HOME CARE

what we have
what we need

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for the Canadian Health Coalition

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This study was commissioned by the Canadian Health Coalition to support a deeper understanding about the public policy environment and current role of for-profit companies in the Canadian health care system and, more specifically, in home care.

Many people helped me understand the very complicated terrain of home care and long term care in Canada, and the issues being confronted by many thousands of Canadians in every province and community. First and foremost among these are the women and men whose daily lives are taken up with the struggle for a just and equitable system of service provision outside the hospital sector. In Nova Scotia: Gail Bruhm of Chebucto Links and Joan Cowie of the Family Caregivers' Association; Kevin Murphy of the Canadian Paraplegic Association; John Ryan, Debbie Kelly, Elizabeth Logan, and Iris Steele of the Nova Scotia Citizens Health Network; Ian Johnston and Linda Sorota of the Nova Scotia Government Employees' Union; Lois Miller at the Halifax Metro Resource Centre for Community Living; and Karen Kurtzrock. In Ontario: Ethel Meade of Care Watch and the Older Women's Network; Freida Hannah, Pam Bailey and Georgie Clark at Concerned Friends & Family of Residents in LTC Facilities; Karen Cobb and Corey Vermey at the Service Employees' International Union; Doug Allan, Alison Davidson at the Canadian Union of Public Employees; Michelle Lupa and Lynn Simmons of the Ontario Health Coalition; Abe Rosenfeld at the Sandy Hill Community Health Centre; Terry Lord, Vice President of Olsten Staffing Services (Canada). In British Columbia: Mike Old, Marcy Cohen and Dale Fuller at the Hospital Employees' Union; Catherine Ferguson, Debra McPherson and Art Moses at the BC Nurses' Union. National organizations: Ann Hysert, Janet Helman and Janis Leiterman of the Victorian Order of Nurses; Frances Arbour, Kathleen Connors at the Canadian Federation of Nurses Unions; Mike McBane and Pat Armstrong at the Canadian Health Coalition; Stan Marshall at CUPE's national office in Ottawa; Mary Rowles, former Executive Assistant to the President, Canadian Labour Congress and currently Director of Research, Campaigns and Technical Services, BC Government and Service Employees Union.

Preface

By Kathleen Connors
President of the Canadian Federation of Nurses Unions

In the spring of 2001, many Canadians are asking themselves, "What has happened to the National Home Care Program?" Some will vaguely recall the 1997 National Forum on Health Report which called for the creation of a National Home Care Program and a National Pharmacare Program. After wide consultation with Canadians and well documented research, the Liberal government's National Forum concluded that home care should be considered an integral part of publicly funded "medicare" services. A 1998 National Conference on Home Care enthusiastically identified home care as an important component of a responsive sustainable health care system - a key to the modernization of Medicare. Yet the September 2000 Federal/Provincial/Territorial Accord on health care, and the November Federal election paid only lip service to the issue of a National Home Care Program.

Canadians have witnessed and often personally encountered the restructuring of Canada's national medicare system with resulting closure of hospitals or elimination of hospital beds, and the early discharge of patients from hospital. They have not seen a parallel re-investment in home and community based-care. Instead they have seen home care dollars shift from personal care services (which permit seniors and those with chronic conditions and disabilities to remain at home rather than live in an institutional setting) to acute care services (which provide nursing care services to those discharged home early from hospital.)

Members of the Canadian Federation of Nurses Unions (CFNU) work on the front lines of Canada's healthcare system - in hospitals, in long-term care, in the community and in the home. Canadian nurses are daily witnesses to what is happening to the system in which they work, and more importantly, to the individuals who count on the system to care for them, or their family members. The CFNU recognized that further research was necessary to support the case for a publicly funded, publicly delivered and not-for-profit national home care program based on national standards.

CFNU is an active participant within the Canadian Health Coalition (CHC). Researcher Colleen Fuller's earlier work on privatization of health care (Caring for Profit: How Corporations are Taking Over Canada's Health Care System) had been a valuable resource for both CFNU and CHC. Supported by funding from CFNU and its affiliates, coordinated through the CHC, researcher Colleen Fuller worked to provide this thoughtful analysis of home care in Canada. Colleen's work validates what nurses have described from their personal professional experiences.

As a Registered Nurse graduating and working in Manitoba, the home of the first provincial home care program, I was aware of the philosophy and principles upon which the innovative program was developed and administered. Publicly funded, publicly administered, and publicly delivered, the system - based on the principles of the Canada Health Act - while not perfect - meets the at home personal care needs for seniors, the disabled and patients discharged from hospital.

The Manitoba home care program - the first in Canada - provided my family with the support which allowed our family to care for my father at home. His desire to die at home was supported by the home care program. There was no financial burden to our family for the supplies necessary for Dad's care and comfort.

I personally contrast this experience to another personal encounter - this time with the Ontario home care program. As a cancer patient receiving chemotherapy, I was visited weekly by a home care nurse - employed by the Victorian Order of Nurses (VON) - a reliable private not-for-profit organization with over 100 years of service in home care. The cost of my care was covered by Medicare but the VON had had to bid on the contract for home care in my area. Nurses who visited my home during this period described how the competitive bidding process had changed the manner in which VON worked. The contract outlined strict guidelines of time allocation for a home visit despite the fact care should be based on the assessment and needs of the individual and those needs may fluctuate. The competitive tendering process had led to downward pressure for nurses wages and working conditions which impacted on morale, and affected continuity of care. Nurses described how they could no longer care for individuals with whom they had developed rapport, as a result of loss of a particular contract - frequently to a private American-based for-profit company. They described the sense of loss and frustration experienced by patients and families.

Media coverage of fraud in the United States, by for-profit companies providing home and long term care are cause for concern in Canada. Firms such as Olsten - now Gentiva Health Services - have been charged with fraud in the United States and have paid millions of dollars in fines. Amazingly, Olsten/Gentiva is still welcome in Canada. This is not the kind of home care program envisioned by the National Forum on Health, Canada's nurses, or the Canadian Health Coalition. The Manitoba home care program is publicly delivered. It works well and costs less than a system where a profit margin for owners and shareholders must be included. The Manitoba system is based on the principles of the Canada Health Act, and any national program must have these principles as its foundation. The Canadian Health Coalition believes that a publicly funded, publicly delivered and publicly accountable home care program provides the optimum means to guarantee a quality continuum of care for in-home medical services and home support services.

In one of Tommy Douglas' last public speeches, he made reference to the need to build the next phase of Medicare. He acknowledged that the provision of hospital care and doctors' services were the first steps in providing care to Canadians. Now it is essential that the next phase be built and a national home care program is integral to this phase. This initiative requires effective federal leadership and 50/50 funding with the provinces. The issue of a national pharmacare program is also an important component in building the next phase. Connected to the home care piece - if Canadians are being cared for in their homes rather than institutions, coverage of pharmaceutical costs must be provided. The escalating costs of pharmaceuticals and the burden of those costs must be taken into consideration in order to guarantee an integral public health care system into the future.

Canadians will have an opportunity over the next 18 months to engage in a dialogue about health care. The appointment of Roy Romanow as head of the Commission on the Future of Health Care in Canada and the work of the Commission will provide Canadians with many opportunities to clearly articulate their vision for Canada's health care system. I have every reason to believe a national home care and pharmacare program will be part of that vision.

Introduction

The history of the struggle for an equitable and just system of health care funding and delivery tells us much about the strengths and weaknesses of our medicare program. The dividing line in Canada is drawn starkly between those who believe that a characteristic of "quality" is "equality" of access to services, and those who believe that medicare deprives Canadians of an intrinsic "right"—the right to buy health services if they can afford to do so. The overriding tension in the home care debate, like that which has dominated Canada's health care system since the first discussions about medicare emerged, is between those who want a home care program to provide a service, and those who want it to provide a return on investment.

This study looks into the way that tension has influenced federal and provincial policies that determine how and whether home care is delivered in every part of the country. During medicare's early years, such divisions shaped the health care terrain, at once galvanizing public opinion and immobilizing "please everybody" politicians until an election was called. However, as the following pages illustrate, the lack of decisive political action, especially at the federal level, today is set against a backdrop of trade agreements, globalization and powerful investors, on the one hand, and home care recipients, their families, caregivers and taxpayers on the other.

In several parts of the country, these forces have clashed publicly. In Manitoba, to the shock and delight of medicare champions everywhere, home support workers, backed by their union, were joined by clients, patients and health care activists to drive one of North America's largest home care companies out of the province. In Newfoundland, home support workers courageously stood up to Comcare, rejecting poverty-level wages for the good work they did – in response to which the company, backed primarily by rich and powerful Bay Street investors, closed its doors in that province.

Disagreements are also emerging about the very definition of what this service is, with some arguing in favour of a progressive system of home care based on the principles of prevention and wellness, and those who see home care as a cheap alternative to hospitals for acutely ill patients. The "official" definition of home care used by Health Canada describes "an array of services which enables clients, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying, or substituting for long-term care or acute care alternatives."[1]

Advocates of a national home and community care program which captures all of the services outlined (next page) are confronting very difficult questions about how to proceed with this just demand. A 1998 poll by the Canada Health Monitor found that 84 percent of respondents support a national home care program, yet a majority also stated that the federal government's role should be minimal. Similar polls also indicate that Canadians identify home care as a key to enable the elderly and the disabled to avoid institutionalization, yet at the same time they oppose public payment for non-medical home care services.[2] Such results point to a daunting level of, at best confusion and, at worst, ignorance. But it also suggests the areas that proponents of a national program need to consider.

[1] Health Canada. Report on Home Care, prepared by the Federal/Provincial/Working Group on Home Care, a Working Group of the Federal/Provincial/Territorial Subcommittee on Long Term Care, Ottawa, 1990.

[2] "Putting a Face on Home Care, Report on Home Care in Canada" conducted by Queen's University Health Policy Research Unit for the Canadian Association of Retired Persons (Toronto: CARP, 1999)

There are four main areas that fall within the generally accepted designation of "home care":

1. Services that are non-medical in nature, such as housekeeping, transportation, maintenance, and meal preparation.

2. Services such as bathing, toileting, or assistance moving from bed to wheelchair, also are important aspects of home care for people who are not sick but who need personal support.

3. Services may be required for chronic and disabling conditions on a regular, but not necessarily daily basis, while for others these services may be needed at various times of illness. These include nursing, speech language pathology, physical, respiratory and occupational therapy.

4. Respite care is essential for family caregivers, many of whom are elderly people looking after elderly people. It is non-medical in nature, but may require skilled providers of personal care.

However, it is equally important to remember that the struggle for home care and, more broadly, for universal access to all health care services, is about rights and not simply the mechanics of funding and jurisdiction. On the one hand, Canadian governments have not legally enshrined health care—and certainly not home care—as a right; on the other hand, Canadians generally are encouraged to believe that they have a right to health care, and that this entitlement is upheld in the *Canada Health Act*. But those fighting to protect and extend such rights are not merely demanding individual "legal privileges" under the Charter of Rights and Freedoms, but rather collective rights and entitlements extended through and guaranteed in Canada's social policy framework.

Existing records of the debates surrounding Canada's health care system over most of the 20th century provide ample evidence that the Canadian people have been debating the notion of entitlements and rights. The problems governments have experienced implementing pro-privatization policies in the area of health care have arisen, not because of legal barriers, but because of a conviction among the Canadian people that "universal access" supports and provides entitlement to these services. The *Canada Health Act* is central in this social and political environment, but is perhaps less decisive than the resolve among many Canadians to protect and even extend their rights.

The fight for home care is as much about winning a universal national program as it is about how we get there: it is self-evident that if we aren't on the right road, we will never get to the right place. History tells us that today's medicare system is shaped as much by the vision of its original advocates as by the path taken to implement the principles they articulated. Not only must we envision our destiny, therefore, but our journey there must be planned with equal care and passion.

Canadian Health Care: Open for Business

Since the mid-eighties, the federal government has pursued an economic growth strategy based on the export of Canadian goods and services to the "global market". The lead ministries in designing such strategies are the Department of Foreign Affairs and International Trade (DFAIT) and Industry Canada. In 1986, the Mulroney government commissioned studies of the services sector, including health care, "to lay the foundation for a range of initiatives in support of Canada's future growth and competitiveness".[3] This process of consultation with "industry practitioners" identified health care goods and services as economic activities in which the country had a potential advantage over competitors, many of whom dominated trade and investment in the global health market. It was reasoned that Canada's excellent reputation in the efficient delivery of high-quality health care — a reputation earned after more than two decades of substantial public funding and administration of the sector — would assist domestic health care companies in securing a position in the global marketplace.

However, the path to the global market is potted with challenges, according to Industry Canada, challenges which threaten to undermine corporate success. The first of these is the composition of Canada's health industry: there are simply too many small- and medium-sized, "domestically oriented and controlled" companies which lack the necessary girth and capital to compete globally. This has led to a fragmented domestic market, a problem exacerbated by the sparse number of rich domestic investors with enough capital to support "consolidation", that is, mergers and acquisitions.
A second challenge is the inability of Canadian health exporters to offer competitive prices on their products and services. "Although Canadian companies are generally in a position to supply quality and even superior health services," an Industry Canada paper advised, "their costs tend to be prohibitive, due to domestic factors such as high salary levels." US, British and other competitors "have learned with experience that the value of tenders is often the key factor considered by local governments or other purchasers in their allocation of contracts. In this context," the paper continued, "those suppliers do not hesitate to recruit and utilize lower-quality expertise and services available at cheaper prices to fulfil part of these contracts."[4]

The need for health industry consolidation is an article of faith within the federal government, seen as a prerequisite to successful entry into the global market. It is also understood that consolidation without "foreign" — that is, US — participation is doomed to failure. Small Canadian-based companies not only lack money, but "the requisite outlook and orientation" that more experienced investors acquire in the global trade arena — the domain of the multinational corporation.[5]

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[3] Future Markets for Canadian Health Care Service Providers: "Introduction" (Ottawa: Industry Canada, Health Industries Branch, November 12, 1996). The paper on health services was co-written by the Fraser Institute, and entitled "Caring for Profit: Economic Dimensions of Canada's Health Industry".

[4] Ibid, "Constraints to the Export of Canadian Health Care Services". These documents are available on Industry Canada's website at http://strategis.ic.gc.ca

[5] This comment is contradicted somewhat by the observations of the Canadian consular office in Chicago, which states that Canadian firms are export oriented at a much earlier stage in their growth than are similar sized Midwest firms which have often worked exclusively within the domestic market". In the health sector, Canadian companies have tended to develop an outward focus because of the dominance in the domestic market of non-profit quasi-public providers. See "Why Canadian companies are desirable strategic alliance partners", in STRATEGIC ALLIANCE, www.dfait-maeci.gc.ca.

Before coming to Canada, however, global investors require that certain conditions be met before dropping a dollar in the domestic market. These conditions include a "liberal" regulatory environment, a demonstrated and, in effect, eternal commitment to privatization and low corporate taxes.[6] To meet these requirements, a strategy emerged during the 1990s designed to attract foreign capital to Canada's private health industry, and to support cross-border corporate alliances and foreign-, mainly US-funded, mergers and acquisitions.

Capturing and profiting from the "market potential" in the world's US$2 trillion worth of trade in health goods and services "is primarily the responsibility of private companies," says Industry Canada, "But governments have an important role to play in setting the business climate at home, in managing the Canadian regulatory regime, and in supporting international business development."[7] Policies and programs that support increased privatization and enhanced profits are central to efforts establishing the appropriate business climate in the health sector.

According to the ministry, there are eight "general categories" for health services in Canada, including institutional and facilities management, clinical services, health insurance, and contract research. (Contract research is the term applied to clinical trials organized by large companies such as MDS under contract to the pharmaceutical industry.) The "areas of strength" which have potential for attracting foreign investors include home health care, long term care, information systems, health and hospital management services, and occupational health.[8]

Home health care, in particular, says Industry Canada, is an attractive area to invest in — a "high growth area" because of "an increasing number of affluent, older citizens with chronic health conditions". More hospital procedures done on an outpatient basis, early discharge policies, and "the need for cost efficiencies in providing regular medical support for those with chronic and terminal conditions", are sparking interest in "home care options". The fact that studies on the subject are yielding mixed results has not deterred Industry Canada from asserting that the "advantages in cost containment and clinical benefits" make investments in home care "attractive both in urban settings and with geographically dispersed rural populations".[9]

The Department of Foreign Affairs and International Trade is also doing its part to promote US investment in Canada's health care sector, including home care and long term care. In 1995, DFAIT, together with Industry Canada, launched an "International Business Strategy" to boost exports of Canadian services and products, and to "attract and retain investment in all regions of Canada".[10] The business strategies set the overall direction for government, while "action plans" integrate "policies, instruments and programs" across government ministries.

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[6] For an eye-opening discourse on how to attract foreign investors, see "Facilitating Foreign Participation in Privatization" by Kathy Megyery and Frank Sader (Washington DC: International Finance Corporation and the World Bank, 1996). The paper was funded by DFAIT through the Canadian International Development Agency.

[7] Canadian International Business Strategy (CIBS): "Introduction" (Trade Team Canada, Health Industries, April 1, 1999)

[8] ibid. Future Markets: "Canadian Supply Capability"

[9] ibid. CIBS: "The Health Services Sector"

[10] "Canada's Action Plan for the United States", Department of Foreign Affairs and International Trade (Ottawa: DFAIT, December, 1998). This document is available at DFAIT's website: www.dfait-maeci.gc.ca/geo/usa/old/cap1-e.htm.

According to DFAIT, "The private sector has been involved in developing these plans, along with federal departments, agencies and the provinces and territories." Such extensive consultations do not extend to Canadians worried about diverting scarce health care dollars into the pockets of private investors, or to the thousands of people who would not view "older citizens with chronic health conditions" as a mere investment opportunity. DFAIT's job is to "gather intelligence" for Canadian investors interested in moving their money to markets outside of the country, and to scout out the potential for "strategic alliances" with companies that want to invest in Canada. The department has identified a number of "priority sectors" in "our top priority market: the United States of America". Health and life sciences fall into the priority sector designation, and DFAIT's efforts are directed both at identifying opportunities for Canadian investors in the US home care, medical devices, biotech and pharmaceutical markets — and drawing similar US investors into Canada. — efforts that "make us key partners in the Canadian export of medical and pharmaceutical products and in the promotion of foreign investments in Canada".[11]

These efforts are good for business, but are they good for Canada's health care system? During the last five years the impact of federal policies has increased private sector involvement in both the financing and provision of health care. While this has benefited investors, the health system as a whole appears to be in chaos. Emergency rooms are in crisis at the peak of the flu season. Wait lists have increased for elective surgery. Under-serviced areas in rural and isolated communities cannot attract and keep physician specialists. Physicians in many parts of the country are openly defying laws prohibiting extra billing, while hospitals are charging user fees for cataract surgery "top ups". Nurses are leaving the profession in droves, discouraged and burnt out after years of cutbacks and increased workloads. New and younger recruits are in short supply. Non-nursing staff are equally underpaid, overworked and increasingly angry. Provinces cannot afford to increase the percentage of their budgets consumed by health which is needed to make up for the tens of billions of federal dollars withdrawn during the 1990s..

Overall, therefore, it would appear that Health Canada's new enthusiasm for big business has not benefited health care consumers or providers in the health system. In fact, quite the opposite is true. While health was a battleground throughout the 20th century between investors and virtually everyone else in the country, it wasn't until the last 15 years that public policy was so thoroughly captured by an increasingly powerful minority which also was well-represented in the media, among employers, and increasingly on the volunteer boards of large, urban hospitals and hospital foundations. Their influence is evident today in Ottawa's reluctance to enforce the terms of the *Canada Health Act* in ways that may undermine investment opportunities, or even to collect the information necessary to ascertain provincial non-compliance. Even the Auditor General, Denis Desautels, noted in his annual report in 1999 that "Health Canada does not have the information it needs to report to Parliament on the extent to which each province and territory has satisfied the Act's criteria and conditions." In addition, he added, "some compliance issues have remained unresolved for a number of years".[12]

Canadians have been remarkably successful in defending the country's single payer system from complete erosion, in spite of Ottawa's perverse indifference or outright deceit. But the struggle to extend medicare to new frontiers confronts a powerful array of interests whose greatest ally is not necessarily government, but rather anonymity. Before we examine some of these powerful players, it will be helpful to provide a broad overview of Canada's home care environment.

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[11] Presentation to the International Health Business Opportunities Conference (IHBOC '97) by Mr. Edward M. Aliston, Director General International Affairs Directorate, Health Canada, Calgary, Alberta, October 29, 1997

[12] "Canadians Deserve Accurate Information on Federal Health Care Spending and on compliance with the Canada Health Act", New release: Office of the Auditor General of Canada and the Commissioner of the Environment and Sustainable Development, November 30, 1999

A National Picture of Home Care

The current discussions about home care recall the decades-long struggle among farmers, workers and other Canadians that led to the momentous launch of a national strategy during the 1960s to enable all people to obtain health care services — one of the country's most significant achievements of the 20th century. But if the determination of so many people to build on this legacy is reminiscent of an earlier time, so, too, is the lethargy in the ranks of the federal government.

In March 1998, Health Canada and the Nova Scotia Department of Health co-sponsored a National Conference on Home Care in Halifax. More than 300 people attended the conference, convened to "foster dialogue on the complex issues associated with home care in Canada and with national approaches to home care".[13] After three days of discussion and debate a consensus emerged among participants that a national home care program not only was needed—but that this need was urgent. The Halifax conference was convened amidst expectations that Ottawa would soon unveil a plan to establish, at long last, a program covering home care. All the major organizations had been invited to attend, from the Canadian Association of Retired Persons to the CD Howe Institute, and from the National Anti-Poverty Organization to Comcare Health Services. With great fanfare, federal health minister, Alan Rock, announced that "the time has come to bring a national perspective to home care".[14]

But people were in need of programs, not perspectives. The home care system described by participants in the national conference was characterized by a lack of high standards and the absence of medicare's "five principles". They criticized the poor working conditions and wages of "formal" (paid) caregivers, and the lack of training opportunities for the workforce. Participants decried the lack of support for "informal" caregivers – friends and family members who provide 80 percent of the home care across the country. What the conference participants were identifying as the most urgent need was not a perspective, but national funding and national standards.

The conference hosts, however, were not accepting or proposing any recommendations. In spite of these constraints, participants expressed overwhelming support for a national home care program and called on Ottawa to allocate new funding to home care in the 1999 federal budget and move decisively to assume a leadership role in launching a national program. They identified three immediate steps they wanted to see taken by Health Canada to realize this long-held dream:

1. The federal government should set up an action group/task force to begin developing and implementing a national home care program;

2. A number of sub-groups should be established to look at specific aspects of such a program, for example, principles and national standards, and whether the private sector has an appropriate role in the provision of home care; and

3. A follow -up conference should be held in one year's time.

[13] Health Canada Publications: "Proceedings, National Conference on Home Care, March 8-9-10, 1998", p. 3, prepared by Helen Partiquin of the Nova Scotia Association of Health Organizations.
[14] Speech by Allan Rock at the National Conference on Home Care, Halifax, March 1998 (Ottawa: Health Canada Publications).

Over three years later, conference participants are still waiting for Health Canada to move forward on their suggestions, and many are convinced that the commitment of the federal government to a national home care program is waning, if indeed it ever was firm.

Yet, as was noted by many of those in Halifax, action is needed immediately to ease the burden now being carried by Canadians who depend on services that they are told are delivered outside the terms of the *Canada Health Act*. And that, in a nutshell, is what makes this issue an urgent one. The growing number of people being forced into the private market for home care services—whether they like it or not—is challenging our pocketbooks, as well as our notions of fairness and equity. The free market in health care products and services, many are discovering, is not about access, but rather about profit margins and market dominance. And most of those who are learning this hard lesson are elderly citizens and people with disabilities.

Who Pays?

There are three main sources of funding for home care services in Canada. The largest payers are provincial governments, followed by individuals who spend directly out of pocket. The third largest payer is the insurance industry, which is expanding its presence in North America's "long term care market" thanks, in part, to generous tax breaks offered by the Clinton administration in the United States. Developments south of the 49th parallel affect the course of events in Canada as our economy becomes increasingly integrated with that of our southern partners in NAFTA.

Public funding for home care is inadequate at every level of government in Canada, and in every part of the country. Estimates put national public home care expenditures in 1997 at $2.1 billion, with wide funding disparities from one province to another, as well as within provinces. Canadians spend, through the federal and provincial public purse, about $69 each on home care per year, an amount that falls pathetically short of even the most basic costs being shouldered by mainly low-income seniors and people with disabilities. This figure does not include expenditures on home medical and mobility equipment, estimated to be approximately $190 million annually.[15] The corresponding figures for private expenditures are not known, but most of the costs for home and long term care are borne by individuals and families. A poll conducted for PriceWaterhouseCooper in November 1999, suggests that people who use home care services on an on-going basis spend an average of $407 a month out of their own pockets, plus $138 for prescription drugs. Those who require post-acute home care are spending approximately $202 a week.[16]

A profile of the "typical" user of home care services shows that nearly two-thirds are elderly. Only eight percent of elderly Canadians are in assisted living or long term care facilities, while the remainder of those who need assistance depend on family members, friends or provider agencies. Approximately 40 percent of Canadians over age 65 have a permanent disability, and the fastest-growing segment among the elderly population is over 80 years of age. Both of these groups are likely to require some form of home care service.

[15] "Home care and mobility equipment", Pierre Richer (Washington DC: US & Foreign Commercial Service and US Department of State, 1999). Expenditure figure for this category is derived from US estimates in US dollars at 1997 exchange rates of 30 percent.

[16] Andre Picard, "Home health care: Only if you can afford it", Globe and Mail, December 6, 1999

Home care recipients are also low- or fixed-income earners, which is not surprising given the age of the population, and they are more likely to live alone. In 1994-95, people with cancer or stroke were twice as likely to receive home care than those with other medical conditions. Forty-six percent of home care recipients reported having arthritis or rheumatism, but in the overall population only eight percent of adults with these conditions reported receiving these services. By contrast, according to Statistics Canada, "just 10 percent of all home care recipients were stroke victims, but over one in four people who had a stroke received home care".[17]

Over 80 percent of home care is delivered by unpaid or "informal" family members, and almost one in five of these are women between 45 and 64 years of age who spend an average of 28 hours per week in a care-giving role.[18] Almost two-thirds of informal care-givers report caring for one person in the home, while 22 percent are caring for two people, and another nine percent are caring for three people. Many of these care-givers also are in the paid workforce, with over 46 percent of employees reporting some eldercare responsibilities. Yet, according to the Conference Board of Canada, 16 percent of adult Canadians live more than 1000 kilometres from their parents, 14 percent live between 400 and 1000 kilometres away, and 14.5 percent live between 100 and 400 kilometres away.[19] This suggests that many care-givers are unable to provide support except on an occasional or emergency basis, and underscores the need for more formal, state-supported delivery of appropriate services both in the home and in the community.

The insurance industry is another growing fixture on the payer side in the home care sector. American insurers, encouraged by US$1,000 tax credits now offered to people buying long term care insurance, have begun to develop LTC products for the "junior senior" and "senior senior" markets. Older Americans qualify for Medicare at age 65, but this program does not provide funding for in-home, non-medical support, while recent changes in the funding structure for long term care is threatening the high profit margins of nursing home corporations. The insurance industry, which expressed reluctance for many years about providing insured services to such a high-risk population, has begun to develop hard-sell strategies targeted at the "boomer" generation. American workers eligible for federal tax credits are being encouraged to pay high dividends for long term care insurance to protect them—and their aging parents—from bankruptcy in their older years.

Insurance executives undoubtedly are waiting to see what direction Ottawa takes on home and institutional care before they follow the direction of their US counterparts. According to insurance industry analysts there is a potential market among "junior seniors" aged 50-65 years in Canada, a group confronting increased responsibilities for elderly parents—and on the verge of needing help themselves. During the last three years, several large Canadian insurance companies have launched new product lines for long term and home care, but marketing plans are relatively low-key. Commenting on the market potential for such products, Dick Gilbert, president of Mississauga, Ont.-based Megacorp Insurance Agencies Inc., complained in early 1998 that Canadians are the "world's worst procrastinators," and predicted a "slow, gradual acceptance" over the next five to 10 years. "Lots of boomers will do it because they're selfish and will want it for their parents," he said, while "wealthier people will buy it for asset protection."[20]

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[17] Health Report, Summer 1998, Statistics Canada

[18] "Equity Considerations, Home Care Researchers and Planning", a paper prepared by the Maritime Centre of Excellence for Women's Health for the National Conference on Home Care, March 1998. The report is available at: http://www.mcms.dal.ca/mcewh/Publications/HC-equity-e.htm

[19] Eldercare and the Workplace, Report 150-95 (Ottawa: The Conference Board of Canada, 1995)

[20] "New choices in long term-care insurance market", The Financial Post, September 26, 1997. Gregory's comments are interesting, given that Canada is one of the most insurance-saturated markets in the world, second only to Japan.

Privately insured home and long term care is being structured in a similar fashion to other forms of insurance coverage. Premiums are higher for the population most in need of the services—senior citizens—since this group is considered "high risk". The calculations among industry executives have led to marketing strategies targeted at high- and middle-income earners in their 40s. These calculations are based on average home care costs of $35 to $48 an hour for nursing care, $70 an hour for an occupational or physical therapist, and $15 an hour for help with eating or light housework.[21] Government programs, with increasingly stringent eligibility criteria, may provide up to 60 hours a month for home care for those who qualify for the full array of services.

To qualify for coverage, subscribers must be between the ages of 40 and 80 years when the policy is purchased, with the costs of premiums rising steeply after retirement age. The benefits that policy holders are paying for do not include medically necessary health care services, as these are covered by public health insurance plans. A basic, no-frills policy for subscribers 40 years of age costs about $130 a month for 20 years, which entitles them to $50 in home care benefits per day up to a lifetime maximum payout of $75,000. A low-cost benefits plan includes a 90-day "elimination period"—the period between the time care is needed and the day that benefits are triggered. So, for example, if the beneficiary required three days of home care a week, 30 weeks might have to lapse before benefits kicked in. To purchase a package without the elimination period can add 30 percent to the premium rate, but in the interests of greater "choice" customers can choose 30-, 60- or 90-day elimination periods and pay different premiums for each. At $140 a month for a home care and long term care package, the premiums paid amount to $31,000 over 20 years. Benefits may provide home care services for 365 days, 720 days or lifetime duration. Facility care may be purchased for periods of one, two or five years or for a subscriber's lifetime.

On the other hand, to insure an 80-year old for $100 worth of home or facility care a day without an elimination period may cost nearly $20,000 a year for a lifetime maximum benefit worth $400,000. The "premium-paying" period is 20 years for most purchasers, while those at older ages will have a different paying period at different (higher) rates. The "only down side" to such plans, according to one insurance agency, is that they are "so new to Canada, the actuaries have had to use experience from other countries to structure the rates. It is because of this that there is a clause [in the policy] which would allow the insurer to change the rates after five years."[22]

To qualify for benefits, subscribers must need "substantial assistance" to perform two of five or six "activities of daily living" (ADL). Specific legal wording in an insurance policy is the only thing that is enforceable, but there are hazards in interpreting the terms of every insurance policy. "Beware of restrictive or vague definitions of 'assistance'," warns the US Long Term Care Insurance National Advisory Council. Private insurers also apply eligibility criteria, and higher rates or exclusions for some pre-existing conditions are common.

[21] These figures do not reflect the actual wages earned by nurses and other home care workers, but rather the hourly rates charged by the providers who employ them.

[22] The premium rates and benefits are derived from several sources: Commercial Union of Canada (Scarborough, Ontario), ITT Hartford Canada (Burlington, Ontario); and Barber, Piper Insurance Agency Ltd. (Toronto, Ontario)

How They Say 'No'

Across the country, elderly and disabled home care recipients are finding that the eligibility criteria that enables them to obtain services are changing, and that home care is being "medicalized". Although home support services are clearly identified as the difference between staying home or moving into an institution for many recipients, it is precisely these services that are being reduced. Regional or community agencies are increasingly unable to adequately fund home support services because of increased demands for acute care in the home. "Early discharge is a result of hospital downsizing and bed closures" in Ontario, says Abe Rosenthal, a community health care worker at the Sandy Hill Community Health Centre in Ottawa. "The fewer acute care beds, the more pressure to discharge." In Ontario, patients discharged early, but still in need of acute care, now account for 40 percent of the home care caseload, and 30 percent of expenditures.[23]

Across the country, elderly and disabled home care recipients are finding that the eligibility criteria that enables them to obtain services are changing, and that home care is being "medicalized".

Rosenthal's words are echoed by health care workers, patients and activists in every part of the country. Early discharge and delayed admissions of hospital patients also are increasing the acuity levels of those who need home care, and placing greater demands on care-givers, both paid and unpaid. "If caregivers aren't given breaks," said Gail Bruhm of Chebucto Links in Halifax, "they'll burn out." Similarly, the use of sophisticated medical equipment and drug therapy in the home requires a corresponding level of sophistication on the part of patients and care-givers.

Most recipients of home care are able to participate in the decisions regarding the support they need, and how that support should be extended—that is, they are not "passive" recipients. In most cases, elderly recipients are able to look after themselves, and need only minimal, non-medical support in their day-to-day activities. This suggests that the current emphasis on home care as primarily a medical, as opposed to a health or preventative, service is inappropriate and contradicts the experience of the majority of those who require such support. The need of elderly people for higher levels of care, however, is unpredictable, and will increase rather than decrease with age.

Provincial governments hope that the relocation of some hospital services to the home will relieve acute care institutions of the cost of providing care. This may be the case, however, it will not necessarily reduce overall health care expenditures. In addition, this process is "medicalizing" home care and actually re-orienting the home care funding envelope to acute care. It ignores the benefits of home support services, both to the health system as a whole and to the quality of life of the elderly and disabled. These benefits are difficult to measure in terms of statistical health outcomes, but include increased or maintained independence, promoting recovery and slowing a deterioration of health, and supporting or enhancing relationships within the family unit.

Early discharge and late admissions are only one reason that home and community care are being medicalized. The move towards establishing "outcomes measurements" is a world-wide phenomenon, one that was given an early push by the US health insurance industry to support the denial of claims by beneficiaries.

[23] "Regional variations in the use of home care services in Ontario, 1993/95" by Peter C. Coyte and Wendy Young. CMA Journal, April 20, 1999

In many jurisdictions, outcomes measurements have been used to significantly decrease the amount of care that patients receive in hospitals, since evidence compiled by the insurance industry dictates that desirable outcomes can be obtained with shorter hospital stays, increased outpatient procedures and the provision of some types of acute care in the home. Physician practices also have been submitted to rigorous "evidence tests" to determine what procedures are necessary to yield desired outcomes. Information technology is used to transmit the "evidence" to doctors and health professionals, who then must follow the prescribed treatment protocols if they wish to be reimbursed for their services.

The emergence of managed care (or managed competition) in the US was one result of a kind of integration between private payers and providers: insurers who wanted more control over what providers were doing began taking over existing or establishing new health maintenance organizations (HMOs). The majority of HMOs operated on a non-profit basis when the powerful insurance industry began its acquisition drive, and have since been converted to for-profit status. While insurers knew everything about maximizing the return on investments, most of them knew nothing about whether the procedures patients received were medically necessary or not. Thus was born a new industry whose task was to develop "evidence-based guidelines" that essentially would enable cost conscious insurers to say no.

If a procedure, unsupported by scientific evidence that it would improve the condition of a patient with "*x*" condition, was provided by a hospital or doctor, these providers could find themselves working for free. The guidelines were embraced by frantic US hospitals and physicians who feared they would be denied a reimbursement by a patient's insurer unless they could show they'd done everything by the book. And insurers began refusing to reimburse for procedures that were not designated for specific conditions in the growing volume of so-called "medical cook books".[24]

Quality measurements also serve to placate demands for increased accountability in contracts awarded to home and community care providers, particularly if the providers are profit-based.

The push for standardization in medical care and treatment, couched in the language of medical (as opposed to actuarial) science, supported drastic reductions in patient hospital stays and physician treatment throughout North America, and fuelled the growth of out-patient services delivered in the community or in the home. But this growth has put increased pressure on public payers to fund those services, and thus to develop tools that will help them say no, too. Quality measurements also serve to placate demands for increased accountability in contracts awarded to home and community care providers, particularly if the providers are profit-based. Such measurement tools define and narrow the scope of services that care providers are contractually obliged to render to patients. In essence, if a service cannot be shown to produce an improved "measurable outcome" in the recipient, the logic goes, then it probably should not be included in a public health funding envelope.

Thus, the Canadian government is funding massive studies and pilot projects designed to establish information tools to support evidence-based decision-making in home care. To this end, the Canadian Institute for Health Information (CIHI) obtained a grant from the Health Transition Fund to develop national information standards to determine what types of home care services are being provided, by and to whom, the effectiveness of the programs and the client outcomes rendered by the services.

[24] See Colleen Fuller, op.cit., pp. 129-131.

During a consultative workshop organized by CIHI in October 1999, some 40 health professionals, academics, consumer advocates and government representatives struggled to assess the merits of proposed "national information requirements" for home care. In its report, CIHI stressed that standardized data would help regional health authorities, in particular, to ascertain whether (and which) home care services were cost-effective and produced improved "client outcomes"—that is, would noticeably improve the health status of recipients of in-home services.[25]

Many participants in the 1999 workshop were concerned that expectations of improved outcomes in home care recipients were not realistic, especially given the profile of most people in need of these services. The main tool for determining whether one is a candidate for home care is referred to as Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL). These measurement tools have been refined by the US insurance industry to meet the criteria of legislation introduced by the Clinton administration which offered a tax credit of up to $1,000 annually for home or institutional nursing care. Under the new law, "tax-qualified" insurance policies would have to conform to federal guidelines that stated "medical necessity" could not be used as the trigger for benefits. Instead, a patient's condition would have to be certified as one that would last for at least ninety days, or one in which the patient would have either a cognitive impairment or require "substantial assistance with two of six activities of daily living".

It is worthwhile to assess the level of care required by patients. But within an environment which stresses improved functionality and funding restraints, the value of such tools is undermined for many people whose ability to shop for groceries, perform housekeeping tasks, or prepare meals without assistance cannot be expected to improve.

Activities of daily living are defined as eating, bathing, toileting, transferring (for example, from bed to chair), continence, and dressing. ("A policy that excludes bathing as an ADL is NOT competitive in today's market", warns the US Long Term Care Insurance National Advisory Council.) Instrumental activities of daily living include all of the ADL functions, as well as meal preparation, handling personal finances, shopping, travelling, doing housework, using the telephone, and taking medications. To their credit, participants in the CIHI workshop identified IADL as a higher "information priority" than ADL, since the latter would identify those who required nursing and personal care, but not those who primarily need home support.

ADL and IADL—and perhaps other determinants on a rapidly growing list of tests—may be useful to assess the health status of patients, a very different goal than "improve functional ability". In addition to ADL and IADL, these assessment tools now include: the Basic Activities of Daily Living (BADL), Geriatric Depression Scale (GDS), Mini-Mental Status (MMS), the Functional Status Questionnaire, Dartmouth COOP Poster Charts, Duke Health Profile, SF-36 Health Survey, the Health Measurement Questionnaire (HMQ), the General Health Questionnaire (GHQ), the Nottingham Health Profile (NHP), the Physical Performance Test (PPT), and the Acute Physiology Assessment and Chronic Health Evaluation (APACHE-II) system. Nonetheless, the focus on improvements in functional status to assess the value of a service, or the continuing eligibility of clients, may limit the services available to home care recipients in the future, and impose unrealistic requirements on providers.[26]

[25] Consensus Workshop on National Priority Information Requirements for Home Care: Final Report, Canadian Institute for Health Information (Ottawa), 1999.

[26] Michel Bédard, D. William Molloy, David Pedlar, Judith A. Lever, and Michael J. Stones, "Associations Between Dysfunctional Behaviors, Gender, and Burden in Spousal Caregivers of Cognitively Impaired Older Adults", International Psychogeriatrics, Vol. 9, No. 3, September 1997.

These limitations already are evident in the private insurance market, which stresses improvements in activities of daily living and applies a more medical framework to adjudicate eligibility for benefits. It is worthwhile to assess the level of care required by patients. But within an environment which stresses improved functionality and funding restraints, the value of such tools is undermined for many people whose ability to shop for groceries, perform housekeeping tasks, or prepare meals without assistance cannot be expected to improve. The denial of in-home services is a hallmark of home care across the country. As Pat and Hugh Armstrong pointed out in their important study of health reform in Ontario, "In 1994-95, more than half of those [across Canada] who needed help with personal care received no formal care and the percentage was even greater for those who needed help with the Instrumental Activities Of Daily Living".[27] These measurements, which could be used to positively assess what kind of care is required, instead are being used to deny care.

Insurers mainly want to sell group health insurance policies sponsored by employers. Over 20 million people in Canada are covered by employer-sponsored supplementary benefits plans with a wide variation in entitlements. Employers have begun to tackle the problem of increased absenteeism among employees who look after family members in the home. In addition to nursing care, notes Benefits Canada magazine, "the cost of medical supplies and medications...falls on families once the person goes home" from the hospital. "For those covered under employer benefits plans," the magazine cautions, "paying for nurses and drugs at home could end up draining group benefits plans".

But many employers are reluctant to add more benefits to supplementary health plans, and in fact many are demanding reductions in coverage for health and prescription drugs. Despite employer complaints that the gap between what governments will fund and what home care actually costs is forcing business to "pick up the slack", many companies are leading the call for cuts to corporate taxes—which publicly funded health care needs to survive, let alone expand. "At the end of the day, the responsibility does lie with employees," said Laurie Harley, director of diversity and workplace programs for IBM Canada Ltd. But if companies see a "competitive advantage" in sponsoring home care benefits, Harley added, they may be compelled to act.[28]

Is it true that employers are broadening coverage on supplementary plans to accommodate employees' needs for home, long-term or community care? The honest answer is "no". Susan Bowyer of William M. Mercer, one of many consulting corporations helping employers cope with the rising cost of benefits, says the trend is to tighten up adjudication of nursing care benefits—not to expand them. "It's doubtful home care will ever be fully paid [on public health plans] and we need to stop and assess just exactly what the impact on private plans will be" she told Benefits Canada in 1998.[29]

[27] *Women, Privatization and Health Reform: The Ontario Case* by Pat and Hugh Armstrong, National Networks on Environments and Women's Health, York University, 1999

[28] Sonya Felix, "The Burden Of Home Care", Benefits Canada magazine, Maclean Hunter Publishing Ltd., December 1998.

[29] Ibid.

Demographic terrorism

Demographics are another important tool used to justify increased participation of corporate providers. The inability of governments to "cope" with an aging population is blamed on "very costly" elderly and disabled patients who are exacerbating the fragility of the health system, not just in Canada but world wide. Not only are the elderly adding stress to the system, but their uncontrollable aging is placing "unsustainable burdens on our children and, therefore, [undermining] their ability to raise our grandchildren" according to then-US President Bill Clinton.[30] But even as this generation is passing, a sleeping volcano is lurking on the horizon. The system is threatened with collapse "under the financial burden imposed by the aging of the baby boomers",[31] who forced their way into the world in too close proximity to one another. As Benefits Canada described it, "there is what many are calling a potential crisis ahead in terms of health care, and it all comes down to demographics".[32]

The demographics scare is largely unfounded. The demands of an aging population, these authors wrote, even to the year 2050 when most of the baby boomers will have gone through the health system, will not be as great a challenge to governments as that faced during the 1950s and 1960s.

While issuing regular warnings of the global demographic terror represented by the elderly, the health industry has invested heavily in studies that detail every aspect of the lives of the baby boom generation, and the current population of older men and women, particularly their income levels, age-related illnesses and health needs, and geographic dispersal. Such studies, coupled with the anticipation of decreased public funding for health care, have prompted some of the most frenetic merger and acquisition activity in the history of Wall Street as health corporations try to position themselves advantageously.

Demographic trends certainly are important for public policy planners. But according to one recent (and under-reported) study by Frank Denton and Byron Spencer of the Research Institute for Quantitative Studies in Economics and Population at McMaster University, the demographics scare is largely unfounded.

The demands of an aging population, these authors wrote, even to the year 2050 when most of the baby boomers will have gone through the health system, will not be as great a challenge to governments as that faced during the 1950s and 1960s. At that time, the country was putting in place a public housing program, medicare, old age security, the Canada Pension Plan and was greatly expanding its elementary, secondary and post-secondary education infrastructure—and Canada not only survived but flourished. In addition, the number of elderly in the future will be counter-balanced by far fewer younger people, resulting in lower demands for training and education and unemployment benefits. Numerous studies of demographics, the study's authors said, actually predict fewer demands on public spending at the height of the baby boom generation in 2031, than were made in 1991.[33]

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[30] "Remarks of the President at a roundtable discussion on long term care", Regulatory Intelligence Data, February 18, 1999.

[31] "Medicare Nursing Homes Shun Some Medicare Patients", Washington Post, June 07, 1999.

[32] "Evolving for the Future, Part I: Making a Case for Benefits", Benefits Canada, report of a roundtable sponsored by the Health Alliance, a division of Astra Pharma, undated.

[33] Bruce Little, "Boomer gloom's voice of reason: The coming glut of seniors won't be so taxing, these researchers say", The Globe and Mail, July 19, 1999.

The hysteria surrounding demographics seems designed to prepare the public for increased out-of-pocket expenditures for health care services and reduced or eliminated public pensions in the future. The argument that governments cannot afford to support the population of the country with social and health services adequate to its needs is a modern invention unsupported, many argue, by both history and serious study. The main challenge facing Canadians is not demographics, but rather how to ensure that the collective wealth of the nation is put to the greatest good, rather than into the pockets of fewer and fewer wealthy individuals.

The long term care industry is a designation that covers an array of services outside of the acute care hospital sector, including in-home health services, chronic care, residential care, nursing homes, staffing services, and emerging areas of the health system known as sub-acute care. The industry is in a state of flux throughout North America as smaller, mainly not-for-profit organizations have been thrown into a vicious competitive environment where large companies are fighting for tens of billions of dollars in both public and private reimbursements. Governments, either because of stupidity or ideological bent, are erecting a rigid and regressive public policy regime to support investment in the health industry, justified in part by assertions that publicly-funded providers cannot cope with current and future demographic realities.

The main challenge facing Canadians is not demographics, but rather how to ensure that the collective wealth of the nation is put to the greatest good, rather than into the pockets of fewer and fewer wealthy individuals.

Quality Assurance

Home care investors have launched a concerted public relations campaign to soothe public concerns about deteriorating quality and corporate greed as service provision shifts to the corporate sector. Accreditation—for which standards of care are developed and monitored by the providers themselves—is being promoted as a "quality assurance" measure and an alternative to government regulation of the industry. Partly in response to subjective patient evaluations about the kind of care they receive, an entire quality measurement industry has arisen using what is described as objective evidence. If the evidence shows that the type of care being provided yields improvements in functionality, then the "perception" that the quality of care is substandard can be more easily dismissed.

The quality measurements industry is a global phenomenon. The International Society for Quality in Health Care (ISQua) was established in 1993 "to promote research in quality improvement in health care, with particular regard to cost effectiveness, cost benefit and cost utility analysis, clinical epidemiology and measures of quality of life and consumer satisfaction". The 1500-member Canadian Council on Health Services Accreditation (CCHSA) was founded in 1958 to assess the performance of hospitals. It has since expanded to include non-hospital organizations, and in early 2000 it began its first survey of home care groups, leading to the accreditation of these providers. The CCHSA has increasingly focused on quality improvement management techniques, such as "patient-focused care" and other multiskilling programs designed to reduce labour costs and increase "efficiencies". Companies seeking accreditation claim that patients will benefit from knowing that an organization's performance is meeting the national standards set by the CCHSA.

Quality measures are important tools to support a transfer of service provision from the non-profit to the for-profit sector. Canadians are told that the private sector is being enlisted in a selfless effort to ease the "burden of illness" that threatens to place unmanageable strains on the public purse. Thus, governments assert that the public system is being overwhelmed with the growing demands of an aging population. Patients are forced to accept care from companies whose primary mandate is to maximize revenues and minimize the cost of providing services. In this environment, quality measurements are being used to placate public concerns about deteriorating standards of care.

Patchwork of Home Care

The lack of federal leadership has created a vacuum that is now being filled by aggressive corporations in partnership with provincial governments determined to expand the market for health industry investors. Instead of strong national standards, Canadian provinces are struggling to follow national trends set by provinces with the strongest economies, namely Ontario, British Columbia and Alberta.[34] Consequently, health care delivered in Canadian communities is an uneven patchwork depending on a range of factors including: income levels within the community, the legislative and regulatory framework within the province, proximity of the community to areas with high population density, and last but not least, the political commitment of the party in power to privatization.

The lack of federal leadership has created a vacuum that is now being filled by aggressive corporations in partnership with provincial governments determined to expand the market for health industry investors.

Long term care covers those services delivered on an on-going basis in the home or in institutions such as nursing homes. As mentioned elsewhere in this report, the majority of care recipients are people with disabilities and seniors, of whom a growing portion are disabled. Almost 60 percent of all patients or clients in Canada's health care system depend on some form of long term care, but the variations from province to province are extreme, ranging from a low of 34.5 percent in British Columbia to 75 percent in Prince Edward Island at the other extreme.

[34] Allan Rock, Minister of Health, told the Globe and Mail that "Ontario is such a key player in the whole [health] system" that changes to primary care introduced there would lead to changes across the entire country. See "Rock enthusiastic about Ontario's health-care plans", Globe and Mail, January 15, 2000.

Table 1:

Percentage of acute, long-term and other clients, 1996/97 in jurisdictions with available data[1]

Province/ Territory	Acute Care Clients	Long Term Care Clients	Others	Total
BC	56.4	34.5	N/A	90.9
Alta.	41.0	52.0	7	100.0
Sask.	22.9	70.5	6.6	100.0
Que.	21.1	63.7	15.2	100.0
NB	53.3	46.6	N/A	99.9
PEI	20.0	75.0	5	100.0
Yukon	16.6	73.7	9.6	99.9
Canada	33.0	58.0	8.7	99.7

1. Services included in data vary among reporting jurisdictions.

The number of residents using home care services per 1000 population also varied dramatically among provinces, and so did data depending on source. The national average is estimated at 25 per 1000 residents, with Quebec registering the highest number of residents using home care services. However, there is inconsistency across the country in types of services included in home care programs. The Canadian average is based on clients who receive professional nursing services, home support services, therapy services (occupational therapy, physiotherapy, speech therapy, social work), or other publicly funded services such as Meals on Wheels, transportation, or friendly visiting.

Table 2:

Number of Home Care Clients per 1000 Residents

Province/ Territory	1996-1997	1997-1998
BC	31.0	31.0
Alta.	23.0	24.0
Sask.	28.0	28.0
Man.	24.0	26.0
Ont.	29.0	32.0
Que.	46.0	N/A
NB	40.0	43.0
NS	19.0	19.0
PEI	16.0	16.0
Nfld.	11.0[1]	N/A
Yukon	9.5	9.2
NWT	10.0[1]	N/A
Canada	25.0	25.0

Source: Provincial/Territorial Annual Reports,
Canada Health Act, 1996/97; 1997/98.

In the mid-1990s, 90 percent of home care was publicly funded, but this situation has changed dramatically as private providers have entered the picture, and as eligibility rules for public subsidies have excluded growing numbers of people. Public spending levels on in-home long term care range from a high of $124 per person in Manitoba, to a per capita low of $33 in Prince Edward Island. As Table 3 shows, spending increases among provinces from 1996/97 to 1997/98 are inconsistent, and that even where increases have been substantial, very large gaps remain in per capita expenditure levels among provinces.

Table 3:

Per capita expenditures and provincial revenues for home care 1997-1998

Province/ Territory	% of health spending on home care	Per capita spending	Revenues collected from home care clients[1]	Revenues collected per home care client
BC	8.0	$ 79.60	$10,400,000	$ 83.80
Alta.	3.6	52.70	540,000	8.07
Sask.	4.1	66.00	6,600,000	227.33
Man.	7.5	124.00	0.00	N/A
Ont.-CCAC clients	6.1	75.00	0.00	N/A
Ont.-other[2]		98.00	25,600,000	825.80
Que.	N/A	37.40	0.00	N/A
NB	6.2	105.00	6,400,000	192.89
NS	4.3	64.00	0.00	0.00
PEI	2.6	33.00	45,000	20.11
Nfld.	N/A	72.00	N/A	N/A
Yukon	1.1	34.20	N/A	N/A
NWT	1.8	61.00	0.00	N/A
Canada	4.5	72.00	49,585,000	74

1. These figures taken from Provincial and Territorial Home Care Programs, Table 2, p.75. The per client calculations are based on provincial estimates of the number of home care recipients.

2. The revenues collected from an estimated 31,000 home care clients who paid user fees in 1997/98 for community programs and services such as Meals on Wheels outside the CCAC system.

These statistics illustrate how the lack of national standards and funding for health care delivered outside of the hospital sector is undermining Canadians' access across the country. Of the 12 provinces and territories, seven are spending below the national average of $72 per person per year.[35] By way of comparison, only three jurisdictions (Quebec, Prince Edward Island and New Brunswick) record per capita spending below the national average for publicly funded health services, most of which are hospital and physician services governed by the *Canada Health Act*.

[35] Per capita expenditure data varies wildly from source to source. For example, Health Canada estimates per capita spending in the Northwest Territories at $216.10 for 1997/98, while the territory itself reports $61.10. I have used provincial and territorial data wherever possible, excluding Nunavut for which only data from 1999 is available

User charges for home care also vary from one province to another, with residents in Ontario outside the CCAC system each paying an average of $825.80 a year, while those next door in Manitoba pay no user fees at all.

The absence of national standards also creates difficulties in evaluating the information that is available. The types of services provided in provincial home care programs are not the same within, let alone between, provinces—in fact, it is unlikely that the quality, quantity, and regulation of home care services will be the same on two sides of the same street. For example, some provinces do not provide palliative care outside of hospital, some include home maintenance and meal preparation in home support services, some people are ineligible for subsidized home care altogether while others are subjected to demeaning income tests and user fees. Canada-wide averages show that the home care pie is divided between nursing services (38.8 percent), home support (27.4), therapies (26.5) and other services (7.20). The level of home support available in Ontario, Quebec and Alberta is below the national average, with Manitoba and British Columbia far above. Registered and licensed nursing care account for half the funding envelope in Quebec at one end of the spectrum, while in Alberta nursing services account for only 25.4 percent of the whole. Alberta claims over 40 percent in the "other" category, while Manitoba registers 2.8 percent of home care funding for the same services.

These figures provide a picture of publicly funded services, but mask the levels of private sector spending for services required by the country's home care clients. Private spending data is even more difficult to collect and evaluate than data provided by public payers, because these expenditures reflect mainly direct out-of-pocket spending by clients and their families. Long term care insurance is not common in Canada, and most people use their personal savings, pensions and other benefits to obtain necessary services outside the hospital sector. Clients who require 24-hour care in their homes could easily spend $20,000 annually (if they or their families had it) on top of services subsidized by government, and in addition to all health care services provided by the public health insurance system. Costs related to medical equipment and assistive devices (beds, lifts, wheelchairs, walkers), prescription drugs and other necessary supplies are paid for either wholly or partly (subject to income testing) by the clients.

Elderly patients, especially those coping with painful conditions, can be vulnerable to the recruitment efforts of a pharmaceutical industry anxious to gain market approval for new drugs.

Data also conceal the increasing amount of public spending directed at investor-owned, for-profit companies in all jurisdictions of Canada. Public authorities at the regional and local levels are contracting home care companies to provide services in their communities, while provincial governments engage nursing home companies in so-called public-private partnerships or other contractual arrangements.

There is a clear across-the-board preference for long term care services provided in the home, rather than in institutions. Consequently, the home care market is attracting a variety of medical equipment and other product suppliers, and pharmaceutical companies which have had long-established relations with acute and long term care hospitals. To gain access to that market, these companies form partnerships with public payers and with home care service providers. It is not uncommon for companies that supply oxygen equipment, for example, to contract with service companies which, in turn, market these supplies to their home care clients – for a fee, of course.

In a more ominous vein, home care companies such as Comcare and Olsten (now Bayshore Health Group) are contracting with pharmaceutical companies to recruit and monitor clients in clinical drug trials. Comcare and Dynacare, a multinational lab company, are joined together in Dynacare Clinical Research, Inc. (DCRI), a clinical research organization that oversees a broad range of clinical trial services for pharmaceutical and biotechnology companies in North America. In its promotional material, DCRI boasts that "Our parent companies, Comcare Canada Ltd. and Dynacare Health Group Inc., provide DCRI with easy access to community-based home health and central laboratory services".[36] Dynacare was facing a heavy debt load in 1997 when it had "responded to pressures on its revenues caused by governmental funding constraints by...pursuing private-pay services such as substance abuse testing and clinical drug tests".[37] Thus, DCRI, created in January 1998,[38] appears to have been a response to Dynacare's own financial picture and the potential for increased revenues from the drug industry for contract research services.

Like Comcare, Olsten also offers clinical drug trial services to pharmaceutical and medical device companies. Olsten's "Clinical Business Solutions" will "help sell products" in patients' homes and provide staffing for drug companies that need someone to oversee patients as they administer experimental drugs. The company says its clinical trials service "administers medications according to protocol" and "provides home infusion of investigational drugs".[39] Elderly patients, especially those coping with painful conditions, can be vulnerable to the recruitment efforts of a pharmaceutical industry anxious to gain market access and approval for new drugs.

The idea of a nurse coming into one's home to administer experimental drugs can be unsettling for patient and nurse alike. One report from Windsor, Ontario, said that patients were being released from hospital in nearby London "on experimental drugs the nurses had never administered before".[40] Nurses across Canada are confronting the reality of in-home drug experiments on a more frequent basis, and the reasons are not hard to fathom. In many parts of the country home care, at best, takes place in a loosely regulated environment. A recent poll showed that, on average, seniors who require long term care are spending $138 for prescription drugs, while acute care patients discharged quicker and sicker from hospital are spending $202 a week on prescribed medication.[41] Prescription drugs provided in a hospital are covered by the patient's public health plan, but that coverage ends at the hospital door. People on fixed and low incomes who are ineligible for provincial drug plans, may be susceptible to companies searching for volunteers to take part in advanced stage clinical trials because they can receive medication free of charge.

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[36] DCRI, Company Overview, accessed on the Internet at CenterWatch, Clinical Trials Listing Service (http://www.centerwatch.com/provider/prv24.htm) on August 25, 1999.

[37] "Arrangement Involving Dynacare Inc., and Its Shareholders", Notice of Special Meeting and Management Circular, March 25, 1997. SEDAR filing, March 27, 1997. This is a very interesting and revealing document of a large Canadian company's perspective of its home country. Dynacare is rapidly expanding in the US market, and its accreditation on both sides of the border "enables the Company to process tests collected in the United States in its Canadian laboratories". Canadians should take note of this, since trade in blood products and services is a two-way NAFTA street not covered by any exemption.

[38] Canadian Trade-Mark Data, Application Number: 0865905, July 27, 1999.

[39] Olsten Health Services' Clinical Business Solutions on the Internet at http://www.olstenhealth.com.

[40] Brian Cross, "A new face for health care: For thousands of sick and dying, there's no place like home", Windsor Star August 19, 1999.

[41] André Picard, "Home health care: Only if you can afford it", The Globe and Mail, December 6, 1999.

There is growing world-wide concern that random clinical trials, which originated in agricultural research, may endanger patients' lives. Random trials describe experiments in which patients don't know if they are receiving a drug or a placebo. Graham Ball and Wendy Bohachuk, partners in a London, England-based firm that has been auditing trials for 10 years, say patients are not properly informed and that the standards used in trials are consistently poor. One study found that 43 percent of patients were not given clear instructions for using the medicine. In an editorial in an industry journal, Dr. Bohachuk wrote "Frankly, after 10 years of detailed auditing, I would never go into a clinical study myself and I would certainly try to discourage anyone in my family from doing so". A database of 800 audits compiled by the firm shows that 37 percent of patients were not asked to sign a required consent form to take part in the trial until after the study had begun. "The pharmaceutical company is making millions and the clinician is being paid thousands of pounds," Dr. Ball told The (London) Guardian. "It is not wilful disobedience—it is just that people get biased in terms of making money." Although these comments pertain to England, pharmaceutical companies and clinical trials span the globe.[42]

Home medical equipment is another market beating a path into the home care sector. The US State Department keeps a watchful eye on what it calls the "unprecedented changes in the Canadian health care system". These changes, it observes, "are so deep that they affect the very nature and functioning of the medical sector", with "community care and home care service structures…emerging throughout the country".[43] US manufacturers have already seen opportunities increase since 1998, when tariffs on US and Mexican imports were removed under NAFTA.[44] These developments are creating opportunities for US companies, including those in the business of selling home medical equipment. The State Department estimated the 1998 value of Canada's medical equipment market to be approximately US$1.1 billion, with US$900 million supplied by mainly US imports. Of this amount, US$167 million worth of medical equipment was sold directly in the home care sector, most of it by US companies. Canadian manufacturers control about 20 % of the home market, mainly in wheelchair fabrication, diagnostic apparatus and disposable supplies.

Drugs, home medical equipment, assistive devices and other necessary supplies are not included in Health Canada's calculation of public spending in the home care sector, but both Industry Canada and DFAIT encourage investment in these "high priority" markets. The biggest market for medical equipment is the hospital sector, but with funding reductions and downsizing, manufacturers and retailers have targeted individual consumers. Public subsidies for equipment purchase and rental is inconsistent across the country, but with more patients being treated on an outpatient basis, the market for equipment and supplies will grow.

Doncaster Home Health Care, a former subsidiary of MDS, Inc., for example, operates 16 2500 square foot sales centres in BC and Ontario, supplying both products and services to the home health care and rehabilitation markets in Canada. In 1998, MDS got out of the home care business and sold Doncaster to its main retailing competitor, Shoppers Drug Mart. Shoppers wanted to expand its existing 32 "full-service" home heath care outlets to 100 medical supply outlets. It planned to locate many of these next to their drug stores "to leverage off their chain's name, as well as take advantage of referrals from their pharmacies" according to one industry publication. Shoppers, said CEO David Bloom, is "cultivating the segment as a means of giving us a major competitive advantage", one that promised to move the company closer to its goal of establishing a national chain of home health care outlets.[45]

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[42] Sarah Boseley, "Trial and error puts patients at risk", The Guardian, July 27, 1999.

[43] Pierre Richer, "Home Care and Mobility Equipment", Industry Sector Analysis, US & Foreign Commercial Service and US Department of State, September 1, 1998.

[44] Medical devices and drugs are dealt with in a single NAFTA chapter, but many of the provisions were negotiated in the Canada-US Free Trade Agreement. For more detail, see NAFTA, Chapter 19.

[45] Jack Evans, "Know Product and Customer When Marketing Home Health Care Equipment", Chain Pharmacy magazine, November 23, 1998

Who Pays the Providers—and How?

Home care is a complex area of the health sector, composed of public regulators and funders, direct service providers, staffing agencies, medical equipment and supply distributors, pharmaceutical and information technology companies, and insurance corporations. Historically, service providers have been non-profit agencies such as the Victorian Order of Nurses and religious or membership organizations. Most of these have relied primarily on public funds allocated on a contractual basis with provincial or local authorities. The introduction of tendering procedures, however, is threatening to wipe out the non-profit sector altogether, a development that can only be described as deliberate and planned.

Traditionally, home care services have been designed to enable the elderly, those with chronic conditions, and the disabled to stay out of institutions, and to support their independence and autonomy. Home and community health services have been dominated by non-profit providers in every province of the country. Health care reform has brought an increase in the types of services provided on an outpatient basis in both the community and the home. This trend is in keeping with that in most developed countries, where public policies have supported a downsizing in the more costly acute care sector generally. Consequently, health providers outside of the hospital system have seen a corresponding increase in demand for services without adequate increases in funding to meet the growing need.

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However, the definition of home care is growing more complicated as patients in need of acute medical services are discharged earlier from hospital, or whose admission to hospital is delayed. In all jurisdictions, early discharge and delayed admissions policies have been instituted in the hospital sector, shifting the burden—and the cost—of care directly to patients, their families or their friends. This is not happening by accident, but rather is a form of privatization, supported increasingly by pseudo-scientific “outcomes measurements”, technological changes in medicine and, most importantly, funding reductions by provincial ministries of health. The impact on home care has been dramatic, with funding allocations within the home care envelope shifted to acute or post-acute medical care at the expense of non-medical personal support and home-making services.

Inadequate funding, however, is only one part of a much larger picture that is threatening to undermine equity and access to health services. The move to competitive tendering and contracting for health services is transforming Canada’s system of health care to one similar to that found in the United States.

Competitive tendering and contracting (CTC) as a replacement for direct public funding was a product of the anti-government Reagan White House and the neo-liberal regime of Margaret Thatcher in England. In the United States, the proponents of “less government is better” who came to power in the 1980s also touted the benefits of greater decentralization. In 1981, Congress passed legislation that reduced federal funding for many grant programs and simultaneously devolved more decision making responsibility to the states. These moves were accompanied by substantial cutbacks in federal funding.

Because the economy was booming, however, the full impact of the 1981 legislation was not felt until some years later. In the late 1980s, the proponents of less government got support from two advocates of decentralization, David Osborne and Ted Gaebler, known as the founders of the "Reinventing Government" movement. Osborne and Gaebler said governments were inefficient, ineffective, and insensitive to the needs of the people they served, and that to correct these problems, governments should "steer" the public services ship, and leave the "rowing" to others.[46]

The ideas of Osborne and Gaebler found a strong supporter in Alain Enthoven, the "godfather" of managed competition in health care. More than any other single individual, Enthoven has played a key role, both directly and indirectly as a kind of "guru" for right wing ideologues, in health reform in North America, the Netherlands, Australia, New Zealand, Israel, Britain and Canada. His theory of "managed competition" was introduced in 1989[47] and championed by President Bill Clinton five years later. But it was Margaret Thatcher who first provided Enthoven with a live laboratory in which to apply his managed care theories in the 1980s.[48]

Enthoven is credited as the "brains trust" behind Thatcher's reforms to the National Health Service (NHS), which in turn are credited with creating hardship for patients and decline in the quality of Britain's health care system. During a time of rising costs within the NHS, Enthoven strongly advocated managed competition as a solution that would transform the country's socialized health care system to one based on the free market.[49] His ideas were captured in the Public Finance Initiative (PFI), the centre piece of NHS reforms, which separated the public payer of health services from the provider. PFI introduced on a grand scale hospital outsourcing – or competitive tendering and contracting – of both labour-intensive services and capital-intensive infrastructure projects through public-private partnerships. These changes, which the Thatcher government claimed would give the public sector access to private funds, in fact enabled private companies to dip into a substantial pool of public money designated for health care.[50]

The Enthoven-inspired reforms transformed the NHS from a system of government financed and provided services to one based on competitive tendering and contracting (CTC). A central aspect of the reforms was the movement of patients out from under the NHS umbrella and into the reluctant arms of under-funded local authorities, which share responsibility with the NHS for health services. NHS services are "free", but nursing care, whether provided in the home or an institution, is subject to means-testing and user charges for those above specified income thresholds if the care is funded by a local authority. Moreover, "non-acute NHS capacity has been [shrinking] rapidly in the last 10 to15 years as private investment increased in nursing home provision".[51] The existence of user-fee barriers in the non-acute care sector is pushing more and more patients into nursing homes.

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[46] D. Osborne, T. Gaebler, "Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector" (New York: Penguin).

[47] Alain C. Enthoven and Richard Kronick, "A Consumer-Choice Health Plan for the 1990s," New England Journal of Medicine, Vol. 320, Nos. 1 and 2 (1989). Although Enthoven is credited with inventing the term "managed competition", Deborah Shapley, author of a biography on Robert McNamara, says the term actually was coined by McNamara himself while he was president of Ford Motor Co. and pushing for a more streamlined operation. When he became Secretary of Defence, McNamara used the phrase to describe his strategy of playing off the armed services against each other. Enthoven denies he got the idea from McNamara, and dismisses Shapley's account as "preprosterous" and "fanciful". See Priscilla Yamin and Robert Dreyfuss, "The godfather of managed competition", Mother Jones, May/June 1993.

[48] Enthoven is credited with designing Thatcher's health reform initiatives. See Alain Enthoven, "Reflections on the Management of the National Health Service: An American Looks at Incentives to Efficiency in Health Services Management in the UK", London: Nuffield Provincial Hospitals Trust, 1985.

[49] Donald W. Light, "From managed competition to managed co-operation: theory and lessons from the British experience", The Milbank Quarterly, Fall/1997.

[50] David Price, Allyson Pollock, Jean Shaoul, "How the World Trade Organisation is shaping domestic policies in health care", The Lancet, November 27, 1999.

[51] David Price, personal correspondence, December 12, 1999.

In theory, the NHS reforms were supposed to let "money follow patients," but competitive contracting has resulted in the opposite: patients follow the money. The original predictions that the contracting model in the NHS would realize a 20-percent reduction in service costs, is now estimated to be between five and 10 percent more expensive than public "in-house" provision, mainly due to previously ignored transition (or monitoring) costs. Contracts, awarded annually, consume months of administrative time, critics charge, so that "both purchasers and providers have hardly caught up with their other work before they must turn once again to the next round of contracts". This has necessitated an increase in the number of managers in the NHS by approximately 300 percent, "largely to handle the complex and relentless requirements of contracting".[52]

In an assessment of Britain's experience with managed competition, Donald Light, a professor of comparative health systems in New Jersey, wrote that even if the British had saved money, "competition has historically been an engine of economic growth, not restraint", a lesson of history usually ignored by policy makers around the world. "For while competition may decrease expenditures in the short run," Light continued, "in the long run it strongly rewards the creation of new products, new markets, and economic growth. Adam Smith's famous book was about increasing wealth and was not entitled 'The Efficiency and Cost Containment of Nations'."[53]

Payment Reform in Canada

The proponents of managed competition and market-based reforms found a sympathetic ear in Canada, as well, at both federal and provincial levels. Canada's system of health services delivery is unique among nations, and this applies to both hospital and community-based non-institutional forms of care. Federal legislation in 1957, 1966 and 1984 mandated public health insurance, but at the same time implicitly supported private delivery as did the Hall Commission. Provincial governments quickly established a system of operating and capital grants to acute care hospitals, and embedded a definition of these institutions in law which included the designation "non-profit". In Britain, where elements of this system have been introduced as part of the reform of the NHS, the arrangement is referred to as a "purchaser/provider" split—that is, the purchaser is public, but the provider is private.

Canada's system of health services delivery is unique among nations, and this applies to both hospital and community-based non-institutional forms of care.

As public health insurance extended in whole or in part to services provided outside of the hospital sector, many organizations became recipients of public funding so that insured or partially insured services were accessible to Canadians. Often such funding was awarded through a system of direct core funding or government grants. Governments have also contracted for specific health goods and services, using competitive tendering procedures as a matter of course only relatively recently.[54]

[52] Donald W.Light, op.cit.
[53] Donald W. Light, op.cit.
[54] Competitive tendering has become the established form of contract awards at virtually all levels of government, and the procedures are becoming standardized within the global trading environment.

Most health and social service providers were neither wholly "public" or wholly "private", but formed part of Canada's large non-profit/non-governmental sector. With new infusions of public money a more formal sector emerged within the Canadian economy. This sector has a variety of names, including civil society, non-profit, not-for-profit, voluntary, third sector, and community, social and/or charitable sectors. Still others refer to this publicly-funded, non-profit part of the economy as the "quasi-public" or "broader public" sector.[55] The sector also is distinguished by its broad "public purpose" orientation, public accountability and transparency, and advocacy on behalf of clients or patients.

The creation of an economic sector through which to provide services was a direct consequence of public policy. It was no accident that the majority of providers were non-profit entities which depended entirely or substantially on public funds. Indeed, one of the main differences between the quasi-public and private sectors in health and social service delivery is the element of public funding, in addition to the designation of for-profit or not-for-profit.[56] This funding relationship between governments and health services providers, more than any other single factor, has supported Canadians' claim of entitlement to those services, and of "rights" in the area of health care—rights that are not supported in legislation. It stands to reason, therefore, that if this relationship is over, both the sense of entitlement, and Canadians' ability to realize such fundamental and collective rights, is also threatened.

The relationship between governments and non-profit health and social service providers is the subject of scrutiny at all levels of funding. In March 1999, the Privy Council initiated a round of joint discussions to "improve and strengthen" the government's "long-standing relationship" with the voluntary sector. Three separate discussion tables were established to specifically address three issues: building a new relationship between the federal government and the sector, strengthening the sector's capacity, and improving the regulatory framework. A joint report was published in August 1999 detailing the findings of the three discussion tables.[57]

One table examined the legislative and regulatory environment in which the non-profit sector functions, and the "administration and accountability of charities and other non-profit organizations". Importantly, the table also studied federal funding options, including tax credits to donors, matching grants, core funding, contributions and contracts. The examination of various "funding vehicles" was considered "a first step in resolving the complex issues regarding who receives what type of funding for various purposes".

It is not surprising that there were different perspectives which came to bear on the issue of funding. The greatest divergence arose over the option that would see governments contracting organizations for clearly defined services from an organization. The advantages cited by government representatives included: ability to contract for a specific need for information or services; can be an efficient mechanism for "going where governments cannot go"; scope for program or results-based accountability is highest of all options; provides some indirect support for public policy priorities; and is flexible—can stop and start according to government needs. On the negative side, this group could only identify two potential problems: contracting would not provide general support to an organization and it could exact high administrative costs.

[55] I am grateful to Gordon Floyd, Vice-president, Public Affairs, Canadian Centre for Philanthropy, for his valuable insights and comments on these ideas.

[56] Canada's health system is unique in that the majority of health services are delivered by publicly-funded entities governed and/or administered by members of the communities in which they operate. These groups are not government entities, but rather non-profit, publicly accountable, quasi-public organizations.

[57] "Working Together: A Joint Initiative of the Government of Canada and the Voluntary Sector. Report of the Joint Tables", (Ottawa: Privy Council Office, Government of Canada) August 1999. The report is available on-line at http://www.pco.bcp.gc.ca/prog_e.htm.

The voluntary sector participants, on the other hand, could only see one possible merit in this option: contracts, they said, "can be a source of revenue for organizations", after costs are deducted. But they had many criticisms of a system of contracting, including: it is an unstable form of funding; the contract price may fall short of overhead costs; an organization's "mission" may be compromised by meeting the contract's criteria; lack of support from supporters and/or donors; potential favouritism in contract awards.

The voluntary sector representatives were clearly reflecting the recent experiences with competitive tendering and public contracting to provide health and social services. Many provinces have already moved to a system of contracting organizations in the community to provide health services, and many of these are contracted through a system of competitive tendering open to both non-profit and for-profit bidders—the worst of all alternatives. Contracting changes the very nature of the relationship between providers and the communities in which they operate, undermining the principle of accountability in part because the terms of the contracts are shielded from public scrutiny. Contracts also can wield a perverse influence on the level and quality of services provided. This is because providers are paid a fee only for each service detailed in the contract. Public funding, on the other hand, generally provides operational funds in exchange for a range of services. In addition, contracts are shielded from public scrutiny, while public funding arrangements are not. (For an excellent overview of "contracting out" and "competitive tendering" in Ontario see "The costs of contracting out Home Care: A behind the scenes look at Home Care in Ontario" by Ross Sutherland, Ottawa, CUPE Research, February 2001)

Contracting changes the very nature of the relationship between providers and the communities in which they operate, undermining the principle of accountability in part because the terms of the contracts are shielded from public scrutiny.

When Less Was Better

The entry of the "reinventing government" rhetoric into Canada coincided with the election of the Conservatives and the emergence of Brian Mulroney as Prime Minister. It also shaped the politics of what has been referred to as the "epidemic" of health reform that occurred during the early 1990s. These reforms were largely characterized by the downloading of responsibilities from federal to provincial and hence to regional levels of government, and by steep public funding cuts and privatization. This also is the context within which public demands for increased resources for home care escalated, since services were shifting from hospitals to communities.

In November 1991, a Royal Commission in British Columbia issued a report that would become a point of reference for health care reform across the country.

The home care programs set up in most provinces during the 1970s were designed specifically to provide mainly home support, nursing care and, when required, physiotherapy services. The country was in the process of building an infrastructure for its health care system after the recent release of millions of dollars under the 1968 *Medical Care Insurance Act*. Home care was seen as an important service that would keep the elderly and disabled out of long term care hospitals, but it was not viewed as a replacement for acute and chronic care, both of which were also expanding.

All that changed during the 1990s after years of steep cuts in federal transfer payments. In November 1991, a Royal Commission in British Columbia (the Seaton Commission) issued a report that would become a point of reference for health care reform across the country. The report, entitled, appropriately enough, Closer to Home, called for radical changes in the health system, including a 25-percent reduction in the number of BC's hospital beds. The context in which the Royal Commission's work took place was one of funding reductions, with steep cuts in federal transfer payments just beginning to be felt across the country. "From the beginning," the report stated, "we have assumed that any report calling for a major commitment of new money to the health-care system would be unacceptable, and therefore unhelpful, to the people and government of BC."[58]

In addition to bed reductions, the Seaton Commission recommended stepped up efforts to convince physicians to work for salaries instead of fee-for-service[59], a cap on hospital budgets, and a transfer of long-stay patients out of acute care hospitals and into long term care facilities. The Commissioners recognized that many of their recommendations would result in hospital job losses, but said that "jobs should move outside hospital walls, along with the funds, into expanded out-patient and community health services." The report's most far-reaching recommendations advocated a more decentralized, regional model of governance for the health system.

Spurred by the recommendations of the Seaton Commission, as well as the tight fiscal policies of the federal government, BC became the first province to implement a program to move non-acute care services into the community and out of hospitals, beginning in 1993. The goal of the NDP government was to reduce hospital utilization, reduce the hospital workforce, and reduce health care costs. This was done within the context of an overall health reform package called "New Directions" whose goal was to bring services "Closer to Home". The reforms transferred authority for acute, extended, long term, and home care and rehabilitation to regional health boards, community health councils and community-based health service societies throughout the province.[60]

BC's plan became a model for a report produced for deputy health ministers in 1994 called "When Less is Better", a title that provided provinces with much needed validation for planned and actual bed reductions, layoffs and hospital closures. The document suggested that the provision of non-acute care in acute care hospitals was tantamount to a cardinal sin. And it pointed to studies that showed "from 48 percent (in large urban hospitals) to 65 percent (in small community hospitals) of the patient days in adult medicine were non-acute".[61] Clearly governments and hospitals were guilty of waste on a massive scale.

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[58] Closer to Home, Report of the Royal Commission on Health Care and Costs (the Seaton Commission), Victoria, BC, 1991.

[59] The recommended salaried payment system would collide with the rejection of new money", since, unbelievably, the 1993 agreement between the BC government and the BC Medical Association provided that funds to support new salaried positions must not draw upon the existing fee-for-service allocation—in other words, they must be funded with "new" money. This ensured that no cost savings could be achieved by transferring fee-for-service doctors to salaried positions. See Working Agreement Between the Government of the Province of British Columbia and the Medical Services Commission and the British Columbia Medical Association, December 21, 1993.

[60] BC's use of the term "continuing care" has normally referred to the full range of services for the elderly and people with disabilities, while "long term care" refers strictly to facility care. With regionalization and the push for nationwide terminology some of these terms are changing.

[61] "When Less is Better: Using Canada's Hospitals Efficiently", a paper written for the Conference of Federal/Provincial/Territorial Deputy Ministers of Health, June 1994. One example of the report's view of the world concerns its solutions to the overcapacity of lab services in Canada, a problem that arises because of the proliferation of for-profit companies dipping into the public purse. Rather than ending licensing of more costly private labs, the report actually advises that the capacity of more efficient and cost-effective hospital labs should be decreased. See p. 28.

That Canada had a high rate of hospital utilization compared to other industrialized countries was not news – it had, in fact, been noted by the 1964 Hall Commission. Patient advocacy groups, particularly for people with disabilities, had campaigned against institutionalization for many decades by the time provincial and federal governments concluded that "less is better".

The flawed logic of the report rested on the theory that hospitals were being overused because they lacked the "say no" tools widely used in the United States. But it ignored the more obvious problem, which was that community-based service delivery lacked the necessary infrastructure and public funding that would enable people to access those services on the same terms and conditions as hospital care.

BC probably had one of the least developed community-based health infrastructures in the country, with only two or three primary care community clinics in the entire province, when the government began implementing the Seaton report recommendations. The first continuing care program had been launched in 1978 when a plan for long term care was introduced. The program provided services outside of the hospital sector for seniors and people with disabilities. Two years later, a continuing care division was established, coordinating the provision of long term care, outpatient community-based physiotherapy and home care. When BC introduced its regionalization scheme following the Seaton report, these services were decentralized.

Since the early 1980s, continuing care has been characterized by a single point of entry with common screening criteria, and coordinated case management. There is a three-way focus of the province's continuing care system today: assessment and case management, community care, and residential (long term) care. Community care is itself divided into three streams of nursing care, rehabilitation and home support services. Early hospital discharge policies and late admissions have increased the number of clients with higher care requirements, leading to increased demand for professional nursing and therapy services. Between 1993/94 and 1997/98, public funding for in-home personal care services declined by 56 percent, while Level 1 intermediate care funding (the lowest of three levels) was reduced by 21 percent.[62] There was an overall decline of 15.5 percent in homemaker hours in the first half of the decade, with a similar decline in the number of nursing care visits during the same period.[63] On the other hand, extended care services provided in hospitals increased by 11 percent, while higher levels of intermediate in-home care requiring professional nursing and therapy services climbed by 21 to 22 percent.[64]

These disturbing figures were complemented by a 46 percent decline in the number of hospital stays during the 1990s in BC. According to a report published in November 2000 by health care unions and the Canadian Centre for Policy Alternatives[65], as the number of people waiting for long term care beds climbed, reaching 7000 by the end of the decade, the number of long term care beds fell by 18 percent. The number of people receiving nursing services in their homes grew by 13 percent over the decade, while the number of those receiving home support declined by 19 percent over the same period.

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[62] "Community for Life, Review of Continuing Care Services", Report of the Steering Committee, British Columbia Ministry of Health, October 1999.

[63] Health System Reform in British Columbia, Health Canada, 1998. This is one of 11 papers outlining health system reform at the provincial level.

[64] "Community for Life", op.cit.

[65] Without Foundation: How Medicare is Undermined by Gaps and Privatization in Community and Continuing Care, published jointly by the Canadian Centre for Policy Alternatives (BC), British Columbia Government and Service Employees; Union, British Columbia Nurses' Union, Hospital Employees' Union, November 2000

The long march of services into the community in most cases had halted as soon as they were out the hospital door. The result, as documented in the CCPA report, was declining patients' health due to poor nutrition, stress and isolation. These factors increased pressure on hospital emergency wards pushing health care workers towards burn out and deteriorating morale. The lack of adequate funding for in-home care also eroded standards and continuity, and increased the burden on family caregivers, many of whom were too poor to obtain services from the growing number of companies looking for revenue. One result, the report's authors wrote, was "the denial of people's basic human right to live at home and participate in their community".

The Seaton Commission had assumed that the money saved from hospital bed closures and layoffs would be enough to fund community-based health care delivery, but this was, in retrospect, naive. In fact, there was inadequate capacity in the community, and there was not going to be a major investment in infrastructure, training and education as there had been when medicare was first introduced. Where the Seaton Commission saw patients, services and funds moving to the community, the reality was a 40 percent reduction in acute care beds without a parallel transfer of equivalent resources to BC communities.[66] The impact of this was felt most especially by the low-income elderly and people with disabilities and chronic illnesses who used the hospital system for non-acute care services the most. "We had all hoped that when there were cutbacks in the acute care, that money would come to the community, to make home support work," said one senior in 1997. "But it hasn't happened."[67] In addition, while the hospital sector was being downsized, so were publicly funded home support services that enabled many people to stay out of institutions. Inevitably, pressures mounted on the long term care sector for beds, beds, and more beds.

BC is a target market for several very large companies in the long term care business. Olsten, Paramed (a subsidiary of Extendicare) and We Care are all established in the home care end of the BC market. Regionalization has shifted the focus of these companies to the health board level, where they compete with non-profit and community based providers in a competitive tendering environment. There is no formal quota system, but it appears that some health authorities want to divide up the market "fairly" among for-profit and non-profit providers, a strategy that will inevitably benefit commercial enterprises if the experience in every other market is anything to go by (and it is). This is occurring despite legislation that directs the health minister to "ensure...that health services in British Columbia continue to be provided on a predominantly not for profit basis".[68]

BC is a target market for several very large companies in the long term care business. Olsten, Paramed (a subsidiary of Extendicare) and We Care are all established in the home care end of the BC market.

[66] Blended Care: Making the Most of the Health Care Team", The HEU Guardian, June/July 1999.
[67] Barbara L. Brody, Harold J. Simon, Kathleen L. Stadler, "Closer to home (or home alone?): the British Columbia long-term care system in transition", The Western Journal of Medicine, November 1997.
[68] Health Authorities Act, RSBC 1996, 1.3 Provincial Standards.

Where Goes Ontario, So Goes the Nation

More than any other province, Ontario has embraced Enthoven's theory of managed free market competition in health care. Ontario also is the only province that did not regionalize acute care services, choosing instead to decentralize community and home care through a system of Community Care Access Centres. The government of Mike Harris has introduced the most sweeping privatization of home and community care in the country, a move that is expanding investment opportunities for a few very large companies while simultaneously threatening to wipe out the non-profit sector altogether. The province has many attributes that appeal to the corporate sector, including high population density, a legislative and legal environment that is hostile to non-profit providers, and a market that can be easily accessed from across the 49th parallel. Ontario also establishes and leads national trends in Canada, something that is well understood by investors and politicians alike. It is worthwhile, therefore, to examine the public policy terrain in Ontario, since it has influenced, or is likely to influence, the direction other provinces take, particularly in the absence of any federal leadership.

The government of Mike Harris has introduced the most sweeping privatization of home and community care in the country, a move that is expanding investment opportunities for a few very large companies while simultaneously threatening to wipe out the non-profit sector altogether.

Public expenditures for home care increased by 18 percent in Ontario between 1996/97 and 1997/98, while the demand for home care increased by 30 percent. Long term care provided in the home now represents approximately six percent of public spending in the sector.[69] An increasing portion of those public funds are going to large Canadian and US corporations in the home care business. Of equal importance to investors, Ontario has the highest rate of private spending for health services in the country, amounting in 1999 to about $1015 per person, compared to Alberta at $850 and British Columbia at $775.[70]

Ontario's per capita public expenditures—$1975—are only 65 percent of total spending by residents on health care. Of this total, approximately $98 per person goes towards home health care. This is the second highest level of spending in the country after Manitoba at $124 per person. But Ontario also has the highest rate of home health care clients per 1000 population in the country.

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[69] Pierre Richer, Commercial Officer, Home Healthcare, Canada. International Market Insight series, November 5, 1999, prepared for US & Foreign Commercial Service and US Department of State. Statistics on home care spending in Canada are highly inconsistent. Information on provincial home care expenditures from the US government is among the most reliable I have come across, and thus I have used data available from the US State Department's commercial intelligence units. This is a poor comment on the availability of information from both federal and provincial governments in Canada.

[70] Health Expenditure by Source of Finance by Province/Territory and Canada, 1975B1999. Available from the Canadian Institute for Health Information, on line at http://www.cihi.ca/facts/nhex/hexdata.htm. All 1999 figures are forecast. Ontario's private spending amounts to nearly 35 percent of overall expenditures of $2989, a figure which does not convey the comparatively high percentage of public funds going to private companies. Canada's per capita national average in 1999 was $856.

Ontario's deteriorating state of community and home health care is the subject of public controversy and concern, particularly among those who depend on these services to remain in their communities. But, according to the US State Department, "current and foreseeable market conditions in Canada" such as those being undertaken in Ontario "offer expansion and/or export business opportunities for many US home care product and services companies".[71] From the point of view of the US government, Ontario's system of contracting out for home health care presents further opportunities for US investors. And in case American investors had any doubts about whether they would be welcome in Ontario, the Conservative government amended the Independent Health Facilities Act in 1996, removing the preference for Canadian-owned, non-profit groups in funding and licensing arrangements. From now on, US-based corporations would have the same access to Ontario's public health dollars as local not-for-profit providers.[72]

The Conservatives exhibited a pronounced antipathy towards the non-profit health sector before their election in 1995, and this perspective has helped shape the present environment in the province. The astonishing changes in Ontario's health care system during the last half of the 1990s include:

- Cumulative reductions in health spending exceeded $1.9 billion between 1996 and 1998;
- Hospitals saw their funding cut by approximately $830 million, forcing a ten percent reduction in nursing staff, the layoff of thousands of other hospital employees, and program and bed closures;
- Hospitals throughout the province were closed;
- Patients were moved from acute and chronic care facilities into long term care and/or home or community-based areas of service delivery;
- After closing hundreds of long term care beds the government announced funding for up to 20,000 more beds over six years;
- A majority of the first 6700 publicly funded LTC beds went to for-profit companies;
- Use of in-home health care has increased by 30 percent, but eligibility criteria for access to publicly funded home care services have become more stringent;
- Prescription drug costs were deregulated, and user fees were imposed on seniors and people on social assistance. Seniors are now forced to pay a $100 deductible each year, plus up to $6.11 for each prescription.
- Patients and clients who can afford to do so are buying needed services from private companies, while those who do not have the money go without or depend on family members, most of whom are female, and many of whom are elderly.[73]

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[71] Richer, ibid.

[72] The amendment was part of an omnibus bill, Bill 26, The Savings and Restructuring Act., passed in 1996. During committee hearings many presenters opposed the legislation, but the Employers Committee on Healthcare-Ontario (ECHO) strongly supported the bill, arguing for increased private sector participation in the health system. For a copy of ECHO's presentation, see Standing Committee on General Government, 18 December 1995, Savings and Restructuring Act (1995).

[73] Rita Daly and Kellie Hudson, "Opening door to health profits, but critics say reforms bringing 2-tier system", Toronto Star, March 29, 1999. The Toronto Star has consistently offered informative articles about changes in Ontario's health system during the last decade. Much of the information in the preceding bullets was drawn from this newspaper.

Mike Harris has told Ontarians they "have to move with the times". Change, the Premier told a meeting of nursing home representatives in March 1999, "even change for the better, is never easy". Describing the actions of his government in heroic, almost mythical, terms, Harris said he had "made the tough decisions that were necessary to protect our health care system," adding "That's why I chose to take the heat" during public demonstrations across the province demanding change of quite a different kind.[74] Harris may have chosen to "take the heat", but it is doubtful he will have to live with the consequences of his "tough decisions". Certainly the Premier will never have to forego health care services as a growing number of his fellow Ontarians are now doing, tough decisions they could have—and should have—done without.

One important change not referenced in the premier's speech occurred between the 1995 campaign, when the Conservatives promised they would not cut the province's $17.4-billion health care budget, and the post-election period, when the same party proceeded to do just that. Over the next four years, one out of five hospitals in the province were closed, thousands of health care jobs disappeared, and millions of dollars in new user fees were imposed. Predictably, bed closures and funding reductions in acute care have reverberated throughout the entire system: patients discharged "quicker and sicker" to their homes are using a growing portion of the available funds allocated to home health care, pushing many elderly and disabled people who depend on publicly-funded non-acute home care services into a lengthening queue for long term care beds.

Paying for health care is a leading cause of bankruptcy in the United States, whose health system a growing number of business-backed Canadian politicians point to as a miracle of modern health economics.

These are the mechanics of building and sustaining a private market in health services. The crises experienced by society's most vulnerable are necessary to create what Industry Canada describes as a "high growth area" for investors marketing long term and home care services to "older citizens with chronic health conditions". For investors, however, there is no crisis—only expanding opportunities. Health care is not a market in which consumers can simply choose not to buy if the price isn't right. When people need health services, either for themselves or for family members, they will deplete their savings, sell their homes, and go into debt. Paying for health care is a leading cause of bankruptcy in the United States, whose health system a growing number of business-backed Canadian politicians point to as a miracle of modern health economics.

A poll released by the Ontario Nurses' Association in December 1998, indicated that a majority of people throughout the province were uneasy, and even fearful, about the growing presence of for-profit companies in the health care system. Ninety percent of those surveyed said they worried that seniors, palliative care patients and patients discharged early from hospital could not obtain home care services when they were needed. An equal percentage said that patients were being released from hospital too early, requiring intensive home nursing care that they might not be able to access . These perceptions were supported by media accounts about personal experiences with a health system that was less accessible, exacting higher out-of-pocket costs, and pushing patients in directions they felt were inappropriate.

[74] Notes for remarks by The Honourable Mike Harris, Premier of Ontario to the Ontario Nursing Home Association, Toronto, Ontario, March 9, 1999

Dismantling the unionized, non-profit provision of health care was a key objective of the Harris government and a necessary step to entrench a privatized system of health services delivery financed by sharply increased out-of-pocket spending by mainly elderly and disabled patients and their families.

It also perfectly reflected the Conservative government's goal to move Ontarians who needed health care services away from local non-profit providers and into the arms of the corporate sector. While home care spending by the Ontario government has increased from $23.2 million in the mid-1970s to more than $1 billion today, the province has all but eliminated direct public funding for a non-profit, community-based health care system. Instead, these public funds are being targeted at large corporations through a system of competitive tendering weighted against not-for-profit providers. Many Ontarians may think that health system changes are not working as planned. But, in fact, the changes are meeting the objectives of the Harris government: revenues for both the domestic and US-based corporate health industry are up in Ontario. That, and not improved access to hospital or community care, *was* the plan.

Investors in home and long term care are interested in public subsidies, but not public oversight and accountability. Deregulation, which can be a specific policy in and of itself, or the consequence of shifting the locale of service provision from a regulated to an unregulated environment, is another form of privatization. That is, when a government eliminates its responsibility for setting standards and rules concerning a service, it is, in effect, privatizing the regulatory activity. Thus, while the province of Ontario has expanded the provision of care in patients' homes, it has not similarly expanded the reach of regulations that govern many of the same services provided in hospitals. In another regulatory abandonment of the elderly and disabled, the provincial government repealed the law guaranteeing a minimum 2.25 hours a day of personal and nursing care for residents of long term care facilities in mid-1996.

In contrast to its desertion of Ontario's patients, the Harris government has bent over backwards to—in its own words—"nurture opportunities" for health industry investors. **But much of the strategy to "facilitate government-industry relations" and identify investment opportunities within the province can be traced to the previous NDP government.**

In April 1993, health minister Ruth Grier kicked off the first annual "Health Economic Development Week" to "spotlight one of the most promising sectors of the Ontario economy". As part of this effort, Grier had opened the Health Economic Development (HED) office to work with the province's leading health industry executives on a strategy to support increased investment in the sector.[75] One result of these activities was the Health Industries Advisory Committee, headed by Bill Blundell of Manulife insurance corporation, set up in June 1993.[76] Although the impact of federal cutbacks was beginning to hit all areas of the health sector with dramatic force, the committee's goal was to "foster the growth and development of a globally competitive health industries sector in Ontario". It did not have a mandate to deal with the looming crisis confronting the not-for-profit backbone of health care delivery across the province.[77]

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[75] Personal correspondence, Bill Mantel, Director, Life Sciences & Technologies Branch, Ministry of Energy, Science and Technology, January 11, 2000. Mantel wrote that the HED did a lot of consultation with industry and would have set priorities based on those consultations and day to day industry involvement". The office was closed some time in 1999.

[76] Blundell was described by Grier as "the chair of the Wellesley Hospital", but she failed to mention his role as board chair at Manulife, a key qualification for a committee advising the government on how to beef up investments in the health industry. Blundell also had been appointed to head a transition team developing new directions for the Workers Compensation Board.

[77] Healthy & Wealthy: A Growth Prescription for Ontario's Health Industries, The Report of the Health Industries Advisory Committee to the Minister of Health, March 1994 (Queen's Printer for Ontario, 1994).

The advisory committee was "a joint effort of four industries," Grier explained to the Ontario legislature during HED Week in 1994: "pharmaceutical, medical devices, biotechnology and private health services".[78] The committee's "Vision of the Future", outlined in its final report to the minister, saw profits flowing to Ontario health corporations with "an important presence on Canadian stock exchanges". Baby boomers would invest "billion of dollars of [their] savings into equities in the 1990s", a "large portion" of which "will flow to companies in the health industries sector, helping them grow". Its final report recommended that the government immediately set up a Health Industries Competitiveness Network and a Health Industries Sector Council. The Council would "take the lead" in showing investors that "government finally understands the equation that states: "profits + jobs = a healthy society".

If there was one area in which the committee seemed "unplugged" from reality, it was procurement. "To serve the public interest, purchases made with public funds," the committee advised, "must maximize the benefits to society", a view it described as "holistic". It urged the government to implement "modern procurement practices in cooperation with industry" that would favour Canadian over US and other foreign companies and develop a system "to measure true Canadian content". Anxious to assure readers that it did not "advocate closing our borders to imports", the group "nevertheless holds the view that Ontario-based companies can and should supply more than 40 percent of its own home market".

Paradoxically, however, the advisory committee also declared its support for both the North American Free Trade Agreement and the global General Agreement on Tariffs and Trade (GATT—now the WTO).

Both agreements make it difficult or illegal for governments and public bodies to favour domestic providers of goods and services in their procurement practices. "Market access is an issue of overriding concern to the Ontario health industries sector," the committee reported, because the domestic market was a vital launching pad for companies that wanted to "go global". But the global trade rules which many in the industry had had a hand in developing were not designed to support a launching pad, but rather a welcome mat, something that more informed (and, frankly, more honest) observers had pointed out during the previous decade.

Grier's enthusiasm for the report and its recommendations was, she told the legislature, "shared by my cabinet colleagues", which was why she was "happy to tell you today...that the government will be proceeding with many of the committee's recommendations". But the main task of implementing the proposals would fall to the Conservatives, who were elected in a provincial election in mid-1995. The recommendations of the advisory committee helped set in place a framework that would guide public policy in the years ahead.

[78] Debates, Hansard, April 21, 1994, Health Economic Development Week.

The committee wrapped its proposals around three main elements that now frame health policy in the province:

1. The creation of an infrastructure to support the health industry, which in reality has meant an infrastructure supported with generous infusions of public money;

2. Improved access to capital;

3. Better access to markets, both domestic and international.

The consolidation in 1997 of 38 home care programs and 36 Placement Co-ordination Services into 43 Community Care Access Centres (CCACs) around the province fit squarely within this market framework. CCACs were established as non-profit, provincially-funded corporations to contract for the provision of nursing, home support and personal care services within provincially capped budgets. The province continues to directly fund and provide some community services, such as Meals on Wheels and Friendly Visiting, which operate outside the CCAC umbrella. These providers rely heavily on volunteers, and their services are not offered by private companies since they are highly unlikely to earn a return on investment. Each CCAC has a board of directors elected by members drawn from among the residents in its jurisdiction. The reduction in non-profit provision of home care has been engineered through the CCACs in stages.

The legislation paving the way for the CCACs had been passed by the NDP government, which was unable to fully implement the bill before going down to defeat in the 1995 election. Bill 173, introduced on June 6, 1994, was to have established multi-service agencies throughout the province to "integrate health and social in-home and community services". The legislation was fiercely opposed by the Conservatives because of what they described as a built-in preference for non-profit home care providers. It was opposed by many non-profit agencies because they felt the bill threatened their reliance on volunteers in the community and home health care sector. Ironically, the Tories encouraged this view while simultaneously attacking the NDP for harbouring a bias against for-profit private companies, which used no volunteers at all.[79] "When a Mike Harris government gets in," vowed Tory health critic, Jim Wilson, "we're going to restore the balance between the private sector and the not-for-profit sector in this province".[80]

At the time Wilson promised to "restore the balance" in Ontario, for-profit home care agencies employed 20,000 people across the province and provided approximately 45 percent of the services in the sector.[81] Although this information was offered to the legislature by Wilson himself, the view that the system was seriously out of balance was shared by many of his Conservative colleagues and was reflected in the very structure of the new Community Care Access Centres.

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[79] Daphne Nahmiash and Myrna Reis, An Exploratory Study of Private Home Care Services in Canada, Health and Welfare Canada (Ottawa: 1992) Based on surveys of both for-profit and non-profit home care providers the authors found that "Only non-profit agencies stated that they offered cultural and volunteer services". See pp. 28-32.

[80] Debates, Legislative Assembly of Ontario, 21 April 1994, Health Economic Development Week.

[81] Legislative Assembly Of Ontario, Orders Of The Day, Long-Term Care Statute Law Amendment Act, Hansard, 26 April 1993. These figures were offered by Wilson during legislative debate , but it's not clear where he got his information. The Ontario Home Health Care Providers Association (OHHCPA) stated at the time that 20,000 people were employed by its 40 members.

The Conservatives' vow to create an environment that would better support what they referred to as the "private sector" was expressed through a rigid system of competitive tendering. That system, already tested in the US market, was initially designed to eliminate the non-profit "competition" from the community health sector.

The Conservatives' vow to create an environment that would better support what they referred to as the "private sector" was expressed through a rigid system of competitive tendering. That system, already tested in the US market, was initially designed to eliminate the non-profit "competition" from the community health sector.

This step was necessary for one simple reason: profit-making companies are unable to compete with community- or provincially-based non-profit providers, which deliver a higher quality of service, offer more consistent contact with care providers, pay higher wages, and with superior benefits and working conditions contribute to stability in the sector. While quality is considered a difficult-to-measure characteristic, numerous US studies have shown that for-profit companies have lower staff-to-patient ratios, put less money into patient services, average half the number of home visits as non-profits, and are less accountable.[82]

In most economic sectors companies attempt to reduce labour costs and increase output, since this helps support growing revenue and profits. **In health care, however, profits are made by reducing labour costs and cutting, not, increasing services.** When Wall Street rules on the investment "worthiness" of a health insurance company, for example, it uses a measure called the "medical/loss ratio", which means the fewer benefits paid to patients, the higher the profit margins for the insurer. While non-profit health maintenance organizations (HMOs) in the US spent roughly 90 percent of premium income on payments for their members' health care in the 1990s, for-profit companies registered medical/loss ratios of between 68 percent and 76 percent in 1994. The less an HMO spent on patient care, the more money it earned, and the more attractive it was to investors.

This measurement extends into the area of service provision, as well. HMOs, for example, push patients out of hospital "quicker and sicker", and have reduced home care services to maximize profits, refusing to pay for meal preparation, bathing and other needs of frail elderly patients. Home care companies, therefore, reduce the level and quality of service they provide to patients, while nursing homes impose user charges for deteriorating services not covered on a patient's health plan. According to one study, in 1993 for-profit home care companies in the United States offered an average of 18 visits a year for each client, compared with 46 for public and not-for-profit providers. Successful prosecutions of home care companies on fraud charges and reports of patient abuse by unskilled, underpaid and over-worked employees have added to the public image of the private sector model south of the border.[83]

In December 1998, Cam Jackson, newly appointed minister for Long Term Care, described the government's strategy to balance Ontario's "skewered non-profit system" with an expanded role for the private sector. The CCACs, Jackson boasted, were breaking up the unaccountable "monopoly" that had dominated Ontario's home care sector. The monopoly providers Jackson was referring to were not-for-profit agencies which, he said, instilled in patients a fear that access to care would be jeopardized if they complained about the services.

[82] Nahmiash and Myrna, ibid.
[83] Harris Meyer, "Home care goes corporate", Hospital & Health Networks, May 5, 1997.

This monopolistic stranglehold over patients, he said, was being weakened by the CCACs and the use of competitive tendering in contract awards. “People who determined who got home care were in many respects the same people who provided care” Jackson told a Globe and Mail reporter, who wrote that the minister also accused “some not-for-profit providers of actually defrauding the province”.[84]

Two years later, Ontario residents had had plenty of time to evaluate the way the Harris government was overseeing its home care system. Had more private providers in the province instilled higher levels of confidence among clients and patients? Had competitive tendering “busted up the home care trust”, as Jackson described its purpose, and increased accountability?

The period 1996-2000, when the Harris government “busted up” the non-profit home care monopoly, saw the virtual disappearance of transparency in the system.

A request by the Canadian Centre for Policy Alternatives for information about CCAC expenditures, for example, was turned down in November 1999 by Ontario’s Ministry of Health and Long-Term Care. “The detailed proprietary financial reports submitted by each CCAC,” a Ministry letter stated, “are considered to be third party financial information supplied in confidence, and as such, are not available for public release.” Information about service contracts cannot be disclosed by the CCAC, says the ministry, because it could damage the commercial interests of the agencies who are contracted. According to Paul Leduc Browne of the CCPA, “It is very difficult for the public to get an overall picture of who is getting the money, and how and why spending decisions are made”.[85]

The difficulty in obtaining information makes it difficult to know exactly what is going on in Ontario’s home care system. But discussions with care givers, as well as clients, their families and advocacy organizations, all point to a system in crisis. Despite limitations on the availability of information, Browne’s important study of health care privatization in Ontario found that “a handful of for-profit agencies expanded significantly across Ontario in the area of nursing, home support and therapy services”. This conclusion was reached after a survey of CCACs to get information about which agencies got which contracts in which regions – a difficult and painstaking exercise.[86]

The crisis in Ontario’s home care system can also be seen in increasing staff turnover rates across the system. “Residents of Ontario requiring home care are falling through the cracks of a crumbling system,” warned David Wright, President and Chief Executive Officer of VHA Home Healthcare in the summer of 2000. Many community care workers, he continued, whose wages were 20 per cent less than their counterparts in hospitals and long-term care facilities, “were leaving the field due to poor working conditions caused by sicker patients, heavier caseloads and insufficient time to serve their patients”.[87]

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[84] John Barber, “Saving ‘an awful lot of money”, The Globe and Mail, December 14, 1998.

[85] Browne, Paul Leduc, Unsafe Practices, Restructuring and Privatization in Ontario Health Care, Canadian Centre for Policy Alternatives (Ottawa), 2000, p. 99. This is a very thorough and revealing look at changes to Ontario’s home care system implemented during the past four years, and should be read by all Canadians interested in the issue of privatization.

[86] Browne, op.cit., pp. 117-130.

[87] Province must shore up crumbling home care system, Letter, David Wright, The Kingston Whig-Standard, August 18, 2000.

By the end of 2000, the policies of the Harris government were driving the prestigious Victorian Order of Nurses out of business in a number of communities. In June of that year, the Ontario Association of Community Care Access Centres (OACCAC) released a report outlining the increase in demands for CCAC services throughout the province – a demand the umbrella group said was not being met. Although the total numbers of clients served by CCACs had increased 18 percent in the previous three years, specific areas of service had grown far in excess of this figure. Nursing visits, for example, increased by 1,606,000 across Ontario (31 percent); personal support worker hours have increased by 3,780,000 (25 percent). In addition, the Ministry of Health and Long Term Care waiting lists data showed 11,255 people waiting for service from their local CCAC.

The most reliable home care provider is one which is public and community-based, since these are not dependent on large numbers of revenue-generating clients to support targeted profit margins.

Atlantic Canada

The largest market in long term care is for the provision of services, and this is growing rapidly as provinces move towards active privatization and contracting out. The introduction of competitive tendering in the community sector is diverting public dollars away from non-profit providers and towards large corporations. But large companies are attracted to areas with high population densities, and thus their participation in rural communities and in more sparsely-settled provinces in Canada is less consistent across the country. When public funding is absent in these smaller communities, the costs to elderly and disabled people are extraordinarily high: they may be forced to move from their communities in search of health care or rely heavily on family members and friends. The most reliable home care provider is one which is public and community-based, since these are not dependent on large numbers of revenue-generating clients to support targeted profit margins.

Comcare, which in 1992 stuck its toe in the sparsely populated market of Newfoundland, illustrates this dilemma well. Home support in this eastern-most province was established in 1982, seven years after professional home care services became available in St. John's. Home support services include personal care, home management, respite for care givers, and equipment and supplies. Public subsidies up to a maximum of $2268 a month are available to low-income seniors who pass a means test, but as of 1998 these subsidies were not available to disabled people. The home support program was administered under the Department of Human Resources and Employment until 1995 when it was transferred to the Department of Health. The province administers the home care and home support programs through regionally-based community health boards.

Private companies like Comcare provide home care and home support to clients who can afford to pay for the services themselves, or to those who are subsidized by government programs. While it poses as a "community-based resource", in fact Comcare is the largest home care corporation in Canada, with its base in London, Ontario.[88] Like all large corporations its mandate first and foremost is to earn investors a healthy return on their investments. The company was founded in St. Catherines, Ontario, in the mid-1970s and now provides in-home nursing, rehabilitation, home support services, and occupational health services.

[88] Comcare's website at www.comcarehealth.ca. is promotional rather than informative.

Its current operations can be found in most provinces, and the company is actively seeking links into the US market, possibly through an alliance or partnership with an existing company.[89] Comcare's fortunes are also boosted by what one might call its parental links to two other global corporations, one of them its DCRI partner, Dynacare.

Owned by the powerful and politically well connected Latner family of Ontario, Dynacare's original business was retirement homes. In 1987 it entered the home care business with a company it called Personicare, in two years merging its home care operations with Med+Care Partners of London, Ontario. In 1996, Dynacare reported revenues of $18.3 million from its home health operations, a full 7.5 percent of its total annual revenues.[90] A year later, Med+Care, with 3000 employees, joined forces with Comcare, creating Canada's largest home care company with some 10,000 employees and locations in New Brunswick, Nova Scotia, Quebec, Ontario, and BC.[91] .

In 1997 the Latner family announced it was taking Dynacare off the Toronto Stock Exchange, and in March shareholders voted in favour of a "going private" transaction. That was the end of any comprehensive, publicly available information about Dynacare and its operations in Canada. The company began looking for US investors, complaining that "Canada is a slow growth market" where its long-term projections "show a stable earnings pattern without any meaningful growth". Dynacare's future growth opportunities, its final public report said, "lie largely in the United States". Although the report noted that "as revenues in the United States grow, the Company's US orientation will become more pronounced", Dynacare planned to pursue partnerships with Canadian hospitals in its main line of business, laboratory testing services.[92]

A heavy debt load convinced Dynacare to unload some of its subsidiaries not directly related to its core laboratory business in 1997. It is unlikely that Comcare was part of this shedding exercise. The following year Ontario NDP leader, Howard Hampton, said his party had "discovered Comcare is owned by Dynacare, and Dynacare is owned by the Latner family, a very generous contributor to [the Harris] government". Hampton charged that since the government's move to privatize home care, "Comcare, a Latner company, has come up with new contracts in Lanark county, Perth, Smiths Falls, Brockville and Sarnia". He demanded a public enquiry into the matter, but the health minister, Elizabeth Witmer, declined to respond, except to say that "those are some very serious allegations that are being made" and that she, personally, was not acquainted with the Latners.[93]

Dynacare's financial interest in Comcare's parent company may have been unclear, but it would seem unlikely it would have given up interest in an enterprise that in 1998 pulled in $262.5 million in sales revenue, with another $82.5 million from Med+Care Partners. Both companies share a London, Ontario, address with Dynacare, and Mary Jo Dunlop, Comcare's president, is listed as Med+Care's "partner".[94]

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[89] See Comcare Health Services on Industry Canada's website: Canadian Company Capabilities at http://strategis.ic.gc.ca

[90] "Notice of Special Meeting and Management Circular", March 25, 1997.

[91] Dun & Bradstreet, The Canadian Key Business Directory, 1999.

[92] Notice of Meeting, op.cit. Dynacare labs are accredited on both sides of the border, something that "enables the Company to process tests collected in the United States in its Canadian laboratories" The cross-border movement of blood products and provision of blood services is allowed under NAFTA. The trade deal, of course, is a two-way street.

[93] "Government Contracts", Ontario Hansard, June 1, 1998.

[94] Dun & Bradstreet, The Canadian Key Business Directory, 1999.

Comcare's healthy income undoubtedly is what sparked the interest of the Toronto Dominion Bank, pinpointed by Michele Landsberg as "a major shareholder" in the home care company in 1998.[95] In April of that year, Charles Baillie, the bank's chairman and CEO, told a meeting of the Vancouver Board of Trade that "we've simply got to get serious about community care and home care", but did not offer details, nor did he reveal TD's financial stake. He did not suggest, for example, that with 1997 profits of $1.1 billion, the TD Bank might begin to "get serious" by getting out of the health care business and paying an appropriate share of the nation's tax bill. This would support high quality, affordable services provided by non-profit agencies paying much fairer wages than Comcare appears able to do.[96]

Comcare is closely associated with low wages in the home care sector, and this certainly was the case in **Newfoundland** until the company pulled out of the province. Comcare, which set up shop in the province in 1992, cut the hourly wage rates of its employees from $7.00 to $5.25 two years later. In 1996, 140 underpaid, unionized female home support workers went on strike when the company refused to conclude an agreement with higher wage levels.[97] Comcare blamed the province, saying reduced funding for home support services had forced the wage cut. The company agreed that employees should get more money, but not from Comcare, while the union representing the women said the home care agency was nothing more than a "payroll company" for the government, the true employer. With home support funding a continuing uncertainty, and employees determined to win higher wage rates, Comcare decided to leave the province, vowing it would never return to Newfoundland again.

"Comcare has fought for its workers in other provinces and been successful in obtaining higher benefits for them," the company's president claimed, accusing the union of "sacrificing Comcare" in its attempt to restore wages that the company had cut by 25 percent.[98] If Comcare had been "community based", as it claims, it may have felt a deeper commitment to raising the wages of its employees above the poverty level, instead of waiting for the government to do so. Southern Shore Home Support, a Newfoundland agency that was also struck, did not abandon the province.

Like other locally-based providers, Southern Shore was still in the community when the Newfoundland government announced, less than a year later, that it would increase funding by $4 million for home care workers' salaries.[99]

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[95] Michele Landsberg, "Home care privatization squeezes sick to ensure profits", The Toronto Star, January 31, 1998. For some reason the TD Bank is not required to report on its activities or the revenues it earns through subsidiaries such as Comcare in its public filings with SEDAR.

[96] "Health care in Canada: Preserving a Competitive Advantage", Speech to the Vancouver Board of Trade by A. Charles Baillie, Chairman and Chief Executive Officer, Toronto Dominion Bank, April 15, 1999. Employees of Comcare might be interested to know that Baillie's 1998 total compensation package was over $8.5 million, a 218 percent increase over 1997.

[97] "Striking workers no longer have employer to picket," Canadian Press Newswire, August 10, 1996. The workers, members of the United Food and Commercial Workers union, had been bargaining for two years with Comcare when they commenced strike action.

[98] ibid.

[99] "Newfoundland to increase home care salaries", Community Action, April 14, 1997.

New Brunswick's shift to community care underscores the problems being confronted in a part of the health system bereft of federal funding and national standards, and increasingly dominated by for-profit operators such as Comcare and Olsten, the latter of which operates three agencies in the province.

Comcare's **New Brunswick** business was one of a number of home care providers in the small province which benefited from one of the most comprehensive hospital-to-community shifts in the country. The innovative Extra Mural Hospital (EMH) program was created in the early 1980s to facilitate this transfer, and ten years later was well in place throughout New Brunswick. EMH, also known as "hospital without walls", is a home-care program administered by the New Brunswick hospital system, providing publicly insured acute and palliative care in patients' homes. The Extra Mural Hospital system contracts for-profit or non-profit agencies to provide home-based nursing and hospital services, while home support is funded by a long term program.[100]

New Brunswick's shift to community care underscores the problems being confronted in a part of the health system bereft of federal funding and national standards, and increasingly dominated by for-profit operators such as Comcare and Olsten, the latter of which operates three agencies in the province. The goal of the province in moving non-acute services out of hospitals was to save money. But the cost-savings have been born almost entirely by home support workers—who provide an estimated 80 percent of paid in-home care—and home care clients. The province has followed up its transfer of services from hospital to community with a shift out of the health care system altogether of clients who need help with daily activities. In a clear violation of the *Canada Health Act*, home care recipients in need of chronic care are subjected to a means test—euphemistically referred to as a "contribution scale"—to determine how much they will have to pay for services and prescription medicine.[101] If they are disqualified altogether, they must pay directly out of pocket for home support services that cost between $11 and $16 an hour.

Unorganized, underpaid and overwhelmingly female, New Brunswick's home support workers earn between $5.50 and $7.50 an hour, the lowest wages in the country. Since 1996, home care agencies have received $9.50 an hour to cover wages, administrative costs and profits. A full-time worker will earn well below the poverty line in New Brunswick, compared with attendants doing similar work in hospitals and nursing homes who earn between $12.40 and $12.79 an hour.[102] Most of the seniors receiving home care in 1998 were women, and their average annual income was $13,949—about the same level of poverty experienced by many of those who are employed to provide them with care.

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[100] "Provision of Care", Annual Report, 1997-1998, New Brunswick Ministry of Community Health and Social Services.

[101] Health Services Review: Report of the Committee, November 1998. Available on line at: http://www.gov.nb.ca/hcs-ssc/english/publications/hsrc/5/longterm.htm. The committee reported that Aall persons with chronic conditions" were being subjected to a "newly designed income test", while the "de-institutionalization of chronic care patients" was shifting "the burden of care" to the home and community. Chronic care is subject to the criteria of the *Canada Health Act*.

[102] André Picard, "Hard wages: Why workers don't stay", part of a series in "Behind Closed Doors: The struggle over home care", Globe and Mail March 27, 1999. This is an excellent and often moving series by Picard, which provides an overview of Canada's home care givers and care recipients, as well as the sometimes callous disregard of governments for the dilemma facing Canadians.

In 1998 a health review committee was struck by the provincial government to assess the quality and the accessibility of health and community services. Its final report noted the "shamefully inadequate" wages paid to home care workers, most of whom received no benefits. "Travel time between clients," the committee added, "is not considered work time and is not paid". The Committee conveyed the "strong messages" it had received during hearings about "the low level of remuneration for, and the poor working conditions of, homemakers and how the well-being of clients could not help but be adversely affected".[103] Low wages, no benefits and poor working conditions translated into annual turnover rates of more than 50 percent, a less skilled workforce and instability for home care clients.

Workers who have an opportunity to upgrade their skills often see no corresponding improvement in their wages, while their employment options are likely to increase. At the same time, as clients' needs become greater home care workers are under pressure to provide services they have not been trained to handle. According to the review committee, "home care workers are being asked to perform nursing care" but lack "the training for this level of care giving" posing "a serious liability issue".

New Brunswick's 60 nursing home facilities, with one exception, are run by non-profit organizations (a situation almost unique in the country), two-thirds of whose yearly income is provided by the province. The government has been criticized by patients and providers alike for inadequate funding to support the high levels of care required by residents of these facilities. In addition, the province has 631 special care homes run by proprietary companies, plus 63 non-profit community residences, which provide 24-hour non-nursing support.

Nursing homes, special care homes and community residences are all seeing rising acuity levels among patients, requiring a corresponding increase in the level of training and education available to employees. Since 1993 the province has maintained a freeze on the per diem rates paid to these facilities, raising concern that the homes may be unable to provide the higher levels of care patients require.

Admission to nursing homes became more difficult after a series of reforms introduced in 1993 and today only those patients with the highest care requirements are allowed entry, placing greater demands on both paid and unpaid in-home caregivers. In contrast to the non-profit nursing home sector, the roughly 9,000 people who receive home support do so from mainly proprietary companies, including for-profit Comcare.[104] These companies are hanging on in New Brunswick by a slender thread, according to Shirley Clayton, regional manager for Comcare in Quebec and Atlantic Canada. The company pays home support workers between $6.00 and $6.50 an hour, plus benefits, compensation levels that Clayton suggests are threatening to drive the company out of New Brunswick. "We have to look seriously at continuing in a business that is a money loser," Clayton told a Globe and Mail reporter in March 1999. "If I'm going to pay these wages and still lose 35 cents an hour, why would I want more business?"[105]

[103] ibid. The Committee noted that "a rate of $10.13 per hour would approximate the rate that a single parent with two dependent children would receive on Income Assistance" in New Brunswick.
[104] Ministry of Community and Social Services, 1997-1998 Annual Report. In 1996, Sharon O'Brien, President of the New Brunswick Home Support Association, in a submission to a Senate committee said there were 12,000 home care clients.
[105] Picard, op.cit.

While most provinces defined what kinds of services were "non-acute" and therefore more appropriately delivered outside a hospital setting, Nova Scotia's goal was to actually move acute care itself into the home.

Why indeed. Comcare offers home support , but its real interest is in nursing care, a money-maker. Clayton said the high cost of training workers who leave for better paying jobs once they obtain a certificate is discouraging her company from remaining in the province. "Everybody wants the best-trained workers, but training them is a losing proposition," Clayton said. For the same work in a unionized hospital, these workers will earn twice as much as Comcare is willing to pay.

The story is much the same in **Nova Scotia**, where Comcare is also active. The province initiated its first home care pilot project in 1981, but it wasn't until 1995 that the government introduced a coordinated, province-wide program. The program, called Home Care Nova Scotia, targeted two main areas for in-home service provision: chronic care and acute care. Like many other provinces, cost reduction appears to have been the Nova Scotia government's primary objective in setting up a home care program. But unlike the rest of Canada, where home care had been part of the health system for 20 years, Nova Scotia's program was being introduced within the context of fiscal restraint and barely visible federal funds.

A Blueprint Committee, whose report helped lay the foundation for the home care program, commented in 1994 that "many Nova Scotians are falling through the cracks or using expensive hospital services"—which were publicly funded.[106]

Nova Scotia appears to be the only province which has envisioned home care as an acute care service, rather than an acute care replacement. While most provinces defined what kinds of services were "non-acute" and therefore more appropriately delivered outside a hospital setting, Nova Scotia's goal was to actually move acute care itself into the home. The answer was home care, where patients had to buy expensive hospital services themselves, or be subjected to user fees and demeaning income tests, all of which had been outlawed by the *Canada Health Act* for chronic and acute care. In addition, Home Care Nova Scotia will only provide in-home chronic care to those with "unmet needs" due to a lack of family caregivers, or the absence of neighbourhood resources. Acute nursing care is provided to people "with acute episodic illnesses" that can be safely treated in the home.

Nova Scotia has the highest rate of disability in Canada, consequently the home care program has a higher rate of use among people with disabilities than that experienced in other provinces. The province also has a higher-than-average number of people over 65 years of age. In the first year of operation, the home care program saw an increase in clients served of 120 percent, most of it for chronic and acute care services. Home support in Nova Scotia had been provided to seniors with disabilities whose annual income was below $15,624 since 1988. The 1995 program set a ceiling on public expenditures of $2200 per person per year for those receiving chronic in-home care.

[106] Nova Scotia Blueprint for Health System Reform, 1994. Nova Scotia Department of Health.

The province's overall spending on home care increased from $30 million in 1992/93 to $60 million in 1995/96, an increase of 100 percent. Over the same period, funding for hospitals dropped by $140 million, resulting in a total reduction of $110 million for acute and chronic care. This represented a decisive—and, for many, brutal—shift out of hospitals and onto the backs of family members and the patients themselves. But not everyone was ready to condemn such steep cuts to health care—some, in fact, praised the cuts for leading to a higher level of involvement by patients and their families in their own health care. One health ministry official, appearing before a public accounts committee in 1997, suggested that medical technology was replacing the need for skilled and knowledgeable home nursing and support personnel.

"When you think about IV therapy...medical technology has ensured that there are things in place that make it very simple to look after an IV," she told the committee. "So when an individual administers IV therapy to themselves, they are simply taking a little twist-tie, undoing it, putting in another tube and letting the IV run into it. That is the kind of involvement we are asking of individuals and of families."[107] The fact that most home care clients are elderly people, few of whom would have been skilled nurses during their working years, places such optimism in its proper context.

The province's non-profit Victorian Order of Nurses was the first in the country to experience the full impact of the shift to a system of competitive tendering for in-home nursing care. It has been in Nova Scotia for about 100 years, a dependable and highly committed group that provides nursing care to patients in their homes. The VON had expanded to 16 offices in Nova Scotia in 1956, receiving provincial grants that provided a minimum of stability. The organization was keen to maintain good relations with the provincial nurses' association, and one way to do that was to offer salaries recommended by the RNs' group. The VON is also largely unionized, and nurses are hired as full-time employees, with fairly negotiated wages and benefits. Although these factors attracted skilled nurses through the organization's history, adding to the VON's reputation as a trustworthy provider of high quality services. In the 1990s it was these very strengths that threatened its existence throughout eastern and central Canada.

The VON offers a stark contrast to corporate providers such as Comcare, providing skilled nursing professionals employed on a full-time basis at fair rates of pay to home care recipients. The VON's nurses are no better or worse than those employed by investor-owned corporations, but they are able to practice their healing arts in an environment that is not primarily structured to earn profits. The venerable institution is not threatened because it's being abandoned by its clients and patients. Rather, its continued existence is being undermined by a system of competitive tendering that puts downward pressure on wages for home care nurses and other staff. Shortages of skilled nursing and professional health care providers means that fewer people will choose to stay in home care unless the wages are at least comparable to those paid in the highly unionized hospital sector. Cross border traffic of nurses is becoming a one-way street from Canada to the United States where wages are reportedly the highest in North America. All of these factors will continue to erode the ability of poorer regions like the Maritimes to attract and keep skilled providers – unless Canada adopts a more coherent, nationally-coordinated system of health services delivery.

[107] Standing Committee on Public Accounts, Nova Scotia Hansard, January 29, 1997.

Case Studies: Corporate Providers vs. Patients and the Public in Manitoba

The home care "provider industry" – that is, the market-driven, private sector – is composed of basically three types of entities. The first and largest group are privately-held companies. Many of these are small operators with a local or regional focus, and with very narrow margins between (mainly public) revenues and expenditures. Smaller operators are targeted as prime candidates for "consolidation", viewed by large corporations and many government officials as mere clutter on the landscape. The second group within the industry also are privately held and Canadian-based, but are expanding with the support of investors, both individual and institutional. The third group is characterized by larger, publicly-traded multinational companies which provide home health care services as well as staffing services to other institutions, home medical equipment, and information technology services. Such corporations are active in both the Canadian and US markets, and are able to utilize wider economies of scale with great effect.

The largest home care companies in Canada operating in 1999 are Winnipeg-based We Care, Comcare, based in London, Ontario, New York-based Olsten Corporation, and Paramed (a subsidiary of Extendicare).

Manitoba's public home care system was introduced in 1975 during the government of Premier Ed Schreyer. In 1988, a report by Price Waterhouse said the Manitoba system was a model for North America, an opinion shared by two Minnesota public health experts. "In our view," the US experts said, "Manitoba illustrates one of the best long term care systems in North America. It seems ironic to turn to the US, where long-term care systems are much less developed and coherent, to provide guideposts for Manitoba".[108] Such observations, however, did not deter the Conservative government of Gary Filmon. In 1994, Seven Oaks Hospital in Winnipeg unveiled a 12-week pilot project using a private company called We Care. The program was part of a government plan to support early patient discharges by utilizing private, for-profit home care providers.

Manitoba illustrates one of the best long term care systems in North America.

It was the first time in Canada that a private nursing company had been invited on to a hospital ward, then-NDP health critic, Dave Chomiak, told reporters in April 1994. Tim Sale, at that time a progressive health care consultant based in Winnipeg, said that "the closest thing we've seen [to contracting a private company for home care] in Canada is the Victorian Order of Nurses, and they are non-profit." But the hospital had by-passed the VON, whose staff was under-utilized in the city of Winnipeg, according to its executive director. Rumours were mounting, as well, that the venerable institution was in trouble because more private firms were entering the home care business. The hospital claimed that the VON could not provide the service, an assertion the VON – the only non-profit provider in Winnipeg – hotly disputed.[109]

[108] Frances Russell, "Home care is healthy as is", Winnipeg Free Press, March 1, 1996.

[109] Doug Nairne, "A breach of privacy?", Winnipeg Free Press, April 17, 1994. The other home care companies in Manitoba at the time were Medox and Central Health Services. The Olsten Corporation had not yet appeared on the scene.

We Care is a franchise operation founded by "nurse entrepreneur" Bev McMaster in 1984 in Brandon, Manitoba. McMaster's idea, backed by a $50,000 bank loan, was to set up a fee-for-service home care company, using her extensive network in the health system to obtain clients. By 1998, there were some 65 We Care franchise offices in all provinces, with the exception of Newfoundland, employing more than 4,000 people, a clientele of 25,000 and annual revenues of $40 million. Although most offices are located in British Columbia, the company is pursuing plans to expand in Ontario and Quebec.

McMaster's approach to home care was unique in the private health sector. The company used a rigorous selection process to determine whether a potential franchisee had the "right stuff". We Care asserted that the best franchisee was a nurse with "medical skills and the determination" to succeed in the competitive marketplace.[110] Potential business partners are carefully screened before being granted a license to operate under the We Care banner. Eleven characteristics have been identified as essential to the thriving entrepreneur, including good health, emotional stability, and a "basic need to control and direct". Using a system developed in 1928 called the "DISC Personality Profile", the We Care selection committee is able "to apply the powers of scientific observation to behaviour and to be Objective and Descriptive rather than Subjective and Judgmental". The scientific methodology is a "forced choice adjective checklist device" that enables the interviewer to determine the "patterns of behaviour" – Dominance, Influence, Steadiness, Compliance (or DISC) – the potential franchisee possesses.

We Care's role in the pilot project would be to "facilitate the discharge process by providing a bridge to existing services, or providing services not presently offered by Home Care", such as intravenous therapy or companionship.[111] To meet these goals, the hospital provided We Care with access to patient information without the patient's consent in order, critics charged, to identify potential clients. The records enabled We Care to screen patients who might be candidates for the pilot project, but many wondered what would happen to the patients when the "trial" period was over and they still needed services.

Opponents of the scheme produced statistics showing that wages earned by We Care employees were low in comparison to hospital nurses, but that the hourly fees the company charged to clients were higher. We Care paid $10.50 an hour to Licensed Practical Nurses and $13.25 to Registered Nurses compared to hourly rates of $17.18 and $21.65 for union members doing the same jobs. But We Care's client charges were $18.75 an hour for LPNs and $24 for RNs.[112] Manitobans were shocked, but the plan was part of the provincial government's health policy, which stated its objective bluntly in a Treasury Board presentation the following year: "Divestiture of all Service Delivery to Non-Government Organizations".[113] The ministry of health hoped to reduce the public payroll by 1400 home care workers and 350 nurses, and to exchange a highly unionized workforce for one that was lower-paid and unprotected by collective agreements.

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[110] Management System For Creating Nursing Entrepreneurs, GE McMaster, Bev McMaster, and Sean Magennis, Brandon University and We Care Health Services, 1998 (check credit)

[111] Appropriate Utilization of Acute Care Medical Beds Through Effective Discharge Planning and Implementation: A Joint Trial Project Between Seven Oaks Hospital and We Care Home Health Services, December 23, 1993. Interestingly the proposal was attached to a letter sent to the health ministry on We Care letterhead, signed by the company's CEO and by Nick Kaplansky, CEO of Seven Oaks. Perhaps the hospital was also hoping to save money by piggy-backing on We Care's stationary.

[112] Home Care Wages and Client Charges (Hourly Rates), Manitoba Nurses Union, February 29, 1996.

[113] "Strategic Redirection of Home Care", Treasury Board of Manitoba presentation, December 16, 1995.

Seven Oaks said it had saved $20,000 during the three-month pilot project, a claim that probably had less to do with We Care, and more to do with the simple fact that transferring patients out of an acute care ward and into their own homes was less costly. Nonetheless, Jim McCrae, Manitoba's health minister, said the project was just the beginning. "Watch for similar initiatives in the coming months," he said.[114] A year and a half later, McCrae announced that the province's home care program would soon be open to the private sector on a competitive tendering basis. The public system, he said, often fell short during the holiday season, and the private sector would offer more flexibility to meet these problems. "The private sector can offer the flexibility we need to act quickly to serve as a back-up in circumstances like that," McCrae said.[115]

Manitoba would be forced to abandon this course during a protracted strike among home care workers protesting the government's privatization scheme in 1996. We Care, by that time, was itself moving towards a major reorganization. In May 1999, according to Profit magazine, the company faced the hard truth that McMaster's "personal charisma and dedication to health care" were not enough to capture "robust revenues". "We Care," said the magazine, "needed traditional marketing and business organizational skills to translate its national franchise base into financial returns." John Schram, described simply as "an investor", was appointed by the board to replace McMaster as President and Chief Executive Officer. Shcram rounded up several other investors to "kick-start a new strategy" that hopefully would enable the company to compete successfully with its main competitor, Comcare, whose revenues were more than double that of We Care. Higher profits were needed to support the new direction.[116]

In addition to training its franchisees in better business tactics, We Care planned to develop new product lines, such as a risk assessment procedure to determine vulnerability to osteoporosis. We Care would test the new programs in the marketplace through company-owned franchises "before selling them to organizations such as pharmaceutical companies looking for services to attract customers to their drug stores". We Care also was pursuing contracts with other companies, signing a deal with National Rehabilitation Consulting Services, Inc., touted as "Canada's largest rehabilitation company". The deal would give NRCS "one-stop shopping for the in-home nursing and other programs delivered by We Care's franchisees", who, in turn, would gain referrals and increased revenues".[117]

In February 1998, the company had entered into a "strategic partnership" with Aetna Health Management (AHM), and was reportedly providing staff to the controversial private hospital company, Health Resources Group, in Calgary.[118] The deal, said Bill Brown, head of AHM, would allow Aetna to "expand our services to include a complete range of integrated home health care, from nursing to elder and child care, in tandem with our private sector health solutions."[119]

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[114] Linda Quattrin, "Home is where to get care", Winnipeg Free Press, February 3, 1995.

[115] Alice Krueger, "Home care trade rises, Province privatizes services delivered outside hospitals", Winnipeg Free Press, June 17, 1995. This assertion would have surprised the people of Ottawa, Ontario, who were left in the lurch by private home care providers during Christmas of 1998, only to be rescued by the VON (who had previously lost the contract).

[116] Yasmin Glanville and Helene Desruissseaux "Doing well by doing good", Profit Magazine, October 1, 1999.

[117] NRCS is described by Profit Magazine as a company which "coordinates rehab patient care for insurance companies and government agencies across Canada", but no further information was found after a thorough search. It is possible that NRCS, based in Sudbury, was Columbia Health Care, Inc., a Canadian subsidiary of New Mexico-based Sun Healthcare before Sun sold its Canadian holdings in 1997 before declaring bankruptcy.

[118] "HRG Allowing Patients To Stay Overnight In Private Hospital, New Democrats Reveal", News Release, Alberta New Democrats, February 18, 1998.

[119] "Aetna Health Announces Strategic Partnership With We Care Health Services", Canada NewsWire, February 23, 1998. Brown was formerly President and CEO of Columbia Health Care, Inc., a Canada-wide rehabilitation company.

A year earlier, AHM had welcomed Canada's move towards increased privatization of services. "Growing government cutbacks in health care, such as hospital closures have created business opportunities" for corporations like Aetna Health Management, said a company spokesperson. "We intend to set the standard by which all Canadian health care companies will be measured."[120]

At the time of the merger, AHM was a subsidiary of Aetna Canada Holdings, which aimed to provide disability managed care programs to employers. It had moved into the field of outpatient rehabilitation services with its 1996 purchase of Associative Rehabilitation, Inc., of London, Ontario. But by October 1999, Aetna Canada's parent, Boston-based John Hancock Mutual Life Insurance Co., had decided to merge Aetna with its other Canadian subsidiary, Maritime Life Assurance. After the deal was finalized on January 1, 2000, Aetna became a subsidiary of Maritime Life, Maritime Life remained a subsidiary of John Hancock and We Care looked like it would have to find a new strategic partner. The operations of Aetna Health Management, which had a $15.4 million operating loss in the previous year, "were substantially terminated" by John Hancock Canada. Where We Care ended up in this corporate shuffle is not known.

The Olsten Corporation in Winnipeg

The Olsten Corporation, founded in 1971 by its namesake, William Olsten, is based in Melville, New York. It is the largest home care company on the continent, with skilled nursing, infusion therapy, health care staffing and hospital-based home health agency management as part of the operation. During the 1990s, Olsten embarked on an aggressive buying binge, beginning with the purchase of Johnson's home health division in 1992. In 1993, Olsten purchased Lifetime Corporation for US$450 million, which included its home care subsidiary, Kimberly QualityCare. In February 1997, Olsten changed the name of its home care subsidiary, Olsten Kimberly QualityCare, to Olsten Health Services. A year later, Olsten reported revenues in excess of US$4.6 billion – about $1.3 billion of which came out of the home care business – and more than 700,000 employees in the US and Canada providing services to approximately 625,000 clients/patients.

Before the decade was out, Olsten would undergo another major face lift after settling a massive fraud suit with the United States government involving tens of millions of dollars. In December 1999, the company announced a name change to Gentiva Health Services, promising to maintain its 400 offices and 38 pharmacies in Canada and the US. But by the end of 2000, Gentiva – which boasted it was the leading US provider of home care as well as "specialty pharmaceutical services" – would move to shed its Canadian assets.

Edward A. Blechschmidt, Gentiva's new Chair, President and Chief Executive Officer, said the word "Gentiva" was tested in focus-groups and identified as "a trusted name for care with a progressive biotech/pharmaceutical focus".[121] **In plain English, it appeared that Olsten would strengthen its work with the biotech, pharmaceutical, contract research and medical device industries to support clinical trials.** Olsten's role in these investigational efforts is to collect biological samples from its home care clients, administer injections and home infusion therapy of drugs on behalf of a drug sponsor, and perform at-home assessments of and data collection from study enrolees "to support clinical drug trials for pharmaceutical companies". "Additionally," Olsten promised its drug sponsors, "our clinicians can educate your clinicians regarding product use for maximum patient benefit and increased sales".[122]

[120] "Aetna Health makes first acquisition", Globe and Mail, December 12, 1996.
[121] "Olsten Health Services Reveals New Corporate Identity, Split-off Company Selects New Name and Logo", News Release, Melville, New York, December 10, 1999.
[122] Information from "Olsten Health Services' Clinical Business Solutions" on the company's website at olsten.com.

Olsten is one of Canada's largest home care corporations, with 23 agencies located in Nova Scotia (1), New Brunswick (3), Quebec (2), Ontario (12), Alberta (2) and British Columbia (3). The company's Canadian headquarters are in North York, Ontario, and altogether it employs almost 4500 nurses, personal care and home support workers, and claims some 25,000 clients across the country. Olsten's revenues in Canada are largely derived from the public purse, but it also receives money from supplementary insurance plans and out-of-pocket payments. Total revenues from its Canadian operations totalled almost US$156 million in 1998, compared to its reported Canadian income of US$115.3 million two years earlier.[123]

As late as August 1999, Olsten's Canadian website boasted an endorsement from F. DeCock, Deputy Minister of Health in the Manitoba government. "On behalf of Manitoba Health," DeCock was quoted as saying, "I want to convey to your organization and staff my personal appreciation for the positive and professional manner in which your organization has conducted itself over the past many months. Manitoba Health has enjoyed a positive and productive working relationship with your management and staff." What is remarkable about these words of praise is that they force the reader to beg the question: "Why isn't Manitoba listed among Olsten's 23 Canadian locations if it did such an outstanding job there?"[124]

The circumstances surrounding Olsten's abrupt departure from Manitoba provide many valuable lessons for Canadians fighting against providers that hope to cash in on home care. The since-defeated Conservative government accepted credit for "cancelling" the company's contract with Manitoba Health in December 1997, but Olsten itself claims that it "shut down" in Manitoba because the contract with the ministry of health was not "pure", that is, there were too many stipulations and limitations.[125] However, an equally plausible explanation was conveyed in a CUPE news release in mid-1998, which enthusiastically announced "Home Care Giant Run Out of Manitoba".[126]

The fight against Olsten began in April 1996, when 3000 home support workers and members of the Manitoba Government Employees' Union (MGEU) walked off the job to protest a $5.6 million contract awarded to the company by the Filmon government. The move was part of a broader plan to privatize the home care program, beginning with a "pilot project" involving 25 percent of home care services in the city of Winnipeg. But while describing the initiative as an "experiment", the government appeared to have drawn its own conclusions before the test was completed – in fact, before it had begun.

In February 1996, 14 months before the first contract with the Olsten Corporation was signed, Jim McCrae, the health minister, had already concluded that the whole home care program should be contracted out and subjected to competitive tendering.

Three private firms, and the VON – which worried it would not be able to successfully compete – would be invited to submit bids. "That gives us the best price for a more efficient service," he said, apparently unaware of numerous studies drawing quite opposite conclusions.[127]

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[123] Olsten Corporation, 10K filing, US Securities and Exchange Commission, April 1, 1999. Olsten's fiscal year runs from January 1 to December 31.

[124] This quote was obtained on Olsten's Canadian website (www.olsten.ca) in August 1999.

[125] Telephone interview with Terry Lord, spokesperson for Olsten Staffing (Canada),

[126] It is probably fair to say that Olsten left by mutual agreement of all the parties involved, since expanding its market would have been very difficult in the heated, anti-privatization environment of Manitoba.

[127] Doug Smith, op.cit. The VON's concerns were based on significant differences in wages earned by its own nurses, and those earned by nurses working for private firms.

But the costs of privatization were not the only facts that seemed to have eluded McCrae. In early 1998 when he was asked in the legislature for details about the Olsten Corporation, McCrae admitted that "I do not know an awful lot about the company". In fact, McCrae appeared to know nothing about Olsten, except that it had won a contract to provide home care in the province. "I understand that it has subsidiaries or franchise operations in various other places, including outside Manitoba," he said, adding "I do not know if it is a Manitoba company".[128]

One of the great strengths of the province's home care program was its place in the publicly-funded, non-profit sector. This provided Manitobans with a high degree of public oversight and control over how home care was provided, and how much it cost. Home care workers were not highly paid – far from it – but as unionized public sector workers they were able to negotiate and improve their terms and conditions of employment. Such conditions included greater full-time, secure employment and benefits, and opportunities to form continuous and strong attachments to care recipients. Equally important, when the program was threatened with full-scale privatization in 1996, organized home care workers were able to play a crucial role in defending the public interest.

Described as one of the most important strikes in the province's history, home support workers brought the Filmon government's privatization plans to the public's attention, sparking widespread protests, especially among elderly and disabled home care recipients. A poll commissioned by the MGEU showed 64 percent of those surveyed opposed the government's plans, a level of opposition that would grow over the coming months.[129]

For home care recipients, continuity in terms of who provided services was an important characteristic of Manitoba's home care program. Personal care involves intimate contact between the care provider and the recipient, making continuity one of the most important aspects of in-home services from the point of view of the client. Providers must spend time learning the preferences and sensitivities of their clients, something that can only happen over time and in an on-going relationship. But for-profit providers save money by employing home care workers on a part-time or on-call basis, thereby avoiding the cost of benefits associated with full-time employment. Not surprisingly, therefore, one of the most controversial aspects of the provincial government's plan to contract private companies for such services was the anticipated shift to part-time, poorly trained and on-call providers.

The experience of home care workers and their clients with for-profit companies in Manitoba provided enough anecdotal evidence to fuel the opposition to increased privatization. If there was a single thread connecting one person to the other – whether that person was a care provider or recipient – it was the issue of continuity. Clients who had used private companies said "there was a constant turnover in staff", and there was "a different person coming to the door all the time". Care providers complained that they "were always going to a different place" and "every week you have different clients".

However, both the Premier and the new health minister, Darren Praznik, continued to insist that Olsten could provide high quality home care at a lower cost than the government. The Filmon government, firmly and defiantly entrenched in an unsupported (and insupportable) ideological position, did not cancel the contract with Olsten. Instead, under public pressure, Praznik, announced in March 1997 that Olsten had been awarded a contract, on an experimental basis, to provide ten percent of the home care services in the city of Winnipeg. But the hostility to the company and towards the government's privatization scheme was, by this time, equally defiant and as firmly entrenched. In December, Praznik said Olsten's contract would not be renewed and within five months, the home care giant had closed its office in Winnipeg and left the province.

[128] Hansard, January 28, 1998.

[129] For an excellent and moving account of the strike, see Doug Smith, "We Are Workers Just Like You: The 1996 Manitoba Home-Care Strike", Manitoba Government Employees' Union (Winnipeg, 1996).

One interesting element in the MGEU settlement was an agreement that the Manitoba government would undertake an independent study of public and private home care a year after Olsten's contract commenced. Calvin Hawley, a policy consultant to the government, said the report showed that things were "much leaner and more efficient on the government side than anyone had suspected". Publicly funded home care, he said, was part of a large, in-place infrastructure that did not exist in the private sector. "A private company would have had to accept a loss on the front end" in set up costs he said, [130] pointing to at least one important lesson to be drawn from the experience in Manitoba: public funding and delivery is an appropriate starting point at which to place benchmarks.

The 1998 study, prepared for Manitoba Health by Prairie Research Associates and Price Waterhouse Coopers, found that public home support agencies visited clients twice as often as Olsten, the only private provider included in the report.[131] The study found that clients receiving public home care saw a higher number of different staff providing different services each week than those whose care came from Olsten. In addition, Olsten provided half the number of hours of service per client compared to public agencies. When clients were asked how important it was to have the same home care workers visiting them most of the time, between 85 and 90 percent said it was "very important". When asked if they saw too many different providers because of inconsistent scheduling, 15 percent of Olsten's clients said yes compared with 11 percent who used public agencies. Almost twice as many Olsten clients reported that they had requested changes in scheduling during the previous six months, while an equal number said they had asked for more services or care giver time.

The strike among Manitoba's home care workers was a key part of the political battle against privatization. It is doubtful that without the dramatic actions of this group Olsten would have left the province. The combination of organized care providers, clients, family members and caregivers, and social activists forced the Filmon government to back away from a complete privatization of home care. Equally important, the Olsten Corporation was unable to sway public opinion to support its investment

By mid-2000, Gentiva/Olsten was struggling to reduce a US$68.6 million debt. To meet its financial obligations, it shed its staffing business and sold its entire Canadian operation to Mississauga-based Bayshore Health Group. Canadian earnings were poor, according to Blechschmidt, amounting to less than three percent of the company's total revenues, which in 1999 amounted to over US$1.5 billion.[132] At the time of the sale – for an undisclosed amount – Gentiva had 18 branch offices in Canada, while Bayshore operated its home nursing, rehabilitation care, dialysis and related services in BC, Alberta, Manitoba and Ontario. Bayshore's president, Stuart Cottrelle, said the purchase would double the size his company's staff to 5000 employees and establish it as a national Canadian home care provider.[133]

[130] Interview, Calvin Hawley, policy consultant in the Continuing Care division, Manitoba Ministry of Health, January 20, 2000. Hawley said part of the settlement with MGEU required that the government share the report with the union, something that has not yet occurred.
[131] Assessment of the Winnipeg Home Care Contracting Initiative, August 1998, Prepared for Manitoba Health, Winnipeg, Manitoba.
[132] "Gentiva Health Services Completes Sale of Staffing Business and Announces Canadian Home Health Sale Agreement", PR Newswire, October 30, 2000.
[133] "Canadian Health Care Company Purchases Division of Major U.S. Firm", Canada News Wire, October 10, 2000.

Home Care and the Canada Health Act

The fight for a national program of publicly funded, non-profit, universally accessible home care services is a social justice and equity issue in Canada. The question uppermost in the minds of many activists across the country, however, is not whether home care should be recognized as a right, but rather how to put that right into law.

Since 1984 the *Canada Health Act* (CHA) has been the national framework governing our health care system. The Act strengthened the public role in health care and thereby supported the principles of equity and access embraced by Canadians. It re-enforced the leadership role of the federal government in ensuring that uniform terms and conditions were being upheld in all provinces. The Act went further than previous legislation, raising the "principles" of medicare to the level of legally enforceable "criteria". It outlawed extra billing and user fees, and clarified the link between the five criteria and the 1977 Federal-Provincial Fiscal Arrangements and Established Programs Financing (EPF) Act. Together, EPF and the *Canada Health Act* conveyed a simple message to the provinces: no compliance, no cash.[134]

When the Act was introduced, then-Health Minister, Monique Begin, made it clear that her intention was to weaken the push for free-market medicine by doctors and other entrepreneurs. The legislation would force physicians who wanted to bill patients for their services to leave the public health plan, something that very few wanted to do. Just as important as the ban on extra billing was the prohibition placed on user fees for hospital services.

The ban on user fees affected all providers, effectively blocking the use of this source of revenue. Providers receive money from either public or private sources. For-profit entities raise money in three ways: selling shares either privately or publicly through the stock market; incurring debt by borrowing; and charging fees for their services. Investors would not be interested in putting money into health care unless they could earn a return on their investment. Since fees are the most important source of profits for service providers, the impact of the *Canada Health Act* was to discourage the participation of these entities.

Non-profit providers, on the other hand, depended on public re-imbursements for providing services, plus modest fees to cover operating expenses. The ban on user fees would have had a negative impact on these groups, as well, if provincial governments were not legally obligated under the terms of the *Canada Health Act* to ensure access to a comprehensive range of services. The ban rationalized the move within provinces to provide not only re-imbursement for insured services, but also core funding to providers to enable them to function.

While the intent of the Act may have been clear in 1984, 15 years later much of that clarity has disappeared. This situation has been greatly exacerbated by the absence of regulations to support the legislation. Regulations provide people with a road map long after the debates have ended, clarifying the original intent of the law. Without regulations, one must delve into the original records to discover what words or passages meant. Although regulations were developed and circulated to the provinces by Monique Begin, implementation by the Liberal government was precluded by a federal election.

[134] This was a very different message than the one put forward by the Royal Commission. Instead of providing funds that would *enable* compliance with the principles of medicare, Ottawa now says that "The requirements of [the Canada Health Act] will continue to be enforced by withholding funds, if necessary." See United Nations High Commissioner For Human Rights, "Implementation of the International Covenant On Economic, Social and Cultural Rights, Addendum: Canada, October 1997" (Geneva: 1998)

It was left to the newly-elected Conservative team to put the regulatory meat on the bones of medicare. But during more than eight years in government, the Conservatives offered only the "Extra-billing and User Charges Information Regulations" in 1986 to interpret the legislation. These specified what, when and how the provinces must report to the federal Minister of Health in respect of extra billing and user fees.[135] The overall lack of regulations has created confusion among legislators and the public alike. Sixteen years after the *Canada Health Act* was passed, for example, Canadians were unable to agree about whether the legislation allowing profit-making hospitals in Alberta – changes that held consequences for the entire country – were compliant or not.

In April 1996, the *Canada Health and Social Transfer* (CHST) was enacted, combining federal cash contributions to social assistance, post-secondary education and health into a single block transfer.[136] This was accompanied by an immediate $7 billion cut to federal cash transfers for the three programs. In 1995/96, federal transfers for health alone totalled almost $15.5 billion, but the following year – the first in which the CHST became operational – combined cash transfers for the *three* programs totalled only $15 billion.[137]

The CHST was originally designated as a two-year program, after which federal funds for health, post-secondary education and social assistance would eventually vanish altogether. In the 1996 budget, however, the federal government extended its funding guarantee to five years and set out a timetable for further reductions in transfer payments between 1996 and 2003. The budget also established a "floor" of $11 billion; that is, Ottawa's share of spending for the three programs would, by the turn of the century, bottom out. The federal share of total health expenditures had already declined sharply since 1986, falling from 33 percent in 1977 to 22 percent in 1994.[138] But in 1998, the Canadian Medical Association estimated that "using the pre-CHST percentage distribution, the federal government's current cash allocation to health care stands at roughly $5.0 billion, or 7% of total health care expenditures".[139]

In 1995, the Chretien government introduced consequential amendments to the CHA to replace earlier references to the 1977 EPF Act with the *Canada Health and Social Transfer*. In his annual report to parliament on the CHA, then-Minister of Health, David Dingwall, noted that "the *Canada Health and Social Transfer* (CHST) was introduced in the 1995 Budget Bill. The consequential amendments to the *Canada Health Act* did not affect any of the criteria or conditions of the Act, nor any of the provisions for their enforcement."[140]

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[135] Consolidated Regulations of Canada. Canada Health Act. "Extra-billing and User Charges Information Regulations, SOR/86-259. Consolidated Regulations of Canada. Canada Health Act." In his 1999 report, Denis Desautels, Canada's Auditor General, said Health Canada was not collecting the information it needed to determine whether provinces were in violation of the extra billing and user fee criteria of the Canada Health Act. Thus, even the sole regulation giving clarity to the Act is being violated by both provincial and federal governments.

[136] The original title of the legislation was The Canada Social Transfer, with "Health" being added later in what many described as "an after thought".

[137] "The New Canada Health and Social Transfer: One more excuse for downsizing and restructuring", Report of the 1996 Social Services Restructuring Conference, National Union of Public and General Employees (Ottawa: 1996)

[138] According to the National Forum on Health, "cash and tax transfers to provinces in 1994 under Established Programs Financing amounted to approximately 30 percent of publicly funded health expenditures, or 22 percent of total health expenditures." See "Canada Health Action: Building on the Legacy – Report of the National Forum on Health: Working Group on Striking a Balance (Synthesis Report)", Ministry of Public Works and Government Services, February 1997.

[139] Canadian Medical Association: "Canadians' Access to Quality Health Care: A System in Crisis", submission to The House of Commons Standing Committee on Finance, August 31, 1998.

[140] Canada Health Act Annual Report 1995-96 (Ottawa: Minister of Public Works and Government Services Canada, 1996)

This was not the case, however. At least nine amendments were made to the *Canada Health Act* in 1995, including the repeal of Section 6, which read:

> In addition to the cash contribution referred to in section 5, a full amount is payable by Canada to each province under section 23 of the Act of 1977 for each fiscal year in respect of the extended health care services program if the province complies with the conditions set out in section 13 of this Act.[141]

Section 5 of the Act provides that the federal government will contribute a cash payment for the cost of services included in a province's health care insurance plan, but does not apply to extended health care services. The Act of 1977 refers to the legislation that detailed how federal contributions would be transferred to provinces. Section 23 applies specifically to federal payments for extended health services. Section 13 of the *Canada Health Act* requires that provinces report annually the details of their compliance with the Act, and that they give due recognition to federal financial contributions. Extended health care services are defined by the CHA as nursing home intermediate care services, adult residential care services, home care services, and ambulatory (outpatient) health care services.

Although legislation left the amount of federal payments for extended health services to the discretion of the minister, the services were not covered by the five "principles" of the *Canada Health Act*, including the ban on extra-billing and user charges. The 1995 repeal of section 6 removed any obligation on the part of the federal government to provide funds specifically for extended health services, and also removed any requirement on the part of provinces to report to the federal Minister of Health about their activities in respect of this increasingly important area of health services delivery.

The repeal of section 6, and the merging of health, post-secondary and social services funding generally, has weakened, rather than strengthened, efforts to establish national standards for home care, long term care and community-based health services. This was underscored in early December 1999, when the federal government was criticized by the auditor-general for failing to adequately monitor provincial compliance with the *Canada Health Act*. Denis Desautels, the Auditor-General, criticized the government's "passive stance" towards provinces which were violating the criteria of the Act. In response, Health Canada asserted that block funding provided "flexibility" to the provinces, which, under the CHST, could "allocate funds as they deem appropriate". Incredibly, the ministry said that "all the CHST cash is available to maintain the *Canada Health Act*" – although it might require stealing social assistance money from poor people to do so.[142]

The Spirit and the Intent of the Canada Health Act

The conflicting priorities surrounding health care policy at the federal level, coupled with the lack of clear regulations, has apparently immobilized health ministers in the government during the last decade. In 1995, prompted by the growing prevalence of so-called "facility fees", then-Health Minister, Diane Marleau, became the first elected federal official to attempt to clarify the ground rules in the *Canada Health Act* regarding user fees. The showdown occurred in 1995 after Alberta was caught allowing private eye surgery clinics to charge patients a fee of $1275 for cataract operations, on top of the reimbursement from the provincial health plan. Alarmed, Marleau sent a letter to her provincial counterparts pointing to a developing trend "toward divergent interpretations of the Act". As she prepared for battle with the provinces she would soon discover that she had to fight a rear-guard action against officials in her own ministry and, more importantly, her own government.

[141] Canada Health Act – RS 1985, c. C-6, s. 6.
[142] Health Canada's response to the Auditor General's Report, November 1999, Chapter 29: Federal Support of Health Care Delivery.

Marleau wanted to enforce the *Canada Health Act*'s ban on user fees applied to hospital services. But what, exactly, was a hospital service – and for that matter, what was a hospital? In a 1995 "ministerial letter" to her provincial counterparts, Marleau provided the first-ever federal guidance on these questions.

"[T]he definition of 'hospital' set out in the Act," she wrote, "includes any facility which provides acute care, rehabilitative or chronic care".[143] That meant that "where a provincial plan pays the physician fee for a medically necessary service delivered at a clinic, it must also pay for the related hospital services provided or face deductions for user charges". In the same letter, Marleau also told the provinces that "The accessibility criterion of the *Act* was clearly intended to ensure that Canadian residents receive all medically necessary care without financial or other barriers and *regardless of venue*" [emphasis added].

Marleau's ministerial letter remains the most important policy guideline to be attached to the *Canada Health Act* since its passage. It clarified the meaning of the Act's ban on user charges and extra billing and prohibited facility fees for physician services delivered in clinics. Marleau's ruling also banned extra billing for hospital services delivered outside a hospital setting, explicitly encompassing the community and, by implication, the home. In keeping with the intent of the Act, Marleau's interpretation also banned income testing, sliding fee scales, and fees for top ups and upgrades to hospital services.

Marleau's clarification may have reflected the intent of the federal government in 1984, but it was not the direction that many of her own officials wanted to travel, nor some of her government colleagues. By September 1995, Alberta had negotiated a tentative deal with health ministry officials – behind the minister's back – to allow private clinics and doctors to top up their public payments with user fees for community-based hospital services. When her deputy minister presented her with the deal, Marleau refused to sign it.

By the end of the year, with apparently little support in the Cabinet, Marleau was clearly ready to impose a $7 million fine on Alberta, which, in turn, charged that "The Canada Health Act's interpretation has been changed". Prime Minister Jean Chretien, meanwhile, was publicly outlining his own vision of medicare as a "no frills" plan covering only "major surgery". In this environment, Marleau's ability to enforce her ruling on a belligerent Alberta was doubtful. In fact, by January 1996, Marleau was no longer the Minister of Health, and soon she would no longer be in the Cabinet.

When David Dingwall replaced Marleau as health minister he told MPs in the House of Commons that "With its focus on hospital and physician services the *Canada Health Act* does not cover the range of health care providers, services and delivery venues that are an increasingly important part of today's health care system". This suggested that the Act would only apply to hospital services if they were delivered in an acute care setting – an interpretation that ran counter to that of his predecessor.

By May, a "working understanding" had been agreed to by the Alberta and federal governments. Dubbed "Principle 11", the deal would allow doctors to receive money from the public purse while charging fees for hospital services that Alberta physicians deemed "not medically necessary". "Without Health Canada's agreement on the principle that it is acceptable for physicians to work in both public and private sectors," wrote Robyn Blackadar of Alberta's Health Policy Division a year later, "the existing clinic policy would not have been possible to implement". By this time, of course, Blackadar was referring specifically to the Health Resource Group, Alberta's for-profit, private hospital.[144]

[143] Letter from Minister Diane Marleau to all provincial and territorial Ministers of Health, "RE: Canada Health Act", January 6, 1995.
[144] Alberta Health Policy Division, "Fact Sheet: Health Resources Group, Incorporated", March 17, 1997

Dingwall's action supported Alberta's plans for private hospital services. More generally, he also signalled that extra billing and user charges would be tolerable if they were applied to hospital services (especially rehabilitation and chronic care) delivered outside an acute care venue. If Marleau's ruling had been upheld, any acute care, chronic care or rehabilitation services delivered in nursing and intermediate care homes, adult residences, or private homes may have been covered by the criteria of the Act.[145]

Instead of upholding Marleau's ruling, the 1996 amendments resulting from the CHST repealed Section 6. The repeal of this section of the Act means that there is no longer any relationship between federal funds and extended health services, and provinces are no longer required to report on how citizens are able to access extended health services – or on any other aspect of this increasingly important venue of health services delivery. When section 6 was wiped out, the federal government was providing $51.32 per capita specifically to extended health services, about 10 percent of its total health contribution for that year. Now, provinces do not receive one thin federal dime in transfer payments for the fastest-growing sector in the health system – and one subject to soaring user fees and out-of-pocket payments.

However, in April 2000, health minister Alan Rock reiterated Diane Marleau's 1995 ruling in a letter to his Alberta counterpart, Halvar Jonson, regarding that province's hospital privatization bill. Rock, quoting Marleau's 1995 letter, wrote that "the definition of 'hospital' set out in the Act includes any facility which provides acute, rehabilitative or chronic care". Rock warned Jonson that all medically necessary services must be provided on "uniform terms and conditions", meaning that user fees and extra billing would be considered a violation of the Act. "[T]he position of the federal government has not changed since the introduction of the federal policy on private clinics in 1995," Rock wrote.[146]

By upholding Marleau's 1995 ruling, Alan Rock has suggested that the application of the Act to acute care, rehabilitation and chronic care delivered in the home or the community is appropriate. It now is up to health activists to push the minister on this interpretation, and indeed to hold the Liberal government to its long outstanding promise for a national home care program for Canadians.

Bringing Medicare Home

The fight for home care is being waged in every province, territory and region of Canada. Many different organizations are involved, ranging from those who represent disabled people to seniors' groups to patient advocates and health care workers. While differences of opinion exist on how to achieve a national home care system, there is a virtual consensus on the need for a program that is publicly funded, publicly delivered and publicly accountable.

A key question confronting supporters of a national home care program involves the *Canada Health Act*. Can this legislation encompass the kind of program that Canadians want and need, or is new legislation necessary?

The *Canada Health Act* was intentionally designed to be flexible, a feature of the law that is both a source of frustration and a great benefit for those fighting for a more progressive and generous interpretation. The Act also had incorporated the term "medically necessary" in its criteria in 1984, a caveat that enabled private insurers to develop, and then expand, a market niche in health services that presumably were not medically necessary. In the mid-1990s, investors demanded empirical research on what kind of care and which medical procedures were effective and appropriate. This, they claimed at a Conference Board of Canada round table, would "enlarge our knowledge base and lead to informed decision making on the scope of services to be covered by public health insurance."[147]

[145] Marleau's ruling, especially the term "regardless of venue", has never been implemented.
[146] Letter from the Hon. Alan Rock, Minister of Health, to Halvar Jonson, Alberta Minister of Health, April 12, 2000.
[147] Shahid Alvi, Health Costs and Private Sector Competitiveness, Conference Board of Canada, Ottawa, 1994.

Diane Marleau rejected these demands, arguing that it would be counter-productive to entrench definitions of medical necessity in law. "The principles of the *Canada Health Act*," the health minister wrote in 1995, "are supple enough to accommodate the evolution of medical science and of health care delivery".[148] In fact, if such definitions had been included when the Act was passed in 1984, many of the medical procedures now in use might not be covered. The Act retained much of its flexibility when legislators rejected the inclusion of rigid definitions of "medical necessity".

The lack of regulations and the absence of an entrenched definition of "medical necessity" may support the inclusion of a national home care program in existing legislation. Similarly, Health Canada's 1995 position on user fees strengthens the argument for a regulatory, rather than legislative approach. This position stated that extra billing and user fees for "hospital services" are illegal regardless of the venue in which these services are delivered. It can be stressed that the home is such a venue in which such fees would violate the Act.

Within the current fiscally conservative environment, it might be more difficult to argue that home support services are "medically necessary" – despite the fact that these are undoubtedly the most effective preventive measures that can be taken for disabled and/or elderly Canadians. However, the removal of federal responsibility to fund extended health care services in the *Canada Health Act* – passed as a consequential amendment to the Act in 1996 – weakens the federal government's options. To link the federal government legislatively to home care it would be necessary to reinstate section 6 in the Act. It may be necessary, therefore, to further consult with legislators familiar with the Act, as well as legal counsel, before supporters of a national program decide upon the best course of action.

The fight for a national home care program is being fought by those who provide health services, as well as by those who depend on them. These individuals and groups have been very consistent about what they are fighting for. Among the main elements they have identified in a national home care program are:

I. National standards based on the criteria of the Canada Health Act to ensure universal access to a program that covers all medically necessary health care as well as the Instrumental Activities of Daily Living. IADL include all of the ADL functions (eating, bathing, toileting), as well as meal preparation, handling personal finances, shopping, travelling, doing housework, using the telephone, and taking medications.

II. Fair wages and decent working conditions are linked to the quality and continuity of care provided in the home. The majority of home care and home support providers are female, and many are from communities of colour. The establishment of wage parity with those in the acute care sector, as well as safe and healthy working conditions is a social justice issue.

III. Fully funded respite care programs that recognize the essential role played by family members in the on-going care and support of clients. Respite care programs should be developed in close consultation with primary family caregivers and include the full range of supportive services.

IV. Assessment, coordination and delivery of services that are integrated through one organizational structure using a multi-disciplinary salaried team of professionals. Such a program would provide professional medical care and rehabilitation as well as non-medical preventive and support services.

V. Home support services that complement in-home medical services, and to keep the elderly and the disabled out of institutions. Home support services play a role in promoting health, autonomy and independence and support the ability of elderly and disabled people to continue living in their own communities.

VI. Pharmaceuticals, supplies and equipment are provided to hospital patients without charges or fees. These items should be provided without additional cost and on the same terms as they are available in the acute care system.

[148] Letter to all provincial and territorial Ministers of Health from The Honourable Diane Marleau, Minister of Health, January 6, 1995

Who Pays?

The last decade has been characterized by what is often referred to as "an epidemic of health care reform", particularly restructuring of the hospital sector and the health system's "governance" structures. The changes wrought by the reform movement were delivered with government promises and commitments that health services would be available "closer to home" – that is, that services would be more accessible than they had ever been.

Unfortunately, health care reform has brought with it a significant increase in user fees and extra billing charges – both in the number of services subjected to these practices, and in the amounts charged. Thus, for many Canadians, services may be "closer to home", but they are less accessible.

In many communities located far from large population centres, some service providers are disappearing altogether. Whether for-profit or not-for-profit, health care providers who do not receive public funding as their main source of revenue depend on user charges. In more sparsely populated areas of the country, providers must charge higher user fees to compensate for the spare number of fee-for-service clients, or move on to larger cities. Residents may have to travel away from home to obtain health services, or pay higher user fees within their own communities than their urban cousins.

The movement of services out of the hospital sector and into the community has led to increased privatization. This happens because the quasi-public sector, composed of publicly funded, community-based non-profit agencies and organizations, is being dismantled. In many cases, public funding has been eliminated altogether, and replaced by a system of public procurement and competitive tendering. Without an adequate infrastructure and public funding, the community cannot deliver services on the same terms and conditions as the hospital sector.

There is an urgent need across the country for an infrastructure to support delivery venues outside of hospitals, and within the quasi-public or public sectors. At the same time, a moratorium on competitive tendering practices at provincial, regional and local levels is needed so that studies can be conducted to look at the long term implications for cost, effectiveness, quality and breadth of care, equitable access, training and education of providers, provider continuity, accountability, and working conditions and fair compensation for home care and home support workers.

Although recent federal initiatives have allocated more money to the provinces for health care, federal-provincial bickering about jurisdiction continues. When Alan Rock proposed a 50-50 cost shared home care program in the Spring of 2000, some provinces rejected what they considered a federal manoeuvre into provincial jurisdiction. In addition, within 24 hours the Prime Minister's Office had disassociated itself from the health minister's proposal. This bodes ill for future attempts to establish national standards in home care and federal/provincial cost sharing.

Instead of fighting with each other, federal and provincial governments should conduct a national audit to determine what is required to establish an adequate community infrastructure to provide health care services to people in their homes, in adult and long term care residences, and through primary care community clinics. This should include publicly available and detailed expenditure information showing the amount of money Canadians are spending out of pocket for community- and home-based delivery of health services. Such an audit could also track expenditures by private insurers for home and long term care and the premiums paid for such services through individual and group insurance plans. Information of this kind would enable governments to determine the appropriate amount of money needed to create a comprehensive and publicly funded home care infrastructure.

Alliances

Non-profits, home care and community care clients, employees in the health sector, unions and health activists have common ground that needs to be identified. There is no common ground with the corporate sector, which aims to establish market dominance by putting non-profit and smaller, marginal operators out of business. This has occurred in the United States and is occurring in Ontario where competitive tendering practices are well-established.

Some non-profits believe they can succeed in the competitive tendering field on the basis of superior quality. Other non-profits are increasingly alarmed at the threats to their existence, but lack of a political analysis and the resources needed to place their experiences within a broader context make it difficult for them to develop or act upon an effective strategy. On the other hand, many of these agencies and their employees, are able to mobilize their clients when needed.

Non-profit providers are more likely to be unionized, and thus many have established a formal relationship with unions representing home care and community care employees. This relationship includes areas of tension between unionized workers and non-profit employers with regard to specific questions – for example, the use of volunteers.

The most effective anti-privatization fight in home care occurred in Manitoba in 1995/96 against a scheme to contract the Olsten corporation to service 10 percent of the home care market in Winnipeg. A victory there rested, in large measure, on strong alliances among unionized home care workers, their clients and the non-profit sector.

These clear lines are not likely to exist in other jurisdictions, where unions are actively assisting employees of large home care corporations who are interested in union representation. Questions related to “quasi-public vs. private” home care delivery, therefore, will need to be addressed by the unions involved.

Conclusion

Legislative redress – whether in the form of an entirely new law, or amendments to existing law – is a key demand for a national home care program in Canada. However, we must not lose sight of the fact that, while the mechanics of how we establish and govern the system are important, our struggle is about rights.

Those rights historically have been built upon Canada's unique system of publicly funded, publicly accountable service provision. So while it's important to ensure that the law provide us with criteria and structure, it's equally important to acknowledge that people will be mobilized to support their right of access to health services delivered in the home and in their communities under the same terms and conditions as services delivered in a hospital or a physician's office.

The author completed the research for this report in mid-2000. It does not therefore take into account the ongoing health industry consolidation since that time.