Is Canada Ready for a New Universal Social Program? Comparing the Cases of
Universal Medicare in the 1960s and "Universal" Child Care in the New Millennium

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On April 29, 2005, Prime Minister Paul Martin, Manitoba Premier Gary Doer,
along with their respective federal and provincial social services ministers announced an
"agreement in principle" on early learning and child care (ELCC). The agreement set out
a "long-term vision, principles, and goals to guide the development of regulated early
learning and child care for children under six," which would expand on a five-year plan
the Manitoba government previously had in place (Manitoba 2005).[2]   Although the
terms and conditions of the agreement were specific to Manitoba, the agreement was not
entirely unique. It was one of ten bilateral agreements reached between the federal
government and each of the provinces following two years of broader federal, provincial
and territorial negotiations, between 2003 and 2005, on a national ELCC vision.   At the
conclusion of these broader negotiations, the federal government committed $5 billion in
the February federal budget for new ELCC spending over 5 years in collaboration with
provincial and territorial levels of government (Canadian Intergovernmental Conference
Secretariat 2005). During the Manitoba announcement, the Prime Minister suggested
that this was perhaps the first step toward a long-promised Canadian universal child care
program:

> The Agreement in Principle between Canada and Manitoba marks a major
> milestone that will move us toward a shared vision for early learning and
> child care. More agreements will follow. Decades ago, it was a series of
> such agreements that led to the creation of Medicare in Canada - a program
> that now helps to define us as Canadians (quoted in Manitoba 2005:1).

However, even though there are some similarities between the policy framework that
eventually produced universal Medicare and the federal/provincial/territorial consensus
agreement, resulting in ELCC bilateral deals, in 2007 Canada is still without a universal
child care program.

This paper attempts to gain a greater understanding of why universal child care
did not materialize following the 2005 announcements. Drawing on neo-institutional
theories of public policy, it will examine how relevant institutional frameworks, ideas and
interests guided federal/provincial hospital and medical insurance negotiations,
particularly between 1957 and 1961, culminating in the Medical Care Act of 1966.[3] It
will then compare this broader universal policy framework to the more recent ELCC

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[1] This draft paper is part of preliminary research for a larger post-doctoral project I'm conducting on the current
viability of a universal child care program in Canada. Comments are most welcome.
[2] Details of specific bilateral early learning and child care agreements between the provinces and the federal
government were obtained from Rianne Mahon, personal communication, June 2006. The Manitoba
bilateral agreement included federal transfers totalling $176 million scheduled for the years 2005 to 2010
for wage and benefit increases to provincial child care workers, training and recruitment, replacement staff
during training and tuition support in early childhood education (ECE) programs.
[3] The analysis also includes the subsequent bilateral deals that followed the 1966 Medicare Act and ended
in 1971.

negotiations, focussing mainly on the 2000 - 2005 federal/provincial/territorial mulatilateral framework and consensus negotiations and concluding with a look at the current ELCC policy context in 2007. Despite similarities in the bilateral cost-sharing nature of both social programs, their lengthy paths to consensus agreements and some similar national guiding principles, important differences in institutional and ideational frameworks help us understand divergent policy outcomes in terms of universality. In both cases, even though interests had some impact on outcomes, these were less significant than the impact of institutions and ideas.

In order to illustrate these arguments, the paper will begin by discussing the importance of universal social programs to the Canadian welfare state establishing significant similarities between universal Medicare and "universal" child care policies and why they are good comparative cases for this analysis. Following this, the paper will explain the neo-institutional theoretical policy framework used, identifying how an examination of institutions, ideas and interests can enhance our understanding of public policy. It will then comparatively apply this theoretical framework to both cases, highlighting important areas of similarity and difference. Finally, the paper will conclude by extending the analysis to the current state of child care in Canada in 2007 and by assessing the prospects for universal child care in the not-too-distant future.

Universal Social Programs and the Canadian Welfare State
According to Keith Banting, "universality lies at the very heart of the development of the welfare state in Canada and indeed in most industrial nations"(1985:7). This is especially the case since the establishment of universal programs for specific groups (the elderly, unemployed) or for specific purposes (ie. health care) has historically been such a dominant Canadian welfare state theme (1985:8). Universal welfare state programs are desirable to federal states because they can connect individuals more directly to the federal government essentially erasing "difference in social policy attitudes across regions" (1985:13). Universal social programs can also provide a modest level of security to individuals over time (Mahon 2006:7; Banting 2005:10). Titmuss (1968) argues that they also reaffirm citizenship rights. While selected or targeted welfare state programs usually involve some level of means testing and foster "both the sense of personal failure and the stigma of a public burden," universal social programs do not involve any "humiliating loss of status, dignity or self respect" (quoted in Burke and Silver 2006:377).

Banting defines universal programs as those that "cover the entire [relevant] population...and provide gross benefits, which are not reduced with income or wealth" (1985:7).[4] The concept of universality is central to Canadian health care policy and has been since before the advent of universal Medicare. Former Saskatchewan Premier Tommy Douglas who is credited with being one of the key architects of universal health care first provincially and then federally, insisted that health care must be available to every resident not just in theory, but in practice (Armstrong, Armstrong and Fegan 1998:18). Ever since, "equity based on need alone" and not one's ability to pay, has been the central distributive principle of Canadian health care (Burke and Silver 2006:375).

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[4] Banting uses "gross benefits" as most Canadian universal programs and benefits are taxed and if these were excluded, "there really are no universal programs in Canada" (1985:7).

Universality has also been one of the main pillars of a desired national child care program amongst Canadian child care advocates. The Royal Commission on the Status of Women's 1970 report included a call for a federal universal child care program as one of its four central recommendations (RCSW 1970). Canadian feminist movements, as well as provincial and federal child care advocacy organizations, further argue that child care needs to be universally accessible, available, affordable and of high quality to, among other things, assist women in their goals toward societal equality (Collier 2006).[5] Thus the aim of universality as a desired policy outcome is one of a number of important similarities between Canadian health care and child care policies.

Comparing Health Care and Child Care Policy Development in Canada

Before highlighting other important similarities between health care and child care policy development in Canada, it is important to make a clarification regarding the main question posed in the title of this paper, "Is Canada Ready for a New Universal Social Program?" The obvious answer to this question in a broad social policy context is, yes, evidenced by the federal Conservative government's 2006 implementation of the Universal Child Care Benefit, shortly after being elected. The Universal Child Care Benefit (UCCB) which transfers $100 per month, per child to parents of children under the age of six, clearly fits Banting's definition (stated above) of a program available to the entire relevant population that provides gross benefits[6] unlimited by income or wealth. However, while the UCCB is similar to other Canadian universal social programs, particularly the 1944 Family Allowance to which it is often compared (Mahon 2006),[7] it falls solely under federal jurisdiction as a direct cash transfer to individuals. Health care and child care programs, on the other hand, fall into a different and arguably more complex category. Health care constitutionally (section 92, subsection 7 of the BNA Act) falls solely under provincial jurisdiction. Any federal involvement in health care policy, then, is facilitated by significant transfers in funding to the provincial level. This shared-cost nature of the program necessarily involves constant negotiation between two levels of government as opposed to opportunities for unilateral state action. Relatedly, this can introduce obstacles to any long-term goal toward universality in program delivery (Aucoin 1974). Armstrong et. al argue that the task of providing universal health care in Canada is "never completed, but rather must be seen as a process evolving in response to new needs and possibilities" (1998:32).

Even though child care is not formally confined to provincial level jurisdiction, historically the provinces have assumed the bulk of the fiscal and legislative responsibility in the child care arena. Like health care, child care has been a shared cost welfare-state program between the federal and provincial (and sometimes municipal) levels of government particularly since the advent of federal Canada Assistance Plan

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[5] Child care and early learning advocates argue that there is an important educative benefit for children with this type of care as well (Collier 2006).

[6] The Universal Child Care Benefit is a taxable benefit (Mahon 2006).

[7] I argue that the UCCB is essentially a reduced version of the Family Allowance which at its height transferred monthly payments to parents of children under 18 years of age and at one point in time was non-taxable (Government of Canada 2007).

block funding transfers to the provinces beginning in 1966 (Collier 2006).[8] Therefore, child care policy advocates, like those in the health care field, must navigate a difficult area between federal and provincial jurisdiction which can, at times, hinder efforts to achieve universality in program delivery. Thus the question of whether Canada is ready for a new universal social policy is much more complicated to answer in areas of shared federal/provincial jurisdiction. This theme will be revisited later on in the comparative analysis.

There are other similarities between Canadian health care and child care policy that help justify their comparative worth for this analysis. Both of these social programs have had lengthy and tumultuous histories leading up to bilateral shared-cost consensus agreements and more definitive action at the federal level under the umbrella of national standards. Along the way, each policy has seen the provinces step in with important policy innovations that have helped raise the profile of the issue nationally. By the time the Hospital Insurance and Diagnostic Services Act was passed on May 1, 1957, it had been 38 years since health insurance first appeared as a Liberal Party election issue. It would take another ten years until national medical insurance was introduced (1966/67) and four years after that until the bilateral Medicare details with the ten provinces were ironed out (Taylor 1987:161).   In the meantime, Saskatchewan went ahead and pioneered a provincial hospital insurance program in 1947 and later a province-wide medical insurance program in 1959 (Taylor 1987:239). These initiatives led the way for other provinces to establish health insurance programs to help put pressure upon the federal government to establish national legislation in both areas.[9]

National-level child care policy has a similar long, slow history in Canada. As mentioned, advocacy demands for a national universal child care program have been around since at least 1970 when they were first articulated federally in the Report of the Royal Commission on the Status of Women. While the 2005 bilateral deals were not the first federal attempt toward a "national" child care program[10], they were arguably the closest the federal government has come to establishing a federally-funded national-level program since 1970. Similar to health care, two provinces made moves toward province-wide comprehensive publicly-funded child care programs in the void left by the lack of concrete federal action over 35 years. The first and most significant provincial child-care program was established in Quebec in 1997 when it introduced the only publicly-funded child care program in North America (Jenson 2002).[11] This was followed by the short-

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[8] It is important to note that education constitutionally falls under provincial jurisdiction and this can help justify provincial action in the child care arena particularly since the "early learning" aspect of child care programs is often emphasized in ELCC program delivery.

[9] According to Malcolm G. Taylor, "no provincial government failed to send its official to Regina to learn at first hand how the program operated and what policies and procedures could be adapted to their home provinces" (1987:104). BC, Alberta, Ontario and Newfoundland all had hospital insurance plans in place prior to federal legislation in 1957 (Ibid 167-170).

[10] In 1988, the federal Conservative government introduced Bill C-144, a National Strategy on Child Care, which died on the order paper in the Senate before it could become law (see Phillips 1989).

[11] This program addressed a number of areas within family policy reform but is best known for its introduction of a five-dollar-a-day provincially funded child care program where parents regardless of income would pay five dollars each day for child care services that cost much more than that to provide. The province provided direct grants to child care centres to fill the gap between the fees and actual operating costs (Jenson 2002:323). The cost of child care was later raised to seven dollars a day but the concept of universality remained intact.

lived introduction of a similar program in British Columbia in 2000.[12] While the BC program was not in place long enough to impact federal level activity, the publicly-funded Quebec child care program is often cited by child care researchers as a flawed, but important example of how child care can become "a publicly provided citizenship right" (Jenson, Mahon and Phillips 2003:149).

A third important similarity between Canadian health care and child care programs at the point in which they reached federal/provincial (and in the case of child care, territorial) consensus, is how they both were guided by overarching national guidelines. Although the federal approach to the 1957 hospital insurance act closely followed the model established first in Saskatchewan, the federal government agreed to provide the provinces with a level of flexibility in how they operationalized a national hospital insurance scheme. However, in order to qualify for federal financial support, the provinces needed to meet certain national standards within this flexible framework. In particular, hospital care needed to be universal, accessible, comprehensive and readily available to all (Armstrong et. al 1998:12).

Some of these same principles were repeated during the 1965 federal/provincial conference to discuss national Medicare proposals. Federal and provincial representatives generated four guiding principles for a national Medicare program including that it must cover a "comprehensive range of medical services," be "universal," be "portable between provinces" and "administered by a public agency" (Gray 1991:43). Both sets of these guiding principles were defined more precisely and brought under one piece of legislation in the Canada Health Act (CHA) of 1984. The CHA clearly articulated a national commitment to five principles of health care: "public administration, comprehensiveness, universality, portability and accessibility," and identified specific penalties to any of the provinces that failed to live up to those principles, particularly regarding "extra billing" of patients for medical service delivery (Armstrong et. al 1998:30).

The 2005 ELCC bilateral agreements reached between the provinces and the federal government stated that provincial ELCC programs needed to follow what were known as the "QUAD principles". QUAD stood for quality, universality, accessibility and developmental. Quality was defined as "evidence based practices" in support of early childhood education. Universality meant "universally inclusive" in support of all children of diverse needs including Aboriginal children, children with disabilities and children of different cultural and linguistic origins. In order for programs to be "accessible" they needed to be broadly "available and affordable to all," including flexibility in the range of options provided. Finally, developmental meant that the care should "strengthen the learning and developmental component...to meet the cognitive, physical emotional and social development needs of children" through evidence-based practices.[13]

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[12] This child care plan was set to provide after-school care for children under the age of 12 years of age for a cost of seven dollars a day and would have been only the second publicly-funded child care program in North American after Quebec. Even though it was not immediately as comprehensive at the Quebec plan, the BC announcement marked the first phase in a longer-term program to extend child care to cover a broader age-range of children and to expand the length of care. However, the program was terminated after an 2001 provincial election brought in a change in governing party (Collier 2006).

[13] Mahon personal communication June 2006.

Both sets of guiding principles are similar by including key concepts of accessibility and universality in program delivery. However, there are important differences between these sets of principles as well. The Canadian health care principles included specific calls for public administration of health care delivery and portability between jurisdictions, whereas neither of these was included in the QUAD child care principles. Conversely, the latter principles include a developmental element particular to child care service delivery that was not necessary for the Canada Health Act. Another important distinction is that the health care principles were enshrined into legislation in the 1984 CHA, whereas the child care principles remained outside the legislative framework and without enforceable penalties for non-compliance. In order to better understand the similarities and differences between these two policy cases, the paper now turns to a discussion of the comparative framework.

A Neo-Institutional Comparative Public Policy Framework

Richard Simeon argues that if we are to understand policy and in particular are attempting to explain how or why certain public policy decisions are made, it is important to turn to policy theory rather than policy analysis. Quoting Randall Ripley (1969), he notes that the former helps explain "why certain alternatives are chosen and others are not," whereas the latter is more concerned with providing actual "advice on the choosing of alternatives" (in 1976:550). Simeon suggests that a theoretically-based policy study should utilize a comparative framework that takes into account "various characteristics of the broad social and economic environment, the system of power and influence, the dominant ideas and values in the society, and the formal institutional structures" involved (1976: 555-556). Although Simeon does not suggest one specific policy theory to achieve this goal, many aspects of this framework are included in neo-institutional policy theory.

Although neo-institutionalism naturally emphasizes the role of institutions in its conceptualization of the formation of public policy alternatives, newer versions of institutional and historical institutional theory also include the impact of ideas and interests on policy decision-making. According to John L. Campbell, institutions or "the formal rules and procedures governing policy making" serve as filters to "which ideas penetrate the policy-making process and are adopted and implemented as policy" (2002:30).[14] Daniel Béland adds that historical institutionalism, based on the "assumption that a historically constructed set of institutional constraints and policy feedbacks," also structures the behaviour and influence of political actors and interest groups (2005:1).[15] Despite variations in approaches as to the relative explanatory weight which should be assigned to each, it is clear within this newer institutional literature that in order to gain a better understanding of public policy decisions, it is important to identify and consider the impact of relevant institutions, interests and ideas.[16] Campbell argues that we should not consider these factors on their own, but should aim to "better understand the connections between ideas, institutions, and interests" (2002:33). A neo-institutionalist framework focussed on the relationships and connections between

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[14] He cites authors in this tradition including Hall 1989, Weir and Skocpol 1985, Jasper 1990, and Risse-Kappan 1994 (Campbell 2002:30).
[15] Béland cites Pierson 1994 and Skocpol 1992.
[16] This approach is also supported in the policy community/network literature. See Skogstad 2005.

institutions, ideas and interests also can address the main aspects of the policy framework design suggested by Simeon above.[17]

Since an important aspect of both health care and child care policy in Canada involves the ways in which policy actors can navigate the challenges posed within the institution of federalism, the neo-institutional approach seems particularly useful for this comparative analysis. Due to space limitations and in the interests of achieving the broader goal of identifying the overarching policy framework that informs the decisions in both of these social policy arenas, it is important to specifically identify what the paper will include in its comparison of institutions, ideas and interests.

In order to establish the policy framework in place leading up to and encompassing significant federal policy decisions in the Canadian health care and child care fields, the paper will compare the federal framework and the process of intergovernmental decision-making as a consideration of institutions. It will then compare ideas broadly using a 'varieties of liberalism' framework (Mahon 2006) and then more specifically by including a discussion of shifting partisan ideas and how these were operationalized specifically through political actors.[18] Finally, it will identify the perceived impact of organized interests in support and in opposition to the programs under review.[19]

Even though the policy road leading to universal Medicare (1966) and the Canada Health Act (1984), as stated above, had been very long, this paper will mainly focus on an analysis of the bilateral health care negotiations which took place between 1957 and 1961, leading up to the 1966 Medicare Act and further bilateral deals with the provinces ending in 1971, which operationalized this legislation. This time-frame will be compared to the federal/provincial/territorial early learning and child care negotiations which took place between 2000 and 2005. The paper will conclude with a discussion of the current policy context in 2007. Of course the choices made in both limiting the explanatory variables through a choice of a neo-institutional theoretical framework and by limiting the time frame of the policy process in both cases will undoubtedly limit the conclusions that can be drawn in this paper. However, I believe that this comparative framework will help uncover some of the main structural reasons for divergent policy results in these two welfare-state policy arenas within the limited space provided.

Canadian Universal Hospital Insurance and Medicare in the 1960s

Federal/provincial negotiations surrounding, first, universal hospital insurance in the late 1950s and then, later, surrounding universal Medicare in the mid- to late 1960s/early 1970s, largely fell within an era of executive "cooperative" federalism characterized by cooperation between relatively equal levels of government. This era of

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[17] The inclusion of institutions is common to both Simeon's policy framework and neo-institutionalism. A consideration of dominant societal ideas and values along with the broad social/economic environment can be accomplished under the umbrella of "ideas". A look toward interests can help establish the system of power and influence among policy actors.

[18] The partisan theory of public policy argues that differences in party ideology between different governments over time can help explain diversity in policy approaches (for a discussion of this literature see Collier 2006). As well, neo-institutional theory argues that ideas have little policy influence unless they are seized upon by powerful political actors (Béland 2005:10).

[19] The importance of interests to policy study in Canada is well documented in the policy community/network literature. For a comprehensive review of this literature, see Skogstad 2005.

cooperation helped establish the welfare state in the decades following the end of the Second World War (Cameron and Simeon 2002:50). The social mood of frustration after years of deprivation following the Depression and the War served as a backdrop to Medicare policy. During these years ideas of social liberalism were dominant and state expansion of social policy helped define what would be known as the "golden age" of the Canadian welfare state (Mahon 2006:1). Relatedly, the political landscape was experiencing a new surge of left-wing influence from the social-democratic Cooperative Commonwealth Federation, both federally and in many provinces. The governing federal Liberals were struggling to respond to all of these pressures without alienating many of its core, more conservative, members. The Canadian Medical Association (CMA) representing professional doctors in the country, along with commercial insurance providers, were sceptical of the introduction of hospital insurance. Interest-based opposition grew stronger particularly when discussions turned to expanding insurance to cover all medical services. Yet even though these interests exerted some influence, they were no match for the institutional and ideational forces in this policy arena.

Institutional Framework
Federalism

It took a while to gain federal and provincial consensus on the issue of hospital insurance in the years leading up to the 1957 federal act. These early years included a failed 1945 federal/provincial conference where disagreement over the scope of the problem and the wording of national initiatives remained quite strong (Taylor 1987:67). However, the federal framework of cooperative federalism that characterized the Canadian policy landscape from the end of the Second World War until the beginning of the 1960s helped facilitate national legislation in the long run (Cameron and Simeon 2002:50). During this era of federalism, the federal spending power was a key policy instrument used to facilitate federal state involvement in areas of provincial jurisdiction. Governments were decentralized and "close professional relationships developed among provincial and federal officials and ministers within specific policy areas" (Ibid).

Many of the policies generated during this cooperative period resulted from joint decision-making between relatively separate jurisdictions operating within "close and frequent consultation" (Gray 1991:17). Both the national hospital insurance and national Medicare bilateral deals emulated this cooperative shared-cost model. Four years after the federal government passed the Hospital Insurance and Diagnostic Services Act (1957), all of the provinces had negotiated hospital insurance plans (some of which preceded the 1957 federal act but were later reaffirmed under principles of universality). Even though the plans themselves were varied because the provincial governments remained the "chief decision-makers in health care," the federal government was able to use its spending power to ensure compliance with national standards (cited above) (Armstrong et. al 1998:15).

Despite the fact that the national Medicare Act (1966) and subsequent provincial agreement reached in 1971 arguably fell outside of the cooperative federalism framework period as typified by Cameron and Simeon,[20] there were still elements of cooperative

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[20] They argue that a shift from cooperative to a more competitive federalism occurred between the early 1960s and the mid-1970s, when the Quiet Revolution in Quebec helped heighten competitive tensions

federalism evident in the outcome of this policy. The lure of federal cost-sharing incentives proved too persuasive for the provinces, some of which had already begun expanding insurance into the wider medical arena. By the end of 1971, all ten provinces had signed deals which altogether constituted a national plan. This plan would clearly be comfortable under a cooperative federalism framework as it was achieved through "interlocking ten provincial plans, all of which shared certain common features" (Burke and Silver 2006:378).

The Impact of Ideas
Overarching Ideational Frameworks

The Second World War brought with it an acute demand for hospital care, not only from the returning wounded, but also from those already in the country who wanted a certain level of quality health care but could not afford it. This mood of "rebellion against the universal risks of unemployment and sickness, disability and old age, widowhood and poverty" was prevalent in the years following the end of the war and the earlier Depression (Armstrong et. al 1998:8). This broader social landscape shaped efforts to develop the Canadian welfare state between the 1940s and into the 1970s. This policy context also fit well under the "moderate Keynesian social liberalism" label (Mahon 2006:1).

Rianne Mahon argues that Canada and other Anglo-American countries fall within an overarching liberal regime framework. Thus Canada embraces key roles for markets and families and occasional supplements from "modest state supports."[21] However, Canadian liberalism has not remained static over time, but has gone through a number of important changes. Mahon places these within a 'varieties of liberalism' framework (Ibid). She argues that this 'varieties of liberalism' framework can aid our understanding of welfare state policy development over time and for the purposes of this study can shed light on some of the constraints placed on government policy-making at different points in time.

Thus negotiations toward hospital and medical care insurance in Canada in the late 50s and into the 1960s, according to Mahon, would fall under a social liberalism rubric, which emphasized the "positive freedoms of opportunity and person development" (2006:3). Social citizenship grew in importance during this era and the role of the state expanded to create "the conditions for all to develop their full potential, even if this involved measures to counteract the impact of market forces" (Ibid). This ideational social liberal framework helps us understand how the provinces could be convinced to embrace national health care principles and standards, particularly those that spoke of universality and accessibility. Clearly these health care principles enhance individual social citizenship and issues of personal security which are central within a social liberalism framework.

Partisan Ideology and Influence of Key Political Actors

Gray (1991) and Taylor (1987) both argue that competition between political parties at the federal and provincial levels, along with the rise of the social democratic

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within Canada, particularly between the provinces which put pressure on larger goals of cooperation (2002:51).

[21] Mahon references the well-known welfare state classification scheme by Esping-Andersen (1990; 1999).

Cooperative Commonwealth Federation (CCF, later NDP) are important factors to consider in understanding why universal hospital and medical insurance policies were politically successful. Although the CCF did not form a national government, it was elected to the official opposition in Ontario in 1943 and, more importantly, won the Saskatchewan provincial election in 1944. Not only was the party as a whole committed to "freely available" health care services (Regina Manifesto 1933), but CCF Saskatchewan Premier Tommy Douglas was a tireless advocate for Medicare. Douglas not only ensured that both hospital and medical insurance were established provincially, he then eventually became a federal Member of Parliament to ensure Medicare's adoption on the national stage as well (Armstrong et. al 1998).[22] The persuasive power of the Left continued to influence federal health care policy even during the implementation of the 1984 Canada Health Act. According to Gray, the Left helped keep the health care issue on the agenda both federally and provincially and "inside and outside the House of Commons" (1991:185).

However, Taylor also argues that the federal Liberal Party, despite struggles within its own caucus, extra-parliamentary membership and at times its leadership, was instrumental in securing universal Medicare in Canada. He suggests that even though the twenty-year period between 1945 and 1965 saw a complete full circle change in Liberal attitudes toward Medicare "from initiation to reluctant acquiescence to initiation," a major factor in the eventual adoption of national Medicare was "the long-term commitment of the Liberal Party to health insurance" (1987:332 & 352). Taylor not only points to the party itself, but also singles out specific Liberal health ministers who doggedly pursued the issue throughout their tenures, including Ian Mackenzie who held the portfolio between the mid 1930s until June 1944 (1987:45) and Paul Martin [Sr.] who served as health minister during the early to mid-1950s, working under constant opposition from the more conservative-minded Prime Minister Louis St. Laurent (1987:108).

The Role of Interests

The two most influential organized interest groups[23] involved in the Canadian health care debates leading up to and throughout the 1960s both provincially and federally, were the Canadian Medical Association, representing Canadian doctors, and the commercial insurance companies.[24] Yet despite the fact that both were mainly opposed to government provision of national hospital and medical insurance, their opposition tactics were largely unsuccessful compared to the forces of powerful state and political actors.

Although the CMA did not strongly oppose national hospital insurance when it was first being negotiated in the early 1940s, it eventually moved against the proposal later in the decade (Taylor 1987; Armstrong et. al 1998). According to Armstrong et. al, even though the doctors "were happy to have the government pick up the tab for those

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[22] Douglas's commitment to health care was also deeply personal. For more see Armstrong et. al 1998:6-7.

[23] This paper does not include all of the interests involved in the health care policy community. Assessments of which interests were most influential were made after consulting the secondary empirical evidence used throughout the paper.

[24] Other medical service interests (including the Canadian Hospital Council and the Canadian Dental Association) were also on-side with the CMA during this period, but the CMA remained the largest and most influential (Taylor 1987:29-30).

who could not pay for insurance, they did not want the government to control all hospital insurance" (1998:14). However, this position eventually softened when the doctors realized they could use the new universal system to their own advantage including ordering hospital care without worrying about a patient's ability to pay and generally being responsible for less paperwork than in the past (Ibid).

Commercial insurance companies were less easily swayed and remained opposed to hospital insurance, promoting the private US insurance system as a preferred model for Canada (Ibid). Their arguments in support of this system largely fell on deaf ears as the federal government's own research showed weaknesses in this approach. Thus it was decided that private insurance companies could not compete with the public scheme, but they could cover "extras" including dental work, prescription drugs, etc. (Armstrong et. al 1998:15).

Both the CMA and commercial insurance providers were more strongly opposed to provincial and national Medicare insurance. Doctors in Saskatchewan went so far as to protest the move by going on strike. Although the battle was "bitter and long" the provincial government prevailed, offering only minor concessions to appease striking doctors in the end (Armstrong et. al 1998:19). When the fight for universal Medicare moved to the national stage, both the CMA and the commercial insurance providers pushed the federal Conservative government of John Diefenbaker to launch a Royal Commission on Health Services to perhaps derail or at least postpone the process (Armstrong et. al 1998: 20-21). But the resulting Hall Report released in 1964 concluded, much to the disappointment of the doctors and private insurance providers, that "the best solution for Canada is the establishment of a comprehensive, universal Health Services Programme" (quoted in 1991: 43).

On the other side of the health care debate, and one of the major interest groups in support of public hospital and medical insurance, was the Canadian labour movement. It essentially agreed with the Hall Report and the conclusion that health care was a public service rather than a market one (Armstrong et. al 1998:23). However, neither the support of organized labour, nor the opposition of the doctors or commercial insurance providers were cited as having much influence on the federal/provincial negotiations, despite their varied efforts.

The Policy Context of National Hospital Insurance and Medicare in the 1960s

In summary, the neo-institutional analysis above helps explain the federal provincial consensus agreements leading to the Hospital Insurance and Diagnostic Services Act of 1957 and subsequent bilateral deals, along with the 1966 Medicare Act and related bilateral deals finalized in 1971. The fact that both of these universal programs were achieved within a more difficult shared-cost framework can be attributed to the intergovernmental openness typified by cooperative federalism and the invitation to broaden the welfare state in a post-war and post-depression era environment characterized by moderate Keynesian social liberalism. Political action was hastened by the strength of social democratic political forces on the Left as well as through the long-term commitments of individuals in the CCF and the federal Liberal Party who facilitated positive outcomes. While major organized interests both for and against universal hospital and medical insurance were active within the health care policy community

during this time frame, neither side was particularly influential in determining policy outcomes.

In order to further assess the importance of these policy determinants, the paper will now turn to an examination of Canadian child care policy.

Canadian Universal Child Care? The 2000 Multilateral Framework on Early Learning and Child Care and the 2005 Federal/Provincial Bilateral Agreements

The Federal/Provincial/Territorial Multilateral Framework on Early Learning and Child Care began in 2000, reached an agreement on initial ELCC funding in 2003 (Multilateral Framework Agreement on Early Learning and Child Care 2004) and then after two more years of negotiations, finalized the QUAD principles and set the groundwork for the separately negotiated bilateral deals that were concluded later in 2005. These series of multilateral ELCC negotiations took place within an era of "collaborative" federalism where national goals are achieved by some or all of the 11 governments and two territories acting collectively. What distinguishes collaborative federalism from the era of cooperative federalism which informed the universal health care negotiations analyzed above, is that the former does not necessarily offer opportunities for or see the federal government acting within a leadership or equal role to the provinces, whereas the latter sees a much more equal distribution of power leaving more room for federal leadership (Cameron and Simeon 2002:54). Along with this, the multilateral child care negotiations were impacted by more "inclusive liberalism." Inclusive liberalism falls somewhere between social liberalism and neo-liberalism, by embracing a commitment to the market alongside social investments to better an individual's place within it (Mahon 2006: 4). Federally, the political landscape was entering an era of some instability with minority governments elected in 2004 and 2006. While this left room for the Left to have some minor impact, it was not as influential as it was during universal health care debates. Pro-child care advocacy interests, including the leading national voice - the Child Care Advocacy Association of Canada - had always been quite weak at the national level and this did not change much during this period, especially since the multilateral framework did not open many doors to interest involvement.

Institutional Framework
Federalism

To understand the dynamics of the multilateral negotiations between 2000 and 2005, it is important to step back a bit further in time to 1996/97 when the federal government introduced the Canada Health and Social Transfer (CHST). The CHST replaced Canada Assistance Plan funding arrangements that the provinces had been using to fund child care programs across the country since the late 1960s. CAP funding was a 50/50 cost-sharing program for social services, including child care, between the federal government and the provinces. Limits on CAP funding began in 1990 when a cap was put on CAP dollars to the three richer "have" provinces at the time (BC, Alberta and Ontario), but the significant reductions came in 1996/97 with the introduction of the CHST which replaced CAP. The CHST combined CAP funding with separate transfers for health care and reduced the entire amount. Essentially, all social program funding

suddenly had to compete with health care funding within provincial budgets and as health care costs rose, social services lost the fight for limited federal dollars. The fact that all of this funding represented a significant reduction in federal shared-cost transfers exacerbated the problem even further (Collier 2006).

In the aftermath of the 1996/97 CHST, the provinces got together on their own, much in line with the era of collaborative federalism described by Cameron and Simeon,[25] to initiate the National Children's Agenda (NCA) which the federal government later joined in 1999 (2006:19). This is significant because the power relationship between the federal and provincial governments clearly had shifted within the lead-up to the multilateral framework in what could be seen as an era of distrust. Following the introduction of the CHST, the provinces knew that they could no longer rely on the federal government to come through with important social service cost-sharing transfers, even though those transfers were crucial to the delivery of those social services, and this is especially so for child care. Therefore, whereas the federal government always needed to "buy into" federal/provincial/territorial arrangements in the past, the significance of federal funding guarantees over the long term is arguably greater in this era of mistrust under collaborative federalism.

The other institutional body that guided the multilateral ELCC framework negotiations, at least in the beginning, was the Social Union Framework Agreement (SUFA) of 1999. Like the NCA, the SUFA was initiated "to come to terms with the somewhat dysfunctional state of federal-provincial relations on social policy and fiscal issues" (Noël, St-Hilaire and Fortin 2003:3). The SUFA's stated objectives were to, among other things, better manage the interaction between the two levels of government and to ensure sustainability in social program funding in a non-constitutional setting (Ibid). Although Noël et. al suggest that the NCA and the Multilateral Framework Agreement were somewhat successful extensions of the SUFA principles, most researchers have been critical of the potential of the SUFA to solve intergovernmental wrangling over social program delivery (Noël, et. al 2003:4 & 21; Cameron and Simeon 2002:57).

Regardless, the impetus behind the multilateral framework negotiations, which followed directly from the NCA, and use of the SUFA principles to guide intergovernmental negotiations in general fit well under the collaborative federalism model. This institutional framework also explains potential shifts in power between the two levels (three, including the territories[26]) that likely occurred during the negotiations themselves, making it more difficult for the federal government to take a leadership role, particularly in establishing national principles or standards to guide a "national" or "universal" child care program, or to ensure compliance thereof. Indeed the lack of inclusion of a portability requirement or a public administration delivery requirement within the QUAD principles, such as those that were included in the Canada Health Act, indicates that the federal government was perhaps weaker inside of these negotiations than was the case during those for universal health care four decades ago. Mahon and Phillips argue that this lack of a leadership role means that participants in these

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[25] Collaborative federalism allows for provincial agreements that do not necessarily (at least initially) involve the federal government (2002:55)

[26] Information regarding negotiations with the territories is not included in this analysis as specific data was not immediately available to the author.

multilateral negotiations (including the NCA and the SUFA) likely are more concerned with the relationships between the actors and their respective "political image[s]" than the actual policy outcomes (2002:206).

Another two features of collaborative federalism that were evident in the multilateral framework negotiations were that first, any agreements reached would likely have to be followed up with separately negotiated bilateral deals and second, that this allows for considerable asymmetry, resulting in a form of "checkerboard federalism" (Cameron and Simeon 2002:60). While bilateral deals were present with both policy areas being compared in this paper, some of the earlier universal health care bilateral deals informed or preceded the actual setting of the national principles themselves and therefore this arguable created more opportunity to secure compliance on a broader range of commonality beforehand. It is possible that the cooperative federalism era of universal health care allowed provincial policy innovations to impact the resulting federal model of universality. With child care and the multilateral framework bilateral negotiations, this was not the case.[27] In fact, even though the 2005 separately negotiated bilateral deals follow the broad QUAD principles, they are very diverse in focus ranging from spending on ECE training in Manitoba to expansion of child care spaces at the junior and senior kindergarten level in Ontario to a $100 a month stay-at-home-parent benefit for licensed nursery or other approved early childhood development programs in Alberta.[28] Clearly the separate deals were comparatively asymmetrical and because the multilateral negotiations failed to ensure a baseline level or type of child care delivery across the country, there was no mechanism in place to correct that asymmetry in the future.[29] The portability and public administration requirements established for universal health care arguably helped keep any asymmetry between the provinces at a much lower level than was and is the case with child care services.[30]

The Impact of Ideas
Overarching Ideational Frameworks

Much has been written about the shift to neo-liberalism that has been embraced by Western governments, including Canada, beginning in the late 1970s and lasting well into the 1990s in an era of globalization.[31] During these years, states looked to the ideals of competitiveness, efficiency and an embrace of classical liberal principles that privileged a freer hand for the market in order to thrive in a global world. However, many researchers have noted a softening to this approach even while governments continue to embrace neo-liberal principles in order to remain competitive. This newer era of "inclusive liberalism" beginning in Canada in the later 1990s, can be seen to sit

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[27] It's important to note that Quebec, the only province with a model "universal" child care program in place that could inform the multilateral discussions, did not sign onto the SUFA. It also did not participate fully in the multilateral framework negotiations, although it did negotiate separate funding for its own child care program following the consensus agreement of 2005. This, of course, also limited the ability of the final agreement to be informed by the Quebec child care program.

[28] Mahon personal communication, June 2006.

[29] This was aided by the fact that the QUAD principles were not legislated whereas the Canada Health Act principles were.

[30] For more on the current variation in child care services delivery countrywide, see http://www.childcarecanada.org/ECEC2004/ .

[31] See for example Brodie 1996; Bashevkin 2000, 2002.

somewhere between neo-liberalism and the social liberalism of the past that saw the expansion of the welfare state and the introduction of universal health care programs. Inclusive liberalism seeks to meet the challenges of economic globalization by empowering individuals through modest social supports or "carrots" (which were also championed under social liberalism) to encourage them to be full worker-citizens and to contribute to global competitiveness (which is also embraced under neo-liberalism) (Mahon 2006).

According to Mahon, inclusive liberalism was evident with the "activation" programs that the Liberal government introduced in the late 1990s and early 2000s. These programs put the emphasis on the individual and aimed to "enable" that individual within society using incentives such as "foundations for lifelong learning, early childhood development and education" (2006:18). Mahon also sees the National Children's Agenda (and resulting multilateral framework negotiations and agreements) as being synonymous with inclusive liberalism "at least in rhetoric":

> Of particular importance is the fact that it seemed to reopen the way for universality, reasserting the goal of ensuring provision of an equivalent level of children's services across the provinces. Thus, the NCA committed the federal and provincial governments to work together to develop a comprehensive, cross-sectoral and long term strategy to ensure that *all* Canada's children receive the best possible opportunity to develop to their full potential (Mahon 2006:19-20).

Thus, the move away from neo-liberalism toward a more inclusive liberalism framework appears, at least on the surface, to open the door toward universality in federal/provincial/territorial negotiations. The fact that a national set of guiding QUAD principles were agreed upon in 2005 and that these would be subject to reporting within the provinces, does indicate an openness to a level of universality that would not have been possible within a strictly neo-liberal framework (Manitoba 2005; Multilateal Framework on Early Learning and Child Care 2004). The question remained, however, whether this potential for universality was merely rhetorical in nature or whether it would be operationalized.

Partisan Ideology and Influence of Key Political Actors

The partisan federal landscape began from a position of relative government stability with the Liberal Party of Jean Chrétien holding majority party status in the House of Commons between 1993 and 2003. At the same time, the opposition went through various periods of disarray. The Progressive Conservative Party which served as the major party of opposition in the past when the Liberals were in power, suffered a humiliating defeat in 1993 and was left with only two seats. Afterward, the Party essentially split into three factions, one stayed true to the Progressive Conservative label and centre-right principles, the other, the Reform/Alliance Party, was more decidedly right-wing with a political base in the West, and the third was basically a federal representative for Quebec's drive towards sovereignty under the label of the Bloc Québecois.[32] The NDP on the left was not the same federal force that it was when it was

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[32] This is a truncated summary of the changes in 1993. For more see, for example, MacIvor (2006:108-111).

operating as the CCF during the 1960s health care negotiations. The immediate beneficiary of opposition disarray was the Liberal Party, which was rewarded with successive majorities until 2004.

However, by the time of the 2004 election, politicians on the right were able to regroup under the Conservative Party label and gained strength, the Bloc Quebecois remained strong in Quebec, and the NDP was able to recover some of its former strength representing the voice of the centre-left. This new reconfiguration of the federal parties resulted in two successive minority governments in 2004 and 2006, one Liberal and the other Conservative. Even though the Liberals immediately remained in power under a new leader, Paul Martin [Jr.], the minority position of the federal government likely impacted the on-going multilateral framework negotiations by further weakening federal opportunities for leadership along the lines already discussed under collaborative federalism. This again would hamper efforts to reach true universality in child care policy and helps explain the somewhat more limited nature of the national QUAD principles negotiated for child care when compared with those included in the Canada Health Act.

Another potential result from this instability, particularly with the Liberal minority government of 2004-2006, was that in order to pass important pieces of legislation, the government would need support from other parties in the House of Commons. That support, at times, came from the NDP giving some room for further influence from the Left.[33] The most obvious example of this influence came in April 2005 when the NDP negotiated inclusions in the Liberal budget in order to secure NDP support and ensure its passage (CBC News , April 27, 2005). None of these particular inclusions involved child care. Yet even though some potential existed, there was no evidence the Left had any impact on the multilateral ELCC framework negotiations or the agreement reached that same year.

The Role of Interests

Child care advocacy at the national level has traditionally been weaker than at the provincial level where program delivery actually occurred (Collier 2006). Even though feminist groups were the first to articulate a need for a national child care program in the early 1970s as an emancipatory right for women, this message did not influence the debate during the multilateral framework negotiations. One reason for this lack of influence has been the tendency for child care to be defined as a gender neutral/family issue more in line with neo-liberalism and inclusive liberalism where the focus has shifted wholly to the child (Mahon 2006:18). Thus women's movement actors are seen by government and other social policy advocates as "radical, adversarial, and irrelevant" (McKeen and Porter 2003:128).

At the same time, the nature of intergovernmental negotiations under collaborative federalism and more specifically the SUFA, NCA and the multilateral framework negotiations focused more on intergovernmental actors and "marginalize[d] an already weakened advocacy community" (Mahon and Phillips 2002:206). Despite this, the national child care advocacy community continued to work to influence the child care debate, most notably under the leadership of the Child Care Advocacy Association

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[33] This level of influence was not static due to slight shifts in party membership in the House which changed the dynamic of partisan influence by benefiting different parties at different timepoints.

of Canada (CCAAC). The CCAAC has tried to widen its influence and appeal within the child care policy community by joining forces with other likeminded advocacy groups. Coalitions, such as Campaign 2000, were active on the child care file during the multilateral framework negotiations. However according to Mahon and Phillips, the coalitions focussed more on a wider "children's agenda" which can speak well for a collective but ends up watering down child care interests inside of it (2002:209). Thus child care advocacy interests have had little impact on the multilateral framework negotiations, despite remaining active throughout this period.

The Policy Context of "Universal" Child Care Agreements 2000-2005

In summary, this neo-institutional analysis helps us understand the federal/provincial/territorial child care multilateral framework agreement and subsequent bilateral deals negotiated under the QUAD principles between 2000 and 2005. The reduced leadership role of the federal government, along with greater potential for asymmetry in policy results, worked against any potential for universality found under an inclusive liberalism framework. The fact that inclusive liberalism was not as strong a vehicle for discussions of universality as social liberalism had been, also helps explain why the QUAD principles were not as comprehensive and strong as the national principles later enshrined under the Canada Health Act. Instability in government after 2004 also helped weaken federal actors, while at the same time opening the door for some small influence from the Left, although no evidence of this influence was found. Likewise, child care advocacy interests were also weakened by the intergovernmental process and by being forced to work within broader child-focussed interest coalitions.

In the end, the overall policy context for child care negotiations included potential avenues for universality alongside potential roadblocks and detours embedded in the system itself. To further assess child care policy results, the paper will conclude with a brief neo-institutional analysis of federal child care policy post-2005.

Federal Child Care Policy 2006-2007

The minority Conservative Party elected to office in early 2006 campaigned on child care as one of its five main priorities. Once elected, the Conservatives made good on this promise by putting its own stamp on child care and without negotiating with the provinces beforehand, much different than both 2000-2005 and from the 1960s with health care. Prime Minister Stephen Harper also indicated that he would be approaching federalism from a new standpoint - "open federalism" - which seemed to place even greater power in the hands of the provinces than in the past. Actions by the Conservatives made some question whether the Canadian state was turning back to neo-liberalism (Mahon 2006:27). Even though this was another minority government, it did not court support from other political parties, but instead remained committed to its own campaign agenda. Child care interests that were already weak remained so during these years.

Institutional Framework

Federalism

While it is too early to tell whether or not Canada has experienced a significant change in federalism since the election of the Conservatives in 2006, it is a matter of

record that the new Prime Minister is at least rhetorically committed to approaching federalism from a different perspective. Harper campaigned in 2005 using the phrase "open federalism" stating that it was a different approach from previous iterations because it would "respect" the constitutional division of powers" between different levels of government and would recognize "a commitment to redress the fiscal imbalance in the Canadian federation" (Courchene 2007:16). According to Thomas Courchene, this "new" federal approach was evident in the 2007 federal budget, although it is unclear how different this is from collaborative federalism. Courchene argues that the 2007 budget "resurrects aspects of the Meech Lake Accord and even SUFA in terms of how Ottawa will henceforth approach the exercise of the federal spending power" (2007:16). In other words, the federal government would not act unilaterally with regard to shared-cost social programs that fall under provincial jurisdiction but would ask for majority provincial consent ahead of time and allow the provinces to opt out and receive compensation if they provide "similar programs with comparable accountability structures" (2007:17).

If this can be construed as being any different from collaborative federalism, it would be that it further decentralizes social policy-making and weakens the federal government even more. Even though the Conservative's introduction of the Universal Child Care Benefit was done without provincial consultation, this was not in a shared area of responsibility. Beyond that, the Conservatives have chosen to reduce child care transfer amounts to the provinces negotiated by the previous government through the bilateral deals. This reduction of transfers was also made without any input from the provinces, but was in an area of shared responsibility. Therefore, it is hard to say whether the Conservatives will move to embrace their own open federalism model as far as child care is concerned, but to date this does not appear to be the case.

The Impact of Ideas
Overarching Ideational Framework
Again, it is likely too early to conclude that Canada has moved away from an inclusive liberal framework to something entirely new, however, Mahon does argue that recent decisions by the Conservative government appear to fall outside of an inclusive liberal rubric. She argues that the so-called Universal Child Care Benefit is much more neo- than social liberal because it rewards high income single breadwinner families more than working parents (2006:27). Further, she sees the new government's approach to past social policy initiatives in areas such as elder care and poverty as a move back to neo-liberalism by shifting responsibility for social well-being back to the family, market and community instead of an inclusive approach that would allow for state supports to improve labour market functionality (2006:28).

Partisan Ideology and Influence of Key Political Actors
While the Conservative government is more likely than the Liberals to approach social policy from a small 'c' conservative or neo-liberal position, its minority status likely softens this to a certain extent as successful federal governing parties in Canada historically stay closer to the centre of the political spectrum ideationally (Clarke et. al 1996). However, this means that the Conservatives are likely less open to any influence

from the Left in the area of social policy than would be the case under a minority Liberal government. To date there is no evidence of outside partisan influence.

The Role of Interests

Generally the same interest groups and coalitions remain in place from the previous child care period, although the Conservative's move away from the bilateral deals of 2005 and willingness to spend money on the UCCB instead of on the creation of child care spaces did prompt the formation of a new coalition in 2006 called Code Blue for Child Care (Integration Network Project 2007). Despite new activity, advocacy influence is likely lessened further by the presence of a more right-wing Conservative governing party that has traditionally been less open to child care advocacy both provincially and federally over the years.[34] The fact that the intergovernmental process has remained the same or is even further decentralized, would help to solidify this situation. Thus, while it is difficult to predict whether child care interests will eventually develop avenues of access under this new federal regime, early indicators suggest that this is unlikely.

The Policy Context of "Universal" Child Care Post 2005

Although these are early days under the new Conservative regime in Canada, all preliminary indicators from a neo-institutional perspective seem to suggest that any prospects for universality in the child care field are weaker in the current political context than in previous years when the bilateral deals were first negotiated. Even though the provinces appear to have more room to influence federal decisions, they have yet to be consulted on child care policy. The UCCB is clearly not a "child care" policy in anything but in name alone as the transfer of $100 per day/per child for children under six years of age can be spent on anything parents desire. What is clear is that the cost of monthly child care far exceeds the $1200 before tax benefit and it does not help create spaces or help parents find those spaces in their respective communities.

The Conservatives announced a Child Care Spaces Initiative in its 2006 and 2007 budgets. When it was first announced in the 2006 budget, the initiative offered businesses up to $250 million in tax breaks to create child care spaces and facilities on their own, bypassing the provinces altogether. To pay for this and the UCCB, the Conservatives also announced the cancellation of the bilateral agreements in 2006. However, since the child care spaces initiative program has yet to be operationalized, the Conservatives were forced to temporarily restore some of the child care transfer spending to the provinces in the 2007 budget to show they were addressing the spaces issue. Unfortunately, these transfers were greatly reduced from the original bilateral deals negotiated in 2005.[35] Despite the fact that the provincial transfers have not been completely halted, their decreased value has left the provinces scrambling to keep long-term child care commitments made since 2005, thus increasing the likelihood that some of these bilateral initiatives will be cancelled altogether.[36]

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[34] See Collier 2006.

[35] According to the CCAAC, the Conservatives have pledged $250 million per year to the provinces whereas the bilateral deals promised $1.2 billion, for a net loss of $950 million (CCAAC 2007).

[36] This has so far varied cross-provincially. Manitoba has pledged to make up for the federal short-fall on its own, while BC has pledged child care cuts in the wake of lost funding (see Manitoba 2007; BC 2007).

Conclusion

In summary, it appears that even though some progress was made toward the goal of a universal child care program in 2005, the current policy context does not seem conducive to ensuring that potential comes to fruition in 2007 or beyond. Much has changed since the introduction of universal hospital and medical care during the 1960s and these changes in federal structure and in ideational landscape have created obstacles for a new universal cost-shared program in Canada as opposed to greater opportunities. Even the movement made in 2005 on the child care file, was tenuous due to the state of intergovernmental relations and the instability in the overarching ideational culture and within the government itself. Those factors have yet to see improvement to the present day. It is clear, too, that the factors in place that produced the "golden age" of the welfare state in Canada are not on the horizon. Decentralizing movement away from cooperative federalism to collaborative and perhaps open federalism dims the prospects for federal leadership in areas of provincial responsibility. The fact that inclusive liberalism does not appear to have fully taken hold of the Canadian political culture, which remains open to neo-liberal ideology and practice, also works against the prospects for a universal child care program in the new millennium. Despite the fact that advocates are still committed to this goal, the policy framework does not give them a strong voice within the larger policy community. It appears that significant institutional and ideational change would be necessary to bring universal child care to Canada and this type of change is unlikely in the short term and even harder to predict in the long term.

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