

# Federalism as a Strength: A Path Toward Ending the Crisis in Long-Term Care

Carolyn Hughes Tuohy

## IN BRIEF

In the first eight months of the COVID-19 pandemic, more than 80 percent of Canadian deaths occurred in long-term care facilities. There have been calls for the federal government to play a stronger role, but this is complicated by the fact that provinces have adopted a wide range of long-term care policies. Nevertheless, governments could bring new resources and regulatory tools to these challenges by drawing on the untapped possibilities of Canadian federalism. The most promising path lies in areas of concurrent jurisdiction in which both orders of government have an established presence, a history of joint decision-making and action, and the infrastructure that makes this possible. If we do not act now, the failings exposed by the pandemic will continue to take their toll on the lives of Canada's most vulnerable citizens.

## EN BREF

Au cours des huit premiers mois de la pandémie, plus de 80 p. 100 des décès dus à la COVID-19 au Canada ont été enregistrés dans les centres de soins de longue durée. Si des appels ont été lancés pour que le gouvernement fédéral joue un plus grand rôle, les nombreuses politiques provinciales déjà existantes dans le domaine compliquent la tâche. Mais le fédéralisme canadien offre aux gouvernements des possibilités jusqu'à maintenant négligées en termes de ressources et d'outils réglementaires. La voie la plus prometteuse se trouve dans les champs de compétences partagés où chaque ordre de gouvernement a déjà une présence établie, où il y a un historique de prise de décision et d'action conjointes, et des infrastructures qui rendent le tout possible. Si nous n'agissons pas maintenant, les failles mises en lumière par la pandémie continueront d'affecter la vie des citoyens canadiens les plus vulnérables.



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## ABOUT THIS PAPER

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**Carolyn Hughes Tuohy** is a professor emeritus of political science and distinguished fellow at the University of Toronto's Munk School of Global Affairs and Public Policy. She holds a BA from the University of Toronto, and an MA and PhD in Political Science from Yale University. She specializes in comparative public policy, with an emphasis on social policy. Her most recent book is *Remaking Policy: Scale, Pace and Political Strategy in Health Care Reform* (University of Toronto Press, 2018). In addition to her current work on long-term care policy in Canada in a comparative perspective, she is working on a book on the power of narrative discourse in public policy. Other publications include *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada* (Oxford University Press, 1999), *Policy and Politics in Canada: Institutionalized Ambivalence* (Temple University Press, 1992), four coedited books and numerous journal articles and book chapters on health and social policy, professional regulation, and comparative approaches in public policy. From 1992 to 2005, she served in the senior administration of the University of Toronto as Deputy Provost and as Vice-President, Government and Institutional Relations. She has served as a member of the Board of Directors and the Scientific Advisory Committee of the Institute for Clinical Evaluative Sciences (ICES) and as Vice-Chair of the Boards of Directors of the Institute for Work and Health and of the Canadian Health Services Research Foundation (now the Canadian Foundation for Healthcare Improvement). She was Founding Fellow of the School of Public Policy and Governance at the University of Toronto (now merged with the Munk School), and is a Fellow of the Royal Society of Canada.

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## INTRODUCTION

The shocking scale and disorienting impact of the COVID-19 pandemic have drawn public attention to long-neglected issues in ways that promise to reshape the policy agenda. In Canada, this is nowhere more true than in the area of long-term care.<sup>1</sup> In the first eight months of the pandemic, Canada was an international bellwether for problems in this sector, with more than 80 percent of COVID-19 deaths concentrated in long-term care facilities. Even as some other nations came to exhibit a similar pattern, Canada's concentration of deaths among long-term care residents remained among the highest internationally. This is a grim and lamentable history. But its jarring effect on public consciousness may spur Canadian governments, and Canadian society as a whole, to address rankling issues of quality and access to long-term care.<sup>2</sup>

We need to put this problem in perspective. Overall, Canada's COVID-19 deaths relative to population, whether in long-term care or in the community, were in the mid to low range among advanced nations in the pandemic's first year (see table 1 on page 7). Moreover, deaths of long-term care residents disproportionately occurred in a relatively small number of facilities. For example, 15 percent of Ontario's long-term care homes accounted for 90 percent of all deaths of residents as of mid-November 2020.<sup>3</sup> But the fact that the problem is concentrated in a troubled segment makes it no less urgent.

Over the course of the pandemic, there have been calls for the federal government to play a stronger role in developing national standards, providing new funding or both.<sup>4</sup> The federal Liberal parliamentary caucus, as well as grassroots party organizations, called on the government "to develop enforceable national standards for long-term care homes and to provide provinces with the funding needed to meet those standards."<sup>5</sup> The government's Fall Economic Statement, following commitments made in the September Speech from the Throne, established a Safe Long-term Care Fund of up to \$1 billion. The Fund is to be allocated to provinces and territories on a per capita basis conditional on the submission of detailed spending plans and follow-up reports. The Statement also made a number of targeted commitments including temporary funding for the training of personal support workers.

However, the provinces have jurisdiction over long-term care, and they have adopted a wide range of policies and organizational models. These are the institutional facts of

<sup>1</sup> D. Béland and P. Marier, "COVID-19 and Long-Term Care Policy for Older People in Canada," *Journal of Aging & Social Policy* 32, no. 4-5 (2020): 358-64.

<sup>2</sup> Throughout this paper, unless otherwise indicated, I use "long-term care" as synonymous with continuing care, encompassing support for health needs requiring ongoing management, regardless of the site of care, whether in the recipient's private home or in an institutional facility.

<sup>3</sup> Calculated from data available at Ontario, "Status of COVID-19 Cases in Long-Term Care Homes," <https://www.ontario.ca/page/how-ontario-is-responding-covid-19#section-2>

<sup>4</sup> Béland and Marier, "COVID-19 and Long-Term Care Policy," 358-364; Royal Society of Canada, *Restoring Trust: COVID-19 and The Future of Long-Term Care, A RSC Policy Briefing* (Ottawa: Royal Society of Canada, June 2020).

<sup>5</sup> J. Bryden, "Liberal MPs Call for National Standards for Long-Term Care Homes," *Canadian Press*, May 29, 2020, <https://www.cbc.ca/news/politics/liberal-mps-long-term-1.5589797>.

life in Canada. This highly decentralized model means that Canada has forgone the advantages that a federal system, in theory, could offer for long-term care. Certain inherent characteristics of such care, notably the need for localized delivery and the bundling of care with lifestyle arrangements, are consistent with a high degree of decentralization. But other characteristics, such as the need for equity in matters so closely connected to human dignity, and the requirement for public pooling of risk, mean that a stronger federal presence could have considerable advantages.

We need to find new ways of working within the institutions of Canadian federalism, to find better ways of balancing decentralized and centralized components of long-term care. In that way, we can exploit the strengths of federalism and minimize its weaknesses. Seizing this moment will require strategic thinking. We need to identify the range of the possible within our existing and political institutional context, develop a menu of options to be considered and chart an expeditious and effective way forward. This paper is intended to inform each prong of that threefold strategy.<sup>6</sup>

## THE POLITICAL CONTEXT: A WINDOW OF OPPORTUNITY

Media attention to the problem has been intense. Figure 1 compares newspaper coverage of long-term care as a policy issue with coverage of pharmacare (or universal drug coverage).

Heightened public attention to the issue creates an incentive for government action.<sup>7</sup> But it does not tell us what, if any, action can and should be taken, nor who can and should take it. Any pan-Canadian policy response, especially one involving an enhanced role for the federal government, will have to navigate an institutional environment in which the principal responsibility for oversight of long-term care rests with provincial governments. Nonetheless, there is scope for joint intergovernmental action in long-term care, by picking up instruments not yet considered. Particular promise lies in areas in which federal and provincial governments have concurrent jurisdiction: old age security (to provide both funding and harmonization of benefits) and immigration (to raise and harmonize standards for the qualifications and working conditions of caregivers). Acting in these areas would add a set of complementary mechanisms to the existing institutional framework, rather than attempting a major institutional transfer of responsibility to the federal government.

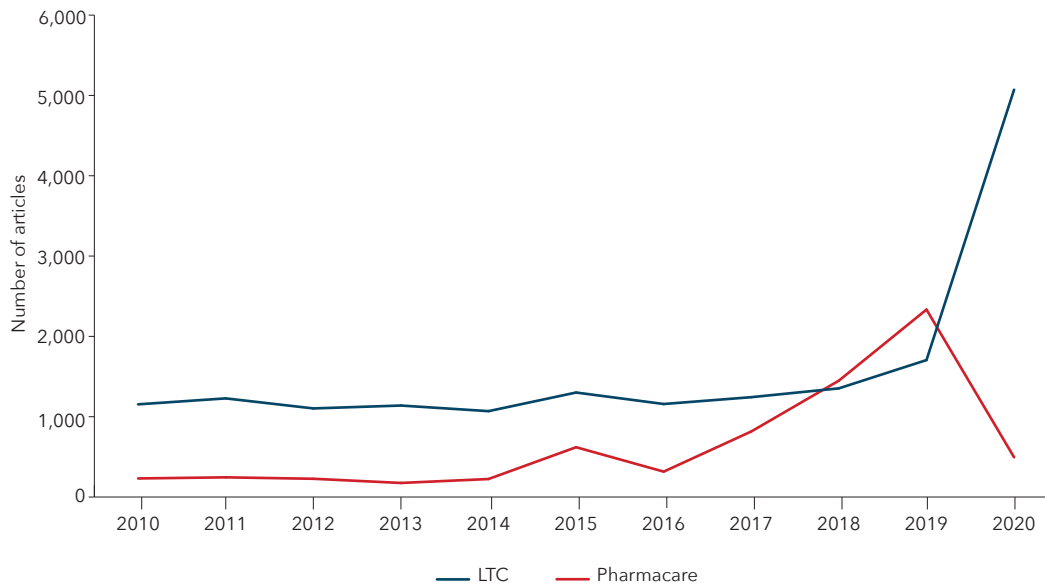
This would constitute what I have termed a “mosaic” reform, a suite of additions to established arrangements that build on existing models.<sup>8</sup> Current political and institutional conditions appear ripe for such a strategy. Mosaics are likely to occur when a set of independent political actors, each with their own agenda, agree on

<sup>6</sup> An earlier, more concise version of this argument appears in C. H. Tuohy, “A New Federal Framework for Long-Term Care in Canada,” *Policy Options*, August 20, 2020, <https://policyoptions.irpp.org/magazines/august-2020/a-new-federal-framework-for-long-term-care-in-canada/>.

<sup>7</sup> Béland and Marier, “COVID-19 and Long-Term Care Policy.”

<sup>8</sup> C. H. Tuohy, *Remaking Policy: Scale, Pace, and Political Strategy in Health Care Reform* (Toronto: University of Toronto Press, 2018).

**Figure 1. Media coverage of long-term care and pharmacare, Canadian newspapers (English), 2000-2020**



Source: Author’s calculation based on Canadian Newsstream database search.  
 Note: “Long-term care” only counts mentions of long-term care together with government. “Pharmacare” counts mentions of either pharmacare or universal drug coverage. The articles are drawn from daily newspapers in Canada, in English, with weekly circulation of more than 40,000, with continuous coverage in the Canadian Newsstream database, to September 20, 2020. The restriction to English publications leads to understating the extensive coverage of long-term care as a policy issue in Quebec, where the concentration of COVID-19 deaths in long-term care facilities was worse than in any other province.

the necessity of reform on an urgent basis and negotiate a set of mutually agreeable changes to the existing policy framework. The set of independent actors in long-term care – federal and provincial governments and a multiplicity of public and private providers – is not going to change in the foreseeable future. The unprecedented wave of deaths in long-term care institutions during the COVID-19 pandemic has created the sense of need and urgency necessary for them to act in concert.

### THE INSTITUTIONAL CONTEXT OF FEDERALISM AND LONG-TERM CARE

There is little evidence from other countries that federal or unitary governance structures, per se, have done better or worse in managing the COVID-19 pandemic, at least as measured by death rates in long-term care facilities or more generally. As of the end of January 2021, the highest death rates and the highest shares of total deaths in long-term care had occurred in federal countries (Australia,<sup>9</sup> Belgium and Canada, respectively). But there is wide variation within each governance

<sup>9</sup> Note, however, that the high scores for Australia, New Zealand and Norway on this measure are anomalous. They reflect the low proportion of deaths overall, most of which occurred in long-term care.

category (see table 1).<sup>10</sup> Similarly, all national jurisdictions, federal or unitary, have shown regional variations. It is in the nature of the coronavirus SARS-CoV-2 (causing COVID-19) to have localized effects, like many other infectious pathogens. Various hot spots flare through community transmission. Some communities are more vulnerable than others. In the United Kingdom, for example, cumulative deaths per 100,000 people as of May 28, 2020, ranged from 29.8 in Northern Ireland to 65.5 in England. Within England, the range was from 79.6 in the northeast to 33.5 in the southwest.<sup>11</sup> In Germany, cumulative deaths per 100,000 people as of September 3, 2020, ranged from 20.2 in Bavaria to 1.2 in Mecklenburg-Western Pomerania.<sup>12</sup> Canada's experience of significant variation across provinces, from 79.5 cumulative deaths per 100,000 in Quebec to zero in Prince Edward Island as of mid-November 2020,<sup>13</sup> fits within this broad, cross-national pattern. Caution should be exercised in comparing these data across, rather than within countries, because there are some differences in how deaths are attributed to COVID-19.

Despite this varied experience, a number of characteristics of long-term care suggest that federal systems should be well suited to the delivery and financing of care, at least in theory, if their strengths can be harnessed and their weaknesses mitigated. Localized delivery and bundling of care and living arrangements argue for decentralized arrangements. The value of ensuring equity in provision of essential services and the need to pool financial risk has a centralizing thrust. Well-designed federal systems should be able to incorporate these different policy elements.

Even in an age in which the range of health services that can be delivered virtually is expanding, a wide range of services inherently requires physical contact between provider and recipient. This is especially true in the case of long-term care. Care is typically delivered in a residential setting, whether in the recipient's private home or in an institutional facility, and involves services that must be provided on a regular and frequent basis. Providers must therefore be located in proximity to recipients. Catchment areas are accordingly localized. There is also a significant lifestyle aspect to long-term care and the context in which it is provided. Preferences may vary not only across individuals but across communities. These local variations in preferences are reflected in the fact that, historically, much of long-term care was provided by religious and other community-based groups, including municipal governments. All of these factors militate in favour of a decentralized mode of governing care delivery.

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<sup>10</sup> The three principal ways of attributing deaths to COVID-19 are number of deceased having tested positive for SARS-CoV-2 (confirmed), number of deceased having shown symptoms of COVID-19 (probable) and aggregate number of deaths above seasonal average (excess deaths); A. Comas-Herrera, J. Zalakaín, C. Litwin, A.T. Hsu, N. Lane and J-L. Fernández, *Mortality Associated with COVID-19 Outbreaks in Care Homes: International Evidence*, LTCcovid.org. International, <https://lccovid.org/wp-content/uploads/2020/10/Mortality-associated-with-COVID-among-people-living-in-care-homes-14-October-2020-5.pdf>

<sup>11</sup> Public Health England, "Coronavirus (COVID-19) in the UK," <https://coronavirus.data.gov.uk/#category=nations&map=rate>

<sup>12</sup> Robert Koch Institut, "Coronavirus Disease 2019 (COVID-19) Daily Situation Report of the Robert Koch Institute," [https://www.rki.de/DE/Content/InfAZ/N/Neuartiges\\_Coronavirus/Situationsberichte/Sept\\_2020/2020-09-03-en.pdf](https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronavirus/Situationsberichte/Sept_2020/2020-09-03-en.pdf)

<sup>13</sup> COVID-19 Canada Open Data Working Group, "Epidemiological Data from the COVID-19 Outbreak in Canada," <https://art-bd.shinyapps.io/covid19canada/>



**Table 1. COVID-19 mortality in 16 countries, as of January 2021**

Country	Governance category (federal/unitary)	Reporting date	Approach to measuring deaths	Deaths/100k pop.	Deaths of care home residents as % total deaths	Deaths of care home residents as % all residents
Australia	Federal	22/01	Confirmed	<b>3.64</b>	<b>75</b>	<b>0.33</b>
Belgium	Federal	19/01	Confirmed + Probable	<b>185.75</b>	57	<b>9.35</b>
Canada	Federal	23/01	Confirmed + Probable	54.94	59	2.61
Germany	Federal	22/01	Confirmed	72.08	<b>28</b> <sup>1</sup>	1.72
US	Federal	07/01	Confirmed + Probable	137.75	39	7.21
Austria	Unitary <sup>2</sup>	24/01	Confirmed	89.32	44	4.65
Denmark	Unitary	19/01	Confirmed	37.45	39	1.79
Finland	Unitary	22/01	Confirmed	12.41	33 <sup>3</sup>	0.42
France	Unitary	20/01	Confirmed + Probable	116.05	43	5.02
Netherlands	Unitary	15/01	Confirmed	82.88	51	5.44
New Zealand	Unitary	12/01	Confirmed + Probable	<b>0.51</b>	<b>64</b> <sup>3</sup>	0.04
Norway	Unitary	20/01	Confirmed	10.80	60 <sup>3</sup>	0.81
Singapore	Unitary	24/01	Confirmed	<b>0.51</b>	<b>14</b>	<b>0.02</b>
Sweden	Unitary	18/01	Confirmed + Probable	<b>117.24</b>	47	<b>5.66</b>
United Kingdom	Unitary (devolved)	15-17/01	Confirmed + Probable	<b>164.76</b>	<b>34</b>	<b>7.22</b>
Spain	Unitary (devolved)	22/01	Confirmed + Probable	<b>129.21</b>	<b>40</b>	<b>7.88</b>

■ Highest within governance category ■ Lowest within governance category

Source: Johns Hopkins University & Medicine, Coronavirus Resource Center, "Mortality Analyses," <https://coronavirus.jhu.edu/data/mortality>; A. Comas-Herrera et al., Mortality Associated with COVID-19 Outbreaks in Care Homes. In LTCcovid.org.

Note: Democratic states with more than 5 million population.

<sup>1</sup> Includes other communal establishments, such as prisons, with younger populations. Therefore, figures given overstate deaths in care homes as a percentage of all COVID-related deaths but may underestimate deaths as a percentage of total care home population.

<sup>2</sup> Although Austria is nominally a federation, the centralized distribution of powers means that it is better treated as a unitary state for comparative purposes.

<sup>3</sup> Deaths in long-term care facilities.

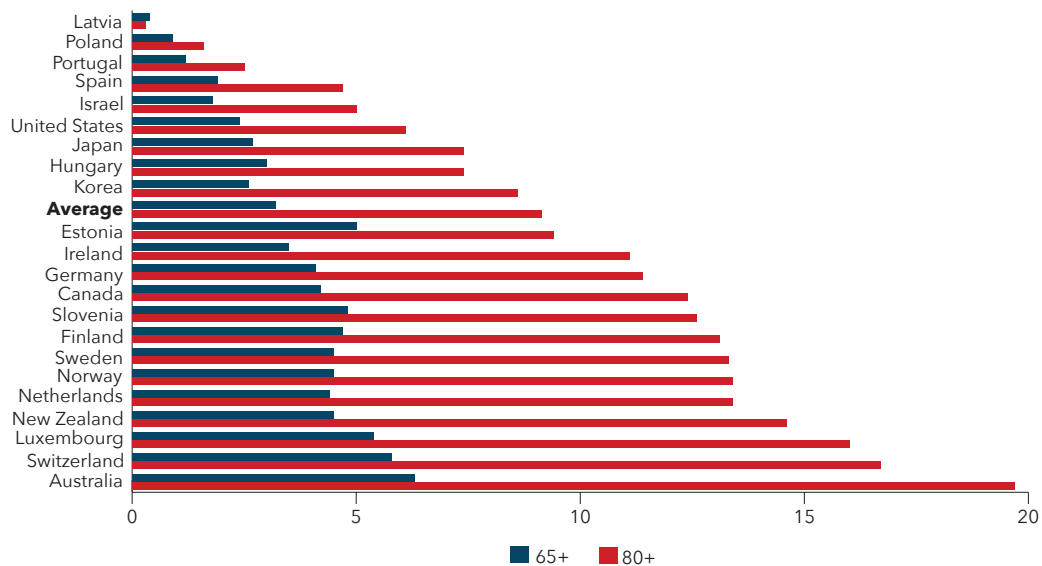
Weighing against that decentralist pressure, however, is the value of equity: the principle that any national polity should strive to ensure common standards of health and well-being for its members. All national systems of governance, whatever the degree of autonomy enjoyed by subnational units, wrestle with this decentralist-centralist tension. In most member states of the Organisation for Economic Co-operation and Development (OECD), the regulation or operation of long-term care facilities and the determination of the eligibility of care recipients is divided between central and local authorities. The particularities of these arrangements vary widely.<sup>14</sup>

<sup>14</sup> Organisation for Economic Co-operation and Development, *Long-Term Care and Health Care Insurance in OECD and Other Countries* (Paris: OECD, February 2020), 13-14.

Another important centralizing force in long-term care is the need to pool risk. The risk of requiring such care is heavily concentrated in the elderly population, especially at age 85 and above. As shown in figure 2, the proportion of the population 65 years of age and older in long-term care facilities was less than 4 percent, on average, across 24 OECD members for which data are available for 2016. It was 4.2 percent in Canada. For those 80 years of age and older, the residential long-term care population still constituted less than 10 percent, on average, across the 24 members. In Canada, 12.4 percent of those 80 and older are in institutional care, and only at age 90 and above does the likelihood of requiring such care rise above 25 percent for women and 15 percent for men.<sup>15</sup> As for long-term care delivered in the recipient’s private home, the proportion of individuals receiving home-care services in Canada in 2015-16 was estimated at 4.7 percent for those in the 65-74 age category, rising to 12.2 percent for those 75-84 and escalating sharply to 34.1 percent for those 85 and above.<sup>16</sup> Unmet need was estimated at 1.8 percent for those aged 65-74, 4.3 percent for those aged 75-84 and 8.5 percent for those aged 85 and above.

In the private realm, individual households largely pay for long-term care, almost entirely in the form of out-of-pocket payments. Private markets for long-term care insurance are slim to nonexistent in Canada and across OECD members.<sup>17</sup> At first blush, this absence of private insurance is puzzling. The data show that, for most people, long-term care is a distant, unlikely, but potentially costly requirement to

**Figure 2. Proportion of population 65+ and 80+ in long-term care facilities, 2016**



Source: Organisation for Economic Co-operation and Development, “Dataset: Health Expenditure and Financing,” [https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH\\_LTCR](https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_LTCR).

<sup>15</sup> R. Garner, P. Tanuseputro, D. G. Manuel, and C. Sanmartin, *Transitions to Long-Term and Residential Care among Older Canadians*, Statistics Canada Health Reports (Ottawa: Statistics Canada, May 2018), 18.

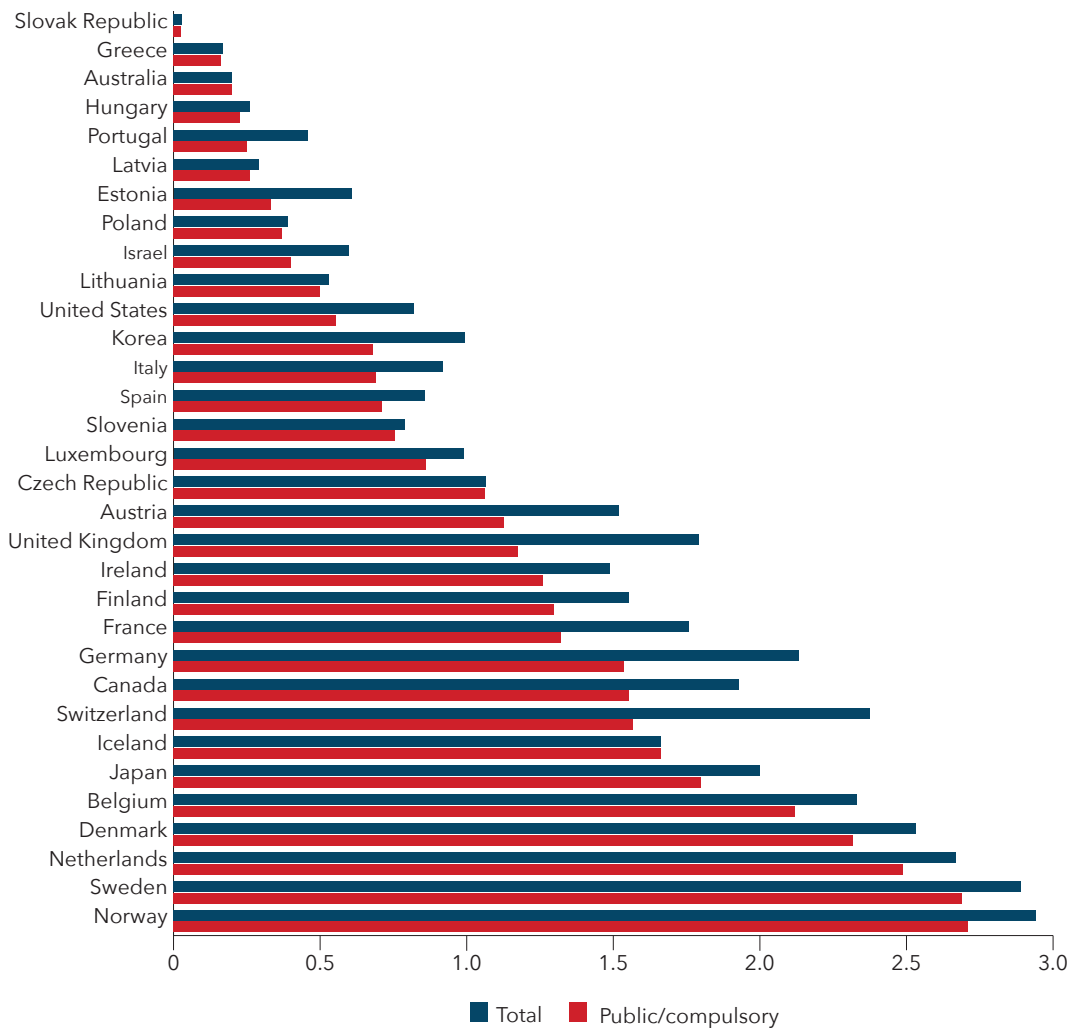
<sup>16</sup> H. Gilmour, *Unmet Home Care Needs in Canada* (Ottawa: Statistics Canada, 2018).

<sup>17</sup> OECD, *Long-Term Care and Health Care Insurance*, 16.

which private insurance would appear suited. However, the very fact that such care is likely to be needed at the end of life militates against the development of private insurance markets. Care can be financed largely by selling accumulated assets, such as equity in a home, that can no longer be enjoyed. Forgoing income in earlier years to purchase private insurance serves largely to protect bequests. It makes sense only for a slim slice of the population in the upper-income categories. This slice is not large enough to sustain a private market in most countries, including Canada.

Pooling the risk of needing long-term care has therefore fallen largely to the public sector. As shown in figure 3, the public treasury is the principal source of funding in the OECD countries listed. Figure 4 indicates the considerable variation in the type of public funding, especially the different weight of general revenue and social

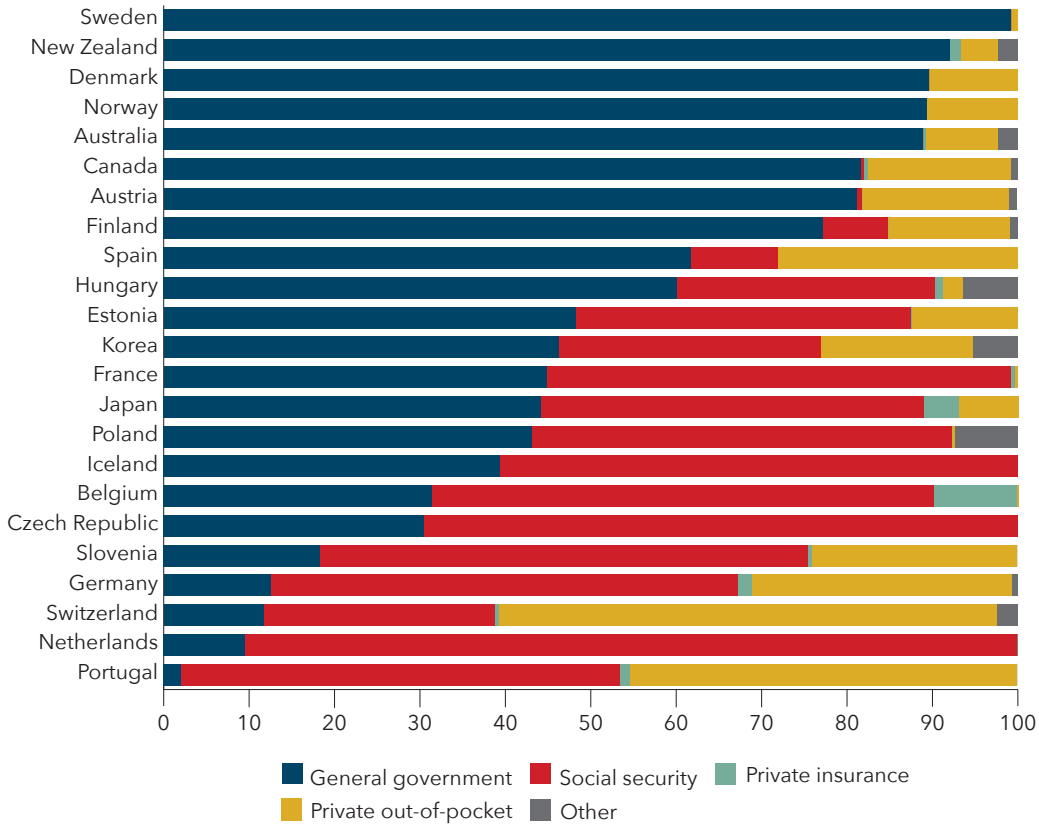
**Figure 3. Total spending and public sector spending on long-term care services as a percentage of GDP, 2018**



Source: OECD, "Dataset: Health Expenditure and Financing." The public/compulsory figure is for 2016 for Israel and 2017 for Australia and Japan.

security funds as mechanisms of public finance. Canada ranks just above the OECD average in spending on long-term care, both publicly and overall, and is one of a group of countries that draws public funding almost entirely from general revenue.

**Figure 4. Long-term care expenditures by sources of funding in 2007. Countries ranked by decreasing share of general revenue**



Source: Adapted from F. Colombo, A. Llana-Nozal, J. Mercier and F. Tjadens, *Help Wanted? Providing and Paying for Long-Term Care* (Paris: OECD, May 2011).

### Federalism and long-term care in Canada

Federalism allows the risk of needing long-term care to be pooled on a national basis while maintaining subnational responsibility for the delivery of care, in accordance with conditions and preferences in local catchment areas. The involvement of multiple jurisdictions provides venues for experimentation with policy options. Intergovernmental connections afforded by federal arrangements allow for diffusion of best practices. Against these advantages, however, must be weighed the risk that the division of authority inherent in federal systems will further exacerbate the difficulties of coordination of funding and delivery of an already diverse set of goods and services, and will undermine the principle of equity across the nation.

Canada has experienced more of the weaknesses than the strengths of federalism as it applies to long-term care. By relegating such care to an uncoordinated realm of mixed private and public finance, with coverage provisions that vary widely across provinces and territories,<sup>18</sup> Canada has forgone the advantages of a nation wide risk pool. The operational financing of long-term care is lodged largely, and at the margin entirely, with provincial governments. The federal government provided an unconditional, per-capita grant to each province for extended care from 1977 to 1996. It was then folded into the general Canada Health and Social Transfer (later the Canada Health Transfer). But this mechanism for federal funding was essentially an afterthought, tagged onto a model that is better suited to physician and hospital services than to long-term care.

Provincial discretion over the delivery of care, which should produce benefits, has been a double-edged sword, especially during the pandemic. At the start of the pandemic, British Columbia demonstrated potential best practice for other provinces, and it continued to have one of the lowest ratios of deaths to population among the provinces. But cross-provincial learning did not occur. Poor performances by Ontario and Quebec demonstrated problems of equity across the country. Nor was there evidence of learning over time. The problems in the first wave on the pandemic (the focus of most of the data presented in this paper) were replicated in the second wave, when Alberta, Saskatchewan and Manitoba struggled with incidence of the virus yet higher than in Ontario. The modest, unconditional and now diffuse nature of the federal transfer means that the federal government lacks any leverage or channel to diffuse best practices incubated at the provincial level and to enforce common, minimum standards across provinces. Nor has any other pan-Canadian mechanism of diffusion arisen. The Health Care Innovation Working Group, established in 2012 by the premiers' Council of the Federation, made seniors' care one of its first priorities. But as a convening body, the council's ability to foster cross-provincial policy diffusion and harmonization is only as strong as the incentives that individual provinces have to do so. After issuing a report in 2016 highlighting some provincial innovations in home care and dementia care, the council moved on to other priorities in which provincial incentives to cooperate were stronger. Adoption of a common stance in negotiating drug prices with brand-name pharmaceutical firms was high on this list.

Part of the problem is that intergovernmental arrangements in long-term care have operated in the shadow of the *Canada Health Act*. Under the Act, the federal government transfers funds to the provinces to support provincial programs of universal coverage for physician and hospital services. It does so on condition that those programs comply with federal principles relating to access to a comprehensive package of services on uniform terms and conditions, including the absence of financial barriers. This shared-cost model, in which the federal government exercises influence using its judicially recognized

<sup>18</sup> The federal government transfers funds to Canada's three territories, in addition to the 10 provinces, for the operation of health care programs. The territories are represented at the federal-provincial-territorial table, but they do not have formal constitutional responsibility for health care. For most of their history, they have operated their plans under agreements with the federal government, under which they are variously and gradually assuming devolved powers. Each territory accounts for only about 0.08 percent or less of total spending by the provinces and territories – less than half the amount spent by the smallest province, Prince Edward Island. For ease of reference here, I refer to provincial governments throughout.

spending power, is well established in the physician and hospital sectors and enjoys broad popular support. But to the extent that it works in these sectors, it is because of features that have no analogues in long-term care. The single-payer system of the *Canada Health Act* has effectively established a bilateral monopoly between the medical profession and the state that places organized medicine in a very strong intermediary position in policy development and implementation. The maintenance of similar, acute-care standards, practices and scopes of coverage across provinces has much more to do with the commonality of interest within the medical profession, than with the infrequent and limited federal enforcement of the conditions of the *Canada Health Act*.<sup>19</sup>

However, the shared-cost version of health-care federalism is only one possibility. Keith Banting has recognized two other models: a classic model in which each order of government acts within its own exclusive sphere of jurisdiction; and a joint-decision model in areas of concurrent jurisdiction, under which both federal and provincial governments must agree for any action to be taken.<sup>20</sup> To these one can add a functional variation in which both orders of government are involved in a policy sector but are confined to the respective functions for which they have jurisdiction. An example of the latter in health care is prescription drugs. The federal government regulates the safety of all drugs and the patenting and pricing of brand-name pharmaceuticals, while the provinces operate drug coverage programs.

### The German example

To stimulate our thinking about policy options for long-term care in the Canadian federation, it is useful to consider the experience of another federation. Germany has managed long-term care more successfully, and the impact of COVID-19 has been less skewed to the long-term-care population (table 1). In Germany's model of functional federalism, both federal and state governments perform different functions within the same policy areas.<sup>21</sup> Typically, overall policy design is lodged at the federal level. Implementation is carried out at the level of the states (Länder). This greater reliance on a functional, rather than jurisdictional, sorting of responsibilities makes for greater intergovernmental complementarity and cooperation in Germany than in Canada.

German federalism involves not only national and subnational governments but also a web of civil society organizations in what Crouch has called a "shared political space."<sup>22</sup> This institutional web is particularly important in health care. German health-care finance is organized on a social insurance model, established in federal legislation. A comprehensive range of health care is funded primarily through a set

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<sup>19</sup> Tuohy, *Remaking Policy*, 414-22.

<sup>20</sup> K. Banting, "The Three Federalisms and Change in Social Policy," *Canadian Federalism: Performance, Effectiveness, and Legitimacy*, 4<sup>th</sup> edition, eds. H. Bakvis and G. Skogstad (Toronto: University of Toronto Press, 2020): 285-86.

<sup>21</sup> W. M. Chandler, "Challenges to Federalism: Comparative Themes," *Challenges to Federalism: Policy-making in Canada and the Federal Republic of Germany*, eds. W. M. Chandler and C. W. Zöllner (Kingston: Institute of Intergovernmental Relations, Queen's University Press, 1989): 11-2.

<sup>22</sup> C. Crouch, *Industrial Relations and European State Traditions* (Oxford: Oxford University Press, 1993): 50-63; T. Gerlinger and R. Schmucker, "A Long Farewell to the Bismarck System: Incremental Change in the German Health Insurance System," *German Policy Studies* 5, no. 1 (2009): 3-20.

of not-for-profit corporations known as social insurance funds. These are recognized by statute and are funded by mandatory employer and employee contributions, set as a proportion of wages. The contributions are state-subsidized for the self-employed and those not in work, on an income-scaled basis. The social insurance funds negotiate with provider associations and are closely involved in the governance of the system under the overall supervision of the federal government. Capital funding for health-care facilities is provided by the state governments.

The funding stream for long-term care is separate from acute care, but is also administered through the insurance funds.<sup>23</sup> Regional associations of insurers negotiate framework contracts with provider associations, which govern not only payment but also the monitoring of the quality of care through inspectorates maintained by the insurers themselves. The result is a knowledgeable cadre of inspectors who build relationships with providers that allow for some latitude in enforcement. For example, regulations were actually relaxed during the COVID-19 pandemic to allow greater flexibility in the deployment of long-term care staff. The federal government also operates a number of major research and advisory institutes. One of these, the Robert Koch Institute, has played a significant role in monitoring and advising on the COVID-19 pandemic, including its manifestations in long-term care facilities. The German system is not without its own challenges. But it has passed the COVID-19 stress test more successfully than Canada's.

Attention to the German model and experience can offer some insights into possibilities not yet considered in Canada, with the caveat that significant structural and cultural differences between the two systems mean that we need to think about how analogous, but not directly comparable, arrangements might work in Canada. First, the German example could spark *reconsideration of how responsibilities are assigned* between the two orders of government on a functional basis. This could be done through intergovernmental agreements and would not require constitutional change. Second, the key role of social insurers points to the potential *for robust intermediary organizations* to act as both agents and mediators within the federation. There is no analogy to the German social insurers in Canadian long-term care, but other candidates for the role could emerge under a new policy framework.

## EXPLOITING THE POTENTIAL OF CONCURRENT JURISDICTION: LONG-TERM CARE INSURANCE AND IMMIGRATION REFORM

The remainder of this paper sketches out a menu of options for the development of a comprehensive federal framework for the financing and delivery of long-term care. I do not assume that the provincial responsibility for the delivery of health care precludes a role for the federal government beyond the exercise of its spending

<sup>23</sup> P. Nadash, P. Doty and M. von Schwanenflügel, "The German Long-Term Care Insurance Program: Evolution and Recent Developments," *Gerontologist* 58, no. 3 (2018): 588-97; European Commission, *Germany's Latest Reforms of the Long-Term Care System*, Directorate-General for Employment, Social Affairs and Inclusion (Brussels: European Commission, 2018).

power to transfer funds to the provinces. This section addresses the question of how to better exploit the risk-pooling potential and fiscal capacity offered by the federation as a whole. After considering one conventional area of mutual activity – infrastructure funding – I turn to two underutilized levers in areas of concurrent jurisdiction.

### Infrastructure funding

Excess demand for places in long-term care facilities is a problem across OECD countries, largely owing to population aging.<sup>24</sup> Canada is no exception, as evidenced by substantial waiting lists for long-term care and the growing problem of hospitals accommodating patients who should be in long-term care facilities but for whom no place is available.<sup>25</sup> The Conference Board of Canada has projected a near-doubling of demand for long-term care beds by 2035.<sup>26</sup>

A number of provinces have aging-in-place strategies aimed at enhancing home care and other community support and reducing some of the pressure for institutional care. However, the German experience is not encouraging. German long-term care insurance provides both in-kind and cash benefits, and allows recipients to opt for a cash payment that they can use to remunerate informal caregivers for care provided in the home or community. Although this arrangement may indeed enhance the provision of home and community care, it does not appear to substitute for institutional care. After the insurance program was introduced in 1995, the proportion of beneficiaries requiring institutional care marginally increased in the following decade before returning to its 1996 level by 2016.<sup>27</sup>

The supply constraint that Canadian projections demonstrate matters not only for access to long-term care but for the *quality* of care and accommodation. Under conditions of such excess demand, the lack of choice among facilities means that there is little reputational risk for operators of facilities that fail to maintain quality. This means that the market cannot be relied on to maintain quality. The burden of enforcement falls almost entirely on the state.

The Conference Board of Canada<sup>28</sup> estimated the cost of meeting its projected demand for beds by 2035 to be approximately \$64 billion in capital costs and \$134 billion in cumulative operating costs (all in 2017 dollars). Canada's federal system offers the potential to spread the fiscal burden of expenditures of that magnitude.

<sup>24</sup> E. Stancanelli, "Institutional Long-Term Care and Government Regulation," *IZA World of Labour* (2015).

<sup>25</sup> R. Gibbard, *Sizing Up the Challenge: Meeting the Demand for Long-Term Care in Canada* (Ottawa: The Conference Board of Canada, 2017); B. J. MacDonald, M. Wolfson and J. P. Hirdes, *The Future Co\$ of Long-Term Care in Canada*, National Institute on Ageing White Paper (Toronto: National Institute on Ageing, 2019).

<sup>26</sup> Gibbard, *Sizing Up the Challenge*.

<sup>27</sup> T. Gerlinger, *ESPN Thematic Report on Challenges in Long-Term Care: Germany*, Directorate-General for Economic and Financial Affairs (Brussels: European Commission, 2018), 16.

<sup>28</sup> Gibbard, *Sizing Up the Challenge*.



Under various heads of constitutional authority, infrastructure is an area of de facto shared jurisdiction for federal and provincial governments, often involving bilateral agreements. The current vehicle is the Investing in Canada Plan, under which the federal government has committed to spend \$188 billion on provincial and municipal infrastructure projects. The funding, done under federal-provincial agreements, has two phases, between 2016-17 and 2027-28. In May 2020, \$3 billion of this funding was set aside in a COVID-19 Resilience Stream for shovel-ready projects specifically related to mitigating the impact of COVID-19. Another source of infrastructure funding is the Canada Infrastructure Bank, established in June 2017 as a Crown corporation with a \$35-billion allocation to facilitate the infrastructure initiatives of federal, provincial and municipal governments. It does this through advice and research, and through investment aimed at leveraging other private sector and institutional finance. On October 1, 2020, the government announced a further allocation of \$10 billion to the bank for a Growth Fund. This fund targets five priority areas: transit, clean energy, retrofitting, broadband and irrigation.

Directing federal infrastructure funding to long-term care would face several hurdles. At the federal level, the Investing in Canada Plan comprises 11 different funds under the aegis of different departments and agencies. None of these funds has an obvious link to long-term care. The COVID-19 stream is somewhat more flexible than other categories. But none of the identified priorities for this stream relates directly to long-term care. That is also the case for the priority areas of the Canada Infrastructure Bank. (However, funding for the energy-efficient retrofitting of long-term care facilities could free up other provincial or municipal funding for other long-term care improvements and expansion.) There is also the danger that federal funding could just substitute for provincial spending without increasing the total, as has occurred in some cases under the Investing in Canada Plan.<sup>29</sup>

The importance of upgrading and replacing dated long-term care facilities has been underscored by the COVID-19 experience. Evidence from Ontario showed the likelihood of an outbreak in a facility to be closely related to the degree of community spread in the surrounding area, the size of the facility and the datedness of its design. Dated design includes a predominance of multibedded rooms, which is inconsistent with current design standards. There was a higher prevalence of such outdated designs among facilities owned for profit, which tended to experience larger and more lethal outbreaks during the first wave of the COVID-19 pandemic.<sup>30</sup> This association of dated design with for-profit status suggests that private sector investors are less likely to invest in upgrading existing facilities or in building new ones. Furthermore, although there is a great range of variation in quality across providers, the balance of Canadian and cross-national evidence suggests that for-profit providers are more

<sup>29</sup> Canada, Office of the Parliamentary Budget Officer, *Infrastructure Update: Investments in Provinces and Municipalities* (Ottawa: Office of the Parliamentary Budget Officer, 2019).

<sup>30</sup> N. M. Stall, A. Jones, K. A. Brown, P. A. Rochon and A. P. Costa, "For-Profit Long-Term Care Homes and the Risk of COVID-19 Outbreaks and Resident Death," *CMAJ* 192, no. 33 (2020): E946-55.

likely to offer lesser-quality care, as measured by hours of care,<sup>31</sup> mortality and hospital admissions<sup>32</sup> and broader ranges of quality indicators.<sup>33</sup> In Ontario, for-profit homes were somewhat over-represented among the 15 percent of homes in which 90 percent of deaths were concentrated as of mid-November 2020.<sup>34</sup> The weight of this evidence suggests that improved regulation of established facilities is essential. It also suggests that there is a pressing need for public infrastructure investment in facility upgrades, and to build up the public and nonprofit sector more generally.

## Long-term care insurance

We need to fundamentally rethink the financial model if Canada is to meet the challenge of providing operating funding for long-term care on the order identified by the Conference Board. We need a model that is sustainable, equitable across economic classes and regions, adaptive to demographic change, and that harnesses the fiscal capacity and risk-pooling reach of the federal government while respecting provincial responsibility for program delivery. Fortunately, a ready-made model exists in one of the federation's social policy success stories in an area of concurrent jurisdiction. Public pensions are covered by the federal-provincial Canada Pension Plan/Quebec Pension Plan (CPP/QPP), and buttressed by the federal government's universal Old Age Security (OAS) and the income-scaled Guaranteed Income Supplement (GIS) programs.

Long-term care is overwhelmingly consumed in later years, unlike other health-care services, which are consumed episodically throughout life and more heavily in later years. While those over 65 account for about 44 percent of overall government health spending in Canada, they constitute more than 90 percent of residents in long-term care facilities.<sup>35</sup> In such skewed circumstances, it makes sense to think of a model of public finance for long-term care as somewhat more akin to a pension than to health insurance. This is especially true if long-term care benefits include non-institutional as well as institutional care and therefore apply to a broader range of the elderly population. Germany's long-term care insurance program, financed through mandatory employer and employee contributions, is of this form. It operates alongside, but separate from, the similarly funded health insurance funds. It

<sup>31</sup> A. T. Hsu, W. Berta, P. C. Coyne and A. Laporte, "Staff in Ontario's Long-Term Care Homes: Difference by Profit Status and Chain Ownership," *Canadian Journal on Aging / La Revue Canadienne Du Vieillessement* 35, no. 2 (2016): 175-89.

<sup>32</sup> P. Tanuseputro, M. Chalifoux, C. Bennett, A. Gruneir, S. E. Bronskill, P. Walker and D. Manuel, "Hospitalization and Mortality Rates in Long-Term Care Facilities: Does For-Profit Status Matter?" *JAMDA* 16, no. 10 (October 2015): 874-83.

<sup>33</sup> M. Geraedts, C. Harrington, D. Schumacher and R. Kraska, "Trade-Offs Between Quality, Price, and Profit Orientation in Germany's Nursing Homes," *Ageing International* 41 (2016): 89-98; V. R. Comondore, P.J. Devereaux, Q. Zhou, S.B. Stone, J.W. Busse, N.C. Ravindran, et al., "Quality of Care in For-Profit and Non-Profit Nursing Homes: Systemic Review and Meta-Analysis," *British Medical Journal* 339 (2009): b2732.

<sup>34</sup> Two-thirds of this higher-death segment of homes were for-profit (calculated from data available at: Ontario, "Status of COVID-19 Cases in Long-Term Care Homes," <https://www.ontario.ca/page/how-ontario-is-responding-covid-19#section-2>). This proportion exceeds the 57-percent share of for-profit homes among all Ontario long-term care homes (Canadian Institute for Health Information, *Health Spending - Nursing Homes* [Ottawa: CIHI, 2020]).

<sup>35</sup> Canadian Institute for Health Information, *Health Spending - Nursing Homes* (Ottawa: CIHI, 2014); Canadian Institute for Health Information, *National Health Expenditure Trends 1975 to 2019* (Ottawa: CIHI, 2019).

typically pays out when contributors are no longer in the workforce and need care. Grignon and Pollex<sup>36</sup> have recently advocated a version of long-term care insurance for Canada. The thrust of my commentary here is to consider the merits of such a policy from a federalism perspective.

A Canadian version of long-term care insurance could be attached to the CPP/QPP as a supplementary benefit. Like the CPP/QPP, it would be funded through employer and employee contributions. It would be paid in the form of a capped cash transfer to the beneficiary. But unlike the CPP/QPP, it would be assignable to a qualifying third-party provider of institutional or home care. As in the case of retiree health benefits in the private sector, payment would be based on need for care. In this case, need would be assessed through existing provincial mechanisms.

The definition of the benefit would have to include the determination of qualifying providers, which would require integration with provincial mechanisms of quality enforcement. At the outset, the long-term care insurance could simply deem providers currently recognized by their respective provinces. Over time, the federal and provincial governments should work to raise and harmonize quality standards across the country. An appropriate mechanism could be a research and advisory body, set up under the aegis of the Canadian Institute for Health Information (CIHI). It would play a role similar to the Robert Koch Institute in Germany. As a condition of recognition, all qualifying providers should have to submit specified information on their activities to that central body. Informed by those data and further research, this body could recommend appropriate standards of qualification on an ongoing basis. Given the welter of regulatory requirements across provinces, an independent body with a pan-Canadian purview can play an important role in identifying which forms of regulation are necessary and effective, and which ones are needless constraints.

Although the infrastructure of long-term care insurance could be established as soon as federal-provincial agreement is attained, the funding of the system would have to be on a hybrid basis (a combination of general taxation and contributions) as funds are built up.<sup>37</sup> Over the history of the CPP/QPP, different funding approaches have been taken. This would be yet another.<sup>38</sup> But the long-term care insurance infrastructure provides a better mechanism for the flow of federal funding from general taxation than does the conditional transfer model. It builds on the established administrative structure of the CPP/QPP, and lies in an area of uncontested concurrent jurisdiction for federal and provincial governments. On the CPP/QPP model, it

<sup>36</sup> M. Grignon and S. Pollex, "The Case for Public Long-Term Care Insurance." *Policy Options*, May 25, 2020, <https://policyoptions.irpp.org/magazines/may-2020/the-case-for-public-long-term-care-insurance/>

<sup>37</sup> Indeed, Japan and South Korea finance their long-term care insurance plans through a mix of contributions and general taxation on an ongoing basis. If this approach was taken in Canada, transfers from general taxation should be statutorily mandated and not dependent on the budgetary process each year. However, such earmarking of funding from general taxation without a dedicated source of revenue is not advisable.

<sup>38</sup> The CPP/QPP was established in 1966 on a pay-as-you-go model whereby current contributors paid the costs of care for current beneficiaries. By the 1990s, the aging of the population and the demands of intergenerational equity necessitated a shift to a hybrid, steady-state model to "build a reserve of assets and stabilize the ratio of assets to expenditures over time" (Canada Pension Plan, *Thirtieth Actuarial Report on the Canada Pension Plan* (Ottawa: CPP, 2019), 168.) Enhanced additions to CPP/QPP were introduced in 2016 in a fully funded basis.

could be designed to be self-sustaining so that contribution rates can be adjusted according to actuarial projections, unless federal and provincial governments agree to intervene. It would thus establish a dedicated funding stream in perpetuity that would be sensitive to demographic change.

The long-term care insurance model is preferable to transfers under the *Canada Health Act* on a number of other grounds. It provides an institutional setting better suited to the recognition of long-term care as a bundle of services and accommodation options, extending beyond medically focused health care,<sup>39</sup> and for which the *Canada Health Act* premises of exclusively public coverage with no patient cost-sharing are not suited. As a dedicated, self-sustaining stream, long-term care insurance would not have to be continually renegotiated in the federal-provincial arena, as is the case for the Canada Health Transfer and for earlier transfers for home care under health accords in the early 2000s. Importantly, it would not require long-term care to compete with acute care in the budget process, a competition that historically has disadvantaged long-term care.

The principal challenge of such a model would be to integrate it with existing provincial programs of long-term care in institutional and home settings. The current and projected need for substantially increased operating expenditure means that long-term care insurance should be seen as adding to, not replacing, current provincial funding for long-term care. However, the insurance benefit could free up provincial funding currently allocated to long-term care and home care subsidies to individuals. This funding could be redirected toward increasing the number of places in institutional and home care programs. As a condition of participating in the federal-provincial plan, provincial governments should undertake not only to maintain but to increase their own funding and to report publicly on their long-term care spending. Such an undertaking is no guarantee of compliance, however. Ultimately, the sanction can only be through sustained public attention.

A detailed costing of this proposal and estimation of necessary contribution rates would require a more comprehensive specification of design features and a fuller actuarial analysis than is possible within the scope of this paper. Gibbard's estimate for the Conference Board of Canada, the most careful analysis to date, puts the annual operating cost of the additional beds required by 2035 at \$14.4 billion in 2017 dollars.<sup>40</sup> Although additional funding would also be required for home care, Gibbard's estimate provides a useful reference point for assessing the magnitude of the funds required. On the revenue side, it is possible to piggyback on recent projections of the effect of changes to the CPP/QPP to generate a rough estimate of the necessary contribution rate. Extrapolating from data presented in the latest available actuarial report for the CPP, and adjusting for the

<sup>39</sup> Ito Peng has noted this advantage of long-term care insurance in Japan in The Massey Dialogue, "COVID, the Old and Canada: What's Wrong with Us?" <https://www.youtube.com/watch?v=0Nnz6gAgtDE&list=PLZ-PXYnb596caihPXKM0ZaWKJGufnnVwhe&index=5>

<sup>40</sup> I acknowledge, with thanks, the provision of the data point for 2035 underlying Chart 4 in Gibbard's report, as provided by Bryan Benjamin at the Conference Board of Canada; Gibbard, *Sizing Up the Challenge*, 16.

assumption that the QPP would adopt a similar supplementary benefit,<sup>41</sup> I estimate that a 2 percentage point increase in CPP/QPP contribution rates would yield about \$15.8 billion (in 2019 dollars) annually by 2035.<sup>42</sup> This is commensurate with Gibbard's cost estimate (which equates to \$15.2 billion in 2019 dollars).

Additional federal government spending would also be required to add a supplementary long-term care benefit to the OAS/GIS pension tier. It would cover those whose work history does not yield sufficient CPP/QPP coverage. It could take the form of a federal long-term care benefit, at the same level as the flat-rate long-term care insurance benefit. It could be triggered when the beneficiary is assessed through provincial agencies as in need of long-term care, either at home or in an institutional facility. This is analogous to the way in which application for the Canada Child Benefit can be made at the time the child's birth is registered, usually at a hospital or birthing facility. Beneficiaries would register for either the long-term care insurance benefit or the long-term care benefit at the time when they are assessed to need care.<sup>43</sup>

An important design question is whether beneficiaries could apply the insurance benefit to the cost of private care of their own choosing, either in a private retirement residence or from a live-in caregiver. There are a number of advantages to such a provision. It would provide a platform better suited to the integrated regulation and management of the continuum of care for the elderly than do current siloed public budgetary and regulatory arrangements. It would offer beneficiaries greater choice and lifestyle flexibility. It could also yield greater political buy-in for long-term care insurance from upper-income groups. Against these considerations must be weighed the additional regulatory burden implied by the expansion of the private market.

Experience elsewhere may offer some guidance. Japan's long-term care insurance system, in which local care managers coordinate the provision of in-kind services, has been incrementally extended to allow care managers to authorize cash payments from the insurance plan to quasi-institutional providers. These include private retirement homes and a range of community-based options, some of which charge beneficiaries

<sup>41</sup> A proposal for a public program of contributory autonomy insurance, albeit not linked to the QPP, was made by the Parti Québécois government of Quebec in 2013. But the legislation died when the government fell in the 2015 election. The then-minister of health, Réjean Hébert, has recently advocated that the proposal be revived: R. Hébert, "Financing for Home Care Must Rise, and Be Done Differently," *Policy Options*, May 13, 2020, <https://policyoptions.irpp.org/magazines/may-2020/financing-for-home-care-must-rise-and-be-done-differently/>

<sup>42</sup> The CPP actuarial report shows the projected increase in annual revenue from a 2 percentage point increase in the contribution rate in 2023 (Canada Pension Plan, *Thirtieth Actuarial Report on the Canada Pension Plan*, Table 22). After that year, the revenues from that 2 percentage point increase are not separately reported. It was therefore necessary to extrapolate to 2035 to account for the increase in the number of contributors (CPP 2019, table 16) as follows: 2035 revenue from 2 percent contribution rate = 2023 revenue from 2 percent contribution rate \* number of contributors in 2035 / number of contributors in 2023.

<sup>43</sup> The Canadian Medical Association and the Conference Board of Canada have proposed a somewhat similar seniors' care benefit. However, unlike the long-term care insurance program recommended here, the Canadian Medical Association and the Conference Board would fund the seniors' care benefit from general tax revenue. A. Arcand and C. Heschl, *Measures to Better Support Seniors and Their Caregivers* (Ottawa: The Conference Board of Canada, May 2019).

additional fees to be paid out of pocket.<sup>44</sup> Ensuring that there is a sufficient supply of qualified care managers is critical to the effectiveness of this system. In Germany, beneficiaries requiring non-institutional care can opt for a discounted cash payment from the insurance scheme to cover services from caregivers, chosen at their discretion, including family members. But Germany has also wrestled with the regulation of an essentially dualized market in long-term care, as a flourishing market has arisen for private agencies who employ lower-wage immigrant caregivers, particularly from neighbouring Poland.<sup>45</sup> Germany's labour market more generally shows a pattern of dualization into segments of secure and precarious employment.<sup>46</sup> The extent to which the cash-out option in long-term care insurance has exacerbated that phenomenon in the long-term care sector has not been systematically studied. On balance, it would seem wise to keep the broader application of the long-term care benefit alive as a possibility in Canada while a more robust and comprehensive regulatory infrastructure is being established – an area to which we now turn.

### Immigration reform and professional regulation

The pandemic experience has exposed glaring flaws in the quality of care in a subset of long-term care facilities in Ontario and Quebec. This has been documented in academic work<sup>47</sup> and in two reports filed by the military health-care personnel deployed to supplement and oversee care in the worst-performing facilities.<sup>48</sup> The military reports offered stark depictions, sometimes graphic and sometimes clinical, of neglect and errors in care resulting from staff shortages as well as inadequate training and support for existing staff. Long-term care insurance could address such problems by enhancing quality regulation through the certification of qualifying providers. But more is needed to get to the root causes of quality problems and strengthen enforcement mechanisms.

The flaws exposed by the pandemic, often appalling in nature, can be traced to inter-related problems with physical facilities and with the long-term care workforce. The problems with physical facilities have been addressed above. This section will address related problems in the workforce. They include chronic shortages of qualified

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<sup>44</sup> Ito Peng, private communication. See also J. C. Campbell, "Japan's Long-Term Care Insurance System," in *Eldercare Policies in Japan and Scandinavia*, eds. Y. Saito and U. Edvardson (New York: Palgrave Macmillan, 2014): 9-30; Government of Japan, Health and Welfare Bureau for the Elderly, *Long-Term Care Insurance System of Japan*, Ministry of Health, Labour and Welfare (November 2016).

<sup>45</sup> W. Eichhorst, P. Marx and V. Tobsch, "Non-Standard Employment across Occupations in Germany: The Role of Replaceability and Labour Market Flexibility," *Institute for the Study of Labor, IZA Discussion Papers*, no. 7662 (October 2013); Gerlinger, *ESPN Thematic Report on Challenges in Long-Term Care*; A. Rogalewski and K. Florek, *The Future of Live-In Care Work in Europe* (Brussels: European Economic and Social Committee, 2020), 20-3.

<sup>46</sup> B. Palier and K. Thelen, "Institutionalizing Dualism: Complementarities and Change in France and Germany," *Politics & Society* 38, no. 1 (2010): 119-48.

<sup>47</sup> Stall, et al, "For-Profit Long-Term Care Homes"

<sup>48</sup> C. J. J. Mialkowski, *Op LASER: JTFC Observations on Long Term Care Facilities in Ontario*, CAF 4<sup>th</sup> Canadian Division and Joint Task Force (Central) (Ottawa: National Defence, 2020); Commandement de la composante terrestre, Force opérationnelle interarmées - Est., "Observations sur les centres d'hébergement de soins longues durées de Montréal," [https://cdn-contenu.quebec.ca/cdn-contenu/sante/documents/Problemes\\_de\\_sante/covid-19/Rapport\\_FAC/Observation\\_FAC\\_CHSLD.pdf?1590587216](https://cdn-contenu.quebec.ca/cdn-contenu/sante/documents/Problemes_de_sante/covid-19/Rapport_FAC/Observation_FAC_CHSLD.pdf?1590587216)



personnel, which lead to overextended workers and gaps in care.<sup>49</sup> Long-term care facilities and private residences are not only sites of institutional and home care, respectively, they are also workplaces. Unsafe conditions for recipients of care are thus unsafe conditions for caregivers as well. They lead to a vicious cycle in which staff shortages produce excessive demands on existing staff, leading in turn to problems of recruitment and retention that exacerbate shortages.

Like problems of underfunding, the shortage of qualified staff is also amenable to federal-provincial action. In this case we can exploit another instrument of concurrent jurisdiction – immigration policy. This area has increasingly become a site for joint federal-provincial action in recent decades, with provinces playing a more active role alongside the federal government.<sup>50</sup>

Immigration is an important source of long-term care personnel, with immigrants accounting for more than a third of personal support workers.<sup>51</sup> Quebec has responded to the COVID-19 emergency by recruiting these workers, domestically and through immigration, and ensuring they all complete the same training programs. Something similar could be done on a national basis. The federal and provincial governments could agree on common requirements for personal support workers recruited through a dedicated immigration stream to receive training in Canada. This would contribute to raising and harmonizing standards for training, education and certification across provinces. Recognition of relevant foreign credentials could provide advanced standing in or exemption from domestic training programs, and could lead over time to a tiered certification of skill levels for personal service workers.

A recent Statistics Canada report revealed the perennial problem of foreign credential recognition in the Canadian immigration process, and the resulting underemployment of many of these immigrant workers. The report showed that, in 2016, 25 percent of immigrants working as nurse aides, orderlies and patient service associates had at least a bachelor's degree, versus 5 percent of non-immigrants. Among recent immigrants, the proportion was even higher (45 percent). Of those with degrees, 44 percent were in a health-related field. This is twice the proportion among non-immigrant degree holders.<sup>52</sup>

The requirements for a nursing licence vary across provinces. Each province charges a substantial application fee and has a separate credential recognition process. This has led many foreign-trained nurses and other health-care workers to enter Canada through temporary programs targeting caregivers for private households (including both child and elder care). These programs provided a pathway to permanent

<sup>49</sup> Government of Ontario, *Long-Term Care Staffing Study*, Report of the Long-Term Care Staffing Study Advisory Group (Toronto: Ministry of Health and Long-Term Care, 2020); Royal Society of Canada, *Restoring Trust*; MacDonald, Wolfson and Hirdes, *The Future Co\$ of Long-Term* 63-6.

<sup>50</sup> M. Paquet, *Province Building and the Federalization of Immigration in Canada* (Toronto: University of Toronto Press, 2019).

<sup>51</sup> M. Turcotte and K. Savage, *The Contribution of Immigrants and Population Groups Designated as Visible Minorities to Nurse Aide, Orderly and Patient Service Associate Occupations*, Statistics Canada (Ottawa: Statistics Canada, June 2020), 1-2.

<sup>52</sup> Turcotte and Savage, *The Contribution of Immigrants*, Statistics Canada, 6.

residency. The longest-running such program went from 2003 to 2014. It was succeeded by two five-year pilot projects for caregivers, one for child care in the home and one for high-medical-need care in private homes and institutions. Applications closed in 2019. Future programs and projections have not been announced. Meanwhile, the immigration stream for temporary foreign workers has continued to provide a route for recruitment of personal support workers in nursing homes. It requires that employers demonstrate the non-availability of sufficient domestic labour through a Labour Market Impact Assessment, which was waived during the COVID crisis. Replacing the impact assessment with a requirement that employers demonstrate working conditions of a specified standard would be an incremental step toward demonstrating the potential of immigration policy as an instrument of standard-setting. Learning from past problems with immigration programs for live-in caregivers and reinstating a path to citizenship for immigrant personal support workers would build a more established cadre of personnel.

### **Creating a self-regulation regime**

More broadly, a comprehensive federal-provincial agreement on immigration policy for health-care personnel working in long-term care could not only expand the workforce. It could also provide national standards for the qualifications which immigrants must possess or acquire within specified period and for the employment standards which employers must demonstrate before job offers are approved. Such standards for immigrant workers and their employers could have important spillover effects for the domestic workforce, providing a common baseline for standards across provinces. Most provinces require the completion of specified programs as a condition of employment as a personal support worker in nursing homes. These provisions vary across provinces. Some standardization of these requirements would help to solidify the professional base and prepare the ground for a more robust regulatory regime.

The development of common standards could have another benefit over time in laying the groundwork for a regime of professional self-regulation. The military reports on long-term care homes are instructive in the substance of what they reveal. But they also demonstrate the importance of having an independently empowered presence, physically on site, to identify failings, enforce standards and provide transparency. Features of the German system can be instructive here. In Germany, the quasi-independent social insurance funds play an important intermediary role between providers and governments. In Canada, professional associations might be the bodies best suited to playing an intermediary role to provide or reinforce robust, on-the-ground enforcement of quality standards in long-term care as the medical profession does in the physician-hospital sector.

The issue of regulation or self-regulation for personal support workers has been percolating for several years in Canada. Movement in that direction has been hobbled by two key constraints. The first is the fear of exacerbating the chronic shortage of qualified personnel. The second is a lack of agreement on the underlying knowledge necessary for the provision of care. The Ontario minister of health asked the Health Professions



Regulatory Advisory Council to consider the issue in 2006. The council's response advised that there was neither a sufficient systematic body of knowledge on which qualifications could be based, nor a large enough cadre of experienced practitioners to provide the infrastructure of self-regulation. The council further advised against a more modest regulatory measure, a certification registry, again citing problems of determining minimum qualifications and also expressing concerns that a registration requirement would limit supply. Instead, it advised focusing on the further development and standardization of educational programs for personal support workers.<sup>53</sup> Ontario has experimented with a voluntary registry on two occasions (2012-2016 and 2018-2020). Associations representing personal support workers, including the Canadian Support Workers Association and the closely related Ontario Personal Support Workers Association, continue to advocate for self-regulation.

It is not clear that the conditions identified by the advisory council have materially changed. However, the requirements for self-regulatory status can be put in place over time, if done in the context of a national strategy for long-term care. That strategy should include funding for a substantial increase in the number of personal support workers and an augmented immigration regime, with common standards for caregivers. Some of the funding could come from the additional revenue generated by long-term care insurance, as recommended above. A concerted push to expand the workforce would alleviate supply constraints and could provide a cadre of peers on which a self-regulatory framework could be built.

Over time, such policies can provide both the membership base and the common standards of practice necessary for a self-regulatory regime for personal support workers, made up of provincial associations under a federal umbrella. Standards of qualification and designations would likely be on a tiered basis. Professional status and a supportive self-regulatory regime can improve the workplace experience for personal support workers and hence the attractiveness of the occupation. In turn, this could increase recruitment and further fuel supply. This is a long-term process, and Canada's record in this area is not promising. But despite this sorry history, the shock of the COVID-19 pandemic might have brought us to a turning point and provided the impetus for a national strategy on long-term care that confronts and addresses these pressing human resource issues.

## **A WAY FORWARD: A COMMISSION OF INQUIRY ON A LONG-TERM CARE STRATEGY FOR CANADA**

Any policy action must involve intense federal-provincial negotiation. Mobilizing and sustaining the necessary political will across federal and provincial governments to enter and conduct those discussions will not happen automatically. History suggests that there are two routes that could prepare the ground for the ultimate

<sup>53</sup> Health Professions Regulatory Advisory Council, *The Regulation of Personal Support Workers* (Toronto: Health Professions Regulatory Advisory Council, 2006).

negotiations. The world of public pensions provides an example of one route, led by finance departments. The federal Department of Finance played a leading role in the establishment, reform and expansion of the CPP/QPP. The department conducted cross-country consultations prior to the 1966 establishment, the 1998 reform and the 2016 expansion of the plans. It then convened provincial finance ministers to hammer out the policy framework.<sup>54</sup> The 2016 process differed only in that it was initially characterized by competing consultations and reports commissioned by federal and provincial finance ministries.

The world of health care provides another route, involving commissions of inquiry. Formal commissions appointed under the federal *Public Inquiries Act* preceded the establishment of universal physician services insurance in 1966, the consolidation and elaboration of physician and hospital insurance legislation in the *Canada Health Act* in 1984, and the enhancement of federal health transfers to the provinces in 2004. In the 1966 and 2004 cases, these commissions led to negotiations among federal and provincial first ministers. In 1984, the federal government acted unilaterally.

In the present case of long-term care, a consultation process led by the Department of Finance could have some advantages. It would not require establishing a separate institutional apparatus. The current minister, Chrystia Freeland, has established generally good relationships with her provincial counterparts and their first ministers.<sup>55</sup> Keeping the entire policy process under the same institutional umbrella would also make for a relatively seamless transition between the consultation and advice phase and the decision-making and implementation phase.<sup>56</sup>

Nonetheless, there are strong reasons to prefer holding a commission of inquiry. On a practical level, the issues involved span the finance, health and immigration portfolios. More importantly, a commission would provide the high-profile mechanism necessary to seize this window of opportunity to build consensus around a national strategy and to lay the groundwork for carrying it out. Such a strategy requires a set of feasible policy options, sustained and dedicated attention to its implementation, and a mechanism for ongoing consensus-building and attention-focusing once the COVID-19 crisis is past. The mandate of a federal commission of inquiry should accordingly be:

- a) to recommend a national strategy for long-term care, including institutional care and home care;
- b) to consider whether the institutions of Canadian federalism are being optimally used to ensure access to high-quality and appropriate long-term care;
- c) to recommend changes in institutional arrangements and policies, taking par-

<sup>54</sup> Banting, "The Three Federalisms"; D. Béland, "Narrative Stories, Institutional Rules, and the Politics of Pension Policy in Canada and the United States," *Policy and Society*, 38, no. 3 (2019): 356-72; R. K. Weaver, "Pension Reform in Canada: Lessons for the United States," *Ohio State Law Journal* 65, no. 45 (2004): 45-74; B. Christensen, "Ontario Pension Policy Making and the Politics of CPP Reform, 1963-2016," *Canadian Journal of Political Science* 53 (2019): 1-18.

<sup>55</sup> The importance of such relationships was demonstrated during the negotiations leading to the CPP/QPP reforms of 1998.

<sup>56</sup> I am grateful to Mel Cappe for this point.

ticular account of the potential for a federal-provincial long-term care insurance plan and a comprehensive agreement on an immigration strategy for long-term care workers.

The federal commission of inquiry could complement inquiries at the provincial level, which are focused on establishing accountability for and redressing the failures of care in nursing homes. It could also lay the groundwork for a more permanent research and advisory body, using the Robert Koch Institute in Germany as a model. The research body could be linked to the Canadian Institute for Health Information, as suggested above.

There is evidence that commissions of inquiry conducted in the wake of crises can be effective mechanisms of policy learning and (partial) preparation for future episodes, and can sow the seeds for the implementation of their recommendations. This was demonstrated in a notable study of four cases of inquiries launched in the wake of natural disasters and health crises in Canada, New Zealand, the United Kingdom, and the Australian state of Victoria.<sup>57</sup> (The Canadian inquiry followed the SARS outbreak in 2003.) Nonetheless, the impact of commissions depends on how well they construct bridges from their own work to the implementation of their recommendations. One important mode through which commissions of inquiry can embed their lessons is through the crafting of powerful narratives to keep the history of the crisis alive in both institutional and public memory. Stark, for example, shows how the deliberate narrative framing of the 2006 report on SARS in Ontario by Justice Archie Campbell left a legacy within the public health community.<sup>58</sup> More generally, commissions can play an important role in consensus-building as a sort of communicative hinge. They can convene those most actively involved in the field under review, which Schmidt refers to as “coordinated discourse,” and they can develop a frame to shape broader public understanding, which Schmidt calls “communicative discourse.”<sup>59</sup> This communicative link, however, requires that the elite discourse find a narrative bridge to public understanding.<sup>60</sup> The current crisis has created conditions for success on both sides of this hinge. It has made coordinated discourse among the decision-makers most closely involved with long-term care policy more likely by creating a political incentive to act. On the other side of the hinge, the conditions for building consensus and sustained attention in the broader public through communicative discourse are also in place. The story of long-term care in the COVID-19 era, for all its misery, is now a widely shared frame for public understanding of the kinds of policy change we need.

<sup>57</sup> A. Stark, *Public Inquiries, Policy Learning, and the Threat of Future Crises* (Oxford: Oxford University Press, 2018): 116-17.

<sup>58</sup> Stark, *Public Inquiries, Policy Learning*: 116-7.

<sup>59</sup> V. A. Schmidt, “Discourse and the Legitimation of Economic and Social Policy Change in Europe,” *Globalization and the European Political Economy*, ed. S. Weber (New York: Columbia University Press, 2001), 229-72.

<sup>60</sup> C. H. Tuohy, “Welfare State Eras, Policy Narratives, and the Role of Expertise: The Case of the Affordable Care Act in Historical and Comparative Perspective,” *Journal of Health Politics, Policy and Law* 43, no. 3 (2018): 427-53; I. Peng, “Testing the Limits of Welfare State Changes: The Slow-moving Immigration Policy Reform in Japan,” *Social Policy & Administration* 50, no. 2 (2016): 278-95.

## CONCLUSION

Canada has a window of opportunity to make once-in-a-generation changes to its policy framework for long-term care. The COVID-19 pandemic has made it impossible to ignore inadequacies that have been long neglected. By seizing untapped possibilities inherent in Canadian federalism, Canadian governments can bring new resources and regulatory tools to bear on these problems. Political circumstances, including the need to capture the moment while achieving agreement among federal and provincial governments, argue for a “mosaic” reform strategy that builds on and augments existing institutions.

The most promising path to federal-provincial cooperation in long-term care lies in areas of concurrent jurisdiction in which both orders of government have an established presence, a history of joint decision-making and action, and the governance infrastructure that makes this possible. A long-term care insurance plan can be attached to the CPP/QPP as a supplementary benefit. The insurance plan can provide a dedicated source of funding and an established infrastructure of joint federal-provincial management. Similarly, federal-provincial agreement and action on immigration can address caregiver shortages and harmonize standards. This would have spillover effects for professional regulation, helping build a cadre of health human resources, with commonly recognized qualifications.

A new Canadian strategy for long-term care, launched by a commission of inquiry, can drive this agenda forward and flesh out its components. Establishing such a process now, before the spotlight of political attention shifts, is a matter of highest priority. If we do not act now, the failings that have been exposed by the COVID-19 pandemic will continue to take their toll on the lives and the quality of life of Canada’s most vulnerable citizens.





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