Submission to the Standing Committee on the Legislative Assembly concerning Bill 175 (*Connecting People to Home and Community Care Act, 2020*)

from the

Canadian Union of Public Employees Ontario

and the

Ontario Council of Hospital Unions / CUPE

CUPE Research
June 2020

With over 270,000 members in Ontario, the Canadian Union of Public Employees (CUPE) is the largest union in Ontario. Over 75,000 CUPE members work in Ontario hospitals, long-term care facilities, home care, Local Health Integration Networks (LHINs), public health, emergency medical services, community care, and other health care services. CUPE members live and work in virtually every city, regional municipality, town, village, and unincorporated area in the province.

As a result, CUPE Ontario and the Ontario Council of Hospital Unions/CUPE take a great interest in Bill 175 (*Connecting People to Home and Community Care Act, 2020)*. Unfortunately, this Bill will privatize health care services in five ways, weaken public oversight, create different home care structures in different parts of the province, remove legislative protections, require yet another round of home care restructuring, undermine home care working conditions, and unleash an untested, home care experiment. Years of restructuring and chaos beckon.

The Bill: Bill 175 is permissive, allowing a laissez-faire framework for home and community care. It repeals the more detailed *Home Care and Community Services Act, 1994,* does not establish a new Act focused on home and community care, and leaves most details to policy or regulation.

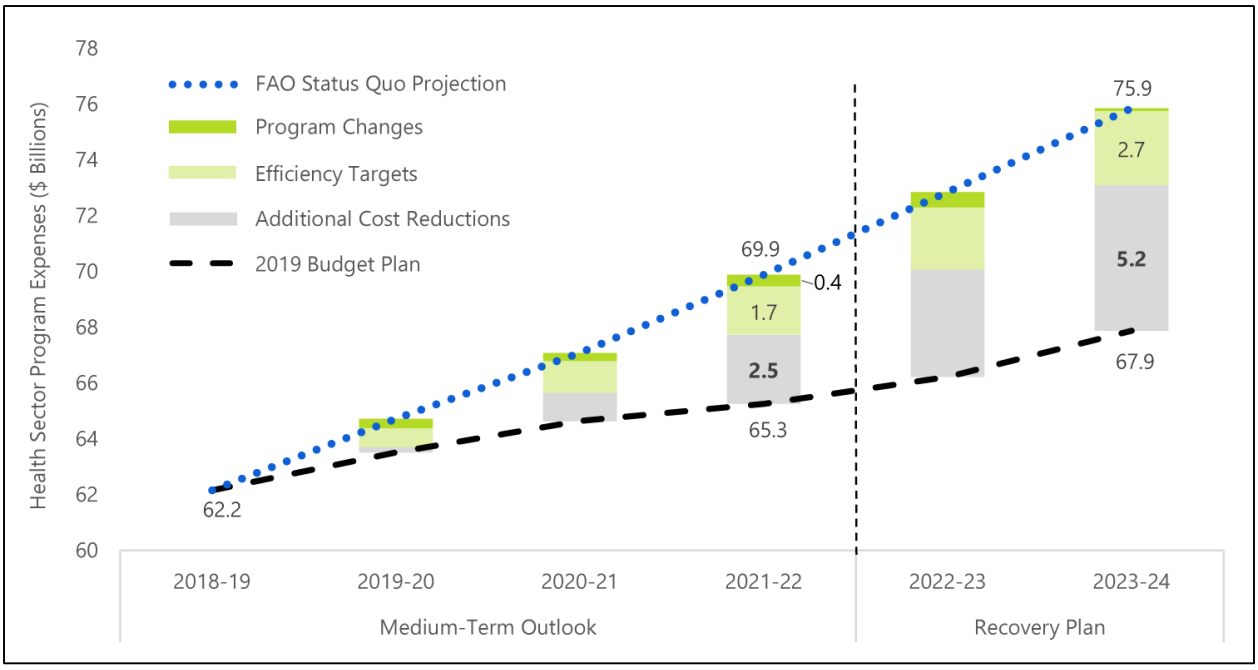
So, for example, the Home Care Bill of Rights is part of the existing legislation but is not in the proposed legislation. Instead, the government suggests, it will be put into regulation. This approach removes the public accountability and oversight that comes with legislation. Regulations and policies can be changed with little or no public consultation, or notice. One would think that in today's world a Home Care Bill of Rights would, at the very least, not be removed from legislation. But that is what this Bill proposes.

The context: These reforms were started in a world of cuts. The first Progressive Conservative Budget claimed that by 2021-22 the merger creating Ontario Health will save $350 million annually. Part of this was done through the elimination of 815 positions at Ontario Health and LHINs that created much outrage last year.

However, even if we estimate a well-above average total cost for those 815 jobs, the savings would only amount to $81.5 million, i.e. less than a quarter of the $350 million cut that the government says they will cut. They still would have to cut another $268.5 million to meet their plan. If the government sticks to this

plan, there's more cuts to come – we just don't know where, yet. In September, Minister Elliott flagged several thousand job cuts.

Moreover, the Financial Accountability Office (FAO) Budget and Economic review showed that much more health cuts would be required to meet the government's initial Budget plan – $5.2 billion in extra, unidentified health care funding cuts by 2023-24.



While the COVID-19 health crisis has led the government to temporarily increase health care funding this year, it is almost a certainty that the corporate sector will demand major austerity cuts in the year ahead to balance the budget, rather than face tax increases for corporations and the wealthy.

We are in for an intense fight over cuts to health care. We must not waste our time and treasure on another health care privatization scheme, nor put up with excuses for health care cuts.

What will this Bill mean if passed? Some clear indications of the reforms can be pieced together from previously passed legislation (*Connecting Care Act, 2019*), the new Bill and, especially, from the government's discussion of the Bill's proposed regulatory framework.

The ministries of health and long-term care will fund Ontario Health. Ontario Health will fund Ontario Health Teams (OHTs) and Health Service Providers (HSPs). OHTs and HSPs will contract for home care. Home care providers will deliver home care services but also take over care coordination functions currently done by the LHINs.

While the funding and oversight role of LHINs is being turned over to Ontario Health, the government says the home and community care side of LHIN's will be renamed "Home and Community Care Support Services" (HCCSS). These will, for a time, continue to operate that aspect of LHIN operations.

This is only transitional, however. Over next few years they are planning a "phased and gradual" transition of responsibility for home and community care from LHINs (i.e. government organizations) to any of a variety of health service providers (e.g. hospitals, LTC facilities, primary care organizations, community care organizations), or to the newly forming Ontario Health Teams, which are loose coalitions of health service providers.

These organizations are, in turn, expected to contract for home care with home care businesses and organizations. LHIN care coordination work may also be given to these same businesses, creating an ***obvious conflict of interest***. They will deliver the service *and* provide care coordination, e.g. determine the amount of service. It's like putting the Colonel in charge of the chickens.

This is especially troubling as home care delivery organizations are often for-profit corporations and can be expected to focus on making a profit rather than putting patients and clients first. Compounding the problem, these businesses are usually non-union and provide inferior wages and working conditions. LHINs are the one area where reasonable conditions of work in the home care sector exist. The wind-up of LHINs will make home and community care an even less attractive area of health care work. This puts home and community care at a distinct disadvantage.

Notably, Ontario Health was able to redeploy LHIN staff to assist in responding to the COVID-19 pandemic. We would lose that oversight and ability to respond to other health system challenges if this work is privatized.

While the LHINs contract for home care services and provide LTC placement services, in some cases they also directly provide home and community care services. The government's plan to displace the LHINs means that these services (to the extent they continue at all) will also be under threat of privatization.

Other forms of privatization in this reform: Private, for-profit hospitals have been frozen for years – but this Bill (schedule 3 s. 9) would modify the *Private Hospital Act* to allow them to expand "home and community care" beds (under the guise of excluding such beds from the definition of a private hospital).

Similarly, the ministry is also proposing to add via regulation unlicensed "residential congregate care settings" as a location for "home and community care services" – with no restrictions on for-profit operators. This would introduce new settings for patients who cannot be treated at home. These new settings would be *instead* of hospitals or long-term care homes. These unlicensed congregate care homes could provide care to patients on a transitional or rehabilitative basis. Surely, however, we have learned from the COVID-19 that poorly regulated and overseen congregate care is a fatal danger for vulnerable populations. Instead of introducing new, lower levels of care, we need to increase and improve our best types of care that have decades of experience. If this was a plan to expand public sector supportive housing with clearly defined protections designed to improve existing levels of supportive housing services, this might be worth supporting. But it is not. Instead of introducing new, lower levels of care, we need to develop and strengthen our best types of public health care.

Finally, the government has indicated that under regulation the (usually for-profit) home care companies will now be able to operate within the hospitals themselves, alongside hospital staff. This despite what we have learned about the infection threats that arise when you increase visitors to health care facilities. Multiple chains of command within hospitals are also a recipe for confusion, miscommunication and error. Home care workers moving from one hospital to the next will also be an excellent vector for the spread of infection.

This Bill should not be passed – but even if it is, these sections of the Bill and regulations must not proceed.

Undermining Public Sector Governance: By dismantling LHINs the government is dismantling public sector governance and provision of home care. Community and labour organizations have long called for stronger public accountability to local communities by LHINs. Now we are getting the very opposite. All of the key players in the new set-up operate on a very different basis. Ontario Health operates largely in secrecy, and has no regulations for public input, has a board that is not subject to Ontario conflict of interest legislation and that is close to the corporate sector. The newly forming Ontario Health Teams are little more than loose coalitions. They have no set structure, no requirements for boards or public meetings, and no requirement for public or community accountability. The for-profit home care organizations operate on the basis of commercial confidentiality. That is the very opposite of public accountability and transparency.

Deepening past mistakes: The transfer of care coordination to the corporate sector and the destruction of the last public sector organizations in home care completes the privatization of home care begun under the last PC government in the late 1990s.

Over the last 25 years for-profit health care has been tried repeatedly. Each initiative resulted in failure: for-profit MRI and CT clinics that would provide "non-medically necessary" scans, ultra-expensive privatized P3 hospitals, physio clinics with an "unlimited" ability to bill the province, rotten contracting out practices at e-Health, Ornge air ambulance privatization that disguised whopping executive salaries and scandal, death at a private surgical clinic and years of problems that followed as the government tried (and failed) to enact adequate oversight, and private plasma clinics that openly defied government attempts to shut them down.

More recently still we have seen the failure of for-profit long-term care homes to protect their residents, with larger rate of deaths in for-profit homes. Not surprisingly, the staffing levels of for-profits homes has also been revealed to be much lower than the municipal and not-for-profit homes.

Home care in Ontario has been undermined for years by an ill-advised privatization of the previous PC government that marred the sector for decades and resulted in multiple failures. The new PC government is now coming back to privatize the

small part of home care that remained in the public sector and that, almost alone in the home care sector, provided reasonable working conditions.

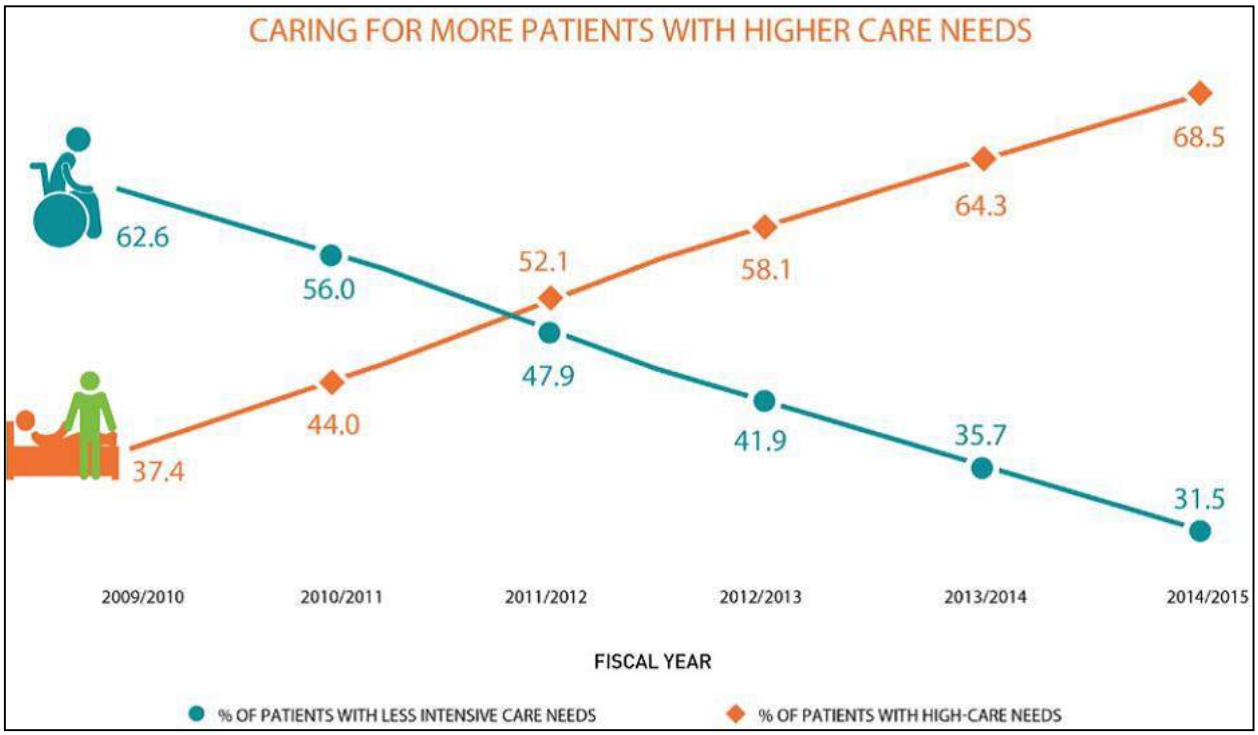
Thirty years ago, home care was largely provided by not-for-profits and municipal government. The NDP government of the day initiated a major consultation on reform and eventually proposed the creation of public, not-for-profit "multi-service agencies" with elected boards to directly provide home care services. Although legislation was passed, this was never implemented as the new PC government established instead "Community Care Access Centres" (CCACs) that would contract out the delivery of home care services through competitive bidding. This led to the widespread take-over of the home care sector by for-profit corporations.

However, problems also ensued – conditions of work at the home care providers were very poor making the sector undesirable, which, in turn, undermined the continuity of care. Continuity of care was also undermined by the loss of contracts by not-for-profits that had been in the sector for decades.

The CCACs began campaigning for better funding, but then were taken over by the provincial government, quieting, for a moment, the unrest. The next government, however, was forced to impose moratoriums on competitive bidding in the sector. This provided some stability and continuity of care, but also froze in place the privatization that had already happened.

To deal with the appalling, largely privatized and non-union working conditions in the sector, government made two major interventions in the sector to push up wages and benefits, the last being a $4 an hour increase in wages for PSWs. Other plans to improve working conditions were set out but these were lost when the current government was elected. The sector remains far behind the decent (but far from generous) working conditions found in the hospitals and long-term care, creating an unfavourable situation for home care.

At the same time, home care was changing dramatically. Access became a bigger problem as home care services were cut for less ill clients as home care was forced to focus on the most ill.



Trying everything but the public sector model, two more rounds of restructuring were also implemented. First, the CCACs were merged to fit the LHIN boundaries, and then, very recently, the CCACs were folded directly into the Local Health Integration Networks. These reforms were to little or no avail and will now be set aside entirely by the current government.

So now a third restructuring of CCAC/LHIN workplaces is occurring. The government was already on the verge of transferring a small portion of the LHIN staff (the LHIN legacy staff that help fund and oversee hospitals, LTC, and other providers) to the new Super Agency, Ontario Health. This was put on a temporary pause when COVID-19 struck hard in March, and those workers remain in limbo. The rest of the LHIN workforce is still waiting to be restructured out of existence.

Each of these successive rounds of restructuring was sold as a major step forward – just like Bill 175. The reality was that the privatization was a ***complete failure*** that led to successive crises in home care. Ignoring this by erasing the last portion of public home care, as enabled by Bill 175, will only make this worse.

The wrong bill at the wrong time: As was the case with this government's previous health care Bill (*The Connecting Care Act, 2019*), the government was rushing this Bill through the legislature. Then the COVID-19 outbreak hit home. We had hoped that the outbreak would cause the government to pause until the outbreak was under control. Unfortunately, the government is now pushing the legislation forward even as the province is still under emergency orders.

We find the timing completely inappropriate. The COVID-19 outbreak has exposed major shortcomings in our health care system, particularly in long-term care. Thousands of LTC staff and residents have been infected, over 1,780 have died, and we are not through this crisis yet. COVID-19 should be the government's health care focus, not prior plans that originated before COVID-19 was even an issue.

There is an urgent need for health care reform – but it has nothing to do with this Bill. Instead the focus should be on stopping the urgent threat of a second peak of COVID-19 infection and death, especially in long-term care. This would mean urgently making plans to ensure COVID-19 residents in long-term care are treated in hospitals and not left to die untreated and unquarantined in under-staffed and over-crowded long-term care facilities, and instead are treated in hospitals. It would mean increasing pay for LTC workers so the sector can attract and retain staff, particularly personal support workers. It would mean increasing full-time work in LTC to at least 70% of hours. It would mean stable regular hours for any part-time staff. It would mean weekly testing for COVID-19. It would mean phasing out for-profit LTC. It would mean moving quickly to eliminate multi-person rooms and shared bathrooms. It would mean increasing staffing in our long-term care facilities. It would mean extra resources to improve infection control in LTC facilities.

It would not mean setting off on an unrelated privatization of home care. Yet, this is what the government is proposing, even while it is making little or no progress on the urgent reforms needed in LTC to prevent a second peak in LTC sickness and death.

The Experiment: As noted, with the abolition of the LHINs, there will be no set organization to oversee home care. In different areas different types of organizations would contract for home care services. There are no restrictions on what the winning contractors may do in terms of sub-contracting our restructuring. Even the government cannot say what arrangements will emerge.

This model does not integrate services, it instead turns home care over to a variety of different providers and overseers, with very different types of governance, ownership models, delivery models, restructuring capacity and motivations.

The new model will require restructuring, not just of the LHINs, but also of home care service providers. Right now, 14 LHINs contract for home care services within the LHIN boundaries. Under the new model, contracting may be turned over to 50, 70, 90, or more OHTs, HSPs, and primary care organizations. No one can now say what geographic areas these contractors will oversee – but they will be very different and much smaller than the current LHIN boundaries. Home care providers will simply have to adjust their services -- and workers likewise. Given that there will be many more contractors, home care providers may decide that mergers or acquisitions are the best way to maintain business. A small operator faced with smaller contracts will not be in a strong position. More restructuring and tumult is on the way for home care providers.

Weak government oversight: Government will be a very distant voice – having to work through at least four different levels of organizations before they can impact what home care workers actually do: [1] the Ministry of Health (and, perhaps, the Ministry of The Long-Term Care), [2] Ontario Health, [3] Ontario Health Teams (OHTs), or health service providers (HSPs) chosen by Ontario Health, [4] whatever companies or organizations the OHT or HSP contracts to provide home care services in the area, and [5] the employees of the contracted companies or organizations that actually provide the home care.

The government itself appears to have only limited ideas about what may happen beyond that – they are creating a deregulated home care environment and expect OHTs and HSPs to provide solutions.

The negative impact on LHIN workers: This new model creates uncertainty for home and community care workers employed by the LHINs. To date we have ***no*** assurances from government about the security of LHIN home and community care workers beyond the immediate period ahead. The government has told us that in at least some cases they wish to transfer the work without transferring the worker.

They are, it appears, very worried that LHIN workers will abandon ship as the government experiments. They should be worried. A "gradual and phased transition" suggests that the LHIN work will disappear piece by piece from under the feet of the LHIN home and community care workers, even as they continue to provide dedicated care to the public.

Finally, as noted, this reform will fracture the work of the existing 14 LHINs into scores of different organizations – Ontario Health Teams, Health Service Providers of various descriptions, primary care organizations, home care businesses, the Ontario Health super agency, and unnamed third-party organizations. Even if workers transfer with this work and with their collective agreements (an outcome that, unfortunately, remains ***very far from certain***), our current employment relationships and bargaining unit structures will fundamentally change.

Supervisors and labour relations: In schedule 1, the Bill introduces amendments to section 27 of the *Continuing Care Act 2019*:

> Not successor employer
> (7.2) The appointment of a supervisor under this section in respect of a health service provider or Ontario Health Team funded under section 21 to provide prescribed home and community care services that include residential accommodation is not a sale of a business for the purposes of section 9 of the Employment Standards Act, 2000, section 69 of the Labour Relations Act, 1995 or section 13.1 of the Pay Equity Act.
>
> Related employers
> (7.3) If a supervisor is appointed under this section,
> (a) no person is entitled to make an application under subsection 1 (4) of the Labour Relations Act, 1995; and
> (b) the supervisor and the health service provider or Ontario Health Team funded under section 21 to provide prescribed home and community care services that include residential accommodation shall not be treated as one employer under section 4 of the Employment Standards Act, 2000.

These amendments appear heavy handed and we do not support them. Failing removal we would suggest changing the amendment so that the appointment of a supervisor alone shall not indicate that a sale of business or related employer argument can be made. This way both the sale of business and related employer protections would still apply if changes are made that normally would bring those provisions into play.

Conclusion: The government plans to move LHIN work to an unknown number of different organizations, creating chaos and employment uncertainty for LHIN workers. In effect the government is hoping LHIN workers will continue to provide excellent service even as their work is being taken away from them, with no promises for continued employment security or fair conditions of work. Their plans also raise the threat of privatization, conflicts of interest, restructuring of home care delivery, lower wages, weak government oversight, different home and community care structures in different parts of the province, and drastically weakened legislative oversight of home and community care.

All of this for an untested experiment that offers no solutions to the obvious problems in home and community care: for-profit delivery, rising demand, inadequate services levels, weak continuity of care, missed visits, and unfavourable working conditions.

This legislation should be withdrawn. The government should instead be focusing on preventing a second peak in LTC deaths and other COVID-19 issues.