Engaging the public in long-term care (LTC) policymaking in Canada:

A comparative analysis of three cases

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May 2022

Public Engagement
in Health Policy

Abstract

The COVID-19 pandemic has highlighted the long-standing deficiencies in Canada's long-term care (LTC) sector. Calls for government action to ensure the delivery of high-quality LTC have skyrocketed. As policy reform is debated, it will be critical to include the voices of those directly impacted by policy decisions. This study aims to inform these decisions by describing past and current public engagement (PE) efforts in this policy sector and the political influences that have shaped these initiatives. This study employed a descriptive comparative case study design and examined three cases: 'the development of the Long-term Care Homes Act in Ontario [2004~2010], Ontario's COVID response in relation to LTC, [2020~2021], and the development of National Long-term Care Standards at the Federal level [2021~2022]. Data sources include publicly available and internal government documents, news articles, organizational websites. PE was described using predefined categories (i.e. rationale/goals, participants, recruitment methods, type of PE), and the political environment in which PE occurred was chronologically constructed. Case findings demonstrate that most of the PE initiatives undertaken were characterized by 1) engagement of multiple stakeholders, with many 'proxies' for the public, 2) reliance on targeted invitation along with self-selection methods for recruitment, and 3) frequent use of consultation-type activities. They also varied in the degrees to which 1) access to engagement opportunities was open and inclusive and 2) the engagement format supported two-way interaction between participants and engagement organizers. To explain these differences, we reflect on the surrounding political environment and hypothesize that when the surrounding political environment is supportive of the government's intended policy direction, it favours open and inclusive PE initiatives. Meaningful PE can effectively reflect the needs and wants of those directly impacted, ultimately resulting in higher-performing systems. In this regard, understanding how the public is engaged in LTC policy decision-making and what shapes different approaches provides valuable insights into how to help rebuild a person-centred LTC sector in Canada.

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Acknowledgements

We thank project team members Alpha Abebe, Joanna Massie, and Roma Dhamanaskar for their helpful comments on the earlier version of the summary report. Special thanks go to Katherine Boothe for her valuable inputs throughout the project.

This research report was prepared by members of the Public Engagement in Health Policy team, which is supported by the Future of Canada Project at McMaster University.

1.0 Introduction

Over the last two decades, the field of public engagement (PE) has evolved significantly across different sectors of health policymaking, such as health technology assessment, primary care, mental health, and long-term care (Dhamanaskar et al., 2022). Policymaking that includes PE differs from more traditional types of governance where the public function as passive recipients of policies set by policymakers with the help of nominated professional experts (Rowe & Frewer, 2005). PE in health policymaking has a wide range of intended benefits, including making better-informed and possibly more effective policy decisions to achieve its goals (Boivin et al., 2014), promoting democratic values such as increased accountability, legitimacy, and transparency (Abelson & Gauvin, 2004; Daniels & Sabin, 2018), and mitigating difficulties in solving wicked policy problems (Carcasson, 2016). Accordingly, governmental bodies increasingly seek the lived experience and knowledge of the public in a variety of roles and activities as an integral element in developing health policies and governance (Health Canada, 2016; Peña-López, 2020).

As the demographic shift towards the ageing population has become a global phenomenon, the call for greater engagement of the public in long-term care (hereafter LTC) policies and governance have gained significant attention based on these rationales (Falanga et al., 2021). Older adults are the biggest users of the healthcare system, and the number of older adults is growing dramatically (McNeil et al., 2016). As this segment of the population grows, so does the demand for policies to address their health needs, often through new programs and services and expanded public funding for them. However, many health systems are struggling to meet this increasing demand (Manis, 2021). Furthermore, the health needs of older adults have become increasingly heterogeneous and complex. Increasing frailty compounds the burden on the health systems (Estabrooks et al., 2020). In Canada, the attention given to LTC and calls for action to reform the sector have spiked as the COVID-19 pandemic has highlighted the long-standing deficiencies in the LTC sector (ibid.).

While it is critical to ensure the voices of those who directly get affected in order to address the evolving policy needs (Cranley, 2020), little is known about how the public has been engaged in LTC policymaking processes. Many existing studies have shown that older adults, one of the main stakeholders in the LTC sector, have been engaged in direct care settings (ibid.) or health research settings (Baldwin et al., 2018; McNeil et al., 2016). However, limited research has focused on describing the engagement of senior citizens at the health system level (Falanga et al., 2021). Existing literature has also fallen short in exploring the political environments (e.g. political actors, institutions, and social norms) that have shaped the initiation and implementation of public engagement initiatives (Whyle & Olivier, 2020). This study aims to address these gaps by describing public engagement in three Canadian LTC policymaking cases. We also set out to examine the governments' policy directions and political landscape relevant to each case to inform future research that will seek to explain the different patterns of engagement identified across the three cases. Our primary research question is "how has the public been engaged in Ontario and Canadian LTC policymaking?" This study aims to describe the goals, participants, and approaches to public engagement initiatives in three cases of LTC policymaking in Canada, and to explore how the aforementioned characteristics of PE aligned with the political environment at the time.

2.0 Methods

2.1 Setting

This study focuses on 24-hour long-term facilities-based care as defined by Health Canada. Long-term care facilities (also known as nursing homes) provide living accommodation for those who require on-site supervised care delivered 24 hours, seven days a week. It includes professional health services, personal care (e.g. bathing, feeding) and other services (e.g. meals, housekeeping). Unlike hospital services, LTC is not included under the Canada Health Act. Instead, it is governed by provincial and territorial legislation (Health Canada, 2003). Consequently, there is considerable inconsistency across the country in terms of what facilities are called, the types and scope of care and services provided, cost coverage, or how facilities are governed and regulated (Estabrooks et al., 2020). LTC is distinguished from assisted living services (commonly known as retirement homes and home care services) in that residents of long-term care homes have complex care needs and require access to 24-hour nursing care, whereas recipients of assisted living services do not (Manis, 2021).

2.2 Design

This study employed a comparative case study design (Yin, 2017). In this study, a case is defined as a process in which the public was engaged to contribute to long-term care policies. The term 'public' can refer to a variety of individuals or groups of individuals such as citizens, community members, patients, families, advocacy or interest groups who have different levels of interest in a policy issue and who may seek, or be invited, to engage around this issue (*Key Terms and Concepts*, n.d.). The focus of this article is on the engagement of direct users of LTC, their families, and the general public who can bring lived experience and or broader social values to engagement efforts. The cases were identified through a two-stage process. First, public engagement initiatives in Canadian health policy between 2000-2021 were identified by a search of the academic literature and grey literature using government databases, Google Scholar, and Google web search (Dhamanaskar et al., 2022). Among the cases collected at this stage, several public engagement initiatives in the LTC sectors were identified. These cases were followed to trace the associated policymaking process and accompanying PE efforts. In this second stage, additional PE activities were identified that informed the policy decisions that were closely linked to those in the initially collected cases, which expanded the initial scope of the cases. Through this two-stage case identification process, the researcher identified three specific cases for descriptive analysis: i) the development of the Long-term Care Homes Act in Ontario [2004~2010]; ii) Ontario's COVID response in relation to LTC, [2020~2021], and iii) the development of National Long-term Care Standards at the Federal level [2021~2022].

2.3 Data collection

Peer-reviewed and grey literature sources were initially searched with a focus on public engagement in long-term care in Ontario between [2000-2021]. Few published articles meeting the search criteria were found so the search focused on collecting grey material relevant to the research questions across the three cases. The following searches were undertaken: websites of relevant organizations (see Table1 for details), six electronic databases (FACTIVA; ProQuest Dissertations & Theses A&I; MacSphere; Canadian Public Documents Collection; ProQuest Historical Newspapers: The Globe and Mail; Voila: Canada's Catalogue), google search engine, and hand searching.

Table 1. Relevant organizations
• AdvantAge Ontario (Formerly Ontario Association of Non-profit Homes and Services for Seniors) • Advocacy Centre for the Elderly • Canadian Association for Long Term Care (CALTC) • Canadian Health Coalition • Canadian Standards Association (CSA Group) • Concerned Friends • Family Councils Ontario • Health Standards Organization (HSO) • Legislative Assembly of Ontario • Ontario Association of Residents' Councils (OARC) • Ontario Health Coalition • Ontario Human Rights Commission (OHRC) • Ontario Long Term Care Association (OLTCA) • Ontario's Long-Term Care COVID-19 Commission • Registered Nurses' Association of Ontario (RNAO) • The Council of Canadians • The Government of Ontario • The Standards Council of Canada (SCC)

Search strategies were subject to variation based on the search platform types. For some platforms, a variety of word combinations was used, including terms related to the public (public, resident, caregiver, stakeholder, etc.), engagement related terms (e.g. dialogue, involvement, consultation, engagement, submission, roundtable, etc.) and case-specific terms (see Table 2 for details). When the document searches yielded thousands of results, the first ten pages were screened (approximately ten results emerged per page, resulting in around 100 links). The screening continued for another five pages if relevant material was found and ended when no more relevant information came up. The researcher also used hand searching and followed links to other websites provided by relevant organizations' websites. As the research progressed, the researcher expanded search terms and conducted additional searches, primarily using google search engines. It was when the researcher discovered a critical event in relation to PE and surrounding political environments in the political sequence of the three cases. By doing so, the researcher was able to make reasonable sense of all collected information and refine the narratives of the study.

Table 2. Case-specific Search Terms (including expanded search terms)

Case 1	Case 2	Case 3
Long-term Care Homes Act Bill 140 or O. Reg. 79/10 Independent staffing study Commitment to Care Ontario	Ontario COVID-19 Commission COVID response in Long-term care homes Auditor General's Report Health Command Table	National standards for long-term care or National Long-Term Care Services Standards CSA Group or CSA Z8004 HSO or CAN/HSO 21001:2022

The grey material selected included publicly available and internal government documents and files, news articles, web articles, blog posts etc. The researcher read more than 200 documents that contained relevant

information on public engagement and surrounding political environments across the three cases. All material collected was stored on the researcher's hard disc in pdf format. In particular, most web postings were downloaded in the form of screenshots of the entire screen. It was done to prevent some important temporary data (e.g. the number of views on the meeting notice and information) from being erased, moved, or lost over time, as is with grey literature and information. The researcher developed and used data extraction forms to record information in order to gather and manage all relevant documents found across the three cases, respectively.

2.4 Data analysis

A stand-alone description of each case, focusing on PE surrounding the policy decision-making process, was chronologically constructed. Cases were further refined following additional searching to identify crucial events that had a significant impact on each case and to remove unnecessary detail. To address the first research aim (describing how the public has been engaged in LTC policymaking in Canada), PE was described using predefined categories (i.e. rationale/goals of PE, participants and recruitment methods, and type and format of PE). Once the case descriptions were constructed, a cross-case analysis was undertaken, which involved both within-case analysis and across-case analysis (Yin, 2017).

2.4.1 Public engagement categories

Some predefined themes were used to describe who was involved in PE initiatives and how the initiatives were conducted. *Participants* refer to those individuals or groups involved in each engagement initiative but external to the PE host organization (e.g. governments). Where possible, both the targeted and actual participants in each initiative were documented. The purpose or objectives for engaging with the participants in each initiative were labelled *Rationale/goals*. The rationales were documented as accurately as possible in line with how they were reported by the host organizations, and as described by the different perspectives in the collected literature. *Recruitment method and type of engagement* were organized using predefined categories developed in a previous study (Dhamanaskar et al., 2022). *Recruitment methods* were categorized using 'self-selection', 'targeted invitation', or 'appointment' methods. *Type of Engagement* was classified as 'feedback', 'consultation', 'deliberation', or 'co-design'.

3.0 Results

3.1 Case1: The Long-Term Care Homes Act development process [2004-2010]

The Long-Term Care Homes Act, 2007 (hereafter LTCHA) was proclaimed by the Ontario government in July 2010. This legislation consolidated and replaced three existing Acts: the Nursing Homes Act, the Homes for the Aged and Rest Homes Act and Charitable Institutions Act (Advocacy Centre for the Elderly, 2010). The LTCHA and accompanying regulations laid the foundation of the Ontario government's commitment to improve the quality of care and well-being of residents in LTC homes, strengthen transparency and accountability of the LTC homes' operation, and enhance residents' rights (Canada NewsWire, 2009; Legislative Assembly of Ontario, 2006b). Highlights of the LTCHA include yearly inspections of LTC facilities, protections for those who report abuse or neglect of LTC home residents, Residents' Bill of Rights, and limiting the use of restraints, to name a few (Canada NewsWire, 2007d).

3.1.1 Government's policy directions and political environment at the time

Government's policy directions*:* Ontario had no care standards in LTC homes since 1996 when the Conservative government withdrew the regulation requiring a minimum of 2.25 hours of care per resident per day (Canada NewsWire, 2007e; Toronto Star, 2007). Reinstating this minimum care standard was a key promise made by the Liberal Party in the 2003 election when they were in opposition, along with the promise of increased funding of $6,000 per resident per year for all LTC facilities (Canada NewsWire, 2007a, 2008b; Legislative Assembly of Ontario, 2006a). However, there were delays in bringing a relevant bill forward once the Liberal government was elected. It was not until October 2006, just before the 2007 election, that the proposed Long-Term Care Homes Act (Bill 140) was finally introduced (Legislative Assembly of Ontario, 2006c, 2006e).

The Liberals were seeking to pass the Act before an upcoming provincial election. The Health Minister at the time, George Smitherman, promised that the government would put a minimum standard of care of 2.25 hours in place within three months of the next government taking office (Legislative Assembly of Ontario, 2006a; Toronto Star, 2007). However, the minimum care standard was not included in the LTCHA (2007) until its implementation in July 2010. In supporting its shift away from committing to a minimum care standard in Bill 140, the government stated that a legislated care level would not be responsive to residents' changing health needs and front-line workers should be empowered to determine what level of care is required for each resident (Legislative Assembly of Ontario, 2006d, 2007c). Further, it cited the PE input it received through government-commissioned reports as part of its argument for not requiring a minimum care standard in the legislation. It was later revealed that the industry representative (i.e. the Ontario Long-Term Care Association) was the source of this input (the only stakeholder group that opposed the care standard) (Legislative Assembly of Ontario, 2007c). Instead, the government set a requirement for an annual quality inspection that would be performed on every LTC facility.

Political environment: While almost all policy actors seemed to agree with the need to improve care quality in LTC homes, opinions on how to do it varied significantly. In Ontario, LTC homes were funded through several funding envelopes including 1) nursing and personal care, 2) programs and support services and 3) accommodation. The accommodation envelope is the one from which for-profit LTC homes can earn profits. Since the long-term care operators had interests in shifting more funding into the accommodation envelope, they had reason to oppose the establishment of care quality standards (Ontario Health Coalition, 2007; Smith, 2004).

One of the most called-for elements in the legislation to improve the quality of LTC was the setting of a minimum care standard (Legislative Assembly of Ontario, 2007b). Residents, families, and their proxies argued for this using similar indicators from other Canadian provinces and the U.S. (Canada NewsWire, 2007d, 2008a). In contrast, the industry representatives framed the call as increased red tape. They argued that reinstating the standard of care will eventually worsen care quality due to the paperwork burden imposed on staff, especially if it is implemented without additional funds to carry it out (Legislative Assembly of Ontario, 2006d). They went on to claim that these increased legal requirements would negatively affect the flexibility of LTC facilities' operation and therefore decrease the quality of care and services for residents (Campbell, 2007a; Legislative Assembly of Ontario, 2006c).

Bill 140 brought huge disappointment to LTC residents and those advocating for the rights of seniors (Legislative Assembly of Ontario, 2006f). Senior advocacy organizations and relevant unions argued that Bill 140 merely merged three existing pieces of legislation, which added little to the existing pieces of legislation (Legislative Assembly of Ontario, 2006b). Most importantly, despite Liberal promises, it made no mention of a minimum standard of care which had been considered imperative for ensuring high-quality care for residents (Legislative Assembly of Ontario, 2006a). The Health Minister and government were actively pressured to establish a minimum care standard (i.e. 3.5 hours of care per day per resident given the increased health care needs), and it quickly became the main agenda that was continuously debated and requested during the legislative process (Campbell, 2007a; Canada NewsWire, 2008b).

Seniors advocacy organizations continued to organize grass-roots level activities to raise awareness of the poor care and living conditions of LTC residents and ultimately urge the government to add minimum standards and other provisions as the election approached (Canada NewsWire, 2007c, 2008b, 2008a). These activities included a number of petitions (Legislative Assembly of Ontario, 2006a, 2006c, 2006d), sending letters to or visiting the office of MPPs (ibid), issuing a press release on proposed legislation and their views about it, speaking at a media conference (Canada NewsWire, 2007b; Legislative Assembly of Ontario, 2006c), picketing and rallying at local MPP offices and LTC homes across the province (Canada NewsWire, 2008b, 2008a), and conducting surveys to demonstrate their collective opinions and delivering the results to MPP offices (Canada NewsWire, 2007e). Policymakers from opposition parties echoed this call and tried to block the Bill from being fast-tracked by requesting more public engagement (Legislative Assembly of Ontario, 2006b). Most active, in particular, was the NDP which held considerable bargaining power as the Liberal government could be reduced to a minority government (Campbell, 2007b). In the end, public engagement was built into the legislative process, although it was not planned from the outset, and occurred largely in response to political pressure. As the public's disappointment deepened as a minimum care level was not included in the proposed legislation after a series of PE initiatives (National Union of Public and General Employees, 2007), seniors and health advocates criticized the government for running meaningless public consultations (Canada NewsWire, 2008a).

3.1.2 Public Engagement in the LTCHA development process

The public was primarily engaged in two key ways during the LTCHA policy process: i) by providing input to government-commissioned reports; and ii) by contributing directly to informing the legislative process. A number of government reports were commissioned throughout the development process, in the early stages to suggest the establishment of LHTCA (Sonnenberg, 2010), and in the later stages that informed the details of the Act such as the vision of care quality (Ministry of Health and Long-Term Care, 2008) and quality indicators (Sharkey, 2008). The public was also engaged through the legislative process itself through participation in public hearings on the draft LTCHA (presentations and or written submissions) (Advocacy Centre for the Elderly, 2007; Canada NewsWire, 2007d; Legislative Assembly of Ontario, 2007a), and at the regulation drafting stage (Canada NewsWire, 2009; Sonnenberg, 2010).

Table 3. The list of PE initiatives conducted in the LTCHA development process				
	Title	Year	Category	Key documents
1	Stakeholder consultation for *Commitment to Care: A Plan for Long-Term Care in Ontario*	2004	Government-commissioned report	Smith, 2004
2	Public hearings on the draft LTCHA (Bill 140)	2007	Legislative Process	Official Reports of Debates (Hansard)
3	Stakeholder consultation for *Common Vision of Quality in Ontario Long-Term Care Homes*	2008	Government-commissioned report	Ministry of Health and Long-Term Care, 2008
4	Stakeholder meetings and brief submissions for *People Caring for People: A Report of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario*	2008	Government-commissioned report	Sharkey, 2008
5	Drafting Regulations	2008	Legislative Process	Sonnenberg, 2010
6	Public consultation on Part 1 & 2 of the draft regulation	2009	Legislative Process	Sonnenberg, 2010

Rationales/ goals: Various rationales and goals for PE in policymaking have been theorized or observed in practice. They include promoting the quality and relevance of decisions by complementing the expertise of decision-makers *(instrumental*), enhancing the openness and inclusiveness of the decision-making procedures (*democratic)*, and increasing the public's understanding and capacity to contribute to policy decisions *(developmental)* (Abelson et al., 2016). The rationales for PE in the LTCHA development process appeared to differ between the two main inputs to the policy process (commission reports and legislation). Many of the officially reported rationales in government-commissioned reports reflected the traditional goals of gathering a broad range of inputs from various sector stakeholders as a form of policy advisory input (Smith, 2004). Meanwhile, PE in the legislative process appeared to be conducted for other reasons. Public hearings on the draft LTCHA were initiated at the request of MPPs from opposition parties and advocates in order to have reasonable opportunities to review the legislation, implying that the rationales for PE were to enhance public accountability (Legislative Assembly of Ontario, 2006b; Ontario Health Coalition, 2007; Whitwham, 2006). After it was discovered that the proposed Bill lacked substantively new content (especially a minimum care standard that the Liberal government pledged when they were in opposition), politicians demanded province-wide public hearings on the Bill to prevent it from being fast-tracked (Legislative Assembly of Ontario, 2006b, 2006c, 2006e; Ontario Health Coalition, 2007).

In drafting regulations, the goal of PE was to obtain specific feedback from diverse stakeholders to refine policies that are highly complex and regulatory in nature (Sonnenberg, 2010). By doing so, the PE initiative aimed to not only enhance the legitimacy and transparency of the regulation development process but also to increase shared ownership and buy-in to the new Act (ibid.). Afterwards, Section 184 of the LTCHA provided the rationales for PE, which sets the obligations for public consultation prior to the enactment of initial regulations (ibid.). The government provided PE opportunities in the drafting of regulations as required, yet individuals who participated in these public consultations recalled that the engagement initiatives lacked authenticity (Long-Term Care COVID-19 Commission, 2020).

Participants and recruitment methods: Throughout the case, multiple stakeholders were engaged in the PE initiatives. This includes not only individuals and groups representing and or advocating for the rights of residents, families and caregivers, but also medical providers and their unions, academic experts, and LTC home operators. While all the initiatives were discrete events that differed in terms of the timing of the engagement implemented (see Table 3), there was considerable overlap in the participating organizations and individuals affiliated with organizations. The most frequently involved organizations were: Advocacy Centre for the Elderly, CUPE Ontario, Ontario Association of Residents' Councils, Ontario Health Coalition, and the Ontario Long-Term Care Association. The engagement of multiple stakeholders was often highlighted as the government's attempt to ensure the representation of 'diverse' and 'holistic' perspectives (Ministry of Health and Long-Term Care, 2008).

In the government-commissioned reports, lay perspectives (i.e. LTC home residents and families) were not distinguished from other stakeholder inputs despite known differences in their positions, for example, on the topic of setting a minimum care standard (Ministry of Health and Long-Term Care, 2008; Sharkey, 2008; Smith, 2004). Portraying different perspectives on this issue as a monolith became a problem for the Liberal government later on. When supporting their approach to a minimum care standard in Bill 140, they claimed that the public did not require a minimum care standard in the legislation, citing the PE input that informed the government-commissioned reports. However, it was later revealed that the industry representative (i.e. the Ontario Long-Term Care Association) was the only stakeholder who was uninterested in the care standard (Legislative Assembly of Ontario, 2007c). Many PE initiatives conducted in this process did not clearly mention what recruitment methods were used, raising questions about how the participants were recruited for the initiatives (e.g. self-selection, targeted invitation, and appointment).

The majority of PE in the legislative process was, formally, organized using self-selection methods, open to all interested parties wishing to weigh in on proposed legislation. However, it was combined with an invitation method that restricted the number who were given oral presentations during the public hearings; these oral presentation slots were prioritized and selected by relevant officials (Legislative Assembly of Ontario, 2007a). Notably, PE in the regulation drafting stage was restricted to certain organizations and individuals using the targeted invitation method (Sonnenberg, 2010).

Type and format of PE: While there were several PE initiatives implemented throughout the process, most of them were limited to feedback and consultation-style engagement. All initiatives were conducted as one-off activities. The PE initiatives described in government-commissioned reports were, for the most part, not documented in detail, although a strong emphasis was placed on their engagement activities. With one exception (Sharkey, 2008), reports indicated the list and number of participants only (Ministry of Health and Long-Term Care, 2008; Smith, 2004). Based on a review of the reports' contents, most PE activities were consultative where participants were asked to answer broadly-designed questions around themes suggested by engagement sponsors (see Table 4) (National Union of Public and General Employees, 2007; Sharkey, 2008). PE initiatives were carried out through either in-person meetings formats (e.g. anonymous visits to LTC homes, meetings with key stakeholder organizations and individuals active in the LTC community etc.) or document submissions within relatively short timelines (e.g. carried out for two months (Ministry of Health and Long-Term Care, 2008; Smith, 2004) to seven months (Sharkey, 2008)).

Table 4. Questions used in stakeholder engagement conducted for *People Caring for People: A Report of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario*
1. What are the key factors that affect human resources/staffing requirements and standards related to quality of care and quality of life of residents of LTC homes?
2. What are the implications of these factors on human resources/staffing requirements and standards?
3. What are the components that would go into establishing a staffing standard and what is the evidence to support this?
4. What are the key priority areas that directly impact on resident outcomes related to human resources/staffing requirements and standards?
5. What are innovative approaches, research, performance indicators and best practices that we should consider?

PE in the legislative process mostly occurred through feedback where the agenda for seeking public input was narrowly framed (e.g. the public was engaged in providing comments on the proposed draft Bill or Regulation). PE in regulation drafting was also carried out in a fairly superficial manner through an online survey and 2-day stakeholder forums where participants were invited to help refine the regulation based on a set of focused themes selected by engagement sponsors. The public could provide open-ended comments (e.g. through an "other comments" section at the end of the electronic survey), it mainly aimed to obtain stakeholders' input on specific but different questions depending on the participants (see Table 5) (Canada NewsWire, 2009; Sonnenberg, 2010). A government document noted that this approach was used to ensure the discussion was specifically linked to the priorities of the regulatory policy development process of the time rather than to allow for more free-flowing comments (Sonnenberg, 2010).

Table 5. Questions used in stakeholder dialogues in drafting the regulations

Plan of Care
- What measures best demonstrate the effectiveness of the plan of care in supporting enhanced care delivery and outcomes for the resident?
- What are the areas that you feel you do not need to document? [front-line staff]

Care and Services
- What outcomes could be measured to demonstrate that residents are treated with respect and dignity, safe, living in a clean home and receiving care according to their needs [front-line staff]
- In your opinion, what services in the home promote your independence? [resident & family]
- What are key factors that influence resident participation in recreation activities? [resident & family]

Mandatory Reporting
- How can the regulations support improved communication across all homes and to all health care providers in the event of an infectious disease outbreak or other emergency? [front-line staff]

Home Leadership, Management and Operations
- What measurable outcomes demonstrate strong leadership in a home? What needs to be in place to allow homes to build a strong leadership capacity? [front-line staff, advocacy and associations, bargaining agents]
- In your view, what makes a good Personal Service Worker? [resident & family]
- How important do you think volunteers are in the home? [resident & family]

Training
- What can the regulations do to ensure that staff receive timely and meaningful training? How is it measured? [front-line staff]

Compliance and Inspection
- How can the regulations incorporate ideas of quality management and performance improvement into recognizing homes with an excellent record of compliance? [advocacy and associations]

3.2 Case2: Ontario's COVID-19 pandemic response in the LTC sector [2020-2021]

The Government of Ontario declared a state of emergency under the Emergency Management and Civil Protection Act on March 17th, 2020 (Office of the Auditor General of Ontario, 2020). The provincial emergency response structure put in place was the Health Command Table established in February 2020, to offer a single point of oversight for the health response to COVID-19 that would span multiple workstreams, including immediate emergency response, outbreak control, and preparation for future waves (Cabinet Office & Ministry of Health, 2021). Initially, the LTC sector was not considered a top priority in the emergency response, as acute care (i.e. hospital) took precedence. However, LTC quickly became the epicentre of the province's pandemic response.

In the first wave of the COVID-19 pandemic (March to August 2020), more than one-third of all Ontario LTC homes reported an outbreak, resulting in 6,036 resident cases and 1,815 resident deaths. LTC home residents accounted for 64.5 percent of the COVID-19 deaths in Ontario (Stall et al., 2021). The disproportionate mortality in LTC homes continued in the second wave beginning in September 2020, resulting in 3,211 resident deaths, totalling 60.7% of all Ontario COVID-19 fatalities (as of January 14, 2021) (ibid.). When LTC facilities became the front-line in the fight against COVID-19, various sub-tables specific to LTC were established (see Figure 1 and Table 6). The role of these emergency response structures was to serve as a venue for discussions and coordination to support the decision-making of the Cabinet; these structures do not have independent decision-making authority (ibid.). The first state of emergency ended on July 24, 2020, and just five days later, the government launched Ontario's Long-Term Care COVID-19 Commission (hereafter Commission), mandated to provide the government with guidance on how to better protect LTC home residents and staff from any future outbreaks (Marrocco et al., 2021). The Commission's operations officially ended in April 2021, after the third state of emergency was declared (Marrocco et al., 2021; Office of the Premier, 2021).

Figure 1. Health Command Table Structure (as of September 8, 2020), (Cabinet Office & Ministry of Health, 2021, p.13)

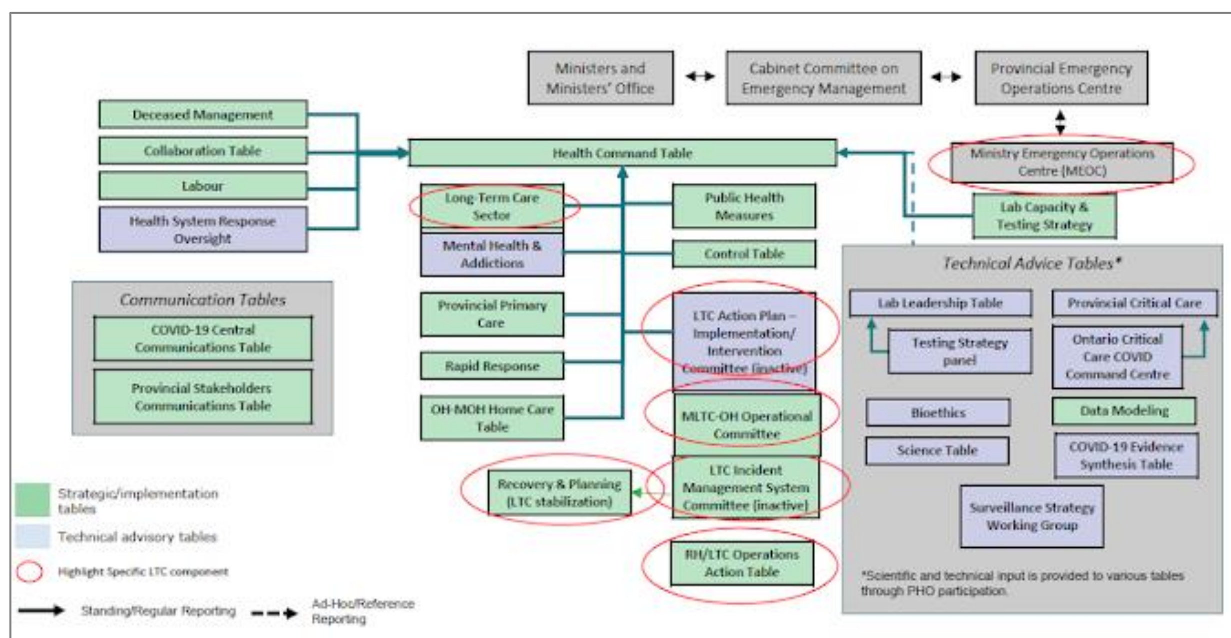

Table 6. The overview of Long-term care specific sub-tables (Office of the Auditor General of Ontario, 2020b, p.96-98)			
Category	**Name**	**Description**	**# of members**
Strategic/ Implementation tables	Long-Term Care Sector Table	To provide advice and support in addressing issues related to Long-Term Care, including effective testing and outbreak containment.	Not reported

	Retirement Home/ Long-Term-Care Operations COVID Action Table (formerly Long-Term-Care Table)	Provides advice and support in addressing issues related to long-term care, including effective testing and outbreak containment.	63
	Recovery and Planning Table Long-Term Care Sector Stabilization	Maintains gains achieved in protecting residents and staff and managing the COVID-19 public health emergency.	23
	MLTC-OH Operational Committee	Forum to coordinate OH's provincial and regional responses to local/LTC home. A key priority is to drive stabilization efforts of the long-term care recovery coming out of the COVID-19 pandemic	Not reported
Inactive tables	Long-Term Care Incident Management System Committee (replaced by Recovery and Planning Table)	Creates and implements an Incident Management System approach to long-term-care homes in critical need to ensure they have the health human resources, Infection Protection and Control (IPAC) supports and PPE they need to stabilize.	20
	Long Term Care Action Plan*	Identifies and organizes workstreams to implement the Long-Term Care Action Plan, which was released by the government on April 15.	30

3.2.1 Government's policy directions and political environment at the time

Government's policy directions: According to The Emergency Management and Civil Protection Act, the ultimate responsibility for issuing emergency orders lies with the Premier of Ontario and the Executive Council of Ontario, and ministries are required to establish plans that detail how they will manage emergencies relating to their mandate. Previously, the Ministry of Health and Long-Term Care was in charge of the operation of the province's LTC homes (Office of the Auditor General of Ontario, 2021). In this regard, the Ontario government faced an accountability issue due to its lack of emergency preparedness and uncoordinated and slow management of the pandemic. In particular, the government was criticized for its failure to prioritize long-term care and protect residents and staff members in the LTC homes in its emergency planning despite ample evidence that long-term care was at risk (Marrocco et al., 2021). Furthermore, the government faced tough criticism for not conducting enough comprehensive annual inspections of LTC homes (i.e. the alternative to a minimum care standard in Case 1) as required by LTCHA (Office of the Auditor General of Ontario, 2021).

Following the public outrage that swept across Canada after the release of a military report revealing the horrific condition of LTC homes in May 2020, the government directly sought to address this anger by requesting the investigation of LTC deaths by the Office of the Chief Coroner. Additionally, the government

promised to launch an independent commission to increase accountability in the LTC sector and restore public trust (Office of the Premier, 2020).

Political environment**:** As COVID-19 cases spread through the LTC sector, there was a common belief that the disproportionate outbreak was, in fact, a preventable tragedy and that it was time to fix the long-neglected deficiencies in the LTC sector. Numerous statistics and research supported this sentiment by showing that the number of COVID-related deaths in LTC in Canada was disproportionately higher than those on average across OECD countries (MACLACHLAN, 2021). There was a broadly shared sentiment that this was an ‘unprecedented’ and ‘urgent’ situation. The government used this sense of urgency to push its agenda and justify its policy approach. The government’s claim that ‘we simply cannot afford to wait’ was used to successfully resist the opposition parties’ request for a more comprehensive public inquiry over a government commission (Toronto Star, 2020). In response to opposition parties’ argument that a government commission is subject to political interference, and therefore falls short of a full public inquiry, Long-Term Care Minister Merrilee Fullerton said *“Peoples’ lives depend on us getting the answers as soon as possible. We cannot afford to wait years. So, speed is of the essence here,”* (Ferguson, 2020, no page number).

Meanwhile, a government structure change just before the start of the COVID-19 pandemic not only hampered Ontario’s emergency response to COVID-19, but also brought unclear lines of accountability to the public (Ontario’s Long-Term Care COVID-19 Commission, 2020d, 2020e). Previously, the Ministry of Health and Long-Term Care was in charge of the operation of the province’s LTC homes. This Ministry was split into the Ministry of Health and the Ministry of Long-Term Care (hereafter MLTC) in June 2019 (Marrocco et al., 2021). As a result of this division, the MLTC took over responsibilities for some aspects of the LTC system while other responsibilities continued to be shared with the Ministry of Health. When the COVID-19 pandemic hit, the two ministries had not yet fully disentangled and specified their respective responsibilities, including those related to the province’s emergency response (Office of the Auditor General of Ontario, 2021; Ontario’s Long-Term Care COVID-19 Commission, 2020d). Furthermore, the transition to the newly established Ontario Health structure following the election of the Conservative Party in 2018 was in its early stages of implementation and the takeover of roles previously held by the Local Health Integration Networks added further complexity to provincial policy-making structures (Marrocco et al., 2021).

> “*Who’s in charge? We have Ontario Health, we have Toronto LHIN, Ministry of Health, Ministry of Long-Term Care, they all have their own communications and we get directives from different bodies. We get the same documents coming from these different branches of government, and it becomes very confusing and overwhelming, all these documents and communications from these various sources within one government.”* (Ontario’s Long-Term Care COVID-19 Commission, 2020f, p.44)

> *“I did email everyone so as my emails ramped up throughout the outbreak, I started to include everybody into the emails. So it would go to Minister Fullerton's office, the Premier's office, the Minister of Health, Toronto Public Health, Ontario Health. I never did receive any response from anyone other than the form letter that you receive, Thank you for your email. That is the only response that I did get”* (Ontario’s Long-Term Care COVID-19 Commission, 2021, *p. 53-54*)

While the government claimed that the Commission’s investigation would provide a clear vision for who should be accountable, the Commission’s capacity to do this was limited. In contrast to a public inquiry, which has broad authority to compel witnesses and documents, a government commission is under the government’s control over many things ranging from the subject of an investigation to the type of information to be released to the public (Toronto Star, 2020). That is, the Commission is still bound by the government’s mandated duties. The conflict between the Commission and the government on the Commission’s mandate was observed through the refused requests of the Commission to extend the deadline and data provision for more comprehensive investigation (Fullerton, 2020; Marrocco et al., 2020; Ontario’s Long-Term Care COVID-19 Commission, 2020f).

LTC residents, families, and their proxies also took actions at the grass-roots level to criticize the government's failure in responding in a timely and effective way to the COVID-19 emergency situation. The collective actions include sending letters to Premier and other policymakers (Ontario Health Coalition, 2020b; Ontario's Long-Term Care COVID-19 Commission, 2021a), issuing a fact-checker to clarify what has been conducted with the homes' inspection and enforcement regimen (Ontario Health Coalition, 2020a), and holding a press conference to call for immediate action to address critical staffing and care shortages. However, public calls for action at the system level were constrained due to the demands concentrated at the facility level (e.g. visiting policies, meals for residents, staff shortages, etc.) as observed from the interviews with the Commission. Every LTC facility had a different level of emergency preparedness and response, which resulted in the need for localized responses to the fight against COVID-19 (Ho, 2020). The limited role of residents' councils and family councils defined by LTCHA may also help to explain the lack of more concerted pressure at the provincial level. According to the law, the roles of the councils that advocate for the rights of LTC residents and families are limited to the home operations level and have little formal influence over policymaking (Change Foundation, 2016). Instead, intermediary institutions such as the Ontario Association of Residents' Councils and Family Councils Ontario were required to represent the collective perspectives of residents across LTC homes in advising governments (Ontario's Long-Term Care COVID-19 Commission, 2020c). However, this role was severely constrained since the communication channels between those associations and individual councils largely ceased or did not function as usual during the COVID-19 pandemic.

"In many homes, it has been silenced, the function of Residents' Council. And even though there were guidelines from government that showed what safe, small group physically distanced programming can look like, many homes, management teams decided that during COVID or any significant outbreak, Residents' Council would not function. (…) generally speaking I feel very, very confident that residents in general were not consulted. As a rule, Residents' Councils were not consulted in any systematic or meaningful, engaged way any time during COVID, the first wave" (Ontario's Long-Term Care COVID-19 Commission, 2020c, p.64, p.74, respectively).

3.2.2 Public Engagement in Ontario's COVID-19 pandemic response in the LTC sector

There were significant differences in the extent and manner in which PE was implemented in Ontario's emergency response structure (i.e. the Health Command table and its sub-tables) and the work of the Commission (see Table 7 for the list of PE initiatives). In the emergency response structure, PE seemed to be conducted in a relatively closed manner with limited interaction (Office of the Auditor General of Ontario, 2020b), although the government continuously highlighted the collaborative cooperation with diverse stakeholders in the sector. While the Ontario government does not make information about command table meetings publicly available, except for the minister's orders, directives, and memorandums resulting from the meetings (Government of Ontario, n.d.), some clues are found in the report of the Auditor General. Some attendees at the tables noted that no official minutes were taken or distributed for these meetings. As a result, members were not informed of who participated in each teleconference, who said what in the meetings, any dissenting opinions emerged to the decisions, and eventually, the final decisions (e.g. what advice to be given to the Minister of Health, Premier and Cabinet) were not distributed to members. Furthermore, materials for the meetings were often received the morning of the meetings, discouraging review prior to the meeting (Office of the Auditor General of Ontario, 2020b).

PE undertaken during the Commission's work, on the other hand, showed a considerably higher level of open engagement. Since the Commissioners were appointed in July 2020 and until the day of submitting the final report (April 2021), the Commission received input from a variety of perspectives through more than 170 official interviews with over 700 people and 300 written submissions. This result is remarkable given the Commission's short investigation period (approximately six months) and the fact that their work took place in the midst of the pandemic (Marrocco et al., 2021).

Table 7. The list of PE initiatives in Ontario's COVID-19 pandemic response in the LTC sector				
	Title	Date	Category	Key documents
1	Ontario's Emergency Response structure	From the 1st provincial emergency state till the start of 2nd emergency state	Governance	Office of the Auditor General of Ontario, 2020a Office of the Auditor General of Ontario, 2020b Cabinet Office & Ministry of Health, 2021
2	Ontario's Long-Term Care COVID-19 Commission	Jul, 2020 - APR, 2021	Government Commission	Interview transcripts and presentation slide decks on the Ontario's COVID Commission Webpage Marrocco et al., 2021

Rationales/Goals: The goal of Ontario's COVID-19 response structure was to enable a rapid, whole-of-government approach that would ensure that important parts of the government work together seamlessly in producing an integrated response to key issues. However, the Health Command table and its sub-tables do not have decision-making authority, and their role is limited to serving as a forum for discussions and coordination to support eventual decision-making made by Cabinet. Accordingly, the rationales of PE in this structure were to support the implementation of Cabinet directives and facilitate connections across various stakeholders in a rapid and effective manner (Cabinet Office & Ministry of Health, 2021; Office of the Auditor General of Ontario, 2020b). Due to the unpredictable nature of the pandemic, timely decision-making was essential to address key issues. Given the urgency, engaging with diverse stakeholders at the Health Command table and its sub-tables was critical to organizing discussions and supporting the execution of decisions across and outside government as a single point of reference. This is well reflected in the iteratively evolving structure of the emergency response over time in response to the pandemic's trajectory (Cabinet Office & Ministry of Health, 2021).

Meanwhile, the Commission was established in the midst of the pandemic to investigate what caused the disproportionate COVID-19 outbreak in LTC facilities and how it affected residents, families, and staff. It also aimed to give suggestions to prevent future pandemics in LTC facilities, with the hopes of not only preventing the continued spread of COVID-19 in LTC homes at hand but also providing longer-term solutions (Ontario's Long-Term Care COVID-19 Commission, 2020a, 2021c). The Commission believed that a comprehensive understanding acquired from various perspectives was necessary for accomplishing its mandate. The Commission's endeavour to gather a wide range of public input is well observed in its guiding principles (see Table 8), which were articulated by the Commission at the commencement of its investigation. According to one of the principles, 'inclusiveness,' the Commission will seek information from a wide range of individuals and organizations relevant to various factors surrounding the outbreak in LTC homes (Ontario's Long-Term Care COVID-19 Commission, 2020a). The inputs from stakeholder engagement were indeed critical in providing real-time information to support its recommendations as well as filling missing gaps in existing reports and documents. The Commission noted the difficulty in obtaining necessary information and policy documents from the government ministries and agencies in a timely manner.

Table 8. The COVID-19 Commission's Guiding Principles (Marrocco et al., 2021, p.292)
2. Thoroughness: The Commission will conduct a comprehensive investigation to ensure that the questions set out in its Terms of Reference are explored and answered. 3. Inclusiveness: The Commission will ensure that it obtains information from the full spectrum of individuals and organizations who have information relevant to determining the factors that led to the outbreak in long-term care homes, and to developing strategies to prevent future outbreaks.

"The Cabinet – well aware of the extraordinarily short time in which the Commission was required to complete its work – directed its ministries by Order in Council to cooperate with the Commission. When it was clear that, despite the Order in Council and the April 30 deadline, timely production of records would not be forthcoming, a summons to produce documents was issued in October. The government produced documents episodically through to early December. Government counsel advised the Commission early in its investigation that hundreds of thousands of documents would be produced. By early December, only a fraction of this amount had been produced. The failure to produce documents in a timely fashion was a specified reason why the Commissioners sought an extension of the deadline, which was denied" (Marrocco et al., 2021, p. *299*).

One possible rationale for PE that is worth mentioning is that the voices of individual residents and families were used to raise awareness of the long-neglected systemic deficiency in the LTC sector. By directly quoting heart-wrenching remarks from LTC residents, families, and front-line staff members, the Commission was able to vividly highlight the tragic situation. The Commission later portrayed the opportunities to hear first-hand stories from those who have suffered as they "brought discussions of policy to life – or, perhaps more appropriately, they brought life to discussions of policy" (Marrocco et al., 2021, p. 296).

Participants and recruitment methods: Ontario's COVID-19 response structure was purposefully designed to offer a coordinated response with input and leadership from specialists in a variety of fields. Accordingly, diverse participants were reported to have participated in this table. Nonetheless, the membership at this structure appears to be relatively closed, as opposed to being openly recruited. As a result, open accessibility and visibility appear to be constrained. For instance, the LTC Stabilization: Recovery and Planning table is made up of 23 members who respectively represent the Ministries (Health, Long-term Care, and Seniors and Accessibility) Ontario Health, Public Health Ontario, and other Long-term care sectors (e.g. clinicians, hospitals, LTC homes, and family caregivers). There were only nine members who were not affiliated with the government and government agencies (2 from hospital sectors, 4 representing LTC homes and operators, one clinician, one academics, and one family caregiver) (*LTC STABILIZATION: RECOVERY AND PLANNING TABLE MEMBERSHIP*, 2020). More than half of the members represented government and government agencies, and the rest were professionals and industry representatives. The exclusivity seemed to be attributable to its recruitment strategy, which was based on targeted invitation. There was no open nomination and self-selection found in recruiting participants to sit at the tables.

"I sit on the collaboration table, which is led by the Ministry of Health and has the Chief Medical Officer of Health and the Deputy Minister on it, as well as many associations (…) I said, Oh, is there going to be long-term care representation on these tables because we see that long-term care is one of the hardest hit areas internationally and in BC and in Italy and in the U.S. And the answer was, No, we are starting with acute care" (Ontario's Long-Term Care COVID-19 Commission, 2020b, *p.58*).

The public engagement in the commission, on the other hand, attempted to involve various stakeholders who were thought to have the relevant knowledge to address their mandate. The Commission met various stakeholders, including residents, families, their advocates (e.g. residents' councils and family councils from many LTC homes across the province), LTC home staff, LTC facility operators, researchers in a variety of fields, and people from organizations representing the interests of various stakeholders mentioned (Marrocco et al., 2021). Notably, the Commission showed remarkable effort to communicate directly with

those affected by the pandemic outbreak, rather than relying on intermediary institutions (Ontario's Long-Term Care COVID-19 Commission, 2021b).

Accordingly, special considerations were made to recruit participants and increase the number despite the unique challenge posed by the pandemic when in-person meetings were impossible to be held. Along with the targeted invitation, the Commission used a self-selection approach based on multiple channels for the public to voluntarily provide inputs in their investigation. In this process, the Commission contacted the Ontario Association of Residents' Councils, Family Councils of Ontario other regional family council organizations to help publicize the meetings and obtain input on the needs of residents and families (Marrocco et al., 2021). Organizations were also requested to provide a link to the Commission's website on their own website so that members of the organizations could easily track the Commission's progress. The Commission also collaborated with unions that represent staff in LTC facilities to ensure that participants felt comfortable sharing their experiences with the Commissioners without the fear of repercussion. One of the approaches was to make an amendment to the original Terms of Reference drafted by the government to allow individuals to provide information on a confidential basis (Marrocco et al., 2021). The Commission ensured that the public had access to all information it was able to share, such as the mandate, terms of reference, meeting transcripts, and slide decks used during the presentation, by posting the information on its official website (Marrocco et al., 2020). The Commission explained in its final report that providing public access to these materials not only helps keep the public informed of the Commission's progress in real-time but more importantly, allows the public to judge if the investigation is made appropriately and develop their own opinions about what the Commissioners are being told (Marrocco et al., 2021).

Type and Format of PE*:* The PE activities in Ontario's COVID-19 response structure appeared to take place in the format of consultation where diverse players could express opinions and seek cooperation on the agenda set by the government. The meetings were ongoing initiatives despite the time duration of each sub-table in Ontario's COVID-19 response structure varied. However, some participants noted that the meetings were limited to mere information sharing for governments' directives despite the format of consultation.

> *"It was more of a, I would say, information-sharing and consultation mechanism. (…) there would typically be a presentation …from the Ministry of Seniors and …the Ministry of Long-Term Care with an update and …then they would ask if there were any questions or comments, and we would provide those. (…) that is a great opportunity to provide some ongoing input. But again, the amount of information that is being shared quickly and the time frame for implementation continues to be fast and furious, and not allowing for, you know, a really good consultative process to understand all the possible implications of those changes and ensuring that long-term care homes, you know, have adequate time and resources to get the precautions in place to move forward with the next directives* (Ontario's Long-Term Care COVID-19 Commission, 2020b, p.12, p.86, respectively).

The findings of the Auditor General Report also echo this view. The report revealed that the meetings of the Health Command Table were rarely effective for clear discussions since it was held by teleconference until July 2020 occasionally with as many as 90 participants. Participants at the Health Command Table noted in the report that the medium of teleconferencing and the size of the meetings made it difficult to provide advice. They were not always aware of who was speaking and therefore unsure whether the speaker was knowledgeable about the subject matter at hand. (Crawley, 2020).

The PE initiatives conducted for the Commission's investigation similarly took the form of consultation and information sharing. Interactive engagement was enhanced through group meetings using Zoom convened with people who were affiliated with the same organization or who might provide a similar perspective. Commissioners posed varied questions based on the perspectives represented by the participants in order to address multi-aspects of the LTC situation. Participants were able to provide a written submission prior to and/or after the meeting. Those who did not wish to participate in meetings also could express their opinions via written submission to a designated email address or a message on a toll-free phone line (Marrocco et al., 2021). Specific pages of the Commission's official website were assigned to solicit the

views from various stakeholders such as long-term care home residents and their families, LTC homes management and staff, and members of the general public. Lastly, the dedicated website had an information-sharing function regarding the progress of the Commission's investigation and relevant materials (Marrocco et al., 2020), allowing the public to track the Commission's progress in real-time and, more importantly, form their own judgements about what the Commissioners were being told (Marrocco et al., 2021).

3.3 Case3: National LTC Standard Development [2021-2022]

The call during the COVID-19 pandemic for the establishment of national LTC standards to ensure quality care for seniors was not a new one (Guly, 2021). However, it drew a lot of public attention, coming in close proximity to the release of the Canadian Armed Forces' report in May 2020, which described examples of abuse, negligence, and horrifying living conditions within some Ontario LTC homes. As the number of COVID-19 related deaths in LTC facilities mounted, so did the voices asking for national standards across Canada (Osman, 2020; The Angus Reid Institute, 2020). Given this climate, the Federal government promised to set national standards in its Throne Speech in September 2020 (Jackson, 2021; Silver, 2020). However, it drew immediate opposition from Premiers who feared federal control over the provision of LTC that constitutionally falls under the provincial jurisdiction (Bryden, 2020b; MacCharles, 2021). As a result, the Liberal's proposal was dismissed, and Prime Minister Justin Trudeau announced that instead of imposing national standards on reluctant provinces, he would focus on developing a national framework that could help share best practices across the country (MacCharles, 2021).

In response, a new effort to establish practical LTC standards launched in March 2021, led by the Health Standards Organization (HSO) and the Canadian Standards Association Group (CSA). HSO's National Long-Term Care Services standard (CAN/HSO21001:2022— Long-Term Care Services) is a revision of the organization's current Long-Term Care Services standard (HSO 21001:2020 – Long-Term Care Services). Once developed, it will be used as a National Standard of Canada in future LTC accreditation programs across the country (HSO, 2021a). It looks at how existing standards for safe and high-quality care could be improved to fix the deficiencies in the LTC sector highlighted during the COVID-19 pandemic (HSO, n.d.-a, 2020). At the same time, CSA Group works on developing the National Standard of Canada for Operation and Infection Prevention and Control of Long-Term Care Homes (CSA Z8004). It will focus on topics such as heating, ventilation, HVAC, plumbing, etc. This standard also will be informed by the existing standards, combined with the lessons learned from the COVID-19 experience (CSA Group, 2021a).

3.3.1 Government's policy directions and political environment at the time

Government's policy directions: LTC is not governed by the Canada Health Act. It falls under the jurisdiction of the provinces and territories which means the federal power in the LTC sector is limited (Estabrooks et al., 2020). In this regard, the pursuit of national LTC standards is a policy solution that requires greater involvement from the federal government given the institutional system where provincial governments have primary responsibility for LTC (Tuohy, 2020). Despite announcing the intention to set national standards in the September 2020 Throne Speech, Prime Minister Justin Trudeau appeared lukewarm about overcoming the barriers needed to pursue this policy direction. In media interviews, he often stated that the federal government would respect provincial powers and responsibilities and avoid wading into specifics (Bryden, 2020a; Osman, 2021a).

In the face of significant political opposition, the Federal government dismissed its plan to set national standards and convert the National Standard to Accreditation (MacCharles, 2021). Instead, it promised to provide $3 billion dollars over the five years, beginning in 2022, to help the provinces implement these new accreditation requirements (Jackson, 2021). The federal government's influence via its funding power is already well established in the physician and hospital sectors. Compared to establishing national standards, health transfers require much less institutional maneuvering on the part of the Federal government (Tuohy, 2020). As a result, the federal government could successfully avoid major political challenges of getting provinces to buy into their plan as well as the accusation that the Federal government imposed a mandatory top-down approach at the expense of provincial authorities (Osman, 2021b). Given an upcoming Federal election in September 2021, the Liberal government took a step back by promising to legislate safety in long-term care as part of the party's re-election campaign (i.e. the Safe Long-Term Care Act) (CBC News, 2021; Osman, 2021a).

***Political environment**:* The COVID-19 pandemic's shocking impact drew huge public attention to the long-neglected sector. The media consistently reported that Canada ranked among the highest in the world in death rates in the LTC sector, with more than 80% COVID-19 related deaths occurring in LTC facilities in the early wave (Tuohy, 2020). After months of debate over what caused the crisis, who is to blame, and how to prevent the future pandemic, strong calls for fixing the LTC system emerged. Yet, there was no consensus as to what action could and should be done or who could and should do so (The Angus Reid Institute, 2020; Tuohy, 2020).

The establishment of the national standard was one of the suggested solutions. Those in support of a national standard insisted that this national standard needs to have an enforcement mechanism in public legislation so that it can ensure a better quality of care and meaningful accountability (Ontario Health Coalition, 2021). Among them was the Royal Society of Canada Task Force on COVID-19, which was formed to provide evidence-informed perspectives on major societal challenges in response to and recovery from COVID-19. They recommended that the Federal government immediately act on establishing and executing national standards for LTC homes that ensure infectious disease control training and resources and protocols for staff expansion and visitor restriction during outbreaks (M. Brown, 2020; Estabrooks et al., 2020). The idea of creating a common standard that could be applied across the nation was further supported based on the value of equity. Different jurisdictions performed differently in combating the pandemic, demonstrating a double-edged characteristic of federalism and revealing problems of equity across the country (Tuohy, 2020). Building on this idea, NDP and Green party leaders took a further step, suggesting the LTC sector be nationalized and fall under the provisions of the Canada Health Act (J. Brown, 2021; Guly, 2021; NDP, n.d.). Echoing this call, some Liberal backbenchers also pressured Prime Minister to enact enforceable national LTC standards (Bryden, 2020a; The Canadian Press, 2021).

In contrast, the highly decentralized systems in LTC derived from Canadian federalism gave the reluctant policymakers a legal justification to reject the Federal government's plan (Jackson, 2021). Opposition leader Erin O'Toole directly objected to the federal control of the LTC sector by questioning its 'Ottawa-knows-best' approach (Boutilier, 2021). This sentiment has also been shared with some Premiers. For instance, Quebec Premier Francois Legault said that if the Federal government wants to help with the LTC sector, it must increase recurring funding (Bryden, 2020b). Ontario's Premier Doug Ford also echoed Legault's sentiments. (J. Brown, 2021; The Angus Reid Institute, 2020). Furthermore, since not all provinces experienced the same high death rate in the LTC sector as Ontario and Quebec, they were less eager for the federal government's proposal. In this regard, Saskatchewan Premier Scott Moe stated that all provinces require federal funding to help with pandemic costs, but his province does not require it for LTC facilities (Bryden, 2020a).

Meanwhile, concerns were raised as to the effectiveness of a national standard in fixing the sector's long-rooted deficiencies as well as the feasibility of implementing it. Various studies and investigations showed that a number of problems were attributable to the deficiency, such as the lack of available beds, staffing

shortage, and a lack of integration across other health sectors such as continuing and community care (Estabrooks et al., 2020). Furthermore, the severity of the aforementioned problems varies by province and territory, as does their capacity to implement a common standard (CMA, 2020). That is, a national standard is an important, but insufficient condition for quality. Furthermore, every province and territory (except Nunavut) has its own legislation in place for LTC that offers a different scope of services, facility types, and cost coverage (Estabrooks et al., 2020). This generates inconsistencies across different jurisdictions that create additional institutional barriers to the establishment of National Standards. In this regard, some experts warned that achieving national standards is more than simply agreeing on common quality indicators. Some jurisdictions currently have little or no capacity to build the quality improvement process (CMA, 2020).

Accordingly, discussion around possible policy solutions shifted its focus to the health transfer, which has been used to support provincial programs of universal coverage for physician and hospital services under the Canada Health Act. The fund is provided on the condition that provincial programs adhere to federal principles relating to access to core services on uniform terms and conditions (Tuohy, 2020). Industry actors, medical associations, and some organizations that advocate for seniors agreed that dedicated funding for long-term care is essential to provide adequate care, while a condition of federal transfers is attached (CMA, 2020). This was considered to be a good fit with the planned change in a national standard developed by accreditation organizations, as they could be used to measure provinces' commitment as a condition of federal transfers, holding them accountable for improving the conditions in LTC homes (CALTC, 2021).

Advocates for enforceable national standards expressed major disappointment about the Federal government's decision to delegate the task of developing national standards to the accreditation companies (Ontario Health Coalition, 2021). They argued that the fact that around 70 percent of LTC homes in the country were already accredited prior to the pandemic demonstrates that accreditation would not address the shortfall and ensure the accountability mechanism in the LTC sector (BC Health Coalition, 2021; Ontario Health Coalition, 2021; Roman, 2021). Nonetheless, following the launch of the national standard development by HSO and CSA groups in March 2021, much of the argument over making a mandatory standard waned, as various political pledges to fix the long-term care system ranging from abolishing for-profit care to offering tax credits, continued to be made as a federal election campaign (MACLACHLAN, 2021; Tunney, 2021).

3.3.2 Public Engagement in National LTC Standard Development

As a standards development organization (SDO), HSO and CSA need to adopt a rigorous development process (i.e. Requirements & Guidance for SDOs) set by the Standards Council of Canada (SCC) in developing National Standards of Canada (CSA Group, 2021a; Standards Council of Canada, 2019). The requirements define basic principles and details of the process that ensure the best standard development practices. Engaging with stakeholders appears to be one of the important aspects of the process as reflected in principles such as consensus, equal access and effective participation by concerned interests, respect for diverse interests and identification of those who should be afforded access to provide the needed balance of interests (ibid.).

Both companies have complied with the guidelines, despite the considerable difference in the amount of public input they gathered from PE initiatives. The HSO National Long-Term Care Services Standard demonstrated remarkable efforts to engage with diverse stakeholders (including the public) in a comprehensive way that went beyond the SCC criteria. Led by Dr. Samir Sinha, director of Geriatrics at Mount Sinai and the University Health Network Hospitals in Toronto, HSO has brought and continued to bring the

voice of LTC home residents, families and Canada's LTC workforce over 21 months of standard development (Family Councils Ontario, 2021). Ultimately it garnered 16,093 responses for the survey, 392 submissions representing 1,805 individuals from the consultation workbooks, and feedback from 179 participants from nine town hall meetings (HSO, n.d.-b). CSA's PE initiative took a similar approach. Led by Dr. Alex Mihailidis, Scientific Director and CEO, AGE-WELL NCE, the CSA group conducted various PE activities that exceeded the SCC requirements. However, the overall visibility and accessibility of CSA's engagement initiatives seem relatively limited. It garnered 776 responses from the survey and 227 participants for six consultation sessions (CSA Group, 2022).

Table 9. The list of PE initiatives conducted in National LTC standard development

	Title	Year	Key documents
1	HSO (Technical Subcommittee, Survey, Consultation workbooks, Townhall meetings, public review)	2021~	Announcements on the HSO webpage
2	CSA (Technical Subcommittee, Survey, Townhall meetings, public review)	2021~	Announcements on the CSA webpage CSA Group, 2022

Rationales/Goals: The Requirements & Guidance for SDOs set by the Standards Council of Canada (SCC) are the baselines of the LTC standard development. It requires SDO to achieve consensus in developing a standard, provide equal access and engagement opportunities for concerned interests, and respect for diverse and balanced interests. From its consensus requirements (see Table 10 for details), the rationales/ goals of engagement are mostly in ensuring a balanced representation of interests so that no single category of interest can dominate the standard development procedures. That is, the procedures take into account the views of all parties concerned. Additionally, this procedure ensures that there is no sustained opposition to substantial issues by a concerned interest and reconciles any conflicting arguments (Standards Council of Canada, 2019).

In addition, both companies demonstrated a more comprehensive approach to engaging with the public that exceeded the accreditation standards. The CSA group explicitly mentioned its aim of the public consultation process as reaching stakeholders across the country to collect their input on what the new standard should address (CSA Group, 2022). Likewise, HSO also noted a goal of its PE activities ranging from gathering inputs to tailoring the scope and contents of the new standard (HSO, n.d.-d, 2021a). Both groups highlighted people-centred approaches to developing standards (CSA Group, 2022; HSO, 2021b). This rationale was consistently applied when it comes to engaging with marginalized populations. HSO emphasized the diversity of thought, claiming that meaningful inclusion necessitates special effort to ensure all voices are heard, knowing that certain groups have been historically excluded from decision-making and equitable distribution of resources (HSO, 2021b). Likewise, the CSA group noted that it is essential to identify and address barriers to care experienced by the marginalized population due to the stigma and discrimination (CSA Group, 2022).

Table 10. Consensus Requirements (Standards Council of Canada, 2019, p.17)

Clause	SCC Requirement	SCC Guidance
6. Consensus Requirements		

6.3	**Equal Access and Effective Canadian Participation to the Standards Development Process by Concerned Interests** The SDO shall ensure that: a) participation in standards development is accessible to affected stakeholders; and b) there is appropriate Canadian participation on technical committees. The SDO shall provide evidence of best efforts to address the challenges of finding resources for participation.	No Guidance
	Balance of Interests The SDO shall provide for balanced representation of interest categories in the development of standards. This representation shall reflect the Canadian interest. When consumer or public interest representation would provide the needed balance of interests, the SDO shall identify and make efforts to secure support for equal access and effective participation of such interests.	The commonly used interest categories may include, but are not limited to, general interest, producers, regulators and users. Securing support for consumer or public interest participation does not require the SDO to provide financial support from their operating budgets.
	Technical Committee Approval Process The approval process shall be based on evidence of consensus reached by the technical committee. The approval process shall not be used to block or obstruct the promulgation of standards.	No Guidance

***Participants and recruitment methods*:** The Requirements & Guidance for SDOs broadly defines a stakeholder as "A party that has an interest in a standard, and can either affect or be affected by the standard" (Standards Council of Canada, 2019, p.8). This definition commonly includes key corporations, industry associations, academics, NGOs, and consumers. That is, a broad range of people at stake could be involved in the engagement activities for developing LTC standards, such as residents, families, frontline workers, LTC management and administration, researchers, and the general public (ibid.). Accordingly, both HSO and CSA engaged with diverse stakeholders noted above. Moreover, there was a noteworthy emphasis on equity and diversity considerations. Both groups strived to include populations that are frequently left out of decision-making (e.g. Indigenous, Francophone, and 2SLGBTQI+ communities) (HSO, n.d.-c, 2021b). The importance of incorporating diverse perspectives was constantly underlined in the standard development process (HSO, 2021a).

In terms of recruitment methods, self-selection was used as a primary approach, along with appointments. All recruitment posts were advertised online since the work of developing the National Standard was carried out during the pandemic. HSO built a dedicated website for the standard development to host all announcements related to the process. HSO started its work by establishing a technical committee through open nomination. HSO accepted nominations from anyone who wished to submit and appointed the members in a way that sought diverse perspectives and balanced regional representation (Family Councils Ontario, 2021). Over a quarter of the 32 members of the committee appointed were LTC residents and family

members, and a third represented frontline workers with firsthand experience of care delivery (HSO, n.d.-c). For subsequent one-time engagement initiatives, (e.g. survey, consultation workbooks, and virtual town hall meetings), self-selection was used. Similarly, CSA also used mainly the self-selection method (e.g. group consultations, surveys) along with appointments (e.g. Technical Subcommittee, Advisory Panel, and Resident and Family Centred Working Group) (CSA Group, 2021b). The CSA group also advertised their PE activities online to allow interested individuals and groups to join the activities. However, the amount of public input gathered by the two accreditation companies differed considerably. Accessibility to information may be one among many possible reasons. As every notice and announcement regarding PE activities were posted online due to the pandemic situation, HSO created a webpage specifically for LTC standard development work. The latest progress was constantly updated on the website. Furthermore, the PE-relevant activities are supported by Patient Partnership Office, a team solely dedicated to PE initiatives. In comparison, the CSA group website was not accessible without a user account and was not designated for the LTC standards development work only, which required users to navigate the full site to look for information of interest. In an effort to address this deficiency, the CSA group collaborated with five organizations to organize and host the PE activities (CSA Group, 2022).

Type and format of PE: Both CSA and HSO conducted public participation in various types and formats in accordance with their guidelines. PE initiatives took various types (deliberation, consultation, and feedback) and formats (ongoing, one-off). Detailed PE activities ranged from participation in technical committees or other governance structures as members, online surveys, virtual town hall meetings, and public review of the draft standard (expected) (CSA Group, 2022; HSO, n.d.-b).

Both companies commenced their work by establishing a technical committee to oversee the drafting, approving, and managing the technical content of a standard in accordance with SDO policies and procedures. PE in this structure was ongoing activity and given their mandate, was more likely a deliberation style of engagement. Soon after the committee was formed, HSO conducted an online survey (from March to July 2021) to kick off the development process. The survey was closed to consultation type of engagement. The questions asked in the survey were broadly framed so that respondents could provide their opinions regarding the new standard in an open-ended manner (HSO, n.d.-b). Building on the feedback from the survey, following PE initiatives such as consultation workbooks and virtual town hall meetings, were conducted in consultation format (HSO, n.d.-b, 2021b). One notable aspect of the consultation workbook was that it encouraged deeper discussions among individuals and groups and gathered reflections from this engagement activity (HSO, 2021b). In order to support this, HSO prepared two versions of workbooks (one for individuals and the other for groups) and provided a discussion facilitator guide which provides helpful tips for facilitators on how to lead the discussion in an equitable and meaningful manner (HSO, n.d.-b). Lastly, the public review of a draft standard, which will be released in Fall 2022, will be in the format of feedback, in which respondents will be able to express their views on relatively narrowly framed issues (HSO, n.d.-a).

The CSA Group has demonstrated engagement efforts in a similar vein. While the details of PE in the governance structure (i.e. Technical Subcommittee and Resident and Family Centred Working Group) are not reported, the CSA group webpage indicated that their work is ongoing (as of January 2022) since their launch in April and June 2021, respectively (CSA Group, 2021d). Soon after the establishment of the governance structure, the CSA group hosted several one-time engagement activities – six consultation sessions and three online surveys. Consultation sessions included discussion broadly focused on barriers, enablers, and gaps to effective care delivery and infection prevention and control in LTC homes. Online surveys included a combination of consultation and feedback style engagement. Respondents were asked to answer multiple-choice questions, rating scale questions, and open-ended questions (CSA Group, 2022).

4.0 Discussion

This study compared three policy processes in the LTC sector: the development of the Long-term Care Homes Act in Ontario [2004~2010], Ontario's COVID response in relation to LTC, [2020~2021], and the development of National Long-term Care Standards at the Federal level [2021~2022]. In general, most public engagement initiatives in these cases are characterized by: 1) engagement of multiple stakeholders, with many intermediary individuals and groups claiming to represent and/or advocate for the rights of LTC home residents and their families; 2) reliance on targeted invitation along with self-selection methods for recruiting participants; and, 3) frequent use of consultation-type activities.

Table 11. Summary of PE in the three cases

	PE initiatives	Rationales/Goals	Participants/ Recruitment	Engagement Type	Additional detail
Case1	Commitment to Care: A Plan for Long-Term Care in Ontario (2004)	To gather inputs from various stakeholders to reflect the sector's ideas and concerns in providing policy advice	Multiple stakeholders (mostly affiliated with intermediary agents) with targeted invitation only	consultation	Meetings with close to one hundred stakeholders
	Public hearings on the draft LTCHA (Bill 140) (January 2007)	to have reasonable opportunity to review the legislation	Multiple stakeholders (mostly affiliated with intermediary agents). Application was made on self-selection, but they are selected based on the judgement of legislative staff.	feedback	5-day Public hearings held in four cities in Ontario (Toronto, Kingston, Sudbury, and London)
	Common Vision of Quality in Ontario Long-Term Care Homes (2008)	To gather inputs from various stakeholders to reflect the sector's ideas and concerns in providing policy advice	Multiple stakeholders (mostly affiliated with intermediary agents). Recruitment method not reported	consultation	Five consultation sessions in Toronto, Hamilton, Ottawa, London, and Sudbury with a total of 600 participants (60% representing LTC homes)
	Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario (May 2008)	gathering inputs from various stakeholders to reflect the sector's ideas and concerns in providing policy advice	Multiple stakeholders (mostly affiliated with intermediary agents). Recruitment method not reported	consultation	Meetings with more than 30 stakeholder groups More than 100 written submissions
	Drafting regulations (2008)	To gather inputs from various stakeholders to reflect the sector's ideas and concerns in providing policy advice	Multiple stakeholders (mostly affiliated with intermediary agents) with targeted invitation only	feedback	Electronic survey with over 50 responses A series of dialogues with key stakeholders (no detail reported)

	Public consultation on the Part 1 /2 draft regulation (2009)	Mandatory public consultation under Section 184 of the LTCHA	Multiple stakeholders recruited through self-selection	feedback	211 submissions for Part 1 105 submissions for Part 2
Case2	Health Command Table and Sub-Table (2020~)	to support the implementation of Cabinet directives and facilitate connections across various stakeholders in a rapid and effective manner	Multiple stakeholders (participants not reported) through targeted invitation only	Consultation, information-sharing	Not reported
	COVID Commission (2020~2021)	to have a comprehensive understanding about the LTC crisis to fill missing gaps in existing reports and documents	Multiple stakeholders including individual residents, families, the general public recruited via targeted invitation and self-selection	Consultation, information-sharing	Interviews with more than 700 individuals during more than 170 sessions 300 written submissions.
Case3	CSA Group (March 2021~)	to collect stakeholders' inputs on what the new standard should address based on a people-centred approach	Multiple stakeholders including individual participants and marginalized populations. Recruitment made mainly via self-selection and appointment (open nomination)	Deliberation, consultation, and feedback	Six consultation sessions with a total of 227 participants Three surveys with 776 responses
	HSO (March 2021~)	to collect stakeholders' inputs on what the new standard should address based on people-centred approach	Multiple stakeholders including individual participants and marginalized population. Recruitment made mainly via self-selection and appointment (open nomination)	Deliberation, consultation, and feedback	16,903 responses from the survey 392 submissions representing 1,850 individuals from consultation workbooks Nine town hall meetings with a total of 179 participants

Despite the high-level similarities observed, the three cases also showed variation in the degree to which 1) access to engagement opportunities was open and inclusive (i.e. targeted and prioritized invitation based on the participants' expertise vs. open access to anyone, combined with strategies to reach out to marginalized population groups); and 2) the engagement format supported two-way interaction between participants and engagement organizers (see Table 12). In Case 1, while participants represent a variety of interests (e.g. residents and families, medical providers, industry), there was a high representation of people from intermediary organizations. They were recruited through a targeted invitation method, and it was observed that similar groups were engaged repeatedly over the series of PE activities. This form of recruitment prevented individuals without organizational affiliations from participating in the process. Even when the self-selection method was applied (e.g. public hearings on the draft Bill 140), it was only for the application process, and the applicants were ultimately prioritized and selected based on the legislative

staff's judgement. Considering the potentially limited knowledge and resources individual stakeholders may have, compared to those representing intermediary organizations, individuals' ability to get selected to express their voices was constrained. Furthermore, all PE was carried out through one-off activities, mostly using consultation or feedback approaches.

Case 2 demonstrates a combination of both inclusive and exclusive engagement. In the emergency structure (i.e. Health Command tables and their sub-tables), only specific invited participants were involved, and the list of participants, except for the representatives of government and government agencies, remained unavailable to the public. Furthermore, it was noticed that the meeting format was often ineffective for meaningful dialogue (i.e. teleconference with more than 60 participants) and sometimes limited to information-sharing levels. The meeting details (e.g. attendees, agenda, and final decision) are not publicly accessible, showing less visibility to those not involved. Meanwhile, the COVID-19 Commission made significant efforts to directly engage with a wide range of stakeholders, including individual residents and families who are not affiliated with high-profile intermediary organizations. For participants who fear speaking honestly due to potential repercussions, the Commission amended its Terms and Conditions to be able to keep the confidentiality of participants' identities so that they might speak in a safe environment. Public engagement took place through multiple channels to increase the number of public inputs received. Interestingly, both initiatives used information-sharing style engagement but for different purposes. While it was considered 'rashly done engagement' in the emergency response structure, the COVID-19 Commission employed the information-sharing approach to encourage more individuals to form their opinion on the issues (Long-Term Care COVID-19 Commission, 2020).

In Case 3, public engagement was embedded throughout the standard development process. Individuals representing various interests and perspectives were involved. Notably, explicit consideration was given to engaging with marginalized populations (e.g. race, gender, etc.). Participants were primarily recruited through a self-selection approach, along with appointments made based on open nomination. Feedback, consultation, and deliberation were all used as part of the PE initiatives. It allowed for HSO and CSA to gather public input to varying degrees at various stages, ranging from the overall governance (e.g. technical committee) to tailoring the contents and reviews on the draft standard.

Table 12. Comparison of PE in the three cases

	Open and Inclusive Access to Engagement Opportunities	Engagement Format for Two-way Interaction
Case1	Low (mostly targeted invitation of similar organizations & prioritized self-selection)	Low (feedback in the legislative process) & Unknown (government reports)
Case2	Low (targeted invitation in Health Command table) & High (self-selection through multiple engagement channels & confidentiality consideration to promote participation in COVID commission)	Low (information-sharing, 60 people met through teleconference in Health Command table) & Moderate (information-sharing and consultation in COVID commission)
Case3	High (self-selection, appointment via open nomination, diversity consideration)	High (deliberation, consultation, feedback)

One could argue that the difference between the three cases stems from the distinct rationales and goals for engagement at the outset. In this account, how PE is conducted should be determined based on the rationales and goals of PE activities as PE initiatives are not always to achieve the highest level of shared power and responsibility between the public and decision-makers (Carman et al., 2013). However, the rationales and goals for PE in the three cases do not seem to have a discernible difference that shows a direct connection with different ways of PE being conducted. For instance, PE initiatives in Cases 1 & 3 aimed to gather diverse ideas in the LTC sector to help the decision-making processes, so this account does not align well with why PE in Case 1 was conducted in a much less open and comprehensive manner than that in Case 3. Moreover, the mandates for PE in both cases also bear scrutiny. In Case 1, PE on Part 1 and 2 draft regulation was conducted in accordance with Section 184 of the LTCHA, which mandates public engagement. However, the participants recalled the process was rushed and less meaningful. In contrast, Case 3 demonstrated the PE efforts of CSA and HSO went beyond mere compliance with SDO guidelines, which mandated a 60- day public review on the draft standard.

Meanwhile, the literature demonstrates that PE in health policymaking is by its nature highly context-driven by the influences of various (and often conflicting) stakeholders, organizational and political climate, and so on (Abelson et al., 2010; Abelson & Gauvin, 2006). From the three cases, it is observed that when the surrounding political environment at the time was supportive of the government's policy direction, more open and inclusive PE initiatives were conducted.

In Case 1, the Liberal government at the time was facing significant political conflict in passing the proposed Long-Term Care Homes Act (Bill 140). Since being elected, it had been criticized by LTC residents and families, their advocates, and other care providers for breaking its election promise to bring in a minimum care standard. Accordingly, the government introduced Bill 140 just before the next provincial election, yet the Bill did not include a clause relating to minimum care. It directly sparked a collective movement at the grass-roots level, and the NDP, which held significant bargaining power as the Liberal government could be reduced to a minority government in the upcoming election, requested opportunities for public engagement. Amid this political environment, PE was overall exclusively conducted with a high representation of intermediary organizations and considerable overlap in the participating organizations and individuals.

In Case 2, the Conservative government faced accountability issues due to its failure to insufficiently prepare for and effectively manage the COVID-19 pandemic in the LTC facilities. Following the release of a military report, public outrage soared, and unprecedented demands for a fix in the LTC sector emerged. Nonetheless, the surrounding political atmosphere allowed it to avoid some of the blame and continue to exercise its power as intended under the name of urgency. The recent government structure change (i.e. the separation of ministries and the creation of OHTs replacing the roles of LHINs) contributed to it by bringing unclear lines of accountability. Furthermore, many LTC residents and families, who were immediately impacted by the crisis, concentrated their demands on the facility level operations (e.g. visiting policies, food, etc.) and therefore, the attention at the system level diminished. In this context, both inclusive and exclusive engagement was conducted.

In Case 3, the federal government had shown its hesitancy to intrude in provincial and territorial jurisdictions over the LTC delivery despite its promise to set national standards. By dismissing the proposal to establish a national standard and delegating the work to accreditation companies, the federal government was able to save itself from the challenges in obtaining reluctant Premiers' buy-in and overcoming institutional barriers. Despite some public calls, there was a growing consensus that legislating an enforceable national standard is unlikely to be feasible given Canada's federalism and the different capacities of provinces and territories in following the common criteria. Instead, the focus on the discussion over potential policy solutions shifted to using the health transfer, which is already well established in the Canadian physician and hospital sectors, along with accreditation. PE in this case was conducted in an inclusive manner, embedded throughout the process.

There are several limitations to this study. This study relied heavily on grey material as a source. PE details in these sources were frequently described in a less comprehensive manner, or additional detail was not always publicly accessible. This limitation was apparent, particularly in Case 1, which took place over a decade ago and on the emergency structure in Case 2, which offered considerably less public access to its detail. To address the lack of available data, the authors gathered and used sources that provide information about the PE, which were often based on the participants' memories (e.g. participants in Case 1 recalled the engagement initiative a decade later in interviews with the COVID-19 Commission), which may be less accurate and only reflect a part of what happened. In addition, PE in Case 2 and 3 is still ongoing. That is, PE activities and the surrounding political environment may evolve at a later phase of the pandemic. Therefore, if the study findings are applied over a longer period of time, the information on PE activities and the political environment in this report may not be complete.

5.0 Conclusion

The COVID-19 pandemic's frightening impact has drawn unprecedented public attention to the deficiencies in the LTC sector. In fact, these deficiencies have been long-standing prior to the pandemic. There had been numerous calls for improvements to the quality of care in LTC homes. This study compared three policymaking cases in the LTC sector - the development of the Long-term Care Homes Act in Ontario [2004~2010], Ontario's COVID response in relation to LTC, [2020~2021], and the development of National Long-term Care Standards at the Federal level [2021~2022] - and described how the public was engaged in each process. While the three cases share some common characteristics such as the engagement of multiple stakeholders, reliance on targeted invitation along with self-selection methods for recruiting participants, and the frequent use of consultation-type activities, they also differed in the extent to which 1) open and inclusive access to engagement opportunities was provided; and 2) engagement formats encouraged two-way interaction between participants and engagement organizers. While the rationales and goals for PE did not seem to have a direct connection with how PE was conducted, an interesting connection is observed between PE and the government's policy directions and surrounding political environment at the time. More specifically, we put forward the hypothesis that when the surrounding political environment is supportive of the government's intended policy direction, it favours more open and inclusive public engagement initiatives. This relationship will be explored and tested in a follow-up study. Understanding why the public is engaged differently, despite the similar rationales and goals for PE, provides important insights to inform current and future public engagement efforts around LTC policy, which is particularly timely and relevant in the ongoing discussion on LTC reform in Canada.

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