

How New Governance Shapes Changes in the Long-Term Care Sector in Ontario, Canada¹

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ABSTRACT

This paper turns to the insights of *New Governance* in order to explain how law was used to promote innovations in health care governance in the Canadian province of Ontario between 2004 and 2012. New Governance refers to a family of approaches that are more flexible and less prescriptive. My research includes review of government documents, legislation and other sources in order to identify changes to regulation and governance. I also draw upon interviews with seven organizations in the sector, which were conducted as part of a larger project to help contextualize and explain the changes in law. I argue that, while the formal legal and regulatory apparatus continue to be used to regulate the provision of care and treatment, New Governance approaches represent additional processes and procedures to *problem-solve* challenges in the sector. Law is being used to formalize or strengthen these processes and procedures in order to allow long-term care home residents, families, friends, and workers to participate in problem-solving. This increasing emphasis on processes can be understood as an attempt to broaden the scope of possible solutions and changes that could be implemented in the sector. For future research, I suggest that more attention be paid to interrogating the relationships that enable New Governance techniques.

Keywords: governance, regulation, experimentalism, long-term care, disability, innovation.

Introduction

In Canada, and around the world, public sector managers and their political masters continue to respond to challenges in their respective health care systems. According to the Institute of Public Administration of Canada, factors such as an aging population, increasing prevalence of chronic conditions, implementation of new technologies, and the introduction of new and costly pharmaceuticals contribute to the rising health care costs of provincial and territorial governments (Institute of Public Administration of Canada, 2013: 3). Most frequently, public discourse around health care is related to the level and quality of services, and the funding for such services. Colleen Flood explains the *crisis talk* in an Ontario context:

In the end, recurrent political debates are reduced to issues of money, and the problems of the system are blamed on the lack of it. We believe, however, that the Ontario crisis in health care, along with similarly situated health care schemes, has more to do with an absence of effective governance (Flood, 2004: 170).

One could ask how the literature on governance responds to current and future challenges in the health care system. By governance, I mean “the changing boundaries between the public, private and voluntary sectors, and the changing role of the state” (Rhodes, 2012: 33). This paper turns to the insights of *New Governance* in order to explain how law was used to promote innovations in health care governance in the Canadian province of Ontario between 2004 and 2012. *New Governance* consists of a range of processes and practices that are less rigid and less prescriptive: increased participation of non-state actors; public/private collaboration; diversity and competition within the market; decentralization; integration of policy domains; non-coerciveness (soft law); adaptability and constant learning; and coordination (Lobel, 2004a and 2012; de Burca and Scott, 2006). There is a shared concern within the literature about how *New Governance* transforms the way law is created and administered (Trubek, 2006: 246). For some scholars and policy makers, *New Governance* is positioned as an ambitious framework for addressing public policy problems, such as occupational safety, discrimination law in the workplace, financial regulation, and health care (Lobel, 2004a and 2012; Sturm, 2006a; NeJaime, 2009; Blum, 2007).

This paper examines how recent changes to the governance of the long-term care (LTC) home sector in Ontario—especially participatory processes and procedures enshrined in law—can help meet some of the pressing challenges in the sector. Long-term care homes provide care, services and accommodation in a secure environment to people whose complex health care and personal support needs mean they can no longer live independently in the community (Long Term Care Innovation Expert Panel, 2012: 13). According to Banerjee, the LTC sector is presently the most highly regulated of the health and social care sectors in Canada (2013: 204). For Armstrong, while some regulation is necessary, particularly at the policy level, the increasingly detailed regulations put in place in response to public scandals have not created the necessary conditions for accessible, quality care (2013: 217). At first glance, looking for innovations in the LTC home sector appears to be an exercise in futility. However, in spite of this “vicious cycle of regulation” (Banerjee, 2014: 203) in Ontario, there are potential innovations in governance—if *properly understood and implemented*—that could help reframe the problems and solutions in the sector.

I argue that, while the formal legal and regulatory apparatus continue to be used to regulate the provision of care and treatment, *New Governance* approaches represent additional processes and procedures to *problem-solve* challenges in the sector. Law is being used to formalize or strengthen these processes and procedures in order to allow long-term care home residents, families, friends, and workers to participate in problem-solving. This increasing emphasis on processes can be understood as an attempt to broaden the scope of possible solutions and changes that could be implemented in the sector. However, questions about conditions that are most likely to influence the realization of *New Governance* approaches remain in the literature.

This paper will proceed as follows: The first section is a review of the literature. I draw upon disability scholarship to expose where and how additional questions can be asked of *New Governance*. The second and third sections present the case study, the LTC home sector in Ontario. I mainly rely on government documents, legislation and other sources in order to

identify changes to regulation and governance. I also draw upon interviews with seven organizations in the sector, which were conducted as part of a larger project to help contextualize and explain the changes in law. After a primer on the sector, the paper describes examples of New Governance approaches: participation of non-state actors; flexibility and non-coerciveness (softness in law); collaboration and collaborative process; fallibility, adaptability and dynamic learning; and enforced self-regulation. The paper will then conclude with my reflections and analysis of the case study.

Review of the Literature

The purpose of this section is to present the key concepts used in the interpretation and analysis of recent changes in the LTC home sector. It begins by outlining the basic premises of the New Governance literature. This section will then make the case for studying the implications of New Governance from the vantage point of people with disabilities.

New Governance – Basic Premises

The New Governance literature is used here primarily to gain insight into the techniques and instruments of regulating and governing the care, treatment, and living circumstances provided in LTC homes. This is not an attempt to argue that New Governance is the only possible theoretical approach to explain innovations in the LTC sector or to relate these innovations to broader public sector reforms. Clearly, there is a rich and growing body of literature on LTC homes, including important contributions in the feminist political economy literature (for example, see Seeley, 2012; Armstrong et al, 2012). The New Governance literature is used to analyze the case study, which focuses on the legal aspects of governance innovations in the LTC home sector. The concepts used in New Governance literature provide a way to describe changes in the law governing LTC homes in Ontario. The discussion here will start with New Governance's controversial claim to *newness* in legal thought, then look at the concept of problem-solving, and finally, discuss the highlights of relevant debates within the scholarship.

Newness in legal thought

As a school of legal thought, New Governance focuses on efforts to move beyond a court-centric and rights-focused legal approach (Nourse and Shaffert, 2010: 88). Generally speaking, it is positioned as *new* because it is the opposite of command-style, fixed-rule regulation (Karkkainen, 2004: 473). In particular, some of the early and frequent contributors to the New Governance scholarship share a belief that the so-called traditional or *old* regulatory approaches can no longer solve the type of public policy problems that have emerged since the 1970s. The old approaches include heavy reliance on litigation (Simon, 2004; Trubek, 2006), command-and-control regulation (Lobel, 2004a), and centralized decision-making authorities that rely on experts (Lobel, 2004a). However, it should be pointed out that New Governance scholars do not embrace total deregulation, and instead seek new alternatives that move beyond the dichotomy of regulation vs. deregulation (Trubek, 2006; Lobel, 2012).

New Governance claims to be an entirely *new* framework with an intrinsic ability to innovate and constantly reinvent itself. It is argued that law must adjust to changing circumstances in the outside world: increased global competition; privatization; fiscal crises; new

production modes and patterns of employment; and advancements in communication, science, and technology (Lobel, 2004a: 277), just to name a few. The goal of this newness in legal thought is to imagine the architecture of a legal system that is most likely to support constant improvement (Lobel, 2004a: 275). In the literature, the push for New Governance techniques in the health sector is tied to the innovations that are necessary for dealing with rapid changes in technology and practices (Trubek et al., 2008: 8).

One could counter-argue the above claim by pointing out the language of *improvement* and *innovation* is also used by scholars in other fields, such as public management reform studies (for example, see Sørensen and Torfing, 2012, study on collaborative innovation in the public sector). It should be noted that the concepts, techniques and tools used by New Governance scholars are not necessarily new in the sense of being distinct from other debates in public management reform. For example, New Governance overlaps with New Public Management (NPM). Given the impact of NPM reforms (for example, see Atreya and Armstrong, 2002: 11-14; Pollitt and Bouckaert, 2011: 15-18), it is instructive to briefly describe the concepts associated with NPM.

NPM has been used to describe a wide range of concepts and practices in public administration that emerged in the late 1970s and throughout 1980s (Klijin, 2012: 203). NPM originated from managerialism (the import of management techniques from the private sector) as well as from the field of economics, including public choice theory, agency theory, and transactional costs theory (Atreya and Armstrong, 2002: 6). The core ideas include greater emphasis on performance measurement; preference for lean and disaggregated organizational forms; substitution of contracts for hierarchical relations; use of market-type mechanisms; emphasis on treating users as customers, and on the application of generic quality improvement techniques (Pollitt and Bouckaert, 2011:10; Atreya and Armstrong, 2002: 5). By the late 1990s, NPM was coming under intense attack, even in countries where it had originated and gone the furthest (Pollitt and Bouckaert, 2011:10). Sørensen and Torfing describe the following unfulfilled promises of NPM: removal of red tape, more autonomy for public agencies and employees, increased responsiveness to users, stimulation of public innovation, and more effective service delivery through contracting out (2012: 6). Equally important, NPM has created negative effects, such as a strict and costly auditing regime, a new breed of opportunistic and sub-optimizing public employees, a new generation of citizens behaving like customers, and a general weakening of the ability of elected politicians to direct the public sector (Sørensen and Torfing, 2012: 6).

For the purpose of this article, it is important to point out that New Governance and NPM have different goals. Most NPM reforms were concerned with transforming governments into leaner, but more effective, steering organizations (Klijin, 2012: 204). In contrast, New Governance scholars began with the concern that the regulatory state was no longer, and perhaps never had been, fulfilling the promise of just and equitable democracy (Lobel, 2004b: 502). Although New Governance scholars have addressed prescriptions about the organization of government (e.g., principle of decentralization), their focus is much broader than reforming the public sector. Furthermore, the use of law and its transformation is central to New Governance scholarship (Trubek and Trubek, 2006; Solomon, 2008: 826-827). It is for this reason that we will rely on New Governance in analyzing my case study, rather than other theories.

Problem-solving

The notion of problem-solving is prominent in the literature because law and regulation are conceptualized as problem solving ventures (Lobel, 2012: 78). For the purpose of this article, I adopt New Governance's approach to law as "problem-solving involving institutional experimentation in a pragmatist sense" (Nourse and Shaffert, 2010: 88). Solutions to public problems cannot be derived analytically, therefore, instead of relying on abstract analytical schemes and methods, these solutions are best derived deliberatively and experimentally (Simon, 2004: 131). Simon explains the concept of problem-solving as follows:

The rhetoric of problems and solutions suggests common interests, rather than the notion connoted by the idea of rights of individual interests competing with group interests. Problem solving connotes the possibility of mutually beneficial outcomes. It treats issues as neither purely distributive nor involving categorical choices between mutually exclusive positions (Simon, 2004: 178).

Simon is careful to point out that this approach "does not ignore conflicting interests or value dissensus" (Simon, 2004: 179). However, neither the individual nor the community can know what their interests are prior to entering a properly designed process. As all parties may learn things in the process about the possibilities for realizing their own goals, the conceptions of those goals may change in the course of the process (Simon, 2004: 179). Finally, problem-solving is a continuous activity: every resolution is provisional and incorporates assumptions about its evolution and potential transformation (Simon, 2004: 179).

Apart from the notion of problem-solving, the basic tenets of New Governance are far from settled. Although a common concern of New Governance scholars is to solve public policy problems, the scholarship cannot be captured by a unified set of prescriptions. Karkkainen argues that New Governance approaches should be seen as a family of alternative approaches, each advanced as a corrective to the perceived limitations of conventional forms of regulation (2004:496). In response to questions about overlooking the diverse ideas within this larger body of thought, Loebel suggests:

. . . it would be self-defeating if there was a fixed and *ex ante* agreement on all of its principles, rationales, and applications. . . It further demands continuously improving the chosen practices and relationships between the public and private policy partners (Lobel, 2004b:500-501).

The main guiding principles of New Governance will be discussed in the next section within the context of the case study. The critiques of New Governance will also be addressed by referring to questions emerged from the case study.

Debates within the literature

One of the debates within New Governance scholarship relevant to the case study is about the realization of participation of non-state actors. The point of contention in the literature is the limits of participation in practice from the perspective of outsiders. Even scholars who forcefully advocate New Governance approaches recognize criticisms about grassroots and outsider participation. A common theme in this debate focuses on the conditions necessary for

New Governance approaches to be effective. As the case study will show, the conditions necessary for the realization of New Governance approaches are still under-theorized in the literature.

In an article about advancing workplace equity through institutional transformation, Susan Sturm summarizes the skepticism about legitimacy and feasibility of grassroots participation in New Governance deliberations (Sturm, 2006a: 269). One of the challenges is developing outsider groups' capacity to engage effectively and thus participate as *equals* in the deliberative process (Sturm, 2006a: 269). Also, it is said that there is a challenge of constructing effective processes that do not simply privilege experts and enable meaningful participation by disempowered groups (Sturm, 2006a: 269). Furthermore, reliance on grassroots organizations in third party monitoring depends on strategies that enable these groups to participate effectively, which are still lacking in the literature. Without attention to these questions, grassroots organizations find it difficult to sustain their involvement over time. They also are limited to the relatively rare situations where outsiders have already organized sufficiently to engage in effective collective action (Sturm, 2006a: 269).

A related debate in the literature focuses on the actual influence of marginalized groups in situations characterized by power imbalances. Writing from the perspective of cause lawyering, there is the fear that a process that purports to include marginalized stakeholders and work toward win-win solutions might instead re-inscribe existing power dynamics to the detriment of the client group. New Governance may fail to deliver meaningful participation for outside interests, and merely confirm the status of outsiders (NeJaime, 2009: 356-357). This is because a New Governance process might produce results that wouldn't exist in its absence; however, the appearance of stakeholder collaboration might make the outcomes more difficult to contest (NeJaime, 2009: 356). In particular, New Governance interventions could make contesting results in courts more challenging because courts might defer to a process that claims to embody community input and consensus, thereby leaving the *have-nots* in an even more difficult position (NeJaime, 2009: 359).

Choosing a vantage point – why disability?

This paper takes the position that the evaluation of New Governance approaches must extend beyond empirical observations of such approaches. New Governance scholars purport to commit to objectives such as “a more just society” (Trubek, 2006: 247) and “political equality” (Lobel, 2004a: 389). The next step in my analysis is to identify a set of public values that could be used to “make normative and prescriptive judgements” about the implementation of New Governance approaches (Lobel, 2004a: 388). In my view, the notion of equality—especially in relation to people with disabilities—should be used to normatively judge the success of New Governance approaches. This is because any New Governance approach needs to operate within Canada's constitutional framework, which includes equality rights for people with disabilities. Furthermore, the sector is usually framed as an *aging* issue; what is missing is an explicit acknowledgment that this is also about disability. Finally, I suggest that past regulatory failures (or at least gaps) in the governance of public benefits schemes for people with disabilities should give us additional incentives to be cautious about any new innovative approaches.¹

If we are to consider the implications of New Governance from the vantage point of people with disabilities, what are the potential theories available to assist with such analysis? I adopt, as my departure point, the social model of disability, which suggests that limitations on activity experienced by disabled people are social in origin (not attributable to impairment) and constitute a form of oppression (i.e., disablism). Thus, limits on activity imposed by disablism can be removed through social change (Thomas, 2006: 178). In other words, the social model stands for the proposition that structural barriers—physical as well as attitudinal—lie at the root of the marginalization of disabled people (Malhotra and Rowe, 2014: 2). A social model analysis has exposed the many barriers to disabled persons' citizenship, workforce participation and economic well-being (Frazee, Gilmour and Mykitiuk, 2005: 225). This is in sharp contrast with a medical or individual model in which individual impairments or conditions are seen as the cause for social and economic marginalization of disabled people (Malhotra and Rowe, 2014: 2; Shakespeare, 2012: 129).

It is acknowledged that disability is more complex than removal of barriers or social oppression. The original *strong* version of the social model has been challenged from both within and outside disability studies, for example, from feminist scholarship. In particular, early disability theorists tended to gloss over complexities that shaped people's lived experience, including gender, race and ethnicity, and assumed a basic dichotomy between people with and without disabilities (Schur, Kruse and Blanck, 2014: 156). Thomas reflects on the work of Jenny Morris and other scholars, and calls our attention to the fact that, in addition to the barriers commonly experienced by both disabled men and women, barriers that are usually associated with gendered role responsibilities in the domestic and family domains tend to be ignored. Indeed, the socio-structural barriers that have been prioritized (such as barriers preventing access to paid employment) tend to be the ones of most significance to disabled men (Thomas, 1999: 26-28).

A more nuanced approach to the lived experience of people with disabilities is called for. One challenge to the social model of disability is the recognition that impairments often contribute to the disadvantage and difficulties experienced by persons with disabilities (Shakespeare, 2012: 131). Although the provision of social support may mitigate the effects of many disabilities, it is impossible to completely eradicate the impact of serious disabilities, whatever services are provided (Herring, 2013: 28). In sum, the disability phenomenon cannot simply be reduced to barriers and oppression (Shakespeare, 2012: 131). I find Tom Shakespeare's description of disability to be particularly helpful. He is correct to point out that disability is far more than just a health issue. However, people with disabilities do have health needs, usually over and above those of the general population. If their health needs are neglected, their quality of life will suffer. More importantly, it will be difficult, and sometimes impossible, for them to enjoy their other human rights (Shakespeare, 2012: 131).

A primer on long-term care homes in Ontario

In response to photographs showing a gangrenous bedsore that developed on a LTC home resident, the former Ontario Minister of Health, George Smitherman, wept and vowed: "I want to bring a sense of missionary zeal to the work we do in this office. We will fix this. We will" (Welsh, 2003). In the ten years since this media story, the public discourse around LTC

homes continues to focus on regulatory issues, such as abuse and neglect, use of restraints, resident-on-resident violence, and quality of care provided to residents. *Fixing* the sector has emerged as a pressing problem due to the intense media and public attention, as well as the risks involved—financial, political, reputational and legal—if *something is not done*.

Between 2004 and 2012, the LTC home sector underwent (and is, in fact, still undergoing) a transformation, which included the adoption of New Governance approaches. A centrepiece of this transformation was the introduction and implementation of a new legal framework for the sector. This section provides background information pertinent to understanding the new legal framework. To create a snapshot of the sector and identify the changes to the sector, I draw on legislation (Ontario), government documents, including web content, and interviews with seven Ontario-based organizations in the LTC home sector.ⁱⁱ Because governance is about the changing boundaries between the public, private and voluntary sectors, I attempt to incorporate the perspectives of those in the private and voluntary sectors in order to highlight some of tensions in the theories and examples of New Governance.

What are long-term care homes?

In Canada, LTC homes, also known as nursing homes or residential care facilities, serve seniors and others who do not need to be in a hospital, but still require a level of care not generally available through home care programs or retirement homes (Canadian Institute for Health Information, 2013: 1). Long-term care straddles nursing/medical care and social services in the form of income-supported housing, assistance with “activities of daily living,” and the provision of recreational and social programs (Banerjee, 2009: 30). The average resident is 85 years of age or older and faces many challenges, including multiple chronic diseases and problems with mobility, memory, and incontinence. Women comprise of about 70 percent of those living in nursing homes (Canadian Institute for Health Information, 2013: 1, 4-5).

Ontario’s 634 LTC homes, which consist of nearly 78,000 beds, provide certain specialized care (e.g., behavioural support units), accommodation, and services to over 112,000 individuals each year (Ontario Ministry of Health and Long-Term Care [MOHLTC], 2012: 131). Government funding (approximately \$3.4 billion annually or 7.5% of the provincial health budget) pays for nursing care and personal care, program and support services, and raw food (Long Term Care Innovation Expert Panel, 2012: 15; Banerjee, 2009: 48). Residents generally pay their homes between \$1,708 and \$2,362 per month, depending on the type of accommodation (Ontario MOHLTC Web content, 2014a). The government may also support the costs of developing or redeveloping (including renovating or retrofitting) homes (Ontario MOHLTC, 2009a). While the government provides financial support for all beds, one key difference in service delivery is ownership of the homes: 53% of beds are run by for-profit, 25% are run by non-profit, and 21% are run by municipal governments (Long Term Care Innovation Expert Panel, 2012: 14).

The issue of private sector involvement in service delivery has been subject to much debate. A number of developments contributed to changes to the structure of the LTC home sector. For example, as a result of a competitive bidding process in the late 1990s, 40% of an additional 20,000 beds went to three major corporate chains (Armstrong, 2013: 218). In addition, the new physical standards put older, smaller homes out of service (Armstrong, 2013:

218). Privatization may also happen in the form of contracting out of *ancillary* services such as cleaning, food and laundry services in both for-profit and non-profit homes (Seeley, 2012: 124). Researchers have shown a particular interest in the impact of privatization on residents in terms of quality of care, on working conditions of care workers, and on the regulation of homes (Seeley, 2012; Daly and Szebehely, 2012; Armstrong et al, 2011; Armstrong, 2013).

The governance and regulation of care and treatment in long-term care homes

A plethora of *hard law* and *soft law* (for definition of soft law, see Pottie and Sossin, 2005) requirements are relevant to care and treatments provided in LTC homes. At the institutional level, all LTC homes, regardless of ownership, are governed by the *Long-Term Care Homes Act, 2007* (LTCHA) and its Regulation. The previous applicable statutes are: *Charitable Institutions Act*, *Nursing Homes Act*, and *Homes for the Aged and Rest Homes Act*. The MOHLTC website describes the objective of the LTCHA as follows:

. . . ensure that residents of these homes receive safe, consistent, and high-quality resident-centred care in settings where residents feel at home, are treated with respect, and have the supports and services they need for their health and well-being. . . to improve the resident experience and quality of life in LTC Homes (Ontario MOHLTC, 2014a).

Effective July 1, 2010, the LTCHA sets out the requirements for resident rights and protections (including zero tolerance for abuse), services, accountabilities, placement rules, system management and compliance inspection and enforcement. The Regulation provides the details to support the requirements of the LTCHA (Ontario MOHLTC, 2014a). It should be noted that although New Governance approaches are present (as argued in the next section), there are still so-called *command-and-control* requirements, which are usually depicted as the state sets and enforces rules or standards and private actors must comply with those rules (for example see Solomon, 2008: 821-822). These requirements are evident in areas such as medication management, nutrition care and use of restraints.ⁱⁱⁱ For one lawyer, who specialized in elderly law, detailed requirements are absolutely necessary because of the vulnerability of residents and past regulatory failures (interviewee #1).

The MOHLTC is responsible for the regulation of LTC homes, including the administration of the LTCHA. The MOHLTC's Long-Term Care Homes Quality Inspection Program (LQIP) was created to investigate complaints, concerns and critical incidents, and ensure that all homes are inspected at least once per year (LTCHA, s.143). The implementation of the new inspection model could be viewed as an attempt at innovation in the governance of the sector. According to the MOHLTC, this inspection model provides a consistent, structured and evidence-based approach. More objective and predictable results encourage homes to focus on problem-solving and continuous improvement. This will prompt them to follow-up and address resident and family concerns (MOHLTC, 2013: 7-8). Despite significant concerns about implementation, interviewees from advocacy groups representing residents and families—Advocacy Centre for the Elderly, Board of Directors of the Concerned Friends of Ontario Citizens in Care Facilities, Family Councils Program, and Ontario Association of Residents' Councils—generally agree that the new inspection program is necessary for the quality of care received by residents (Interviewees # 1, 2, 3 and 4).

Industry participants have contested the expected benefits of the new inspection model. According to one industry association representative, a key concern is that, with more than 600 legislative and regulatory provisions, it is unclear if homes will be able to identify the priority areas they should focus on. However, compared to the previous system, which simply could not generate objective and reliable data, the new inspection system is capable of generating large quantities of data about homes and the sector. The challenge is to shift attention from meeting the statutory obligation of annual inspection of every home in Ontario to the analysis of data generated by the new inspection system and other data collection exercises (Interviewee # 6). One labour union representative expressed a similar concern about lack of analysis of inspection data. While the inspection system is able to capture the number of complaints, little attention has been given to interpreting and understanding cited non-compliances resulting from these complaints and the reasons for such non-compliances (Interviewee # 5).

Context of a new legal framework: the quest for quality

This section will conclude by outlining the context in which the new legal framework finally came to fruition in 2010. It took more than six years for this new framework to be conceptualized, developed and implemented. Despite all other pressing problems in the health care sector, the issue of governing LTC homes captured the political attention of three health ministers long enough for the new statute to be put in place. Due to space constraints, I will focus on the emergence of quality of care as a public policy problem and government priority in order to contextualize the new legal framework.

The innovative part was to slowly shift the emphasis of the health care system from quantity of care to a discourse of quality. In 2004 and 2005, there were indications that the government was concerned with the *quantity* of care, in terms of number of beds, hours of nursing care and so forth; accordingly, the simple solution was to increase the quantity of care by investing in quantifiable (and *announce-able*) initiatives^{iv}. At the same time, it became more apparent that the emphasis on increasing the quantity of care was being re-considered by the government. For instance, the MOHLTC and the Seniors Health Research Transfer Network hosted a consultation to develop a common vision of *quality* in LTC homes (Ontario MOHLTC, 2008c). The 2008 financial crisis reinforced a sense of urgency in demanding more from health care spending. The 2009-10 annual planning document states: “The focus shifted from thinking about what the system can supply, to patients’ needs—the quality and satisfaction of the health care experience. This ensured that Ontarians were getting value for their money and that it was spent well and wisely.”

A clear manifestation of this discourse of quality can be found in the *Excellent Care for All Act*, which became effective in June 2010. The *Excellent Care for All Act* sets out a number of quality related requirements for health care organizations, such as quality committees, quality improvement plans and satisfaction surveys. The Act describes the attributes of a high quality health care system as “one that is accessible, appropriate, effective, efficient, equitable, integrated, patient centred, population health focussed, and safe” (*Excellent Care for All Act*, Preamble). All of these attributes, in turn, need to be unpacked, and it is evident that the definitions of these attributes are far from settled.

Tackling the issue of quality within the current regulatory environment is also difficult. As one industry association representative explained, a compliance culture focuses on what a

home must do minimally (as prescribed in legislation). If a home spends all its time on what it is required to do, there is no time to think about quality, which requires experimentation (Interviewee # 6). Another industry association representative emphasized that it is possible to achieve compliance without delivering quality care because quality care requires much more, including, but not limited to, adequate front-line staff to provide care, knowledge transfer to staff and development of appropriate models of care (Interviewee # 7). Further, what is the role of the government in solving the quality problem? One interviewee stressed that the sector needs more than legislative direction (Interviewee # 7). If the public policy problem is quality, then turning to governance and regulation seems to be a logical place to start.

The Application of New Governance in the Long-Term Care Home Sector

The purpose of this section is to lay out the key guiding principles of New Governance and explore their application. The examples are organized according to the following principles: participation of non-state actors; flexibility and non-coerciveness (softness in law); collaboration and collaborative process; fallibility, adaptability and dynamic learning; and enforced self-regulations. In describing the manifestation of New Governance approaches in the LTC sector, I examine how some of the recent changes in processes and procedures can contribute to meeting the pressing challenges in the sector. At the end of this section, I offer my analysis and reflections on these approaches, including some of the limitations inherent in the New Governance literature.

I argue that these approaches are not about de-regulation; in fact, they are created and sustained by law. They are about strengthening or creating additional processes and procedures for participants—homes, residents, families, advocacy groups, industry organizations and government—to problem-solve challenges in the sector. While state involvement in the sector continues to be necessary, participants in the sector are encouraged to play a more active role in problem-solving in order to broaden the scope of possible solutions and changes that could be implemented in the sector.

Participation of non-state actors

First and foremost, New Governance scholarship emphasizes increased participation of non-state actors because it challenges the conventional assumption that the regulatory policymaking power of administrative agencies is based on their superior knowledge, information, and expertise (Lobel, 2012: 66). New Governance diversifies the types of expertise and experience that new actors bring to the table (Lobel, 2004a: 294). The different sectors—state, market, and civil society—are seen as parts of one comprehensive, interlocking system (Lobel, 2004a: 296).

In the Ontario health care system, the presence of non-state actors is nothing new, but *how* they work with each other and with the government may be changing. The provincial government has initiated opportunities for non-state actors to participate in defining and solving problems outside of the formal legal processes (for example, public hearings held by legislative committees). Equally important, industry associations and advocacy groups are also undertaking initiatives to tackle important issues in the sector. One advocate, representing families, cited The

Long-Term Care Task Force on Resident Care and Safety as an example of a sector-led initiative (Interviewee # 3).

By way of example, a consultation process was undertaken to support the development of a Seniors Strategy for Ontario. This process appears to be the opposite of what Lobel called “centralized, institutional decision-making authorities relying on professional, official expertise” prior to the New Governance era (2004a: 293). An expert lead from outside the government was appointed. Ministries from across the provincial government, including those not traditionally in the health or social policy field, such as Finance, Labour, Municipal Affairs and Housing and Transportation, were also consulted. In addition, the team embarked on a tour of 19 communities to obtain a better understanding of how local contexts have influenced common challenges and opportunities to meet the needs of older Ontarians. Furthermore, the MOHLTC conducted interviews with 800 caregivers across the province (Ontario MOHLTC, 2012:8-9).

Flexibility and non-coerciveness (softness in law)

The idea of non-coerciveness refers to New Governance’s aim to create a fluid and flexible policy environment that fosters *softer* processes (Lobel, 2012: 67). The terms *soft law* and *flexibility* have been used to describe degrees and variations of formality (Lobel, 2004a: 309). Examples of soft law include guidelines, benchmarks, standards, data collection and reporting, private accreditation and certification by non-governmental actors (Lobel, 2004a: 311; Trubek, 2006: 266). Although these instruments may not carry formal sanctions, there is still a continued role for the courts and hard law requirements (Trubek, 2006: 267). In fact, these instruments are interwoven within an authoritative legal system (Lobel, 2004a: 310).

In addition to traditional command-and-control regulation, there are indications that more flexible practices of policy formation and implementation are emerging. For example, more non-state actors can now be involved in the monitoring of the quality of LTC homes. The public nature of the data and the data collection process has the potential to allow all those concerned about care provided at homes to monitor and review the effectiveness of current policies. With a number of quality-related objects enshrined in law, the government agency, Health Quality Ontario (HQO), publicly reports on twelve quality indicators relating to different aspects of LTC quality, such as how effective and safe the care is at the provincial level, on an annual basis. Four of these indicators are also reported on at the individual home level. More importantly, HQO consulted with a panel of family and resident advocates, sector representatives, and research scientists to understand which indicators were most meaningful and useful for Ontarians (*Excellent Care for All Act*, s.12 and s.13 and Ontario MOHLTC, 2014b; HQO, 2014b).

Collaboration and collaborative process

The New Governance model advocates the adoption of cooperative governance based on continuous interaction and sharing of responsibility. In other words, this principle recognizes interdependencies among social actors (Lobel, 2004a: 299) in the sense that they share responsibility for achieving policy goals. Instead of just rigidly asserting its narrow economic or political interests, industry is expected to participate as part of a search for common goals (Lobel, 2004a: 298). Finally, the capacities, as well as the identities of the participants, evolve substantially over time (Lobel, 2004a: 298).

The LTCHA includes a number of features that are consistent with New Governance's emphasis on "deliberative process with acknowledged, agreed-upon norms" (NeJaime, 2009: 332). Some of the norms about collaboration and respect for diversity can be found in the preamble of the LTCHA, as follows:

The people of Ontario and their Government:

...

Strongly support collaboration and mutual respect amongst residents, their families and friends, long-term care home providers, service providers, caregivers, volunteers, the community and governments to ensure that the care and services provided meet the needs of the resident and the safety needs of all residents;

...

Recognize that long-term care services must respect diversity in communities; Respect the requirements of the *French Language Services Act* in serving Ontario's Francophone community; (Preamble)

At the local level, opportunities for collaboration and participation/partnership in LTC homes are also provided through Residents' Councils and Family Councils. These are autonomous bodies empowered by law (see Part IV Councils of the LTCHA) to act as advocates for seniors in homes, advising residents of their rights, monitoring facility operations, reviewing inspection reports and financial statements, and filing complaints (Banerjee, 2009: 46). The Residents' Councils and Family Councils existed in Ontario prior to the implementation of the new LTCHA. The LTCHA contributes to collaboration and participation of residents and families by confirming the respective legal status, functions and powers of the Councils. In particular, the LTCHA requires that each home establish a Residents' Council and only residents of the home may be members of the Residents' Council (LTCHA, s.56). Previously, a home would be required to assist in the establishment of a Residents' Council after a request was made by at least three residents or their substitute decision-makers (*Nursing Homes Act*, s.29.(1), (2) and (3)). Also, under the new LTCHA, if there is no Family Council, a family member or person of importance to a resident may request the establishment of a Family Council (LTCHA, s.59). In contrast, the *Nursing Homes Act* did not contain any reference to Family Councils. Further, a home must co-operate with the Residents' Council, the Family Council, and assistants of the respective Councils (s.62 and s.67 of the LTCHA).

Fallibility, adaptability and dynamic learning

The New Governance model requires adaptability and dynamic learning, acknowledging the inevitability and fertility of change while treating ambiguity as opportunity rather than a burden to overcome (Lobel, 2012: 67). New Governance scholarship stresses the importance of the capacity building of private actors as institutions designed to rely on self-discipline and self-surveillance to ensure performance. It borrows private sector processes, such as information pooling, learning-by-monitoring, reliable feedback, knowledge networks, benchmarks and indicators for best practices (Lobel, 2004a: 317; Sturm, 2006b: 326-327). These processes presume participants have the capacity, opportunity and incentive to act upon information about shortcomings in current practices (Sturm, 2006b: 327).

There are indications that the LTCHA is premised on the acceptance of a level of uncertainty. More specifically, the LTCHA allows for ongoing revisions and improvement at each home, but is silent on what those changes might be in the future. The interesting point is that the LTCHA contains fairly prescriptive procedural requirements for participation to enable innovation, quality improvement and self-surveillance. In other words, it appears that law assigns a right to participate in experimentation while acknowledging the limits of law in controlling the outcome of such experimentation. For example, each home must develop and implement a quality improvement and utilization review system concerning the quality of the accommodation, care, services, programs and goods (LTCHA, s.84). As well, each home must ensure that, at least once a year, a satisfaction survey of the residents and their families is taken. In developing and carrying out the survey, and in acting on its results, the home must seek the advice of the Residents' Council and the Family Council. Documentation about the survey and any actions taken must be made available to residents, families, the Residents' Council and the Family Council. The home must make every reasonable effort to act on the survey results and to improve the home (s.84 and s.85). In contrast, the *Nursing Homes Act* simply required a quality management system to be developed and implemented (*Nursing Homes Act*, s.20.11) without any reference to inputs from residents or their families. The Regulation under the *Nursing Homes Act* contained requirements for regular monitoring of satisfaction of residents and families, participation of staff in quality management activities and record keeping of quality management activities (Regulation 832, s.128). But the language in the LTCHA is much stronger and the emphasis on participation is more prominent.

Enforced self-regulation

From a regulatory perspective, New Governance encourages government agencies to foster a culture of compliance within regulated industries without resorting to de-regulation. The agency, when feasible, asks the regulated private entities to identify problems and risks, and to continuously reflect on possible solutions (Lobel, 2012: 71; Solomon, 2010). Thus, New Governance requires more protection and encouragement of individuals within the organization to point to problems and to engage in active dissent. This increased reliance on social enforcement—the private action of detecting and reporting illegality—has created a need for legal mechanisms to protect and incentivize whistle-blowing (Lobel, 2012: 73).

It appears that there is recognition that reliance on formal sanctions, such as inspections conducted by MOHLTC, is not enough to detect and correct problems in the sector. Rather, private actions for problem-solving are encouraged and supported by legal mechanisms. Previously, legal protection from reprisals was offered to anyone who made a disclosure to an inspector, so long as the disclosure was made in good faith (*Nursing Homes Act*, s.24.3(1)). As well, there was limited protection for persons reporting various information, such as harm to residents as a result of improper or incompetent treatment, to the Director at MOHLTC (*Nursing Homes Act*, s.25.(1) and (2)). Expanded whistle-blowing protections have been included in the LTCHA to protect anyone from retaliation as a result of disclosing information to an inspector, making a report to MOHLTC or providing evidence in a legal proceeding. The definition of retaliation includes, but is not limited to: dismissing, disciplining or suspending a staff member; imposing a penalty upon any person; and intimidating, coercing or harassing any person. More importantly, a resident cannot be discharged from a LTC home, threatened with discharge, or in any way be subjected to discriminatory treatment. Further, no family member, substitute

decision-maker, or person of importance to a resident shall be threatened with retaliation against the resident (LTCHA, s.26(1), (2) and (3); Advocacy Centre for the Elderly, 2010).

Discussion

To conclude this section, I offer some reflections and analysis of the case study from a disability perspective. One clear theme is an emphasis of processes and procedures for participation in problem-solving, many of which are enshrined in law. Critics of New Governance have argued that attempts at New Governance approaches may produce little change on the ground (NeJaime, 2009; Bach, 2012). Even Lobel acknowledges that there is a distinction between gaining power over real decisions and resources versus having merely advisory and knowledge dissemination capacities (2004a: 385). Following the work of disability scholars, I will interrogate some of the assumptions used in New Governance in order to explore its potential implications. I will then discuss how the New Governance scholarship can be extended.

Problem-solving

An implicit underlining assumption embedded in New Governance techniques is that all parties are autonomous and capable of sharing and processing information, and engaging in problem-solving. Due to their lived experience with disability and illness, would some residents need support in order to participate in any problem-solving process? This is an important question to ask if we want a truly inclusive process that can accommodate different capacities and needs of residents while also respecting their autonomy. Consider the example of residents' councils. As one advocate representing residents' councils pointed out, very often the assistants of residents' councils lead the council meetings at homes instead of facilitating and supporting residents in their discussions. Based on the results of a pilot project to promote effectiveness of residents' councils, it is suggested that home administrators, council assistants and council presidents require support in strengthening and empowering residents' councils through fostering relationships among them. With the right tools, they are more willing and able to take risks and try something new in their homes (Interviewee # 4).

The point is that, while New Governance participatory mechanisms (especially those enshrined in law) may remove formal barriers to decision-making, some participants with disabilities may require support in problem-solving. The emphasis should be about what kind of support—legal and non-legal—should be made available to homes and residents in order to maximize the potential for problem-solving and innovation, and foster autonomy of participants. In some contexts, a formal legal right to participate in problem-solving is not always meaningful for those who require support. Accordingly, a potential limitation of New Governance scholarship is that there is a tendency to underestimate the complex needs of those who are involved in problem-solving, and the supports required remain under-theorized.

Further, it is assumed that all parties are able to move away from their entrenched positions (NeJaime, 2009: 332) and focus on problem-solving. This assumption deserves careful attention because in the context of institutional care, the underlining tensions, such as autonomy vs. coercive care and capacity vs. best interest, persist. How these tensions are negotiated using New Governance approaches may be the most challenging type of problem-solving, as these tensions are intertwined with normative issues. One interviewee representing family councils

provided an example to illustrate such tensions. One of the highly contentious issues in the sector is the use of drugs on residents with mental health issues who exhibit aggressive behaviours. Some of these residents are not capable of providing consent to treatment because of their impairments.^v Some families would resist and reject the use of drugs on their loved ones, but other families would demand drugs because of the aggression exhibited by the residents. For the Family Council program, in order to accommodate the diversity of positions among family councils across Ontario, its approach is to aim for alignment rather than consensus by focusing on broad objectives, such as quality care and adequate staffing resources for residents (Interviewee # 3). Here, I take no position with respect to the factual issues surrounding the use of anti-psychotic drugs in LTC homes. This example simply illustrates that there may be limits to New Governance interventions, and scholars have not paid adequate attention to carving out which types of issues are not suitable for New Governance.

The conversation about patient/consumer participation also needs to be extended beyond questions about techniques, and ask whether participation could actually influence how problems and solutions are defined. More precisely, New Governance is, at best, vague at explaining how health care consumers might define problems differently due to disability, gender, race, class and other differences. It should be clear from the gendered disability perspective that women with disabilities may define health system outcomes differently than the dominant policy discourses. For example, in a series of focus groups across Canada, Pat Armstrong et al. asked how women defined quality in health care and concluded that the women interviewed said time in care and time for care are critical components in quality (Armstrong et al., 2012: 230). This understanding of quality may not be reflected in the research literature and policy fields, where quality is defined in terms of hospitalization rates and patients' satisfaction with services (Armstrong et al., 2012: 215). The gap in the New Governance literature is that increased participation of non-state actors appears to be gender-neutral but it is not clear how gender might mediate the effect of its realization. More empirical research is needed to demonstrate whether participation could actually influence how problems and solutions are defined in specific contexts.

It is evident that much remains to be studied about the neglected aspects of consumer/patient participation, such as the lived experience of disabled users of the health care system. This perspective is particularly important for understanding the process of deliberations and decision-making about quality care. The real issue is whether New Governance techniques can translate the lived experiences of users in determining system outcomes, such as quality care. According to one advocate representing residents' councils, some residents see things through the "lens of loss" due to their placement in LTC homes. Residents deserve to have influence over their lives and, at the same time, homes need contributions from residents regarding their lived experience. In sum, the discussion about quality of care cannot be separated from the lived experience of residents (Interviewee # 4). Within the context of LTC homes, the New Governance scholarship may have provided strong normative justifications for participation of residents (and others). However, New Governance tells us very little about the knowledge that *non-expert* participants bring to the table (in our case, the lived experience of residents) and how such knowledge could ultimately influence decisions. It appears that there is a disconnect between the theoretical justifications for participation and the empirical realities of non-expert participants in the literature.

How the New Governance scholarship can be extended

There is still much to be studied—theoretically and empirically—about conditions that are most likely to influence the realization of New Governance approaches (Solomon, 2008: 833) in the LTC home field. For future research, I suggest that more attention be paid to interrogating the relationships that enable New Governance techniques. I propose that the conditions necessary for the successful implementation of New Governance include constructive relationships within LTC homes.

One such relationship, which is of great significance to residents, is the caring relationship. My starting point is that individuals are interdependent and interconnected through myriad networks of roles, structures, and relationships. Some of these relationships are enabling, but many others can be disabling over the life-course (Prince, 2012: 13). Jonathan Herring explains that caring is about relationships, and individual acts of care can only be understood in the context of the relationship between the parties (Herring, 2013: 2). In a caring relationship, the interests and identities of the two people become intermingled. Thus, it becomes impossible to consider the welfare or rights of any one party in isolation. The focus must be on the relationship, rather than the individuals (Herring, 2013: 4). Further, if the caring of dependents is accepted as central, then the values of autonomy, freedom, and justice need to be used to enable and support caring (Herring, 2013: 2).

The New Governance examples above demonstrate that there is some acknowledgment in the literature that inter-dependencies need to be properly addressed and reflected upon. For example, the significance of legal protection for whistle-blowers will be more apparent if one considers how gender is factored into the employment context. The LTC home sector is attracting more women, immigrants, and foreign trained professionals, who often have difficulty accessing careers in the health field (Long Term Care Innovation Expert Panel, 2012: 61). More recently, the working conditions of nurses, and personal support workers in the health care sector in general, have been under the spotlight, and there is recognition that caregivers need to be paid more.^{vi} But I think the issue goes beyond the financial aspect. Their care-giving responsibilities cannot be fulfilled without addressing the precarious employment situations or working environments (generally see Armstrong et al., 2011; Daly and Szebehely, 2012). Therefore, the LTCHA is innovative in that it recognizes, to a limited extent, that quality of care is dependent on constructive relationships between caregivers and care recipients.

However, there are also strong indications that more needs to be done to address disabling relationships, and New Governance scholarship has not addressed problem-solving when groups lack the relationships to collaborate. One labour union representative spoke of a culture of fear among registered nurses, as well as among family members and friends (Interviewee # 5). The processes and procedures enshrined in law may provide possibilities for collaboration. In the context of care work, one could ask what factors may contribute to disabling relationships. One possible explanation is inadequate protection for vulnerable workers against the backdrop of increasing privatization of service delivery. Armstrong concludes that the government has failed to provide regulations to protect the predominantly female LTC home workforce from contracting out, job cuts, benefits or wage loss, and physical violence on the job (Armstrong, 2013). Without addressing some of the difficult questions about working conditions of care workers, the promise of New Governance techniques may not be fulfilled in the context of long-term care.

Conclusion

This paper examined potential governance innovations in the Ontario long-term care home sector, which is undergoing a transformation. While the formal legal and regulatory apparatus continue to operate in the background, New Governance approaches represent additional processes and procedures to help problem-solve challenges in the sector. While New Governance participatory mechanisms (especially those enshrined in law) may remove formal barriers to decision-making, some participants with disabilities may require support in problem-solving. Furthermore, there may be limits to New Governance interventions, and the literature has not paid adequate attention to carving out the types of issues that are not suitable for New Governance. The real issue is whether New Governance techniques can translate the lived experiences of users in determining system outcomes, such as quality care. Finally, for future research, it is suggested that paying more attention to interrogating the relationships that enable New Governance techniques will help to extend the scholarship on New Governance.

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ⁱ On December 9, 2013, Ontario Premier Kathleen Wynne delivered a formal apology in the legislature to former residents of regional centres for people with developmental disabilities who suffered harm after reaching settlements (Ontario Ministry of the Attorney General, 2013 and 2014).

ⁱⁱ The author received research ethics approval from the author's affiliated institution. Interviews were conducted, in person (six interviews) and by telephone (one interview), in September 2014. The interviews were conducted as part of the author's dissertation research. The interviewees were chosen because they are in a position to know something specific, or those who have participated in a particular consultation or event. These seven organizations were selected by checking the participants or stakeholder lists of the following consultations: Parliamentary Assistant Monique Smith's review of long-term care facilities (2004), the Standing Committee on Social Policy's public hearings on the *Long Term Care Homes Act* (2007), MOHLTC's Seniors Strategy for Ontario (2012) and MOHLTC's Long-Term Care Quality Inspection Program Advisory Committee (or its predecessor).

Prior to the interviews, the author reviewed grey literature such as technical reports, position papers, background briefings as well as written submissions to government produced by these organizations to gather as much background information as possible. The interviewees usually began by providing background or historical information about the LTC sector, their organizations and/or their personal involvements or experiences in the LTC sector. The author also asked specific questions of each interviewee about the new compliance system or the implementation of the LTCHA. Based on the answers provided by the interviewees, the author asked follow-up questions or requested clarifications from the interviewees. Some of the interview contents are outside the scope of this paper.

The interviewees were asked to choose to be interviewed with attribution or without attribution. Five interviewees decided to be interviewed with attribution, two decided to remain anonymous. Below is a list of the organizations of those interviewed.

Interviewee # 1	Advocacy Centre for the Elderly Jane Meadus, Barrister and Solicitor, Institutional Advocate
Interviewee # 2	Board of Directors of Concerned Friends of Ontario Citizens in Care Facilities Lois Dent (past President) Georgie Clarke (current President)
Interviewee # 3	Family Council Program Lorraine Purdon, Program Coordinator
Interviewee # 4	Ontario Association of Residents Councils Donna Fairley, Executive Director
Interviewee # 5	Ontario Nurses Association Beverly Mathers, Manager, Negotiations
Interviewee # 6	Industry association representative (anonymous)
Interviewee # 7	Industry association representative (anonymous)

ⁱⁱⁱ For illustration purpose only, consider some of the requirements about menu planning prescribed in Regulation 79/10 under the LTCHA:

71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
 - (a) is a minimum of 21 days in duration;
 - (b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks;
 - (c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner;
 - (d) includes alternative beverage choices at meals and snacks;
 - (e) is approved by a registered dietitian who is a member of the staff of the home;
 - (f) is reviewed by the Residents' Council for the home; and

- (g) is reviewed and updated at least annually.
- (2) The licensee shall ensure that each menu,
 - (a) provides for adequate nutrients, fibre and energy for the residents based on the current Dietary Reference Intakes (DRIs) established in the reports overseen by the United States National Academies and published by National Academy Press, as they may exist from time to time; and
 - (b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time.
- (3) The licensee shall ensure that each resident is offered a minimum of,
 - (a) three meals daily;
 - (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
 - (c) a snack in the afternoon and evening.

^{iv} Consider the following examples. In May 2004, the government announced investing \$191 million to hire new staff including new nurses and \$340 million to fund new long-term care beds (Ontario MOHLTC, 2004b). In August 2004, the government announced \$385,345 to support family and resident councils by increasing their numbers and support the existing ones (Ontario MOHLTC, 2004c).

^v In Ontario, the relevant legislation is the *Health Care Consent Act, 1996* (HCCA), which provides a statutory framework governing consent to treatment for capable and incapable patients.

^{vi} For example, Ontario Budget 2014: "To support the high-quality care that PSWs provide, the Province is proposing to give PSWs in the publicly funded home and community care sector a \$1.50 per hour wage increase in 2014–15, an additional \$1.50 per hour increase in 2015–16, and a further \$1.00 per hour increase in 2016–17. This increase would bring up the base wage to \$16.50 per hour by 2017. By strengthening recruitment and retention of PSWs in this sector, Ontario is building capacity to help transform the health care system by delivering high-quality care to patients in the most appropriate setting." (Ontario Ministry of Finance, 2014).