HOME CARE PAPER

SEIU Local 1 Canada

Respectfully Submitted
to a Panel Conducting
Home Care Hearings

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Introduction

SEIU Local 1 Canada believes that quality of care for our senior citizens and others receiving home care can not be sustained if there is no continuity of care provided. In 2002 the then Hamilton CCAC drove its biggest home care provider, the Hamilton VHA, out of business and gave the contract to for profit non-union provider agencies at higher rates. Over 700 SEIU members lost their jobs and their severance pay. (See the academic work of Denton et.al. who have analyzed this occurrence).

I. Competitive Bidding is Not Cost Effective

Hollander and Chappell[1] found that home care costs less than residential care and stable home care clients cost considerably less (for clients who remain at the same level and type of care for six months or more, the costs are about half or less than facility care).

Hollander estimated that home care can be 45% to 75% cheaper than institutional care.

What has not been studied is the difference between for profit delivery and non profit delivery of home care on client outcomes, and employee retention or client satisfaction rates despite Elinor Caplan's claim of client satisfaction survey results.

We can all agree health care dollars must be used efficiently. However, savings and cost containment borne largely by front line care providers, through a cheap wage policy is no longer a sustainable strategy. Large turnover rates in home care suggest that the number one priority for home care must be enhanced human resources policies if continuity and quality of care is to be maintained. Continuity and quality of care can not be delivered if there is not a professional stable work force.

[1] Hollander, Marcus and Chappell, Neena. (2002). Final Report of the National Evaluation of the Cost-Effectiveness of Home care.

Home care workers are voting with their feet, moving to other employment because home care work is not valued and it simply does not pay the bills.

The current competitive bidding model does not allow for long range planning. Elinor Caplan is simply wrong when she says competition is good in this sector. In no other health care sector is competition the model used to provide services.

Constant turn over of personnel does not allow home care agencies to plan long term. It disrupts the volume of services and keeps administrative costs high. Since the competitive bidding model first came into being, for profit agencies, many American based, used their deep pockets to under cut non-profit agencies just to achieve market share and drive out the non-profit competition.

In the competitive bidding model set up by the Harris government, RFPs were to be assessed at 75 per cent quality and 25 per cent price. This never happened in practice but the political spin that this model is holy writ for quality care continues.

There are only two ways to compete on anything and that is quality or price. If the price rises, all things being equal, one should expect better quality.

Under the present system, there is no way of knowing whether the competitive bidding process produces better quality for a better price, since home care contracts are kept from public scrutiny.

At the very least contractual agreements concerning price and outcome expectations, regardless of whether they are for profit or non-profit should be subject to public scrutiny.

For health services this simple competitive Adam Smith notion does not hold true.

There are no uniform provincial standards or regulations to compare the quality of services home care agencies provide. Theorically, each agency sets its own standards. The RFP process may adjudicate these

standards, but they are not measured against any province wide standards.

The VON[2] said the managed competitive model has led to the destabilization of client care, job insecurity for an already scarce health human resource; and an unnecessary and avoidable increase in the costs directly attributable to the managed competition process.

The VON also says there are barriers to sharing information and best practices because it could be the competitive edge in any RFP.

The VON claims that five branches alone, from 1997 to 2004, spent $441,565 on RFPs[3].

The Canadian Health Coalition claims that even under guize of 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 "quality assurance measure and an alternative to government regulation of the industry." [4]

The quality assurance arguments particularly coming from the private sector may be more illusionary than real.

When profit needs to be made the only thing that can suffer in the home care equation is quality.

When one talks about quality in home care seldom are outcomes mentioned. Outcomes clearly should be major objectives – such as quality of life – amount of independence and client well being are much

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[2] VON.(2005) Building a better home care system. A Submission from VON Ontario to CCAC Procurement Review.
[3] Ibid.
[4] Coleen Fuller. (2001) Home care what we have what we need. Canadian Health Care Coalition. p. 13

more difficult to measure than the simple cost of providing a specific service.

As the Canadian Research Network for Care in the Community has pointed out, individual clients may experience decline in overall health regardless of quality of care.

The CRNCC study[5] shows that after competitive bidding was introduced there was a loss of rehab and pediatric provider agencies. There were fewer bids as a result but at a higher cost. Professionals in rehab and pediatric voluntarily switched to other sectors due to downward pressure on incomes and working conditions.

According to the CRNCC the RFP process drove up unit costs for specialized nursing and therapy costs also rose.

CCAC overhead costs for RFP processes and monitoring were estimated to have risen 35% in 2001. We have found no comparable figures for subsequent years and bidding was frozen in 2005.

Agencies claimed a typical RFP bid cost $30,000 to produce.

Randall & Williams[6] found that instead of reducing costs and improving quality as the political rhetoric promised, managed competition resulted in higher per-visit costs and reduced access to services.

Denton et. al.[7] analyzed turnover rate data between 1997 – 2001 for nurses and Personal Support Workers in home care. Fifty-two per cent had left their agency because of pay, hours of work, benefits, heavy work loads and lack of supervisors' support.

> "The move to a competitive environment led to increased casualization of work (i.e. many more part-time and

[5] Williams, A. Paul. (n.d) Home and community care in the broader continuum: Reflections from Canada. CRNCC. Power power presentation.
[6] Randall, Glen E. and Williams R. Paul. (2006). Exploring limits to market – based reform: managed competition and rehabilitation home care services in Ontario. Social Science & Medicine, Vol. 62(7), pg 1594 – 1604.
[7] Denton Margaret. et. al. (n.d.). The impact of implementing managed competition on home care workers' turnover decisions.

> temporary jobs and a shift to elect-to-work care) an increase in job insecurity and a decrease in the pay and benefits to home care workers."[8]

Denton et. al. also found there has been an intensification of work in the home care sector meaning heavier workloads and reduced time for visits.

> "In the region we conducted our study, decisions on how and to whom to give contracts were not based on transparent, consistently used standards, instead they were implicitly led by political views and goals, i.e. to open the market to for profit agencies. Working conditions for staff and as an extension of that care for clients were not considered as legitimate concerns in issuing contracts. Workers were seen as dispensable factors in the cost structure and the affects of these deteriorating working conditions staff turnover were not taken into consideration in issuing contracts."[9]

And they go on to say:

> "To stop high turnover… governments need to divert sufficient resources to the home care sector so that jobs may be restructured to be full-time employment with good pay and benefits that match those provided by long term care institutions and hospitals."[10]

The legalistic aspects of RFPs, meaning information can not be made public, lest an agency suffers a competitive disadvantage, has resulted in less transparency and less openness as to where our public health care dollars are directed.

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[8] Ibid p.6
[9] Ibid p.17
[10] Ibid p.18

II. What Services Should Be Included Under Home Care?

The Canadian Institute for Health Information acknowledges there is some debate over what should be included under home care services. The traditional view considers services associated with home support to be outside the scope of health care, including social services. (The OECD and /System of Health Accounts of UN).

The CIHI Home Care Reporting System uses the definition from the Management Information System (MIS) Standards:

> "A program that provides a combination of home health care and home support thus becomes a vital component of home health care and home support services that enable clients incapacitated in whole or in part to live at home, often with the effect of preventing, delaying or substituting for long-term residential care or acute care alternatives."[11]

The panel may want to consult Le Goff's[12] work on various provincial home care structures and expenditures.

SEIU believes that any service provided to a senior in a home environment that will allow a person to lead a more independent life should be included in a public home care program.

Hollander and Walker[13] say that the "continuum of care" in home care must include not only medically based interventions such as home nursing and physiotherapy but non medical services such as housekeeping and personal care.

The National Advisory Council on Aging[14] supported:

1. Home Care be considered an integral part of publicly funded health services.

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[11] Canadian Institute for Health Information (2007). Public sector expenditures and utilization of home care services in Canada: Exploring the Data.

[12] Le Goff, Philippe. (2002) Home Care in Quebec and Ontario: Structure and Expenditures Economics Division. Government of Canada. His paper also include the same topic for other provinces.

[13] Hollander M. and Walker. (1998) "Report of continuing care organization and terminology. Health Canada.

[14] National Advisory Council on Aging. (2000). The NACA Position on Home Care.

2. Provincial governments adopt a set of nationally comparable standards for the training and compensation of professional home care workers.

3. Greater financial support for informal caregivers (caregiver tax credit). For informal caregivers (caregiver tax credit).

Côté and Fox[15] made six principle recommendations. For SEIU the recommendations that training, accreditation, and compensation schemes need to be expanded and improved are a top priority. Measures are also needed in the short-term to counter increasingly dire labour shortages.

Under the current competitive bidding model what, how, when and who delivers good vs. poor quality services is ill defined. We do not even have a clear definition of quality. Until province wide regulations and standards are enacted there is nothing to measure against save best practices.

What is clear is that the worker care provider can not be the sole measurement of good quality. Since, if one agency loses a contract its home care worker is simply hired by the next agency. Home care workers do not control their work practices, care plans nor have any decision making powers for client care.

Even more bizarre in a competitive bidding model is that a home care agency, such as the Red Cross, may lose a contract in one CCAC/LHIN and be granted another contract in another CCAC/LHIN.

What has changed from one CCAC RFP process to another? Since the Red Cross delivery model is provincially based how this scenario might even happen is difficult to comprehend, but under the current system it will happen. Clearly we need provincial standards for the provision of home care services. What services and care a client receives in Windsor should equally apply to a client in Kenora or Cornwall given the same health condition.

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[15] Cote, Andre and Fox, Graham. (2007). The future of home care in Canada. Roundtable outcomes and recommendations for the future. Public Policy Forum.

III. What We Should Work Toward In Improving Home Care Delivery

There is no question that health care delivery practices are shifting towards home care across the western world as governments attempt to control rising healthcare costs.

That new drugs and technology will increase health care spending over all, there is no argument. Electronic medical data retrieval, where Ontario must catch up to the current world standards, will be the tool patients and care providers use to communicate with each other. We foresee a future where medical diagnoses will be done from remote locations without patient or physician physical interaction.

There will be a shift from service delivery to a patient-centric model where patients act as gate keepers to electronic health records. The old framework centered on acute care hospitals, will be increasingly replaced by earlier diagnosis, earlier interventions and proactive wellness models.

The number of people aged 65 and over is expected to double by 2026.

Home care will increasingly become a program for the elderly.

The changing family structure (fewer children, higher divorce rates, offspring living remote distances from parents) suggests that the basis for elder care no longer resides with a family member. Informal caregivers will become an increasingly scarce commodity.

The problem we will have is recruitment of home care health providers, if current human resources strategies and policies do not change.

Low paid demeaning work will continue to be the reasons why home care is not a career option for young people.

To make home care an integral part of the health care system SEIU suggests:

1. Implement the Romanow Commission recommendations for home care including a stable funding base and a continuum of care to ensure recovery and wellness as opposed to re-admittance to institutional care because a patient was sent home too quickly or the support services in the home were not at a level to ensure maximum wellness.

2. Incorporate home care into Canada Health Act. Keep it public.

3. Make home care work pay. Work immediately to achieve pay equity between compensation paid to home care providers and those who do similar work in institutional care. Ensure workers are able to work full time hours with adequate benefits and pensions.

4. The current "managed competition" model must be replaced by a guaranteed of continuity of care model. A guarantee of care model will ensure a stable professional workforce.

5. Certify PSWs – make them an integral part of the health care team – Provide greater and better training especially for palliative care.

   Because employers and agencies control the work and job requirements, standards of care PSW are able to offer are inconsistent.

   Currently there is no common definition of PSW work or what competencies a PSW should possess.

   The development of the PSW curriculum dates from 1997. The Ontario community college program runs for about 500 hours.

   Private for profit career schools can charge as much as $10,000 for a PSW program. This educational price gouging targets the most vulnerable – women, recent immigrants - looking to develop a career.

   The education program must be reviewed. There must be a core educational component, a standardized examination and post

graduate programs whereby a PSW can increase or enhance skills such as for gerontology or palliative care.

For a career that may end up paying only $12.50 per hour with no job security, the fees even at the community college are exorbitant.

Contrary to Elinor Caplan's assertion that competition will enhance quality, there are no provincial standards that determine specifically what a PSW can or can not do. This is left up to the employer. There is no guarantee that employers will implement strategies and procedures that will promote excellent quality care.

The only way to ensure best practices is to ensure a rigorous inspection system and the development of provincial regulations and standards.

SEIU Local 1 Canada suggests a registry program under the Ministry of Health and Long Term Care be developed. Such a program should have the ability to conduct background checks and have an inspection branch to monitor all agencies and act on all complaints.

PSWs must have full whistleblower protection and safeguards against any employer reprisals if they report inadequate care.

This panel should categorically reject the Caplan Report's Recommendation 20. It called for:

> "The removal of barriers to entering the home care workforce. CCACs not to require 100% PSW staffers within the procurement process. Employers to commit to training and supervision of personal support workers until they achieve PSW status, generally within two years from the date of hire."

This suggests home care agencies can underbid if they do not employ PSWs, because a non PSW worker will cost even less than a PSW. There is nothing that compels a home care agency to provide employer paid training, so why should an agency

submit a RFP with a full complement of PSWs, if it can increase the odds of winning a contract by submitting a lower price because there are no, or fewer PSWs attached to the contract that would increase the price of the bid.

Caplan's recommendation suggests a cheap wage policy is the way to sustain the current system.

As we have pointed out quality can not be increased merely by lowering human resources costs.

6. Develop policy and strategic planning to coordinate care and transition between institutional care and home care. There is a lack of coordination currently. Health care planning done by the CCAC merely pigeons holes patients. What is really needed is the establishment of multidisciplinary teams of healthcare professionals who can rapidly move between delivery services in hospital, in nursing homes, or the community.

7. Stop fee for service or charges per service hour and move toward integrated health care teams. Utilize the skills and competence of all, particularly a greater role for PSWs.

8. Integrate Senior Support programs with health care services. End the fragmentation of care.

   The Ontario government is pouring more money into its "Aging at Home" initiative. To date this is a disjointed scattered strategy that focuses on programs such as "Meals on Wheels" and volunteer programs. It is not health care and will not keep seniors out of institutional care.

   What must be done is that programs such as "Meal on Wheels" are co-ordinated with health care services. Seniors need nutritional care not meals that sit in the freezer months on end. Seniors need exercise programs. Seniors need non-profit cooperative housing. Seniors need companionship.

9. Develop non-profit assisted housing programs for seniors. Assisted living residences are more cost effective than nursing homes. Home care services are also more nursing homes. Home care services are also more efficiently managed when multiple clients live in close proximity. (See the Independent Living BC program under the BC Housing Ministry and in various other provinces).

10. SEIU Local 1 Canada thinks the role of "family volunteer caregivers" under Family Medical Leave both provincial and federal should be expanded.

    Many services are not provided by the CCAC because clients do not meet the qualifications and families, therefore, are forced to find alternative care.

    According to Statistics Canada one in five Canadians 45 years and over provides care to a senior[16]. Caregivers live in a variety of arrangement usually not with the care receiver. ¾ of male caregivers aged 45 to 64 also worked at a job outside the home.

    More than 1/3 of caregivers incur extra expenses.

    Clearly the current caregiver tax credits are not adequate. The value of care provided by family members and volunteer workers to dependent persons is estimated to be $5.7 billion annually based on 1996 data.17 Conservatively this would be over $7 billion in today's dollars worth of unpaid work.

    Caregivers need a direct tax credit and not linked to any other disability support program.

    Ontario ESA Family Medical Leave provisions provide 8 weeks leave of absence without pay to care for a spouse parent or child and 10 days Personal Emergency Leave. A certificate of a serious medical condition signed by a qualified health practitioner must accompany the employee's request for a leave.

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[16] Cranswick, Kelly. (2003). Caring for an aging society. <u>Housing and Social Statistics Division.</u> Statistics Canada.
[17] Le Goff. P Lilippe. (2002) Home care sector in Canada. Economic problems. Government of Canada.

Federal Family Medical Leave provisions provide for unpaid leave of up to 8 weeks in a 26 week period.

Employees can apply for EI compassionate care benefits. The bureaucratic nature of the application makes it difficult to apply and a two week waiting period applies. The maximum benefits under EI are 8 weeks.

Governments must bridge the gaps between current caregiver tax credits and the unpaid value of volunteer caregivers. Current caregiver tax credits under the Income Tax Act does not allow a senior to claim a caregiver credit if their income is above $17,500. SEIU believes, as government policy, leave for caring for an elderly family member should reflect similar provisions to those currently provided for maternity and parental leave.

In order to ensure private sector providers are not taking over the system through private sector insurance home care must come under the Canada Health Act.

IV. Human Resources Best Practices

Ontario must create a stable permanent professional workforce for home care if it is to provide quality home care. There can be no other way.

Competitive bidding must be put to rest forever. Canadian values demand our public health care dollars only support public non-profit heath services delivery.

At the very least Ontario home care workers deserve the same rights under the Employment Standards Act and the Ontario Labour Relations Act as all other Ontario workers. Elect to work must be totally discarded. Home care delivery must move to a goal of 70 per cent full time work, a standard regulated health professionals working in health institutions try to maintain. The late Justice Archie Campbell also recommended the 70 per cent full time standard in his report on SARS.

If an agency no longer delivers a home care service, employees of that agency must have the right to move with their work to another service delivery organization. Home care workers must have the right to move with their job.

Every home care worker must have the right to a pension plan. Every home care worker must be paid for the time on the job and that includes travel time and reimbursed for travel costs that reflect the real for operating and maintaining a motor vehicle.

In Saskatchewan Home Health Aides or Continuing Care Aides have the same provincial job description and some rates of pay (start $17.64/hr, Step 2 $18.25/hr; Step 3 $18.89/hr in the provincial health provider collective bargaining agreement. Compare this to Ontario's $12.50 base rate for PSWs.

All benefits between institutions and home care are equal. Travel time is paid. Home care workers are enrolled in the Saskatchewan Health Employers Pension Plan.

The reimbursement for the use of personal vehicles is a per kilometre rate with quarterly adjustments.

The Ontario government must move to correct the vast discrepancies that exist between home care compensation in other health care institutions.

In 1994 the Ontario NDP government under the Long-Term Care Act established Multi-Service Agencies that would establish a framework for the delivery of community based long term care services and above all create uniform and equitable eligibility criteria across the province. The panel should study the MSA model as a possible alternative to the present competitive bidding environment.