Still Waiting:

An Assessment of Ontario's Home Care System After Two Decades of Restructuring

Ontario Health Coalition

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The Ontario Health Coalition encompasses more than 400 organizations, thousands of individuals and more than 50 local health coalitions. Our membership includes health professionals, nurses, doctors, patients and patient advocacy groups, non-profit health and social services, unions, student groups, ethnic and cultural organizations, seniors' organizations and many others. We are a broad-based non-partisan advocacy organization and network dedicated to safeguarding and improving our public health system under the principles of the Canada Health Act.

Ontario Health Coalition
15 Gervais Drive, Suite 305
Toronto, Ontario M3C 1Y8
Tel : 416-441-2502
ohc@sympatico.ca
www.ontariohealthcoalition.ca

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Misguided Priorities

After Decades of Restructuring Ontario's Home Care System Remains Ad Hoc and Insufficient

In December 2010, the Annual Report of Ontario's Auditor General included an audit of Ontario's home care system.[1] In it, the Auditor General found that home care in Ontario is inequitable, insufficient and ineffectively measured and managed. Among the issues uncovered in the 2010 audit are unresolved problems previously identified in the 2004 audit and even as far back as the 1998 audit. These are not insignificant issues. Problems unresolved for more than a decade include huge wait lists, unequal access to care, poorly tracked patient services, uncertain quality of care and high administrative costs. Though home care has been repeatedly reformed since the mid-1990s, changes made by policy makers have not addressed these problems though they are central to the very purpose of our home care system. The auditor's findings reveal a failure by successive governments to make accessible public home care their priority. The priorities reflected in home care reform are the result of misguided priorities and an imbalanced decision-making process that has eschewed democratic input, transparency and public accountability.

Since the beginning of competitive bidding in home care, successive governments have claimed that the system was dedicated to improving quality of care rather than simply cutting costs and facilitating privatization. Instead, 15 years after the inception of competitive bidding in home care, the same problems of inadequate and rationed services, poor and inequitable access to care, ineffective or non-existent measurement of community need for service, high administrative costs, serious staffing shortages, privatization and ineffective measurement of quality and service delivery continue to plague Ontario's home care system. Today, home care in Ontario remains ad hoc and insufficient.

The Ontario Health Coalition has released four reports on home care in Ontario since 2001 covering the last decade of home care restructuring.[2] As with the findings of the provincial auditor, virtually all of the problems identified in our four previous reports remain true today.

Ontario's home care system has been strained by two major policy shifts in recent decades. First is the movement of thousands of sicker and more complex patients out of hospitals to home care, which has been seen by policy makers as a cheap alternative to hospital-based care. At the same time there has been dramatic reform of the structures governing and managing home care.

For the better part of the last two decades, Ontario governments have pursued policies centred on cutting hospitals. At the same time, governments have failed to create and enforce clear standards for accessible quality home as patients are moved to the community. In effect, the continual failure to establish a clear right to access medically necessary home care amounts to an erosion in the scope of

[1] Ontario Auditor General *2010 Annual Report* December 6, 2010: Chapter 3; Section 3.04, pps 113-131.

[2] See: Carol Kushner, Patricia Baranek, Marion Dewar *Home Care: Change We Need Report on the Ontario Health Coalition's Home Care Hearings* November 17, 2008 http://www.web.net/~ohc/home carereportnov1708.pdf; Ontario Health Coalition *Market Competition in Ontario's Home care System: Lessons and Consequences* March 31, 2005 http://www.web.net/~ohc/Home care2005/home care%20paper%20final%20for%20release.pdf ; Ontario Health Coalition *"Dip and Skip" A Supplement to the June 2001 Report on Home care in Ontario* November 22, 2001 http://www.web.net/~ohc/docs/dipandskip.pdf ; Ontario Health *Coalition Secrets in the House: Home care Reform in Ontario 1997-2000* June 2001 http://www.web.net/~ohc/docs/secret.htm

our public health coverage. Today, the patients find their ability to access publicly-funded care in community settings to be severely rationed, poorly organized and subject to user fees. While these changes have not worked for post-acute patients, they are not working for the aging and those with chronic illnesses and disabilities either. Though the provincial government introduced an "Aging at Home" strategy in 2007, most of this funding is directed towards reducing hospital costs and the services funded through this program are ad hoc. The vision of a comprehensive strategy for long-term care, enabling Ontarians to stay at home as we age or experience illness and disability has been largely abandoned.

At the same time as hospital downloading has occurred, the organization of the home care system has changed from a community-based charitable and non-profit service, to a plan for an established systematic public delivery system, to what is called a "competitive bidding" model in which services are contracted out. Ontario's home care is now provided in majority by for-profit companies and case management and care functions are split between the purchasers of service (CCACs) and the providers (a mixture of for- and non-profit companies).

As a result, in Ontario's current home care system vast resources and attention are spent on maintaining an array of providers and rationing care. For more than a decade, setting standards for accessing care, measuring need, and assessing real hands-on quality have taken a back seat. The priorities in system reform have been skewed by private interests and empire-building by provider companies to the detriment of patients. Home care funding is not sufficient to keep up with the combined burden of downloading of post-acute care patients out of hospitals, population growth and aging, and the duplicate administrative tiers required by the competitive bidding system.

As services have moved out of hospitals, Ontario residents have found their ability to access publicly-funded care in community settings to be severely rationed. In effect, these continual failures in home care amount to a significant erosion in the scope of our public health care coverage.

Within Ontario home care is the only health care sub-sector run through competitive bidding. Moreover, though some provinces engage in limited contracting for home support and personal care, Ontario is the only province in Canada that runs its home care system entirely through this method.[3] Consequently, Ontario's home care system is the most privatized of any in Canada. Currently, 58% of home care nursing and 64% of home care personal support services are privatized to for-profit corporations. In researching this report, we found evidence that government policies lobbied for by the for-profit providers are contrary to the public interest in creating a stable, quality, publicly-funded and accessible home care system.

Since the beginning of competitive bidding in home care, successive governments have claimed that the system design is dedicated to improving quality of care rather than simply cutting costs and facilitating privatization. Instead, 15 years after the inception of competitive bidding, the same problems of inadequate and rationed services, poor and inequitable access to care, ineffective or non-existent measurement of community need for service, high administrative costs, staffing shortages, privatization and ineffective measurement of quality and service delivery continue to plague Ontario's home care system.

[3] Canadian Home Care Resources Study (2003) http://www.cha.ca/documents/pa/Home_Care_Research_Study.pdf

The problems described by the auditor, in our previous reports, and in this report, represent an abrogation of both our government's responsibility to safeguard the principles of universal access to publicly funded health care. After two moratoriums on competitive bidding, after repeated promises by two different governments and continual "tweaking" of the competitive bidding system, after a major review of the home care by former Health Minister Elinor Caplan, home care in Ontario remains ad hoc and insufficient. The Auditor General recommends a full review of competitive bidding, with the goals of achieving value for money balanced with meeting the needs of home care clients and communities.[4] We concur.

[4] Ontario Auditor General, pp. 129.

Failure to Address the Problems

All the problems identified in Ontario's home care system for more than a decade remain unresolved

For decades, Ontario's policy makers have taken measures to close hospital beds and ostensibly move care "to the community". Since 1990, more than 18,500 hospital beds have been closed down.[5] Palliative care, outpatient rehabilitation, chronic care have been dramatically cut in hospitals all across Ontario. But home care in the community has been insufficiently funded and organized to meet the needs of downloaded hospital patients, as well as the elderly and persons with disabilities who require these services. The most recent auditor's report reveals that 10,000 Ontarians are currently on wait lists for home care. Our research shows that home care wait lists have consistently totaled more than 10,000 people since 1999. Often, Ontarians in need of home care simply cannot access services and are forced to pay or go without. While governments have focused on policies and priorities that respond to the lobbying efforts of provider companies, they have neglected to undertake basic planning functions for Ontario's residents and patients such as assessing community need for services, establishing standards of care and creating a home care system that can provide these.

Despite recent tinkering with competitive bidding, virtually all of the major problems evidenced in Ontario's home care system for more than a decade remain.

Starting in 2001, the Ontario Health Coalition began tracking problems with quality, access, democracy and administrative costs in home care. Over a similar period, in 1998, 2004 and 2010, Ontario's Auditor General produced critical audits outlining very similar complaints. For over a decade wait lists for home care have consistently numbered more than 10,000 people, unmet need for care has not been measured, and care levels across Ontario have been uneven. Basic management and planning functions have fared equally badly. For over a decade quality of care has been inadequately measured, patient services have been poorly tracked and standards for access to care have not been established. Yet today, administrative costs for home care are higher than ever.

Fifteen years after the inception of the competitive bidding system in Ontario's home care sector the evidence of consistent problems is indisputable.

- Services are inadequate and continue to be severely rationed
- Access to care is inequitable
- There is no measurement of community need for services and no right to access care
- Staffing shortages are persistent and imperil access to care
- For-profit privatization has increased
- Measurement of quality and service delivery are ineffective
- Administrative costs are very high

Initially, in the late 1990s and early 2000s, the provincial government responded to public criticism by stifling the flow of public information and dismantling democratic structures. Since the McGuinty government was elected it has made some policy changes and has placed two moratoriums on competitive bidding, freezing the system in place and slightly improving working conditions for the poorest paid home care workers in a bid to improve continuity and reduce extraordinary levels of staff

[5] Ontario Hospital Association *Health System Facts and Figures* http://www.healthsystemfacts.com/Client/OHA/HSF_LP4W_LND_WebStation.nsf/page/Beds+staffed+and+in+operation+Ontario+1990+to+large

turnover. Despite recent tinkering with competitive bidding, virtually all of the major problems evidenced in Ontario's home care system for more than a decade remain.

Summary of the Key Problems

For more than 12 years, inequitable access to care has resulted from uneven funding and failure to assess needs:

- 1998 - In the 1998 audit, the Ministry of Health indicated that it was working "toward eliminating the inequities in funding and differences in service levels" among service areas and would regularly review and validate the effectiveness of the funding formula.[6]
- 2004 - The 2004 audit found, "at the time of our current audit, there were still significant differences among regions in the proportion of funding allocated to CCACs and CCS agencies."[7] It also noted, "The formula used by the Ministry to determine the level of funding to be provided to CCACs and CCS agencies still does not assess the need for services or ensure equitable province-wide access to services."[8]
- 2010 - In the 2010 audit, the auditor found, "…funding is still not being allocated primarily on the basis of locally assessed client needs but rather remains a historically based allocation. This can result in clients with similar home care needs not receiving similar levels of service."[9] He further found, "The longstanding issue of funding inequities among CCACs for home care services remained largely unresolved. We found that the home care funding per capita across the 14 CCACs still varied widely across the province. For instance, one CCAC received twice as much in per capita funding as another. Total funding to CCACs has not been allocated on the basis of specific client needs or even on a more representative basis…"[10]

Poor access to care has persisted for more than a decade:

- 1999 - The Ontario Association of Community Care Access Centres (OACCAC) reported that more than 11,000 Ontarians were on wait lists for home care.[11]
- 2000 – 2003 – As of March 31, 2003 there were 13,613 Ontarians on wait lists for home care, according to the provincial auditor. These figures were consistent with the trend over the previous two years.[12]
- 2010 – As of March 31, 2010 there were 10,000 Ontarians on wait lists for home care.[13]
- 1998-2010 - In each report of the Ontario Auditor General, from 1998 – 2010, it is noted that wait times are inconsistent and poorly tracked.[14] Some CCACs do not wait list when their services are full and others do. Ontarians with the same need for services may get services in one area but not in others.

Funding is decreasing per client and as a proportion of health care spending:

- Home care funding has decreased from 5.5% to less than 4.5% of the provincial health care budget between 1999 and 2010.

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[6] Ontario Auditor General *2004 Annual Report* Chapter 3: Section 3.07; pp 194.
[7] Ibid, pp. 195.
[8] Ibid, page 193.
[9] Ontario Auditor General *2010 Annual Report*, page 114.
[10] Ibid, page 115.
[11] These figures come from 1999 Ministry of Health data that showed 11,225 people on wait lists across Ontario as of March 31, 1999.
[12] Ontario Auditor General *Annual Report 2004*, page 198.
[13] Ontario Auditor General *Annual Report 2010*, page 122.
[14] Ibid, page 115 and Ontario Auditor General *Annual Report 2004*, page 198.

- While the number of clients increased by more than 66% from 2003- 2010, funding for the CCACs increased by just over 40%. Thus, average funding per client has decreased from $3,846 in 2002/03 to $3,003 in 2008/09.
- Even as home care has increased in strategic importance, as Ministry of Health policy has focused on moving patients out of hospitals and residents out of long term care homes, funding per client has decreased.

Lack of standards for care and poor quality control continue after more than 12 years:

- 1998 - In the 1998 audit, the provincial auditor recommended that the competitive bidding system be evaluated. In addition, he recommended that standardized methods be created and implemented to ascertain whether quality of service commitments by successful bidder were in fact being met.
- 2004 - In the 2004 audit, the provincial auditor noted that this monitoring of quality was still not done.[15]
- 2010 - In the 2010 audit, serious questions about monitoring quality, lack of standards for care provision and assessment of provider agencies' performance were again raised. The issues outlined in the audits since 1998 have not been addressed.[16] The auditor again called for a review of competitive bidding.
- Basic systematization of processes such as a standard intake and assessment tool has taken 13 years to be created and rolled out. In the 2004 audit, the Ministry reported that progress was being made on this. By 2010, the auditor reported that a standardized assessment tool had been developed and is supposed to roll out in March 2011, thirteen years after the issue was initially raised by the provincial auditor.

Inconsistencies and inadequacies in tracking of complaints not addressed after 12 years:

- 1998 - In the 1998 audit, the auditor noted that the Ministry did not have a system to record the receipt, details and status of complaints regarding home care services. The Ministry indicated it would develop a formal process for the consistent recording and disposition of complaints and would require CCACs to report statistical information on the number, type and disposition of client complaints.
- 2004 - In the 2004 audit, two of three regions visited still did not have a system to monitor and track complaints. Variations in the definitions of complaints and in tracking persisted.[17]
- 2010 - In the 2010 audit, these problems had not been addressed. The LHINs indicated that they do not require CCACs to report on the major areas of complaint to help them assess overall quality of services being provided through the CCACs. The CCACs have inconsistent and inadequate methods for tracking complaints. They have re-defined complaints as "events" and these are not counted as complaints.[18]

Public accountability and democratic control over home care has decreased:

- In 2003 elected community boards and community memberships in CCACs were eradicated and public access to information was stifled.
- Since 2003, democratic structures for home care governance have never been revived.
- Access to information on wait lists, funding and other issues is more difficult to access than ever before. Since the Ministry of Health created the LHINs, it no longer reports on home care funding. All funding is lumped into one category. There is no readily-accessible venue to obtain

[15] Ontario Auditor General (2004), page 199.
[16] Ontario Auditor General (2010), pages 115, 124-125
[17] Ontario Auditor General (2004), page 202.
[18] Ontario Auditor General (2010), pages 125-126.

information on funding trends. Fewer OACCAC and industry reports are available to the public, as websites now contain password protected "member only" sections. Accessing basic information on wait times from local CCACs has taken us months. After repeated requests we were not able to obtain wait times information that would provide a comparative picture across Ontario. Reports on wait times and access to care issues are reliant on local media pursing the information.

- There are few methods by which patients can reasonably affect home care policy.
- Virtually all government decision-making regarding home care reform has occurred without public consultation and Ministry consultation is primarily directed towards provider corporations and entities.

Comparison of key findings re. Ontario's home care system 1998 – 2010 From Provincial Auditor General and Financial Reports		
1998/99	**2004**	**2010**
1998 audit found inequities in funding and service levels across Ontario	2004 audit found "significant differences" in funding and service levels across Ontario	2010 audit found "the longstanding issue of funding inequities among CCACs for home care services remained largely unresolved"
1999 Ministry of Health data revealed more than 11,000 people on wait lists for home care	2000 – 2003 – auditor reported that as of March 31, 2003 there were 13,613 people on wait lists for home care and that these figures were consistent with the trend over the previous two years	2010 audit found 10,000 people on wait lists for home care
1998 audit recommended instituting quality measures	2004 audit found that monitoring of quality was still not done	2010 audit found that problems with monitoring of quality, lack of standards of care, and lack of assessment of provider agencies' performance still not addressed
1998 audit noted that there was no system to record and track complaints re. home care services	2004 found that the majority of regions assessed did not have systems to track complaints and there were variations in definitions of complaints and tracking mechanisms where they existed	2010 audit found inconsistent and inadequate tracking of complaints; LHINs do not require CCACs to track and report on complaints
1999 funding for home care was 5.5% of health care budget		2010 funding for home care was less than 4.5% of health care budget. The number of clients had increased by more than 66% since 2003.

Ontario Health Coalition reports over the same period have revealed similar issues as the auditor's reports. But we also reviewed issues pertaining to the costs and effects of competitive bidding and governance, including loss of democratic control, increased administrative costs, privatization and instability. Like the findings of the provincial auditor, the problems we have uncovered have persisted for a decade, as follows:

OHC summary of findings 2001[19]:

1. Lack of democracy and public consultation.
2. Lack of accountability.
3. Lack of standards and quality control.
4. Chronic and planned underfunding.

[19] Ontario Health Coalition *"Dip and Skip" A Supplement to the June 2001 Report on Home care in Ontario* November 22, 2001 http://www.web.net/~ohc/docs/dipandskip.pdf ; Ontario Health *Coalition Secrets in the House: Home care Reform in Ontario 1997-2000* June 2001 http://www.web.net/~ohc/docs/secret.htm

5. Burgeoning wait lists and lack of assessment of population need.
6. Severe staffing shortages.
7. Increased administrative costs through duplication, waste and profit-taking.

OHC summary of findings 2005[20]:

1. Competitive bidding has resulted in dramatic increases in privatization.
2. Market consolidation has taken place, meaning that there is little real competition in competitive bidding. Six companies held 66% of service contracts in 2004, compared to 8 corporations holding 66% of service contracts in 1995. Small community-based non-profit agencies have been the hardest hit.
3. Destabilization of staff is severe. Turnover rates range up to 76% for nurses. Our report traced the dislocation of more than 1,000 workers due to competitive bidding in 2004.
4. More than 22,000 clients were affected by loss of their careworkers when contracts changed hands in 2004.
5. No evidence of quality, poor measurement of quality.
6. Excessive administrative costs through duplication, waste and profit-taking,
7. Lack of democratic processes, community control and accountability.

OHC Summary of Findings 2008[21]:

1. Concerns about access to care.
2. Insufficient funding.
3. Disruptions in care and staffing due to competitive bidding.
4. Poor working conditions and unstable workforce.
5. Lack of democracy, transparency and accountability.
6. For-profit privatization and market concentration.

OHC Summary of Findings in this report, 2011:

1. No assessment of community need for care, no standards for access to care.
2. Underfunding and poor access to care.
3. High administrative costs.
4. Poor oversight and lack of assessment of quality.
5. Staffing shortages and poor conditions.
6. For-profit privatization.
7. Poor public input, no democratic governance, lack of public accountability.
8. Failure to address longstanding problems.

[20] Ontario Health Coalition *Market Competition in Ontario's Home care System: Lessons and Consequences* March 31, 2005 http://www.web.net/~ohc/Home care2005/home care%20paper%20final%20for%20release.pdf

[21] Carol Kushner, Patricia Baranek, Marion Dewar *Home Care: Change We Need Report on the Ontario Health Coalition's Home Care Hearings* November 17, 2008 http://www.web.net/~ohc/home carereportnov1708.pdf;

SUMMARY: Failure to Address the Problems

Comparison of key findings re. Ontario's home care system 2001 – 2011 From Ontario Health Coalition Reports			
2001	2005	2008	2011
Lack of democracy, accountability and public consultation	Lack of democratic processes, community control and accountability	Lack of democracy, transparency and accountability	Poor public input, no democratic governance, lack of public accountability
Lack of standards and quality control	No evidence of quality, poor measurement of quality	Not studied	Poor oversight and lack of assessment of quality
Chronic and planned underfunding	Not studied	Insufficient funding	Underfunding of front-line care and poor access to care
Burgeoning wait lists and lack of assessment of population need for services	Not studied	Concerns about access to care	No assessment of community need for care, no standards for access to care
Severe staffing shortages	Severe destabilization of staff. Turnover rates up to 76% for nurses. Dislocation of more than 1,000 workers in 2004.	Disruptions in care and staffing due to competitive bidding. Poor working conditions and unstable workforce	Staffing shortages and poor conditions
Increased administrative costs through duplication, waste and profit-taking	Excessive administrative costs through duplication, waste and profit-taking	Not studied	High administrative costs
	Dramatic increase in privatization	For-profit privatization and market concentration	For-profit privatization and market consolidation
	More than 22,000 clients were affected by loss of their careworkers when contracts changed hands in 2004	Disruptions in care and staffing due to competitive bidding	N/A - Competitive bidding under moratorium.

From Public to Private: How We Got Here

Movement of Patients Out of Hospitals

Since the 1980s, Ontario's hospital beds and outpatient rehabilitation services have been systematically cut and closed. Chronic care patients have been routinely reclassified and closure of this category of hospital beds has occurred without much heed paid to community need. From 1990 to 2010 complex continuing care (chronic care) hospital beds have been cut in half, from 11,435 beds to 5,798 beds.[22] Hospital-based palliative care has been slashed along with hospital clinics, outpatient rehabilitation, and other therapies. In total, since 1990, more than 18,500 hospital beds have been shut down.[23]

Using a variety of mechanisms to accomplish their goal, governments of all stripes have pursued a policy of hospital downsizing. Initially bed closures were accomplished through less coercive strategies. These were followed by dramatic hospital budget cuts in the mid-1990s and cuts ordered by the Health Services Restructuring Commission. After a period of stability and capacity-building in the early 2000s, over the last three years another round of significant hospital bed and service cuts has occurred. This latest round of health restructuring has been effected through provincial government policy that has held hospital global budgets to less than the rate of inflation to force hospital cuts. It has been executed by hospital executives and cabinet-appointed Local Health Integration Networks (LHINs). Currently there is little if any planning to provide enough hospital beds to meet population need for services.

Despite the increasing importance of home care, the public has had little say over the changes that have fundamentally reshaped Ontarians' access to and quality of care. Since the mid-1990s there has been no public consultation on the governance and provision of home care. Today, it is common practice for governments to consult almost exclusively with provider organizations and companies when forging public policy regarding home care. Unsurprisingly, policy has come to reflect private interests over the public interest.

Rationing

While hospital beds have continued to be cut, care in the community has been subject to perpetual rationing. The Harris government brought in regulation 386/99 under the Long Term Care Act (1994) that set caps on service, forcing strict limits on access to home care. This rationing has persisted ever since, despite the increases in the service caps brought in by the McGuinty government in 2008. But underfunding and staffing shortages mean that clients cannot access this care. Many who are assessed as needing services go without or suffer wait times. As of 2010, the provincial auditor found 10,000 Ontarians on wait lists for home care services. The vision of the early 1990s dedicated to creating a public long-term care system in the home has been abandoned.

[22] Ontario Hospital Association, *Health System Facts and Figures* at http://www.healthsystemfacts.com/Client/OHA/HSF_LP4W_LND_WebStation.nsf/page/Beds+staffed+and+in+operation+Ontario+1990+to+large

[23] Ibid.

Privatization

With each wave of restructuring, new capacity in long term care homes and home care has been privatized to for-profit corporations. Privatization has taken two forms: increased for-profit ownership of provider companies, and increased privatization of payment for services. For profit delivery of home care services has increased dramatically with the inception of competitive bidding. In 1995, prior to competitive bidding, 82% of home care nursing was delivered by non-profit entities and 18% was delivered by for-profit companies.[24] By 2011, only 42% of home care nursing was delivered by non-profits. The majority – 58% is now privatized to for-profit corporations.[25]

Throughout this period governments have claimed that services can be provided better and more cheaply in the community. But successive governments have failed to measure needs and the impacts of their cuts, to provide meaningful ways for residents to be heard about gaps in services, to provide clear requirements for access to home care and a public/non-profit system that can deliver these. The result is that those who would have been patients receiving care in a non-profit hospital a decade or more ago are now required to access long term care in facilities, the majority of which are owned by for-profit companies and all of which require user fees for residents. Or those same patients are now left to try to access rationed home care, the majority of which is provided by for-profit companies. Patients face user fees because publicly funded home care is rationed and because for-profit companies have a profit motive (and a conflict of interest) in selling top-up home care for user fees to their clients.

Each Stage of Reform Has Entrenched Privatization and the Erosion of Democratic Control and Public Accountability

Even as capacity in home care services has been required to increase, under each successive government's changes home care delivery has become more deeply privatized, less democratic, and less accountable. Since the early 1990s, Ontario has moved from a public system, to a short-term mixed for- and non-profit system, to a long-term for-profit privatization system. [26] Accompanying the privatization of ownership of provider organizations has come a privatization in the modalities of care and policy-making. Ontario has moved from full-scale public consultations, to less public input, and currently, to no public input.

> Phase I: Attempts to build an integrated public home care system out of ad hoc non-profit services
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> Prior to the 1990s, home care was delivered by municipal public health departments, public hospitals and the Victorian Order of Nurses under the Home Care Program (HCP) and budget shortfalls were paid by the provincial government. Seniors' groups criticized the system as fragmented and inequitable. In the early 1990s, the Rae government held extensive

[24] Doran, Diane, Jennie Pickard et al. Management and Delivery of Community Nursing Services in Ontario : Impact on the Quality of Care and Quality of Worklife of Community-based Nurses, 2004: pp. 4.

[25] Calculated from OACCAC service contracts data. See page 30 for details on method.

[26] Overviews of home care restructuring can be found at: OACCAC *"CCAC Procurement Improvements: Ready for Market"* powerpoint presentation by Anne Bell, OACCAC Conference 2007; Baranek, Patricia M, Raisa B. Deber and A. Paul Williams *Almost Home: Reforming Home and Community Care in Ontario* Toronto: University of Toronto Press 2004.

consultations[27], ultimately passing legislation to create a system of publicly-delivered long term care in the home through regional public multi-service agencies.[28]

Phase II: Introduction of competitive bidding & for-profit privatization managed by publicly-elected CCACs

In 1996, Ontario's Mike Harris government changed course, announcing the implementation of "managed competition" in home care. This system has come to be known as "competitive bidding". Under it, for-profit corporations were invited to bid against the non-profits that had created and built home care and integrated social services across the province over the previous decades. The government replaced the NDP's planned Multi-Service Agencies with the Community Care Access Centres (CCACs) and subsequently required these agencies to contract out home care services in competitive tendering contests.

Phase III: Protests followed by eradication of all vestiges of community control and erosion of public access to Information

The first years of competitive bidding were characterized by gross instability caused by repeated rounds of bidding and contract turnovers. Thousands of patients and care workers were displaced. Forced divestment of services from CCACs resulted in highly-publicized increased costs. A period of public criticism of long wait times and insufficient funding by the CCACs resulted in the Harris/Eves government passing legislation that axed the CCACs' elected community boards and community memberships.[29] Using their new powers to fire boards, board chairs, and CEOs, the government effectively clamped down on the public release of information. Even so, public reports on displaced clients, staff lay offs, and reports on staffing shortages still made it into the public domain for a period of time.

Phase IV: Entrenchment of privatization – no public access to information

Following their election in 2003, the McGuinty government initially continued with competitive bidding, then imposed two successive moratoriums (in 2004 and 2008) on the tendering system, effectively freezing the privatization of contracts in place. An announced review of competitive bidding in 2004 was turned into a review of the "procurement process" rather than a review of the policy itself under the leadership of Health Minister George Smitherman and appointee Elinor Caplan.[30] Though Caplan took public submissions, opposition to competitive bidding and privatization were largely ignored. Her recommendations ultimately suited the interests of elements of the home care provider companies. Caplan recommended maintaining the competitive bidding system modified to include longer-term contracts and automatic renewals.

This approach has entrenched privatization. The CCACs restructured to fit the new boundaries of the Local Health Integration Networks, but the undemocratic board structures remained. Undemocratic governance and the almost total lack of community input and control have continued to be the pervasive culture in home care governance and reform. In researching this report we found there is significantly less public access to information in home care than there was even five years ago when we researched our last report. Local wait times are often secret.

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[27] Legislative committee transcripts of the consultations can be accessed here: http://www.ontla.on.ca/web/committee-proceedings/committee_transcripts_details.do;jsessionid=c72d607830da90f38a19b3844a20be5cb59b37c3e51e.e3eQbNaNa3eRe3qMb3uOaNiPe6fznA5Pp7ftolbGmkTy?locale=en&BillID=&ParlCommID=512&Date=1994-08-24&Business=Bill+173%2C+Long-Term+Care+Act%2C+1994&DocumentID=18220

[28] See Bill 173, Long Term Care Act, 1994.

[29] See Bill 130, Community Care Access Centres Corporations Act, 2001.

[30] See Caplan, Elinor C. *Realizing the Potential of Home Care: Competing for Excellence by Rewarding Results* 2005 at http://www.health.gov.on.ca/english/public/pub/ministry_reports/caplanresp06/caplanresp06.pdf

> We have encountered obstacles to accessing information from the CCACs: requests have been ignored, repeated requests have been required, even after repeated requests information is delayed, and when information has been released to us, it is often incomplete and misleading. Information on industry conditions such as staffing shortages is no longer publicly accessible if it is tracked.

Despite the increasing importance of home care, the public has had little say over the changes that have fundamentally reshaped Ontarians' access to and quality of care. Since the mid-1990s there has been no public consultation on the governance and provision of home care. Today, it is common practice for governments to consult almost exclusively with provider organizations and companies when forging home care policy. Unsurprisingly, policy has come to reflect private interests over the public interest. Competitive bidding is supposed to resume over the next year.

Poor Access to Care

10,000 on wait lists, no standards, and no measurement of community needs for care

Though the right to access publicly-funded hospital and physician care across Canada is clearly established in the Canada Health Act, as patients have been moved out of hospitals they find an array of ad hoc and inadequate care in home care, community services and long term care facilities. Often patients are forced to pay out-of-pocket for needed care. Every report since the late 1990s has found home care to be rationed and insufficient. The result is wait times that are chronic and pervasive across Ontario. According to the provincial auditors' reports and Ministry data, home care wait lists have numbered more than 10,000 people consistently since 1998. Wait list figures, however, do not capture the whole picture. The unmet need for care is currently not measured. Wait lists are not tracked in consistent manner across Ontario's CCACs and in many cases there is simply no access to care. While the Ontario government and CCACs have made a priority of procedures that assess clients, maintain competitive bidding, and ration care, over 15 years they have failed to set clear standards establishing the right to access needed care.

Every report since the late 1990s has found home care to be rationed and insufficient. The result is wait times that are chronic and pervasive across Ontario. According to provincial auditors' reports and Ministry data, wait lists have numbered more than 10,000 people consistently since 1998. Wait list figures, however, do not capture the whole picture. Wait lists are not tracked in consistent manner across Ontario's CCACs and in many cases there is simply no access to care.

Despite marginal reforms, home care services remain ad hoc and uneven across the province. The institution of service caps – a system of strictly rationing the amount of care available to home care clients – started formally in 1999 when the Ministry of Health issued service guidelines and later a regulation strictly limiting access to care.[31] Rationing and poor access to care have persisted ever since.

Recently, the provincial government has undertaken a number of funding and policy initiatives in an attempt to address poor access to care. In 2007, the government introduced a new "Aging at Home" strategy. Announced funding for the strategy has amounted to $1.1 billion over three years, but only a portion of that funding has flowed. The focus of the strategy is to keep people out of hospitals and reduce emergency department wait times. The Aging at Home services are contracted through the 14 Local Health Integration Networks (LHINs), not the CCACs, and are not integrated with CCAC home care services.

In addition, in 2008, the government announced a change in the regulations rationing care available to clients:

- Caps were entirely eliminated for people waiting for a long term care bed.
- For all other home care clients, caps were raised from 80 to 120 hours of service per month for the first 30 days and 60 to 90 hours of service per month after the first 30 days.

The government provided targeted funding increases to facilitate early discharge from hospital for patients waiting for hip and knee surgeries by providing in-home rehabilitation and support services. In addition, the government increased funding to increase the hours of personal support and homemaking in tandem with the increases in the hours permitted under the service caps.

[31] Regulation #386/99 passed by the Harris cabinet. This meant home care was not to be provided based on need, but according to strict service caps.

Despite the changes since 2007, chronic home care underfunding, increased demand and poor organization of the sector mean that care continues to be severely rationed and inadequate. Policy is not centred on measuring and trying to meet community need for care. In fact, need for care is not measured. Continued downloading of hospital patients caused by closure of hospital outpatient rehabilitation across Ontario and the continuing closure of hospital beds means that funding increases have not translated to increased amounts of care for those on home care caseloads. In reality, funding per client has gone down.[32] The number of people trying to access care and failing is not measured. Moreover, inadequate measuring and restructuring of home care has resulted in an inability to assess whether the targeted funding accomplished its goals.[33] The auditor notes that the CCACs reported that the funding increase was not sufficient to meet the new allowable hours of care.[34]

Findings of the Provincial Auditor (December 2010)

- 10,000 Ontarians are on wait lists for home care services, with wait times ranging up to 262 days.[35]
- 11 of 14 CCACs across Ontario have wait lists for services.[36] The causes for wait lists were attributed to inadequate funding for homemaking and personal support services and shortages for health professionals' services.
- Wait lists vary significantly. In some areas of Ontario, wait times are extremely long. One CCAC had 1,400 people waiting for speech language pathologists. Another had more than 1,300 people waiting for personal support services. Another had more than 770 people waiting for occupational therapy services.[37]
- There is an absence of standard service guidelines for frequency and duration of services resulting in each CCAC developing its own guidelines.[38]
- Funding is not allocated on the basis of locally-assessed client needs. Therefore clients with similar needs do not access similar levels of service.[39]
- Even in managing wait lists there is a lack of policy and standards. The auditor found that a lack of direction and guidance from the Ministry of Health on management of wait lists and ranking of clients has continued since before 2004.[40]
- There is inequitable access to care. In one CCAC profiled by the auditor, clients assessed to be of moderate risk were deemed ineligible for services. In two other CCACs, these clients were deemed eligible and were either provided with services or were put on wait lists.[41] Thus, even the spotty data on wait lists that is available to the public understates the insufficiency of the services available.

[32] See the next section for calculations.
[33] Ontario Auditor General, page 118.
[34] Ibid, page 119.
[35] Ibid, page 122.
[36] Ibid, page 115.
[37] Ibid, page 122.
[38] Ibid, page 115.
[39] Ibid, page 114.
[40] Ibid, page 121.
[41] Ibid, page 115.

Inadequate Funding

Home Care funding has failed to keep pace with the downloading of patients from hospitals, nor with population growth and aging. In fact, home care is declining as a percentage of health care spending. One result of underfunding is that long term home care that would enable people to age at home or live in their homes with chronic illnesses and disability has been severely rationed. Another consequence is ongoing pervasive wait lists for care across the province.

Findings of the Provincial Auditor (December 2010)

From the 2004 audit to the 2010 audit, total expenditures for home care increased from $1.22 billion to $1.76 billion. In the same period, the total number of clients increased from 350,000 to 586,000.[42]

This means that while the number of clients has increased by more than 66%, funding has increased by just over 40%.

Based on the auditor's figures, average per person funding for home care clients was $3,486 per client in 2002/3 and declined to $3,003 per client in 2008/9.

Figure 1. Ontario Home Care Funding Per Client

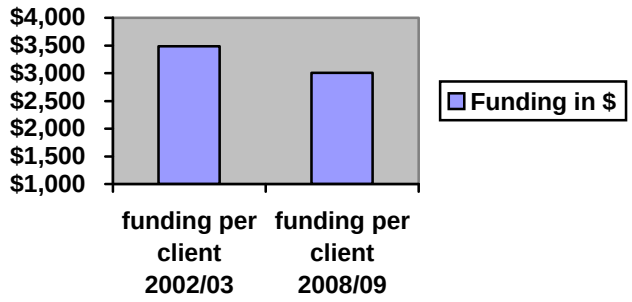
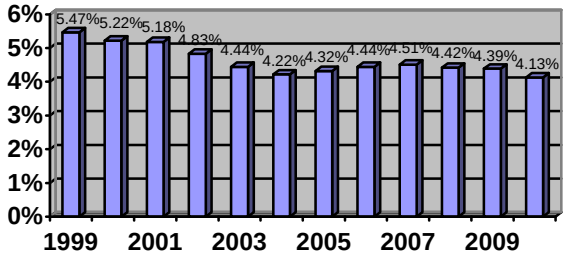


Figure 2. CCAC Funding as Percentage of Health Care Budget



Source: Ontario Community Support Association[43]

[42] Ontario Auditor General, pp. 113.
[43] http://www.home careontario.ca/public/about/home-care/system/how-much-care.cfm

Additional Findings

The auditor's figures reveal an important part of the story. However, as the auditor found, not all Ontarians needing home care services are able to access them. Some people are placed on wait lists. Others are simply denied care. To gain a further understanding of the trends in home care funding, we have tried to access data on home care spending as a percentage of the provincial health care budget. According to the most reliable available data, home care spending is declining as a percentage of the provincial health budget, even while the provincial government continues to pursue a policy of significant hospital bed cuts and movement of services out of long term care homes into home care. (See Chart 2 above.)

High Administrative Costs

Competitive bidding has redirected resources away from front-line care

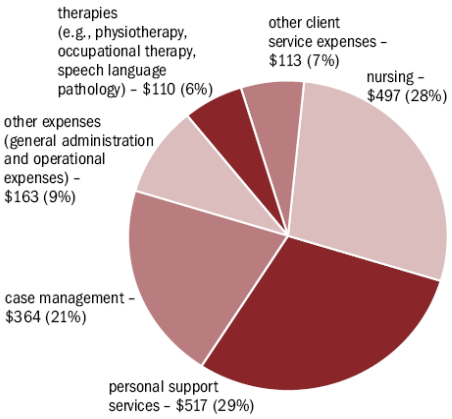
Overall Findings of the Provincial Auditor

The recent Auditor's report highlights problems directly attributable to contracting out through competitive bidding. According to the auditor 9% of the home care budget is spent on general administration and 21% of the budget goes to case management.[44] These figures understate the full cost of administration in home care because they do not capture the administrative costs of each contracted provider agency.

Within the CCACs themselves, administration includes running the competitive bidding process, monitoring the care and services given by contracted companies and rationing the provision of services in an attempt to keep within budget. In addition, there are dozens of duplicate provider agencies in each CCAC, each with their own administrations – a planned redundancy required to set up a "market" for competition. As of January 2011, there were more than 700 contracts with provider agencies in the 14 CCACs across Ontario.[45] On top of all of these levels of administration, there are the LHINs that are supposed to oversee the CCACs and the Ministry of Health which oversees the LHINs. This means that there are multiple tiers of administration for home care – more than any other health care sector. In fact, home care funding passes through four tiers of administration before it reaches front line care workers.

Figure 1: Breakdown of CCAC Expenditures, 2008/09 ($ million)

Source of data: Ministry of Health and Long-Term Care



This chart is from the Ontario Auditor General's Report, pp 113. It shows that the combined costs of general administration and case management take up 30% of total home care spending.

- 30% ($527 million) of the total home care budget is tied up in primarily administrative and case management functions of the CCACs alone. In addition, multiple duplicate provider companies maintain their own administrations.
- There are now redundant tiers of administration in the LHINs, CCACs and provider companies.
- Under competitive bidding there is a need for strict monitoring of contractors, yet monitoring is insufficient.
- Contractors cannot be relied upon to accurately report their own performance, nor to measure whether they are delivering on contracts.
- Serious questions about quality of care and patient accessibility remain.

Ultimately, the auditor's report shows that the significant bureaucracy within the CCACs that exists to govern and manage home care does not measure community need for services and plan services to meet them. He also found that the LHINs do not measure and try to meet community need for home care services either. He uncovered self-reporting from contracted companies that is unreliable and not subject to verification by the CCACs. The auditor's findings are a powerful indictment of the inability of even this multi-tiered bureaucracy to control the contracted work.

[44] Ontario Auditor General, page 113.

[45] List of service providers from OACCAC website accessed in January 2011. We counted the number of contracts listed. Note: In its 2007 pre-budget submission, the OACCAC reported that CCACs oversee contracts with 1,000 provider companies. This includes nursing, personal care, medical supplies and technology contracts. Reference: OACCAC *Building Bridges to Better Health: Submission to the Standing Committee on Finance and Economic Affairs*, January 25, 2007.

Analysis

The costs of competitive bidding have not been properly assessed by the provincial government. The auditor's findings show administrative costs in CCAC budgets that are extraordinary, without any evidence of improved quality or access to care as a result. The value and purpose of the 30% (½ billion dollars) of CCAC budgets that are spent on administration and case management has not been assessed. In addition, each contracted agency has a mark-up in their pricing for services that covers their own administrative costs and profit-taking. What the auditor's report does not show is the cumulative additional cost of maintaining a vast array of duplicate provider companies simply in order to facilitate competition. In fact, in Ontario's home care system, public funds are transferred through four separate levels of administration before any money reaches the front-lines of care (see Figure 4).

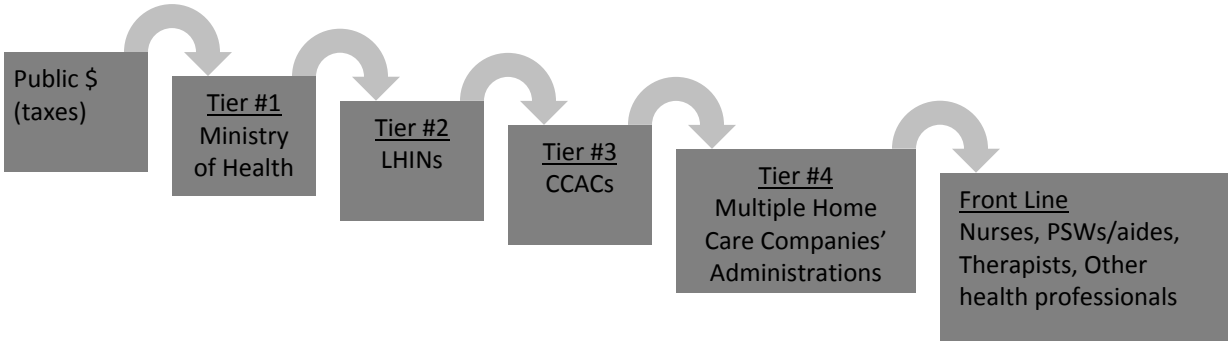


Figure 4. Public funds for home care are transferred through 4 tiers of administration before they reach the front lines

These issues raise serious questions that have not been addressed in the 15-year experience of competitive bidding in Ontario. In his latest audit, the Ontario Auditor recommends a full review of competitive bidding. This review is long overdue and must include a value-for-money analysis of the administrative costs and redundancies entailed in the competitive bidding model as compared to an integrated public non-profit home care system.

Poor Oversight and Serious Concerns with Quality of Care

From the inception of competitive bidding in Ontario's home care sector, successive governments have claimed that this system has been centred on quality of care. Yet after 15 years of competitive bidding and reforms that are supposed to address these problems, issues regarding continuity of care, assessing quality, monitoring performance and addressing client input and complaints remain inadequate. Competitive bidding has effected privatization of the majority of the sector, but it has not led to any measurable increase in efficiency (indeed, its requirement for multiple tiers of administration is inefficient) nor has it measurably improved quality.

Despite repeated assertions that quality is paramount, a key element of quality – continuity of care – is antithetical to competitive bidding. This contradiction is noted by CCACs in the most recent report of the Ontario Auditor General. Clients are afraid about losing their care workers as bids are lost and contracted providers change. With the loss of their nurse, therapist or personal support worker, clients' histories need to be re-established with a new care worker. The new care worker has to be oriented to the patient's preferences and their home. Since home care is often very personal and private care done in peoples' homes, this issue is very important and cannot be solved within a competitive bidding environment.

The severing of case management and care means that there is no longer the sense of teamwork in home care. Not only does this fail to meet best practices for care work and lead to duplication, it stifles the sharing of information and the creation of effective care teams.

In addition to concerns about continuity of care, the auditor's report raises serious questions regarding the monitoring of providers and complaints. Key quality and access issues such as proper tracking of complaints, dealing with missed or cancelled appointments and service providers refusing clients are poorly done. Actual monitoring of hands-on care is also inadequate or poor.

Findings of the Provincial Auditor

The auditor reviewed the work of the sizeable tier of hands-off case managers and administration, and found insufficient monitoring of contracts and quality of care, poor oversight, and a total failure to measure and try to meet community need for services. System resources are being spent to maintain a costly structure of competitive bidding and care rationing, while access and quality have taken a back seat. Among the auditor's findings:

- On admission initial assessments of patients are to be done within 14 days. Yet most take longer, with delays up to 15 months.[46]
- After admission case managers are supposed to perform a face-to-face review with each patient every six months. Yet many had not been done for over a year.[47]
- Case manager caseloads vary significantly from CCAC to CCAC.[48]
- Only one CCAC studied conducted routine site visits to audit its contracted providers in the last year.[49]
- There was limited oversight of providing agencies but when it has been done it has found that most providers have no mechanisms in place to determine whether services were provided in a

[46] Ibid, page 121.
[47] Ontario Auditor General, pages 126-127.
[48] Ibid, page 120.
[49] Ibid, page 124.

timely manner and whether visits had been missed or cancelled. Actual observation of care provision by home care workers is inadequate.[50]

- There were significant differences between the self reported data provided by the contracted agencies and what was verifiable in chart audits.
- LHINs do not require CCACs to report on the major areas of complaints and client "events" to help them assess the overall quality of the services being provided.
- A telephone survey found that of the 4,700 people called only 29% reported good or excellent service. Most declined to be involved in the survey.[51]

There is no doubt that complex long-term patients would receive better care if they had a dedicated case manager that coordinated their care. In addition, assessments and referrals to community services such as supportive housing are important functions. But many short-term home care patients can be managed effectively and cost-efficiently by their primary hands-on caregiver provided that the home care structure is not populated by competing profit-driven companies with a vested interest in selling unnecessary services. Undoubtedly competitive bidding has added redundant and unnecessary administrative expenses related to an increasingly complicated and dysfunctional home care system.

Despite the sizeable administrative burden in home care the auditor also found serious issues with the quality and accessibility of care. Eleven of the 14 home care districts have some form of wait-list for various home care services. There are 10,000 people waiting for home care services in Ontario, with average wait times that ranged from eight to 262 days. And the waiting does not end after a patient is admitted to the program. Quality of care is further compromised by long waits to receive required services. In an extreme case, one patient had to wait 134 days after admission for the services they needed to start. While wait lists for homemaking and personal support were attributed to lack of financial resource and wait lists for therapies were attributed to human resource shortages, wait times for assessments and re-assessments were not explained, though administration takes up 30% of home care budgets.

Though weighty administration costs have not contributed to measuring population need for services and monitoring quality effectively, the Auditor's report clearly indicates the need for monitoring if care is to be delivered by contracted agencies. The auditors' office checked reports from the agencies on their rate of taking patients against the records kept by the home care agencies, the CCACs, and patients charts and found significant discrepancies. One provider reported that it had rejected about 7% of requests for its services. The auditor's review of the data showed that this provider had rejected 39% of requests. Another agency said it had rejected only about 2% of requests for its services but the data showed that the provider had rejected more than 10% of requests. A third company reported that it had accepted 100% of requests for its services while the provider had in fact rejected 12% of requests for its services. The CCACs -- the government-appointed entities charged with ensuring that these agencies deliver the service contracted-- had not done this cross-checking themselves. The Auditor found a lack of on-site visits by the CCACs to assess the quality of care provided by contracted agencies. Instead they were relying on the inaccurate reports from the contracted provider companies.

[50] Ibid, page 124.
[51] Ontario Auditor General, page 126.

Staffing Shortages

In addition to underfunding, and in part because of it, staffing shortages are a consistent and serious problem in home care. Though poorly researched and reported, staffing shortages are evidenced - particularly for health professionals but also for support workers and nurses – to varying degrees across Ontario. Staffing shortages are a function of inter-related problems, including:

- Significantly poorer pay and working conditions in home care compared to other health care sectors
- Province-wide shortages
- Job insecurity due to competitive bidding
- Relative status of home care compared to other health care sectors.

The provincial government, in recent years, has responded to widespread criticism and crisis-level shortages by very small steps towards improving working conditions in home care and by extending the duration of service contracts under competitive bidding. However, much more significant reforms are needed to redress shortages and solve the problems of access to care services, high turnover and lack of continuity of care that are a result.

According to the Ontario Community Support Association, wages for home and community support workers are 20 – 40 % lower than their counterparts in hospitals and long term care homes. Hundreds of full time community workers earn $35,000 or less per year. They note: "Retention of staff, specifically personal support workers – the backbone of the delivery of services to seniors and those living with disabilities in the community – is an ongoing challenge and directly affects the quality and accessibility of care to the public."

Poorer pay and working conditions

According to the Ontario Community Support Association wages for home and community support workers are 20 – 40 % lower than their counterparts in hospitals and long term care homes. Hundreds of full time community workers earn $35,000 or less per year. They note: "Retention of staff, specifically personal support workers – the backbone of the delivery of services to seniors and those living with disabilities in the community – is an ongoing challenge and directly affects the quality and accessibility of care to the public."[52] The Ontario Nurses Association finds that home care nurses working in a unionized environment make $8,400 per year less than their colleagues working in hospitals.[53]

A research report submitted to the SARS commission found that casualization of staff affected a large percentage of home care workers. They found that 2/3 of home care workers in non-profit companies and up to 90% in for-profit companies are part-time.[54] The study found that during the SARS outbreak, home care agencies lost 20 – 30% of their staff due to the directive for nurses to work only in one agency (to contain the spread of SARS from site to site). Researchers recommended, "The managed competition model should be reviewed and new funding models created for the community sector so more staff are offered full-time work."[55]

[52] OCSA *Letter to Dwight Duncan*, Ontario Minister of Finance, May 7, 2010.
[53] VON Canada *Pre-Budget Submission to Finance Minister Dwight Duncan*, February 2010.
[54] Baumann, Andrea, RN, PhD et al. *Capacity, Casualization and Continuity : the Impact of SARS* Report to the Walker Expert Panel (research funded by Ministry of Health) pp. 5.
[55] Ibid, pp. 4.

The majority of home care workers are women. Agencies estimate that 65% are immigrants and many are women of colour. The poorer working conditions in home care are part of the systematic discrimination experienced by these groups.

Impact of competitive bidding

In our previous reports, we have detailed the deleterious impact of competitive bidding on the home care workforce. A clear summary of the issues is provided in the McMaster University researchers' report to the Walker Expert Panel:

> "The problem is most profound in home care where managed competition makes for-profit and not-for-profit home care agencies rivals for time-limited contracts administered by Community Care Access Centres. Home care agencies cannot build capacity or offer full-time jobs because if their contracts are discontinued employees must move on. Bidding means that nurses in not-for-profit agencies earn less than their colleagues in acute care. Because they are paid per client seen, nurses in for profit agencies can earn more, but only at the expense of spending less time with clients. Nurses work for multiple employers to increase their hours and to counter job insecurity. They cannot consolidate practice, build experiential knowledge, plan careers, or accumulate seniority or pensions (Leiterman, 2003)."

Reforms to date are inadequate

Policy changes since 2005 have been undertaken to slightly improve conditions of work for the home care workers with the poorest compensation and working conditions. In response to the Caplan report, a Personal Support Worker (PSW) stabilization program was introduced. Among the measures taken was a legislated minimum wage of $12.50 per hour. In 2009 additional changes were announced. In January 2009 exemption for public holiday pay for so-called elect-to-work employees withdrawn.[56] (Elect-to-work is a euphemism for temporary and casualized jobs.) These changes are marginal and have not addressed the casualization of the workforce and the precarious nature of home care work, the concerns about inadequate travel reimbursement, and the disparity between home care and other health care sub-sectors. Moreover, under competitive bidding, if contracts change hands home care workers lose their jobs and all of their accumulated vacation and seniority. In addition to relatively poor working conditions, care workers cannot therefore plan a career with any security in this sector while competitive bidding continues.

[56] Amendment to *Employment Standards Act*, 2000 regulation 285.

Increasing Privatization

For-profit corporations lobby against improving equitable access and working conditions

Increased privatization

Prior to the introduction of competitive bidding, Ontario's home care system was overwhelmingly public and non-profit. With the introduction of competitive bidding, for-profit delivery of service has dramatically increased while non-profit market share has decreased. Today, the majority of home care is provided by for-profit corporations. In our 2005 report, we also found that corporate ownership in the home care "market" had consolidated, meaning that there is less competition. Today, large companies dominate, holding the vast majority of large contracts.

Home care nursing market share provided by for-profit corporations increased from 18% in 1995, two years before the inception of competitive bidding, to 46% in 2001.[57] Today, the for-profit share has increased to 58%.[58] For home care personal support, the for-profit takeover is even more dramatic. Today, 64% of home care personal support is provided by for-profit corporations.[59]

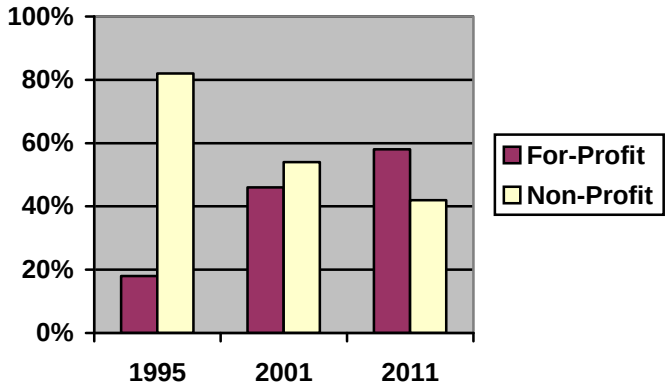


Figure: Ontario Home Care Nursing Privatization 1995-2011

Promoting Poor Working Conditions

Ontario's for-profit corporations generally use "elect-to-work" labour practices to reduce labour costs while several of the large non-profit providers in Ontario have eschewed this practice. This means that as the sector has become more privatized, work has become more casualized, temporary and precarious for personal support and home nurses. Baumann et al found that for-profit home care corporations had up to 90% casualized staff compared to approximately 66% in non-profit agencies.[60] Extendicare REIT's Annual Report notes that Ontario is Extendicare subsidiary ParaMed's largest market, representing 97% of its revenue, and the majority of their home care workers are "elect to work".

[57] Doran et al. Pp. 4

[58] Figures calculated from OACCAC data on current contracts accessed in January 2011. See the appendix for a listing of volumes, by ownership type, by CCAC. For home care nursing services, results are calculated using data from all CCACs that reported contracted volumes in comparable units (nursing visits) totaling 7 CCACs with an aggregate volume of 3,132,709 nursing visits. For home care personal support services, results are calculated using data from all CCACs that reported contracted volumes in comparable units (hours) totaling 8 CCACs with an aggregate volume of 8,891,223 hours of personal support.

[59] Ibid.

[60] Baumann, Andrea, RN, PhD et al. *Capacity, Casualization and Continuity : the Impact of SARS* Report to the Walker Expert Panel (research funded by Ministry of Health) pp. 5.

Though the literature from the for-profit lobby groups often pays lip-service to improved or ethical working conditions, in fact, where improved pay and conditions for workers might eat into profits, the for-profits have opposed. In 2009 the provincial government made a regulatory change that removed an exemption under the Employment Standards Act, thereby giving casualized home care workers the right to public holiday pay. The government also changed the Employment Standards Act in 2009 to give temporary employees the right to severence and termination notice, but excluded casualized home care workers. According to Extendicare's 2009 Annual Report, the government has indicated their intention to remove those exemptions in 2012. This would bring home care workers up to the basic employment rights of other workers in Ontario. Extendicare is opposed to such an improvement in its worker's rights: in its annual report, it is noted: "though the Ontario Community Support Association we will be making submissions that support keeping the exemptions".

Promoting privatization

Public interest advocates have promoted policies for better publicly-funded coverage of home care and improved standards for access to care. At the national level, public interest organizations are calling for a federal act to explicitly extend the principles of the Canada Health Act to cover home and community care so that patients are protected as they are moved out of hospitals. The goal of these organizations is to achieve a comprehensive net of medically-necessary and preventive services that is equitable and accessible.

The private sector lobby does not favour single-tier home care. Instead, a review of position papers and documents from the for-profit lobby shows that they favour a mixed system of government subsidies and the ability for these companies to charge extra fees and sell additional services for private payment. This formula maximizes their profit-making income. This position is evident in a recent briefing note from an industry lobby group, "Private home care – a vital component of the health care continuum in Ontario"[61]. Thus, increased for-profit ownership has fed a lobby that works against an equitable single-tier home care program.

[61] Ontario Home Care Association, September 2010.

Conclusion

The 2010 Ontario's auditor's report adds to growing body of knowledge that the Ontario system is not working. Thousands of Ontarians remain on wait lists for services and untold numbers of additional people have not been able to access publicly-funded care at all. Funding is declining both as a percentage of health care spending and on a per client basis. Despite repeated reports identifying serious problems, key issues have not been resolved since 1998, including:

- Uneven and inequitable levels of service
- Insufficient funding
- Poor access to care
- Poor oversight
- Inadequate tracking of complaints
- Excessive administrative costs, duplication and waste
- Disruption of client care as a result of competitive bidding
- Increasing privatization
- Reduced democratic governance, public accountability and community input
- Severe staffing shortages

Despite multiple tiers of administration that consume more than $500 million each year, oversight is persistently poor. Home care priorities have tended to suit the interests of provider companies rather than the public. A prime cause is that the focus and resources of home care are needlessly siphoned off to maintain the structures of competitive bidding. A secondary cause is a lack of democratic processes and public input into home care reform that would amplify priorities of patients and citizens.

Competition cannot occur unless there is a surplus of providers to bid for contracts. There is no surplus of workers, and we have documented in previous reports bid-winning companies' plans to hire all laid off workers from companies that lose bids. Thus, competition in Ontario's home care system is simply an exercise of competition among different companies' administrations. It is impossible to find a public-interest rationale for spending millions in public funds to maintain a structure and process simply to facilitate corporate interests in increasing their market share and profit-seeking.

For Ontario patients, home care will only continue to grow in importance. The chronic insufficiency of home care is an abrogation of our government's requirement to provide public health care services based on need, not on wealth. We hope this report will contribute toward the establishment of clear standards for improved access to care. But improved access to care within a context of limited resources requires a fundamental rethink of the design of our home care system. The current provincial auditor repeated his predecessor's recommendation for a full review of the competitive bidding system. We agree, with the additional recommendation that it is time to again raise the desirability of an integrated, locally controlled, non-profit home care service.

Appendix

Home Care Contracted Services By Type of Ownership (For-Profit vs. Non-Profit)[62]		
CENTRAL CCAC		
Personal Support	Amount	Percentage
For-Profit	1,511,845 hours	72%
Non-Profit	591,040 hours	28%
Total	2,102,885 hours	
Nursing	Amount	Percentage
For-Profit	270,608 visits plus 120,836 hours	
Non-Profit	293,159 visits plus 89,121 hours	
Total	563,767 visits plus 209,957 hours	
CENTRAL EAST CCAC		
Personal Support	Amount	Percentage
For-Profit	1,053,722 hours plus $34,800	
Non-Profit	911,177 hours	
Total	1,964,895 hours plus $34,800	
Nursing	Amount	Percentage
For-Profit	408,094 visits	53%
Non-Profit	356,443 visits	47%
Total	764,537 visits	
CENTRAL WEST CCAC		
Personal Support	Amount	Percentage
For-Profit	359,272 hours	63%
Non-Profit	208,614 hours	37%
Total	567,886 hours	
Nursing	Amount	Percentage
For-Profit	73,766 visits plus 93 hours	
Non-Profit	52,270 visits plus 2,422 hours	
Total	126,036 visits plus 2,515 hours	
CHAMPLAIN CCAC		
Personal Support	Amount	Percentage
For-Profit	1,156,826 hours	68%
Non-Profit	547,200 hours	32%
Total	1,704,026 hours	
Nursing	Amount	Percentage
For-Profit	412,720 visits	63%
Non-Profit	246,970 visits	37%
Total	659,690 visits	

[62] List of service providers from OACCAC website accessed January 11, 2011. All providers were contacted by telephone or researched on internet to determine ownership type. The OACCAC reports contracts in a mixture of volume units (hours, dollar values and visits) as reflected in this chart. See page 35 for aggregates.

ERIE ST. CLAIR CCAC		
Personal Support	Amount	Percentage
For-Profit	$14,065,526	50%
Non-Profit	$14,054,230	50%
Total	$28,119,756	
Nursing	Amount	Percentage
For-Profit	$12,864,925 plus 6,351 hours	
Non-Profit	$15,140,251	
Total	$28,005,176 plus 6,351 hours	
HAMILTON NIAGARA HALDIMAND BRANT CCAC		
Personal Support	Amount	Percentage
For-Profit	115,930 visits plus 1,105,376 hours	
Non-Profit	96,042 visits plus 654,801 hours	
Total	211,972 visits plus 1,760,177 hours	
Nursing	Amount	Percentage
For-Profit	335,188 visits plus 4,624 hours	
Non-Profit	448,275 visits plus 43,003 hours	
Total	783,463 visits plus 47,627 hours	
MISSISSAUGA HALTON CCAC		
Personal Support	Amount	Percentage
For-Profit	557,650 hours	53%
Non-Profit	489,850 hours	47%
Total	1,047,500 hours	
Nursing	Amount	Percentage
For-Profit	182,815 visits	47%
Non-Profit	202,895 visits	53%
Total	385,710 visits	
NORTH EAST CCAC		
Personal Support	Amount	Percentage
For-Profit	377,764 hours	72%
Non-Profit	149,409 hours	28%
Total	527,173 hours	
Nursing	Amount	Percentage
For-Profit	60,938 visits	82%
Non-Profit	13,566 visits	18%
Total	74,504 visits	
SOUTH EAST CCAC		
Personal Support	Amount	Percentage
For-Profit	193,250 hours	47%
Non-Profit	215,750 hours	53%
Total	409,000 hours	

Nursing	Amount	Percentage
For-Profit	198,100 visits	66%
Non-Profit	103,050 visits	34%
Total	301,150 visits	
SOUTH WEST CCAC		
Personal Support	Amount	Percentage
For-Profit	130,182 visits plus 362,751 hours	
Non-Profit	329,010 visits plus 504,807 hours	
Total	459,192 visits plus 867,558 hours	
Nursing	Amount	Percentage
For-Profit	292,028 visits	45%
Non-Profit	359,990 visits	55%
Total	652,018 visits	
TORONTO CENTRAL CCAC		
Personal Support	Amount	Percentage
For-Profit	983,477 hours	54%
Non-Profit	829,276 hours	46%
Total	1,812,753 hours	
Nursing	Amount	Percentage
For-Profit	20,441 hours plus 372,579 visits	
Non-Profit	107,246 hours plus 180,895 visits	
Total	127,687 hours plus 553,474 visits	
WATERLOO WELLINGTON CCAC		
Personal Support	Amount	Percentage
For-Profit	510,000 hours	71%
Non-Profit	210,000 hours	29%
Total	720,000 hours	
Nursing	Amount	Percentage
For-Profit	255,500 visits	87%
Non-Profit	39,600 visits	13%
Total	295,100 visits	

Aggregate For-Profit Versus Non-Profit Service Provision (inclu. CCACs with comparable data only)		
Personal Support[63]	Amount	Percentage
For-Profit	5,650,084	64%
Non-Profit	3,241,139	36%
Nursing[64]	Amount	Percentage
For-Profit	1,810,195	58%
Non-Profit	1,322,514	42%

[63] All CCACs with consistent data units (hours only) for volumes of personal support contracts are included in these calculations. They are: Central, Central West, Champlain, Mississauga Halton, North East, South East, Toronto Central, and Waterloo Wellington.

[64] All CCACs with consistent data units (visits only) for volumes of nursing contracts are included in these calculations. They are: Central East, Champlain, Mississauga Halton, North East, South East, South West, and Waterloo Wellington.