CARE WATCH
Advocating Quality Home & Community Care

When Profit Conflicts with Care:
Privatizing Home and Community Services
March 21, 2024

What Care Watch recommends

Home and community services help keep older adults where they want to be – in their own environments and out of institutions. Increasingly, for-profit corporations have been providing these services and overtaking smaller non-profit community agencies. When home and community services are commercialized, clients and workers can suffer and communities will lose valuable resources. We recommend that standards be established, that compliance with standards be publicly reported, and that future contracts prioritize non-profit delivery.

What is privatization?

Privatization technically means the transfer of a property, business, service, or role from a government to a non-government (or private) entity. Care Watch uses the term to refer simply to the role of the private sector.

Not all privatization is the same, and the differences are particularly important to health care.

- ***A for-profit organization*** has owners, or shareholders. When it generates profits, these owners may receive dividends (or disbursements) and/or the value of their ownership may increase. The organization is therefore motivated to generate as much profit as possible and reward its shareholders.
- ***A non-profit (or not-for-profit) organization*** has no owners or shareholders. It treats any revenue that exceeds costs as operating surplus rather than profit. With no shareholders to reward, this surplus can support the organization's activities. In health care, these funds can provide more services and compensate the people who deliver them.

Canada's Medicare program requires provinces and territories to insure hospital and medical services, but doesn't include home and community care. The provinces and territories determine who will provide these services and who will pay for them. In Ontario, home and community services are delivered by both non-profit and for-profit organizations. Most receive some government funding. For some services, there is no charge to the client; others have a user fee or co-payment (which may be geared to income).

The proportion of home and community services delivered by for-profit organizations in Ontario continues to rise. Balance in the system has shifted dramatically. Before 1995, for-profit corporations delivered only 18% of home and community services across Ontario. They currently deliver about 64% - nearly two-thirds.

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It wasn't always this way.

Before 1990, home and community service programs developed independently. They were regulated by different legislation and different ministries. Services, providers, and responsibility for payment varied. Over time, more programs were concentrated in ministries of health and/or long-term care.

Non-profit organizations delivered most home and community services. These organizations were often charities with long histories of serving older adults and people with disabilities. Agencies tended to share information, knowledge, and resources with the common goal of improving service.

In the mid-1990s, it began to change. The Harris government promoted privatization of services as a way to cut costs. "Managed competition" was the catch-phrase for competitive bidding that encouraged and favoured for-profit providers. In an environment that pushed cost cutting,

agencies that submitted the lowest bids tended to win the contracts. Rather than being only requests for proposals for specific services, these contracts evolved to cover multiple services. When corporations were pitted against each other, and when cost and profit became the primary criteria, the incentive to cooperate and share information was lost.

At first, smaller non-profit community agencies could still flourish alongside individual for-profits. Then large for-profit conglomerates, sometimes based outside Canada, began to take over the smaller for-profit home and community services. Some of these conglomerates had questionable records in their home countries, and some owned and/or managed the long-term care homes that had the most resident deaths and worst staffing practices during the COVID pandemic. To continue operating in their communities, some smaller non-profits amalgamated and also delegated specific services to others.

There is a basic conflict between profit and care.
Home and community care suffers from a scarcity of data, particularly quantitative data, on quality and staffing, so rigorous comparisons are difficult. When we compare for-profit and non-profit delivery, however, it's useful to recognize that structures and incentives influence policies, actions, and results. We can also look at the results of for-profit care in other elements of the health care system.

For-profit delivery can shortchange workers, compromise care, and jeopardize equity.

- ***For-profit corporations answer to investors and not to clients or communities.*** The primary obligation of a for-profit operator is to shareholders. Money that rewards shareholders is money that can't go to care.

  Non-profits must use their funding to provide services and compensate the people who provide them. They often supplement government funding with charitable donations and/or municipal tax revenues. They also draw on the expertise and services of volunteers. Each year, volunteers donate more than 3 million hours of service to home and community care across the province. These volunteers contribute to many essential services – for example, friendly visiting and meal delivery - that government doesn't fully fund. Volunteers, many of whom are also older adults, make more funds available for front line, professional, and complex services. In turn, they are able to contribute to their communities.

- ***The largest single cost in health care is the labour of the people who provide it.*** The only way that for-profit corporations could underbid each other was to pay workers less, which doubly penalized them. Not only were they earning less, but the door was opened to more precarious employment, with less full-time employment, fewer predictable shifts, minimal (or even no) benefits, and higher workloads. Agencies often found themselves serving more clients with fewer workers. Before later legislation guaranteed these rights, many workers also lost the successor rights that would have let them keep their unions when their employer lost a contract to another provider. As a result, unionization rates fell, and workers lost much of their bargaining power. When workers have less ability to bargain effectively for wages, pensions, and benefits, working conditions can deteriorate.

  Personal support workers provide the large majority of home and community care services. They are predominantly female, and many are racialized and/or newcomers to Canada. They earn $10 per hour less than those working in hospitals and $4 per hour less than those working in long-term care homes, making them the lowest paid workers in health care. It's no surprise that each year 25% of them leave these jobs. Some take jobs in other health care settings, and others leave the profession.

  Poor working conditions and high turnover can damage continuity and quality of care. Many clients resist care from people they perceive as strangers or as not familiar with their culture. Personal support workers need to build trust and rapport. Relationships can last for years, but not if workers are constantly changing.

- ***Incentives to provide fewer and less expensive services can threaten equity.*** Medical and technological advances mean that patients can be discharged sooner from hospitals to their homes, so many home care clients now have more intense needs than in the past. These clients with higher needs may be less profitable, so for-profit operators have less incentive to serve them. For-profit operators may also charge fees not everyone can pay or may upsell by offering services clients either don't need or don't know they could obtain without paying. Clients with lower incomes, who live in remote or rural communities, or come from various cultural and linguistic backgrounds may be forced to enter institutions, pay privately for services, or draw on family and friends. Burdens on unpaid caregivers become even heavier. Disparities in income then lead to disparities in health care and in turn to disparities in health.

- ***Claims of efficiency can be misleading.*** It is important not to confuse efficiency with cost cutting. True efficiency is achieving the same or better results with less effort or fewer resources. There is no efficiency if decreasing costs means decreasing the range and quality of services or if the results are worse for clients. With funding for home and community services already scarce, and with agencies already relying on volunteers and charitable donations, there are fewer resources to juggle to achieve real efficiencies. Profit does not demonstrate efficiency, and we lack the metrics and public reporting that could tell us more.

- ***Non-profit agencies are accountable not only to their clients, but also to their communities and to the public.*** Conglomerates can dictate centrally, and often from a distance. Local input may be limited or absent. Non-profit community agencies are familiar with the people who live in their communities and able to provide sensitive and linguistically and culturally appropriate services. When an organization has a presence in its community, people are aware of it before need and panic set in. The boards of these agencies, which often include local officials or councillors, hold open meetings and issue public reports. The public reports of conglomerates are corporate ones intended to inspire confidence in shareholders. They don't have the information that can keep them accountable to the communities where they operate.

Living with privatization

When health care systems struggle to meet growing needs, it can be tempting to look to the private sector, but these "solutions" can be ineffective. They also lose sight of basic principles. The *Canada Health Act* doesn't cover home and community care, but its foundation – care for all based on need and not on ability to pay – should still apply to these services.

We recognize that some privatization is already built into health care. For example, hospitals tend to be non-profit corporations and many physicians and other practitioners operate as private contractors. What we must beware of is an emphasis on profit to the detriment of care and service. We can't completely dismantle privatization and profit, but we can limit it and put safeguards in place. Whether publicly or privately owned or managed, all home and community care agencies receive public funding, so all require public oversight. Care Watch recommends:

- ***Setting and enforcing province-wide standards for home and community services.*** Standards for care, pay, and working conditions must apply to <u>all</u> providers – both for-profit and non-profit. They should reflect what is truly important – the people who receive care and those who provide it – rather than simply costs, expenses, or seeming "efficiencies." These standards need to be measurable and, whenever possible, quantifiable. They should also be part of any funding discussions and negotiations. Enforcement of these standards should include:
    - An independent body to measure adherence to standards and enforce compliance
    - Consequences (including suspending contracts, withholding funding, revoking licenses, or barring violators from future contracts) for not meeting standards

  The new federal long-term care standard is an important step, but it applies only to long-term care homes. In addition, it is voluntary, so it can't be enforced. The next step is to develop comparable, but

mandatory, standards for home and community services. Although health care is a provincial responsibility, the federal government has already provided leadership for long-term care. It can provide the same leadership for home and community care.

- ***Requiring public reporting.*** The public has a right to see that providers are using public money to provide services and compensate workers fairly. Both for-profit and non-profit providers need to open their books to the public. Monitoring and reporting on practices and on adherence to standards for care and quality will yield the hard data needed to make fair comparisons and drive improvements.
- ***Prioritizing non-profit service delivery.*** As long as standards and accountability are in place, current contracts with for-profit operators can be "grandparented" for the remainder of their terms. However, the province needs a careful plan to reduce for-profit delivery and give preference to non-profits when it awards future contracts. Non-profit providers can be encouraged to bid on contracts by:
    - Structuring the contracting process to specify that priority will be given to applicants that demonstrate they can meet specified and measurable high standards for quality of care, equitable staff compensation and benefits, and training for staff
    - Opening contracts and bidding first to non-profits. For-profits will then be eligible only if non-profits decline to bid.

Non-profit home and community care agencies are valuable resources to clients and communities. We can't change the past, but we can learn from it.

Care Watch advocates for high quality, accessible, and affordable home and community services – the services that help keep older adults in their homes and communities safely and productively. We believe that non-profit agencies are the best providers of these services and that privatization, and particularly for-profit delivery, should be kept to a minimum. We can't change the past, but we can learn from it to create a more balanced and equitable system.