Submission on Bill 175, Connecting People to Home and Community Care Act 2020

to the Standing Committee on the Legislative Assembly

June 15, 2020

15 Gervais Drive, Suite 201,
Toronto, ON M3C 1Y8
(416) 441-2502
ohc@sympatico.ca
www.ontariohealthcoalition.ca

Ontario Health Coalition
Protecting public healthcare for all.

Who We Are

The Ontario Health Coalition represents more than half-a-million Ontarians in more than 400 member organizations and a network of Local Health Coalitions and individual members. Our members include: seniors' groups; patients' organizations; unions; nurses and health professionals' organizations; physicians and physician organizations that support the public health system; non-profit community agencies; ethnic and cultural organizations; residents' and family councils; retirees; poverty and equality-seeking groups; student groups; women's organizations, and others.

Mission and Mandate

Our primary goal is to protect and improve our public health care system. We work to honour and strengthen the principles of the Canada Health Act. We are led by our shared commitment to core values of equality, democracy, social inclusion and social justice; and by the five principles of the Act: universality; comprehensiveness; portability; accessibility and public administration. We are a non-partisan public interest activist coalition and network.

To this end, we empower the members of our constituent organizations to become actively engaged in the making of public policy on matters related to our public health care system and healthy communities. We seek to provide to member organizations and the broader public ongoing information about our health care system and its programs and services, and to protect our public health system from threats such as cuts, delisting and privatization. Through public education and support for public debate, we contribute to the maintenance and extension of a system of checks and balances that is essential to good decision-making. We are an extremely collaborative organization, actively working with others to share resources and information.

Bill 175 Should be Withdrawn

Bill 175 is so misguided and flawed that it is irredeemable. The process by which this Bill was created was profoundly undemocratic. Key advocacy groups, client representatives, workers' and health professionals' representatives were not included in consultations prior to its drafting. The Bill as written reflects the interests and priorities of provider corporations (the majority of which are for-profit) over and against the public interest.

This Bill was rushed through First and Second Reading in the Legislature in ten business days with very little time for stakeholders to learn about its implications and without adequate time for proper parliamentary debate. Yet the Bill has profound implications. It will result in the wholesale restructuring of home care, the dismantling of much of the existing public governance and oversight, the privatization of existing public and non-profit home care, the creation of a new tier of residential "congregate care", the potential expansion of private for-profit hospitals and the privatization of public hospital care, among other major changes. It repeals significant clauses in existing legislation that protect clients' and the public's interests in home and community care. It moves all of the key items of governance and democracy, and of public protection and client protections, to regulations that may or may not ever be written and that can be changed by Cabinet without ever going back to the Legislature. In this way, it takes Ontario's home and community care backward more than 25 years. It would fragment home care and destabilize the workforce, which already suffers from severe staffing shortages.

There is no justification that would warrant moving forward with this legislation even under normal circumstances. Currently, Ontario is in the midst of the first wave of the COVID-19 pandemic. The last thing that is needed in home care, community care and hospitals in Ontario is significant destabilization and more privatization. Given the terrible experience of COVID-19 in long-term care homes and other congregate care settings, and in the for-profit homes in particular, we cannot understand how the government could countenance the expansion of another tier of congregate care without any clarity about the purposes; total permissiveness regarding for-profit privatization; no regulatory, inspections and enforcement system; and no governance regime.

For all of these reasons, Bill 175 should be withdrawn and a proper consultation process regarding reform of home and community care in the public interest should be undertaken when the pandemic is under control and the context is appropriate.

Introduction

The new regime set out for home and community care in Bill 175 and the summary regulation dismantles most if not all public governance of home care. The general thrust of the Bill is to repeal the existing legislation and dismantle the existing governance of home and community care. Almost all of the key aspects of the governance and structures for home and community care are moved out of legislation into regulation that can be changed by Cabinet without ever going back to the Legislature. In this way, the Bill takes us backward more than 25 years.

Under Bill 175 all of the remaining publicly owned and controlled parts of home care would be transferred (in an unspecified time period) to an array of provider organizations including for-profit and non-profit organizations. The legislation is permissive, repealing the previous Home Care and Community Services Act and enabling the provider organizations to structure, contract, subcontract and run home care in an array of different ways that they would develop themselves. This reflects what appears to be a trend in major health restructuring legislation by the current government: a "laissez faire" ideology that leaves the planning and governance of vital health care services to provider corporations and organizations without governance structures and with meager oversight, if any. It is not supported by the evidence of the need for democracy, meaningful public input, oversight in the public interest and protections for patients, residents and clients who use public health care services. The history of home care in Ontario supports the need for proper governance, organization, clear standards, a principled approach that reflects the values and priorities of Ontarians and which supports equity and compassion.

Under Bill 175, a significant proportion of the organizations that would take over previously publicly controlled home care functions have either no governance and public accountability structure (as in the Ontario Health Teams, OHTs, which are loose coalitions including for- and non-profits that self-govern with no public meetings, no access to information, no elected boards of directors, etc.) or are private (as in private for-profit home care companies) or are non-profit with often limited memberships and little public accountability. There are a small minority of non-profit agencies left in home care that are actually community-based and democratic. In this legislation, private chain corporations who are poised and have a vital interest in expanding their market share and profits would be given opportunity to take over more control of home and community care; and the control over home care from top to bottom would be unaccountable, without any of even the normal public protections and governance.

The Bill and summary regulation also reach beyond home and community care to expand residential congregate care, with no clear definition that limits what services this might include, posing a risk to existing standards for long-term care and even hospital care. The summary regulation also includes a list of current public hospital services in the range of services that would be moved under the desultory or non-existent governance and regulatory regime it sets up. The Bill itself enables private for-profit hospitals to expand for the first time since the formalization of the public hospital system in Ontario.

We must warn the government in the strongest possible terms that we will do everything in our power to stop the expansion of private for-profit home and community care, privatization of hospital care, and the expansion of private for-profit congregate care. If Ontarians have learned anything from COVID-19 it is that we cannot allow governments to continue to privatize health care at the behest of self-interested for-profit companies.

Summary of Key Concerns

1. The new regime set out for home and community care dismantles most if not all public governance of home care. All of the remaining publicly owned and controlled part of home care would be transferred (in an unspecified time period) to an array of provider organizations including for-profit organizations. The legislation is permissive, repealing the previous Home Care and Community Services Act, including vital public interest protections, and moves all of the governance and structures of home care into regulations. It enables the provider organizations to structure, contract, subcontract and run home care in an array of different ways that they would develop themselves. A significant proportion of the organizations that would take over previously publicly controlled home care functions either have no governance and public accountability structure (as in the Ontario Health Teams, OHTs, which are loose coalitions including for- and non-profits that self-govern with no public meetings, no access to information, no elected boards of directors, etc.) or are private (as in private for-profit home care companies) or are non-profit with often limited memberships and little public accountability. There are a small minority of non-profit agencies left in home care that are actually community-based and democratic.

   For clarity, under the proposed legislation and regulation, the following changes would happen:

   a. The Super Agency, now called Ontario Health, would take over funding home and community care services from the Local Health Integration Networks (LHINs). The Super Agency (Ontario Health) is governed by a Board that is not subject to the Ontario public service legislation regarding conflict of interest. The majority of Board members come from private industries such as banks, financial corporations including REITs, pro-privatization organizations, private consulting firms, and for-profit long-term care, among others. Ontario Health has no regulations for public input, open board meetings, public access to information and even less democratic protections than the LHINs.
   b. The power to contract home care services (and apparently placement coordination functions) currently held by the LHINs would be handed off to an array of different organizations that are not publicly governed and accountable. These can include non-profit agencies, the Ontario Health Teams (which are loose coalitions without any public governance structures that include for-profit and non-profit companies) and primary care providers (most of which do not have public governance and accountability structures). The LHINs, which we advocated to be reformed to make them more public and accountable not less, are Crown Agencies, set up as public entities and operated on a non-profit basis.
   c. The care coordination functions of the LHINs would be contracted by these organizations to provider home care companies (majority for-profit) or to unnamed third parties.
   d. The LHINs will be renamed and continued on an “interim” basis until home care is transferred on a phased and gradual basis to the Ontario Health Teams or Health Service Providers.

   This change means that significant and vital parts of home care could be privatized, including transfer of control from publicly-controlled LHINs to the Ontario Health Teams which are loose coalitions that include for-profit companies, and transfer of care coordination functions to an array of provider companies that are dominated by for-profit chains.

   This plan is chaotic. It would mean that home care will be governed by different entities in different regions according to different models. The plan would enable this array of different providers to structure and contract home care themselves. The Ontario Health Teams have

no governance provisions. Not all of Ontario is covered by them. They are all different and it is uncertain how they will work. The first set are just getting started. This model does not "integrate" home care. It dismantles all existing public governance and devolves it to an array of service providers with very different cultures, motives, capacities, and governance models (or no governance model).

This proposal would enable for-profit corporations to both coordinate care and be the providers of that care. This means that they themselves determine how many visits a person can have, how many supplies and resources are allotted to them, and supervise their own care. Already missed visits and non-fulfillment of contracts is a major longstanding problem for home care clients, compromising their care and safety. This is a conflict of interest and it is not in the public interest.

Recommendation: These Sections of the Bill and the attendant proposals in the regulation summary should be removed.

5. Among the changes proposed is a provision to send privatized home care into public hospitals.

Recommendation: This proposal in the regulation should be removed.

6. The proposal includes expansion of the new regime to cover Aphasia services, Pain and symptom management, Diabetes education, and Psychological services for persons with acquired brain injuries.

Recommendation: This proposal in the regulation should be removed.

7. The proposal includes the creation of a new tier of unlicensed residential services without any public interest protections, and no protections against downloading and erosion of existing protections in hospital and long-term care. If this proposal were to expand the provision of supportive housing and was clearly defined as this, it would be welcome. However, it is undefined (and unlimited) in the proposed regulation and therefore poses a significant threat of erosion of already insufficient care levels for Ontarians who are trying to access chronic care and long-term care. Of concern is that instead of increasing care levels for our elders and vulnerable people, this tier would actually lower them.

Recommendation: This proposal in the regulation should be removed.

8. The proposal includes provision for the expansion of private for-profit hospitals into these and other residential care services (including potentially services that are provided by public hospitals and by long-term care homes). It is not in the public interest to expand private for-profit hospitals. In the Act – this section should be removed.

Recommendation: This Section in the Bill should be removed.

9. The proposal removes a host of existing public interest protections under the Home Care and Community Services Act and does not improve on existing provisions regarding access and eligibility, out-of-pocket costs, expansion of virtual home care without patient protections, and others. Vital sections of the existing Home and Community Services Act are repealed including: the Bill of Rights; the ability of the Minister to enforce the Bill of Rights; the ability of the Minister to not approve an agency based on financial record, enforcement of the Bill of Rights and other public interest protections; the governance of complaints from clients; requirements of providers to put clients on the wait list if services are not currently available, and others. These are important public protections that belong in legislation. There is nothing in the new plan that provides any better protections for

home care clients regarding access to care, assessments that do not measure actual need, rationing of home care, inequities from region to region, missed visits and other major problems in home care.

Recommendation: These Sections of the Bill and attendant proposals in the summary regulation should be removed. Better public interest protections regarding response to complaints, access and eligibility should be instituted.

10. The proposal moves most of the key elements of home care governance out of legislation and into regulation which can be changed at any time without going back to the Legislature and without any meaningful public input. Act and regs.

Recommendation: These Sections of the Bill should be removed.

11. The process by which these dramatic changes are being made has been profoundly undemocratic. The majority if not all public interest voices have been excluded from consultations prior to the drafting of this legislation. The Bill was rushed through First and Second Reading in the Legislature in only ten business days. This is unprecedented. The public hearings are occurring during a pandemic with short public notice. The process is unacceptable and has resulted in legislation that is poorly conceived and reflects private for-profit interests over and against the public interest.

Recommendation: A proper public consultation process that is equitable and that does not disproportionately favour industry representatives over client, public interest and worker voices could have led to draft legislation that reflects the public interest rather than provider corporations' interests. When the context is appropriate the government should start a proper public consultation process on reforming home care in the public interest.

Overall Recommendation:

This legislation should be withdrawn.

Detailed Analysis of the Legislation, Summary Proposed Regulation and Our Concerns:

Bill 175 repeals and amends at least 11 pieces of legislation. The following is a review of these and includes a more detailed analysis of our concerns:

Acts Amended/Repealed under Bill 175:

Connecting Care Act, 2019 (amended)
Excellent Care for All Act, 2010 (amended)
Health Care Consent Act, 1996 (amended)
Health Protection and Promotion Act (amended)
Home Care and Community Services Act, 1994 (repealed)
Local Health System Integration Act, 2006 (amended)
Mental Health and Addictions Centre of Excellence Act, 2019 (amended)
Ministry of Health and Long-Term Care Act (amended)
Ministry of Health and Long-Term Care Appeal and Review Boards Act, 1998 (amended)
Personal Health Information Protection Act, 2004 (amended)
Private Hospitals Act (amended)

The following are the amendments/repeal introduced in Bill 175, Connecting People to Home and Community Care Act 2020:

Amendments to the Connecting Care Act 2019:

The Connecting Care Act 2019 was part of Bill 74 in 2018, the legislation that set the stage for the government to entirely restructure the health care system. The Bill allows much to be determined in regulation, including the scope -- which health service providers are covered and which are not – any requirements or standards for public input if there are any (none have been created and there is no requirement for any public input) and many other major items. Note: For example, Cabinet amended the Act since it was passed last year to exclude private hospitals as providers under the Act. This means they are exempt from the oversight provisions and the "integration" orders etc below.

The Act creates the Super Agency, now called Ontario Health. The Board of the Super Agency is appointed by Cabinet. Cabinet has the power to appoint the Chair and Vice Chair.

The Act confers powers on the Super Agency and the Minister to fund and direct health care services through a variety of mechanisms:

- The Minister has a new power to direct health providers under this Act with few if any fetters.
- The Minister/Super Agency can enter into Accountability Agreements (contracts) that make service providers accountable to the Minister/Super Agency. These Accountability Agreements can be forced onto providers if they are not agreed upon.
- The Super Agency has new powers to send in auditors, investigators, supervisors (excluded are long-term care homes and hospitals).
- The Minister has power to designate Integrated Care Delivery Systems which they have called the Ontario Health Teams (OHTs).

- The Super Agency has powers to force “integration” on a health provider (including starting or ceasing to provide a service, mergers and amalgamations, partnerships, transferring services to another provider, ceasing operation and closing down) by changing its funding (coercion) or by negotiation.
- The Minister may order service providers to provide a service or cease to provide a service, provide a certain level of service, transfer services to another provider or location, cease operating and close down, amalgamate or merge, transfer all its operations to another entity.
- The Minister may order the transfer of assets, liabilities, rights and obligations including any right or obligation under a funding or accountability agreement to a health service provider or an integrated care delivery system.
- There are all kinds of protections included for the government against action taken as a result of the order of these transfers, closures, amalgamations, etc.

The Act contains few if any public interest provisions. Much of the Act is written to give extraordinary powers to the Minister and the Super Agency to restructure health care without public input, with virtually no procedural protections or feedback from the users of health care services, and with very few protections for the public interest. There are multiple ways for the Minister and the Super Agency to force restructuring on provider organizations and privatize services. There are: no access to information provisions, no protections against conflict of interest in the Super Agency, minimal notice and no rights to appeal restructuring decisions.

There are pages of exemptions in this Act, exempting the Minister, the government and the Super Agency, from existing legislation in order to enable them to exercise these extraordinary powers. For example, in the Connecting Care Act 2019, Ontario Health (the Super Agency) is exempt from the Non-Profit Corporations Act and the Corporations Information Act except as prescribed in regulation (regulations are set by Cabinet and none have been set regarding this meaning Ontario Health is entirely exempt). It is exempt from the Charities Accounting Act and from Subsection 1 (4) of the Labour Relations Act. Part III (Regulations) of the Legislation Act does not apply to the Minister’s power to issue directives under the Act. The Statutory Powers Procedure Act does not apply to the Minister’s power to issue integration orders. The integrations are not deemed regulations as defined in Part III (Regulations of the Legislation Act, 2006). The Business Corporations Act and the Corporations Act are overridden by the powers of the Minster to order integration.

In Bill 175, the Connecting Care Act of 2019 is amended as follows:

- Ontario Health (the SuperAgency) will replace the LHINs in funding health service providers or Ontario Health Teams for them to purchase home care services for individuals or provide funding to an individual to purchase their own home care. The Super Agency has no proper governance and far fewer public protections than even the existing LHINs. This is not an improvement.
- The regulations can allow private payment for home care. Privatization of payment for health care should not be allowed to happen by regulation changed by Cabinet without any requirement for public input, scrutiny, legislative debate, public hearings and so on. This is not an improvement.
- The Act is amended to allow the Minister to appoint an investigator with powers to investigate problems if the regulations allow for it, and only for community care services that include residential dwellings. Any congregate care (residential) settings should be created under proper legislation with proper public oversight, inspections and other attendant public protections.

- The Act is also amended to waive the notice requirements for the Minister to appoint a supervisor to a health service provider or Ontario Health Team allowed for in the regulations, that provides residential accommodation but only if there is an immediate threat to the health, safety, or well-being of persons receiving home and community care services. Certain provisions of the Employment Standards Act, Labour Relations Act and Pay Equity Act do not apply when a supervisor is appointed under this section. The appointment of a Supervisor should not wipe out the protections of existing labour legislation.
- The Act is amended to prohibit obstruction or interference with an investigator, provide false information, refuse to provide information as required under this Act and to fail to comply with an order. It is prohibited for a person or entity to represent themselves as an "Ontario Health Team" unless they have been designated as one.
- The Act is amended to give the Minister authority to issue binding compliance orders.
- Home and community service providers are required to establish their own process for reviewing complaints in accordance with requirements in the regulation, if any. Since there is already a major problem with responsiveness to complaints, including frequent complaints about missed home care visits and inadequate care, enabling the provider companies, the majority of which are for-profit, to establish their own process without any real protections for clients is unacceptable.
- A new section allows a person to appeal to the Health Services Appeal and Review Board concerning a complaint in circumstances according to requirements in regulation. Again, core rights of Ontarians, to make appeals (and all other public interest protections) should not be left to regulation.

Amendment to the Ministry of Health and Long-Term Care Act:

- The Act is amended to allow the Minister to enter into agreements with Indigenous organizations to provide for home and community care services for Indigenous communities.

Repeal of the Home and Community Care Act of 1994:

With the repeal of this Act, most of the public interest provisions developed over several decades will be removed altogether or will be moved into regulation where they can be changed without going back to the Legislature for approval. The following are the major components of the Act that will be removed or moved. These plans are a significant step backward and should be withdrawn.

To be moved to regulation:

- The definitions of Community services, Community support services, Homemaking services, Personal support services and Professional services.
- The Bill of Rights for clients of home and community care will be moved and changed. Currently the Bill of Rights includes provisions regarding: respect, sensitivity, information, refusal and consent, the right to participate in assessment, development and review of plan of service, raise concerns without fear of reprisal, informed of the laws and written process for complaints, confidential records. The enforcement of the Bill of Rights is currently provided in the Act through the Minister's ability to approve/disapprove agencies based on the Minister's assessment of whether they comply with this Bill of Rights and through the

complaints process laid out in the Act. The latter provision will be removed and is not listed in the provisions to be moved into the proposed regulation.

- Requirements of the provider agencies:
    - Development of a plan of service in accordance with regulations, rules and standards. (This is changed and moved.)
    - Provision of the service in a reasonable timeframe.
    - Requirement to put people on wait list if the service is not immediately available.
    - Prohibition of charges for professional or personal support services in accordance with the plan of care.
    - Allowance of charges for homemaking or community support service in accordance with the plan of care.
- Sections regarding complaints, including timelines, requirements to respond to the client in writing, appeals, hearings, evidence, etc.

To be removed with the repeal of the Act:

- The enforcement of the Bill of Rights is currently provided in the Act through the Minister's ability to approve/disapprove agencies based on the Minister's assessment of whether they comply with this Bill of Rights and through the complaints process laid out in the Act. The Minister's assessment is to be removed and the complaints process is unspecified and will be moved to regulation.
- Currently the Act states that the Minister may approve an agency to provide community services provided that the Minister is satisfied that the agency is financially capable of providing the service, that the service will be operated in compliance with the Bill of Rights, and with competence, honesty, integrity and concern for the health, safety and well-being of the persons receiving the service. This would be removed.
- Currently the Act states that if the Minister is satisfied that premises are suitable for the provision of a community service, the Minister may approve the premises for the provision of the service by an approved agency and may give financial and other assistance for the maintenance and operation of the premises. This is to be removed.
- Currently, the Minister may impose terms and conditions on financial assistance provided and may amend these from time to time. This is to be removed.
- The current requirements of the provider agencies to be removed:
    - Public filing of records regarding the agency (letters patent, articles of incorporation, by-laws etc.).
    - Notice to clients in writing of the Bill of Rights, the name of the service provider, procedure for making complaints, how to request a record, where the client can access the service's Accountability Agreement, any other matters in the regulations.
    - A plan for preventing, recognizing and addressing physical, mental and financial abuse of persons who receive community services.
    - A quality management system. (This is removed and the requirements for the Excellent Care for All Act 2010 appear to replace it.)
- Currently the Act contains a provision allowing the Minister to approve the LHIN to provide community services, and clauses prohibiting the LHIN charging for such services and governing how that arrangement would operate (with accountability agreement under the provisions that cover approved agencies under the act etc.). These are to be removed.
- Currently there are sections regarding the collection and disclosure of personal health information and health records, access to records, plans of service are to be removed. Some of these appears to be moved into regulation.

- Currently there are sections giving the Minister the right to revoke an approved agency if they have contravened the requirements of the Act. These are to be removed.
- Ditto for approval of a premises.
- Currently there are powers for the Minister to take over an agency or preplace some or all of its board, take control of, operate or manage the agency, provisions for appeal, hearing etc. The Minister has power to act immediately without hearing if there is an immediate threat to health, safety or well-being. These are replaced with a regime of investigators and supervisors in the new Act with powers to investigate or take over some but not all provider companies in circumstances prescribed in the regulations.

Amendment to the Private Hospitals Act 1990:

- This Act prohibits any new private hospitals in Ontario and it prohibits the expansion of the number of beds in existing private hospitals. The new Act amends the Private Hospitals Act to exclude from the definition of private hospitals (and therefore to exclude from the prohibition on expansion of private hospitals) residential care beds operated by a health service provider or Ontario Health Team under the Connecting Care Act, 2019. This appears to allow the expansion of private hospitals. This is unacceptable and should be withdrawn.

There are numerous additional consequential amendments to the above-listed Acts.

Analysis of the proposed regulation covering home and community care:

Undemocratic Process

The meat of the changes proposed by the government are not found in the new legislation which guts existing home care legislation and shifts virtually all the key elements to regulation and policy. In the process, significant public interest provisions of the existing legislation would be lost and/or subject to change without any meaningful public input. Legislation must be passed by the Ontario Legislature. Draft legislation goes through three readings in the Legislature, with opportunities for amendment at each stage until the Bill is finalized. In this process, legislation goes through a Standing Committee of the Legislature made up of the political parties that meet the threshold for party status and is subject to debate by all of those political parties as well as public hearings and input. The government has changed the rules of the Legislature in order to push legislation through with unprecedented speed. The consequence is that opportunity for public scrutiny and debate are much more limited than before. The new home and community care legislation was introduced in the Legislature on Tuesday February 25, was passed by the government and was moved into Second Reading by Monday March 2. It passed Second Reading and was sent to Committee on March 10. The speed of the passage of this Bill meant that there was not adequate time for public notice, for scrutiny of the legislation which amends or repeals at least eleven existing pieces of legislation, and for legislative debate. This process is undemocratic and unacceptable.

Regulations, unlike legislation, do not have to go through the Legislature. They are passed by Cabinet which is made up of the Ministers of the ruling party. They do not require the full public process of debate, committee hearings and passage in the Legislature and can be passed or changed without any meaningful input or opportunity for public debate and scrutiny. It is significantly more undemocratic to make major changes to public policy through regulation rather than through legislation. The government says public policy will also play a role replacing legislation. Policy can be changed with no public oversight or even public announcement. In fact, the government has not even provided the actual text of the regulation, only a summary.

Dramatic changes to the provision of home and community care including new threat of privatization

Key changes to home care structures and service providers are buried in the middle and towards the end of the summary of the proposed regulation https://www.ontariocanada.com/registry/showAttachment.do?postingId=31727&attachmentId=42836 under the sections "Eligible Providers" and "Care Coordination Functions".

Much of the "Eligible Providers" section is factually incorrect. Either through obfuscation or error, the scope of the changes proposed and the extent to which services that are currently fully public would be privatized is falsely stated and minimized. The fact is that the LHIN services would, according to the outline of the array of different providers that can take them over, according to the draft regulation, would be split between the Super Agency (Ontario Health) as funder and the middleman groups (mixed for- and non-profit) and contracted agencies (majority for-profit). This section of the draft regulation appears to be designed to minimize through obfuscation and outright factual error the scope of the changes proposed.

Currently, the LHINs (which are public "crown agencies" under current legislation) contract home care services including nursing, health professionals' services, and personal support and homemaking services to for-profit and non-profit providers. The LHINs also provide some direct services including: placement coordination; care coordination; direct professional services and direct personal support services in areas where contracting out was not possible; school visiting nurse programs, and others. The LHINs also fund and govern the planning and provision of Community Care services through Accountability Agreements with non-profit and for-profit agencies and companies.

In home care, a sizeable bulk of the work that the LHINs currently do is care coordination which, under the proposed new regulation, would be contracted out to the companies that are contracted to provide home care. Some care coordination may go to primary care entities (many of which are incorporated as private companies). Some care coordination may be directly provided by the middleman agency (non-profit) or an Ontario Health Team (these are the loose coalitions that the government created in Bill 74 that are just at beginning stages of forming and they include for- and non-profit companies). Some may be done by unnamed third parties.

How is this privatization?

- Currently, all placement coordination and care coordination are publicly controlled and provided on a non-profit basis. Under the new model placement coordination will be given to a new middleman entity which could be a non-profit or a doctor's group or primary care group (for-profit, minority non-profit, some perhaps not incorporated) or the so-called Ontario Health Teams (which are loose coalitions made up of for-profit companies and non-profit organizations).
- Currently all care coordination is publicly controlled and provided on a non-profit basis. Despite the untrue wording of the regulation summary, the majority of the contracts for professional services, personal support and home support services are controlled by for-profit corporations. Chain companies (mostly for-profit and one non-profit chain) have taken over the majority of services. Under the new regime the government is planning, these companies or other contracted companies will expand to take over care coordination functions.

This is a very significant privatization of a currently public (non-profit) and vital aspect of service. To place care coordination services in the same for-profit organizations that provide direct care is a conflict of interest. For profit companies should not be able to decide to provide less care for clients.

It is not in the public interest to do this. (For more on this, see former Deputy Minister of Health Bob Bell's Opinion Editorial here: https://www.thestar.com/opinion/contributors/2019/02/14/are-private-home-care-companies-about-to-become-more-profitable.html)

For clarity: In the regulation summary, the section "Eligible Providers" states, "This is a continuation of the current home and community care delivery model where approved agencies under the Home Care and Community Services Act, 1994 are Health Service Providers funded by LHINs. These approved agencies must also be non-profit." This is simply not the truth. The LHINs are public. The service providers are private for-profit (majority) and non-profit (minority). The public role of the LHINs would be split so that Placement Coordination will go to a set of middleman companies and entities that are a mixture of for-profit and non-profit (the Ontario Health Teams, primary care, and non-profit corporations) who will then contract out the rest. Thus, the Care Coordination function of the LHINs will be privatized and contracted out to a range of for-profit and non-profit entities or provided by the same middleman companies, along with the direct care services. The new regulation proposed by the government moves placement coordination, care coordination and potentially direct service provision to different organizations than currently exist and privatizes the majority of the currently public services provided by the LHIN without carrying most or all of the public interest provisions (inadequate as they are) to the new regime. It is far from a continuation of the current delivery model.

What will happen to the LHINs?

According to the amendments to the Connecting Care Act, 2019 (this was last year's health omnibus bill) LHINs could be deemed Health Service Providers "on an interim basis". They will be renamed Home and Community Care Support Services (HCCSSs) until their work is gradually turned over to OHTs and other providers as discussed above. The Ministry is proposing new regulations (unspecified) to effect this change.

Changes to the definitions of home and community care services

Under the new regime, the services covered will no longer be defined mainly in the legislation. Cabinet would define "home and community care services" in regulation. The summary of the proposed regulation states that the Ministry is proposing to maintain the definition of "community services" under the Home Care and Community Services Act 1994 (though that could be changed easily through changing the regulation). These services include a list under each of the following subheadings: Community Support Services; Homemaking Services; Personal Support Services; Professional Services (and additions to those lists in Regulation 386/99).

- The government is proposing to classify these services into two broad categories:
    - Home care services which would cover professional services, personal support services and homemaking services where personal support services are also provided, also security checks and reassurance services where other home care services are also provided, and;
    - Community care services as per the Home and Community Services Act 1994 and in the Regulation, and homemaking and security checks and reassurance services.
- They state that the duplication of security checks and reassurance services under both classifications is purposeful.
- Additional Professional Services currently in Regulation 386/99 are not specifically listed in the new proposal.
- They are proposing to add four new community care services that are currently governed under the LHINs into the new framework:
    - Aphasia services
    - Pain and symptom management

- Diabetes education
- Psychological services for persons with acquired brain injuries.

These services are sometimes provided by public hospitals also. It is not clear what the intent is with regards to privatization of these services.

Privatization and dis-integration of hospital care

In the new regulation, the government is proposing that home care provide services in public hospitals for complex clients. This is potentially a violation of the Canada Health Act (under which patients have the right to needed hospital care without user charges and extra billing and this includes meals, accommodations, nursing care and other care required during their hospital stay). Moreover, hospitals are funded for and are responsible for the care of people in their hospitals and employ a workforce to provide this care. It is not clear what scope of services the government would have contracted out to home care companies for hospital patients. This raises serious questions about liability, management, dis-integration of care, continuity and quality of care, privatization, funding and more. Conversely, the government is proposing to maintain the ban on home care going in to long-term care homes to provide care which is already funded through long-term care funding.

Privatization/downloading of transitional care beds, rehabilitation beds & long-term care

The proposed regulation includes a provision for new non-licensed residential "congregate care" models for patients who "do not require the intensity of resources provided in a hospital or long-term care home, but whose needs are too high to be cared for at home". This could include transitional or rehabilitative care over longer periods of time, to be defined in regulation. There is currently no definition in law for transitional beds. Rehabilitation beds are supposed to be covered under the Canada Health Act. It could also include many types of residents who currently receive more care through long-term care homes. Both hospital and long-term care are severely rationed in Ontario (Ontario has the fewest hospital beds of any province and the second fewest long-term care beds. Wait lists are extremely long for long-term care. Prior to COVID-19 overcrowding has routinely been at crisis levels in hospitals.) Already acuity levels (complexity and heaviness of care needs) among residents in long-term care is very high, often dangerously high, and inadequate to meet the needs of residents.

It is of deep concern that this second tier of unlicensed and potentially unregulated care be used to further download patients into lower (and cheaper) levels of care. This section raises the spectre of private for-profit retirement homes (many owned by for-profit long-term care chains) expanding a tier of unlicensed unregulated long-term care with public funding (which is now banned for retirement homes which are not health care facilities and are not regulated). Unregulated settings put people at risk. Combined with the proposed amendment to the Private Hospitals Act, it also raises the spectre of for-profit hospitals or other for-profit entities expanding into this area. There is also a distinct threat that categories of long-term care residents will be forced into facilities that provide much less care. A plan to expand supportive living environments for the frail elderly to live independently would be welcome but that is not what this section of the proposed regulation states.

Expansion of virtual home care without protections for patients

The regulation proposes the expansion of the use of "virtual visits". In the description of the regulation they state that the regulatory amendment that came into force January 1, 2020 clarifies that services may be delivered virtually using electronic means. They are proposing to continue to allow this "if appropriate and based on the assessed needs and preferences of the patient" but there is nothing in the regulatory proposal that protects the patient's right to express and have their preferences listened to. The record of assessing needs in home care is already very poor and there are frequent complaints about it. The ability for companies to save money and increase their profits by denying patients real home care visits and replacing them with "virtual" check ins is not in the

public interest and not in patients' interests. Consumer advocates report they are concerned about the costs and maintenance of equipment needed for virtual care; that there need to be protocols and infrastructure to support it and someone available to fix it if something goes wrong. Overall, there need to be robust patient/client protections around this but such protections are neither in the existing regulation nor in the proposal.

No improvement to eligibility for home and community care

The Ministry is proposing to maintain the existing eligibility criteria for services as outlined in regulation 386/99. However, there is no positive right to access home care (such as the right to hospital and physician care under the Canada Health Act) only prohibitions on eligibility in certain circumstances (eg. residents of long-term care homes whose daily care is already covered under funding to the long-term care home). This has been a consistent problem and it means that rationing will continue based on funding. What rationing currently looks like is this: people may access all the publicly funded home care services they need, usually for short periods of time; people may access some publicly funded home care services they and are required to pay for the rest even if they cannot afford them (in which case, they go without), or; people cannot access any publicly funded home care services despite need and either pay privately or go without.

The Minister has stated that the government will remove service caps (maximum number of hours of service). On the surface, this sounds positive. However, in reality, all public relations statements about removing service caps are relatively meaningless since care is rationed by inadequate funding. Already, the regulation provides for exceptions to the service caps for people with high needs, those waiting for long-term care and for the dying. People still do not have adequate care because care is rationed by inadequate funding levels. Without a positive right to access care, people needing home care cannot even get onto a wait list, they are simply denied services. (For example, for many years, everyone whose needs were assessed as medium or below were denied access in various CCACs/LHINs because all of the home care resources were taken by people whose care needs were determined to be high. They could not even get onto a wait list they were simply told that they were not eligible.)

The current regulatory regime for charging user fees to patients for services will continue. People who are deemed to be eligible for home care (with all the inadequacies that currently exist as outlined above) will receive a range of services that are publicly funded that may or may not meet their level of need and people will be deemed ineligible based on rationing.

On a positive note, according to the summary regulation, the government is considering allowing eligibility for pharmacy and physiotherapy services if there is nothing available in their region or in their local community. (No details.)

Home and Community Care Bill of Rights moved out of legislation to regulation

With the repeal of the Home Care and Community Service Act 1994, the Bill of Rights for home and community care clients would be repealed. The proposed regulation states that the Ministry intends to create a new Bill of Rights under the new regulation (not in legislation) which means it could be changed without any meaningful public input as noted above.

Complaints and Appeals moved out of legislation to regulation

The specific wording of the proposed regulation summary refers to continuing the requirements in Regulation 386/99 for a process for reviewing complaints and the list of complaint topics in the regulation (but not the legislation). It appears this is a typographical error. In the 1994 Act, there is a list of complaint topics (similar to those listed in the new proposed regulation summary) and timelines in which they need to be responded to, as well as a process for appeals. The proposed new

regulation would move these requirements to regulation and says that they will continue to be similar, though they could be changed easily in the regulation without any meaningful public input as noted above. The same analysis applies to Appeals.