HOME CARE:
CHANGE WE NEED

Report on the Ontario Health Coalition's Home Care Hearings

Carol Kushner
Patricia Baranek
Marion Dewar

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Dedicated to the Memory of Marion Dewar

Our fellow panelist, Marion Dewar, died very suddenly in September just as we were beginning to work on the final version of this report. We feel very lucky to have been on the receiving end of her wisdom, her humour, her unfailing support, her excellent cooking, and most of all, her profound commitment to social justice.

Marion Dewar 1928-2008

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Carol Kushner and Pat Baranek

Executive Summary

In January 2008, the Ontario government imposed its second province-wide moratorium on competitive bidding in home care. This decision encouraged the Ontario Health Coalition, with support from the Service Employees International Union to appoint a three-person panel (Carol Kushner, Patricia Baranek and Marion Dewar) to conduct public hearings on home care in five cities in Ontario: Toronto, Sarnia, Peterborough, Ottawa and Thunder Bay. In total, the panel heard 78 presentations and received 69 written submissions from individuals and/or organizations from across the sector including clients and caregivers, concerned citizen and public interest groups, front-line home care workers (personal support workers, nurses, therapists, and social workers), unions, and non-profit home care agencies. The panel regrets not hearing from the Ontario Association of Community Care Access Centres or any individual CCAC but understands that they are not permitted to engage in what might be perceived as advocacy. Also, although the panel regrets not hearing from any individual for-profit provider organization, it did receive a submission from the association representing their interests. The sponsors provided feedback on an earlier draft of this report; however, the panel was free to accept or reject this input in preparing this final version which should be considered independent.

Main Findings

Clients and caregivers expressed gratitude for having access to home care but also concerns about service sufficiency and properly qualified staff. They emphasized the need for more integrated care, how highly they value continuity of care and how both are adversely affected by the competitive bidding process. They expressed a preference for not-for-profit delivery. They raised fears about the consequences of complaining and their concerns about being pushed prematurely into facility care.

Citizens and Public Interest Groups identified key principles for home care such as respecting client choice and maintaining client independence and dignity, and emphasized the need for greater accountability, transparency and democracy in this sector. The requirement to divest direct service staff was seen as a waste of scarce resources. They criticized the competitive bidding process and its increasing reliance on for-profit agencies, warned about market concentration in the sector, and suggested that it might be time to consider new home care legislation.

Workers found home care work highly meaningful and, although they largely felt appreciated by their clients, they felt unappreciated by the system, citing job insecurity, low wages, and few, or no benefits. They described the negative impacts of casual 'elect-to work' employment, how the volatility of gas prices was affecting them, of traveling long distances without compensation for their time. While some could not get enough hours others had very high workloads as a result of their agency being short-staffed. Some told about starting over again at the bottom with a new agency having lost any seniority and often for lower wages. They objected to having to sign "gag" orders, and noted how competition had undermined cooperation among agencies. Many said work in a nursing

home or hospital offered better pay, guaranteed hours and more security. They spoke about high levels of stress at work and having to cope with unsafe working conditions. PSWs talked about the high costs of formal training, particularly in private schools.

Labour organizations noted that home care workers often lack the same protections other workers in the province have, pointing out that many have no pensions, no sick pay, no statutory holiday pay, and no right to severance or successor rights. While the vast majority of hospital workers belong to a union, union density in the home care sector is very low. Labour organizations advocated for a return to card–based certification to help improve the level of union representation in home care. Unions also criticized competitive bidding noting that its impact in driving down wages does not necessarily translate into public savings. For example, when the service volumes of one non-profit home support agency were transferred to five for-profit firms, all but one charged higher prices. The additional revenue, however, was not passed on to workers who, on average, were paid almost a dollar an hour less.

Provider Organizations noted multiple threats to the stability of the home care system including: the challenges of meeting goals with insufficient funding, very high turnover rates, the difficulties of attracting and retaining workers, an aging workforce, the lack of regular hours, large differences in the wages and benefits between home care and other health care sectors. They pointed out the risks of focusing on post-acute care clients (those discharged from hospital) at the expense of those with long term needs and applauded the province's recent decision to remove or raise service caps. They pointed out the absence of a level playing field with one noting, for example, that non-profit employers with a long history who lost a contract were subject to very high severance payouts while the for profit firms, as newcomers relying, in some cases, exclusively on casual labour, had no similar obligations. They pointed out that prices for home care have gone up since competitive bidding began but that service volumes have declined suggesting that the increased revenues have gone to profits or surpluses not to direct care. The high costs associated with competitive bidding were highlighted especially those associated with preparing bids and monitoring for quality.

System Issues Ontario is the only province relying exclusively on competitive contracting for professional and home support services and the only health sector in Ontario where direct patient care is contracted out, raising questions about the appropriateness of using market mechanisms to allocate home care contracts. Assessing bids and monitoring performance is very costly and involves significant challenges in measuring outcomes reliably and validly, especially when for-profit organizations are permitted to keep much of their information secret. Competition was also described as generating a climate of fear and reluctance to share best practices, and made it harder to attract and retain staff.

Conclusions and Recommendations

Home care needs to be seen as a strategic service, since its adequacy, quality and safety has a direct impact on our system as a whole and its total cost. The home care system described in the public hearings process revealed worried and even frightened clients, exasperated citizen and public interest groups, demoralized workers and a seriously destabilized provider community. While our report highlights evidence in each of the sections, which along with the submissions from the hearings, give rise to our recommendations, we note the serious need for more research and evaluation of this sector.

The following recommendations do not tackle all the concerns raised but they do reflect the panel's consensus about which are the most urgent and which can actually be implemented within a fairly short time frame.

Clients' Rights:

1. Home Care policy should respect client choice in the decision to receive care at home provided the total public costs for home care do not exceed the total public costs for care in a nursing home or hospital.

2. Ensure that clients are told about their rights to have a case review and to make an appeal if they are dissatisfied.

Addressing citizens' concerns about accountability and transparency:

3. As permitted by the current LHIN legislation, re-establish CCACs as non-profit organizations, restore their right to select their own boards, and hire their own CEOs.

4. Restore the right of CCACs to hire their own direct service staff where this option offers a more cost-effective alternative.

5. Outlaw gag orders and establish whistle-blower protection so workers can report their concerns about the quality and safety of home care.

Stabilize the workforce to protect continuity and quality of care:

6. As soon as possible, establish wage parity for all professional and personal support workers (sometimes called health care aides) so that new minimum wages reflect the average minimums paid in the nursing home and hospital sectors.

7. Immediately ensure that mileage rates paid to PSWs and homemakers reflect the volatility of gas prices (as well as the costs of wear and tear and

vehicle maintenance) and ensure parity in the mileage paid to all workers throughout the home care sector; within 18 months require that all home care workers be compensated for travel time, with the amount of compensation based on a proportion of their hourly rate.

8. Within 3 years, ensure permanent full-time work for at least 70 percent of all home care professionals, PSWs and homemakers.[1]

9. Within 3 years, ensure all home care workers are entitled to receive benefits, including a pension plan, health coverage (dental and drugs) and sick pay.

10. Immediately eliminate "elect to work" and ensure that all home care employees receive payment for statutory holidays, notice of termination and severance and create a regulatory requirement for successor rights.

11. Limit the proportion of workers without PSW certification employed by any agency offering home care to a maximum of 10 percent of its workforce.

12. Create a special provincial government fund to facilitate the implementation of recommendations 6-11.

To Address System Issues:

13. Given the increasing importance of home care as a strategic service in providing cost-effective care, ensure sufficient funding levels to meet client needs for homemaking, personal support and professional services.

14. Continue to establish province-wide standardized quality indicators, and set multi-year targets for improvement as part of the ongoing performance monitoring of home care delivery, and conduct comparisons of CCACs' performance.

15. Halt all competitive bidding by extending the current moratorium indefinitely and do not issue any new RFPs until recommendations 6-11 have been fully implemented. In the interim, protect service volumes for those who can demonstrate good employment practices and good quality of care and shift volumes away from those who cannot.

16. To further innovation, encourage LHINs to pilot and evaluate alternative models of allocation, reimbursement, and service delivery in home care.

[1] As noted, Manitoba has recently taken steps to ensure that 93 percent of all jobs in home care are full-time guaranteeing workers at least 75 hours over each two-week period. The 70 percent figure suggested here is a first step and is comparable to the target already set by the Ontario government for hospital nursing jobs.

Examples could include Veteran's Independence Program[2]; PACE[3]; and Balance of Care[4]; as well as direct service provision by CCACs.

17. Provide government funding to conduct a systematic evaluation of for-profit, not-for-profit and public home care delivery models.

18. Ensure a standardized curriculum for PSW training, an accreditation program for all public and private schools offering the program, and provide tuition assistance to ensure that home care clients have access to a skilled workforce.

19. Conduct ongoing human resources planning for the home care sector and establish a registration program for PSWs and homemakers so their employment within the system can be tracked.

20. Give serious consideration to the possibility of embarking on a process for legislative renewal in the home care sector.

[2] The Veterans Independence Program or VIP uses case management and client- based envelope funding to purchase services from approved providers; clients can opt to receive this funding and purchase their own care.

[3] PACE stands for " Program of All-inclusive Care for the Elderly and is a widely replicated American model using a capitated budget to serve all of the health needs of its participants, including hospital and nursing home care. It has demonstrated the viability of meeting care needs of its extremely frail elderly participants by maximizing access to community based services – especially through adult day centres, home care, home support and management of chronic conditions through primary care available at the adult day centres.

[4] Balance of Care was developed in the UK by David Challis as a method for determining which client in or waiting for long term care could be served cost-effectively with a tailored package of home and community care. It is currently being tested in Ontario by Paul Williams PI, CIHR Team Grant.

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1.0 Historical Context and Purpose of this Report

In January 2008, competitive bidding, the process for allocating health care resources to home care service providers, was suspended for the second time in its 10 year history.[5] The trigger for this action was the decision in December 2007 by the CCAC responsible for home care in Hamilton to disqualify two non-profit agencies with a long history of service provision in the region from making a bid.

Widespread protests followed this decision as home care workers and concerned citizens expressed their dismay at the treatment of these agencies: St. Joseph's Health Care and the VON-Hamilton. To date, no satisfactory reason has been provided for barring them from the competitive process. The explanation was a client-satisfaction survey, whose results unfavourably compared the quality of home care services in Hamilton to those in Niagara. This survey, however, has never been released to the public to determine, among other things, if the questions were appropriately worded or if there were even enough responders to provide a representative sample. Later, the VON was told that they were disqualified because their pre-qualifying document lacked "metrics", an issue which VON claims they could have easily addressed had they realized it was an essential element to qualify for making a bid.

In 2005, The Honourable Elinor Caplan conducted and reported the results of a major review of the procurement process in home care. While her mandate did not extend to reviewing the appropriateness of managed competition in home care, her final report did offer several recommendations for improving the processes of competitive bidding. Nevertheless, many client, caregiver and worker's concerns identified and addressed in the Caplan report are still very much in evidence today, three years after the Ontario government said it intended to implement her recommendations.

The imposition of the second moratorium (still in effect) has renewed hopes that the government might be prepared to reconsider both competitive bidding and other policies adversely affecting the sector's operations and future growth. At the end of May 2008, the government announced an important change in its policy governing the amount of home care service that could be approved by CCACs:

- Caps were completely eliminated on home care for persons requiring a long-term care bed.
- For all other home care clients, the cap was raised from 80 to 120 hours of service a month for the first 30 days, and from 60 to 90 hours a month after the first 30 days.

These adjustments are further examples that the government is open to the idea that home care has value as a strategic element in health care and that its availability can have an impact on other parts of the health system including emergency room use, hospital admission rates, nursing home placements and the total cost of care.

In May 2008, the Ontario Health Coalition, in conjunction with the Service Employees International Union, Canada, Local 1, announced that a series of hearings on home care in

[5] The first moratorium on competitive bidding was in effect between 2004 and the fall of 2007.

Ontario would be conducted by a three-person panel in June in five cities: Toronto, Sarnia, Peterborough, Ottawa, and Thunder Bay.

The panelists (the authors of this report) were: Marion Dewar, former mayor of Ottawa[6] and former MP: Patricia Baranek, PhD, a health services research and policy consultant who has written on home care reform in Ontario; and Carol Kushner, a health policy author and consultant who had been an advisor to the Senior Citizens' Consumer Alliance for Long Term Care Reform which held its own an extensive consultation process in 1992. Panelists were asked to submit a draft of their report to the sponsors for comment, but were assured that they were free to accept or reject this input and that the independence of their findings and recommendations would be respected.

Invitations to make a presentation and/or a written submission to the OHC's Home Care Hearings were widely circulated using newspapers ads and electronic networks. A discussion document to guide input was included with the electronic invitations, but participants were free to comment on other aspects of home care if they wished. All were welcome to participate.

Between June 9th and June 16th the panelists heard 78 individuals make oral presentations and by June 21st had received written submissions from 69 individuals and/or organizations. Presenters included home care clients, family caregivers, home care workers (personal support workers (PSWs), registered nurses (RNs), registered practical nurses (RPNs) and therapists), home care service agencies, academics, citizen groups, and representatives from organized labour.

Given the relatively short notice to participate, the panel was very pleased with this high level of participation, but regrets that there was no input from the OACCAC[7], any individual CCAC, or any for-profit agency.[8] Nevertheless, the panel did have the benefit of a wide cross-section of informed input and feels confident that its recommendations offer important elements in stabilizing the home care sector and in ensuring its future sustainability.

[6] This report is dedicated to the memory of Marion Dewar who died in September 2008 before our report had been finalized.

[7] The OACCAC explained that they are not permitted to do advocacy and felt that a presentation or written submission might be interpreted as such.

[8] The panel did receive a written submission from the Ontario Home Care Association representing for-profit home care and home help agencies.

2.0 Background Information about Home Care in Ontario

Home care in Ontario is largely publicly funded, but not subject to the *Canada Health Act* (CHA) or its five principles[9]. However, because home care sometimes substitutes for hospital care, which *is* subject to the CHA, this interpretation is open to challenge on the grounds that what ought to count is the type of care (i.e. medically necessary or medically required care) not the site of care.

Access to publicly funded home care in Ontario is through 14 Community Care Access Centres, statutory agencies established by the Ministry of Health and Long Term Care. CCACs receive their funding from 14 Local Health Integration Networks, who share the same geographical boundaries.

With respect to home care, CCACs are responsible for assessing client eligibility and needs for home care, for developing an appropriate care package of professional services (for example, nursing and therapy), personal care services and home support services, for providing information and referrals to community support services, and for on-going case management services, including reassessment and discharge. When the home is no longer deemed suitable for care, CCACs determine eligibility and arrange for placement into Long Term Care (LTC) facilities. Clients receiving home care also receive provincially funded prescription drug benefits and some of the supplies needed for their care are covered as well.

Provincial expenditures on home care in Ontario in 2005/06 were $1.41 billion, or 4.2 % of total provincial government health expenditures. In that year, 649,244 clients received home care and almost 26 million visits/hours of home care were provided. On any given day, about 185,000 clients are receiving home care.[10]

In 2005/06, the majority of clients were over 65 years of age (58%) with adults comprising 32% and children 10%. Personal support and homemaking services comprised 67% of total services provided, nursing 27% and therapy services 6%. [11] While the majority of admissions to home care are short stay (mainly post acute) clients, a snapshot of CCAC clients in 2006 reveals that over half were receiving long-term support and maintenance services.

CCACs do not, for the most part, provide in-home services directly[12]. Instead, they contract with home care service agencies in the private sector (both for-profit and not-for-

[9] These principles are called 'program criteria' in the Act and are universality, comprehensiveness, portability, accessibility, public administration.
[10] Ontario's home care system in 2008: A Growing History of Quality and Excellence. Ontario Home Care Association, June 2008
[11] Ibid.
[12] Despite provincial policies requiring CCACs to fully divest their direct care staff, a few CCACs continue to employ some staff, mainly therapists (OTs, PTs, Speech Language Pathologists, for example), especially in parts of the province where the lack of external provider agencies make contracting out impossible.

profit). Service provider agencies win the right to service volumes through a competitive bidding process. CCACs are responsible for managing and determining the outcomes of this competitive process and for monitoring the performance of successful provider agencies.

The Canadian Home Care Human Resources Study classified home care delivery models in Canada into four models. See Table 1.

Table 1: Care Delivery Models

Public-provider model (PP)	Professional and home support services are delivered mainly by public employees. Examples include Manitoba, Saskatchewan, Quebec, Prince Edward Island, Yukon, Northwest Territories and Nunavut.
Public-professional and private home support model (PHS)	All professional services are delivered by public employees. Home support services are contracted out to private not-for-profit and private for-profit agencies. Examples include New Brunswick, Newfoundland, and British Columbia.
Mixed public-private model	Streamlining functions are provided by public employees. Professional services are provided by a mix of government/RHA employees (predominantly) or through contracting out to private, third-party agencies. Home support services are contracted out to for-profit and not-for-profit agencies. Examples include Nova Scotia and Alberta.
Contractual model	Single entry coordinating functions are provided by employees in publicly funded Community Care Access Centres (CCACs). Professional services and home support services are contracted out by CCACs to private agencies (for-profit and not-for-profit) which provide care to consumers. This model reflects home care in Ontario as organized through its Community Care Access Centres.

As shown in this table, an exclusive reliance on contracting out for both professional and home support services occurs only in Ontario.[13]

[13] Canadian Home Care Human Resources Study (2003) http://www.cha.ca/documents/pa/Home_Care_HR_Study.pdf Accessed July 14, 2008.

3.0 Principles and Goals: What we heard

Twenty-two of the written and oral presentations received endorsed the need for Ontario's home care system to operate under a set of well-defined principles and goals. The principles identified reflected a great deal of consensus and are summarized here:

Principles

Ontario's home care program should:

1. Conform to the same principles as set out in the program criteria of the Canada Health Act which governs necessary hospital and medical care: universality, accessibility, comprehensiveness, portability and public administration.
2. Afford clients the right to choose their own home as the setting for care and support services.
3. Maximize the opportunities for health promotion, disease prevention and rehabilitation.
4. Support the independence and dignity of clients
5. Offer clients choices of having a different worker or agency when they are dissatisfied and ensure they know that their complaints will be addressed.
6. Ensure that resources for home care are determined by clients needs and not merely by the level of program funding.
7. Favour not-for-profit delivery.
8. Be accountable for offering high standards of care and service through active monitoring of performance.
9. Be transparent by ensuring public access to information about the operations and performance of the home care system.
10. Require responsive and accountable governance via local boards.

Goals

Many of the goals suggested for the home care program in submissions and presentations were actually quite similar in nature to the set of operating principles listed above. Much of this input did not address what is generally meant by the term "goals", i.e. what the home care program is expected to accomplish. For that reason, the panel opted instead to insert a set of three goals, adapted from the 2003 Canadian Home Care Human Resources Study,[14] which are widely understood to be the desired purpose of a home care program and to add a fourth, to recognize home care's role in palliative care.

- Maintenance and prevention, which serves people with health and/or functional deficits in the home setting, both maintaining their ability to live independently and, in many cases,

[14] Canadian Home Care Human Resources Study (2003) http://www.cha.ca/documents/pa/Home_Care_HR_Study.pdf Accessed July 14, 2008.

preventing health and functional breakdowns and eventual institutionalization.

- Long term care substitution, in which home care meets the needs of people who would otherwise require institutionalization; and,
- Acute care substitution, in which home care meets the needs of people who would otherwise have to remain in, or enter, acute care facilities.
- Palliative Care, in which home care meets the needs of clients who choose to die at home.

4.0 Key Issues

4.1 Client Concerns

What we heard

Clients emphasized that being able to stay at home to receive their care matters a great deal to them and that it contributes to their independence and preserves their dignity. The majority liked their caregivers and valued their work highly. However, others expressed concerns about their workers' level of competency and argued for more and better training, especially in caring for clients with Alzheimer's disease and other dementias but also for those managing clients with a mental illness or with complex medical needs. Most said they needed more service than they were currently getting and many long-stay clients had experienced cuts in the amount of care they received in spite of no change in, or even a worsening of their condition

> [My husband] can be quite difficult to care for – he is quite angry and easily upset. One man came in only once and won't come back again. I don't know why we're sent people without the necessary skills to provide this care.
> *Family caregiver*

> When my wife first became bedridden, they sent a nurse, but I was told there was a one-year wait for a personal support worker.
> *Family Caregiver*

Some explained how competitive bidding had affected their quality of life. A decrease in continuity and integration were cited most often. They talked about the devastating personal impact of losing their regular personal support worker when the employing agency lost its contract. Continuity of care, as defined by access to the same worker, was a particular concern among long-term clients requiring help with personal care but also among those who needed specialized nursing skills. Integration of care was also important; clients expected relevant information about their care to be known by new workers and resented having to explain things over and over to a succession of new ones. Most clients and caregivers at the Hearings expressed a strong preference for service from non-profit agencies. Most but not all, opposed competitive bidding and felt it diverted resources that could otherwise be spent on direct services.

> When you have a worker see the things they see, showering and bodily functions, you don't want to change workers. Some people pay to keep their workers.
> *Client with a disability*

Some clients and family caregivers expressed concerns about the long hours and low wages paid to workers in the sector. Caregivers said they also needed more flexible respite care options to help them avoid burning out.

> "My son's RPN earned $13.00 per hour. His RN earned $19.00 per hour. My cleaning lady makes $20.00 per hour. Something is wrong with our values!"
> *Family Caregiver*

At the same time, others said the system requires the families to do too much.

> I have a severe disability. When I got married, my services were cut down and all the work fell on my wife. … Thank God, she developed a disability because it meant we got more services.
> *Client*

Several nurses advocated for better home care and home support services for specific populations currently underserved by home care. For example, one who worked with patients with severe forms of mental illness noted that the decision to live independently often coincided with the onset of symptoms in late adolescence and that these individuals often had a urgent need for support in life skills that might not be obvious without a good assessment of their capacities. Another advocating for people with developmental disabilities noted problems associated with aging may occur at an earlier age than in the general population and thus an earlier need for support services.

Attitudes about means-testing and user fees for community support services varied with some people saying that fees are appropriate for homemaking and home maintenance and others arguing that such services should be available without charge based on need alone.

Several family members said that the nursing home option was being pushed by the home care agency inappropriately. Some said they were afraid to complain about the adequacy of service levels or the quality of care provided, because of fears they might lose access altogether.

> Are clients afraid to speak up? Absolutely.
> *Client*

What we know

Continuity of care is how one client experiences care over time as coherent and linked. Integration and continuity involve three related concepts: 1) informational – information about prior events used to give care that is appropriate to the client's circumstances; 2) relational – knowledge of the client as a person and the importance of an ongoing relationship between the provider of care and the client helping to bridge discontinuous events, and 3) management - to ensure that care from different providers is connected in a coherent way.[15] Consistency of care staff has been found to be an important element of continuity.[16]

Integration and continuity are important elements in care for any patient population group. However, these issues are more important for people who have chronic conditions or are vulnerable due to age or disability. Although there has been considerable evidence pointing to the changing nature of home care due to hospital discharges, it is sobering to remember that while the majority of admissions to home care through the CCACs are for short-stay clients, a snapshot of the CCAC caseload on April 1, 2006 showed that over half were receiving long-term supportive and maintenance services.[17] Furthermore, the majority (58%) of home care clients in 2005/06 were seniors.[18]

Evidence from a 2003 four-year study of elderly home care recipients in seven CCACs areas in southern Ontario found that of the four factors identified as constituting good and responsive care, "minimizing exposure" and "being known" were important along with "being able to speak" and "staying in charge." Due to the intimate nature of care, especially personal care, the change in providers and workers was especially upsetting to this group of home care clients.[19] Other research demonstrates that eligibility to care depended on resources rather than need thereby failing to make care client-centered.[20] The introduction of managed competition into the home care sector was seen to have reduced social connections and personal continuities that these elderly clients valued in the care they received. [21]

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[15] Reid R, J Haggerty, R McKendry (2002). Defusing the Confusion: Concepts and Measure of Continuity of Healthcare. CHSRF. http://www.chsrf.org/final_research/commissioned_research/programs/pdf/cr_contcare_e.pdf . Accessed July 17, 2008

[16] Aronson J, M Denton, I Zeytinoglu (2003). A follow-up study of Hamilton home support workers laid off in 2002. www.ocsa.on.ca/PFD/aronson. pdf Accessed July 17, 2008

[17] Ontario Association of Community Care Access Centres (2007) *Building Bridges to Better Health.* Submission to the Standing Committee on Finance and Economic Affairs. January 25, 2007

[18] OACCAC cited in Ontario Home Care Association (2008) Ontario's Home Care System in 2008: a Growing History of Quality and Excellence. June

[19] Aronson J (2003). 'You Need them to Know Your Ways': Service Users' Views about Valued Dimensions of Home Care. *Home Health Care Service Quarterly* 22(4): 85-98.

[20] Aronson J, C Sinding (2000) Home Care Users' Experiences of Fiscal Constraints: Challenges and Opportunities for Case Management. *Care Management Journals* 2(4): 1-6

[21] Aronson J & S Neysmith (1997). The retreat of the state and long-term care provision: Implications for frail elderly people, unpaid family carers and paid home care workers. *Studies in Political Economy.* 27(2).

Although there has been much evidence in other health sectors regarding client satisfaction of not-for-profit or public care versus for-profit care, little has been done in home care in Ontario. Reference has been made to an "Ontario-wide client satisfaction survey conducted by the CCACs." However, it has not been possible to obtain the study. A piece of academic research did, however, find that clients cared for by nurses from for-profit as opposed to not-for-profit agencies reported higher quality and satisfaction. Nevertheless, according to the study's own authors the findings while significant were small but more importantly due to sampling weaknesses were not generalizable to the broader home care population.[22]

[22] Doran, D., Picard, J., Harris, J., Coyte, P. C., MacRae, A., Laschinger, H., Darlington, G., and Carryer, J. (2004). *Management and Delivery of Community Nursing Services in Ontario: Impact on the Quality of Care and the Quality of Worklife of Community-based Nurses.* Canadian Health Services Research Foundation. *www.chsrf.ca*

4.2 Citizen and Public Interest Group Concerns

What we heard

Citizen groups and concerned individuals who presented at the Hearings contributed enormously to the principles set out in Section III. They also advocated for improvements to restore greater accountability, transparency, and democracy in Ontario's home care system.

They shared concerns about the lack of information about the contents of contracts between service provider agencies and the CCACs, deplored the elimination of CCAC boards, decried the decision to force CCACs to divest their direct service staff, pointing out that such decisions appeared to be ideologically driven given that they were imposed even though contracting out appeared to involve much higher costs.

> "Divesting the 50 or 60 OTs, PTs and social workers added some $513,000 in additional costs over and above what we had been paying – 9 percent of the total."
> *Former Vice Chair of a CCAC*

> The CCACs have gone underground. We don't know what they're doing. There are no longer community boards.
> *Nurse*

Competitive bidding and for-profit delivery were criticized on various grounds, including the lack of a level playing field, the fact that large for-profits may have access to private capital that allows them to low ball in the bidding, and even if unsuccessful in the first attempts, survive to bid again. Concerns about market concentration with large firms buying or forcing out small ones were raised along with worries that non-profit agencies were being forced to adopt similar practices in order to compete. One warned about the high prevalence of fraud among large international for profits, and recommended that previous convictions should be used as a screen to disqualify bidders.

Several groups praised the recent investments of the government in the Aging at Home Strategy, but also warned that this program had the potential to increase regional disparities as each region experiments with its own set of innovations.

Others with direct experience as former board members or Advisory Council members criticized the practice of imposing gag-orders on workers and called for an end to what was called a climate of fear and secrecy. Some focused on specific patient groups, such as those with a mental illness, and pleaded for a system that was more responsive to client needs. Others identified budgetary restrictions that limited access to home care as tantamount to age discrimination.

A few suggested that it was time to consider the possibility of legislative renewal in home care and to reopen debates about the relative merits of competing models of allocation and service delivery.

What we know

The strength of a country's civil society is an indicator of its social cohesion, which in turn is a factor that can contribute to individual health, healthy public policy and ultimately help to create the conditions for a vibrantly healthy society. [23] [24] For example, in Bowling Alone in America, Robert Putnam cites research showing that joining and participating in one [voluntary or social] group cuts in half your odds of dying next year.

One measure of the strength of civil society in Ontario has been the level of participation from citizen groups and individual citizens who over the past 20 years have demonstrated a sustained interest in sharing their views about home care. Over these two decades, Ontario has been subject to several waves of intense public consultation and probably received more submissions from public interest groups on home care than any other program area. Certainly, the views of citizen groups were instrumental in shaping the original legislation governing home care which passed into law in 1994 and was only amended this year.[25] The provisions for home care that remain in this Act – for creating integrated models of service delivery -- have never been implemented.

[23] Torjman, Sherri. Voluntary Sector Roles in Public Health, *Caledon Institute*, Toronto. April, 2008. http://www.caledoninst.org/Publications/PDF/672ENG.pdf Accessed October 10, 2008.
[24] Putnam, Robert. *Bowling Alone in America*. Simon and Schuster, 2000.
[25] Carol Kushner. Consumers and Health Policy Development: Confessions of a Guarded Optimist. *International Journal for Quality in Health Care*. 1996. 8 (5): 479-484.

4.3 Workers' Concerns

4.3.1 Wages and Benefits:

What we heard

PSWs who presented to the panel said they loved their work. They felt it was extremely important and very meaningful to them and to those they served. However, they also said that while they feel their work is highly appreciated by their clients, they do not feel valued or respected by the system.

> "Personal Support Workers care for people, not furniture."
> PSW

> "We are part of the health care system and want to be treated as such."
> *PSW*

Job insecurity posed by competitive bidding leaves them feeling very vulnerable every time contracts come up for renewal.

> Asked about how she would characterize stability in the system, one PSW replied, "Stability? What stability?"
> *PSW*

Low wages, poor or no benefits, including sick time and pensions, the lack of sufficient compensation for travel time and mileage were mentioned frequently throughout the hearings by PSWs. Many expressed concern that they performed the same work as PSWs in nursing homes and hospitals but were paid less and received fewer benefits. These conditions had already driven some of them to seek work in the institutional sector, mainly in long term care facilities.

> "Many young people are leaving the job because they aren't being treated right. A PSW in home care makes $11.00 per hour. Those in nursing homes make $15.00 per hour.
> *PSW*

> (After working in home care for 20 years) "I switched to a nursing home because the agency I was working for didn't have enough work for me and couldn't guarantee hours. Besides the work is less hard in nursing homes."
> *PSW*

Despite ever increasing gas prices, (and the closure of some community support agencies due to these prices) mileage rates paid to PSWs have not kept pace. Most quoted receiving 32 cents/km. A number questioned the policy of paying higher mileage to nurses, most of whom reported receiving 52 cents/km. As presenters indicated, both pay the same gas prices. One PSW said she got no mileage compensation at all and received only one dollar between each visit to compensate for her travel time. She said that all of the increase she received from the recent minimum wage guarantees ($12.50 an hour) has

gone into her gas tank. Given the low reimbursement for mileage and travel time, a number of PSWs said they felt that although they were already the lowest paid workers in the system, they were in effect subsidizing the care they provided to clients.

> ""I'd be better on welfare. I would be able to pay my rent and go to school for free."
> *PSW*

Both PSWs and nurses questioned why the home care sector was the only direct care sector where competitive bidding was allowed. From their perspectives, competitive bidding raised prices but lowered wages, increased the entry of for-profit agencies which were seen to push out long-standing not-for-profit agencies, and decreased the stability of the sector overall. The impacts of managed competition exacerbated the lack of parity already felt with the other health care sectors, in terms of job security, wages and working conditions. A number of presenters made the case that at a time when both hospitals and long term care facilities were also actively recruiting for permanent full-time staff at much higher compensation levels, the home care sector was becoming less and less attractive.

> "…eliminate competitive bidding. All it does is auction us off to the lowest bidder."
> *PSW*

Rehabilitation workers (physiotherapists) told us that they had always enjoyed co-operative relationships with OTs, nurses, PSWs and homemakers but that they have lost that open communication in the competitive system. They also said that the decision to divest rehabilitation services was very expensive for the system.

PSWs said that some agencies use untrained staff and pay them even less than certified workers. Presenters noted that PSW training courses are offered in community colleges, but also in private schools, often at highly inflated prices. Some PSWs said they had paid exorbitant fees (between $6000 - $10,000) for these courses.

What we know

A survey of home care workers, service providers and unions found that the two biggest concerns of working in home care were lack of hours/no job security (20%) and low wages (15%).[26] Other studies of home care workers indicate that low wages, lack of benefits and lack of job security were the three top reasons given for workers leaving the sector. Compensation for travel time was identified as one of the top three ways to

[26] Caplan, E (2005). *Realizing the Potential of Home Care: Competing for Excellence by Rewarding Results.* Government of Ontario, CCAC Procurement Review.

improve working conditions in the sector.[27] Trend data from the Colleges of Nurses of Ontario show that the percentage of part-time and casual work status was higher in community nursing than in hospital or long-term care. The increase in these job types over time was also highest in the community.[28]

Wage disparity is present between the home care sector and other health care sectors. The Ontario Association of CCACs found that community nurses were paid $4 to $7 per hour lower than hospital nurses and had inferior benefits packages. In additions, because community nurses are paid by the visit rather than on salary, their wages are much less predictable.[29] The evidence of the impact of managed competition in Ontario on wages has shown a decline in wages for both RNs and RPNs between 1995 and 2000.[30]

Within home care, a national study found that hourly wages differed according to union status and type of employer (government, regional health authorities, not-for-profit and for-profit). Consistently those working for government or regional health authorities received the highest rate of pay. The pay structure between NFP and FP agencies was mixed – RNs and RPNs typically received higher rates of pay in NFP agencies, while physiotherapists, occupational therapists, social workers and home support workers received higher rates in FP agencies. However, RNs and home support workers received significantly higher salaries in unionized agencies, while PTs, OTs, and social workers received higher pay in non-unionized settings.[31] An Ontario study showed that FPs paid lower gross RN wages compared to NFP agencies,[32] and another found that unionized workplaces paid the highest wages.[33]

An Ontario study found that working conditions tend to be better in NFP agencies. For example, more nurses (38%) from FP agencies were employed on a casual basis than those working for NFP agencies (25%); more nurses from NFP agencies were employed full-time than those from FP agencies (35% vs. 25%). Lastly, significantly more nurses

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[27] Canadian Home Care Human Resources Study (2003). http://www.cha.ca/documents/pa/Home_Care_HR_Study.pdf Accessed July 14, 2008.

[28] CNO. Registered Nurses In The General Class Employed in Nursing in Ontario. Practice Sector by Working Status.

[29] JPNC Implementation Monitoring Subcommittee, 2004. *Good Nursing, Good Health The Return on Our Investment*. Progress Report. November 2003. http://www.health.gov.on.ca/english/public/pub/ministry_reports/nursing_roi_04/jpnc_roi_2004.pdf. Accessed July 10, 2008, 3:16 p.m.

[30] Zarnett, Dara., Laporte, Audrey., Nauenberg, Eric., Doran, Diane. and Coyte, Peter. "The Effects of Competition on Community-Based Nursing Wages" *Paper presented at the annual meeting of the Economics of Population Health: Inaugural Conference of the American Society of Health Economists, TBA, Madison, WI, USA*, Jun 04, 2006 <Not Available>. 2008-06-2

[31] Canadian Home Care Human Resources Study (2003) http://www.cha.ca/documents/pa/Home_Care_HR_Study.pdf Accessed July 14, 2008.

[32] Zarnett et al. (2006) *Ibid.*

[33] Aronson, J et al.(2004) Market-Modeled Home Care in Ontario: Deteriorating Working Conditions and Dwindling Community Capacity. *Canadian Public Policy* 30(1).

from NFP agencies than from FP agencies were reimbursed for mileage (85% vs. 70%) and for travel time (61% vs. 25%).[34]

Nurses report higher satisfaction with their work and the time they can spend with clients when they are paid on an hourly rather than on a per visit basis. Nurses from NFP agencies were more likely to be paid on an hourly basis than their counterparts in FP agencies who were more often paid on a per visit basis.[35]

[34] Doran, D., Picard, J., Harris, J., Coyte, P. C., MacRae, A., Laschinger, H., Darlington, G., and Carryer, J. (2004). *Management and Delivery of Community Nursing Services in Ontario: Impact on the Quality of Care and the Quality of Worklife of Community-based Nurses.* Canadian Health Services Research Foundation. *www.chsrf.ca*

[35] Doran et al. (2004). *Ibid.*

4.3.2 Staff Shortages

What we heard

Many PSWs who presented at the Hearings said their agencies had lost many workers and were having trouble attracting new hires.

> "Our agency is trying to hire staff but only offering $11.00 an hour. So no one wants to work for that."
> *PSW*

As a result of staff shortages, some were being asked to care for 7 or 8 clients a day and putting in 12 hour days. Some reported that their agencies offered sign-on bonuses as high as $2,000 but even so were still having trouble getting and keeping staff because of the job demands, low wages/benefits and high job insecurity.

> "I love my job and I love my clients, but I really can't afford to do this anymore. I have no family life and no future."
> *PSW*

Most of the PSWs who presented at the hearings said they were planning to leave the home care sector (or had already done so) because they simply could not afford to remain under current conditions. Most suggested that guaranteed full-time hours, permanent positions with benefits, and better travel compensation (mileage and travel time) would stave off the drain of workers from the sector. Wage parity with those doing similar work in long term care facilities and hospitals was especially singled out as essential to help with recruitment and retention.

> In recent weeks, I have talked to many PSWs and most of them are threatening to either leave the industry or refuse to drive to many of our distant clients."
> *PSW*

However, PSWs and nurses also said the system needed to ensure more realistic assessments of the actual care time clients needed. Both groups said they often felt they had to rush through their work to the point where they felt quality of care was compromised. These working conditions are said to be well known and contribute to difficulties in attracting and retaining staff.

Nurses from St. Joseph's Home Care (SJHC) and the VON in Hamilton explained that the competitive bidding process breeds fear and creates staffing shortages. They noted that in 2004 (the last bidding period) SJHC seriously underbid in a desperate attempt to win a contract. Their success in winning a large market share in that round of bidding meant the company had locked itself into a barely viable contract for 3 years. The January 2008 province-wide moratorium on competitive bidding was imposed following a decision by the CCAC to disqualify St. Joseph's Home Health (and VHA Hamilton) from even making a bid in December 2007.

> "Since December of last year, roughly 30% of our nurses at SJHC have quit and left the Home Care sector entirely citing insecurity and wage disparity as their reasons for leaving."
> *RN (SJHC)*

The Ontario Nurses' Association (ONA), the largest nursing union in the province, also asserted that competitive bidding has resulted in fewer RNs providing direct patient care in home care. For those that remain, workloads have increased. The prevalence of casual employment in home care was also cited as a factor driving nurses to seek employment in other sectors, especially hospitals.

What we know

Governments recognize that recruitment, retention, and tenure of workers in the health sector are of concern in general but these issues are more pressing in the community health sector. Most of the human resource data in home care is for nursing, although personal support workers make up the majority of the workforce in this sector.[36]

Community nursing is becoming less attractive as a career option due to the lack of support it receives.[37] The steady growth of nurses in the community sector in the 1990s reversed in 1999 with a loss of 24% of nurses in this sector between 1998 and 2004, coinciding with the introduction of managed competition.[38] Along with this the community nursing workforce is aging. Results of a Canadian survey indicated that

[36] This is likely due to the absence of a profession-specific college and status within health care.
[37] Alamaddine M, A LaPorte, A Baumann, et al. (2006). 'Stickiness' and 'inflow' as proxy measure of the relative attractiveness of various sub-sectors of nursing employment. *Social Science and Medicine* 63: 2310-2319
[38] Alamaddine M, A Baumann, L O'Brien-Pallas et al. (2006). Where are nurses working in Ontario? Employment Patterns by Sub-sector in Ontario, Canada. *Healthcare Policy* 1(3): 65-86.

community nurses were significantly older than hospital nurses.[39] Between 1993 and 2004 the percentage of nurses under the age of 44 dropped from 60% to 45%.[40]

These data are also reflected in turnover and retention of workers in home care. In a context of human resource shortages, managed competition in home care must rely on the movement of workers from the unsuccessful employer to the successful one. Studies in Ontario since the inception of competitive bidding do not support this supposition. In the early days of managed competition, CCACs and home care providers reported turnover rates between 20% to 75% for RNs and 16% to 61% for RPNs. Of those leaving community nursing, 40% took jobs in the hospital or long term care sector.[41] A study funded by the Ontario Ministry of Health and Long-Term Care compared the impacts of its managed competition model to that of Nova Scotia's long-term contract model. It was found that 57% of displaced workers in Ontario left the home care sector.[42] Another case study of three NFP home care agencies between 1997 and 2001 showed that 52% of nurses and PSWs left their agency. Of those who sought employment, only one-quarter remained in home care.[43] Similar findings were reported in instances of workers being laid off when their agency lost their bid.[44] [45] [46]

The length of tenure in jobs and turnover rates in the Canadian home care sector has been shown to vary by type of employer and by union status. Tenure was longest with government or regional health authority employers and for unionized employees. Employment status also affected the length of employment with full-time workers staying in their jobs the longest and casual workers staying the shortest amount of time. Moreover, those in the FP sector were more likely to leave than their counterparts in the public and NFP sectors.[47] Other studies have shown that public employees have significantly lower turnover rates than non-unionized private sector home care workers, half of whom were shown to leave their jobs annually.[48]

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[39] Cameron, S., Armstrong-Stassen, M., Bergeron, S., and Out, J. (2004). "Recruitment and retention of nurses: challenges facing hospital and community employers," *Canadian Journal of Nursing Leadership, 17(3): 79-92*.

[40] Alamaddine M, A Baumann, L O'Brien-Pallas et al. (2006). Where are nurses working in Ontario? Employment Patterns by Sub-sector in Ontario, Canada. *Healthcare Policy* 1(3): 65-86.

[41] Ontario Association of Community Care Access Centres, (2000). *Human Resources – A Looming Crisis in the Community Care System in Ontario*. Human Resource Task Group

[42] VON News Release, 2006. Competitive Structure Prompts Exodus Of Over 50% Of Contractually Affected VON Home Care Workers From Delivering Client Care, Ottawa – February 3, 2006

[43] Denton M, I Zeytinoglu, S Davies, D Hunter (2006). The Impact of Implementing Managed Competition on Home Care Workers' Turnover Decisions. *Healthcare Policy* 1(4):106-123.)

[44] Aronson, J et al. (2004). Market-Modeled Home Care in Ontario: Deteriorating Working Conditions and Dwindling Community Capacity. *Canadian Public Policy* 30(1).

[45] OCSA (2000). Briefing Note: The Effect of the Managed Competition Model on Home Care in Ontario: Emerging Issues and Recommendations.)

[46] Aronson J, M Denton, I Zeytinoglu (2003). A follow-up study of Hamilton home support workers laid off in 2002. www.ocsa.on.ca/PFD/aronson. pdf Accessed July 17, 2008

[47] Canadian Home Care Human Resources Study (2003). http://www.cha.ca/documents/pa/Home_Care_HR_Study.pdf Accessed July 14, 2008

[48] Shapiro, E. (1997). *The Cost of Privatization: A case study of home care in Manitoba.* Report for the Canadian Centre for Policy Alternatives. December 1997.

One region of Manitoba, (NorMan) successfully addressed staff turnover and restored stability in the sector by increasing the proportion of FTE (full-time equivalent) home care workers to 93 percent, guaranteeing the vast majority working in the sector 75 hours of work for every two week period. The remaining 7 percent of NorMan's home care workforce is employed on a casual part-time basis which they found was necessary to facilitate scheduling. Based on this demonstrable success, in July, 2008 the government asked to re-open the union contracts to negotiate the same terms for the province as a whole.[49]

Job satisfaction was an overriding factor in retention of home care workers. Levels of job satisfaction in this sector have decreased since the inception of managed completion.[50] Other than job security, low wages and poor benefits, the layered structure of home care in Ontario seems to be adding to the lowering of satisfaction rates. The addition of case managers in the CCACs is seen to limit nurses' autonomy and their ability to use clinical judgment or practice to their full scope.[51]

[49] Personal communication by Marion Dewar with Manitoba Home Care Program, July 25, 2008
[50] Denton M, I Zeytinoglu, K Kusch, and S Davies (2007). Market-Modelled Home Care: Impact on Job Satisfaction and Propensity to Leave. *Canadian Public Policy* 33(2): 81-99.)
[51] JPNC Implementation Monitoring Subcommittee, 2004. *Good Nursing, Good Health: The Return on Our Investment*. Progress Report. November 2003. http://www.health.gov.on.ca/english/public/pub/ministry_reports/nursing_roi_04/jpnc_roi_2004.pdf. Accessed July 10, 2008,

4.3.3 Rights of Labour

What We Heard

PSWs said that they had no pensions or paid holidays and most did not receive severance when laid-off. Union representatives said this was because home care workers are not considered subject to the *Employment Standards Act* (ESA) and therefore have none of the protections afforded other health workers in the province under this *Act.*

PSWs and nurses both complained that when they switched to a new employer, their years of prior experience did not count, they lost seniority and had to start all over again at the bottom of the wage scale. Unionized representatives clarified that successor rights[52] have not been established for the home care sector.

PSWs also noted that employment with a new agency often meant they had to wait a long time to build their client base and many found this very discouraging. Some also reported that when their original agency lost its contract they ran into financial difficulties because of the long waiting period for EI.

Many PSWs described the negative impact of being casual employees under "elect-to-work" policies. This status made them feel particularly insecure because "elect-to-work" meant they had to be available round the clock but never knew how many hours of work they would have in a given week. Apportioning available work also seemed to be very uneven. Some PSWs reported only receiving 2 or 3 hours of work a day, while others put in long days starting at 7:30 am and ending well into the evening. Elect-to-work also meant no public holidays, notice of termination or severance pay. One mentioned that "elect to work" policies meant that workers could cherry-pick the easiest clients and refuse to care for others.[53]

The panel was informed that this is chiefly an issue for PSWs and less so for nurses who are less likely to work on a casual basis. It was also noted that only for-profit agencies use "elect-to-work" and that this was perhaps the most clear- cut difference between these different types of organizations.

Several union representatives, similar to other participants, also commented that large for-profit firms were in a position to low-ball on the bidding at first and then raise prices later. However, they indicated that these price increases were not getting passed on to workers, who are among the lowest paid, and least secure workers in health care. Several union representatives also talked about the high costs of preparing bids and the additional

[52] Successor rights are labour code provisions which allow a bargaining agent to continue to represent employees in a bargaining unit and also allow for the continuation of collective agreements (until the term expires) when a cohesive business or function is sold, transferred or otherwise divested. The successor employer becomes responsible for its predecessor's rights, privileges and duties towards the employees under the collective agreement. Treasury Board of Canada Secretariat, *Successor Rights and Obligations*. http://www.tbs-sct.gc.ca/Pubs_pol/hrpubs/TB_858/SRO1-1E.asp#wha. Accessed July 28, 2008.

[53] Others felt that this choice was more theoretical than real and that PSWs did not feel free to turn down work when it was offered.

administrative costs for CCACs in managing the competitive process, both of which divert scarce resources from direct service provision.

> "The Ontario health system is kept functioning by the dedication and commitment of health care workers."
> *Ontario Federation of Labour*

From their perspective, good employment practices are often absent in the sector and that competitive bidding is little more than a strategy to ensure cheap labour at the expense of the lowest paid, least secure workers in our system. To begin to address this, workers and their unions felt that all home care workers should have pension benefits, sick pay, holiday pay, and severance as well as successor rights.

Representatives from organized labour pointed out that in contrast to other health care sectors, most home care workers are not unionized and that this lack of protection has left them very vulnerable to poor labour practices.

In their written submission to the Hearings, the Ontario Federation of Labour told us that when workers attempted to unionize at ComCare in Kingston and WeCare in Sarnia, the companies closed. The OFL argued that a return to card-based certification would be of enormous help in assisting workers to assert their right to organize.[54]

What we know

Experts have found that job insecurity (increases in short and part-time workers) is an outcome of creating markets in labour intensive services.[55] The protection afforded to workers through unionization is minimized in the Ontario home care sector. In contrast to the hospital sector, where the majority of waged-employees belong to a union, home care remains significantly unorganized. Of the 30,000 home care workers in Ontario, only 8,316 belong to one of 10 different unions. The Service Employees International Union Local 1 Canada represents the single largest block with 4,815 members. [56]

Representation by a union also varies by the corporate status of the employer, with non-profit agencies more likely to have unionized employees. To the extent that for profit agencies increase their market share in Ontario, and in the absence of successor rights, which would require new employers to respect the union's representation rights and honour seniority, wage and benefit levels from the previous employer, it is expected that

[54] In card-based certification, signed membership cards are used as an indication of support for unionization and certification by the Ontario Labour Relations Board is granted when a certain threshold is reached. This system prevailed in Ontario until 1995 when it was replaced by a vote-based system.
[55] Burchell, B (2002). The Prevalence and Redistribution of Job Insecurity and Work Intensification, in B Burchell, D Lapido and F Wilkinson (eds.), *Job Insecurity and Work Intensification.* London: Routledge.
[56] Provided by Erinn Graham-Barter, staff, SEIU ACWCC September 9, 2008.

fewer and fewer home care workers will have union representation. While some would argue this will keep costs down, it is important to remember that this sector is already poorly paid compared to comparable workers in other health sectors and that the largest portion of this workforce, PSWs, are some of the lowest paid in all of health care.

Others contend that in sectors where labour is the highest cost, the thrust of managed competition is to drive down wages as earlier evidence showed. This is easier achieved in a non-unionized workforce. However, this does not necessarily translate into savings for the public purse. One set of researchers argue that the closing of the Hamilton VHA (a NFP agency with a unionized workforce that had been in operation for 70 years and provided 58% of all home support in the area) in 2002 was due to a loss of service volumes and a refusal of the CCAC to adjust its reimbursement of services. While under no obligation to renegotiate terms in mid-contract, other CCACs in the province had exercised this discretion in response to unforeseen changes that threatened agencies' viability. As a result, the Hamilton CCAC transferred VHA clients to five other home support providers. Four of the five agencies, all FPs, charged the CCAC higher prices for their services than the VHA. The fifth charged the same price. The mean hourly rate for workers who moved to FP agencies was lower than the VHA rate by almost a dollar per hour. The higher rates charged to the CCACs were not passed on to front line workers. The authors argue that the higher service mark-up is unsurprising given these agencies' responsibilities to their shareholders.[57]

[57] Aronson J, M Denton, I Zeytinoglu (2003). A follow-up study of Hamilton home support workers laid off in 2002. www.ocsa.on.ca/PFD/aronson. pdf Accessed July 17, 2008.

4.3.4 Work and Safety Issues

What we heard

Some PSWs reported injuries (mainly due to heavy lifting) and said they did not have the luxury to take time. With no sick pay benefits they could not afford to book off when work was offered. They noted that the personal care work in home care is much harder than in a nursing home where there are other workers and equipment to help with transfers.

Several also reported experiencing severe stress associated with their working conditions (too much work and too little time) and lack of job security.

Conditions in the home environment sometimes posed health and safety problems for workers. Some presenters mentioned specific examples such as finding dwellings in poor repair, evidence of infestations (insects and mice), aggressive pets, and unsanitary conditions.

Dealing with aggressive and sometimes abusive clients has contributed to workers feeling unsafe. They expressed the need for special training to manage these types of patients.

What we know

Within community nursing, an Ontario study found that home care nurses not only reported greater concerns with working conditions but also safety issues than CCAC case managers or public health nurses. Safety issues were related to the physical and hidden aspects of the client's home as well as work-related injuries.[58] A Workers Safety and Insurance Board study in Ontario supported these findings; i.e. that a number of physical health problems were commonly identified among home care workers. These injuries and illnesses were much higher than among a comparable population in the general population. The health problems included back pain, arthritis and rheumatism, musculoskeletal disorders, migraine headaches, high blood pressure, stomach and intestinal problems, cancer, harassment, and violence.

Home care workers work primarily in elderly or sick client's homes, hidden from oversight. As a result, they are vulnerable to unacceptable racial/ethnic/sexual comments or harassment.

[58] Armstrong-Stassen M, S Cameron (2005). Concerns, satisfaction and retention of Canadian community health nurses. *Journal of Community Health Nursing*. 22(4): 181-194.

Workers are also subject to stress from high levels of job insecurity.[59] Other experts have found increased occupational stress with the introduction of managed competition because of organizational change, job insecurity.[60]

[59] Denton, M. (2003). *Organizational Change and the Health and Well-Being of Home Care Workers*. Workplace Safety and Insurance Board. *www.wsib.on.ca*

[60] Denton M, I Zeytinoglu, and S Davies (2003). Organizational change and the health and well-being of home care workers. *Research Paper No. 110.* Hamilton: SEDAP, McMaster University.

4.4 Provider Organization Concerns

What we heard

Provider Organizations told us that the current system of home care is not sufficiently client-centered. Too often the services available are insufficient to meet client needs, sometimes resulting in an over-reliance on family and friends to provide care.

They noted that home care's priority focus on clients with acute care needs comes at the expense of those requiring long-term care for chronic conditions or needing personal supports due to mental illness, disability or the frailty of aging. They worry that as the demand for care increases, continued insufficient funding will mean even more rationing of care for these most vulnerable clients.

Underfunding and competitive bidding were seen to affect recruitment and retention of workers, and the achievement of what were considered to be the ultimate goals of home care. Representatives felt that home care's role in preventing, delaying, or substituting for long-term facility care and hospital and medical services is under-appreciated in our system as a whole. This lack of understanding has given home care relatively low priority in budgets.

Provider organizations said that competitive bidding is creating enormous human resources challenges in terms of recruiting and retaining workers in the home care sector, a problem everywhere in the province but even more pronounced in rural and remote areas. Some home care agencies require the successful completion of a PSW training course and certification. In some instances, provider agencies have paid for this training, only to have their certified workers leave for jobs in other sectors. Very high turnover rates were seen as a direct result of managed competition. As a result agencies were bearing very high costs to recruit and retain staff. Many workers leave the sector and some leave health care altogether when their employers lose a contract. This has a system-wide impact at a time when staff shortages are evident in hospitals, long term care facilities and in home care.

They talked about the aging workforce in home care, where more than half are over 40 years of age, the lack of parity in wages and benefits, the lack of job security, and being unable to offer staff regular hours, all of which threaten the sector's sustainability now and into the future.

> Some service provider organizations [in home care] are reporting worker turnover rates of 25-40%....the average turnover rate for health workers in Canada is 12%.
> *Ontario Community Support Association*

The expansion of the for-profit sector in home care was seen as a major concern. Market concentration has in effect created a market oligopoly as small agencies with specialty

niches and non profits have lost significant service volumes or disappeared altogether. Prices for home care have increased substantially since competitive bidding began, but service volumes have declined suggesting that higher prices have gone to profits or surpluses, not to direct care.

Provider organizations noted that the competitive environment has led to increased secrecy with agencies' reluctant to share best practices in the sector. These practices are seen to be the very elements that might provide them with a competitive edge.

One agency described the situation in Ontario as "ultra-competition" because there's only one buyer – the CCAC – "and if you lose a contract, you're done for because that's where 90 percent of your business comes from."

Agencies, similar to workers, pointed out that although the system expects staff to move to new employers when their previous one loses a contract, this doesn't always happen and that fact alone severely compromises continuity of care.

> "We know for a fact that a large number of laid- off staff leave the sector….to provide a real example, …when an agency providing homemaking services lost its contract, about 128 workers lost their jobs. The new provider actively recruited these workers, but fewer than 40 chose to move to the new provider, leaving 70% of the existing clients without their *workers."*
> *Ontario Community Support Association*

One organization (VON Ontario) pointed out the incompatibility between Ontario's Health Human Resources Strategy and the effects of Competitive Bidding for nurses. The table 2 below summaries the impacts of the two.

Table 2: Impacts of the HHR Strategy versus the RFP Process

HHR Strategy	RFP Process
70% of nurses working FT	Competition decreases # of FT jobs
Recruitment and retention	Wage inequities, little money for training and continuous education
Creating healthy work environments	Little job security
Expanding roles and maximizing scopes	Needs are assessed twice (by CCACs and service providers)

The recently announced Aging at Home Strategy was welcomed by all. Some had reservations about whether it might actually increase disparities between one region and

another as individual LHINs implement widely varying approaches to service innovations.

Several providers organizations were encouraged when the government instituted a second moratorium on competitive bidding in early 2008 but noted that this meant that in its almost 10 year history, managed competition had actually been in effect for only about half that time. They pointed out that during the moratoria, existing contracts could not be improved (except for cost-of-living adjustments) and that this had, in fact, worsened the disparities between home care and other health care sectors.

> Two years ago, [we] managed to squeeze a small increase from the CCAC but our per visit reimbursement remains paltry by comparison to other agencies in the region.
> *Service Agency*

One provider organization referred to the much higher costs of severance payments for older well-established agencies, a factor contributing to the uneven playing field in competitive bidding between older and newer agencies. Some provider organizations indicated that they simply could not afford to lose more service volumes and stay in business.

Most referred to the lack of transparency from the CCACs in terms of what was specifically required for a successful bid. Some argued that the larger firms had figured out how to satisfy the quality requirements (on paper, at least) and that what really counted in winning a contract was the price.

Some service agencies talked about the very high costs associated with competitive bidding, including the amounts agencies incurred in preparing their bids and the resources required by CCACs to manage the bidding process and monitor performance.

Several presenters (e.g. OCSA and the Red Cross) offered specific suggestions for reducing the negative impacts of competitive bidding in home care by: clarifying quality indicators based on client outcomes, improving monitoring to ensure performance expectations are met; and, if not, establishing a timeframe for improvement, which, if not met, would result in contract termination. Competition according to this model would be limited to those circumstances where a provider lost a contract due to poor performance, or when a provider voluntarily withdraws from a contract. Only those volumes would be subject to tender. Competitive bidding could also occur in this model when service volumes have increased in a particular CCAC area, or if new dollars become available to solve system-wide problems in LHINs. Both provider organizations felt that these changes would improve continuity of care and limit the number of workers exiting the sector due to contract loss.

What we know

Much of the evidence regarding the recruitment, retention and turnover of home care staff has been dealt with in earlier sections of this report.

There is evidence that the home care sector has changed since the introduction of managed competition. Between 1995 and 2001, the market share of FP home care nursing increased from 18 to 48%.[61] What was once largely a sector of NFP agencies with deep roots in the community is now dominated by large NFP and FP organizations, often without a former presence in the community. The market in this sector is becoming increasingly concentrated. In 1995 there were eight organizations that held 66% of the contracts. By 2004, six corporations held 76% of contracts.[62] Increasingly concentrated markets are not suited to competition. Besides the reduced number of competitors, smaller agencies with fewer resources are unable to ride out the loss of a contract.

The bidding process for provider agencies is costly. The process is not only time consuming but the average cost to responding to a single RFP has been calculated between $10,000 to $20,000,[63] and at $30,000.[64] Others have estimated the cost of contracting out and competitive bidding to be 19.4% of nursing agency expenses, 12% of home support agency's expenses, and 21.7% of CCAC expenses.[65] In addition, most CCACs have on average two staff to manage the process and between 5 to 12 additional staff to read and rate submissions.[66] These funds are redirected away from care in the absence of valid evaluation of the benefits of competition.

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[61] Doran, D., Picard, J., Harris, J., Coyte, P. C., MacRae, A., Laschinger, H., Darlington, G., and Carryer, J. (2004). *Management and Delivery of Community Nursing Services in Ontario: Impact on the Quality of Care and the Quality of Worklife of Community-based Nurses.* Canadian Health Services Research Foundation. *www.chsrf.ca*

[62] Ontario Health Coalition (2005). Market Competition in Ontario's Home Care System: Lessons and Consequences. March 31, 2005

[63] Browne, Paul Leduc. 2000. *Unsafe Practices: Restructuring and Privatization in Ontario Health Care.* Ottawa: Canadian Centre for Policy Alternatives. 103) in Status of Women, Canada. Trade Agreements, Home Care and Women's Health. http://www.swc-cfc.gc.ca/pubs/pubspr/0662360565/200403_0662360565_2_e.html. Accessed July 10, 2008.

[64] Ontario Community Support Association (2000). *The Effect of the Managed Competition Model on Home Care in Ontario: Emerging Issues and Recommendations.*

[65] Sutherland R (2001) The Costs of Contracting Out Homecare: A behind the scenes look at homecare in Ontario. CUPE Research

[66] Ontario Community Support Association (2000). *The Effect of the Managed Competition Model on Home Care in Ontario: Emerging Issues and Recommendations.*

4. 5 System Issues

What We Heard

The impact of competition between for-profits and not-for-profits

This topic was raised again and again by most presenters, and most often in a negative context. Several presenters noted that Ontario is the only home care system in Canada that relies exclusively on managed competition and competitive bidding among for-profit and not-for-profit provider agencies as the mechanism for allocating home care contracts. Many submissions questioned the appropriateness of relying on marketplace mechanisms in home care and offered perspectives about its negative impact on the culture of home care, continuity and quality of care, and the ability of the sector to recruit and retain staff.

Lack of Cooperation and Fear

Many noted that competitive bidding had changed the culture of home care. They said that cooperation was impeded when service providers were, in fact, competitors. The competitive spirit has diminished the sharing of best practices, made the integration of services more challenging, and bred an atmosphere of fear. In some cases, workers are explicitly prohibited from criticizing home care policies. One agency required workers to sign an oath of confidentiality preventing them from telling the public about problems with homecare services. This was further supported in a document submitted to the Hearings.[67] Workers told us that clients and caregivers were reluctant to make complaints for fear of being denied service.

> "Clients are afraid to complain as they might lose what little help that they have. 'Don't rock the boat' is a favourite expression because they are truly afraid."
> *PSW*

Problems with Quality

Many submissions emphasized that quality is notoriously difficult to assess in health care, and even more so in the home care sector, which affords little opportunity for direct supervision and monitoring. There are no benchmarks for performance, no baseline standards for home care provision and no simple methods for determining the relationship between client outcomes and the quality of care received. Sector-wide, standardized data collection remains a challenge.

Instead, we heard again and again that the system has relied extensively on proxy measures of quality, including: case managers' paper reviews and limited site visits, and

[67] Ontario Health Coalition. Market competition in Ontario's homecare system: Lessons and Consequences. March 31, 2005.

client satisfaction surveys. Many submissions rejected the repeated assertion that bids are assessed on the basis of quality first (75%) and price, second (25%). The view of many was that the assessment of quality in bidding proposals was based more on what was written in the proposal rather than actual monitored performance.

Reimbursement Methods

Several presenters pointed out that the reimbursement methods used in home care create incentives that may compromise the quality of care, particularly when they are conflated with allocation methods. For example, professionals (RNs, RPNs, social workers, dieticians and therapists) are funded to receive a set fee per visit, which encourages the volume of clients seen in a given day, sometimes at the expense of the time these clients actually need. Some presenters argued for an hourly wage instead, with the amount of time allocated according to the client's actual need.

However, many PSWs who are paid an hourly wage reported that some of their clients needed more time than had been allotted and the workers felt they had to rush through their work. Several said that a one-hour visit was insensitive to clients' needs for human contact.

Others argued for a completely different allocation method, a set amount based on client-needs. The individual client needs-based envelope of funding could then be used to pay workers or be provided to clients to purchase services from their choice of pre-approved providers as is the case in the V.I.P program for Canadian Veterans.

Layers of Bureaucracy and Opportunities for Streamlining

Many presenters at the Hearings told us they felt there were too many layers of bureaucracy in the current system and criticized the enormous costs associated with having home care funding flow through four separate layers of financial administration: from the MOHLTC to the LHINs to the CCACs and then to the home care service agencies. Several identified duplication of effort, particularly in client assessments and reassessments.

Several had suggestions for streamlining this arrangement through major structural change:

- Some thought a merger between CCACs and LHINs would be desirable, and perhaps even inevitable, as the costs of having separate agencies became clear to the LHINs and as evidence mounted about disparate or duplicative programming between the LHIN-managed Aging at Home Strategy and CCAC services.
- Even more presenters suggested that the MOHLTC should reverse its policy on divestment, and have CCACs hire their own home care staff and become direct service providers. Desirable features of doing this included: avoiding the costs of competitive bidding for most service volumes; setting limits on for-profit service delivery; having case managers and service providers working out of the same

office; allowing for more timely assessments; and reassessments and better communication.

- Still others regretted the demise of the multi-service-agency (MSA) model for home care delivery and would like to see it resurrected, under a new name. Features of this model considered desirable are similar to those in the bullet above but also included a restoration of democracy and local control via democratically elected boards.

Testing out different programs for providing a community support service is now being encouraged in the Aging at Home Strategy but we were also told that home care itself could benefit from some experimentation with different models.

In fact, some presenters believe the timing is ripe for embarking on work for a new Home Care Act, pointing out that all existing contracts with service provider agencies terminate in December 2009. Also, they note that what remains of the old *Long Term Care Act, 1994* following the recent passage of the new *Long Term Care Homes Act, 2007* governing LTC facilities is the re-named *Home Care Act* which still contains many of the provisions related to the creation of MSAs, which have never been implemented. Furthermore, the new LHIN legislation amends the *Community Care Access Corporations Act, 2001*, to permit the Lieutenant Governor in Council and the minister to re-organize CCACs and return them to non-profit boards under provisions of the Corporations Act; allows a CCAC in the future to select its own board of directors as well as hire its executive director; removes the requirement for CCACs to have community advisory committees while retaining the ability to establish committees of the board that they consider appropriate; and allows the government to broaden the CCAC mandate to permit an expanded role in the future.[68]

What We Know

In order to fully appreciate the system issues in the Ontario home care sector, it is necessary to understand the workings and prerequisites of competitive markets and service provisions by for-profit and not-for-profit providers. Ontario is the only province in Canada to use competitive contracting exclusively for professional and home support services.[69] Moreover, home care in Ontario is the only *health* sector where direct patient care is contracted out.

To begin with, it is important to understand the distinctions between financing, delivery, and allocation. With respect to *financing*, direct patient home care (nursing, rehabilitation, and personal support) is publicly funded. Community support services such as transportation, meals-on-wheels are publicly funded but can have a portion that is

[68] Ministry of Health and Long Term Care. McGinty Government Introduces Legislation to Address Local Health Care Needs. Backgrounder. www.health.gov.on.ca/english/media/news_releases/archives/nr_05/bg_112405_2.pdf Accessed September 19, 2008.

[69] Canadian Home Care Human Resources Study (2003). http://www.cha.ca/documents/pa/Home_Care_HR_Study.pdf Accessed July 14, 2008.

privately paid by the client. The *delivery* of home care services is done by private not-for-profit and for-profit service providers, both of which can be either small businesses or large corporate structures. *Allocation* is the method for flowing funding (in this case, by government) to providers and can range from direct funding (as in community support services) to competitive contracts through intermediary structures (e.g. CCACs). It is important to keep in mind that competition is not the same as privatization, although they often go hand in hand. You can privatize funding or delivery and you can have competition amongst public, not-for-profit, and/or for-profit providers.[70] In this report, we are interested in the rationale of *public financing* of *for-profit and not-for-profit home care delivery* of services through a *competitive bidding process*. In Ontario, this is called managed competition, where governments provide Community Care Access Centres (CCACs), through the Local Health Integration Networks (LHINs), a global budget from which they are to purchase services from for-profit and not-for-profit service providers through a competitive contracting process.

Delivery: Private For-Profit versus Private Not-For-Profit?

The literature on the relative efficiency and quality of outcomes between for-profit and not-for-profit delivery deals largely with other health sectors such as hospital care and nursing home care and although results can be mixed, they largely favour not-for-profit provision. See Deber 2002 for an extensive review of this literature. Table 3 outlines some of the characteristics of not-for-profit, small business for-profit, and for-profit corporations.[71]

Table 3: Characteristics of Not-for-Profit, For-Profit (small) and For-Profit (corporate)

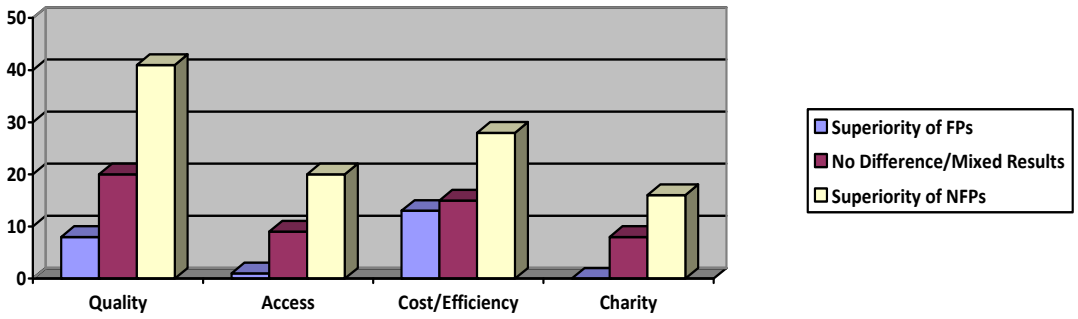
Not-for-Profit	For-Profit (small)	For-Profit (corporate)
Usually have multiple objectives over and above particular service provision including community service	Service provision and profit (surplus)	Service provision with strong emphasis on profit maximization; i.e. maximize revenue and minimize costs
Can run a surplus – reinvested in business (i.e. wages, training, community service, etc.)	Profit – not required to provide return on investments to shareholders	Profit – expected to provide return on investments to shareholders
Have access to tax exemptions	Pay taxes	Pay taxes
Can attract charitable donations and volunteers	Usually cannot attract charitable donations and volunteers	Cannot attract charitable donations and volunteers
Can go bankrupt	Can go bankrupt	Can go bankrupt
Do not use 'elect-to-work'	Use 'elect-to-work'	Use 'elect to work'
Limits on lobbying and political funding	Can lobby and make political donations	Can lobby and make political donations
Can integrate volunteer services with government funded services	Do not typically provide volunteer services	Do not typically provide volunteer services

[70] P Baranek, R Deber, and AP Williams (2005). *Almost Home: Reforming Home and Community Care in Ontario.* Toronto: University of Toronto Press; R Deber, (2002). *Delivering Health Care Services: Public, Not-for-Profit, Private?* Commission on the Future of Health Care in Canada. Discussion Paper No. 17.; Sutherland R (2005) Quality and the Competitive Market: A Case Study of the Purchaser Provider Split in Ontario's Home Care Services. Health Policy Paper. April 2005.

[71] Adapted from R. Deber (2002). *Ibid.*

A review of two decades (1980-2000) of research comparing for-profit vs. not-for-profit health provision (149 studies) in the US found not-for-profit superior to for-profit on the whole. In 77% of the studies, not-for-profits were found to be either superior on cost/efficiency or there was no observed difference from for-profits; 59% found not-for-profit superior in terms of quality while only 12% found the for-profits superior; 67% found not-for-profits to be superior in terms of access to care; 67% found that not-for-profits do better on charity care (defined as uncompensated care provision). Moreover, data on changes over the 20 years saw the performance of for-profits converging with not-for-profits only in the area of access.[72] See Figure 1.

Figure 1: Comparison of For-Profit versus Not-For-Profit Health Care Provision.



One Canadian study reviewed the international research literature comparing the relative performance of for-profit and not-for-profit continuing care organizations. The literature was reviewed for the impact on costs, quality of care, and such intangibles as volunteers, and civic society.[73] Results are shown below in Table 4.

Table 4: Impact of for-profit services on continuing care

Long-term Care Institutions	Home care Services
Health care costs Government costs ***reduced initially then may well increase*** Overall costs ***likely to be increased***	**Health care costs** Government costs ***likely to be increased*** Overall costs ***Likely to be increased***
Quality of care Patient outcomes ***worse*** Staff turnover ***increased***	**Quality of care** Patient outcomes ***worse*** Patient/family satisfaction ***worse*** Staff turnover ***increased***
Intangibles Continuing education ***decreased*** Volunteers ***likely decreased*** Civil society ***likely decreased***	**Intangibles** Continuing education ***decreased*** Volunteers ***likely decreased*** Civil society ***likely decreased***

[72] Vaillancourt Rosenau P, Linder S (2003). Two Decades of Research Comparing For-Profit and Nonprofit Health Provider Performance in the United States. *Social Science Quarterly* 84(2): 219-241.
[73] Rachlis M (2000). The Hidden Costs of Privatization: An International Comparison of Community Care. A report written for the Canadian Centre for Policy Alternatives. BC Office. September 25, 2000

It is a truism to say that for-profit organizations, especially corporate structures, need to make profits. However, in human services, especially health care, there are few avenues for making a profit. Organizations can introduce economies of scale and better management practices. However, it is more likely that they will maximize billings; minimize labour costs (i.e. reduce number of staff, care hours, wages and benefits); avoid unionization; and minimize spending on non-profitable activities (i.e. servicing high cost clients; providing services in low volume areas; staff training; providing free community service).For example, studies of long term care facilities in Ontario[74] and British Columbia[75] show that not-for-profit homes provide more hours of direct care and support per patient than for-profit homes. In home care, where the majority of expenses are labour costs, lowering costs is usually at the expense of workers and outcomes for clients. For example, a British Columbia[76] and Manitoba [77]studies found that for-profit LTC facilities had higher hospital admission rates for several quality of care related diagnoses such as anemia, pneumonia, dehydration. Government regulations can control these tendencies, but at a cost which draws away from client service.[78]

Services regardless of whether they are provided by public, private for-profit or private not-for-profit organizations should be monitored and performance should be measured. Monitoring and measuring, particularly public funding of not-for-profit and for-profit organizations is important to ensure that surplus/profits are not at the expense of quality, working conditions, and false economies. However, performance monitoring is easier in sectors where outcomes are reliably and validly measured. In health care, measuring outcomes is complex and costly. The question must be asked, "If it is difficult to measure outcomes in home care and there are very few avenues for making a surplus/profit that do not harm clients or workers, why should we give public dollars to organizations that have to maximize profits?"

Aside from the issue of profits, growing evidence suggests that not-for-profit providers have a better record of providing services in the interest of clients if this requires going beyond the precise terms specified in contracts.[79] For example, patients of for-profit hospices in the US received significantly narrower range of services (noncore or discretionary services) than patients of not-for-profit hospices.[80]

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[74] Berta W, A LaPorte, V Valdemanis (2005). Observations on institutional long-term care in Ontario. *Canadian Journal of Aging*, 24:70-84.

[75] McGregor M, M Cohen, K McGrail, et al. (2005). Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter? *CMAJ* 172(5): 645-649.

[76] McGregor M, R Tate, K McGrail et al. (2006).Care outcomes in long-term care facilities in British Columbia, Canada: Does Ownership matter? *Medical Care* 44:929-35.

[77] Shapiro E, R Tate (1995) Monitoring the outcomes of quality of care in nursing homes using administrative data. *Canadian Journal of Aging*, 14:755-68.

[78] R Deber, (2002). *Delivering Health Care Services: Public, Not-for-Profit, Private?* Commission on the Future of Health Care in Canada. Discussion Paper No. 17

[79] Bendick, Marc, Jr. 1989. Privatizing the delivery of social welfare services: an ideal to be taken seriously, in *Privatization and the Welfare State*, edited by Sheila B Kamerman and Alfred J Kahn. Princeton, NJ, Princeton University Press. pp. 97-120.

[80] Carlson m, W Gallo, E Bradley (2004). Ownership Status and Patterns of Care in Hospice: Results from the National Home and Hospice Care Survey. *Medical Care* 42(5): 432-438.

When measurability is low, this willingness to do more can produce superior outcomes. "As the literature has noted, it is important to distinguish between high-trust and low-trust models; at a certain stage, it might be wisest to adopt the concept of stewardship and encourage those providers who, because they have goals other than profit maximization, can ensure needs are met even if purchasers have not clearly specified them."[81]

Interestingly, Ontario experimented with for-profit and public delivery of correctional services. However, in this instance, they developed a five year pilot with two correctional facilities that were identical in design and would house similar inmates. An evaluation of the pilot was conducted to determine if there was any advantage to for-profit operations of correctional services. The evaluation found that the publicly operated facility performed better in key areas such as security, health care and reducing re-offending rates. As a result, the government decided to allow the contract with the for-profit provider to expire and transfer the operation of the facility to the public sector.[82] It is not clear why home care recipients are not afforded the same level of thoughtfulness in policy and program design as offenders.

Allocation: Competition

Competition is an allocation mechanism that is rooted in markets. Markets require a purchaser and provider split and work well:

- when there are low barriers to entry and exit,
- where there are multiple provider organizations competing,
- where there is more than one funder of services, and
- in areas where service outcomes are easily and reliably measured (because competition is based on some ratio of best quality, best price).

Competition requires a split between the purchaser and provider. The creation of the CCACs required that they divest themselves of staff who provided services directly. In some areas of the province the only rehabilitation services being provided were by the home care agency (predecessors of CCACs). The legislation required that the newly formed CCACs divest their rehabilitation therapists and hold competitions among these newly independent providers. According to Randall and Williams this increased the cost of rehabilitation services in those areas.[83]

Markets work well when there are low barriers for organizations to enter and exit a market; e.g. where large capital investments are not required, such as in equipment or technology, to provide a service or where equipment can be used for other purposes if the organization loses a bid. One could argue that for most home care services where the

[81] Raisa Deber, Steven Lewis (2007)**.** Thoughts on the Day: Strategic Purchasing and Equity. *HealthcarePapers***,** 8(Sp): p.117, citing Saltman and Ferroussier-Davis 2000; Saltman et al. 2002

[82] Ministry of Community Safety and Correctional Services (2006). Central North Correctional Centre Transferring to Public Sector Operation. Canadian News Wire April 27. http://ogov.newswire.ca/ontario/GPOE/2006/04/27/c1439.html?lang=_e.html

[83] G. Randall & AP Williams (2006). Exploring limits to market-based reform: Managed competition and rehabilitation home care services in Ontario. *Social Science & Medicine* 62:1594–1604

largest proportion of costs are human resource costs, the barriers to entry or exit are low. However, one of the barriers to enter a market is consumer preference and trust of providers. As a result while the small amount of capital investments make it easy to enter and exit the home care market, client preference and trust in long established home care providers, such as the VON in Hamilton, raise barriers to entry and exit.

Competition also requires excess capacity in providers. In some of the areas of the province there is only one provider, negating the possibility of competition for services. Similarly, in labour intensive services competition works well where there is either an excess of human resources (e.g. nurses, personal support workers) to provide a service or where training or professional requirements do not create barriers to the ready access to human resources. An overall shortage of nurses and higher wages and benefits in the institutional health sector (nursing homes and hospitals) for nurses and personal support workers create a shortage of workers in the home care sector. In theory, workers are to migrate from an employer who is unsuccessful in a competition to the one that has won the bid. However, given the high demand and low supply of nurses and personal support workers and the lower wages/benefits in the home care sector, there is mounting evidence that rather than migrate to new employers, workers are leaving the sector.[84] Deber [85] also points out that given the complexity of care in the home and the requirements of coordination with other sectors, home care is probably not a sector of care where one wants to encourage disposable providers.

Competitive markets may also be hard to sustain, particularly when only one purchaser exists, such as the provincial government (through the LHINs and then the CCACs) in home care. Most organizations require predictable and ongoing revenues. The issue is the sustainability and viability of an organization if it loses a contract. Given the low entry and exit requirements for organization, only the large for-profit and not-for-profit one can afford to be unsuccessful in one area. Their viability as a chain is assured by contracts in other areas. However, smaller single operator organizations, usually the ones with deep roots in the community, are the potential losers. In addition, to eliminate competition, large corporate organizations have the professional and financial resources to write successful proposals and to underbid the competition, even if it means sacrificing profits for this contract. For example, when Manitoba put 10% of its home care personal support market out to tender, only one bidder (Olsten Health Services) was able to provide the services cheaper than the public sector. Olsten Health Services, was a subsidiary of a US-based multinational company which at the time was the largest home care provider in the US. The question at the time was, "was it able to provide services less expensively or was

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[84] VON News Release, 2006. Competitive Structure Prompts Exodus Of Over 50% Of Contractually Affected VON Home Care Workers From Delivering Client Care, Ottawa – February 3, 2006; Aronson, J et al. (2004). Market-Modeled Home Care in Ontario: Deteriorating Working Conditions and Dwindling Community Capacity. *Canadian Public Policy* 30(1); Ontario Home Health Care Providers Association and Ontario Community Support Association (2000). *Home Care Worker Compensation*. September http://www.ocsa.on.ca/PDF/Homecareworker.PDF ; Ontario Community Support Association (2000). *The Effect of the Managed Competition Model on Home Care in Ontario: Emerging Issues and Recommendation.* Briefing Note. http://www.ocsa.on.ca/PDF/brief-Managed_care.PDF

[85] R Deber, (2002). *Delivering Health Care Services: Public, Not-for-Profit, Private?* Commission on the Future of Health Care in Canada. Discussion Paper No. 17

the Manitoba contract a loss leader to gain a foothold in the province?"[86] The irony is that one of the prerequisites of competition, i.e. the existence of multiple providers, will eventually translate into a few large corporations or chains. Studies in Ontario show that since the inception of managed competition there has been a growing concentration of service provider organizations as stated earlier in the report.

Competition for most services is usually based on some balance of quality of service and price, and as a result the ability to measure and monitor performance is required. Price is relatively easy to measure. However, in health and social services, including home care, measurability of outcomes and quality is complex and much more difficult. When measurability is low, monitoring is much more expensive and time consuming.[87] The evidence in Ontario is that CCACs have not been diligent in the ongoing monitoring of contracts. The Auditor General in Ontario found in two separate audits that necessary processes were not in place to ensure service quality requirements were being met.[88] As one researcher points out the cost of monitoring contracts is part of the CCAC's operating budget. With tight budgets, it is not unreasonable to expect that funding for client care would displace contract monitoring.[89] In addition, it is hard to monitor contracts with FP providers because they are allowed to keep much of their information secret. As one researcher indicated this makes it more difficult to monitor for fraud – Olsten had to pay the US Government $61 million for fraudulent billings.[90]

To maximize the use of publicly funded services, government and research agencies have been promoting the dissemination of evidence-based care and best practices. However, competition engenders secrecy. Information and best practices are proprietary and are not shared as they may provide the competitive edge for an organization. While organizations in other health sectors communicate their best practices, this is no longer prevalent in the home care sector since the advent of competition for contracts.

Proponents of managed competition claim that it has generated innovation in home care. Examples offered include telephony, GPS systems, digital wound photography, electronic point of care documentation, tele-monitoring, personal digital assistants in the home, leadership excellence programs for staff, accreditation, experiential research linking care to quality outcomes for clients and new models of care (such as home infusion clinics, home care in the ER, home care linkages in primary care, nurse practitioners in home care, adapting environments and providing supports to rehabilitate and enable

[86] Shapiro, E. (1997). *The Cost of Privatization: A case study of home care in Manitoba.* Report for the Canadian Centre for Policy Alternatives. December 1997.
[87] Raisa Deber, Steven Lewis (2007**.** Thoughts on the Day: Strategic Purchasing and Equity *Healthcare Papers***,** 8(Sp): p.117, citing Saltman and Ferroussier-Davis 2000; Saltman et al. 2002
[88] Auditor General, Ontario (2004). 2004 annural Report of the Office of the Provincial Auditor of Ontario to the Legislative Assembly. Toronto: Queen's Printer.
[89] Sutherland R (2005). Quality and the Competitive Market: A Case Study of the Purchaser Provider Split in Ontario's Home Care Services. April.
[90] Sutherland R (2001). *The Costs of Contracting Out Home Care: A Behind the Scenes Look at Home Care in Ontario*. CUPE Research, February.

independence in the home and community through falls prevention programs and comprehensive functional/cognitive assessments. [91]

This is an odd list given that most of these examples of innovation claimed to be a result of managed competition are, in fact, currently offered in systems across Canada that rely extensively on public and/or not for-profit home care delivery and which do not use competitive bidding to assign service volumes for professional services at all.

Studies on contracting out in BC suggest that the hoped-for savings from these policies were offset, if not erased altogether, by lower productivity, higher turnover, and other hidden costs to the health care system.[92]

Competition and For-Profit Delivery

For-profit organizations, particularly the corporate structures, are motivated to maximize profits. Savings are usually made through:

- selecting easier to serve clients,
- not entering markets with low volumes or other high service costs such as travel costs in rural and remote areas,
- lower wages for workers usually achieved through keeping unions out,
- part-time work and therefore, the lack of benefits for workers,
- using lower skilled workers,
- not providing training for workers, amongst others.

To overcome these tendencies, governments have to put in place restrictions and regulations to minimize the selection of clients and geographic areas, mandate minimum wages, provide incentives to increase full-time employment and hence benefits, and require credentialed workers.

Given the above discussion, the overriding questions remain, "In the absence of strong evidence, why are we diverting public funding to for-profit providers, especially corporate for-profit organizations?" and "What are the clear advantages of competitive markets in health care?"

[91] Ontario Home Care Association. Ontario's Home Care System in 2008: A growing history of quality and excellence. June 2008. pages 10-11.

[92] Browne, Paul Leduc. 2000. *Unsafe Practices: Restructuring and Privatization in Ontario Health Care.* Ottawa: Canadian Centre for Policy Alternatives. 103) in Status of Women, Canada. Trade Agreements, Home Care and Women's Health. http://www.swc-cfc.gc.ca/pubs/pubspr/0662360565/200403_0662360565_2_e.html. Accessed July 10, 2008.

5.0 Conclusions

More than ever home care needs to be seen as a highly strategic service helping clients to restore their health and maintain and improve their independence and level of functioning, avoid or delay the need for specialist, facility or hospital care. In other words, the adequacy, quality and safety of home care services have a direct impact on the functioning of our system as a whole. Home care, is of course, not one service, but many different types of service, with the unifying feature being where the care is delivered. Increasingly, health systems in Canada and internationally are recognizing that the ways in which home care programs are set up, funded, and delivered can have profound financial and service consequences. But regardless of the structure, one thing is clear: if the system is unable to attract and retain qualified, dedicated staff it will never be able to achieve its potential.

And yet, the home care system described during these public hearings and in the written submissions revealed worried and even frightened clients, exasperated citizen and public interest groups, demoralized workers and a seriously destabilized provider community.

The following recommendations do not tackle all the concerns presenters raised during the Hearings and in their submissions and mentioned in this report. Instead, they zero in on our consensus about which are the most urgent and which might actually be implemented within a fairly short time frame.

6.0 Recommendations

Clients' Rights:

1. Home Care policy should respect client choice in the decision to receive care at home provided the total public costs for home care do not exceed the total public costs for care in a nursing home or hospital.

2. Ensure that clients are told about their rights to have a case review and to make an appeal if they are dissatisfied.

Addressing citizens' concerns about accountability and transparency:

3. As permitted by the current LHIN legislation, re-establish CCACs as non-profit organizations, restore their right to select their own boards, and hire their own CEOs.

4. Restore the right of CCACs to hire their own direct service staff where this option offers a more cost-effective alternative.

5. Outlaw gag orders and establish whistle-blower protection so workers can report their concerns about the quality and safety of home care.

Stabilize the workforce to protect continuity and quality of care:

6. As soon as possible, establish wage parity for all professional and personal support workers (sometimes called health care aides) so that new minimum wages reflect the average minimums paid in the nursing home and hospital sectors.

7. Immediately ensure that mileage rates paid to PSWs and homemakers reflect the volatility of gas prices (as well as the costs of wear and tear and vehicle maintenance) and ensure parity in the mileage paid to all workers throughout the home care sector; within 18 months require that all home care workers be compensated for travel time, with the amount of compensation based on a proportion of their hourly rate.

8. Within 3 years, ensure permanent full-time work for at least 70 percent of all home care professionals, PSWs and homemakers.[93]

[93] As noted, Manitoba has recently taken steps to ensure that 93 percent of all jobs in home care are full-time guaranteeing workers at least 75 hours over each two-week period. The 70 percent figure suggested here is a first step and is comparable to the target already set by the Ontario government for hospital nursing jobs.

9. Within 3 years, ensure all home care workers are entitled to receive benefits, including a pension plan, health coverage (dental and drugs) and sick pay.

10. Immediately eliminate “elect to work” and ensure that all home care employees receive payment for statutory holidays, notice of termination and severance and create a regulatory requirement for successor rights.

11. Limit the proportion of workers without PSW certification employed by any agency offering home care to a maximum of 10 percent of its workforce.

12. Create a special provincial government fund to facilitate the implementation of recommendations 6-11.

To Address System Issues:

13. Given the increasing importance of home care as a strategic service in providing cost-effective care, ensure sufficient funding levels to meet client needs for homemaking, personal support and professional services.

14. Continue to establish province-wide standardized quality indicators, and set multi-year targets for improvement as part of the ongoing performance monitoring of home care delivery, and conduct comparisons of CCACs’ performance.

15. Halt all competitive bidding by extending the current moratorium indefinitely and do not issue any new RFPs until recommendations 6-11 have been fully implemented. In the interim, protect service volumes for those who can demonstrate good employment practices and good quality of care and shift volumes away from those who cannot.

16. To further innovation, encourage LHINs to pilot and evaluate alternative models of allocation, reimbursement, and service delivery in home care.

Examples could include Veteran's Independence Program[94]; PACE[95]; and Balance of Care[96]; as well as direct service provision by CCACs.

17. Provide government funding to conduct a systematic evaluation of for-profit, not-for-profit and public home care delivery models.

18. Ensure a standardized curriculum for PSW training, an accreditation program for all public and private schools offering the program, and provide tuition assistance to ensure that home care clients have access to a skilled workforce.

19. Conduct ongoing human resources planning for the home care sector and establish a registration program for PSWs and homemakers so their employment within the system can be tracked.

20. Give serious consideration to the possibility of embarking on a process for legislative renewal in the home care sector.

[94] The Veterans Independence Program or VIP uses case management and client- based envelope funding to purchase services from approved providers; clients can opt to receive this funding and purchase their own care.

[95] PACE stands for " Program of All-inclusive Care for the Elderly and is a widely replicated American model using a capitated budget to serve all of the health needs of its participants, including hospital and nursing home care. It has demonstrated the viability of meeting care needs of its extremely frail elderly participants by maximizing access to community based services – especially through adult day centres, home care, home support and management of chronic conditions through primary care available at the adult day centres.

[96] Balance of Care was developed in the UK by David Challis as a method for determining which client in or waiting for long term care could be served cost-effectively with a tailored package of home and community care. It is currently being tested in Ontario by Paul Williams PI, CIHR Team Grant.