# ONTARIO HEALTH COALITION
# Homecare Public Hearings
# Consultation Questions and Discussion Points

**We have provided a brief background and some questions and discussion points for you to use as a basis for your written submissions to the Public Hearings on Homecare Reform.**

- **Please note: There is no requirement that you answer all of the questions.**
- **Please restrict your written submissions to ten (10) pages or less.**
- **Please provide four (4) copies of your written submission to the panel if you are giving an oral presentation at the hearings. If not, please mail four (4) copies of your submission to homecare.reform@gmail.com or Ontario Health Coalition:15 Gervais Drive, Suite 305, Toronto, ON M3C 1Y8 by June 20, 2008**

## Background

Homecare in Ontario has changed dramatically over the last several decades. It grew from an OHIP-covered program in 1970 provided by mainly by religious and non-profit groups, to a system that contained increasingly important but overlapping and relatively uncoordinated services with great regional variation by the 1980s. Homecare was seen as a crucial service to allow people the choice to live or age independently and avoid or delay the need for institutional care but also, over time, as a strategic service to move patients out of hospitals more quickly. By the mid-1980s, for-profit homecare companies started to grow. Since then, every government for more than two decades has attempted some form of reform to Ontario's homecare system. Each government has adopted a different approach reflecting varying values and goals. The differences include:

- The scope of services - and which services would be fully funded publicly and which would be subject to patient/client user fees.
- How eligibility for services would be determined: what processes would be used to assess clients and determine their access to services.
- How or whether care would be limited or rationed.
- What form of entity would provide homecare: ie. a public agency, non-profit organizations, for-profit companies, and in what combinations.
- How funding would flow: ie. through informal contracts (like grants), or "market competition" (competitive bidding).
- What form of governance would the system have, and to what extent would it be centralized: for example local elected boards, centralized CCACs without local democratic governance.
- How home care would ensure the quality of its services, working conditions for front-line providers, access to information, community input and others.
- The extent to which post-hospital services would be integrated into the continuum of care.

A rough outline of the different approaches follows:

- Pre- 1990: homecare grew as an ad hoc system with voluntary and non-profit agencies providing a majority of services. From the mid-1980s on, some for-profit companies also provided services, mostly local small companies. Funding was a mixture of

government informal contracts/grants and charitable fundraising. In this period, more rapid movement of patients out of hospitals was just beginning. Homecare was mainly long term and supportive. Some parts of the province also had an Integrated Homemaking Service which meant that clients could receive home support services for free if they also needed professional (mainly nursing) services. In 1990, the Liberal government was proposing a single entry approach to gain access to homecare and proposed expanding the Integrated Homemakers Program province-wide.

- Initially, the NDP proposed a program similar to the Liberal one but following extensive public consultations, proposed creating "Multi-Service Agencies" to provide homecare as local public entities across the province, governed by local elected boards, that would directly provide services, with 20% of services left to non-profit or for-profit agencies or companies. The funding mechanism for the 20% was unclear. The scope of services covered by public funding was broadly envisioned to cover the range from short term homecare to long term home support services for the frail elderly. Homecare was envisioned primarily as an alternative to institutional long term care.
- Conservative government reform under Mike Harris and Ernie Eves: created 43 Community Care Access Centres as "purchasers" with for-profit and non-profit agencies competing for contracts to provide services. This is the system known as "market competition" or "competitive bidding". In response to severe staffing shortages that emerged, the government lengthened the duration of contracts to three years. Initially, both home support and health care services were covered by public funding, but access was rationed by regulation. In addition, as CCAC budgets ran out, patients/clients were re-assessed and coverage was further rationed. By the last few years of the Eves government, there was a province-wide cut to the scope of services, and most frail elderly clients lost public coverage of home support services. The homecare system was primarily envisioned as a way to contain costs and move patients out of hospitals. The providers of service increasingly became for-profit companies, including large multinational companies. Mid-mandate, the government passed legislation changing the governance of the CCACs by removing community memberships, replacing elected Boards with appointees, and giving cabinet the power to appoint and fire CEOs.
- McGuinty government: continued with CCACs as they were at the end of the Harris/Eves government mandate and continued competitive bidding. In the first year of the mandate, the government finished cuts to basket of services to reduce home support. Also, the number of CCACs was reduced from 42 to 14 and their boundaries were realigned to match those of the Local Health Integration Networks. Now, 75% of services is short-term post-hospital care. In response to protests a moratorium was declared and bidding was frozen from 2004- 2007. In January 2008, a new moratorium was imposed and bidding frozen. The government has created a new aging at home strategy ($1.1 billion) separate from the CCACs. Funding for the varying range of programs and pilot projects in this initiative flows through the Local Health Integration Networks, rather than the CCACs and a major focus is on innovation. The "aging at home" strategy is not a uniform program, or system, and is expected to produce an ad hoc array of projects via funding contracts with external agencies. The services will therefore vary across the province (similar to the pre-1990 homecare system).

*The following are questions and discussion points that we are seeking response to in your written submission. Please feel free to use this form, or to write up your responses in a separate document (limit 10 pages). If you decide to submit a separate document, please ensure that you include references to the section numbers as indicated here. There is no requirement to answer all questions.*

**SECTION I. PRINCIPLES**

Physician and hospital care in Canada's public health system are governed by a set of principles outlined in the Canada Health Act : universality, comprehensiveness, accessibility, portability and public administration. These principles reflect our views on what our responsibility is to each other, whether we embrace market-style approaches, how we see the role of government and the responsibilities of individuals and our communities.

1. What principles should guide reform in Ontario's homecare system?

**SECTION II: GOAL OF HOMECARE SYSTEM**

The different approaches to homecare reform over the last decade reflect varying views on the goals of the homecare system. Some view the system's main role as supporting people with functional decline, disability or the frailty of aging, and preventing or delaying their need for a nursing home placement. Others focus on its role in preventing the need for more intensive forms of hospital care, such as caring for children who are dependent on technology or providing palliative care in the home. Still others believe its primary value is in moving patients out of hospitals more quickly. Many believe the aims should be a combination of these and more.

1. What do you believe the goals of the publicly-funded homecare system should be?

2. Are there some goals you think are inappropriate?

**SECTION III: ACCESS**

Discussion: There are varying viewpoints on what "basket" or scope of services should be covered (ie. publicly-paid for, not subject to out-of-pocket user charges) and whether coverage should be universal or means-tested, capped or limited in some way, and to what extent social supports should or should not be included. For example, in the last years of the Harris/Eves government and the first years of the McGuinty government, many home support services for the frail elderly (such as help with house cleaning, meal preparation and laundry) were removed from public coverage.

1. Determining the scope of services: What scope of services should be covered publicly? Is there a role for means-tested services and if so, what range of services should be would be means-tested? What services should be fully covered? Should there be a cap or limit on services – how would this be determined and what would it exclude? What services should not be covered? Are your proposals here compatible with your vision of the goals of the homecare system – and how?

2. Who should determine access? Should the scope of homecare be set out in legislation? In regulations? In policy (directives from the Ministry)? By the CCACs or some other board or agency? To what extent should this be centrally standardized or locally decided?

3. What is good or bad about the levels of access and how they have been determined in the various models of homecare used to date in Ontario?

## SECTION IV: MANAGED COMPETITION/COMPETITIVE BIDDING

1. What are your concerns with managed competition/competitive bidding?

2. Are there improvements that have resulted from managed competition?

## SECTION V: FUNDING

Methods and levels of funding obviously impact on the scope of services provided. Historically there has been enormous variation in the amount of per-person funding available for home care depending on where you live in Ontario.

1. How should levels of funding be determined? By whom?

2. What are the problems/benefits of current approaches to the levels of funding provided?

3. Should there be a clear set or level of entitlement to services or should these decisions flow from the amount of funding available, or some combination?

4. How should funds be flowed? (Through CCACs, LHINs, direct contracts with government, some other method?)

## SECTION VI: PROVIDERS OF SERVICE

1. Who should provide homecare services? (CCACs, some other public entity, non-profit agencies, for-profit companies, some combination?)

## SECTION VII: CREATING A CONTINUUM OF CARE

This question relates to a set of issues that are sometimes called "integration". This discussion centres around how to create more coordination of services among providers, and how to create better access and seamlessness for patients/clients.

1. What has worked/has not worked to date in improving coordination of care among providers within the homecare system? What about between homecare and other parts of the health care system? And between homecare and social services?

2. What reforms do you suggest to improve seamlessness for patients/clients within homecare, between homecare and other parts of the health system, between homecare and social services?

3. What reforms do you suggest to improve coordination between providers within the homecare system? Between hospitals and long term care facilities and homecare? Between homecare and social services?

4. What are the service gaps?

5. Do you have proposals for changes to funding systems, government or government agency structures that would improve coordination and contribute to creating a continuum of care?

6. How can the sharing of "best practices" be improved?

**SECTION VIII: PROCESSES**

1. How should democratic control be exercised in homecare? Should there be elected boards or democratically controlled entities in the system? At what level? How should these be governed? To what extent should homecare be centrally governed by the provincial government and to what extent should there be local flexibility and/or governance?

2. How should quality be evaluated? Are there sufficient standards to ensure quality of care? What is working and what is not? Are there other standards which should be province-wide? How should these be set (legislation, regulation, policy (directives from the Ministry to providers)?

3. Is the homecare system accountable enough? How could accountability be improved?

4. Have you tried to access information about or within the homecare system that should be publicly available? Were you successful? Is access to information adequate? How could it be improved?

5. Are processes for complaints appropriate and sufficient? How can they be improved?

6. Are processes for appeals appropriate and sufficient? How can these be improved?

**SECTION IX: HUMAN RESOURCES**

1. How can current shortages be addressed most effectively?

2. Are there specific ways in which rural shortages can be addressed?

3. How should working conditions be improved?

4. What initiatives have you seen or experienced that have improved staffing levels and/or working conditions?

**SECTION X: OTHER**

1. What elements or models of homecare in other jurisdictions would you recommend for Ontario?

2. What are some "best practices" in Ontario's homecare system that you would like to highlight and/or see spread?

3. Are there other proposals for reform, not covered in the questions above, that you would like to see addressed?