Ontario Health Coalition

REPORT

Secrets in the House
Homecare Reform in Ontario 1997 - 2000

BACKGROUND

It is not possible to recognize the actual practice of homecare delivery in Ontario from the province's Long Term Care Act - the legislation passed by the provincial legislature in 1994 to govern the distribution of home and long term healthcare services. Indeed, the homecare system that is currently in operation bears little, if any, resemblance to the words contained in our provincial annals. The Act, which was passed after a lengthy consultation process, called for community governance through publicly administered Multi Service Agencies and included a Patient's Bill of Rights. It also provided for the organized transition of governance to a public system. In 1995, the Ontario PC Party was elected and created plans to dramatically reshape the direction of long term care reform in this province. These plans have been executed largely without any democratic scrutiny.

In January 1996, Ontario's Ministry of Health established 43 regional Community Care Access Centres (CCACs) - instead of creating Bill 173's Multi Service Agencies - to govern the delivery of nursing home visits, homemaking services and admissions to long-term care facilities. These Access Centres became operational in 1997 as non-profit corporations governed by Boards of Directors. The CCACs were directed to contract for services through a process established by the province that year. In this process private profit-seeking corporations were invited to compete for contracts against the non-profit service providers and the CCACs were directed to withdraw from providing any services directly.

In January 1999 the Ministry of Health drafted service guidelines for CCACs to determine eligibility, priorities for service and levels of care. Later in 1999, the conservative cabinet passed Regulation #386/99 limiting homecare and home nursing visits. Under these measures, the CCACs were directed to determine eligibility for

care based on several criteria including whether family, friends, volunteers, cleaning ladies, grocery delivery services or others are able to provide care, and were directed to ration care based on service maximums. Access to care was no longer to be based on need.

All of the changes introduced to the home and long term care systems since 1995 have been conducted without concomitant legislative change. Radical policy shifts with far-reaching implications have been accomplished through cabinet-approved regulations and service agreements from the Ministry without any public debate or discussion, and without any rigorous analysis of outcomes. Last fiscal year, according to the Ministry of Health and Long Term Care, the total transfer from the province to the CCACs was $1.14 billion. Yet there has been no comprehensive assessment of need, no public consultation, and a large part of the system which has been set up through these undemocratic processes is shielded from public scrutiny and accountability through deliberate exclusion from provincial freedom of information legislation. In short, the billion dollar publicly funded homecare sector is being run virtually without public accountability.

INTRODUCTION

Since 1997, the Ontario Health Coalition has worked to democratize the process through which the Ontario government is reforming home and long-term care. Concerned about the Ministry's promotion of for-profit providers in the sector and the increasing out-of-pocket cost burden on individuals and families, from 1998-2000 the Ontario Health Coalition conducted a comprehensive review of privatization in Ontario health care. Information gathered from local health coalitions and partner organizations, reports from organizations in the field, and community forums have led the Ontario Health Coalition to identify seven areas of pressing concern regarding the province's reform of homecare as follows:

1. lack of democracy and consultation

2. lack of accountability

3. lack of standards and quality control

4. chronic and planned underfunding

5. burgeoning waiting lists and lack of assessment of population need

6. severe staffing shortages

7. increased administrative costs through duplication, waste, and profit-taking

The driving forces behind the government's restructuring of health care are an ideological commitment to privatization and an attempt to cut funding. In order to make room for profit-taking in the context of inadequate funding, the government has forsaken patient rights, stability and any semblance of coherent outcome-based planning. The changes have been accomplished covertly - veiled by purposeful exclusion from freedom of information legislation - and with notable avoidance of normal democratic processes and accountability. Community care, the fastest growing sector in our healthcare system is in the midst of a process of wholesale privatization and access to the care we need - the most fundamental and critical element of the publicly funded system - is eroding.

1. LACK OF DEMOCRACY

There has been no public consultation regarding homecare since the NDP provincial government passed the Long Term Care Act into law in 1994. That Act has never been implemented. Instead, the Ministry of Health has relied on service agreements it negotiates with the CCACs and regulations passed by cabinet. These comprise a significant change in direction from the 1994 Long Term Care Act (Bill 173) - without any public consultation.

Regulation #386/99 limiting access to homecare services was passed in secrecy with no public consultation despite assurances from the Minister to the contrary. The regulation was passed on March 10, but not filed until July 6, 1999, a month after the provincial election. In fact, even after the caucus had passed the regulation, Cam Jackson assured the Ontario Health Coalition - in writing - that the public consultation would take place prior to its approval (see Appendix 1).

The provincial government is planning to introduce a new Long Term Care Act. Despite appeals from various seniors' groups and health advocacy organizations, and assurances from the Minister of Health to the contrary, there have been no public consultations on the new Act. In addition, no consultation document has been released, no information on the timing of the introduction of the act is available, and the Ministry has not provided stakeholders with information regarding the direction of the legislation.

Currently, the government is in the midst of passing the so-called Public Sector Accountability Act. Already, Community Care Access Centres across the province are reporting that thousands of Ontarians in need of home support and health care will see their services cut. This Act, putting the Ministry of Finance in charge of whether or

not Ontarians can access required home support and health care, does nothing address critical aspects of government accountability. On what expertise will the Finance Minister's decisions based? There is no assessment of population need, no consideration of collateral damage, no increase in access to information, no prospect of community input, no attempt at consultation .

2. LACK OF ACCOUNTABILITY

The $1.14 billion of public money that is transferred this year to CCACs has disappeared into a black hole - characterized by lack of legitimate democratic governance, exempt from freedom of information legislation, replete with agency contracts shrouded in secrecy and sealed with gag orders. The Ministry has never answered crucial questions about expenditure, quality of service and contract issues. Troubling indicators of problems with the management of contracts and the delivery of services have emerged over the last several years - including long waiting lists, bankruptcies, a human resources crisis - but few if any formal means of public accountability and access to information exist.

Despite the fact that they receive virtually all of their funding directly from the Ministry of Health, the CCACs are explicitly exempt from provincial freedom of information legislation. It is up to each CCAC whether or not it is willing to reveal information that is crucial to guage the quality of decision-making and outcomes. Detailed information is all-too-often unavailable to the public. In one example we have managed to find, the contracts between the Kingston CCAC and provider agencies contain a gag clause that binds the provider agency to secrecy regarding the contents of the contract and limits the agency's ability to lobby on certain community care issues- on pain of loss of contract if this clause is violated. Why are certain companies winning the contracts over others that have a long history of providing community care services? What quality of care provisions are in the contracts? How much public money is going to each company? What percentage of funds is going to profit-seeking companies? These questions and many others remain unanswered.

Closed-slate elections and membership selection procedures have led to the perception that CCAC Boards are notably undemocratic and biassed. Although there is no uniformity across the province and some are definitely better than others, all CCACs require an application for membership. The selection criteria for members in some areas is not clear and is open to discrimination based on political viewpoint. For example, in Windsor, a community leader who had chaired the local United Way campaign, who had an impressive track record of community involvement and had no conflict of interest was refused membership until community outrage over perceived

bias forced the CCAC to revise its position. The Kingston CCAC allows only 60 people selected by a Board committee to become members. There is no publicly available set of selection criteria. Those 60 members, picked by the Board, then elect the Board. In several cases, minority or geographical representation issues have been used as an excuse to avoid democratic and transparent nominations processes.

The very point of community governance is to create flexible and democratic community access. Setting up community boards without public access to information and without accountable election processes amounts to a cynical attempt to create the appearance of democracy without real public input or control. This model of governance has, in no small way, contributed to the lack of public awareness about the radical direction of reform and its troubling consequences.

3. LACK OF PROVINCIAL STANDARDS AND QUALITY CONTROL

The Ministry of Health and Long Term Care is on the record as stating that 80% of contract decision-making is based on quality issues while 20% is based on cost. However, different CCACs report varying quality to cost ratios and there is grave doubt about the soundness of the methodologies used to assess quality. Since the contract decision-making process in each locality is determined by the local CCAC and since that information is not public, quality determinants cannot be systematically tested. There is, however, more than enough evidence to conclude that key quality of care issues are not protected in the current model. This situation is further compounded by the total lack of provincial standards setting patient’s rights, accessibility, and minimum acceptable standards and levels of care.

Several reports lend credence to this concern. The Provincial Auditor stated in his 1998 report that the funding formula for this sector would not ensure that funds will be used efficiently, give any assurance about the quality of care provided, or establish the amount of funding required to provide an adequate level of service. Even the Ontario Home Health Care Providers’ Association in March 1999 stated, "at present there is no articulated process in the [competitive bidding] document to determine how each provider arrived at the price/quality structure for services."

Bankruptcies, the awarding of contracts to not-yet-operational companies, and provider corporations unable to meet the terms of contracts they have won, among other experiences to date, show that the Minister’s assertion about quality control is largely an empty claim. In 1998 in Kingston, a company called Caregivers applied for a palliative care contract, won it, and went bankrupt two weeks later. This year in

Kingston, a profit-seeking company called Allcare won the palliative care contract. Subsequent to winning the contract, Allcare hired the non-profit agency Hospice Kingston - which, ironically had lost the bid to Allcare - to train Allcare's nurses in palliative care. In Chatham-Kent last year, a private company called CarePlus won a contract without an operational office or service record in the community. Similarly, the for-profit corporation Olsten* won the contract in Sault Ste. Marie in 1999 when it had only a nominal one-person office in the community. In Windsor in 1999, the VON who had a decades-long track record of service in the community was replaced in part by Olsten - a company that is notorious for its convictions for defrauding the American medical system. This fall in Cornwall, the latest RFP stripped the Red Cross of the homemaking contract for two counties. In that area, the Red Cross had a long history of homemaking service provision, no record of complaints about their service provision from the CCAC and an average length of service for staff that was approximately 10 years allowing excellent continuity of care. How are CCACs measuring quality of care criteria in bids when the bidding companies have no trained staff, no community track record and non-existent service provision?

With no measure of population need, funding that does not meet demand, and regulation that allows the awarding of contracts to companies that have not existed in the community before, there is little meaning in assertions about quality control through quality to cost ratios. Key elements of quality of care - knowing who is coming into your house to give you your bath, bilingual service provision in French-speaking areas, enough trained staff to cover shifts - these components are not and cannot be protected. Even more disturbing, the very basic tenet of good care - stable access to enough care to meet your needs - has been explicitly eliminated.

**** Olsten, convicted more than once for defrauding the US Medicare system, subsequently changed its name to Gentiva Health Services and then to Bayshore Health Care Corporation.***

4. CHRONIC AND PLANNED UNDERFUNDING

The evidence, since the CCACs were created, is that underfunding is chronic and planned. Waiting lists across the province are growing. According to the OACCAC more than 11,000 Ontarians are now on waiting lists for homecare. Last June, VHA Homecare in Toronto reported that between 1997 and 1999 there was a 38% increase in the number of acute care patients the agency was caring for after their release from hospital but the budget for their care had dropped by 22%. The Hamilton-Norfolk CCAC reported that its budget has remained unchanged for the past four years while the patient load continues to grow. In early May, the Waterloo CCAC reported a 10%

increase in demand for service and anticipate more increases as the area's two urgent care clinics eliminate evening service - but their budget remains unchanged.

A pattern of CCACs running regular operational deficits has emerged. These deficits have been planned with the full awareness of the Ministry. In correspondence with the local health coalition, Kingston CCAC CEO reports that Ministry officials were not only aware of, but also advised continuation of the CCACs direction of planning for "over-expenditure". In the 1997/98 fiscal year, 17 CCACs had combined deficits of $34 million. The ministry provided funding at the end of the fiscal year to wipe out deficits. This pattern has continued in subsequent years.

The consequence of constant under-funding and after-the-fact deficit financing? Widespread instability for both service providers and patients. After losing $240,000 last fiscal year due to CCAC contract funding that is below manageable levels, the VON in Haliburton and Victoria - after 26 years of service in that community - will be closing its nursing services, an occurrence that has been repeated in community after community across the province. Bankruptcies and branch closures in homemaking and nursing agencies have risen in frequency over the last three years. Chronic underfunding has created a disturbing trend of CCACs revising their eligibility criteria and levels of service to deal with funding crises. In its Annual Report 1998-1999, the Toronto CCAC reported that due to a $15 million shortfall between need and funding, the Board was forced to implement changes to eligibility criteria for some services resulting in service cutbacks. In September 1998, the Kingston CCAC announced publicly that due to lack of funding it would have to cut services for up to 2000 local people that they previously had assessed as requiring services. On an ongoing basis, across the province, people who receive care are reassessed and eligibility is changed based on the financial position of the CCAC.

In an attempt to force the CCACs to implement cuts that will bring their expenditures into line with the deliberately inadequate funding, the government has introduced Bill 46 - the Public Sector Accountability Act - making it an offense in law for CCACs to operate at a deficit. As a result, CCACs across the province are reporting that they will be cutting thousands of Ontarians' key preventative health care and home support services. In Waterloo, the CCAC reports that approximately 1,900 people will be affected in their region. In Sudbury-Manitoulin, the CCAC reports that services enabling residents to maintain their homes will be cut. The result? Waiting lists will grow, former homemaking clients will be forced into costly residential or hospital care and hospital back-ups will become more acute as referrals are put on waiting lists.

5. BURGEONING WAITING LISTS AND LACK OF ASSESSMENT OF POPULATION NEED

There is consensus from divergent viewpoints that early release from hospitals has increased the demand for and acuity of homecare required. Even the province's health restructuring commission - largely responsible for chaotic health restructuring in this province - in its final report stated, it remained "concerned that [the Ministry of Health's] continued slowness in the pace of reinvestments will jeopardize successful restructuring and risk the loss or diminish the gains made toward the creation of a genuine health system." Despite this, the province has assiduously avoided assessing need, has denied the existence of waiting lists, and has established service guidelines and regulations limiting access to care.

Statistical and demographic evidence points to a pressing need to determine care requirements both in the short and long terms, and to put into place adequate resources to meet this demand. Statistics Canada reports projects a significant increase in the senior population in upcoming years. Statistics Canada has also disclosed that the prevalence of unmet need for personal assistance is greater among lower-income and less educated seniors, compared with those who live in higher income households and have more education. These trends, coupled with the decline in average length of hospital stay, suggest that homecare services will play an even greater role over the next decade and that there are serious inequities in access to care. Yet there is still no assessment of need for homecare services in this province. This situation raises the question: without any assessment of population need and without outcome-based planning how is the government making decisions about providing resources to this sector?

The total lack of evaluation and needs assessment is evidenced across the province. In one example, the Niagara District Health Council's Annual District Service Plan for 1999-2000 calls for reinvestment in community care and cites anecdotal evidence indicating that revised eligibility criteria has led to increased hospital admissions, increased hospital waits for long term care placements and greater financial, physical and emotional burdens on caregivers. The report goes on to raise concerns about inappropriate admissions to acute care facilities due to inability to provide adequate supports in the community. It describes a local CCAC that is barely able to cope with current demand. Tellingly, the Health Council notes that they are unable to estimate the number of clients who are not receiving services and that qualitative needs assessments have not been conducted.

The province’s response? Denial. In its report, the OACCAC states, "Indeed the Ministry of Health and Long Term Care stated position is that there cannot be a waiting list for nursing services. . . .Despite this practice, however, the recent experience of CCACs is that waiting lists for nursing care are a growing reality. For example, from January 1 - March 31, 2000, there were 183 occurences of "unable to service" clients by the four nursing agencies under contract with the Toronto CCAC." According to the OACCAC, Ministry of Health and Long Term Care data for homemaking, therapies, social work and dietetic services shows 11,225 waiting for service as of March 31, 1999, representing an estimated 17% of the total increase in clients over the three year period from 1996-1999.

6. SEVERE STAFFING SHORTAGES

The managed competition model adopted by the province, the outcomes of hospital cuts, closures and restructuring and chronic inadequate funding have combined to create a personnel crisis in the homecare sector. No less than eleven reports from CCACs, associated groups and policy committees have been released since 1999 detailing severe human resources shortages. A position paper on the topic released by the Ontario Association of Community Care Access Centres in July 2000 called the situation "critical and escalating". Predictably, this has created a dramatic degradation of quality of care - with no light at the end of the tunnel.

Numbers of personnel needed are hard to come by. In its report, the OACCAC notes, "[a]n alarming finding of this process is the dearth of data on human resource requirements in the community care sector." They also note the dramatic escalation of demand for care. Since 1997 nursing visits in Ontario have increased by 1,606,000 and personal support worker hours have increased by 3,780,000. Reports from provider companies, health care workers’ organizations, and CCACs clearly show that attracting and retaining personnel is a significant and growing concern.

The situation is further compounded by the rising acuity and complexity of care - and therefore increasing flexibility and training for staff - required in the homecare system. Yet, according to the Ontario government’s Nursing Task Force, average earnings for registered nurses working in the homecare sector are $5 - $6 per hour lower than for those working in hospitals. The Ontario Community Support Association reports that personal support workers in homecare earn $5 - $8 less than do those who work in facilities. In this context, the adoption of a "managed competition" model that has put downward pressure on wages and working conditions combined with chronic underfunding, have contrived to create the serious and worsening personnel crisis. In Cornwall this September, for example, the Red Cross lost the homecare contract for

two counties and was forced to lay off 118 Personal Support Workers. The company that replaced the Red Cross hires staff on a casual "elect to work" basis thereby avoiding payment of staff for holiday time and benefits. In that case, and in others across the province, competitive bidding resulted in a decline of working conditions.

The results are well articulated in the OACCAC's report and in reports from local CCACs. In a sadly ironic twist, homecare - which, by definition, is care provided in peoples' homes - is now being delivered by CCACs in a growing number of communities in clinics to which patients are required to travel due to the lack of staff available to travel to peoples' homes. Gaps exist in care plans due to unavailable staff. CCACs are increasingly unable to assure continuity of care because of scheduling difficulties and changes in personnel. Clients in need are being denied admission. There is a back-up of patients in hospital. It is not possible to achieve a continuum of care across various sectors of care delivery. Patients are ultimately paying the price for lack of planning, poor decision-making and chronic underfunding.

7. DUPLICATION, WASTE AND INCREASED ADMINISTRATIVE COSTS

The competitive bidding model adopted by the province is sucking precious health care dollars out of patient care and into ballooning administration. Three years after its inception, Ontario's homecare system is rife with duplication, inability to use staff efficiently, excess administration and profit taking. A recent report by the Canadian Union of Public Employees uses the data that is available to estimate that these problems cost approximately $247 million per year, or 21% of the provinces C'CAC budget. Yet there is no Ministry assessment of the inefficiencies in the system they have created.

Expenses incurred by tendering requests for proposals, preparing bids, evaluating proposals and monitoring companies are all components of an unneccessary administrative cost burden. Each of the 43 CCACs has often over ten provider agencies involved in the delivery of care. The CCAC and each of these agencies have administrations: CEOs, financial officers, human resource departments and frontline managers. Far from streamlining the process of community care governance, this model drives up administrative requirements and escalates costs.

Further costs are incurred because both the CCACs and each of the direct service provider agencies need to keep record systems to monitor the same set of patients and the same set of visits. Maintaining multiple computer systems -- with the related hardware, software and data entry costs, all performing essentially the same function — is a significant unnecessary financial drain on the system. Furthermore, with average daily visits of 1,500 to 2,000 per day per CCAC, it is inevitable that discrepancies arise between the computer records. The costs in staff time needed to reconcile discrepancies between the systems often mean hiring dedicated staff in provider agencies and thousands of additional hours of staff time in CCACs.

The common practice of using multiple agencies to provide the same service creates inefficiencies in geographical assignments and results in increased travel costs and staff time. For example, rural neighbours may be visited in the same afternoon by two separate caregivers from two separate companies, each paid for having to travel great distances -- an unneccessary duplication of costs and scarce staff time. Moreover, the multiplicity of service providers have to work through CCAC case managers to communicate, adding extra communication time requirements and the increased possibility of mis-communication, with attendant extra cost and safety concerns.

The competitive bidding system has led to an increase in for-profit companies involved in the delivery of care. Under a bidding process that is weighted in favour of opening the market to profit-seeking companies - without support for continuity of care and sound human resource practices - we have seen exponential growth in the proportion of the industry controlled by private interests. It has been estimated that $ 42 million dollars per year of public money is currently paid out in profit to owners and shareholders of these companies. The contracting out of the therapy services by the Ottawa CCAC provides a graphic example of this system creating extra costs. In that region, the CCAC has documented that they are paying over $500,000 more per year to provide exactly the same service that would have been provided had they been allowed to keep the therapists as direct employees. If there was public access to financial and contract information across the province, more examples of this sort would likely be found.

The inherent redundancies and extra costs involved in the current model of home care delivery detract from using our public health care dollars wisely and allowing people to receive adequate home care when they need it. This model has created instability in the industry, has redirected health funds to profit and administration, and has caused a decline in patient care. The adoption of such a radical approach without measuring its outcomes is further evidence of public policy based on a privatization ideology to the detriment of public interest.