and informal care work. In C. Ranci & T. Rostgaard (Eds.), *Research handbook on social care policy* (pp. 250–261). Edward Elgar Publishing.

Pfiffner, J. P. (1987). Political appointees and career executives: The democracy-bureaucracy nexus in the third century. *Public Administration Review*, *47*(1), 57–65.

Philpott, D. (1996). The possibilities of ideas [Review essay]. *Security Studies*, *5*(4), 183–196.

Pieper, R., Sixsmith, A., & Vaarama, M. (Eds.). (2008). *Care-related quality of life in old age: Concepts, models, and empirical findings*. Springer.

Pierson, P. (1994). *Dismantling the welfare state? Reagan, Thatcher and the politics of retrenchment*. Cambridge University Press.

Pierson, P. (1995). Fragmented welfare states: Federal institutions and the development of social policy. *Governance*, *8*(4), 449–478.

Pierson, P. (1996). The new politics of the welfare state. *World Politics*, *48*(2), 143–179.

Pierucci, A. F. (2000). Secularization in Max Weber. *Brazilian Review of Social Sciences*, (1), 129–158.

Pinch, S. (2002). *Worlds of welfare: Understanding the changing geographies for social welfare provision*. Routledge.

Pitters, S. (1995). Long-term care facilities. In E. Sawyer & M. Stephenson (Eds.), *Continuing the care: The issues and challenges for long-term care* (pp. 1–20). CHA Press.

Poletti, A. (2012). *The European Union and multilateral trade governance: The politics of the Doha Round*. Routledge.

Pontusson, J. (2005). *Inequality and prosperity: Social Europe vs. liberal America*. Cornell University Press.

Poocharoen, O. O. (2012). Bureaucracy and the policy process. In B. G. Peters & P. Zittoun (Eds.), *Routledge handbook of public policy* (pp. 331–346). Routledge.

Powell, W. W. (2020). What is the nonprofit sector? In W. W. Powell & P. Bromley (Eds.), *The nonprofit sector: A research handbook* (pp. 3–23). Stanford University Press.

Prentice, C. R., & Brudney, J. L. (2015). Contracting with nonprofit organizations. In K. J. Meier & L. J. O'Toole (Eds.), *Government contracting* (pp. 75–95). Routledge.

Prince, M. J. (1996). At the edge of Canada's welfare state: Social policy-making in British Columbia. In R. K. Carty (Ed.), *Politics, policy, and government in British Columbia* (pp. 236–271). UBC Press.

Rademacher, Y. (2011). Outcontracting in emergency management: More than a business conundrum. *International Journal of Disaster Risk Science*, *2*(4), 15–21.

Ranci, C. (2002). The mixed economy of social care in Europe. In U. Ascoli & C. Ranci (Eds.), *Dilemmas of the Welfare Mix: The New Structure of Welfare in an Era of Privatization* (pp. 25-45). Boston, MA: Springer US.

Ranci, C., & Pavolini, E. (Eds.). (2013). *Reforms in long-term care policies in Europe*. Springer.

Ranci, C., & Pavolini, E. (2015). Not all that glitters is gold: Long-term care reforms in the last two decades in Europe. *Journal of European Social Policy*, *25*(3), 270–285.

Ranci, C., & Rostgaard, T. (2025). Social care policy in the twenty-first century: An introduction. In C. Ranci & T. Rostgaard (Eds.), *Research handbook on social care policy* (pp. 1–19). Edward Elgar Publishing.

Rantz, M. J., Mehr, D. R., Petroski, G. F., Madsen, R. W., Popejoy, L. L., Hicks, L. L., … Maas, M. (2000). Initial field testing of an instrument to measure: Observable indicators of nursing home care quality. *Journal of Nursing Care Quality*, *14*(3), 1–12.

Rayner, J. (2015). Is there a fourth institutionalism? Ideas, institutions and the explanation of policy change. In J. Hogan & M. Howlett (Eds.), *Policy paradigms in theory and practice: Discourses, ideas and anomalies in public policy dynamics* (pp. 61–80). Palgrave Macmillan.

Rea, K. J. (1985). *The prosperous years: The economic history of Ontario, 1939–1975*. University of Toronto Press.

Reid, R. (1998). Young, Henry Esson. In *Dictionary of Canadian biography* (Vol. 16). University of Toronto/Université Laval.

Reilly, R. C. (2010). Process tracing. In A. J. Mills, G. Durepos, & E. Wiebe (Eds.), *Encyclopedia of case study research* (Vol. 2, pp. 741–745). Sage.

Rekart, J. (1993). *Public funds, private provision: The role of the voluntary sector*. UBC Press.

Remuss, N. L. (2018). *Theorising institutional change: The impact of the European integration process on the development of space activities in Europe*. Springer.

Ritzer, G. (1996). *Classical sociological theory* (2nd ed.). McGraw-Hill.

Roberts, W. (1994). *Don't call me servant: Government work and unions in Ontario 1911–1984*. Ontario Public Service Employees Union.

Rodrigues, R. (2017). Evaluating long-term care policies: Challenges and advancements. In B. Greve (Ed.), *Handbook of social policy evaluation* (pp. 323–340). Edward Elgar Publishing.

Rodriquez, J. (2014). *Labors of love: Nursing homes and the structures of care work*. NYU Press.

Rohlfing, I. (2012). *Case studies and causal inference: An integrative framework*. Palgrave Macmillan.

Rosenthal, S. (1999). [Review of the book *Caring for profit: How corporations are taking over Canada's health care system*, by C. Fuller]. *Labour / Le Travail*, (43), 246–248.

Rosenfeld, G. B. (1969). Critical review of fiscal and administrative controls on cost and use in Canada. *Medical Care*, *7*(6), 50–58.

Rothgang, H. (2010). Social insurance for long-term care: An evaluation of the German model. *Social Policy & Administration*, *44*(4), 436–460.

Rothstein, B. (1998). *Just institutions matter: The moral and political logic of the universal welfare state*. Cambridge University Press.

Roux, T. (2018). *The politico-legal dynamics of judicial review: A comparative analysis*. Cambridge University Press.

Rueschemeyer, D., & Skocpol, T. (Eds.). (1996). *States, social knowledge, and the origins of modern social policies*. Princeton University Press.

Salamon, L. M. (1987). Partners in public service: Government and the nonprofit sector in the American welfare state. In W. W. Powell (Ed.), *The nonprofit sector: A research handbook* (pp. 99–117). Yale University Press.

Sanders, E. (2008). Historical institutionalism. In S. A. Binder, R. A. W. Rhodes, & B. A. Rockman (Eds.), *The Oxford handbook of political institutions* (pp. 39–55). Oxford University Press.

Sangl, J., Saliba, D., Gifford, D. R., & Hittle, D. F. (2005). Challenges in measuring nursing home and home health quality: Lessons from the first National Healthcare Quality Report. *Medical Care*, *43*(3 Suppl.), I-24–I-32.

Sassoon, A. S. (1987). Women's new social role: Contradictions of the welfare state. In A. S. Sassoon (Ed.), *Women and the state: The shifting boundaries of public and private* (pp. 158–188). Hutchinson.

Sawyer, E., & Stephenson, M. (Eds.). (2002). *Continuing the care: The issues and challenges for long-term care*. CHA Press.

Schmidt, V. A. (1996). *From state to market?: The transformation of French business and government*. Cambridge University Press.

Schmidt, V. A. (2012). Discursive institutionalism: Scope, dynamics, and philosophical underpinnings. In F. Fischer & H. Gottweis (Eds.), *The argumentative turn revisited: Public policy as communicative practice* (pp. 85–113). Duke University Press.

Schneider, S. K., & Jacoby, W. G. (1996). Influences on bureaucratic policy initiatives in the American states. *Journal of Public Administration Research and Theory*, *6*(4), 495–522.

Schreurs, P. (2002). Symposium: Rationality and public administration: Introduction. *Administrative Theory & Praxis*, *24*(2), 279–286.

Scully, D. (1985, November). History of nursing homes in Ontario. *Ontario Nursing Home Journal*, *1*, 22–25.

Shafran, J. S. (2022). More than agents: Federal bureaucrats as information suppliers in policymaking. *Policy Studies Journal*, *50*(4), 921–943.

Shapiro, E. (1994). Community and long-term health care in Canada. In Å. Blomqvist & D. M. Brown (Eds.), *Limits to care: Reforming Canada's health system in an age of restraint* (pp. 327–362). C.D. Howe Institute.

Shapiro, E. (2000). Community and long-term facility care in Canada. *Journal of Health and Human Services Administration*, *23*(4), 436–451.

Shaver, S. (2019). Gender issues in welfare states. In B. Greve (Ed.), *The Routledge handbook of the welfare state* (2nd ed., pp. 81–91). Routledge.

Sheridan, J. E., White, J., & Fairchild, T. J. (1992). Ineffective staff, ineffective supervision, or ineffective administration? Why some nursing homes fail to provide adequate care. *The Gerontologist*, *32*(3), 334–341.

Shoyama, T. K. (1966). Public services and regional development in Canada. *The Journal of Economic History*, *26*(4), 498–513.

Sikkink, K. (1997). Development ideas in Latin America. In F. Cooper & R. Packard (Eds.), *International development and the social sciences: Essays on the history and politics of knowledge* (pp. 228–256). University of California Press.

Simeon, R., & Robinson, I. (1990). *State, society, and the development of Canadian federalism*. University of Toronto Press.

Skocpol, T. (2008). Bringing the state back in: Retrospect and prospect the 2007 Johan Skytte prize lecture. *Scandinavian Political Studies*, *31*(2), 109–124.

Skocpol, T., & Amenta, E. (1986). States and social policies. *Annual Review of Sociology*, *12*(1), 131–157.

Smyrl, M., & Genieys, W. (2016). *Elites, ideas, and the evolution of public policy*. Palgrave Macmillan.

Snyder, R. (2001). Scaling down: The subnational comparative method. *Studies in Comparative International Development*, *36*(1), 93–110.

Soroka, S. N., & Wlezien, C. (2010). *Degrees of democracy: Politics, public opinion, and policy*. Cambridge University Press.

Stefes, C. H. (2019). Historical institutionalism and societal transformations. In R. Merkel, K. Kollmorgen, & H.-J. Wagener (Eds.), *The handbook of political, social, and economic transformations* (pp. 95–105). Oxford University Press.

Steinmo, S. (2008). Historical institutionalism. In D. della Porta & M. Keating (Eds.), *Approaches and methodologies in the social sciences: A pluralist perspective* (pp. 150–178). Cambridge University Press.

Stensöta, H. O. (2010). The conditions of care: Reframing the debate about public sector ethics. *Public Administration Review*, *70*(2), 295–303.

Stensöta, H. O. (2015). Public ethics of care—A general public ethics. *Ethics and Social Welfare*, *9*(2), 183–200.

Stivers, C. (1993). *Gender images in public administration: Legitimacy and the administrative state*. Sage.

Stivers, C. (1995). Settlement women and bureau men: Constructing a usable past for public administration. *Public Administration Review*, *55*(6), 522–529.

Stivers, C. (2000). *Bureau men, settlement women: Constructing public administration in the progressive era*. University Press of Kansas.

Strauss, K. (2021). Beyond crisis? Using rent theory to understand the restructuring of publicly funded seniors' care in British Columbia, Canada. *Environment and Planning A: Economy and Space*, *53*(5), 1087–1105.

Strauss, S., & Trommer, K. (2018). Productive ageing regimes in Europe: Welfare state typologies explaining elderly Europeans' participation in paid and unpaid work. *Journal of Population Ageing*, *11*(4), 311–328.

Streeck, W., & Thelen, K. (2005). Introduction: Institutional change in advanced political economies. In W. Streeck & K. Thelen (Eds.), *Beyond continuity: Institutional change in advanced political economies* (pp. 1–39). Oxford University Press.

Struthers, J. (1997). Reluctant partners: State regulation of private nursing homes in Ontario, 1941–72. In R. Blake, P. Bryden, & J. F. Strain (Eds.), *The welfare state in Canada: Past, present and future* (pp. 171–192). Irwin Publishing.

Struthers, J. (2017). Home, hotel, hospital, hospice: Conflicting images of long-term residential care in Ontario, Canada. In S. Chivers & U. Kriebernegg (Eds.), *Care home stories: Aging, disability, and long-term residential care* (pp. 283–302). transcript: Verlag.

Tannenwald, N. (2005). Ideas and explanation: Advancing the theoretical agenda. *Journal of Cold War Studies*, *7*(2), 13–42.

Tarman, V. I. (1987). *Looking behind the rhetoric: A political economic history of Ontario's commercial nursing homes 1958–1987* [Unpublished master's thesis]. University of Toronto.

Tarman, V. I. (1988). Ontario nursing home policy in the 1980's: Good news or no news? *Canadian Review of Social Policy*, (22), 61–68.

Tarman, V. I. (1990). *Privatization and health care: The case of Ontario nursing homes*. Garamond Press.

TenHouten, W. D. (2012). A neurosociological model of Weberian, instrumental rationality: Its cognitive, conative, and neurobiological foundations. In D. D. Franks & J. H. Turner (Eds.), *Handbook of neurosociology* (pp. 207–230). Springer.

Theobald, H., & Hampel, S. (2013). Radical institutional change and incremental transformation: Long-term care insurance in Germany. In C. Ranci & E. Pavolini (Eds.), *Reforms in long-term care policies in Europe: Investigating institutional change and social impacts* (pp. 117–138). Springer.

Titmuss, R. M. (1958). *Essays on the welfare state*. Allen & Unwin.

Todorovic, M. (2016). *Rethinking strategy for creative industries: Innovation and interaction*. Routledge.

Torgerson, D. (2011). Policy problems and democratic politics: Instrumental rationality reconsidered. In M. Orsini & M. Smith (Eds.), *Social science and policy challenges: Democracy, values and capacities* (pp. 57–93). UNESCO.

Tribe, L. H. (1972). Policy science: Analysis or ideology? *Philosophy & Public Affairs*, *2*(1), 66–110.

Tribe, L. H. (1973). Technology assessment and the fourth discontinuity. *Southern California Law Review*, *46*, 617–660.

Tronto, J. C. (2019). Creating caring institutions: Politics, plurality, and purpose. In V. Held (Ed.), *Care ethics* (pp. 51–64). Routledge.

Tuohy, C. H. (1999). *Accidental logics: The dynamics of change in the health care arena in the United States, Britain, and Canada*. Oxford University Press.

Tuohy, C. H. (1999a). Dynamics of a changing health sphere: The United States, Britain, and Canada. *Health Affairs*, *18*(3), 114–134.

Tuohy, C. H. (2017). *Policy change as political strategy* [Conference paper]. APSA.

Tuohy, C. H. (2018). What's Canadian about Medicare? A comparative perspective on health policy. *Healthcare Policy*, *13*(4), 11–19.

Tuohy, C. H. (2018b). *Remaking policy: Scale, pace, and political strategy in health care reform*. University of Toronto Press.

Tuohy, C. H. (2020). *A new federal framework for long-term care in Canada*. Policy Options.

Turgeon, L. (2010). *Tax, time and territory: The development of early childhood education and child care in Canada and Great Britain* [Doctoral dissertation, University of Edinburgh].

Turgeon, L. (2014). Critical junctures, feedback effects and constitutional change: Quebec and Wallonia in comparative perspective. In M. Seymour & A.-G. Gagnon (Eds.), *Minority nations in multinational federations* (pp. 13–31). Routledge.

Ullmann, S. G. (1987). Ownership, regulation, quality assessment, and performance in the long-term health care industry. *The Gerontologist*, *27*(2), 233–239.

Urban, P. (2020). Organizing the caring society: Toward a care ethical perspective on institutions. In P. Urban & L. Ward (Eds.), *Care ethics, democratic citizenship and the state* (pp. 277–306). Springer International Publishing.

Urban, P. (2025). *Care ethics and public administration* (Vol. 335). Bloomsbury Publishing.

Urban, P., & Ward, L. (2020). Introducing the contexts of a moral and political theory of care. In P. Urban & L. Ward (Eds.), *Care ethics, democratic citizenship and the state* (pp. 1–27). Springer International Publishing.

Vabo, S. I. (2010). Actors and governance arrangements in long-term care for older people. In Y. Kazepov (Ed.), *Rescaling social policies: Towards multilevel governance in Europe* (pp. 343–363). Ashgate.

van Damme, M., & Spijker, J. (2023). *Country differences in long-term care institutions: Towards a care regime typology* [Preprint]. Center for Cabinet Science.

van Damme, M., Spijker, J., & Pavlopoulos, D. (2025). A care regime typology of elder, long-term care institutions. *European Journal of Ageing*, *22*(1), Article 20.

Van de Walle, S. (2016). NPM: Restoring the public trust through creating distrust?. In T. Christensen & P. Lægreid (Eds.), *The Ashgate research companion to new public management* (pp. 309-320). Routledge.

Van Kersbergen, K., & Vis, B. (2014). Toward an open functional approach to welfare state reform. In *Comparative welfare state politics: Development, opportunities, and reform* (pp. 103–122). Cambridge University Press.

Van Slyke, D. (2003). The mythology of privatization in contracting for social services. *Public Administration Review*, *63*(3), 296–315.

Van Slyke, D. (2007). Agents or stewards: Using theory to understand the government-nonprofit social service contracting relationship. *Journal of Public Administration Research and Theory*, *17*(2), 157–187.

Verhoest, K. (2016). The relevance of culture for NPM. In T. Christensen & P. Lægreid (Eds.), *The Ashgate research companion to new public management* (pp. 47-63). Routledge.

Vicente, J., McKee, K. J., Magnusson, L., Johansson, P., Ekman, B., & Hanson, E. (2022). Informal care provision among male and female working carers: Findings from a Swedish national survey. *PLoS ONE*, *17*(3), e0263396.

Vincent, A. (2013). Conceptions of the state. In M. Hawkesworth & M. Kogan (Eds.), *Encyclopedia of government and politics* (pp. 39–53). Routledge.

Waerness, K. (1984). The rationality of caring. *Economic and Industrial Democracy*, *5*(2), 185–211.

Waldner, D. (2015). What makes process tracing good? Causal mechanisms, causal inference, and the completeness standard in comparative politics. In A. Bennett & J. T. Checkel (Eds.), *Process tracing: From metaphor to analytic tool* (pp. 126–152). Cambridge University Press.

Wallner, J. (2010). Beyond national standards: Reconciling tension between federalism and the welfare state. *Publius: The Journal of Federalism*, *40*(4), 646–671.

Wallner, J. (2014). *Learning to school: Federalism and public schooling in Canada*. University of Toronto Press.

Wallner, J., Savage, G. C., Hartong, S., & Engel, L. C. (2020). Laboratories, coproducers, and venues: Roles played by subnational governments in standards-based reforms in four federations. *Comparative Education Review*, *64*(2), 249–268.

Walsh, J. I. (2000). When do ideas matter? Explaining the successes and failures of Thatcherite ideas. *Comparative Political Studies*, *33*(4), 483–516.

Warburton, J., & Jeppsson Grassman, E. (2011). Variations in older people's social and productive ageing activities across different social welfare regimes. *International Journal of Social Welfare*, *20*(2), 180–191.

Wayman, A., Alexander, S., & Shields, P. M. (2022). Women in Texas local government: The road to city manager. In E. M. Witesman & C. Wise (Eds.), *Handbook on gender and public administration* (pp. 302–316). Edward Elgar Publishing.

Weber, M. (1922/1978). *Economy and society: An outline of interpretive sociology* (G. Roth & C. Wittich, Eds.). University of California Press.

Weber, M. (1991/1994). The profession and vocation of politics. In P. Lassman & R. Speirs (Eds. & Trans.), *Weber: Political writings* (pp. 309–369). Cambridge University Press.

Weir, M., & Skocpol, T. (1985). State structures and the possibilities for 'Keynesian' responses to the Great Depression in Sweden, Britain, and the United States. In P. B. Evans, D. Rueschemeyer, & T. Skocpol (Eds.), *Bringing the state back in* (pp. 107–163). Cambridge University Press.

Weissert, W. (2008). Long-term care politics and policy. In L. Olson (Ed.), *Handbook of long-term care administration and policy* (pp. 343–362). Routledge.

White, L. A., Davidson, A., Millar, H., Pandy, M., & Yi, J. (2015). Policy logics, framing strategies, and policy change: Lessons from universal pre-K policy debates in California and Florida. *Policy Sciences*, *48*(4), 395–413.

White, R. (2016). *Financing the Golden Age: Municipal finance in Toronto, 1950 to 1975*. Institute on Municipal Finance and Governance.

Widmaier, W. (2016). The power of economic ideas–through, over and in–political time: The construction, conversion and crisis of the neoliberal order in the US and UK. *Journal of European Public Policy*, *23*(3), 338–356.

Wilensky, H. L., & Lebeaux, C. N. (1965). *Industrial society and social welfare: The impact of industrialization on the supply and organization of social welfare services in the United States*. Free Press.

Williams, A. P., Barnsley, J., Leggat, S., Deber, R., & Baranek, P. (1999). Long-term care goes to market: Managed competition and Ontario's reform of community-based services. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, *18*(2), 125–153.

Williamson, O. E. (1981). The economics of organization: The transaction cost approach. *American Journal of Sociology*, *87*(3), 548–577.

Williamson, O. E. (1985). *The economic institutions of capitalism: Firms, markets, relational contracting*. Free Press.

Williamson, O. E. (2008). The economic institutions of capitalism. In T. A. Bogart & M. J. Jensen (Eds.), *The political economy reader: Markets as institutions* (pp. 27–42). Routledge.

Witesman, E. M. (2024). Nonprofits as distributors of toll goods. In E. M. Witesman (Ed.), *Reimagining nonprofits: Sector theory in the twenty-first century* (pp. 372–390). Cambridge University Press.

Witesman, E. M., & Fernandez, S. (2013). Government contracts with private organizations: Are there differences between nonprofits and for-profits? *Nonprofit and Voluntary Sector Quarterly*, *42*(4), 689–715.

Wong, E. K., Thorne, T., Estabrooks, C., & Straus, S. E. (2021). Recommendations from long-term care reports, commissions, and inquiries in Canada. *F1000Research*, *10*, Article 893.

Workman, S. (2015). *The dynamics of bureaucracy in the US government: How Congress and federal agencies process information and solve problems*. Cambridge University Press.

Wu, X., Ramesh, M., & Howlett, M. (2015). Policy capacity: A conceptual framework for understanding policy competences and capabilities. *Policy and Society*, *34*(3–4), 165–171.

Yanow, D. (1996). *How does a policy mean? Interpreting policy and organizational actions*. Georgetown University Press.

Yeatman, A. (2020). *Bureaucrats, technocrats, femocrats: Essays on the contemporary Australian state*. Routledge.

Young, D. R. (2000). Alternative models of government-nonprofit sector relations: Theoretical and international perspectives. *Nonprofit and Voluntary Sector Quarterly*, *29*(1), 149–172.

Zijderveld, A. (2018). *The waning of the welfare state*. Routledge.

Zuberi, D. (2006). *Differences that matter: Social policy and the working poor in the United States and Canada*. Cornell University Press.

Policy and Institutional Reports

Canadian Association for Long Term Care. (2024). *Canada's other housing crisis*.

Canadian Centre for Caregiving Excellence. (2022). *Canadian caregivers are at a breaking point*.

Canadian Healthcare Association (CHA). (2009). *Homecare in Canada: From the margins to the mainstream*. https://www.healthcarecan.ca

Canadian Institute for Health Information. (n.d.). *Long-term care*. https://www.cihi.ca/en/topics/long-term-care

Canadian Institute for Health Information. (2018). *Selecting pan-Canadian indicators for access to mental health and addiction services, and to home and community care: Progress report*. CIHI.

Canadian Institute for Health Information. (CIHI). (2020). *Pandemic experience in the long-term care sector: How does Canada compare with other countries?* CIHI.

Canadian Institute for Health Information. (2021). *The impact of COVID-19 on long-term care in Canada*. CIHI.

Canadian Labour Congress. (2020). *Lessons from a pandemic*.

Canadian Medical Association. (1984). *Health: A need for redirection: A task force on the allocation of healthcare resources*. CMA.

Canadian Medical Association. (2016). *The state of seniors health care in Canada*.

Eales, J., Fast, J., Duncan, K., & Keating, N. (2022). *Value of family caregiving in Canada* [Infographic].

European Commission. (2018). *The 2018 ageing report*.

European Commission & Social Protection Committee. (2021). *Long-term care report* (Vol. 1).

Fairstone. (2025, November 20). *The real cost of long-term care in Canada*. https://www.fairstone.ca/en/learn/budgeting-and-saving/how-much-does-long-term-care-cost

Gabel, T., Clemens, J., & LeRoy, S. (2004). *Welfare reform in Ontario: A report card*. Fraser Institute.

Golant, S. M. (2001). *Assisted living: A potential solution to Canada's long term care crisis*. SFU Gerontology Research Centre.

Grages, C., Eggers, T., & Pfau-Effinger, B. (2021). *Long-term care regimes in Europe*. EUROSHIP Working Paper No. 6. Oslo Metropolitan University.

Hospital Employees' Union. (2009, January). *Quality of care in B.C.'s residential care facilities: A submission to the Office of the B.C. Ombudsman on seniors' care*. Hospital Employees' Union.

Hospital Employees' Union. (2012). *HEU calls for overhaul of hospital cleaning audits*.

Huber, M., Rodrigues, R., Hoffmann, F., Gasior, K., & Marin, B. (2009). *Facts and figures on long-term care*. European Centre.

Kalavrezou, N., Pot, M., Kadi, S., Simmons, C., & Leichsenring, K. (2025). *Facts and figures on healthy ageing and long-term care*. European Centre for Social Welfare Policy and Research: Vienna, Austria.

McGregor, M. J., & Ronald, L. A. (2011). *Residential Long-Term Care for Seniors*. CCPA.

National Institute on Ageing. (2019). *Enabling the future provision of long-term care in Canada* [White paper].

OECD. (2005). *The OECD health project: Long-term care for older people*. OECD Publishing.

OECD. (2011). *Help wanted? Providing and paying for long-term care*. OECD Publishing.

OECD. (2013a). *A good life in old age? Monitoring and improving quality in long-term care*. OECD Publishing.

OECD. (2013b). *We must take better care of the elderly, say OECD and the European Commission*. https://www.oecd.org/newsroom/we-must-take-better-care-of-the-elderly-say-oecd-and-the-european-commission.htm

OECD. (2020). *Assessing the Comparability of Long-Term Care Spending Estimates*.

OECD. (2021). *Rising from the COVID-19 crisis*.

OECD. (2023). *Beyond Applause? Improving Working Conditions in Long-Term Care*.

Office of the Chief Science Advisor. (2020, October 29). *Long-term care and COVID-19*. Government of Canada.

Office of the Veterans Ombudsman. (2013). *Transitioning to civilian life*. Veterans Affairs Canada.

Office of the Veterans Ombudsman. (2017). *Continuum of Care*. Veterans Affairs Canada.

Ontario Nurses' Association. (1984). *Care of the elderly: A new agenda*.

Rocard, E., Sillitti, P., & Llena-Nozal, A. (2021). *COVID-19 in long-term care: Impact, policy responses and challenges* (OECD Health Working Papers No. 131). OECD Publishing.

Saskatchewan Population Health and Evaluation Research Unit. (2017). *Home care in Canada: An environmental scan: Supporting healthy aging in place*.

Service Employees International Union [SEIU]. (2025). *History of SEIU Healthcare*.

Shapiro, E. (1997). *The cost of privatization: A case study of home care in Manitoba*. Canadian Centre for Policy Alternatives.

Silversides, A. (2011). *Long-term care in Canada: Status quo no option*. Canadian Federation of Nurses Unions.

Stinson, J., Pollak, N., & Cohen, M. (2005). *The pains of privatization*. CCPA.

World Health Organization. (2002). *Ethical choices in long-term care: What does justice require?* WHO.

World Health Organization. (2024). *State of long-term care: conceptual framework for assessment and continuous learning in long-term care systems* (No. WHO/EURO: 2024-10363-50135-75508 (PDF)). World Health Organization. Regional Office for Europe.

Government & Stakeholder Reports and Publications

Ontario Government & Stakeholder Reports and Publications

Association of Municipalities of Ontario. (2011). *Coming of Age: The Municipal Role in Caring for Ontario's Seniors*.

City of Toronto. (2001). *Report on a study to review the levels of service and responses to need in a sample of Ontario long-term care facilities and selected comparators*.

City of Toronto. (2009). *Long-Term Care system challenges and opportunities for the City of Toronto*.

The Community Information Centre of Metropolitan Toronto. (1983). *Homes for the aged in Metropolitan Toronto*.

Department of Public Welfare. (1953). *Annual report*. Government of Ontario.

Department of Public Welfare. (1954). *Annual report*. Government of Ontario.

Department of Public Welfare. (1955). *Annual report*. Government of Ontario.

Department of Public Welfare. (1956). *Annual report*. Government of Ontario.

Department of Public Welfare. (1957). *Annual report*. Government of Ontario.

Department of Public Welfare. (1958). *Annual report*. Government of Ontario.

Department of Social and Family Services. (1972). *1971-72 annual report*. Government of Ontario.

First Ontario Conference on Aging. (1957). *Aging is everyone's concern: The proceedings of the First Ontario Conference on Aging held at University of Toronto May 31st–June 3rd, 1957*. University Extension, University of Toronto.

Health Services Restructuring Commission. (1997). *Rebuilding Ontario's health system: Interim planning guidelines and implementation strategies: Home care, long term care, mental health, rehabilitation, sub-acute care: A discussion paper, July 1997*. Health Services Restructuring Commission.

Lightman, E. S. (1992). *A community of interests* [Commission report]. Queen's Printer for Ontario.

Ministry of Community and Social Services Statistical Supplement. (1973). *42nd annual report for the fiscal year ending March, 1973*. Government of Ontario.

Ministry of Health. (1982). *Annual report*. Government of Ontario.

Ontario Budget. (1981). *Ontario Budget 1981*. Government of Ontario.

Ontario Council of Health. (1977). *A report of the Ontario Council of Health: The distribution of hospital and nursing home beds in Metropolitan Toronto*.

Ontario Health Survey. (1950). *Report of the Ontario Health Survey Committee*. Government of Ontario.

Ontario Ministry of Community and Social Services. (1984). *Decades of service: A history of the Ontario Ministry of Community and Social Services, 1930-1980*. Government of Ontario.

Ontario Welfare Council. (1959). *Proceedings: Conference on nursing homes*.

Ontario Welfare Council. (1965). *Study of nursing home facilities in Ontario: 1964-65*.

Riedel, M., & Kraus, M. (2011). *The organisation of formal long-term care for the elderly: Results from the 21 European country studies in the ANCIEN project* (ENEPRI Research Report No. 95). European Network of Economic Policy Research Institutes.

Social Planning Council of Metropolitan Toronto. (1963). *Report of study committee on homes for the aged Part I & II*. Toronto, Ontario.

Social Planning Council (1984). Privatization project committee. *Caring for Profit: The Commercialization of Human Services in Ontario*.

Ontario Legislative Records

Ontario Legislative Assembly. (1972, February 29). *Hansard transcript* (29th Legislature, 2nd Session). ola.org

Ontario Legislative Assembly. (1975, March 26). *Hansard transcript* (29th Parliament, 5th Session). ola.org

British Columbia Government & Stakeholder Reports and Publications

B.C. Department of Health. (1976). *Annual report, 1976*. Government of British Columbia.

B.C. Department of Health and Welfare. (1954). *Annual report of the Social Welfare Branch of the Department of Health and Welfare for the year ended March 31st 1954*. Government of British Columbia.

B.C. Department of Social Welfare. (1962). *Annual report of the Department of Social Welfare for the year ended March 31, 1962*. Government of British Columbia.

B.C. Hospital Amendment Act. (1913). Chapter 30: An Act to Amend the "Hospital Act".

B.C. Ministry of Health. (1970). *Annual report*. Queen's Printer.

B.C. Ministry of Health. (1977). *Annual report*. Government of British Columbia.

B.C. Ministry of Health. (1980). *Annual report*. Government of British Columbia.

B.C. Ministry of Health. (2001). *Ministry of Health planning information briefing note*. Government of British Columbia.

B.C. Ministry of Human Resources. (1976). *Services for people: Annual report*. Government of British Columbia.

B.C. Provincial Board of Health. (1913a). *Sixteenth annual report, Provincial Board of Health, nine months ended March 31st, 1913*. Government of British Columbia.

B.C. Provincial Board of Health. (1913b). *Seventeenth annual report, Provincial Board of Health, nine months ended December 31st, 1913*. Government of British Columbia.

B.C. Provincial Board of Health. (1915a). *Eighteenth annual report, Provincial Board of Health for the Province of British Columbia*. Government of British Columbia.

B.C. Provincial Board of Health. (1915b). *Nineteenth annual report, Provincial Board of Health for the Province of British Columbia*. Government of British Columbia.

B.C. Provincial Board of Health. (1916a). *Twentieth report, Provincial Board of Health for the Province of British Columbia*. Government of British Columbia.

B.C. Provincial Board of Health. (1917a). *Twenty-first annual report, Provincial Board of Health for the Province of British Columbia*. Government of British Columbia.

B.C. Provincial Board of Health. (1918a). *Twenty-second annual report of the Provincial Board of Health*. Government of British Columbia.

B.C. Provincial Board of Health. (1919a). *Twenty-third annual report of the Provincial Board of Health*. Government of British Columbia.

B.C. Provincial Board of Health. (1931a). *Thirty-fifth annual report of the Provincial Board of Health*. Government of British Columbia.

B.C. Public Health Services. (1972). *Annual report*. Government of British Columbia.

B.C. Public Health Services. (1973). *Annual report*. Government of British Columbia.

B.C.H.I.S. (1952). *Fourth annual report, British Columbia Hospital Insurance Service, January 1 to December 31, 1952*. Government of British Columbia.

B.C.H.I.S. (1953). *Fifth annual report, B.C. Hospital Insurance Service: January 1st to December 31st 1953*. Government of British Columbia.

B.C.H.I.S. (1954). *Sixth annual report, British Columbia Hospital Insurance Service, January 1 to December 31, 1954*. Government of British Columbia.

B.C.H.I.S. (1955). *Seventh annual report, British Columbia Hospital Insurance Service, January 1 to December 31, 1955*. Government of British Columbia.

B.C.H.I.S. (1956). *Eighth annual report, British Columbia Hospital Insurance Service, January 1 to December 31, 1956*. Government of British Columbia.

B.C.H.I.S. (1957). *Ninth annual report, British Columbia Hospital Insurance Service, January 1 to December 31, 1957*. Government of British Columbia.

B.C.H.I.S. (1960). *Twelfth annual report, British Columbia Hospital Insurance Service, January 1 to December 31, 1960*. Government of British Columbia.

B.C.H.I.S. (1961). *Thirteenth annual report, British Columbia Hospital Insurance Service, January 1 to December 31, 1961*. Government of British Columbia.

B.C.H.I.S. (1963). *Fifteenth annual report, British Columbia Hospital Insurance Service, January 1 to December 31, 1963*. Government of British Columbia.

B.C.H.I.S. (1965). *Seventeenth annual report: Province of British Columbia Hospital Insurance Act, January 1 to December 31, 1965*. Government of British Columbia.

B.C.H.I.S. (1971). *Twenty-third annual report, January 1 to December 31, 1971*. Government of British Columbia.

Goldenberg, H. C. (1947). *Provincial-municipal relations in British Columbia: Report of the Commission*. Government of British Columbia.

Social Welfare Branch of the Department of Health and Welfare. (1945). *Annual Report for the year ended March 31st, 1945*. British Columbia, Canada.

Social Welfare Branch of the Department of Health and Welfare. (1948). *Annual Report for the year ended March 31st, 1948*. British Columbia, Canada.

Government of Québec

Government of Québec. (1970). *Report by the Committee of Enquiry Into Health and Social Welfare*. Canada.

Government of Manitoba

Morison, J. B. (1966). *Nursing homes* [Interest group paper]. Manitoba Department of Health; The Canadian Welfare Council.

Federal Government Reports

Canada Dominion Bureau of Statistics. (1931). *Charitable and benevolent institutions: Seventh census of Canada, 1931* (Bulletin No. 4). Dominion Bureau of Statistics.

CMHC. (1982). *Adult residential facilities: A provincial perspective*. Canada Mortgage and Housing Corporation.

CMHC. (1983a). *Design guidelines for rest homes / retirement homes in Ontario*. Canada Mortgage and Housing Corporation.

CMHC. (1983b). *CMHC funding for nursing homes: Policy and program issues – A background report*. Canada Mortgage and Housing Corporation.

Dominion Bureau of Statistics. (1949). *The Canada Year Book 1948-49*. Department of Trade and Commerce, Canada.

Dominion Bureau of Statistics. (1959). *The Canada Year Book 1959*. Department of Trade and Commerce, Canada.

Federal Department of National Health and Welfare. (1957). *Annual report for the fiscal year ended March 31, 1957*. Government of Canada.

House of Commons. Canada. Parliament. (1964). *House of Commons Debates, 26th Parliament, 2nd Session.* (Vol. 7). Queen's Printer.

Library of Parliament. (2025, January 16). *Long-term care facilities in Canada: How are they funded and regulated?* HillNotes. https://hillnotes.ca/2025/01/16/long-term-care-facilities-in-canada-how-are-they-funded-and-regulated/

Report of the Special Committee of the Senate on Aging. (1966). *Final report of the Special Committee of the Senate on Aging*. Queen's Printer.

Hall, E. M. / Royal Commission on Health Services. (1964). *Report: Volume I*. Queen's Printer.

Statistics Canada. (1964). *List of Canadian hospitals and related institutions and facilities 1964*. Government of Canada.

Statistics Canada. (1971). *List of Canadian hospitals and related institutions and facilities 1971*. Government of Canada.

Statistics Canada. (1973). *List of Canadian hospitals And Related Institutions and Facilities 1973*.

Statistics Canada. (1974). *List of Canadian hospitals And Related Institutions and Facilities 1974*.

Statistics Canada. (1979). *List of Canadian hospitals And Related Institutions and Facilities 1979*.

Statistics Canada. (1980). *List of Canadian hospitals And Related Institutions and Facilities 1980*.

Statistics Canada. (2022, November 8). *More than half of women provide unpaid care to children and care-dependent adults.* https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2022056-eng.htm

Statistics Canada. (2024, April 2). *Study: "Sandwiched" between multiple unpaid caregiving responsibilities.* https://www150.statcan.gc.ca/n1/daily-quotidien/240402/dq240402d-eng.htm

Archival Sources

Archival Sources, Ontario

Note: The Ontario items below do not carry formal archival codes; they were drawn from departmental files and are referenced by issuing body, title, and date.

A. E. Ames & Co. Limited. (1972). *The health care industry in Canada and Extendicare (Canada) Limited*.

Associated Nursing Homes Incorporated Ontario. (1970). *Address by Dr. R. T. Potter, M.P.P. Quinte to Spring Workshop, Geneva Park, Lake Courchicing, ONT*. June 22, 1970.

Associated Nursing Homes Incorporated Ontario. (1970a). *The Committee to Review Nursing Home Act and Regulations, May 8, 1970*.

Associated Nursing Homes Incorporated Ontario. (1970c). *Nursing homes in Ontario, September 8, 1970*.

Associated Nursing Homes Incorporated Ontario. (1970d). *The Committee to Review Nursing Home Act and Regulations, March 18, 1970*.

Associated Nursing Homes Incorporated Ontario. (1970e). *The Committee to Review Nursing Home Act and Regulations, March 31, 1970*.

Associated Nursing Homes Incorporated Ontario. (1971). *Re: Rates in nursing homes, January 15, 1971*.

Associated Nursing Homes Incorporated Ontario. (1972). *The Mercury, Published for Associated Nursing Homes Incorporated Ontario, Vol. 1-No.4, January 1972*.

Associated Nursing Homes Incorporated Ontario. (1973). *Yellow Pages Volume 2 No. 1-P May 1973*.

Blake, B. (1972, October 25). *Speech to OHA Small Hospital Forum*. Ministry of Health Archives.

Cabinet Committee on Nursing Homes. (1967). *Statement of the Ontario Hospital Services Commission on the report of the Ontario Legislature's Select Committee on Aging*. Government of Ontario.

Cabinet Committee on Nursing Homes. (1969). *Joint meeting of the Cabinet Committee on Nursing Homes and of Technical Committee on Nursing Homes, Meeting No. 7, Tuesday, October 14, 1969*. Government of Ontario.

Cabinet Committee on Nursing Homes. (1969a). *Joint meeting of the Cabinet Committee on Nursing Homes and of Technical Committee on Nursing Homes, Thursday, July 10, 1969*. Government of Ontario.

Cabinet Committee on Nursing Homes & Technical Committee. (1969). *Cabinet Committee on Nursing Homes & Technical Committee, meeting August, 1969*. Government of Ontario.

Cabinet Committee on Social Development. (1972). *Chain nursing homes*. Government of Ontario.

Cabinet Committee on Social Development. (1973). *Mtg. #S29/73 August 30, 1973. Nursing home monopoly control*. Government of Ontario.

Canadian Union of Public Employees (CUPE). (1980). *Nursing homes in Alberta: A preliminary report*.

Canadian Union of Public Employees (CUPE). (1982). *Healthcare – Nursing Homes. F128930*.

Canadian Union of Public Employees (CUPE). (1984). *Healthcare – Nursing homes*.

Concerned Friends of Ontario Citizens in Care Facilities. (1984). *Initial seven point plan for nursing home reform in Ontario* [Report prepared for a meeting with the Hon. Keith Norton].

Concerned Friends of Ontario Citizens in Care Facilities. (1985). *Caring for the elderly: Our troubled private nursing homes: A five-part series*.

Co-ordinating Committee Extended Care Health Insurance. (1971). *A meeting of the Co-Ordinating Committee for implementation of the Extended Care Health Insurance took place on Thursday, December 23, 1971*. Government of Ontario.

Co-ordinating Committee Extended Care Health Insurance. (1971b). *A meeting of the Co-ordinating Committee for implementation of the Extended Care Health Insurance took place on Tuesday, October 5, 1971*. Government of Ontario.

Co-ordinating Committee Extended Care Health Insurance. (1971c). *A meeting of the Co-ordinating Committee for implementation of the Extended Care Health Insurance took place on Thursday, September 16th, 1971*. Government of Ontario.

Co-ordinating Committee Extended Care Health Insurance. (1971d). *A meeting of the Co-ordinating Committee for implementation of the Extended Care Health Insurance took place on Tuesday, September 21st, 1971*. Government of Ontario.

Co-ordinating Committee Extended Care Health Insurance. (1972). *A meeting of the Co-Ordinating Committee for implementation of the Extended Care Health Insurance took place on Wednesday, May 17, 1972, commencing at 2.30 p.m.* Government of Ontario.

Department of Health. (1969). *Nursing home programme: Medical Rehabilitation and Chronic Care Division*. Government of Ontario.

Department of Health. (1969a). *Dr. S. A. Holling, Consultant, Chronic Care, re: Extendicare (Canada) Limited*. Government of Ontario.

Department of Health. (1970). *Communications Branch*. Government of Ontario.

Department of Health. (1973). *Submission to Cabinet: Nursing home monopoly control*. Government of Ontario.

Department of Health. (1973a). *Development of extended health care facilities in nursing homes*. Government of Ontario.

Department of Health. (1973b). *Submission to Cabinet: Approval for the development of extended health care facilities in nursing homes in the Province of Ontario, April 5, 1973*. Government of Ontario.

Department of Public Welfare. (1958a). *Re: Nursing home care memorandum, June 24th, 1958*. Government of Ontario.

Department of Public Welfare. (1966). *Physician to a home for the aged*. Government of Ontario.

Department of Social and Family Services. (1969). *Cabinet Committee – Nursing Homes Committee*. Government of Ontario.

Department of Social and Family Services. (1969b). *Position paper: Institutional care other than hospitals*. Government of Ontario. June 18, 1969.

Management Board of Cabinet. (1973). *Re Ministry of Health – Approval for the development of extended health care facilities in nursing homes in Ontario*. Government of Ontario. April 11, 1973.

Ministry of Health. (1971). *A proposed policy for extended care facilities (nursing homes) and home care arrangements in Ontario*. Government of Ontario.

Ministry of Health. (1971a). *Re: Chain operated nursing homes, October 20, 1971*. Government of Ontario.

Ministry of Health. (1972). *Policy for extended care facilities (nursing homes) and home care*. Government of Ontario.

Ministry of Health. (1972a). *Memorandum to Cabinet: Chain-operated nursing homes*. Government of Ontario.

Ministry of Health. (1972c). *Annual report, 1972–73*. Government of Ontario.

Ministry of Health. (1974). *Letter from F. H. Ellingham, M.D., Medical Consultant and Chief Advisor of Extended Care Program, February 26, 1974*. Government of Ontario.

Ministry of Health. (1974a). *Letter from F. H. Ellingham, M.D., Medical Consultant and Chief Advisor of Extended Care Program, March 19, 1974*. Government of Ontario.

Ministry of Health. (1974b). *Correspondence by Frank S. Miller, Minister of Health. Government of Ontario. April 17, 1974*.

Ministry of Health. (1974c). *Correspondence by Frank S. Miller, Minister of Health. Government of Ontario. February 12, 1974*.

Ministry of Health. (1976). *Keynote address by the Honourable James Taylor, Q.C., Minister of Community and Social Services to the 26th Annual Meeting of the Ontario Municipal Social Services Association. June 7, 1976*.

Ministry of Health. (1976a). *Remarks by the Honourable James Taylor, Q.C., Minister of Community and Social Services. February 16, 1976*.

Ministry of Health. (1976b). Annual Report, 1975-1976. Government of Ontario.

Ministry of Health. (1976c). *Remarks by the Honourable James Taylor, Q.C., Minister of Community and Social Services on Joint Financial Restraint Program. January 13, 1976*.

Ministry of Health. (1982). Annual Report, 1982-1983. Government of Ontario.

Ministry of Health. (1989). *Comprehensive reform of long-term care in Ontario: Analysis and options*. Government of Ontario. October 25, 1989.

Ministry of Health. (1992). *Cabinet submission analysis and policy options: Towards not-for-profit administration of nursing homes and pay equity options*. Government of Ontario. October 15, 1992.

Ministry of Health. (1992a). *Communications plan for the Cabinet submission on the not-for-profit administration of nursing homes in Ontario*. Government of Ontario. October 19, 1992.

Ministry of Health and Ministry of Community And Social Services. (1991). *Enhancement of service levels to nursing home residents and stabilization of the nursing home sector*. Government of Ontario.

NDP Communique. (1983). *Notes for a speech by Bob Rae to Concerned Friends of Ontario Citizens in Care Facilities*. December 5, 1983.

Office on Aging Branch. (1974). *Memorandum, Re: Change in Regulations, Homes for the Aged*. Ministry of Community and Social Services.

Ontario Association of Homes for the Aged. (1971). *A brief on the effect of the expansion of health care insurance to cover persons in nursing homes and home care services*.

Ontario Association of Homes for the Aged. (1981). *Guidelines for standards in homes for the aged*.

Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS). (1991). *About OANHSS*. OANHSS.

Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS). (1996). *Letter by OANHSS Past President, Kevin Mercer to Ontario Nursing Home Association, cc: OANHSS Board of Directors*.

Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS). (1996b). *Response to Dianne E. Anderson, President of the Nursing Home Association, January 22, 1996*.

Ontario Cabinet Office. (1991). *Cabinet submission: Commercial delivery of human services*. Government of Ontario.

Ontario Department of Municipal Affairs. (1969). *Re; Nursing Homes June 4, 1969*. Government of Ontario.

Ontario Department of Treasury and Economics. (1969). *Nursing homes, facilities for the aged and related matters*. Government of Ontario.

Ontario Financial Consulting Services Branch. (1971). *Cost sharing implications of the extended care program under the Canada Assistance Plan*. Government of Ontario.

Ontario Homes for the Aged Branch. (1969). *Re: Special Facilities for the Aged. Department of Social and Family Services. May 21, 1969*.

Ontario Homes for the Aged Branch. (1969a). *Re: Comparative Interrelationships Homes for the Aged and Proprietary Nursing Homes. Department of Social and Family Services. April 29, 1969*.

Ontario Hospital Services Commission. (1969). *Position paper, June 16, 1969*. Government of Ontario.

Ontario Hospital Services Commission. (1970). *Nursing home plan, January 27, 1970*. Government of Ontario.

Ontario Hospital Services Commission. (1970b). *Letter from J. M. Walker, Consultant, Special Studies to President, Associated Nursing Homes Incorporate Ontario, Mr. Lloyd Al. Stevenson, January 15, 1970*. Government of Ontario.

Ontario Hospital Services Commission. (1971a). *Notes re Alberta Nursing Home Plan, September 8, 1971*. Government of Ontario.

Ontario Hospital Services Commission. (1971b). *Policy for extended care facilities (nursing homes) and home care, September 10, 1971*. Government of Ontario.

Ontario Hospital Services Commission. (1971c). *Report on the Alberta Nursing Home Plan, Sept. 7, 1971*. Government of Ontario.

Ontario Hospital Services Commission. (1971d). *Report on the Alberta Nursing Home Plan, Sept. 8, 1971*. Government of Ontario.

Ontario Program Co-ordination Branch. (1972). *Table of Information on Homes for the Aged.* Letter from E. Porter, Program Analyst, Program Co-ordination Branch to F. Eickmeyer, Management Board Officer. June 19, 1972.

Ontario Select Committee on Aging. (1967). *Final recommendations of the Select Committee on Aging: Tabled during the fifth session of the twenty-seventh Legislature*. Queen's Printer for Ontario.

Ontario Hospital Services Commission. (1972). *Implementation of extended health care insurance (nursing homes and homes for the aged). Government of Ontario. February 10, 1972*.

Ontario Nursing Home Association. (1984). *Report of a task force of the Ontario Nursing Home Association examining "Health—A need for redirection," the report of the Task Force on the Allocation of Health Care Resources* (Prepared for the Canadian Medical Association).

Ontario Nursing Home Association. (1996). *Letter from Shelly Jamieson, Executive Director, to the Editor, the Toronto Star*.

Ontario Nursing Home Association. (1996a). *ONHA recommendations concerning major opportunities for the reduction of barriers to efficient service delivery*.

Ontario Personal Care Standards Division. (1974). *Extendicare (Canada) Limited February 7th 1974*. Government of Ontario.

Ontario Secretariat for Social Development. (1974). *Proposed study of funding arrangements, Homes for the Aged, et al.* Government of Ontario.

Ontario Special Health Services Branch. (1969). *Memorandum from Dr. S. A. Holling Consultant Chronic Care to Dr. G. E. Large, Director of Special Health Services, July 10, 1969*. Government of Ontario.

Ontario Special Health Services Branch. (1972). *Chain operated nursing homes, February 14, 1972*. Government of Ontario.

Peel Community Services. (1976, January 15). Special report on the social services. *Info-Peel*, *4*(4).

Registered Nurses' Home Association of Ontario. (1983). *Letter to Minister of Health Keith Norton*.

Social Development Services Division. (1970). *Patients in nursing homes*. Government of Ontario.

Sub-Committee on Nursing Home Care. (1974). *Meeting of the Sub-Committee on Nursing Home Care of the Task Force on Long-Term Care, February 4, 1974*. Government of Ontario.

Sub-Committee on Nursing Home Care. (1974a). *Recommendations Sub-Committee on Nursing* Home Care. March 20, 1974. Government of Ontario.

Task Force on Long-Term Care. (1974). *Report Sub-Committee on Chronic Care, April 16, 1974*. Government of Ontario.

Task Force on Long-Term Care. (1974a). *Minutes of meeting, March 20, 1974*. Government of Ontario.

Task Force on Long-Term Services and Facilities. (1973). *Minutes. Meeting of December 12, 1973*. Government of Ontario.

Task Force on Long-Term Services and Facilities. (1974). *Minutes of the meeting of February 6, 1974*. Government of Ontario.

Task Force on Long-Term Services and Facilities. (1974a). *Minutes of the meeting of February 27, 1974*. Government of Ontario.

Task Force on Long-Term Services and Facilities. (1974b). *Minutes of the meeting of January 30, 1974*. Government of Ontario.

Task Force on Long-Term Services and Facilities. (1974d). *Minutes. Meeting of January 23, 1974*. Government of Ontario.

Task Force on Long Term Services and Facilities. (1974e). *Minutes. Meeting of February 14, 1974*. Government of Ontario.

Task Force on Long-Term Care. (1974f). *TERMS OF REFERENCE TASK FORCE ON LONG TERM CARE*. Government of Ontario.

Technical Committee on Nursing Homes. (1969). *Meeting No. 4. Monday, June 30, 1969, 10 A.M.* Government of Ontario.

TLC Villa. (1985). *Correspondence to Bob Rae*.

Archival Sources, British Columbia

B.C. Department of Human Resources. (1976). *The Central Mortgage and Housing Corporation. Review of C.M.H.C. Policy Concerning the Capital Funding of Care Facilities*.

B.C. Department of Social Welfare. (1968). *Intermediate care files*. October 29, 1968.

B.C. Hospital Consultation Division. (1969). *Correspondence to Mr. Chatfield*. April 2, 1969.

B.C. Ministry of Health Service and Hospital Insurance. (1965). *Letter from D. M. Cox to Minister of Health Services and Hospital Insurance, Eric Martin*.

B.C.H.I.S. (1966). *Standards for Private Hospitals*.

GR-078, 1955, 78/92, *Hospital Insurance Service - Proposed Hospital Legislation for 1955 Session*.

GR-078, 1967, 8/20, *Community Care Services Committee, Report And Recommendations on Boarding Homes and Similar Facilities*. September 18, 1967.

GR-0117, 1964, 13/24, *British Columbia Hospitals' Association Brief Presented to the Executive Council of the Provincial Government of British Columbia*. October 8, 1964.

GR-0117, 1974, 94-95/146, *Summary of a Report on Long Term Care in British Columbia, Phase I of Study, by Richard G. Foulkes, Director of Health Security Programme Project*.

GR-0117, 1977, 37/146, *Community Care Facilities Licensing Board, Long Term Care Program: Proposed Organizations and Administration*. May 30, 1977.

GR-0119, 1955, 4/33, *Letter to Minister of Health, Eric Martin*. June 7, 1955.

GR-0119, 1955, 12-13/33, *Letter from Minister of Health & Welfare, Eric Martin*. March 10, 1955.

GR-0119, 1956, 70/82, *Letter from Minister of Health and Welfare Eric Martin to Mr. J. K. Klassen, Chairman of the Investigating Committee of the Mennonite Brethren Conference of B. C. November 14, 1956*.

GR-0119, 1957, 7-8/82, *Letter from B.C.H.I.S Commissioner, D. M. Cox, to Eric Martin, Minister of Health & Welfare. August 15, 1957*.

GR-0119, 1957, 18/28, *Letter from Commissioner, B.C.H.I.S, D. M. Cox, to Eric Martin, Minister of Health & Welfare. March 28, 1957*.

GR-0119, 1957, 20-21/28, *Memorandum, from J. W. Mainguy, B.C.H.I.S Manager of the Hospital Consultation and Inspection Division to D. M. Cox, Commissioner of B.C.H.I.S, Subject: Florence Nightingale Private Hospitals. March 28, 1957*.

GR-0119, 1957, 39/82, *Letter from Medical Health Officer, G. V. Pelton, to Minister of Health*. December 17, 1957.

GR-0119, 1957, 46-48/82, *Letter from D. M. Cox, B.C. Hospital Insurance Services, to the Minister of Health & Welfare, Eric Martin. July 22, 1957*.

GR-0119, 1957, 52-55/82, *Letter from Chairman and Secretary of the BC Private Hospital Executives Division, British Columbia Hospitals' Association, to Minister of Health, Eric Martin. June 25, 1957*.

GR-0119, 1958, 9-11/82, *Letter from B.C.H.I.S Commissioner D. M. Cox to Eric Martin, Minister of Health & Welfare. April 21, 1958*.

GR-0119, 1958, 11/28, *Letter from James D. M. Cox, Commissioner of the B.C.H.I.S., to Minister of Health, Eric Martin, Re: Ownership of Private Hospitals. January 27th, 1958*.

GR-0119, 1958, 12/28, *Letter from James W. Mainguy, Manager of the B.C.H.I.S, to D. M. Cox, Commissioner of the B.C.H.I.S. January 24, 1958*.

GR-0119, 1958, 12-14/82, *Letter from B.C.H.I.S Manager of the Hospital Consultation and Inspection Division James W. Mainguy, D. M. Cox, B.C.H.I.S Commissioner. April 9, 1958*.

GR-0119, 1958, 61/82, *Letter from B.C.H.I.S Commissioner D. M. Cox to Eric Martin, Minister of Health & Welfare*. December 8, 1958.

GR-0119, 1958, 66/82, *Letter from B.C.H.I.S Commissioner D. M. Cox to Eric Martin, Minister of Health & Welfare*. December 18, 1958.

GR-0119, 1958, 79/82, *Letter from B.C.H.I.S Commissioner D. M. Cox to Eric Martin, Minister of Health & Welfare*. October 1, 1958.

GR-0119, 1958, 81/82, *Letter from B.C.H.I.S Manager James W. Mainguy, to Eric Martin, Minister of Health & Welfare*.

GR-0119, 1958, 82/82, *Letter from B.C.H.I.S Commissioner, D. M. Cox, to Eric Martin, Minister of Health & Welfare*. September 19, 1958.

GR-0119, 1959, 3-4/82, *Letter from B.C.H.I.S Commissioner, D. M. Cox, to Eric Martin, Minister of Health & Welfare*. March 12, 1959.

GR-0119, 1959, 76/82, *Letter from B.C.H.I.S Commissioner D. M. Cox to Eric Martin, Minister of Health & Welfare*. February 26, 1959.

GR-0178, 1950, 46/50, *Letter from Assistant Commissioner B.C.H.I.S, D. M. Cox, to A. W. E. Pitkethley, Manager of Private Hospitals, B.C.H.I.S. November 3, 1950.*

GR-0416, 1969, 56/93, *Letter from Andrew Rose, Inspector of Hospitals, to Peter Breel, Manager of Hospital and Consultation Division, Victoria. September 12, 1969*.

GR-0419, 1963, 18-19/20, *Letter from B.C.H.I.S Commissioner D. M. Cox to Eric Martin, Minister of Health & Welfare*. February 18, 1963.

GR-0419, 1964, 3/19, *Letter from B.C.H.I.S Manager James W. Mainguy*. October 29, 1964.

GR-0419, 1965, 116-118/231, *Letter from B.C.H.I.S Deputy Minister Donald Cox to Eric Martin, Minister of Health Services and Hospital Insurance*. June 22, 1965.

GR-0419, 1965, 157/231, *Order in Council No. 283*.

GR-0419, 1965, 185/231, *Letter from D. M. Cox, Deputy Minister of Hospital Insurance, B.C.H.I.S., to Eric Martin, Minister of Health Services and Hospital Insurance, Buildings. Subject: Nursing Home Coverage Program and Private Hospitals. June 22, 1965*.

GR-0419, 1966, 115/231, *Letter from D. M. Cox, Deputy Minister of B.C.H.I.S to Eric Martin, Minister of Health*. July 8, 1965.

GR-0419, 1967, 85–86/231, *Notes To Societies Planning to Operate Extended Hospital Care Facilities, June 1967*.

GR-0498, 1976, 26/54, *Brief: FOR THE ATTENTION OF THE HONOURABLE MINISTER OF HEALTH AND THE HONOURABLE MINISTER OF HUMAN RESOURCES.*

GR-0678, 1950, 48-50/50, *Letter from Inspector of Hospitals E. Pringle, to A.W.E. Pitkethley, Manager of Private Hospitals, B.C.H.I.S.*

GR-0678, 1953, 4/50, *Hospital Act Amendments Explanatory Notes*.

GR-0678, 1953, 7-12/50, *Hospital Act Supplementary Note*.

GR-0678, 1967, 14-15/20, *Letter from J. Bainbridge, Manager, Hospital Consultation & Inspection Division B.C.H.I.S., July 1967.*

GR-0678, 1968, 11-12/20, *Letter from. B.C.H.I.S Deputy Minister D. M. Cox, to Minister of B.C.H.I.S W. D. Black, re: Norwegian Old Peoples' Home Association*. March 26, 1968.

GR-0678, 1968, 12/20, *Letter from L. J. Wallace, Deputy Provincial Secretary to Provincial Secretary W. D. Black*. February 26, 1968.

GR-0678, 1968, 13/20, *Letter from J. Bainbridge, manager, Hospital Consultation & Inspection Division B.C.H.I.S to C. J. Cox, Administrative Officer, Provincial Secretary's Office*. February 16, 1968.

GR-0678, 1969, 3-4/31, *Letter from Director of Hospital Consultation, Development & Research, J. W. Mainguy, to D. M. Cox, Deputy Minister of Hospital Insurance, September 30, 1969, Subject: Intermediate Care*.

GR-0679, 1956, 23/34, *Letter from K. G. Wiper, Administrative Assistance of B.C.H.I.S to D. M. Cox, B.C.H.I.S Commissioner*. August 30, 1956.

GR-0679, 1960, 12/27, *Letter from Deputy Minister of Hospital Insurance D. M. Cox to Eric Martin, Minister of Health & Welfare*. July 28, 1960.

GR-0679, 1960, 14-15/27, *Letter from Deputy Minister of Hospital Insurance D. M. Cox to Eric Martin, Minister of Health & Welfare*. August 9, 1960.

GR-0679, 1965, 7/15, *Statement by the Hon. Eric Martin, Minister of Health Services and Hospital Insurance*. February 11, 1965.

GR-0679, 1966, 10-11/45, *Letter from J. W. Mainguy B.C.H.I.S Director of Hospital Consultation, Development and Research*. January 17, 1966.

GR-0679, 1970, 3/45, *B.C.H.I.S Publication on Extended Care in British Columbia, Prepared by B.C.H.I.S Medical Consultants, D. G. Adams and D. E. Mackay*. June, 1970.

GR-0698, 1950, 46/50, *Proposed amendments to Hospital Act*. November 3, 1950.

GR-0698, 1953, 14/50, *Section number in proposed bill*.

GR-0698, 1954, 24-30/164, *Explanatory Note, 1954 Hospital Act amendment*.

GR-0698, 1959, 84/164, *Proposed Revision to the Hospital Act*.

GR-0698, 1965, 5/29, *Letter from B.C.H.I.S Deputy Minister Donald Cox to G. L. Pickering, Manitoba Hospital Commission*. April 8, 1965.

GR-89, 1974, 24/191, *A Report on Long Term Care in British Columbia, by Richard G. Foulkes, Director of Health Security Programme Project*.

GR-89, 1974, 85/153, *A Report on Long Term Care in British Columbia, by Richard G. Foulkes, Director of Health Security Programme Project*.

GR-89, 1975, 12-13, *Consolidation: Alternatives for a Long Term Care Programme, Richard G. Foulkes, Director of the Health Security Programme Project*.

GR-89, 1975, 25-26 *Letter from Richard G. Foulkes, Director of the Health Security Programme Project to Harvey Lazar, Direction of Co-ordination, Office of the Planning Advisor to Cabinet, RE: Memorandum on a proposal for a long term care programme*. June 11, 1975.

GR-89, 1975, 27–46/67, *Memorandum on a proposal for a long term care programme, By. Richard G. Foulkes, Director of the Health Security Programme Project*.

GR-89, 1975, 50-67/67, *Memorandum To: Cabinet Committee on Human Services. Subject: Financing of Long-term Care*. July 29, 1975.

GR-128, 1965, 54-56/80, *News Release for Extended Care Nursing Home Program*. November 30, 1965.

GR-128, 1966, 3/76, *Letter from J. A. Sadler, Director of Social Welfare to Minister of Health Eric Martin, November 18th, 1966*.

GR-128, 1966, 15/76, *Letter from R. J. Shepherd, President of Private Columbia Association of Private Hospitals, to Leslie Black, Minister of Welfare. September 9, 1966*.

GR-135, 1967, 70/70, *Letter from Director of Social Welfare, J. A. Sadler to E. R. Rickinson, Deputy Minister of Social Welfare*. January 27, 1967.

GR-135, 1968, 17/70, *Note by J. A. Sadler, Assistant Deputy Minister of Social Welfare to Mr. E. R. Rickinson, Director of Social Welfare* .

GR-136, 1967, 4/55, *Community Care Services Committee Report and Recommendations on Boarding Homes and Similar Facilities, September 18, 1967*.

GR-136, 1967, 18/101, *Community Care Services Committee, Minutes of a Meeting held in the Board Room, BCHIS, on September 18, 1967*. September 21, 1967.

GR-136, 1967, 42/101, *Report of the Community Care Services Committee, August 11, 1967*.

GR-136, 1967, 51/55, *Community Care Services Committee Sub-Committee Report, July 19, 1967*.

GR-136, 1967, 64-66/101, *Report of the Community Care Services Committee Sub-Committee, June 13, 1967*.

GR-136, 1968, 5-6/27, *Letter from L. J. Wallace, Deputy Provincial Secretary to Norwegian Old Peoples' Home Association*. July 8, 1968.

GR-364, 1969, 3/36, *British Columbia Revised Hospital Standards, 1969*.

GR-365, 1969, 8/9, *B.C.H.I.S, Institutional Care for the Aged, Chronically Ill and Disabled in Canada*.

GR-365, 1969, 10/21, *Letter from Deputy Minister of B.C.H.I.S D. M. Cox, to R. R. Loffmark, Minister of B.C.H.I.S. January 20, 1969.*

GR-380, 1955, 12/25, *Letter from B.C.H.I.S Commissioner D.M. Cox to Minister of Health, Eric Martin*. May 3, 1955.

GR-380, 1970, 67/80, *Letter from D. G. Adams, Medical Consultant, B.C.H.I.S, to W. J. Lyle, Assistant Deputy Minister of B.C.H.I.S. March, 20, 1970.*

GR-678, 1953, 18-19/34, *Letter from Inspector of Hospitals, E. Pringle, to D. M. Cox, B.C.H.I.S Assistant Commissioner*. March 10, 1953.

GR-678, 1953, 22-24/34, *Report on the Need for Chronic Diseases Hospitals by E. Pringle*.

GR-678, 1953, 27-30/52, *Letter from Inspector of Hospitals E. Pringle to D. M. Cox, Assistant Commissioner, B.C.H.I.S. October 27, 1953.*

GR-678, 1956, 35-36/64, *Letter from James W. Mainguy, Manager, Hospital Consultation and Inspection Division, to Drs. Charron, Roberts, and Horowicz, Department of National Health & Welfare, Ottawa, Canada. July 19, 1956*.

GR-678, 1958, 24/25, *Letter from James W. Mainguy, Manager of the B.C.H.I.S., to D. M. Cox, Commissioner of Hospital Insurance*.

GR-678, 1960, 2-5/18, *B.C.H.I.S Memorandum from L. F. Detwiller, Assistant Deputy Minister of the B.C.H.I.S to D. M. Cox, Deputy Minister of the B.C.H.I.S. RE: Reports on Visit to Nursing Homes in Toronto, Ontario*. November 24, 1958.

GR-678, 1963, 3-5/7, *Letter from Mr. A.W.E. Pitkethley, Manager, Hospital Construction and Planning Division of the B.C.H.I.S. to Mr. D. M. Cox, Deputy Minister, Hospital Insurance. January 15, 1963*.

GR-678, 1963, 3-6/25, *Letter from D. M. Cox, Deputy Minister of Hospital Insurance, B.C.H.I.S., to Eric Martin, Minister of Health Services and Hospital Insurance, Buildings. October 10, 1963*.

GR-678, 1963, 6/7, *Letter from Manager of B.C.H.I.S Hospital Construction and Planning Division, A. W. E. Pitkethley, to Dr. W. A. Fraser, Medical Consultant, B.C.H.I.S.*

GR-678, 1963, 14-15/25, *Letter from B.C.H.I.S Commissioner D. M. Cox to Eric Martin, Minister of Health & Welfare. August 22, 1963*.

GR-678, 1964, 2/16, *Letter from Mr. A. W. E. Pitkethley, Manager, Hospital Construction and Planning Division. To: Mr. D. M. Cox, Deputy Minister of Hospital Insurance. Subject: Nursing Homes & Private Hospitals. October 9, 1964*.

GR-678, 1965, 4/7, *Extension Of B.C. Hospital Insurance Service Coverage To Nursing Home Patients. August 13, 1965*.

GR-678, 1967, 3-4, *Letter from J. Bainbridge, Manager of Hospital Consultation and Inspection Division, B.C.H.I.S, to J. W. Mainguy, Director of Hospital Consultation, Development and Research, B.C.H.I.S. August 8, 1967*.

GR-678, 1971, 5/10, *Letter from B.C.H.I.S Director of Hospital Consultation, Development and Research to Minister of Health Services and Hospital Insurance R. R. Loffmark*. January 4, 1971.

GR-678, 1974, 6/39, *Letter from W. J. Lyle, B.C.H.I.S. Deputy Minister to J. W. Mainguy, B.C.H.I.S Assistant Deputy Minister*. January 14, 1974.

GR-678, 1974, 7/39, *Elderly Citizens' Housing Aid Act, 1971, Grants To Special Care Homes*.

GR-746, 1971, 5/17, *Press Release from the Premier's Office on Special Care Homes*. June 11, 1971.

GR-746, 1971, 8/17, *Letter from Art. E. Langley, Mayor, to Minister of Rehabilitation and Social Improvement, P. A. Gaglardi*. May 1971.

GR-746, 1971, 11-12/17, *Letter from Isabel P. Dawson, Minister Without Portfolio, to Premiere W. A. C. Bennett*. May 21, 1971.

GR-746, 1971, 24/29, *Order-In-Council No. 2350, for Special Care Homes*.

GR-746, 1972, 3/17, *Letter from Assistant Deputy Minister of Department of Rehabilitation and Social Improvement to All Municipal Welfare Administrators and Regional Directors, RE: REST HOMES – Special Care (Personal Care) Homes*. February 23, 1972.

GR-746, 1972, 3-5/29, *Department of Rehabilitation and Social Improvement, Reports and Recommendations: Current Financial Problems in the Provision of Intensive Personal Care to Aged Persons*.

GR-746, 1973, 17, *Review Report on by C. F. Ballam, Senior Medical Consultant of B.C.H.I.S., to Dr. A. A. Larsen, Director, Division of Epidemiology, Health Branch, Ministry of Health, RE: The British Columbia Classification of Types of Health Care*. August 2, 1973.

GR-746, 1973, 20/32, *Letter from Dr. C. F. Ballam, Senior Medical Consultant, B.C.H.I.S., to R.H.B. Ralfs, Chairman of the Board, Glendale Lodge Hospital, RE: Personal Care Homes, Admission Criteria*. July 13, 1973.

GR-911, 1939, 44-45/58, *Report of the Welfare Institutions and Nursing-Homes Commission*. June 28, 1939.

GR-2578, 1958, 57/79, *Letter from Donald Cox, Commissioner of the B.C.H.I.S, to Mr. W. H. Middlhurst, Chairman of the Chronic Hospital Sub-committee. November 28, 1958*.

GR-2578, 1965, 194/231. *Letter from Eric Martin, Minister of Health Services and Hospital Insurance. May 5, 1965*.

GR-2585, 1963, 47/62, *Letter from W. J. Lyle, Hospital Finance Manager, to Mr. K. G. Wiper, Administrative Assistant of the B.C.H.I.S. Subject: Government Policy – Non-Profit Nursing Homes. August 13, 1963*.

GR-2585, 1963, 48-50/62, *Letter from K. G. Wiper, Administrative Officer, B.C.H.I.S, to D. M. Cox, Deputy Minister B.C.H.I.S, c.c. Div. Heads, Government policy re non-profit nursing homes and the situation at Prince George. August 7, 1963*.

GR-2585, 1964, 23-25/62, *Dr. McKay, Survey of Private Hospitals, 1964*.

GR-2585, 1964, 44-46/62, *Letter from Mr. J. Bainbridge, Hospital Consultation and Inspection Division, to Mr. J.W. Mainguy, Manager of the BCHIS. January13, 1964*.

GR-2647, 1971, 34/102, *Provincial Government Document on Licensed Boarding Homes in Nanaimo Regional District – A Need for Special Care Homes*.

GR-2647, 1971, 38/102, *B.C.H.I.S Memorandum*. RE: Personal Care Homes. October 14, 1971.

GR-2647, 1971, 39/102, *Letter from Chairman, Community Care Facilities Licensing Board to L. J. Wallace, Deputy Provincial Secretary, Re: Adoption of Official Name for Facilities Giving "Heavy Care" to the Elderly*. September 13, 1971.

GR-2647, 1972, 3/102, *News Release, Department of Health Services and Hospital Insurance News Release, Personal (Intermediate) Care*. December 11, 1972.

GR-2647, 1972, 16/102, *B.C.H.I.S Definition of Levels of Care*.

GR-2647, 1972, 22, *Letter from the Office of the Minister of B.C.H.I.S to J. Mainguy, Assistant Deputy Minister of the B.C.H.I.S, RE: Provincial Programme for the Construction of Facilities Providing Intensive Personal Care for Aged Persons*. September 22, 1972.

GR-2649, 1967, 28/55, *Notes on a meeting between the Minister of Health Services & Hospital Insurance and the Minister of Social Welfare at 9:30 am on August 23, 1967*.

GR-2649, 1975, 89-90, *Letter from Gary M. Begg, Deputy Minister of Housing, to J. W. Mainguy, Deputy Minister of the Department of Health, Subject: Assistance Grants under the provisions of the Elderly Citizens Housing Aid Act to Special Care Homes*. May 13, 1975.

GR-2649, 1975, 92/212, *Letter from J. H. Nuttall, Assistant Director of Community Affairs, to Mr. J. Willians, Director of Development, RE: Pending Applications for Grant - Elderly Citizens Housing Aid Act*. April, 21, 1975.

GR-2649, 1975, 144-145, *B.C.H.I.S Memorandum, RE: Approvals - Construction of New Personal and Intermediate Care Homes*.

GR-2649, 1975, 162/212, *Letter from Dr. A. Clarke, Medical Health Officer to Mr. J. Rheaume, Administrator, Regional District of Okanagan Similkameen. March 12, 1975*.

GR-2649, 1977, 57/156, *Letter from Minister of Health, R.H. McClelland, to Monique Begin, Federal Minister of Health & Welfare*. October 11, 1977.

GR-2649, 1978, 70/143, *Letter from J. Bainbridge, Assistant Deputy Minister, Planning and Support Services, to J. Mainguy, Deputy Minister of Health, Subject: Group Homes for the Physically Handicapped*. October 5, 1978.

GR-2651, 1977, 34/121, *Raymond H. Goodacre, Director, Research Division, Note to File*. April 29, 1977.

GR-2653, 1960, 6-8/8, *B.C.H.I.S. Minutes of the Meeting held on January 13, 1960 at 8:45 a.m., February 8, 1960*.

GR-2653, 1963, 26/29, *Note For File, James W. Mainguy, Manager, B.C.H.I.S.*

GR-2653, 1963, 97/146, *Letter from B.C.H.I.S Commissioner D. M. Cox to Eric Martin, Minister of Health & Welfare*. June 3, 1963.

GR-2653, 1963, 102-103/146, Letter from R. H. Brisco D. C., Chairman, Projects Committee, to BCHIS Inspector of Hospitals Andrew Rose. April 23, 1963.

GR-2653, 1963, 101/146, Reply from Andrew Rose, Inspector of Hospitals, to R. H. Brisco D. C., Chairman, Projects Committee.

GR-2653, 1963, 110/146, *Letter from Andrew Rose, Inspector of Hospitals of BCHIS*. April 5, 1963.

GR-2653, 1964, 14-15/29, *Letter from B.C.H.I.S Manager James W. Mainguy*. November 19, 1964.

GR-2653, 1964, 88/146, *Letter from R. H. Brisco, D.C, to Hon. D. L. Brothers, Minister of Mines & Petroleum Resources*. October 8, 1964.

GR-2653, 1964, 92/146, *Letter from B.C.H.I.S Manager James W. Mainguy*. January 10, 1964.

GR-2653, 1966, 10/146, *Letter from Cresthaven Rest Home, to J. A. Sadler, Director of Social Welfare, Department of Social Welfare*. December 21, 1966.

GR-2653, 1966, 13/146, *Letter from W. H. Crossley, Regional Director of the Department of Social Welfare, to C. H. Moourhouse, District Supervisor, Department of Social Welfare*. December 14, 1966.

GR-2653, 1966, 44/66, *Letter from James W. Mainguy, B.C.H.I.S Director of Hospital Consultation, Development and Research*. September 19, 1966.

GR-2653, 1967, 4/43, *Letter from D. M. Cox, Deputy Minister of B.C.H.I.S, to W. D. Black, Minister of B.C.H.I.S. February 24, 1967*.

GR-2653, 1967, 7-8/80, *Letter from Mr. J. Bainbridge, Manager of Hospital Consultation and Inspection Division, B.C.H.I.S. to Mr. J. W. Mainguy, Director of Hospital Consultation, Development and Research, B.C.H.I.S., June 8, 1967*.

GR-2653, 1967, 8-9/39, *Letter from Mr. J.W. Mainguy, Director of Hospital Consultation, Development and Research, to Mr. D.M. Cox, Deputy Minister of Hospital Insurance. December 4, 1967*.

GR-2653, 1967, 12/39, *Note for File, J. Bainbridge, Manager Hospital Consultation and Inspection Division*. November 17, 1967.

GR-2653, 1967, 15/17, *Letter to W. D. Black, Minister of Health Services and Hospital Insurance*. April 11, 1967.

GR-2653, 1967, 16-17/39, *Letter from D. M. Cox, Deputy Minister of Hospital Insurance, to The Hon. W.D. Black, Minister of Health Services and Hospital Insurance. July 24th, 1967*.

GR-2653, 1967, 35/121, *Meeting of the Community Care Services Committee, September 21, 1967*.

GR-2653, 1967, 41-43/43, *Letter from J. W. Mainguy, B.C.H.I.S Director of Hospital Consultation, Development and Research, to, Mr. G.J. Chatfield, Administrator, York Central Hospital, Richmond Hill, Ontario. January 13, 1967*.

GR-2653, 1967, 43-45/97, *Letter from D. M. Cox, Deputy Minister of Hospital Insurance, to The Hon. W.D. Black, Minister of Health Services and Hospital Insurance, Buildings. Subject: Long-term care facilities. November 9, 1967*.

GR-2653, 1967, 55, 63/121, *B.C.H.I.S Working Paper on "Intermediate Care"*.

GR-2653, 1967, 65/80, *Letter from Dennis R. Sheppard, Public Trustee, to Mr. Rose, Inspector of Hospitals, B.C.H.I.S., March 7, 1967*.

GR-2653, 1967, 75/80, *Letter from T. T. Hill, Administrator of Social Service Department, to Mr. Andrew Rose, Inspector of Private Hospitals, B.C.H.I.S. March 2, 1967.*

GR-2653, 1967, 87-88/121, *Community Care Services Committee, Notes on a Meeting of the Community Care Services Committee Sub-Committee. February 3, 1967*.

GR-2653, 1968, 10/97, *Letter from J. Bainbridge, Manager, Hospital Consultation Division to Mr. W.H. Swift, Hospital Financing Arrangements Study. December 16, 1968*.

GR-2653, 1968, 11/17, *Letter from B.C.H.IS Deputy Minister D. M. Cox, to Eric Martin, R. R. Loffmark, Minister of the B.C.H.I.S. December 2, 1968.*

GR-2653, 1968, 20/54, *Letter from J. Bainbridge, Manager of Hospital Consultation Division, B.C.H.I.S, to Dr. P. W. Laundy, Medical Director, Social Welfare Department*. September 16, 1968.

GR-2653, 1968, 20/121, *Letter from Dr. Brock M. Fahrni, Department of Medicine, Vancouver General Hospital. Department of Medicine, Vancouver General Hospital. November 5, 1968*.

GR-2653, 1968, 24-25/97, *Letter from E. Nordlund, R.N. Hospital Consultation Division, to Mr. J. Bainbridge, Manager Hospital Consultation Division. July 26, 1968*.

GR-2653, 1968, 26-28/97, *Hospital and Resident Facilities in British Columbia For the Long-Term Sick And For The Aged. July 17, 1968*.

GR-2653, 1968, 37-39/97, *Letter from Andrew H. Rose, Inspector of Hospital. June 25th, 1968*.

GR-2653, 1968, 41/97, *Letter from Donald M. Cox to Minister of Health Services and Hospital Insurance Ralph R. Loffmark. June 24, 1968*.

GR-2653, 1968, 46/130, *Nursing Home Questionnaire from The Reader's Digest Association to B.C.H.I.S.*

GR-2653, 1968, 68/97, *Letter from Andrew H. Rose, Inspector of Hospitals.* March 19, 1968.

GR-2653, 1969, 8/130, *Greater Victoria Board of Health, Report On The Smaller Private Hospitals In The Greater Victoria Metropolitan Board Of Health Area*.

GR-2653, 1969, 10/21, *Letter from Peter M. Breel, Manager, Hospital Consultation Division*. September 30, 1969.

GR-2653, 1969, 15/130, *Letter from Andrew Rose, Inspector of Hospitals, to P. Breel, Manager, Hospital Consultation & Inspection, B.C.H.I.S, re: Continuation of License for Several Private Hospitals in Victoria*.

GR-2653, 1969, 19-20/130, *Letter from D. M. Cox, Deputy Minister of Hospital Insurance, B.C.H.I.S., to Mrs. Lois Neely, October 17, 1969*.

GR-2653, 1969, 44/79, *Greater Victoria Metropolitan Board of Health Report on the Smaller Private Hospitals in the Greater Victoria Metropolitan Board of Health Area*.

GR-2653, 1969, 104/130, *Letter from B. Dunford, Registered Nurse, Hospital Consultation Division, to G. J. Chatfield, President, Medex nursing Homes Limited*. April 2, 1969.

GR-2653, 1969, 118/130, *Letter from B.C.H.I.S Inspector of Hospitals, Andrew Rose, to Peter Breel, Manager, Hospital Consultation & Inspection, B.C.H.I.S. March 17, 1969.*

GR-2653, 1970, 8/79, *Letter from J.W. Mainguy, Director Hospital Consultation, Development & Research to Mr. J. F. Clements, President of Garden of the Gulf Nursing Homes Ltd., May 8, 1970*.

GR-2653, 1970, 39/79, *Letter from B.C.H.I.S Deputy Minister Donald Cox to W. D. Black, Minister of the B.C.H.I.S. April 13, 1970.*

GR-2653, 1970, 42/45, *Letter from J. W. Mainguy, Director, Hospital Consultation, Development and Research, B.C.H.I.S, to R. R. Loffmark, Minister of B.C.H.I.S. June 22, 1970.*

GR-2653, 1971, 5/146, *Letter from Andrew H. Rose, B.C.H.I.S. of Inspector of Hospitals*. November 4, 1971.

GR-2653, 1971, 18/146, *Letter from Andrew H. Rose to Canadian Hospital Street*. September 9, 1971.

GR-2653, 1972, 3/9, *Letter from C. R. F. Elliot, Acting Deputy Minister of Health, "Proposed Construction of a Nursing Home in Kamloops"*. September 5, 1972.

GR-2653, 1972, 9/104, *Letter from W. J. Lyle, B.C.H.I.S Deputy Minister, to J. W. Mainguy, B.C.H.I.S Assistant Deputy Minister*. November 29, 1972.

GR-2653, 1972, 56/104, *Letter from Andrew Rose, Inspector of Hospitals to, J. W. Lyle, Deputy Minister of B.C.H.I.S. September 21, 1972.*

GR-2653, 1973, 17/79, *Victoria Times, 1970, Public-Owned Rest Homes Glaring Need*.

GR-2653, 1973, 104/144, *Letter from Dennis G. Cocke, Minister of B.C.H.I.S, August 29, 1973*.

GR-2661, 1968, 6/7, *Letter from J. D. Black, Minister of B.C.H.I.S. January, 8, 1958.*

GR-2661, 1973, 24/48, *Note For File, J. W. Mainguy, Assistant Deputy Minister, B.C.H.I.S. October 30, 1973.*

GR-2661, 1973, 26-29/48, *Letter from Mr. J. W. Mainguy, Assistant Deputy Minister of Hospital Insurance to Mr. Dennis Sheppard, Civil Law, Attorney-General's Dept. BUILDINGS. November 9th, 1973*.

GR-2661, 1973, 31/48, *Letter from Dennis R. Sheppard, Director of Commercial and Financial Services to Mr. J. W. Mainguy, Assistant Deputy Minister of Hospital Insurance. December 21, 1973*.

GR-2661, 1974, 33/48, *Letter from Dennis R. Sheppard, Director of Commercial and Financial Services, to Mr. J. W. Mainguy, Assistant Deputy Minister of Hospital Insurance, January 18, 1974*.

GR-2665, 1968, 40/93, *Report to Cabinet Committee on Intermediate Care, Community Care Services Committee. May 27, 1968*.

GR-2665, 1970, 24/93, *Letter from J. W. Mainguy, Assistant Deputy Minister of Hospital Insurance, to D. M. Cox. December 4, 1970*.

GR-2665, 1971, 16-18/93, *Board of Administration, Social Service And Health Matters, Lack of Facilities for Aged Requiring Nursing Services. April 28, 1971*.

GR-2665, 1979, 31/36, *Minutes of the Meeting of the Provincial Adult Care Facilities Licensing Committee. May 2, 1979*.

GR-2675, 1968, 13/20, *Letter from Mr. R. J. Shepherd, President of Private Columbia Association of Private Hospitals, to Board of Industrial Relations, B.C.*

GR-2675, n.d., 20/20, *British Columbia Association of Private Hospitals. Emergency Situation Exists in the field of long term nursing care*.

GR-2677, n.d., 33, *Report by the British Columbia Ad Hoc Committee on Long Term Care*.

GR-2677, 1968, 58/96, *Letter from J. A. Sadler, Assistant Deputy Minister of Social Welfare to E. R. Rickinson, Deputy Minister of Social Welfare*. September 18, 1968.

GR-2677, 1968, 92-94, *Sub-Committee on "Intermediate Care" Standards*.

GR-2677, 1969, 43-45, *Community Care Services Committee Report to Cabinet Committee on Intermediate Care*.

GR-2677, 1970, 33/96, *Letter from Senior Citizens Care with Christian Concerns, to Grace McCarthy, Minister Without Portfolio*. July 16, 1970.

GR-2677, 1971, 66-67/96, *Letter from Isabel P. Dawson, Minister without Portfolio, to Premiere Bennett*. February 11, 1971.

GR-2677, 1974, 29/57, *Letter from Elizabeth Bristowe, Director, Special Care Adults Division, RE: Intermediate Care*. December 10, 1974.

GR-2677, 1974, 40/99, *B.C.H.I.S Report, Supplement on Capital Costs: Long Term Care Facilities*.

GR-2677, 1977 3/57, *Letter from Elizabeth Bristowe, Director of Special Care, Adult Care Division, to Lorna Rae, Adult Care Nursing Consultant, Community Care Facilities, Ministry of Health*. March 7, 1977.

GR-2677-1, 1979, 13/15, *Letter from Donald P. Schurman, Vice-President, Operations of Extendicare LTD. to Mrs. Isabel Kimitt, Associate Deputy Minister, Ministry of Health*. January 17, 1979.

GR-2678, 1971, 14/19, *Order-In-Council No. 2350, for Special Care Homes*.

GR-2678, 1971, 15-17, *Extension of the Scope of the Elderly Citizens' Housing Aid Act to Special Care Homes*.

GR-2678, 1975, 11/19, *Letter from Elizabeth Bristowe, Director of Special Care, Adult Care Division, to B.C.H.I.S. Deputy Minister J. A. Sadler*. July 22, 1975.

GR-2678, 1975, 12/19, *Order-In-Council 4104/72 Elderly Citizens Housing Aid Act*.

GR-2678, 1976, 71/84, *Letter from A. A. Larsen, M.D., D.P.H., Chairman of the Provincial Adult Care Facilities Licensing Board to Mr. Allan Robinson, President of British Columbia Association of Non-Profit Community Care Facilities*. April 29, 1976.

GR-2678, 1977, 5/7, *Ministry of Health News Release, Regulations for Adult Community Care Facilities*. May 6, 1977.

GR-2678, 1977, 10/31, *Letter from C.M.H.C Victoria Office to John Herbert, Hospital Administrative Services, Department of Health*. June 16, 1977.

GR-2688, 1980, 138/139, *Letter from J. Bainbridge, Assistant Deputy Minister, Support Services to Dr. C. Key, RE: Privately Owned Long Term Care Facilities*. January 24, 1980.

GR-2690, 1981, 62/149, *Report on Projected Staffing and Organization, Intermediate Care Construction Program, Housing Division, Department of Lands, Parks and Housing*.

GR-2690, 1981, 125/149, *Note on "Some Capital Program Planning Issues" for the Capital Steering Committee*.

GR-2690, 1983, 15/28, *Issue Paper on the Private Development of Intermediate Care Beds*.

GR-2690, 1983, 19/28, *Issue Paper on the Private Development of Intermediate Care Beds*.

GR-2698, 1973, 5/7, *Letter from Acacia TY Mawr Personal Care Homes-Rest Home to Dennis Cocke, Minister of B.C.H.I.S. May 21, 1973.*

GR-2698, 1974, 40-41, *Letter from Rest Home Owner to Minister of Health, Dennis Cocke*. January 8, 1974.

GR-2720, 1949, 4/13, *Letter from C. W. Lundy, Director of Welfare to J. A. Sadler, Regional Administrator of Social Welfare Branch*. March 25, 1949.

GR-2921, 1972, 6-7/31, *City of Vancouver Report on Elderly Care Facilities*.

GR-3578, 1969, 12-13/29, *Letter from Andrew H. Rose, B.C.H.I.S Inspector of Hospitals. June 5, 1969*.

GR-3578, 1969, 14-15/29, *Letter from Andrew H. Rose, B.C.H.I.S Inspector of Hospitals. January 27, 1969*.

GR-3938, 1952, 6/12, *Letter from Inspector of Hospitals Edith Pringle, to K. G. Wiper, Liability & Adjustment Mgr. B.C.H.I.S. February 18, 1952.*

GR-3938, 1952, 10/12, *Letter from Inspector of Hospitals Edith Pringle, to K. G. Wiper, Liability & Adjustment Mgr. B.C.H.I.S. May 30, 1951.*

GR-3938, 1951, 12/12, *Letter from Inspector of Hospitals Edith Pringle, to Liability & Adjustment Mgr. B.C.H.I.S, K. G. Wiper, to E. Pringle, Inspector of Hospitals*. May 25, 1951.

GR-3938, 1955, 5, *Hospital Act Introductory Remarks*.

GR-3975, 1982, 5/30, *News Release Issues by Information Services, Minister of Health. Long Term Facilities Get $2 Million Upgrading*. September 17, 1982.

GR-3975, 1982, 8/45, *Speaking Notes: Garry Cardiff, Assistant Deputy Minister of Institutional Services, To Association of Non-Profit Community Care Facilities*.

GR-3975, 1982, 18/45, *Speaking Notes: Garry Cardiff, Assistant Deputy Minister of Institutional Services, To Association of Non-Profit Community Care Facilities*.

GR-3975, 1982, 22, 25-45, *Speaking Notes For Stan Dubas, Senior Assistant Deputy Minister, Management of Operations Subject: The Elastic Health Dollar*.

GR-3975, 1982, 27-30, *Ministry of Health, Discussion Paper: Private Involvement in Health Care in B.C.*

GR-3975, 1983, 17, *Ministry of Health, Discussion Paper: Private Involvement in Health Care in B.C.*

GR-3975, 1983, 25/124, *B.C Long Term Care Association, Response to Minister of Health, James A Nielsen On Questions Relating to Cost and Efficiency*. December 1, 1983.

GR-3975, 1984, 16/49, *Health Policies in Canada, 1984: Stability and Change. By Anne Crichton, Ph.D.*

GR-3975, 1985, 22/137, *Discussion Paper: Community Care Facility Act, Policy, Planning and Legislation Division*.

GR-3975, 1985, 26/137, *Discussion Paper: Community Care Facility Act, Policy, Planning and Legislation Division, July 25, 1985*.

GR-3975, 1985, 76/137, *Outline: Discussion Paper on Community Care Facility Act (C.C.F.A.), Continuing Care Division*.

GR-3975, 1985, 88/157, *Ministry of Health Discussion Paper on the Community Care Facility Act (C.C.F.A.)*.

GR-3997, 1986, 22/89, *Policy, Planning and Legislation. (1986). Health Care Facilities And the Private Sector*.

GR-4201, 1974, 72, *A Report on Long Term Care in British Columbia, by Richard G. Foulkes, Director of Health Security Programme Project*.

GR-4201, 1975, 13/53, *Memorandum To: Cabinet Committee on Human Services. Subject: Financing of Long-term Care*. July 29, 1975.

GR-4650, 1992, 20-21/60, *B.C Ministry of Health and Ministry Responsible for Seniors. Continuing Care Division. Service Provider Handbook.*

GR-6768, 1975, 18/28, *B.C.H.I.S Letter on "Staffing Proposed Intermediate Care and Personal Care Facilities"*. January 24, 1975.

GR-880057-0091, 1974, 72-73/108, *Letter from the Social Services and Income Security Programmes, Department of Human Resources, to J. A. Sadler, the Assistant Deputy Minister of Social Welfare and J. Noble, Deputy Minister of Human Resources, RE: Need FOR DEPARTMENT AND GOVERNMENT POSITION ON SENIOR CITIZEN HOUSING AND SERVICES TO SENIORS. May 24, 1974*.

GR-880057-0091, 1974, 84, 168/308, *A Report on Long Term Care in British Columbia, by Richard G. Foulkes, Director of Health Security Programme Project*.

GR-880057-0091, 1975, 20/53, *Memorandum To: Cabinet Committee on Human Services. Subject: Financing of Long-term Care. June 29, 1975*.

GR-880057-0091, 1975, 53/107, *Long-term care Services in Alberta and Manitoba, by the Ministry of Human Resources. October 1, 1975*.

GR-880057-0091, 1975, 67/107, *Report on the Long-term care programme for British Columbia, by the Ministry of Human Resources. June 23, 1975*.

GR-880057-0091, 1976, 7/108, *A Comprehensive In Home and Residential Personal And Intermediate Care Program For British Columbia, by: A. A. Larsen, Chairman of Provincial Adult Care Facilities Licensing Board and Elizabeth Bristowe, Director, Special Care, Adults Division, Department of Human Resources*.

GR-880057-0091, 1976, 16-17/107, *Letter from J. A. Sadler, Deputy Minister of the B.C.H.I.S., to Mr. Martin Cook, Department Comptroller, Department of Urban Resources. April 16, 1976*.

GR-880057-0091, 1976, 21, *Letter from A. A. Larsen, Chair of Provincial Adult Care Facilities Licensing Board to J. W. Mainguy, Deputy Minister of Health*.

News and Magazine Articles

Ontario

Chatelaine Magazine. (1965). A shocking report on Ontario nursing homes. *Chatelaine*.

The Evening Citizen. (1953). Nursing homes rapped: Dirty, crowded, AMOH finds. *The Evening Citizen*.

The Globe. (1934). Cabinet approves outside treatment for convalescents. *The Globe*.

The Globe and Mail. (1944). Public funds urged to pay for indigents. *The Globe and Mail*.

The Globe and Mail. (1947). Private homes expensive. *The Globe and Mail*.

The Globe and Mail. (1947a). Public hearing re licensing of lodging houses and keepers thereof. *The Globe and Mail*.

The Globe and Mail. (1952). Nursing home service standard being considered. *The Globe and Mail*.

The Globe and Mail. (1952a). Devise care code for nursing homes. *The Globe and Mail*.

The Globe and Mail. (1958). Financial aid condition: Nursing homes face minimum standards. *The Globe and Mail*.

The Globe and Mail. (1958a). Nursing home licenses asked by York County. *The Globe and Mail*.

The Globe and Mail. (1958c). Nursing home proprietors freed of charge. *The Globe and Mail*.

The Globe and Mail. (1959). Nursing home operators form association to discuss legislation and standards. *The Globe and Mail*.

The Globe and Mail. (1959a). Uniformity is sought for nursing homes. *The Globe and Mail*.

The Globe and Mail. (1964). Controlling nursing home standards. *The Globe and Mail*.

The Globe and Mail. (1964b). Nursing homes offer deal on hospital bed assistance. *The Globe and Mail*.

The Globe and Mail. (1964c). Dymond announces short-term methods to cut bed shortage. *The Globe and Mail*.

The Globe and Mail. (1965a). Dilemma in standards: Enforcing rules would shut many Ontario nursing homes. *The Globe and Mail*.

The Globe and Mail. (1965b). All eyes turn to provincial government: Licensing, inspection and quality of nursing homes inconsistent in Ontario. *The Globe and Mail*.

The Globe and Mail. (1965c). And high time, too! *The Globe and Mail*.

The Globe and Mail. (1965d). Letter from nursing home group claims regulations hinder care. *The Globe and Mail*.

The Globe and Mail. (1965e). Welfare Council report urges Nursing Home Act. *The Globe and Mail*.

The Globe and Mail. (1965f). License nursing homes, welfare group urges. *The Globe and Mail*.

The Globe and Mail. (1965g). Set standard by legislation, committee told: OMA urges provincial inspection of nursing homes. *The Globe and Mail*.

The Globe and Mail. (1965h). Across the land: A summary of the week's Canadian news: Ontario. *The Globe and Mail*.

The Globe and Mail. (1965i). Health care by one body to be urged. *The Globe and Mail*.

The Globe and Mail. (1965k). Nursing homes called poor's death houses. *The Globe and Mail*.

The Globe and Mail. (1965m). The point bears repeating. *The Globe and Mail*.

The Globe and Mail. (1965n). Nursing homes need closer check. *The Globe and Mail*.

The Globe and Mail. (1965p). For the aged. *The Globe and Mail*.

The Globe and Mail. (1965z). More specialized care urged for Ontario aged. *The Globe and Mail*.

The Globe and Mail. (1966). All nursing homes will require license, regular inspections. *The Globe and Mail*.

The Globe and Mail. (1966a). Nursing homes fear cost jump when act passed. *The Globe and Mail*.

The Globe and Mail. (1967). Nursing home manual interprets 1966 act. *The Globe and Mail*.

The Globe and Mail. (1967b). Conscience must balance profit, care of patient. *The Globe and Mail*.

The Globe and Mail. (1967c). Homes decline as hospital beds on increase. *The Globe and Mail*.

The Globe and Mail. (1968). Ontario plans consultants in health work. *The Globe and Mail*.

The Globe and Mail. (1969i). After complaints, Dymond decides to see operators. *The Globe and Mail*.

The Globe and Mail. (1969j). No guilt in profits, nursing homes are told. *The Globe and Mail*.

The Globe and Mail. (1970). Nursing homes affect patients, inquest hears. *The Globe and Mail*.

The Globe and Mail. (1971). A maverick minister's formula for medical reform. *The Globe and Mail*.

The Globe and Mail. (1971a). MD says views misleading on nursing home safety, care, size, profit. *The Globe and Mail*.

The Globe and Mail. (1971b). Helping the aged becomes a growth industry. *The Globe and Mail*.

The Globe and Mail. (1972). New rules for Ontario nursing homes termed impossible. *The Globe and Mail*.

The Globe and Mail. (1972c). New financing system foreseen: Nursing home regulations may be eased. *The Globe and Mail*.

The Globe and Mail. (1973). Security capital. *The Globe and Mail*.

The Globe and Mail. (1981). Freeze ended on expansion of homes for the aged. *The Globe and Mail*.

Hospital Administration in Canada. (1971). Nursing homes: A changing scene. *Hospital Administration in Canada*, *13*(10).

Journal of the Canadian Hospital Association. (1964). Ontario nursing homes enter new era of patient care. *Canadian Hospital*, *41*(11), 45–46.

Journal of the Canadian Hospital Association. (1971). Minister of Health welcomes Nursing Home Association participation in developing guidelines for provincial nursing home insurance scheme. *Canadian Hospital*, *48*(8), 52–53

Leisure World News. (1972). Leisure World has a short but eventful history. *Leisure World News*.

News from the field. (1976). *Canadian Journal of Public Health*, *67*(3), 259–260.

The Ottawa Citizen. (1954). To license nurse homes under bylaw. *The Ottawa Citizen*.

The Ottawa Citizen. (1959). Ease pressure: Urge $2,000,000 rest home here. *The Ottawa Citizen*.

The Ottawa Citizen. (1965). Standards within nursing homes. *The Ottawa Citizen*.

The Ottawa Citizen. (1966). Ontario's Speech from the Throne. *The Ottawa Citizen*.

The Ottawa Citizen. (1966a). Licensing of nursing homes. *The Ottawa Citizen*.

The Ottawa Citizen. (1966b). No financial aid seen to help nursing homes. *The Ottawa Citizen*.

The Ottawa Citizen. (1969). Nursing home closed, officials won't say why. *The Ottawa Citizen*.

The Ottawa Citizen. (1972d). Regulations may force 60 nursing homes to close. *The Ottawa Citizen*.

Raveendran, R. (2025). Ontario bill will protect bad actors in long-term care homes. *CBC News*.

Stevens, G. (2020). On long-term care reform, Ontario could take a page from B.C.'s playbook. *Toronto Star*.

Toronto Daily Star. (1944). Hospitals "couldn't handle" flu epidemic like in 1918. *Toronto Daily Star*.

Toronto Daily Star. (1947). Lodging house licenses. *Toronto Daily Star*.

Toronto Daily Star. (1947a). Public notice: Licensing of boarding schools, children's homes, homes for aged people, hostels and nursing homes. *Toronto Daily Star*.

Toronto Daily Star. (1948). The care of sick old people in Toronto. *Toronto Daily Star*.

Toronto Daily Star. (1948a). City will adjust rentals on emergency home units. *Toronto Daily Star*.

Toronto Daily Star. (1948b). Nursing home curb would affect 1,000 patients. *Toronto Daily Star*.

Toronto Daily Star. (1948c). Residence by-law vs. need dispute rages at city hall. *Toronto Daily Star*.

Toronto Daily Star. (1949). Rosedale change. *Toronto Daily Star*.

Toronto Daily Star. (1952). Profit said first in many nursing homes. *Toronto Daily Star*.

Toronto Daily Star. (1952a). Three needed services. *Toronto Daily Star*.

Toronto Daily Star. (1953). A code for nursing homes. *Toronto Daily Star*.

Toronto Daily Star. (1953a). Praiseworthy action. *Toronto Daily Star*.

Toronto Daily Star. (1958). Scorned nursing homes get big role in Ontario hospital plan. *Toronto Daily Star*.

Toronto Daily Star. (1958a). Animal better protected by law, cadi says. *Toronto Daily Star*.

Toronto Daily Star. (1959). No insurance for 1,500 in homes. *Toronto Daily Star*.

Toronto Daily Star. (1959a). Prophets of doom foiled, hospital plan works. *Toronto Daily Star*.

Toronto Daily Star. (1961). Threat removed. *Toronto Daily Star*.

Toronto Daily Star. (1964). License all nursing homes. *Toronto Daily Star*.

Toronto Daily Star. (1965). Spruce up, province tells nursing homes. *Toronto Daily Star*.

Toronto Daily Star. (1966). Nursing homes: The second phase. *Toronto Daily Star*.

Toronto Daily Star. (1967a). Nursing home: Just a garret? *Toronto Daily Star*.

Toronto Daily Star. (1969). Nursing home "loans too costly." *Toronto Daily Star*.

Toronto Daily Star. (1971c). Nursing homes face strict rules, operators warned. *Toronto Daily Star*.

Toronto Daily Star. (1971d). Nursing home operators warn expansion will hurt case. *Toronto Daily Star*.

Toronto Star. (1972). Medicare may close 60 nursing homes. *Toronto Star*.

Toronto Star. (1972a). Ontario's 4-month old nursing home system creates discontent. *Toronto Star*.

Toronto Star. (1972b). Potter wants to seize homes flouting nursing standards. *Toronto Star*.

Toronto Star. (1972c). Homes "play on sympathy of relatives" to force relaxation of rules: Potter. *Toronto Star*.

Toronto Star. (1972d). Nursing home plan to help widow. *Toronto Star*.

Toronto Star. (1980). Good advice from fire inquiry. *Toronto Star*.

Toronto Star. (1985). Critics want homes' spending made public. *Toronto Star*.

Toronto Star. (1985a). Sick and frail often feel neglected, lonely. *Toronto Star*.

Toronto Star. (1985c). Ruling strikes down 38 charges against nursing home. *Toronto Star*.

Toronto Star. (1999). Nursing home operator ousted. *Toronto Star*.

Toronto Star. (2017). Far too many hospital beds occupied by patients who don't need to be there. *Toronto Star*.

Toronto Star. (2020). Ontario's for-profit nursing homes — which have significantly higher rates of COVID-19 deaths — have 17% fewer workers, new Star analysis reveals. *Toronto Star*.

British Columbia

B.C. Newspaper Archives. (1897, April). *B.C. Newspaper Archives*.

B.C. Newspaper Archives. (1907, March 13). *B.C. Newspaper Archives*.

B.C. Newspaper Archives. (1913a, March 1). *B.C. Newspaper Archives*.

B.C. Newspaper Archives. (1913b, February 3). *B.C. Newspaper Archives*.

B.C. Newspaper Archives. (1916, March 31). *B.C. Newspaper Archives*.

B.C. Newspaper Archives. (1956, February). *B.C. Newspaper Archives*.

Daily Colonist. (1971). Personal care outlined. *Daily Colonist*.

Daily Province. (1916). Premier's explanations of financing of new B.C. building in London. *Daily Province*.

The Province. (1956). Board cracks down on "nursing homes." *The Province*.

The Province. (1957). BCHIS to cover chronics: But not all, says Martin. *The Province*.

The Province. (1957a). Rest homes facing charges. *The Province*.

The Province. (1957b). Looking for a rest home for your elderly mother? *The Province*.

The Province. (1958). Tight rules studied for nursing homes. *The Province*.

The Province. (1958a). Nursing home control urged. *The Province*.

The Province. (1959). Hospital regulation urged by local council. *The Province*.

The Province. (1959a). Change of control demanded. *The Province*.

The Province. (1959b). Legislation on nursing homes moved. *The Province*.

The Province. (1959c). Brief on hospitals goes before council. *The Province*.

The Province. (1959d). New city hospital proposed; welfare patients rejected. *The Province*.

The Province. (1959e). Another $1.50 daily means 30 beds. *The Province*.

The Province. (1970). Last penny given — Loffmark. *The Province*.

The Province. (1973). Lack of intermediate care facilities cited. *The Province*.

The Province. (1974). Intermediate care cases need 3,500 beds — report. *The Province*.

The Province. (1976). Senior citizens center may suffer subsidy axe. *The Province*.

The Sun. (1971a). Bennett, aging committee to meet after session ends. *The Sun*.

The Vancouver Sun. (1932). Premier tells of grants to municipalities. *The Vancouver Sun*.

The Vancouver Sun. (1948). Private hospitals. *The Vancouver Sun*.

The Vancouver Sun. (1952). Small hospitals do big business: Vancouver's sixty little-known institutions are well filled. *The Vancouver Sun*.

The Vancouver Sun. (1955). Probe asked on indigent sick care. *The Vancouver Sun*.

The Vancouver Sun. (1959). "Serious look" for private hospitals. *The Vancouver Sun*.

The Vancouver Sun. (1959a). State hospitals boost too small. *The Vancouver Sun*.

The Vancouver Sun. (1959b). New tactics in hospital rate fight: Private institutions seeking paying instead of welfare patients. *The Vancouver Sun*.

The Vancouver Sun. (1959c). Hospital auxiliaries will convene here. *The Vancouver Sun*.

The Vancouver Sun. (1960). Chronic hospitals up to committees. *The Vancouver Sun*.

The Vancouver Sun. (1961). Letters to the editor: Nursing homes. *The Vancouver Sun*.

The Vancouver Sun. (1971). Private hospital rate controls due. *The Vancouver Sun*.

The Vancouver Sun. (1971b). City plan for homes for elderly expected. *The Vancouver Sun*.

The Vancouver Sun. (1973). Care of home patients at hospital rates urged. *The Vancouver Sun*.

The Vancouver Sun. (1975). Privately-owned rest homes face uncertain future in B.C. *The Vancouver Sun*.

The Vancouver Sun. (1975a). Raise $1-a-day hospital fee to aid intermediate patients. *The Vancouver Sun*.

Victoria Daily Times. (1913). Hospital Act has been prepared. *Victoria Daily Times*.

Victoria Times. (1960). Home nursing grant for VON: Expansion of services planned with extra aid from Province. *Victoria Times*.

Victoria Times. (1967). Nobody wants a penniless individual. *Victoria Times*.

Victoria Times. (1967a). From human being to 'welfare case'. *Victoria Times*.

Other Papers

Chatfield, G. J. (2022, May 21). Gary James Chatfield [Obituary]. *Winnipeg Free Press Passages*. https://passages.winnipegfreepress.com/passage-details/id-307963/CHATFIELD_GARY

The Leader Post. (1972). Local nursing homes purchases to get aid.