Market Competition in Ontario's Homecare System: *Lessons and Consequences*

Ontario Health Coalition
15 Gervais Drive, Suite 305
Toronto, Ontario
M3C 1Y8

March 31, 2005

Introduction

The Ministry of Health and Long Term Care has announced a review of the competitive bidding process in homecare. In our meeting with Elinor Caplan, appointed to conduct the government's review, Ms. Caplan made clear to the Ontario Health Coalition that her mandate is limited to a review of "procurement procedure". The system of "managed competition" or competitive bidding, as it has become known, will not be reviewed and will remain in place. However, our research on the managed competition experience in Ontario has yielded several important conclusions that justify a thorough review of competitive bidding itself and the structures and procedures required by it. A summary of our main findings follows:

1. Competitive bidding has changed the nature and culture of the service providers in the sector. Competitive bidding has led to consolidation of the market, creating a market oligopoly.

2. Competitive bidding has introduced massive and regular dislocation of human resources in the sector.

3. Competitive bidding has introduced massive and regular interruptions in continuity of care in the sector.

4. Competitive bidding has contributed to a climate of fear among staff and patients, and a culture of secrecy.

5. Despite claims of "innovation" resulting from competition, we have been able to find no evidence of bona fide improvements in care methods or administration. Rather, we have found that the competitive bidding process is responsible for declining working conditions and the elimination of job security, factors that have led to an exodus of skilled workers. Conditions appear to be worse in for-profit agencies, or at least, to have worsened more quickly among these providers.

6. Despite assertions of quality assurance, in practice, the bid process is a matter of assessing expensive consultant-written bids and is largely a theoretical exercise.

7. The direct costs of competitive bidding are a significant burden. The structure of the homecare sector as shaped by competitive bidding is rife with duplication, redundancies and higher administrative costs that are unnecessary but for the competitive bidding system. Resources have been shifted from patient care to administration.

8. Democracy has been eroded. Boards are not elected by or representative of the community but are appointed by Order-in-Council and do not necessarily reflect their communities, contrary to the original intention behind regionalizing long-term care services. While many not-for-profit providers are run by boards of directors based in the community with varying degrees of democracy and community control, the for-profit providers are accountable only to investors. Access to information has been compromised due to competition and privatization.

9. Extending the length of contracts while maintaining competitive bidding would fail to address the fundamental problems with the current system, and would create a host of new problems.

10. Competitive bidding will worsen the divide between homecare and other parts of the health care system. It has already resulted in a migration of skilled personnel from the homecare sector to hospitals and long-term care facilities.

1) Competitive bidding has changed the culture of the sector

Prior to the introduction of competitive bidding, the homecare sector was served predominantly by not-for profit agencies with deep roots in the community and a long tenure of operation, in some cases lasting more than a century. The introduction in 1996 of competitive bidding has transformed the culture of the sector resulting in an influx of the for-profit homecare industry. Over time, small, community-based agencies have lost contracts to larger for-profit as well as non-profit companies.

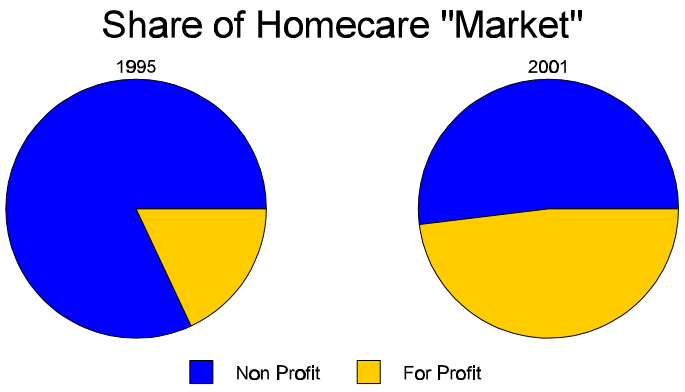
Prior to the introduction of competitive bidding, homecare was provided on a public service basis, largely by non-profit providers.

The culture of the homecare sector has changed due to the expansion of for-profit companies and the consolidation of the "market" in the hands of a few large providers creating a market oligopoly. Now, large companies, for-profit as well as not-for-profit, travel around the province making bids to secure market share. These corporations often do not exist in any tangible way in the communities they seek to serve. Not-for-profit providers have been forced to emulate for-profit providers in order to compete and have adopted a number of negative practices. The most reliable and recent figures show that the percentage of homecare nursing market share provided in Ontario by for-profit service providers increased from 18% in 1995, two years prior to the introduction of competitive bidding to 48% in 2001.

Two major shifts have occurred under competitive bidding.

1) The for-profit homecare industry has entrenched itself in the "market" as a major player.

2) Small agencies have lost out and the sector has been taken over by large providers, creating a market oligopoly.



Not for profit providers have been forced to emulate for-profit providers in order to compete and have adopted a number of negative practices.

There is some evidence that claims that the competitive bidding process favours larger companies (both for-profit and not-for-profit) over small local agencies are true. In a survey of the status of contracts with forty out of forty-two CCACs we found that the overwhelming majority of contracts for both nursing and personal support services are now held by large, for-profit providers or large not-for-profit providers (see Appendix). Our data indicate that 6 corporations held 76% of the contracts last fall, compared to 8 agencies holding 66% of the contracts in 1995. The market concentration figure would be even higher if it was based on volume of services delivered. The big corporations focus on the high volume contracts and the smaller agencies have a larger representation in the specialty areas.

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Competitive bidding has also had a destabilizing impact on small agencies

that do not serve the entire province. While a large corporation or not-for-profit will not go out of business because it's lost a contract in one region, a local not-for profit or for-profit will have its existence threatened by the loss of what may be its sole contract. This dynamic reduces competition and removes whatever benefit the market is supposed to produce.

Our survey, conducted September 2004, also revealed that in the recent round of bidding, several remaining small community based agency contracts were lost leaving those providers virtually unrepresented in the nursing and personal support sectors. The Ontario Community Support Association reports that prior to the introduction of competitive bidding there were 24 small, non-profit agencies servicing local markets in Ontario; only three are left today.

Thus, small, local agencies with depths of experience and respect in the community are being displaced by large, often multinational shells with no standing office, local presence or staff (and thus no local track record) who can afford to hire teams of consultants to write a better sounding bid.

The introduction of market modalities into the homecare sector has resulted in homecare providers becoming or behaving more like large corporate entities at the expense of excellent, community-based homecare.

2) Competitive bidding has introduced massive and regular disruption of human resources

The competitive bidding regime has resulted in a destabilization of working conditions for nurses and support workers. Both job security and working conditions have been negatively affected. Instability makes home care a less attractive career option for both potential and existing staff and has resulted in a migration of staff from the homecare sector to sectors that are seen as more desirable.

In a snapshot picture of eight recent months alone, we have seen the dislocation of over 1,050 workers.

1) In Haldimand-Norfolk, the nursing contract was lost by the VON to Comcare resulting in the lay off of 140 full and part time nurses and nurse practitioners by the time the contract ended in October 2004. [1]

2) In Brant, in the summer of 2004, a contract held by the Red Cross for more than 50 years was lost to Comcare resulting in 115 full and part time workers being laid off.[2]

3) VON and SEN have lost contracts in Niagara Falls to Care Partners and St Elizabeth Healthcare with at least VON 110 nurses[3][4] and an estimated 50 SEN nurses being laid off by the contract's end in September 2004. VON had provided service in the area for 85 years[5].

4) Visiting Homemakers Association (VHA) Health and Home Support laid off 200 nurses and home workers, in Ottawa August 2004, when they lost their contract.[6] They had been providing services for nearly 50 years. [7]

5) In August, Community Care East York lost its contract to VHA Healthcare and Spectrum affecting 50 to 70 staff. They had been providing service for 20 years.[8] [9]

6) Kingston VON lost its nursing contract to Paramed, All-Care and Red Cross forcing it to lay off at least 70 staff in April 2004.[10] VON has provided community nursing in the area for over 100 years. In the same community, Allcare staff was laid off when their contract was lost to the Red Cross and Paramed.

7) Not-for-profit SEN Community Care in Hamilton lost its Halton and Niagara contracts in March to Windsor-based for-profit Care Partners, which has no history in the Niagara/Halton region.

8) VON in Manitoulin-Sudbury closed its homecare division in June 2004 forcing the layoff of 300 to 350 employees[11] blaming its loss at the end of 2002 of a $13 million contract to provide home care to seniors.

9) In December 2004, Community Home Assistance to Seniors (CHATS) lost their personal support contract in York Region forcing the layoff of 350 home care workers.[12]

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[1] *Brantford Expositor*, August 21, 2004, page A3
[2] ibid
[3] *Toronto Star*, October 5, 2005, page A7
[4] *St Catharines Standard*, September 30, page A3
[5] *Welland Tribune,* September 3, page A4
[6] *Brantford Expositor*, August 5, page A5
[7] "Premier Dalton McGuinty insists his government is not trying to put smaller, not-for-profit homecare agencies out of business", Broadcast News, August 5, 2004
[8] *East York Mirror*, August 20, 2004
[9] *Toronto Star*, August 19, page A4
[10] *Kingston Whig-Standard*, March 11, 2004, page 1 (Community section)
[11] *Sudbury Star*, August 5, 2004, page A3
[12] Ontario Community Support Agency press release, December 6, 2004

Competitive Bidding Recent Staff Layoffs Due to Contract Changes	
Haldimand-Norfolk, October 2004 VON lost contract	140 full and part time nurses and nurse practitioners laid off
Brant, Summer 2004 Red Cross lost contract	115 full and part time staff laid off
Niagara, August 2004 VON & St. Elizabeth Nursing lost contracts	160 nurses laid off
Toronto, August 2004 Community Care East York lost contract	50-70 staff laid off
Kingston, April 2004 VON lost contract	70 staff laid off
Manitoulin-Sudbury, June 2004 VON lost contract	300-250 staff laid off
York Region, December 2004 Community Home Assistance to Seniors (CHATS) lost contract	250 homecare workers laid off

Competitive bidding has created extraordinarily high levels of staff turnover. One study has shown that from 1997 to 2002 turnover among nurses in the homecare sector has ranged from a high of 73% in 1999 to a low of 24% in 2001[13]. According to another study that followed former VHA staff in Hamilton following the agency's loss of its contract in 2002, 9.5% of former homecare workers moved to jobs in long term care facilities.[14] The Red Cross estimates that where it has lost contracts, up to 35% of its former workers leave the homecare sector[15].

Staff turnover under competitive bidding is extraordinarily high. One study has shown that turnover among nurses in Ontario's homecare sector has ranged from 24% to a high of 73%.

One study that followed former VHA staff in Hamilton following the agency's loss of its contract in 2002 found that almost 10% of the workers left the homecare sector for jobs in long term care facilities.

The Red Cross estimates that 35% of its former workers leave the homecare sector after its contracts have been lost.

Managed competition has also resulted in increased absenteeism and fears of job loss, increased burnout and stress and decreased health and job satisfaction by homecare workers[16]. In Cornwall, workers who had been employed by the Red Cross with a long tenure have had to reapply for their jobs at least three times since the introduction of competitive bidding and have, in the same period, lost their holiday pay and other benefits[17]. In East York, according to our interviews, the change of contract from Community Care East York to VHA and Spectrum has resulted in a loss of benefits and guaranteed minimum hours and seniority for workers. In Kingston, VON workers had their pensions capped when their jobs ended and lost their seniority based extra vacation time. There is no reason to believe that these specific instances are not to be repeated in other instances when contracts are lost. As a result of these events, a number of workers have decided to retire, seek work in another field or in an institutional setting.[18]

In Cornwall, homecare staff have lost their jobs at least three times since competitive bidding was introduced, losing their holiday pay and other benefits.

This phenomenon prompted Linda Brown, vice-president of the Ontario Community Support Agency, to say "We already don't have enough nurses in the system. Because community nursing is so unstable, they'll leave nursing completely or get jobs in the hospital

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[13] Doran, Pickard et al, *Management and Delivery of Community Nursing Services in Ontario: Impact of Care and the Quality of Worklife of Community-based Nurses,* University of Toronto Community Nurses Services Study, 2004, page 16. This study found some key areas of dissatisfaction for nurses and clients. In addition, it drew conclusions from perceptions by for-profit providers and CCACs about conditions in the sector prior to competitive bidding, even though those entities were not in the sector prior to competitive bidding.

[14] Aronson, Denton, Zeytinoglu, Market *Modelled Homecare in Ontario: Deteriorating Working Conditions and Dwindling Community Capacity*, Canadian Public Policy, XXX (I), 2004.

[15] Interview with Claude Tremblay, Red Cross Community Health Services

[16] Denton, Zeytinoglu and Davies, *Organizational Change and the Health and Well-being of Home Care Workers,* 2003.

[17] OHC, *Secrets in the House* (section 6), 2001.

[18] Interview with East York community agency.

sector."[19] The 2003 Canadian Home Care Resources Study found that the top three reasons home care workers were planning on leaving their jobs were lack of job security, low wages and poor benefits.[20].

At a time when demand for homecare services has increased due to offloading from the hospital and long term care sectors the need to attract and retain care providers has increased.[21] The problem of deteriorating working conditions repelling nurses from the homecare sector is exacerbated by trends in the nursing profession as a whole - 6,000 nurses (in all fields) are expected to retire in Ontario this year but only 3,000 nursing students are expected to graduate and half of those are expected to leave the province to work[22]. With a shortage of nurses in the province, the homecare sector cannot afford to become a less attractive work environment.

There are few industries that would consider turnover rates of 24% to be acceptable, let alone 73%. However, collective bidding necessitates regular and massive dislocation of staff with all the attendant problems created by such an extraordinary rate of turnover.

"We already don't have enough nurses in the system. Because community nursing is so unstable, they'll leave nursing completely or get jobs in the hospital sector," Linda Brown, Vice President, Ontario Community Support Association.

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[19] *Guelph Mercury,* July 26, 2004, pg A4.
[20] http://www.cacc-acssc.com/english/newsroom/links.cfm
[21] Human Resources Task Group OACCAC, *Human Resources: A Looming Crisis in the Community Care System in Ontario*, July 26, 2000, pg 13.
[22] "Nursing home concerns front-line workers say it's a crisis" *Sarnia Observer,* May 13, 2004

3) Competitive bidding has resulted in massive and regular disruption of continuity of care

The impact of competitive bidding on the continuity of care for users of the system cannot be overstated. Each time a contract is lost, clients face a change of caregivers and the manner in which their services are delivered. Instability in the sector contributes to poor working conditions and means care workers are leaving the sector exacerbating poor continuity of care. Competitive bidding has a disruptive and turbulent impact on the continuity of care received by care recipients.

In recent months over 22,000 clients have been affected by the loss of contracts through competitive bidding:

- **600 clients in East York**
- **At least 1,700 clients in the Niagara region**
- **1,300 clients in Ottawa**[23]
- **15,000 clients in York region**[24]
- **1,200 clients in Kingston**
- **2,700 clients in Manitoulin-Sudbury**[25]
- **>1,000 clients in Wellington-Dufferin**[26]

In the case of Manitoulin-Sudbury, the VON withdrew from its remaining contract with the CCAC after not being able to recover from the loss of an earlier $13 million contract for in-home care for seniors. The dislocation of service creates stress among clients. Anne-Marie Bedard, a client affected by the VHA's contract loss in Ottawa, told the Canadian Press "I've had the same home-care provider since I started because I need help with my bath… I've learned to trust her… and now if I'm going to get somebody else or if I get no one at all, what do I do?"[27] Carework is intensely personal and unique to each individual. The impact of changing providers on quality of care has been reported upon in a number of studies, showing that turnover in caregivers impacts clients in many clinical and emotional ways.

The interruption of service and reassignment of care workers creates a major disruption in the lives of those who rely on homecare, with all the attendant consequences for quality of care it causes.

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[23] http://www.ocsa.on.ca/PDF/VHA%20Press%20Release%20Ottawa%20Rally%20Aug%2020-04.pdf

[24] Ontario Community Support Agency press release, December 6, 2004

[25] *Sudbury Star*, August 5, 2004, page A3

[26] *Guelph Mercury,* July 26, 2004, page A4

[27] Canadian Press report in the *Barrie Examiner*, August 21, 2004, page A4

4) Competitive bidding has contributed to a climate of fear and stifles information sharing

Competitive bidding has created a climate in which agencies and staff fear criticizing policy and clients fear criticizing practices. Agencies in the market model are competitors and face disincentives to share information and resources with each other. Bill 130 has stunted CCACs' accountability to communties as they are now appointed by government rather than by communities. They are reticent to discuss the impacts of government funding changes and public policy decisions. Some CCACs are even refusing to divulge basic information about who has contracts and on what basis.

Many CCACs prohibit agencies from publicly criticizing homecare policies on penalty of forfeiting their contract or the implied threat of not having their contract renewed (in fact, this provision is in the template RFP provided by the Ministry[28]). The CEO of one CCAC phoned a contracted agency to find out what an employee of that agency was going to say at a public meeting on homecare. The agency lost the contract in the next round of bidding. Comcare, a for-profit agency contracted for homecare services in Kenora-Rainy River region, demanded that its employees sign an oath of confidentiality that is so broad that it prevents homecare workers from telling the public about problems with homecare services. Clients regularly report to us that they are unwilling to make complaints for fear of having their service reduced. CCACs are allowed to cut off service to a client if they complain about their service provider. Under General Conditions, Section 3.1.6 (5) of the Ministry's template RFP document, "the CCAC may, in its sole discretion, withdraw Services from an individual Client for any reason the CCAC deems necessary, including due to Client complaints about the Service Provider." Additionally, numerous service recipients have informed us that they fear publicly speaking out about problems with their homecare out of fear of being denied service.

Real innovation and responsive public policy relies on an open and frank sharing of information on practices and outcomes. The climate of fear and outright secrecy stifles accountability, public debate and input essential to the checks and balances in the health system. Competitive bidding raises one more, very strong bar, reinforcing fear in the system.

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[28] section 3.4 (4) specifies that prospective respondents, respondents and even successful respondents shall not contact or attempt to contact a wide list of individuals/organizations in the RFP process, including any staff of the Ministry of Health and Long-Term Care, any staff of the Premier's office, any MPP or their staff. Further, the General Conditions section of the template contract forbids the Service Provider from issuing "any publicity or news release or otherwise respond to or contact any member of the news media pertaining to this Agreement of the Services without prior consent of the CCAC."

5) Competitive bidding has not brought innovation to Homecare

Part of the argument for ushering for-profit providers into the sector and implementing "managed competition" is the claim that competition can introduce innovations. However, we have been able to find no evidence of bona fide innovation in care methods or administration. Instead, innovation has been limited to finding ways to drive down working conditions in order to allow bidders to outbid competitors while making room for profit. Changes that have been introduced by both for-profit providers and by not-for-profit providers trying to emulate their competitors, include piecework, split-shifts, strict time limits on care services, the elimination of travel pay for workers as well as benefit reductions. Costs are increasing with no public accounting of outcomes. The culture of volunteerism in the non-profits is being sacrificed as for-profits take over. The implementation of these so-called innovations either directly reduce the quality of service received by the client or indirectly do so by impairing the ability of the homecare sector to attract and keep quality workers.

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Changes which have been introduced by both for-profit providers and by not-for-profit providers trying to emulate their competitors, include piecework, split-shifts, strict time limits on care services such as bathing times, the elimination of travel pay for workers as well as wage and benefit reductions.

Contrary to claims of greater efficiency, there is, in fact, evidence that the agency "markup" portion of the rate charged by for-profit companies to CCACs is higher in than not-for-profit providers. The mark-up is the difference between the rate charged to the CCAC and the wage paid out. In Hamilton, in 2000, the agency "mark-up" by for-profit providers on personal support work is an average of $8.12 per hour while the mark up by not-for-profit providers averaged at $7.37, a difference of more than 11%. However, the hourly wages paid by the for-profit providers averaged $11.08 an hour while the wages paid by not-for-profit providers averaged $12.09.[29] The for-profit providers offered lower wages, while taking a greater portion in profit and administrative fees (see chart below). In the Algoma region the Red Cross pays its workers as much as $1.70 more an hour than Comcare[30]. Further research on this is crucial, but is stunted by the lack of public access to information. For-profit providers are not required to make wage and mark up information available as they consider it proprietary.

Hamilton Agency Mark Up - Pay Rates to Employees Compared to CCAC Contracted Prices
(from Aronson, Denton, Zeytinoglu)

Type of Agency	Rate of Pay (mean hourly)	Price Mark Up (difference between amount paid to agency by CCAC and amount agency pays staff)
Non profit	$12.09	$7.37
For profit	$11.08	$8.12

[29] Aronson, Denton, Zeytinoglu, Market *Modelled Homecare in Ontario: Deteriorating Working Conditions and Dwindling Community Capacity*, Canadian Public Policy, XXX (I), 2004.
[30] *Sault Star*, September 2, 2004, page B3

Another way in which for-profit providers have won bids while maintaining their profit margins is the introduction of strict time limits per service and piecework. Homecare workers, for example, refer to homecare as "dip and skip", a reference to the scant amount of time personal support workers have to bathe clients. Hourly wages are being replaced with fee-for-service piecework, which results in homecare workers trying to squeeze as many clients as they can into one day in order to maintain their level of pay. In Kingston homecare workers who used to be compensated for their travel expenses are now only being paid $1 per visit for travel time and nurses are now required to provide and pay for their own work related cell phones and fax machines[31]. All of these so-called innovations have a deleterious effect on quality of service. Those not-for-profit providers, which have been able to do well in the competitive bidding environment, such as St. Elizabeth Nursing in Kingston, have done so by emulating the for-profit providers by, for example, moving to a modified piecework system.[32] Ross Sutherland, a nurse and co-chair of the Kingston and Area Health Coalition describes this as "paying these nurses to work faster rather than working better." [33]

Hourly wages are being replaced with fee-for-service piecework, which results in homecare workers trying to squeeze as many clients as they can into one day in order to maintain their level of pay.

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Sandra Willard, a homecare worker, says that almost all of the homecare workers in Kingston have been hired as "elect-to-work" employees.[34] In Kingston, after the for-profit company Allcare recently lost their contract at least 75% of their former employees went to work for the new provider or other existing providers in the area. The transferred employees lost their benefit packages as well as vacation time and pay. Continuity of care was impacted as many of the transferred workers were assigned to new clients rather than the ones they had previously provided care for.[35]

Comcare Health Services will soon be taking over a homecare contract in Norfolk from the VON. The CCAC executive director states that Comcare will hire many of the current VON employees. The executive director of the VON noted that Comcare bid at a lower price for services, "The bid was put in to win it. Good luck to them. I don't know how they will do it at that price."

Regarding access to information, Haldimand-Norfolk CCAC executive director Megan Allen claimed, "We're a publicly run agency of the government so if somebody requested information on what is paid per home visit we can give it out".[36] The OHC contacted Allen to request that information and she said she would consider it however the information has not been released to us. VON Executive Director Linda Parkhill said that Comcare was able to outbid the VON by offering lower wages and travel compensation to Personal Support Workers. [37]

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[31] Interview with Ross Sutherland.
[32] *Kingston Whig Standard*, March 11, 2004, pg 1 (Community section)
[33] ibid.
[34] Thursday 14 Oct 2004, *Kingston Whig Standard* pg. 6, letter to the editor
[35] Information from former Allcare worker.
[36] *Simcoe Reformer*, Friday Oct 8, 2004, pg 1,
[37] ibid.

Despite claims that competitive bidding would result in reduced costs over time, in fact, costs are rising. The 2004 Annual Report of the Provincial Auditor in Ontario reports that a one year freeze in funding between 2001/02 and 2002/03 led to an overall decrease in nursing visits of 22% and a decrease in homemaking hours by 30%. However, the auditor also reported that one CCAC complained that competitive bidding led to an increase of 48% in the cost of each nursing visit over the life of the contract. The 2004 operational review of the Ottawa CCAC[38] noted that it experienced an increase in costs for contracted homemaking of 31.7% and an increase to nursing of 35.2% over a three-year period. While the cost of therapy services in Ottawa rose by 35.2%, wages only increased by 5.6% raising the question of where all the extra money is going?

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In the past, not-for-profits and charitable organizations have been able to draw upon a corps of volunteers who donate time or services to the agency in order to help it reduce costs. For instance, in Kingston, volunteers painted the office of the local agency and donated furniture. When organizations fail and lose contracts their large corps of volunteers is lost, particularly when they lose their contract to for-profit agencies which, by their nature, are unable to attract volunteers and charitable donations.

Competitive bidding has not led to innovations in technology or creative new care techniques. Instead, we have seen both for-profit and not-for-profit agencies introduce measures that: impair the quality of service or lead to deteriorating work conditions that drive away experienced staff; change the culture of the sector reducing volunteerism; alienate the community from the services; create secrecy, and; stifle information sharing.

6) Despite assertions that quality is a priority, in practice comparisons in quality are a theoretical paper exercise that draw false comparisons between established community providers and outside bidders (including new start-ups)

Both the Minister of Health and CCACs have asserted that “quality control” is given a priority in the awarding of contracts and that quality accounts for 70 to 80% of the points used to assess bids. However, the use of quality as criteria is problematic due to the nature of the bidders and is, in fact, largely a theoretical bureaucratic exercise.

The quality of care delivered is largely a function of the, quality of the health professional and the quality of their work environment.

In an interview with the OHC, one senior agency administrator referred to competitive bidding as “renting employees”. The individual employees remain; all that changes is the company they work for. When a contract

[38] *Operational Review of the Ottawa Community Care Access Centre*, released September 3, 2004 by the Ministry of Health and Long Term Care.

changes hands the new company aims to hire 100% of its workforce from the employees of the company that has lost the contract. This change, a direct result of the competitive bidding process in which an established service provider competes with a phantom provider with few or no staff of its own, only acts to alienate health care professionals from their employers and from their work, reduces morale and deters experienced and talented professionals from the homecare sector.

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Often contracts are being awarded to companies with no experience in the community making quality comparisons theoretical, based on the application written by contracted consultants. For instance, contracts cancelled with the VON recently in Niagara and with St. Elizabeth Nursing in Halton were awarded to companies with no experience in those communities, no offices and none of the front-line staff who will actually be providing the service if the company is awarded the contract. [39]

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The creation of a "market" in homecare has resulted in an expensive consultant-driven proposal process that favours wealthy companies. One spokesperson for a small care agency complained that "just going in many small community base multi serviced agencies are disadvantaged because we can't pay for a team of lawyers or consultants to write a document," and that contracts are awarded "based on the ability to write a legal document not based on the ability to serve clients in that area. The thing about a large agency is that they have many shots at writing a bid so they have many opportunities at working out a formula for a winning bid and small agencies are funded to serve one particular community so we can't go bidding (around the province)…we only have one shot at writing a bid."[40]

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When the VON lost the contract for home nursing in Niagara it had 20 nurses trained in peritoneal dialysis but the two agencies that took over the contract initially had only one dialysis nurse each.[41] Special regional requirements are often left out of the RFP as a provincial template is now used, in this case no mention of the need for peritoneal dialysis was made, nor were the bidding agencies aware of the need for specialized insulin pumps that are unique to the region. In Kingston, after Allcare was hired to provide palliative care they had to hire the losing agency Hospice Kingston (a local, community-based non-profit) to train their nurses. These examples are at odds with claims that the CCAC considers quality above all else in awarding contracts.

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[39] "Premier Dalton McGuinty insists his government is not trying to put smaller, not-for-profit homecare agencies out of business", Broadcast News, August 5, 2004

[40] Interview conducted with communications officer of small local agency (October 2004).

[41] *Welland Tribune*, Friday Sep 3, 2004, pg A4,

7) The costs of competitive bidding take resources away from care

There is evidence that the bidding process and structure itself add considerably to the cost of homecare services. A 2000 study found that the cost to each service provider of preparing a response to a single RFP is $30,000.[42] That does not include all the time and expense for all the provider agencies, such as staff time in dealing with complaints when contracts change hands. Most CCACs have at least two staff positions for handing the RFP process in their region. As well, each CCAC has from five to nine of its staff read each individual proposal and rate submissions.

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Another study found that contracting out and competitive bidding took up 19.4% of a nursing agency's expenses, 12% of home support agency expenses and 21.7% of CCAC expenditures that could be "more effectively spent on patient care".

Aside from the direct costs of producing and evaluating bids, the managed competition model requires a sector structure that is rife with duplication, redundancies and higher administrative costs

A 2001 study by Ross Sutherland, *Secrets in the House: The Costs of Contracting Out Homecare: A behind the scenes look at homecare in Ontario,* found that ending contracting out and competitive bidding with "free up a minimum of $247.4 million from the current homecare budget". The study found that contracting out and competitive bidding took up 19.4% of a nursing agency's expenses, 12% of home support agency expenses and 21.7% of CCAC expenditures that could be "more effectively spent on patient care". [43]

> 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 CCAC 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 unnecessary 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.

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[42] OCSA, "The effect of the managed competition model on homecare in Ontario" (2000).

[43] Ross Sutherland, *The Costs of Contracting Out Homecare: A behind the scenes look at homecare in Ontario,* CUPE Research, 2001.

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 unnecessary duplication of costs and scarce staff time. Moreover, the numerous service providers have to work through CCAC case managers to communicate, adding extra communication time requirements and the increased possibility of miscommunication, 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 were 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.[44]

Competitive bidding and contracting out of homecare has not resulted in a more efficient distribution of scarce homecare dollars. Instead, they have introduced unnecessary duplication of services and additional administrative overhead needed to administer both the RFP process and the monitoring of service during the life of the contract. These monies could be better spent if applied directly to homecare delivery.

8) Democratic community control of homecare has been eroded

Ontario's home care system is completely lacking in democratic process, community control and accountability. Bill 130 has eradicated democracy within the system. Boards are not elected by or representative of the community they serve. While many not-for-profit providers are run by boards of directors based in the community with varying degrees of democracy and community control, the for-profit providers are accountable only to investors.

Access to information has been compromised due to competition and privatization. A number of CCACs refuse to share even basic information such as the names of their contracted service providers let alone the size or bidding prices of contracts. As the OHC found in our experience with the Haldimand-Norfolk CCAC, even when a director claims in the press that information on the per home visit price will be made available to the public, whether such information is released is up to the discretion of the individual CCAC rather than being determined by the public's right to know[45]. While clients may be surveyed on the care they receive they have no direct input on basic questions such as whether they believe their service provider should have their contract renewed. Additionally, contracts allow CCACs to discontinue service from clients who complain.

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[44] *Secrets in the House: The Costs of Contracting Out Homecare: A behind the scenes look at homecare in Ontario* by Ross Sutherland, OHC, 2001, part seven.
[45] see page 6 earlier in this report.

The Ontario Health Coalition believes that democracy is an essential component in the health care system. Without it, service providers become unresponsive to the needs of the people they serve. Moreover, quality in the system can best be enhanced and maintained by empowering both users and workers so that they, their families and advocates are able not only to draw attention to problems in service delivery but ensure that these problems are addressed immediately.

9) Extending the length of contracts while maintaining competitive bidding would fail to address the fundamental problems with the current system.

Extending the length of contracts would not lessen the impact of each individual contract transfer. Clients would still lose the care workers they've grown accustomed to, workers would still face loss of seniority and other benefits and other pressures discouraging them from remaining in the homecare sector would remain. Companies would pad their margins in order to insulate themselves against the difficulties of making longer-term projections on costs of such items as equipment and supplies. While proponents of longer contracts may argue that the template RFP allows CCACs to change service requirements without reopening contracts as long as the added cost is 5% or less, the natural response by bidders would be to simply assume that 5% addition when calculating their bids.

Problems with Longer Term Contracts

- Continuity of care issues remain
- Bidding prices increase to reduce risk for companies
- Expensive consultant-written bids remain, favouring wealthier corporations over community-based service providers
- Culture of competitive secrecy remains
- Reduced working conditions remain
- Duplication, redundancies, high transaction costs remain
- Costs for monitoring increase, if monitoring is done
- Contracts riskier for public, costly to exit
- Climate of fear remains
- Lack of democracy remains, worsens
- Reduced flexibility

Moreover, the impact of competitive pressures on agencies would remain and the deterioration of the culture of the sector would not be reversed. Agencies would still be under pressure to limit wages and benefits and reduce services in order to remain competitive for the next RFP period or to otherwise keep their expenditures artificially suppressed in order to fulfill the fiscal requirements of their contract. The pressures for "dip and skip" piecework which lead to a culture that diminishes quality and alienates healthcare providers would remain. Nor would the duplication and redundancies inherent in managing the RFP process and the supervision of contracts be alleviated.

We do not anticipate savings from extending the length of contracts. In fact, its quite possible that costs may be increased. The savings had by reducing the number of RFP periods would be offset by the loopholes which would have to be put into a long term contract if agencies are to deal with contingencies such as unanticipated cost increases due to changes in demand or other expenses. Alternatively, the bid price would have to be somewhat higher in order to allow agencies to absorb unanticipated costs. There would also be an increased risk of agencies forfeiting contracts that they can no longer fulfill due to changes in the sector or the community. Longer-term contracts would also increase the need for more extensive monitoring costs, if there were to be any pretense of protecting the public interest.

Merely extending the length of contracts would not solve the lack of transparency and accountability inherent in the competitive bidding process, nor would the other features of competitive bidding which inhibit democracy, create a climate of fear and decrease accountability be alleviated.

Since lengthening contracts would not ameliorate the problems of increasing turnover, deteriorating service

or lack of public input and control over homecare, nor would it provide demonstrable cost savings, we believe that lengthening contracts is a band-aid solution that fails to address the fundamental flaws in the system.

10) Competitive bidding threatens to make homecare inferior to other parts of the health care system.

To maintain competitive bidding is to maintain a system in which homecare provision will always be seen as a less desirable work environment than hospitals or long term care facilities due to instability of employment and the risk that seniority, benefits and wages will be lost when contracts change hands. This reality of turning homecare workers into "elect-to-work" employees who are "rented" by an agency for three to five years is at cross-purposes with the provincial government's stated goal of enhancing health promotion, prevention and community care.

According to a study that followed former VHA staff in Hamilton following the agency's loss of its contract in 2002, 9.5% of former homecare workers moved to jobs in long term care facilities and only 38% of the VHA's home support workers stayed in the homecare sector.[46] The Red Cross estimates that where it has lost contracts, up to 35% of its former workers leave the homecare sector[47].

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There is also evidence that homecare recipients are seeking more care in hospitals, which is also contrary to government goals. According to information from the Timmins and District Hospital, obtained by the Ontario Health Coalition, homecare recipients are now spending more time in hospital because they require treatment more often than homecare can provide or because they do not have the finances to purchase the medications they need. This has contributed to a bed crisis situation in Timmins.

The Peel CCAC states on its website that "due to increasing demands and human resources, some of our services have waiting lists (particularly occupational therapy and speech language pathology)."

The migration of professionals away from the homecare sector occurs at a time when staff shortages are acute and are impairing the ability of CCACs to deliver services. The Peel CCAC states on its website that "due to increasing demands and human resources, some of our services have waiting lists (particularly occupational therapy and speech language pathology)." The Provincial Auditor has reported that as of March 31, 2003, more than 6,000 people across the province were on the waiting list for occupational therapy and more than 4,500 were on the waiting list for

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In a 2001 survey by the Canadian Association of Retired Persons, 59.6% of respondents stated they had difficultly retaining home support staff as these workers had left their organization in search of better pay elsewhere.

[46] Aronson, Denton, Zeytinoglu, Market *Modelled Homecare in Ontario: Deteriorating Working Conditions and Dwindling Community Capacity*, Canadian Public Policy, XXX (I), 2004.
[47] Interview with Claude Tremblay, Red Cross Community Health Services

speech therapy. [48] In a 2001 survey by the Canadian Association of Retired Persons, 59.6% of respondents stated they had difficultly retaining home support staff as these workers had left their organization in search of better pay elsewhere.[49]

If policy makers wish to make homecare an equal partner in the health system, the homecare sector must provide the same level of security, stability and satisfaction for both clients and care providers as other sectors. As one member of agency management told us "managed competition is an anomaly in the health care system; hospitals, long term care facilities and community health centres are not expected to bid for renewal of their funding (instead they and) mental health and support are all funded on a grant funding basis with regular reporting requirements.[50]" As hospital service is not decided upon by a competitive bidding process mandating competitive bidding for homecare puts the sector at a disadvantage and makes it a less attractive environment for those who wish to make healthcare their career rather than a temporary vocation. If homecare is to be equal in status and quality to hospitals than the sector must be on the same footing as institutions through a structure that allows not only stable public funding but also stable public delivery.

Conclusion

A process of consolidation in which a small number of companies gain a larger and larger market share accompanies the privatization of health service delivery. The outcome of this market structure is one in which a handful of large and wealthy companies have an enormous degree of leverage over the conditions of the market including a large say over government regulation. It should be noted that the mandate of for-profit companies is to provide the maximum possible rate of return for their investors. This is at cross-purposes to the public's interest in maximizing the quality of care by protecting the dignity of care providers in their working lives.

The introduction into the system of large and powerful stakeholders whose interests are not those of those who populate the system (homecare recipients, their families and workers) will lead to a powerful lobby for deregulation and diminishment of patient and employee standards with a more limited opportunity to achieve a sound balance of interests. Regardless of the current government's good intentions to provide an optimal quality of care, the system set up through the current review process is undoubtedly intended to last beyond the current government's mandate. It is unlikely that a patient lobby can ever reach the level of sophistication and finance available to a large multinational for-profit industry. It is not guaranteed that future governments will share a commitment to the public interest against those of private industry. Therefore, in the determination of what homecare structure is established, it is imperative that the effects of the for-profit industry, and of managed competition, its culture and characteristics, be seriously considered.

After eight years of practice it is evident that competitive bidding is a failed experiment. Rather than controlling costs, competitive bidding has become a cost-driver in the system. Innovations have not been achieved; rather we have seen the introduction of cost-cutting methods that hurt staff and make homecare a less desirable work experience and diminish the quality of care experienced by the client. Rationing is also forcing many outside the system or denying them the professional care they need. For much of the past century homecare has been on the periphery of the public health care system. If it is to become an equal partner, it must be brought into the mainstream rather than doled out to the lowest bidder. The Ontario Health Coalition believes that the best course is for the government to end competitive bidding.

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[48] *Annual Report of the Office of the Provincal Auditor of Ontario*, November 2004
[49] Parent, Karen and Anderson, Malcolm, *Home Care By Default, Not By Design*, Queen's University and Canadian Association for Retired Persons, 2001
[50] Interview with agency information officer.

Such a move would stabilize the homecare environment for both workers and care recipients, enhance quality and accountability and reduce administrative costs.

Appendix

CCAC	CONTRACT PROVIDERS AS OF DECEMBER 2004
Algoma	(Nursing) Bayshore, Comcare, Lady Dunn Health Centre Nursing Services (Home support) Red Cross, We Care, Batchewana First Nation of Ojibways Home Support Program, Garden River First Nation Health and Community Support
Algonquin (Muskoka)	NA
Brant	(Personal support) VON, Comcare (comm. fall 2004) (Nursing) VON and SEN
Chatham/Kent	(Nursing) VON, VHA, Bayshore (Personal Support) Bayshore, Red Cross VON
Cochrane	(Nursing) Bayshore (Timmins), VON (Hearst, Iroquois Falls, Kapuskasing) (Personal support) Red Cross
Durham	(Nursing) Carepartners, Durham Assoc for Family Respite Services, Paramed, Partners in Community Nursing, SEHC, VHA
East York	(Personal Support) Spectrum, VHA (Nursing) VON, SEHC, ComCare, Paramed
Eastern Counties	(Nursing) SEHC, Bayshore, (Personal Support Services) Comcare Paramed
Elgin	(Nursing) VON and Care Partners (Personal Support and Homemaking) Tilsonberg and District Multi Service Centre, VON, Red Cross, CarePlus (Therapy) Rehab Express
Etobicoke and York	(Nursing) SEHC, Spectrum, VON, Paramed Comcare, CHA, SRT Med Staff (Personal Support) CANES, CanCare, Prohome Health Services, Red Cross, Paramed, Circle of Care, Storefront Humber, Spectrum, Comcare, VHA, Nightingale,
Grey-Bruce	(Nursing) CarePartners and the VON (Grey-Bruce Branch);
Haldimand-Norfolk	(Homemaking and Personal Support) SEHC, VON (Nursing) CarePlus, CarePartners, (Physiotherapy) CarePlus, (contracts expiring fall 2004/fall 2005)
Haliburton, Northumberland and Victoria	Haliburton and City of Kawartha Lakes (Nursing) Paramed (Personal Support Services) Red Cross, SEHC, Paramed /Northumberland (Nursing) VON Hasting Northumberland Prince Edward (Personal Support Services) Red Cross, SEHC
Halton	(Nursing) Comcare, Saint Elizabeth, VON Halton (other services) Calea, Careplus, Comcare, Red Cross, Community Rehab, Erinoak, ParaMed, SEHC, SEN, Shoppers Home Health Care, Therapy Health Care, VON Halton (unspec)
Hamilton	(Nursing) Bayshore, SEN, VON (Homemaking) Bayshore, CarePlus, ParaMed, SEHC, CanCare
Hastings and Prince Edward Counties	(Homemaking) Red Cross, VON, Paramed, Comcare (Nursing) VON, Paramed, Comcare
Huron	Huron County (Nursing) Community Nursing Service, St Elizabeth (Personal Support Services) Town and Country
Kenora-Rainy River	(Nursing) Comcare, (Occupational Therapy and Physio) Kenora Physiotherapy and Sports Injuries Clinic and other local providers
Kingston Frontenac Lennox and Addington	(Nursing) Allcare, Paramed, SEHC (Personal Support and Homemaking) Parmed, Red Cross, SEHC
Lanark, Leeds and Grenville	(Nursing) SEHC, Bayshore, (Therapy) Communicare (Personal Support, Homemaking) Red Cross, Bayshore, Brockville and District Association for Community Involvement
London and Middlesex	Canada Care Medical, ComCare, COTA, Medigas, Paramed, Physical Relief Health Care, St Elizabeth, Thames Valley Children's Centre, VON Middlesex-Elgin, Wilcor Health Services
Manitoulan-Sudbury	(Nursing) Bayshore (Personal Support Services) new contract dec 1 Red Cross, Comcare Bayshore (prev VON used to have both nursing and Personal Support Services until Dec 1)

Near North/north bay	(Nursing) Paramed, VON (Homecare, Personal Support Services) Paramed, Community Health Service Red Cross)
Niagara	(Nursing non palliative) Saint Elizabeth Health Care, CarePartners (Palliative, Visiting Nursing, Nursing) St. Elizabeth, ParaMed (Shift Nursing) VON, Paramed (all begin fall 2004)
North York	(Personal Support) Bayshore, CanCare, Circle of Care, SEHC, Spectrum, SRT, MedStaff International, VHA Home Healthcare (Adult Nursing) ComCare, St Elizabeth, VHA, VON all begin sep 2004
Ottawa	(Nursing Personal Support Services) VON Bayshore, Paramed, WeCare, St Eliz (Adult Therapy) VON and CODA
Oxford	(Nursing) Care Partners, St Elizabeth, (Personal Care and Home Support) Red Cross, Tillsonberg and District MultiServiceCentre (physiotherapy) Physical Relief Health Centre, Thames Valley Children's Centre
Parry Sound	(Nursing) VON (Homecare/Personal Support Services) CCAC provides service directly
Peel	(Nursing) Bayshore, Carepartners, Spectrum, SEHC, VON, (personal sup) Red Cross, SRT MedStaff, ProHome, VON, Spectrum
Perth County	Perth County (Nursing) Community Nursing Service, VON (Personal Support Services)Town and Country, ParaMed
Peterborough	(Nursing) VON, Pro-Home (Nursing and Homemaking) nightingale (both) Red Cross (Homemaking) Tender Loving Care
Renfrew County	(Nursing) Access health care services, Comcare, ParaMed (Personal Support Services/Homemaking) Access, Paramed, Red Cross
Sarnia/Lambton	(Nursing) VON, Bayshore, VHA, (Homecare) red cross, Bayshore, VON
Scarborough	(Nursing) Comcare, St Elizabeth, Paramed, VHA, SRT MedStaff International, VON, Nightingale Health Care (back up only), (Personal Support, Homemaking) Circle of Homecare, ComCare, Preferred health Care services/Ontario Nursing Services, Spectrum, SRT, VHA Home Healthcare, (Physiotherapy) ReHab Express
Simcoe County	(Nursing) Bayshore, Comcare, Paramed, SEHC, WeCare (Personal Support Services/homemaking) Bayshore, Community Home Assistance to Seniors (CHATS), Comcare , Helping Hands, ParaMed , Canadian Red Cross, WeCare
Thunder Bay	(Nursing) VON, COMCARE, SEHC, Bayshore (Homecare, Personal Support Services) VON, ComCare, Bayshore
Timiskaming	(Nursing) VON (Kirkland Lake) Rainbow Providers (for Profit) (Engelhart/Timiskaming and Timiskaming)/(personal support) Timiskaming Home Support (not for profit)
Toronto	(Nursing) Comcare, ParaMed, SEHC, (Adult Nursing) Comcare, Para-Med Home Health Services Inc. Saint Elizabeth Health Care, Spectrum Health Care (Nursing services for child and family services) Comcare, St. Elizabeth Health Care (Occupational Therapy) Community Occupational Therapy Association (COTA) (Personal Support Services-Adults) Can-Care Health Services Inc., Central Health Services, Central Neighbourhood House, Circle of Care, Comcare Health Services, Community Care Services, Nightingale Health Care Inc., Para-Med Health Services, Spectrum Health Care Ltd., S.R.T. Med-Staff International Inc., Toronto Homemaking, VHA Home HealthCare (Personal Support Services – children/families) VHA, Comcare (Physio, Speech, Language Pathologists and Social Work) Bridgepoint
Waterloo Region	(Nursing) ComCare, CarePartners, ParaMed, Etnow (Homemaking/Personal Support) Red Cross, Paramed, ComCare
Wellington Dufferin	(Nursing) Bayshore, Comcare, SEHC (Personal Support/Homemaking) HLO Healthcare, ParaMed Home Health Care
Windsor-Essex	(Nursing) Bayshore, VON, Comcare, Paramed, St Elizabeth (Personal Support) Red Cross, St Elizabeth, Comcare, Paramed, Bayshore
York Region	(Nursing) Bayshore, CarePlus, Regional Nursing Services* SRT, Medstaff, SEHC, VHA (Personal Support Services) CHATS*, CanCare, Preferred Health, Ontario Nursing Services, Regional Nursing Services - rfp under way march 2005 expiry new contract Paramed, Preferred Health care services Inc, Regional Nursing Services (for profit), SRT Med Staff International, We-Care Health Services Inc.