



THE COSTS OF CONTRACTING OUT HOME CARE:

A Behind The Scenes Look at Home Care in Ontario

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INTRODUCTION

The last four years have seen increased contracting out of home care and greater for-profit delivery of community care in Ontario. The Harris government made sure of that

when they introduced compulsory competitive bidding into the sector. Non-profit providers such as the Red Cross and VON are vying for contracts with both large and small private for-profit providers such as ParaMed, Bayshore Health Group (formerly Olsten), Comcare, Bradson, and We Care. Direct public delivery of home care services through the Community Care Access Centres (CCACs), the local agencies set up by the provincial government to coordinate home care, is no longer possible under this model.

The Ontario model has spawned a system in which there are multiple providers with contracts in any given locale. The norm is for more than one agency to be delivering the same service. Non-profit providers will be working along side for-profit providers to deliver nursing, homemaking and other services.

The natural consequence of a competitive bidding model is increased privatization. The natural consequence of a multiple provider model is inefficiency and lack of coordination. Both have costs to the public. Public money directed to home care is misdirected or at worst wasted.

Taking money from patient care belies the provincial government's statement that the competitive bidding system would "make more health care dollars available for front-line services".¹ Instead we have seen a steady increase in duplication, administration, and profit taking coinciding with cutbacks in services and the development of waiting lists.

To investigate this apparent contradiction CUPE wanted to examine the experiences of front line workers in the new system. Workers' descriptions of how contracting out and competitive bidding affected their work was then used in an analysis of the Ontario government's home care expenditures. The results of our study indicate that ending contracting out and competitive bidding for community care patient services would free up a minimum of \$247.4 million of the current home care budget. This money could then be used to improve patient care. We recognize that redirecting these resources back to patient care will not solve all the problems, but it will be a step in the right direction.

Correcting the problems identified in this report will not save the government money but it will increase the quality of home care. The demand for home care is such that all nurses, home makers, therapists, case managers and support staff in the system would continue working in jobs that would improve patient care. In fact, we expect that a home care system that was adequately meeting health needs would cost more.

CUPE has many concerns about privatization for home care services and the waste associated with multiple providers. We believe that a single public service provider is

¹ Ontario Ministry of Health Press Release, January 1996

the most effective model and has proven itself in other provinces such as Manitoba and Saskatchewan. This preliminary study of the efficiencies (or rather inefficiencies) within home care in Ontario underscores the need for a single public service provider.

THE STUDY

CUPE undertook to conduct in depth interviews with 27 nurses, homemakers, therapists, managers and staff of CCACs and provider agencies in Ottawa, Kingston, Hamilton, Toronto, Sudbury, Niagara and Kitchener Waterloo.¹ The interviews took place between September and November 2000. Our sources provided details on what they have to do in their daily work lives to meet the needs of the home care recipients within a context of competitive bidding and multiple providers (see Appendix A).

Could time and resources be better spent on improving patient care? Information from front line workers reinforces many common themes and while there may be individual variations across the province, we believe that the conclusions we have drawn are generally valid.

We have also used publicly available financial data from CCACs and non-profit agencies (annual reports and audited statements) as the basis for our financial analysis. We have taken typical annual expenditures for a visiting nursing agency (Appendix B), a homemaking agency (Appendix C) and a CCAC (Appendix D) as the basis for determining the expenditures that could be redirected to patient care. The results of the typical CCAC expenditures were then extrapolated to the total provincial CCAC expenditures.

Using information from the interviews and the budgets we have tried to gauge how effective and efficient the current system of home care delivery really is at directing resources to patient care. After all, this is one of the main reasons the government gave for imposing this way of delivering care.

While we realize that there is variation within CCACs and agencies providing home care and that generalization is a little risky from our preliminary analysis, we do believe that these data provide us with insights into the situation and that it is only the tip of the iceberg. We also believe that a more rigorous examination of the financial data and more extensive interviews would not only support our findings but would reveal many more areas where the costs of contracting out are diminishing the quality of patient care.

Why It Is Hard To Get Accurate Data

There are several limitations to the data. These limitations should not be viewed as

¹ Equipment, supplies and transportation workers were not interviewed for this project.

casting doubt on the data or the conclusions drawn here but should be interpreted more broadly as limitations on the public's ability to access information on how \$1.14 billion of public money is spent on home care.

The first limitation speaks to the lack of public accountability for public spending in privatized health care. The provincial government and CCACs will not release data on the value and content of the contracts let for the provision of home care. While a few CCACs will provide information on their operating budgets, most will provide only partial data or graphical representations.

The Ministry of Health does collect some information from the CCACs and presumably collates the data, but to date they have not released province wide totals in spite of formal freedom of information requests. This raises a significant problem of accountability as over a billion dollars of public money is spent with very little information on how it is being spent.

Private sector companies delivering care provide limited information that is open to public scrutiny. Most are privately held companies and there is no public data on their operations. ParaMed, a wholly owned subsidiary of a publicly traded company, Extendicare, is the exception. However, financial information specific to its Ontario operation is sketchy at best.

Non-profit agencies in home care all have financial statements that must be audited and made available to the public. In a competitive bidding environment, this requirement leaves them at a competitive disadvantage as for-profit corporations have access to information on the non-profits but the reverse is not true.

It is difficult to obtain a completely accurate picture of what is happening in home care without an in-depth analysis of each individual CCAC. There are 43 CCACs and they operate fairly autonomously. They were set up as private non-profit corporations outside the scope of the *Freedom of Information Act*. Despite the government's insistence that there be provincial standards in other areas such as education they seem content with uneven provision of home care across the province.

A BEHIND THE SCENES LOOK AT WHAT HAPPENS IN HOME CARE

Nursing

The community nurses interviewed estimated that between 15 minutes and 1 hour a day is spent on redundant activities related to the competitive bidding/ contracting out process. They spend their time reporting the same information twice, once for their agency's charts and once for the CCAC reports. They have to double report changes in visits. For example, if a patient wants to be away on the day of a normally scheduled

visit and move the visit to another day, the change must be made in duplicate. It must also be pre-approved by the CCAC. If there is any error, the visit will not be paid for and many more hoops will have to be jumped to recoup money for the visit. Situations such as this would be eliminated completely if a single agency administered the funds and provided the service.

Nurses felt that in the course of their hands-on visits they were in effect case managers to their patients, writing notes to doctors, arranging medications, and follow up. The requirements to consult with CCAC case managers and supply order clerks were repetitious and non-productive.

“What gets me is that we see the patients every day and yet when we feel that extra visit is needed, or it is time to reduce the frequency of visits, we have to call a case manager. They are lucky to see the patient every 4 - 6 months. We have to ask permission from the case manager, fill in forms, and send them to someone who can not evaluate our request. It is a professional insult to say nothing of a waste of time.” - visiting nurse

On average, nurses indicated that approximately 40 minutes of their paid time, or 8.8% of “nursing” activities could be redirected to patient care by reducing duplication and non-productive procedures.

Most CCACs contract multiple agencies to deliver nursing, home making and personal support services. Many separate contracts mean that workers’ visits can not be assigned efficiently. For example, there are often nurses from different agencies visiting patients in the same building or who are neighbours. Nurses estimated that the cost efficiencies would be significant if one or two of the duplicate trips could be eliminated each day. For this to happen, assignments would have to be made in consideration with geographic location. The elimination of one drive a day (an average of 8 kilometres) could save 10 minutes or 2.2% of a nurses’ time. Two drives a day would save 20 minutes or 4.4% of the nurses’ time. Added to the 8.8% of the time already identified as wasteful, 13.2% of the nursing staff budget could be re-allocated to direct patient care.

“There are so many examples [of waste]. The best though is one day I was called by a case manager and asked if we could do a visit that day to take a client’s blood pressure. She was worried it was high. The thing was the case manager, a registered nurse, was calling me from the client’s home. She was sitting next to the person but had to call us to find a nurse on a “stat” basis to drive to that patient’s home to take the blood pressure. That was all, nothing else. I think it has something to do with employees of the CCAC not being able to give patient care. I do not even think the case managers are allowed to carry blood pressure cuffs. It is so stupid.” - a nursing manager in a provider agency.

There are some situations that clearly have not been well thought out or maybe not

even anticipated. Visits from nurses from more than one agency can create a lack of clarity in roles, responsibility and ultimately in liability, not to mention possible confusion in patient care for all concerned.

I have very, very grave concerns about the situation in palliative care with the contracting out process. You could have a shift nurse from [one agency] who is supervised by a palliative care nurse from [a different agency]. Now you have two nursing charts from different nursing agencies in the home. One nurse receives doctor's orders and is expected to supervise a nurse from another agency. The result to me seems inevitable. There is duplication, a lack of clarity and a communication problem all of which are going to harm the client.”
– A visiting nurse

These situations place additional strains on already overworked visiting nurses who now must maintain a more complex communications network with their own agency and a nurse from another agency.

How is the client or the client's family to be assured that they or their loved one is properly cared for? Or is there any system of accountability in place at all?

Home Support

The homemakers, personal support workers and community support workers we interviewed did not have direct contact with the CCAC. Rather, the office staff and management of the worker's employing agency did the reporting

Home support workers typically did not spend time related to activities of contracting out or competitive bidding. Nevertheless, they did feel that competitive bidding and contracting out had negatively affected their ability to provide good quality care. They were forced to rush their work and increasingly prohibited from providing care people need.

As with nurses, poor staff assignments due to multiple agencies were a common complaint. Having home support workers assigned to the same area but employed by a different agency is clearly inefficient. This means that 4.4% of the homemaker's time could be used for patient care if two drives a day were eliminated as was the case with nursing care as discussed above. Indeed, this estimate may be quite conservative as home support workers are often required to take public transit in major cities, increasing the travel time.

Case Managers

Estimating how much time case managers spent on activities related to contracting out direct patient care is complicated by two factors.

First, case managers reported differing impacts caused by the problems associated with contracting out depending on the focus of their work. Case managers who do initial assessments, primarily in the hospital, and those case managers heavily focussed on placement to long term care facilities, felt they performed work that is largely beneficial to patients.

Most case managers, however, carry an ongoing caseload and are severely affected by the competitive bidding/contracting out process. One case manager estimated that up to 90% of her time was spent reading service reports on patients she rarely sees, making sure there is up to date documentation from agencies, approving service requests when she did not have up to date knowledge, and generally shuffling papers to monitor the agency's work.

Second, there was some disagreement on the role case managers might play in a public system. Some argue that there is a need for a large separate body of case managers while others feel that fewer case managers with specific assignments is preferable because frontline staff could provide most of the routine case management functions. Our proposal for a single public agency would significantly simplify the case management function.

Most case managers felt that a significant amount of their time was spent policing the system and shuffling papers that would be unnecessary in a more integrated delivery system.

“Most weeks I feel about only 10% of my time is spent doing something that improves patient care. The rest is office busy work, most of it trying to control expenses. That means trying to figure out who I can cut off, or policing agencies, making sure the right authorizations have been given, making sure service reports are up to date and sent in, that sort of monitoring activity” –
CCAC Case Manager

Based on our interviews we estimate that 25% of the case managers time could be redirected to improve patient care rather than monitoring and running a complicated system of contracted out multiple agencies.

The Therapies

Therapists working in the community reported many of the same problems faced by visiting nurses. Duplication in assessments and reporting, and difficulties in communication were at the top of their concerns.

“Since we were contracted out the job is more segmented and we spend more time trying to communicate. There is also a significant duplication in assessments with the case managers questioning or repeating the work of

other health care professionals.” - Community Therapist.

“As we have become more isolated and segmented [with the contracting out] there is greater probability of communication breakdown. We spend so much time in telephone tag and listening to voice mails. We used to be able to resolve things by bumping into people in the halls [before the therapists were contracted out].” – a CCAC Case Manager.

Therapists report that 40 minutes a day, or 8.8%, of their time is spent on unnecessary phone calls and on unnecessary reporting. This time could be used for improved patient care in a public system. Since most therapy services are delivered by only one agency, there is less likely to be a problem of inefficient assignments for geographical reasons.

While we were unable to analyse a budget for an agency delivering therapy services, it is likely that it would be similar to a nursing agency, with slightly less lost to providing patient care. We estimate that in total 16.2% of the total therapy budget is used to run the system.

Medical supplies and equipment

The separation of the supplies from front line workers was the biggest problem identified by those interviewed. Some workers reported that they were no longer able to pick up supplies from their agencies and take them into a home. Instead, they must order the supplies through the CCAC. For example, if a patient is short of a supply the nurse must call the CCAC, or call the supply desk at their agency. The supply desk then calls the CCAC supply desk. The CCAC supply desk calls the supplier who delivers the supplies. This is a long convoluted and inefficient supply chain. It would be much simpler if a nurse could pick up the supply from his/her agency and deliver it on the next visit to the client, or order supplies directly.

Getting the right supplies can also be a problem as the direct caregiver (a nurse for example) does not talk directly to the supplier. Often, after all the phone calls, the supplies that are delivered are not the right ones. Those supplies then have to be returned and the process starts all over again.

“It is the little things that get me. Like I can not call and directly order supplies. I have to call someone in [my agency] who calls someone in the CCAC who then contacts the supplier. And it is a bit like one of those party games where you whisper in a person’s ear and wait to see what the words are when it reaches the last person. And it is even worse if you order supplies quickly or, heaven forbid, supplies that are not usually ordered. The chances of receiving the wrong supplies go up exponentially, then you have to call the CCAC, who calls the supplier, who has to drive out and replace the supplies. When, if I was allowed

to talk with the supplier directly, we probably would have it right the first time ” - a visiting nurse.

We estimate that 5% of the medical supply budget could be redirected to improving patient care through less administration, fewer mistakes and less driving.

Transportation

We heard numerous examples of patients being visited by several different people in one day to perform tasks that could have been done in one visit by one person. This is particularly inefficient if the patient lives in a rural area where each visit is a long drive.

While it is often not appropriate for a caregiver to pick up supplies, take blood, or perform other functions outside their main duties, having separate contracts precludes the option of assigning and using staff and resources efficiently. For example, many of the nurses we interviewed said that it would be more efficient, particularly for long distances, if they could bring laboratory specimens in themselves, rather than having them picked up by the delivery service.

“There are so many stories of how things could be done more efficiently, I get a couple of good ones a week. The one I still marvel at though is that I work on the IV team and we are contracted to take blood from patients’ intravenous lines. MDS is contracted to take blood the standard way from patients’ arms. One day we had a patient who lived 20 kilometres out of town and he needed blood from the IV line and his arm. I am also qualified to take blood from an arm, but, because of the contracts, both I and an MDS lab person had to drive the 40 km round trip and take blood from that person. What is also amazing, in the evening or on weekends, MDS does not work, and if we need “stat” blood from an arm, we are expected to take it. The process now is completely irrational” - visiting nurse.

We estimate that 10% of the transportation budget could be redirected to direct patient care through coordination of services.

Support Services

Some of the support service budget can also be redirected to improve patient care. The following description of a typical process for admitting a patient to community care illustrates the point

A patient is assessed in the hospital or community by a case manager from the CCAC, who will usually not see this patient again. The case manager reports on the patient’s condition and decides what services they qualify for and what can be provided. The patient’s information and the number of visits are then entered into a

computer at the CCAC. A referral is sent to the various agencies involved and each enters the patient's information and visits into their own computer. A scheduler at the agency(ies) assigns the visits. The community caregiver takes another history, and starts the visits. The visits actually made are reported to the agency's support staff who in turn enter the information into the agency's computer. This information is either transferred directly to the CCAC's computer (on line or by disc), or for smaller agencies, sent to the CCAC where it is manually entered. The CCAC then determines if the visits made were on the right day and in the right amount. If there is a discrepancy, support staff at both the CCAC and the agency have to work out the discrepancy. This can take up some of the caregiver's time.

"You would not believe the number of hours we spend reconciling the visits we think an agency should be making with the ones that they bill for. And it is not just our staff's time but agency staff time. And it is usually something like the client cancelled a visit and some one forgot to report or record it, and an extra visit was authorized but not noted, that sort of trivial detail" - CCAC support staff worker

Both CCAC and agency support staff felt that it takes about one hour per day to straighten out problems created by the division between agencies and the CCAC. Add to this the systemic redundancies and we feel that 25% of all the support staff budgets could be redirected to supporting patient care activities.

While there are many other ways of admitting a patient, the hospital model, which works daily for hundreds of thousands of patients provides some clues. A nurse who is part of a team looking after a patient could do the assessment. The data gathered and decisions made would be entered into a computer. That same computer could provide information to a scheduler who would schedule the visits. Any changes in visits would be phoned in for further scheduling. This is one option that is feasible if the competitive bidding system were abolished and replaced by a more rational system.

Management and Administration

In any given community there could be the CCAC and 10 to 15 agencies involved in the provision of home care. The agencies each have a CEO, a human resources department, financial officers, senior managers and supervisors for front line staff. One set of senior managers (rather than 10 –15 sets) is more than sufficient to run a hospital with a budget many times larger than most CCAC budgets. Many of the resources now spent on senior management in our community care system are redundant. Many of the front line supervisors will still be needed, but one would expect more efficiencies as staff numbers in a larger agency are at more optimal levels.

Extra management is also needed for the tendering process. Competitive bidding does not come free – it adds administrative costs to a CCAC's budget. Preparation of the Requests for Proposals (RFPs), evaluation of the proposals received, costs of lawyers and consultants, and the costs to the CCAC of monitoring contracts after they have been let are all expenses which are in addition to the normal operating costs. The more often the contracts are put out to tender the greater the costs will be. These are all costs that do not contribute directly to patient care. In fact, it is quite the opposite. Competitive bidding and contracting out are processes that direct money away from patient care.

We should be careful to note that the solution does not lie in longer term contracts for private companies. Such contracts merely lock in fragmentation and profit taking and leave little recourse to address problems of patient care. Rather the solution lies in a single public agency which will deliver public services.

We estimate that 60% of the management budgets could be reassigned to improve patient care.

Profit

To determine the amount of public health care dollars being taken from patient care and paid out to owners and share holders of private for-profit companies, it is necessary to know the percentage of contracts going to for-profit companies and their rate of profit. As mentioned previously, the system established by the government and the restrictions private corporations place on their financial information make it difficult to establish exact figures. However, we were able to establish some reasonable estimates on both the amount of work going to the for-profit sector and an overall profit rate for the sector.

We were able to gather information on the volume of nursing services received by each agency in 20 nursing contracts in 18 CCACs for 1999. Fifty-two percent of the contracts went to for-profit companies. Therefore we can assume that the private sector is still receiving at least 52% of the contracts 2001.¹

We were unable to establish the same breadth of volume data for home making and personal support. But it is reasonable to assume that the volume of contracts going to the for-profit sector is at least as great. The homemaking sector is even more fragmented with a larger number of contracts going to for-profit companies.²

The number of for-profit companies delivering therapy services is smaller and we

¹ Fifty-two percent is probably an underestimate because in 1999 some of the CCACs would still have had protected volumes for the non-profit sector. We also know that it does not include some of the communities where the VON was excluded from the public nursing contracts

² Paul Leduc Browne, *Unsafe Practices: Restructuring and Privatization in Ontario Health Care*, Canadian Centre for Policy Alternatives, 2000 p. 120

estimate it to be 40% of the therapy market.¹ Medical equipment and supplies are largely delivered by for profit agencies and they are estimated to hold 80% of the market.²

The vast majority of for-profit companies providing home care in Ontario are privately controlled corporations making it impossible to determine a profit rate. The few publicly traded companies do not provide information that is very useful. Extendicare provides no separate profit breakdown on its Canadian home care operations that operate under the name ParaMed. Extendicare's Canadian operations are more financially profitable than their American division, but the largest portion of their Canadian operation is nursing homes.

Trying to find information for a comparable home care sector in the US is difficult. Many companies that provide home care services ranging from medical supplies to home support do so as part of a larger company that also runs hospitals, outpatient services, medical research or a variety of other activities.

Also, within the American home care sector there seem to be very different levels of financial profitability. For example, medical supplies and infusion therapy seem to be doing well while home support services seem to have had a recent downturn due to restrictions in Medicaid funding. This is not a problem in Ontario where there has been expansion of home care money and volume over the past four years.

Given these considerations we have used a profit rate of 9.65%, the average net profit margin for the last five years of the American health care sector. We assume that this is a relatively conservative estimate and that the difference in profit rates between the American and Canadian home care markets is relatively small.

Office Supplies and Occupancy Costs

Our estimate of the office supply and occupancy cost expenditures is based on the quantity of these resources that go into supporting the wasted activities identified above for all staff. First, a simple correlation was used e.g. if 13.2% of nurses time is wasted on supporting the system, the office space and supplies used for those workers is also supporting those activities. A similar calculation can be used for home support workers, therapists, administrators and support staff. Added to this amount are extra space requirements used to house duplicate equipment such as parallel computer systems tracking exactly the same visits.

We estimate that 25% of occupancy and office supply costs could be redirected to

¹ Ibid. p. 122

² Ibid.

support activities that improve patient care.

Quality Costs

The following are non-quantifiable costs to patient care that are inherent in both contracting out and competitive bidding. Decreases in the quality of care will lead to real costs to our health care system. Many illnesses could be prevented or treated earlier by providing services that patients need, allocating sufficient time to provide the service, and allocating sufficient resources to maintain and attract a qualified workforce.

This fact was recognized in the recent inquest into the death of Joshua Fleuelling. The inquest recommended that “home care expansion is necessary to open hospital beds in order to relieve emergency department pressures. In order to attract nurses to the home care field there needs to be less disparity in the level of compensation and benefits with those who provide nursing services in hospitals. We [the inquest jury] recommend that the [Ministry of Health] reverse the implementation of managed competition marked by a bidding process for service delivery in the home care sector.”¹

Teamwork

When there are many separate agencies working within a single system, it is difficult, if not impossible, for various workers to exchange information on the care of a patient. Teamwork is very difficult under these circumstances. Good patient care develops from the interplay among the many caregivers (professional and non-professional) involved in a person’s care. Only when the health care workers work for the same organization is it possible to approach the optimum level of teamwork necessary to ensure that a patient is cared for well.

Appropriate Quality of Care

When work is divided up among many agencies, there is often a lack of a critical mass in any one organization to ensure that specialists are available for patient care. Upgrading of services to include specialists can happen in a cost-effective manner only when this critical mass is present. Also, this lack of critical mass makes it more difficult for agencies to have the resources to provide training for their staff. Initial training and orientation costs are increased by the high turnover and this negatively affects the experience levels of available staff. Under funding, of course, also contributes to this shortcoming.

Fear

¹ Report on the Inquest into the Death of Joshua Fleuelling November 2000, Office of the Chief Coroner, Toronto

Competitive bidding creates a climate of fear among workers. They are reluctant to criticize CCAC policies on patient care because of possible repercussions in the process of evaluating bids i.e., if negative comments are made, the CCAC may evaluate their agency lower the next time. The ability of workers to freely raise concerns about care is a key feature of effective health care. In fact this is a legal requirement for many health care workers and has been recognized in the recent inquest into the death of 11-month-old Trevor Landry. The inquest jury recommended that “staff should be encouraged to report recommendations and enhancements to improve hospital systems.”¹ Surely, the same logic applies to community care.

There are accountability issues which impact on quality costs as well. Contracts in many CCACs contain a clause that binds the provider agencies to secrecy about the contents of the contract. The agency runs the risk of losing the contract should they release any information. The contracts contain quality of care provisions but these are confidential as well. This means that the agency is not free to release any information on clauses that may hurt the quality of care. What are the costs of monitoring the quality of care provisions in the contract? Or is quality of care monitored at all?

Decreased Continuity of Care

Inherent in the competitive bidding process is the potential for a change of agency (agencies) with every new Request for Proposals. In other words, it is possible that every two to four years the bid will be won by a different agency. Undoubtedly, free market economists will see this as an attractive feature of bidding, but for patients and health care workers, it is nothing but a built-in source of disruption and decreased continuity of care.

Competitive bidding tends to provide a strong downward pressure on wages and working conditions. This increases turnover of staff, which decreases continuity of care, negatively affecting quality of care. A study of home care in Manitoba reported that the 50% per year turnover rate in B.C. for-profit companies was at least twice as high as the 15% - 25% rate for Manitoba public workers.²

REAL COSTS THAT WE COULD NOT ESTIMATE:

There are several other costs that could not be estimated. As with the quality of care costs, these costs will be in addition to the estimated \$247.4 million lost to patient care through the systemic redundancies, and inefficiencies of the competitive bidding/contracting out system.

Home care workers are under incredible stress. Increasingly, they are asked to

¹ Report on the Inquest into the Death of Trevor Eric Landry, March 2000, Office of the Chief Coroner, Toronto

² E. Shapiro, The Cost of Privatization: A Case Study of Home Care in Manitoba, Canadian Centre for Policy Alternatives, 1997

provide care in a shorter time with fewer resources. Stress is also increased by job uncertainty. For example, if your agency loses the contract, you will lose your job. This stress is faced every two, three or four years in the bidding process. The inevitable result is that workers have to book off more sick time (because they really are sick!). They also try to meet the demands by working in an unsafe manner, like driving too fast to meet an overloaded schedule of patient visits.

Most contracts with CCACs require agencies to receive referrals from the CCAC for long hours every day of the year. If an agency does not meet this requirement, they can have their contract terminated with 7 days notice. So the CCAC keeps taking referrals and makes it the agency's problem to find the staff to provide the service. Agencies force the problem on their nurses by asking them to work more hours under the threat that the agency may lose its contract. In the end it becomes the patient's problem because these kind of working conditions drive nurses out of community nursing altogether.

The end result is high rates of absenteeism and elevated turnover rates. The sector is already infamous for both of these features. And recruitment and retention of home care workers is already at crisis proportions. Remuneration in the sector is stagnating at best and decreasing at worst. Wage and benefit levels are not sufficient to attract new workers or to retain the ones already employed. The cost to patient care of these problems is considerable and uncounted in our estimates.

Contracting Out Can Cost More

When the therapy services in Ottawa were contracted out, the cost to the CCAC was \$513,047 a year more than doing the work in house.¹ This is a real cost and one that requires a serious analysis of budgets across the province to see if it has been repeated.

Potential Fraud Related Costs

The experience with for-profit companies in home care in the United States is riddled with extra costs related to fraud. In 1999, Olsten paid \$61 million (US) to the United States Department of Justice for criminal violations in home care including \$10.1 million (US) in fines and penalties for home care fraud.²

LifeScan, a subsidiary of Johnson & Johnson, paid \$60 million (US) in fines during 2000 for selling defective blood glucose monitoring devices to diabetics and

¹ Ottawa Carleton CCAC, "Highlights of the November (2000) Operating Statement". This represents 9.1% of the total budget for that particular therapy. The figure originally was \$830,000 but was later adjusted downwards. Susan McGlasan, CEO of the Ottawa-Carleton CCAC, indicted the figure was somewhere between \$415,000 and \$830,000 in a CBC radio interview, January 12, 2000.

² Gentiva Health Services SEC Filing Form S – 4, January 20, 2000, p. 40. Olsten is the predecessor company to Gentiva. Gentiva has since been sold to Bayshore Health Group.

submitting false information about the problems to federal regulators.¹

HCA – the Health Care Company – has recently agreed to plead guilty to charges of defrauding US government health programs in Florida, Texas, Georgia and Tennessee. As part of the agreement HCA has agreed to pay an additional \$95 million (US) bringing the total payment to \$840 million (US) in 2000 for criminal and civil penalties.²

A study by the Kaiser Family Institute, found that for-profit home health agencies generate higher medicare spending - one billion dollars in 1994 - because they provide more visits to similar patients than non-profit agencies do.”³ In other words, for-profit corporations are likely to provide unnecessary visits to patients rather than to direct the services to others in need of care.

What is the potential for fraud in the home care sector in Ontario? No one really knows for certain because there appear to be few mechanisms to detect fraud should it exist and accountability for spending in home care is not very transparent. Contracts are let and CCACs are supposed to monitor those contracts while the provincial government in turn is supposed to monitor the CCACs. But can this happen in a manner that ensures that public expenditures are being directed to the best advantage of the public? And if it can, at what cost?

Some CCAC's are trying to come to grips with the issue of fraud and other criminal offences by specifying RFP pre –qualification criteria that contracting agencies have no material legal cases pending within the last five years. This includes any insolvency proceeding, any criminal offence, or any civil proceedings based upon fraud, misrepresentation, criminal conduct or negligence.⁴ While this is one attempt to control the potential for fraud, it still requires resources to monitor. A better solution would be to have the services delivered in-house by a publicly accountable agency.

The 1998 Ontario Provincial Auditor's Report voiced some serious misgivings about the accountability of the CCACs. "The Ministry did not have adequate procedures in place to measure and report on the effectiveness of [service agreement and delivery]."⁵ This included doubts about the ability of the Ministry and the CCACs to verify "that services paid for were actually provided."⁶ If CCACs can not be easily held accountable, how can private sector agencies that are another step removed be held accountable?

We acknowledge that we can not put a dollar figure on the potential for fraud in the

¹ Melody Petersen, "Guilty by Division of Drug Giant", New York Times, December 16, 2000: C1

² "US Hospital Firm Pleads Guilty to Cheating Medicare: Seven Year Probe: Must Pay \$840 million in Criminal and Civil Penalties," National Post, December 16, 2000.

³ Kaiser Family Foundation, July 1997

⁴ Ottawa Carleton CCAC RFP July 21, 2000.

⁵ 1998 Ontario Provincial Auditor's Report, p. 106.

⁶ Ibid.

system. However, we cannot ignore that the potential is there (as demonstrated in the US experience) and that there is a cost to patient care when it occurs. There are several ways to handle the situation. The first is to ignore the potential for fraud altogether. However, this means that money may not be reaching its intended target – home care recipients. The second is to increase the degree of monitoring in a competitive system. Monitoring costs money and re-directs resources away from patient care. A third way is to create a home care system where profit motive is not the driving feature, where funds are administered by agencies accountable to the public with democratically elected boards.

CONCLUSIONS

Dollars for home care are scarce in Ontario. Care recipients do not receive the number of hours of care they require nor the quality of care they desire. Competitive bidding and contracting out home care services has not changed that. In fact, as we argue in this paper, competitive bidding and contracting out actually direct money away from patient care. Unnecessary duplication of services as a result of multiple contracted service providers and the administrative costs of competitive bidding are but two of the areas where money could be saved and more effectively spent on patient services.

Our examination of the costs of contracting out and competitive bidding reveals that 19.4 % of a nursing agency's expenditures, 12 % of the expenditures of a home support agency and 21.7 % of the expenditures of a CCAC could have been spent more effectively on patient care. If we extrapolate the CCAC percentage to the total expenditures of all CCACs across Ontario, then at least \$ 247.4 million of the total CCAC expenditures could be redirected to improving patient care.

These figures point to the need to look more closely at how home care is delivered and the budgets associated with that delivery. It seems clear that a single delivery agency would eliminate much of the duplication and problems associated with having more than one delivery agent working within a CCAC's boundaries.

Given the shortcomings of the current system, we need to consider seriously that the best mode of delivery is a model with public funding and public delivery i.e., deliver home care services would be delivered by workers directly employed by a democratic community controlled and publicly funded agency. This model would facilitate coordination of the delivery of the services and eliminate much of the waste associated with administering and monitoring competitive bidding and the contracting out of services.

Appendix A

Information sources and questionnaire.

In total 27 workers in the home care sector were interviewed. Those interviewed included: 8 VON nurses, 4 agency support staff, 2 nursing agency managers, 4 CCAC support staff, 4 CCAC case managers, 3 community support workers and 2 community therapists. The interviews consisted of open – ended questions as noted below.

Interview questions

- 1) What is your job title?
- 2) Who is your employer?
- 3) How much time in your work day is spent on activities that are duplicated by the CCAC, or one of the provider agencies, or would be unnecessary if all home care services were supplied by one organization?
- 4) Provide examples of activities that are required by the competitive bidding process and are the result of using contractors to provide direct patient care.
- 5) For nurses, homemakers and Personal Service Workers, are there services you could easily provide with your visit that would save a visit except that the system makes the extra visit necessary?
- 6) What are some examples?
- 7) Estimate the number of visits per week that could be saved by all contractors without significantly increasing your workload.
- 8) Are there other ways the contracting out /competitive bidding system has increased the cost of delivery of home care services? Provide examples.