Long Term Care Reform in Ontario: The Influence of Ideas, Institutions and Interests on the Public/Private Mix

by

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Abstract

This research focuses on the reform of community-based Long Term Care (LTC) services in Ontario between 1985 and 1996 during which the three major political parties governed. Each introduced its own reform of LTC. The five models that were proposed, are analyzed from a public policy perspective, and an understanding of the factors that influenced policy formation is provided. The thesis focuses on two issues: policy content (an analysis of the design decisions of financing, delivery, and allocation) and policy process (an analysis of the interacting influence of ideas, institutions, and interests on reform).

Prompted by concerns of an aging population its associated medical costs, reform began as a need to improve services for seniors to enable them to live at home for as long as possible. However, with improvements in medical technology and pharmaceuticals and concurrent hospital restructuring, care formerly provided by physicians and in hospitals increasingly shifted to the home where it was no longer covered by the *Canada Health Act*. Underlying the debate were the following:

- the appropriate role of the state,
- the public-private axis in financing,
- models of delivery (not-for-profit versus for-profit), and
- approaches to allocation (centrally planned, command and control decisions versus market-type mechanisms).

To account for the shifts in models, a neo-institutional framework is adopted which argues the importance of considering the relative and interacting influence of ideas, interests, and institutions

to account for policy development and change. None alone is sufficient. Unlike other health policy domains, the LTC policy sector was comprised of a strong state and a loose network of under-resourced societal interests, which allowed the ideas and interests of the government to predominate over societal interests. Institutions, rather than constraining government actions, were marshalled to facilitate state ideology and interests.

The analysis of the shifting public/private mix in LTC reform has broader implications for the future complexion of health care in Canada. By considering all three constructs -- ideas, interests and institutions-- an understanding is not only provided of the changes in the LTC sector, but also a heuristic for comprehending policy development in general.

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Table of Contents

Chapter 1

Introduction and Overview

1.0 Overview

An ongoing dilemma in the design of public policy is the role of the state. Debates about the future of the welfare state rest in part on differing views about the balance between public and private responsibilities. Moreover, the role of the state in the development of policy has been a theoretical debate for decades. Is the state an active interest in policy formation or an arbiter of societal interests? An examination of Long Term Care (LTC) reform in Ontario provides insight into both these questions. However, the reform of LTC services is even more significant as a harbinger of the future of Medicare in Canada.

The proper scope of public policy and the role of government have dominated public debate in recent years. Some of the issues that have influenced the discussion are: globalization of markets and the power of international money lenders; free trade and the reduction of trade barriers; trends towards harmonization of social benefits and taxes; the mounting debts and deficits of governments; the advances of technology and economic restructuring; the economic crises of the 1980s and 1990s; the offence mounted by the Right against the welfare state and the promotion of market systems further substantiated by the demise of the Soviet Union; the loss of faith in political elites and governments, to name a few.

In Canada, both the national and provincial governments have been planning major social policy reforms for some time. Underlying the text of these reforms is a realignment in thinking of the appropriate role of the public and private sector in meeting the social welfare needs of Canadians, and a search for a new paradigm of state-market relations.

Physician and hospital care in Canada falls under the *Canada Health Act* (*CHA*)[1] whose five principles of universality, comprehensiveness, accessibility, portability, and public administration heavily constrain the role of the private sector in health care. Canada has a publicly financed and largely private, not-for-profit delivery of medically necessary services. Societal interests in these sectors (medical and hospital) are well-organized, well-resourced and formidable. Reform of these services by government, consequently, is heavily restrained by the interests of the medical, nursing and hospital associations and a public which is strongly supportive of the *Act*.

LTC services fall outside the *CHA* and therefore are not protected by its principles. Traditionally, these services were provided to the elderly or to people with functional disabilities in order to allow them to live independently within the community. Societal groups in this sector are numerous, poorly resourced, and uncoordinated. Faced with this loose network of interests and a largely uninformed public, governments have been largely unfettered in their attempts to reform

these services. They have been free to reduce the responsibilities of the state and to privatize both the financing and delivery of these services.

With advancements in technology and pharmaceuticals, more and more acute care (that is, care covered under the *CHA*) has shifted to the community and, therefore, its provision no longer needs to conform to the five principles of the *Act*. Because of the shifting site of acute care, LTC as a result no longer merely represents health and social services for the elderly or the disabled to keep them in the community. As acute services move into the community services that were formerly publicly funded and delivered by not-for-profit providers are subject to mixed financing models and for-profit delivery. Governments are able to take advantage of the shifting site of acute care into the community to erode the fabric of Medicare and to reduce their financial exposure. Moreover, the impact of multilateral trade agreements like the NAFTA will make it more difficult for the Canadian and provincial governments to reverse this privatization of health care.[2] The significance of policy change in the LTC sector and the decisions regarding the balance of the public and the private in its design, therefore, goes beyond its boundaries and has implications for health care as we know it.

This research focuses on the reform of community-based Long Term Care services in Ontario between 1985 and 1996. Community-based LTC services include both health and social services and can be broken down into professional services, homemaking services, personal support services, and community support services. These services were both publicly and privately funded, and were delivered by a mostly uncoordinated network of private not-for-profit and for-profit providers.

Over the period from 1985 to 1996, Ontario had four governments led by three different political parties. Each attempted to reform LTC but only the most recent model introduced by the Harris Conservative Government was ever implemented. This research examines the five models brought forward by the governments in this period, analyzes their differences from a public policy perspective, and tries to provide an understanding of the factors that influenced these differences. The thesis, accordingly, focuses on two questions: one deals with policy content; the other deals with policy process.

1. *Policy Content*: How did the design decisions of financing, delivery, and allocation differ across the following models: One-Stop Shopping, Service Access Organizations, Service Coordination Agencies, Multi-Service Agencies, and Community Care Access Centres; and what were/are the implications of these differences from a public policy perspective?

2. *Policy Process*: How do ideas, interests, and institutions, their interactions and relative influence account for the development of the five LTC models across the periods of the Liberal, NDP, and Progressive Conservative governments?

The context in which reform took place was relevant in terms of providing opportunities or modifying intentions and actions. During this period, the role of the state was under debate and scrutiny. Heavy debts and deficits of the national and provincial governments were adding to the rising neo-conservative calls for the retrenchment of the state's responsibilities in health and social services. Globalization of economies was exerting pressures for the harmonization of social policies and for the increase of market mechanisms.

The design or redesign of health and social services must consider three dimensions: financing (who funds what services for whom), delivery (who delivers the services) and allocation (the mechanism by which money flows from the funder of services to the deliverer of services). Moreover, public policy must decide on the role of the state in the financing and delivery of services (the public/private mix) and the extent of its control in allocating the funds (along a continuum from command and control mechanisms to market mechanisms). The way in which governments design a system along these dimensions (financing, delivery, and allocation) has implications for policy goals of equity, security, liberty and efficiency.

Three basic types of models were recommended over the reform period. One type of model was the "brokerage" model where a coordinating agency would purchase services from existing providers through a variety of informal methods. This model represented an incremental reform in terms of the divergence from the existing system. Two versions were proposed by the Liberals (One-Stop Shopping approach and the Services Access Organization (SAO)), and one by the NDP (Service Coordination Agencies (SCA)). The second type of model which was proposed by the NDP was the Multi-Service Agency (MSA) model. The MSA was a quasi-public delivery system created through the amalgamation of existing and new services where all service providers were to be employees of this single agency. There was a limit on the purchase of services outside the MSA. This model represented an almost total restructuring of the system, and a movement in terms of government involvement/encroachment in service provision that ran contrary to mounting popular sentiments. Finally, the third type of model proposed and implemented by the Conservatives was a managed competition model where publicly funded services were purchased through a formal competitive contract process based on price and quality where quality to this day has been inadequately defined.

On the financing side of the LTC reforms, all three governments, while maintaining the full funding of home care services (professional health and homemaking services), recommended its

removal from the *Health Insurance Act* to a global capped budget. As a result, home care moved from a fully funded entitlement to one in which availability could be constrained by budget pressures. Meanwhile, research on health systems has shown both the superior efficiency and equity in publicly funded, single payer systems.

With respect to the delivery of services, the three successive governments shifted from a design that maintained the status quo of a mix of not-for-profit and for-profit providers, to a preference for not-for-profit providers, to a quasi-public deliverer, and finally to a design that favours for-profit providers. Evidence on the public versus the private delivery of health and social services is mixed but slightly supports not-for-profit delivery over public and for-profit delivery.

On the allocation dimension, government models shifted from an informal cooperative brokerage type model with a purchaser/provider split to a more centrally planned model where the purchaser and provider of services were the same, and finally to a formal competitive market type model with a purchaser/provider split. During this period, the international literature showed experimentation in the creation of markets for publicly financed services through purchaser/provider splits and the injection of competitive mechanisms.

While analysis of the five models provides an answer to question #1, question #2 seeks to understand why and how very different models were developed in the same province in a short period of time. Using a neo-institutional approach, which sees the interests and preferences of the state as a key ingredient in policy formation, the research uses the theoretical constructs of ideas, interests and institutions in exploring the influences on policy and its development. It is the contention of this thesis that none of these factors is solely deterministic. While one factor may predominate over the others at any moment in time, all three are necessary to account for policy development and change over time.

Ideas include ideology, dominant ideas, and paradigms. Interests refer to the preferences of stakeholders in a policy arena. Finally, institutions refer to the structural characteristics, formal rules and informal norms of state and societal institutions that shape the actions both of individuals and of the organizations to which they belong. The ideas that were promoted through the reforms by government and societal groups involved the appropriate role of the state; the policy goals of equity, security, efficiency, liberty and their relative balance in policy; and whether a medical model or a more population health model should be developed. Interests pursued by government and societal groups included budget control, cost cutting, job security, provider and consumer autonomy, provider viability, consumer rights, consumer access to quality care, preservation of union successor rights, among others. Institutional factors affecting reform included legislation, the various ministries that were involved in reform, and the changes in them, that is, the changes in lead

ministries and the locus of policy development. (This thesis uses the term "consumer" to refer to the recipient of care. Please see Chapter 3, section 3.6, The LTC Policy Community, for an explanation.)

In the reform of the community based LTC system, all three factors were influential, but state ideas and interests predominated. Societal interests in this sector consisted of a network of fragmented, loosely associated groups. As a result, each government of the day was able to promote its ideas and associated interests over those of societal groups. As Schattschneider[3] argues the way in which a policy problem is framed not only determines who gets involved, but the degree of conflict, which in turn creates cleavages, and leads to the realignment of interests resulting in different institutional structures. In this way, ideas, interests and institutions never work alone but are in constant interaction and account for the changing dynamics in a policy community and the changes in policy.

A qualitative analysis of a number of data sources was employed. Question #1 is addressed through the examination of written documents produced by the Liberal, NDP, and Conservative governments in the ten-year period. Question #2, is addressed through an analysis using QSR NUD*IST software of written submissions from societal stakeholder groups in response to *Bill 173*, the Act legislating MSAs, and face-to-face interviews with government and societal key informants regarding their positions, interests and strategies in the development of the Liberal, NDP and Progressive Conservative models.

1.1 What is Long Term Care?

Long Term Care (LTC) traditionally has referred to the network of personal care, support and health services required on a periodic or ongoing basis by people who, because of physical disability or aging, need assistance to function as independently as possible. Nomenclature for LTC is not standardized across Canada - some provinces refer to "continuing care", others to "home care", and others to "community care".[4] This system comprises services, programs and facilities funded by and accountable to a mix of private organizations and governments. The formal system includes both health and social services, which represents about 20% of the services provided. The informal system involves the support given by family, friends, and volunteers, which represents over 80% of help provided.[5]

These services can be roughly broken down into services provided in people's homes (in-home services) that include professional care (for example, nursing care and physiotherapy), personal supports (for example, bathing and toileting), homemaking, and respite services; community support services such as meals-on-wheels, transportation, security checks, friendly visiting, and adult day programs; Alzheimer community programs and supportive living programs; and long-term care

facilities such as nursing homes and homes for the aged.[6] This research will only deal with community-based services, that is, in-home services and community support services, and not with institutional care.

Community-based LTC services fall under a number of jurisdictions. These services can be dichotomized as falling either into the health sector or into the social service sector, a fact that has significance both historically and in terms of reform. While the *Canada Health Act*[7], s. 6 allows for the provision of extended health care services, these services are not subject to the five principles of the *Act*; i.e., universal, comprehensive, portable, accessible, and publicly administered.

The *Established Programs Financing* (*EPF*) formula provided a per capita allowance for "extended health services" which included home care services and ambulatory health care services. Similarly, no restrictions were placed on these funds. In Ontario, the Home Care program administered by the Ministry of Health represented the largest program on the health side of LTC and included professional health services and homemaking services provided in the home. In 1985 Home Care was legislated and funded under the Ontario *Health Insurance Act*[8] and fully funded by the Ministry of Health. These services were designed to facilitate patient discharge from hospitals.

The community support services included what is commonly referred to as the "soft" services, such as meals on wheels, home maintenance, friendly visiting, transportation, security checks, adult day programs, elderly persons centres, and senior volunteer services. These services came under the jurisdiction of the Ministry of Community and Social Services and the *Ministry of Community and Social Services Act*,[9] These services were not uniformly available across the province, provided by grass roots organizations driven by a large number of volunteers, and funded by different levels of government and a variety of private sources which included private insurance, charitable giving and out of pocket expenditures.

Because none of the federal legislation imposed any constraints on the transfer of funding for LTC services (with the exception of *Canada Assistance Plan* which mandated portability) provinces had complete jurisdiction in redesigning this sector. Accordingly, there were no restrictions on the remodelling of either the financing or delivery of LTC services in terms of the public/private mix.

1.2 Long Term Care in Ontario Before 1985

Historically, most of the attention of governments in Ontario focused on providing institutional care for the elderly. These programs emanated from the Victorian Poor Laws, which embodied beliefs of individual responsibility, with minimal assistance from the state as a last resort. LTC services for the large part became associated with institutional care and loss of independence. Services for seniors and persons with disabilities living in the community were developed in an ad hoc fashion over the past fifty years by municipalities and charitable organizations, were unregulated

and unintegrated, with varying eligibility criteria and terms and conditions. In particular, Ontario developed community-based programs, which grew independently and found themselves overlapping. Homemakers and nurses services, acute home care, chronic home care, and elderly persons' centres developed under different levels of government and different ministries within the provincial government. The various programs consequently reflected their institutional beginnings.

1.2.1 Homemakers and Nurses Services

Before the 1950s, Ontario's primary role in community services for the elderly was as a regulator. Its first statutory involvement in the financing of these services began with the introduction of *The Homemakers and Nurses Services Act* in 1958. This program was not universal, operated at the discretion of municipalities and was cost-shared on a 50:50 basis between municipalities and the province. These services were under the provincial ministry that would eventually become the Ministry of Community and Social Services (MCSS). Homemaking and nursing services could be provided to the elderly, people with disabilities, and those recovering from an acute post hospital episode to prevent institutionalization in a hospital or LTC facility.

Municipalities administered the program, and either provided these services directly through municipal workers, or purchased them from agencies such as the Victorian Order of Nurses, the Canadian Red Cross Society and the Visiting Homemakers' Association. People needing care were charged for these services based on their ability to pay. In 1962, an amendment to the Act allowed for the provision of preventive, restorative and emergency services. In 1968, the *Act* was amended so that 80% of the costs were covered jointly by the provincial and federal government. Between 1961 and 1979, the number of nurse visits went from 106,000 to 133,000, and the number of homemaking hours provided increased from 24,000 to 1.5 million hours. In 1979 these services cost the province approximately $6 million. Over half of the provincial expenditures were for services for the elderly.[10]

1.2.2 Elderly Persons' Centres

Home support services began with *The Elderly Persons Social and Recreational Centres Act* which was passed in 1961, and amended in 1966 to become *The Elderly Persons Centres Act*. Its purpose was originally to assist not-for-profit organizations with capital costs of social and recreational centres, but was eventually to include provincial subsidy for home support services provided by the Centres, such as meals-on-wheels, assistance with shopping and heavy cleaning. By 1979, the Ministry of Community and Social Services funded 115 Centres in the province, 40 of which were providing home support services at an annual cost of $0.44 million. In addition, in 1977, the MCSS started 27 demonstration projects throughout the province to provide alternatives to institutional care, such as the home support services provided by Elder Persons Centres (EPC).[11]

During the 1970s, the MCSS provided additional funding to develop other community-based programs including respite care provided by homes for the aged for families who cared for elderly relatives, day care centres, and other projects providing meal services. Recognizing that the EPCs were unable to fund the growing home support portion of care for the elderly, MCSS provided an additional $2 million for these services. As of April 1980, there were 146 home support services projects.[12]

1.2.3 The Acute Home Care Program

The first acute home care program was developed by the Toronto Board of Health in 1958, the main purpose of which was to facilitate early discharge from hospital through the provision of physician prescribed services. There were direct charges for these services, but often adjusted to each patient's ability to pay. The acute home care program was subsequently taken over by the Ontario Department of Health in the mid 1960s and cost-shared with the Ontario Hospital Services Commission. With the creation of the Ministry of Health (MOH) in 1972, it became an insured service under the Ontario Health Insurance Plan (OHIP).

Consumers were eligible for services if they were covered by OHIP and if a referral by a physician for at least one professional service (nursing, physiotherapy, or speech therapy) was made. Application for the service was made by the physician who headed the team providing the care in the home. With the introduction of the *Canada Health Act, 1984*, home care was not considered part of medically necessary services and therefore not an insured service. However, the federal government provided funding under Extended Health Care Service for provinces to develop discretionary health programs, such as home care. The federal government continued partial funding under the Established Programs Financing arrangements. Ontario expanded the acute home care program eventually to the whole province, and by 1979 expenditures by the MOH reached $15.1 million.

1.2.4 The Chronic Home Care Program

The chronic home care program began in 1975 with pilot projects in Kingston, Hamilton, and Thunder Bay. Like the acute home care program, it was available to OHIP subscribers and eligibility depended on a doctor's referral for at least three visits from a health professional per month. The purpose of the program was to help people who needed continuing care to remain in their homes, to prevent further deterioration and to avoid institutionalization. Like the acute home care program, it was a fully insured service for eligible clients, and followed a "medical model" of service. As of 1981, the program was not available across the province (only 21 communities had these services), but expenditures for the elderly exceeded $6 million in 1979-80.[13] [14]

1.3 The Need for Long Term Care Reform in Ontario

Over the last two decades, demand for LTC has been rising for several reasons - - the ageing of the population and an increase in the number (and proportion) of frail elderly, the restructuring of the health care system in response to a cost control imperative which has led to a shift in care from institutions into the community, and medical and technological advances which have made it easier to provide services in the community which formerly had to be provided in institutions.

There was a growing awareness that the demographics of Ontario were changing. In 1980, 10% of Ontario was over the age of 65. This proportion was predicted then to double by the year 2021. Of more concern was the growth of the frail elderly, a high proportion of whom were single women. Between 1970 and 1980, although the elderly population increased by 34%, government spending on services for this age group increased by 600%. However, the dramatic increase in utilization of services was more a reflection of the newness of most of the programs. By 2001, it was estimated that the number of elderly between the ages of 65 and 74 would increase by about 38%, the number between 75 and 84 by 75%, and the number over age 85 by 110%. The major impact of the demographic change was expected to be felt in health and social services.[15] Because of the dramatic increase in utilization of acute health care by the frail elderly, the development of lower cost alternatives was seen as crucial. While income support for the elderly was viewed as an important concern, the fact that the federal government had the largest responsibility in this area, made it a less pressing issue for the province. In addition, over the decade the income of the elderly had increased by approximately 20%, and approximately 86% lived independently in the community, two-thirds of these in their own homes, most, of which were mortgage free.[16]

The fear of cost escalation was not unwarranted. In the last two decades home care expenditures in Canada have grown at an average annual rate of 21.3% and were predicted to reach almost $3.0 billion in 1998. This growth in spending is almost double the average annual rate of growth in other health expenditures and more than triple the inflation rate. In Ontario, government funding for home care grew from $132.6 million in 1984-85 to an estimated $1,040.0 million in 1998-99, representing a 668% increase.[17] By 2003, it is anticipated that the number of home-based clients will grow by approximately 50% to almost 1 million or 9% of the population of Ontario. [18] At the same time that demand has escalated, the federal government began a systematic withdrawal of funding from Established Programs Financing and the Canada Assistance Plan shifting the cost of these cuts to the provincial governments.

Unlike the Homemakers and Nurses Service Program and the provincial ministry under which it resided, the culture of both the acute and chronic home care programs, as well as the MOH which administered it, was based on a medical model: medical gatekeepers, prescriptive and

paternalistic. The home support services funded by the Ministry of Community and Social Services had very much a community-oriented focus, grass-roots origin, and social welfare orientation. One-off service programs were subsidized by governments rather than fully funded, and run by not-for-profit and commercial agencies. Many of these organizations relied on a battery of volunteers to deliver the services. Eligibility for services was less stringent than those required by the home care programs and did not depend on the decision of a physician, but was not universal. Unlike the home care programs, consumers were charged a co-payment which was means tested. Home care, based on physician referrals was viewed more as a medical necessity and therefore, as a public good, while the state's role in home support was an enabling role to community organizations for the provision of a minimal level of service for clients.

The proliferation of one-off service programs without any efforts at coordination and integration and the split in jurisdictional responsibility between MOH and MCSS made this "system" extremely difficult to access and navigate. As both sets of programs grew, more and more they were serving the same clients, however, with different eligibility criteria, funding mixes and requirements. These factors, along with geographic inequities in program availability across the province, resulted in unnecessary institutionalization or underservicing.

As early as 1974, provincial advisory groups were calling for the introduction of a comprehensive Home Care Program that combined the traditional home care services under MOH and the home support services under MCSS. The total package would include medical assistance, visiting nursing care, rehabilitation therapies, homemakers, home help, eye care, home maintenance, attendant services, transportation, housing subsidies, recreation and education, meals-on-wheels, home aids, friendly visiting, day care and telephone-dial-a-friend. They recommended uniform standards, integrated funding, and a re-orientation to the concept of total delivery of care and all that it implies.[19]

The Progressive Conservative Government's Task Force on Aging in 1981 recognized the future challenges due to the aging population for the province, but felt there was still time to plan for the future. They made a number of recommendations, which reflected a conservative communitarian approach: namely, "to continue to encourage the use of personal, family and community resources to meet the challenge of aging, ... and to respond selectively to future needs of the elderly in recognition of the improved situation of the 'average' elderly, and the shifting character of the 'future' elderly."[20]

Following the 1985 election the Peterson Liberals formed a minority government, ending forty years of Tory rule. They inherited a "system" of community-based Long Term Care from the Conservatives that was split between the MOH and the MCSS. Although the Conservative

government prior to 1985 began looking at LTC services, it was not until the Peterson Liberal government that reform began in earnest.

None of the three provincial governments (Liberal, NDP, and Progressive Conservative) which have held office since that time disputed the need for change, just as all stakeholders appear to have agreed that home care was a priority for reform. Nonetheless, each government found it difficult to develop and implement a policy which did not spark intense debate and which was not immediately reversed by the next government.

1.5 Thesis Outline

The thesis will be broken down into the following remaining eight chapters.

- Chapter 2 provides a description of the theoretical framework that informs this research and a review of related research.
- Chapter 3 outlines the methods employed in the conduct of this research, the data collected, and the analytic tools employed.
- Chapter 4 provides a description and analysis of ideas, interests and institutions during the development of the One-Stop Shopping and Service Access Organization models by the two Liberal governments between 1985 and 1990.
- Chapter 5, using the three constructs, details the development of the Service Coordination Agency model and the events leading up to the development of the Multi-Service Agency model by the NDP government between 1990 and 1993.
- Chapter 6 provides an analysis of the development of and reaction to the MSA model between 1994 and 1995.
- Chapter 7 provides an analysis of the first six months of the Progressive Conservative government in 1995 during which the Community Care Access Centre model was developed.
- Chapter 8 provides an overall analysis of the design decisions inherent in the five models along a public-private continuum for the financing and delivery dimensions and between centrally planned and market allocation mechanisms. In addition, the chapter provides some insight into the implications of the reform for the future of the Canadian health care system.
- Chapter 9 provides a summary analysis of the relative influence of ideas, interests, and institutions in this policy sector over the eleven-year period, and the implications of this research in advancing theory.

In conclusion, LTC reform in Ontario between 1985 and 1996 provides two important insights. Analysis of these reforms adds to the literature on the necessity of ideas, interests and institutions, their interaction and relative influence in understanding policy development.

Furthermore, analysis of the reform models demonstrates the shifting mix of public and private responsibilities, and has implications beyond this sector to the future of health care in Canada.

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[18] Health Services Restructuring Commission, Ontario. 1997. *A Vision of Ontario's Health Services System.* January.
[19] Ontario Advisory Council on Senior Citizens, *Annual Report of the Ontario Advisory Council on Senior Citizens.* 1974/75.
[20] Task Force on Aging,1981. *ibid.*, p.4.

Chapter 2

Theoretical Framework

This chapter will outline the theoretical framework and background literature that informs the analysis in the thesis. To begin with, the chapter will address the schema that will be employed for an examination of the first research question:

1. *Policy Content*: How did the design decisions of financing, delivery, and allocation differ across the following models: One-Stop Shopping, Service Access Organizations, Service Coordination Agencies, Multi-Service Agencies, and Community Care Access Centres; and what were/are the implications of these differences from a public policy perspective?

A summary of the literature on the merits of state versus market provision of social services will be outlined. This synopsis is provided as a backdrop for the examination of the decisions that the Ontario provincial governments made in designing their LTC reform models. In analyzing and evaluating these policies, it will be necessary to separate out the three dimensions of public policy, namely, financing, delivery and allocation. In this thesis each of these dimensions will be evaluated against the policy goals of security, equity, liberty and efficiency as formulated by Deborah Stone.[1]

The chapter will then go on to set out the theoretical framework for the analysis underpinning the second research question:

2. *Policy Process*: How do ideas, interests, and institutions, their interactions and relative influence account for the development of the five LTC models across the Liberal, NDP period, and Progressive Conservative governments?

After a review of the theoretical literature, the thesis will adopt the neo-institutional approach that argues the necessity of considering the role and influence of ideas, interests and institutions in understanding policy. Furthermore, the thesis will argue that, rather than being simply an arbiter of societal interests, understanding the state's role, its interests and ideology is crucial to the analysis.

2.1 Public/Private/Privatization

To understand the policy decisions available to and taken by the provincial governments, it is necessary to summarize the arguments justifying the role of the state versus the private sector in the provision of goods and services, what is meant by 'public' and 'private', and how do we discern shifts in directions from public to private.

A number of justifications have been offered for the intervention of governments, and the superiority of state or collective provision over private market provisions of goods and services.[2,3] The first rationale is that of public or collective goods. The benefits of these types of goods cannot be rationed and are susceptible to the "free-rider" problem - the refusal by rational individuals to pay for such goods while benefits are guaranteed. The resolution is for governments to compel the provision

and financing of such goods and services. A second rationale for government provision is externalities - even in the case of private goods, there are often positive or negative consequences as a result of their consumption. Governments intervene in such instances to ensure standards are met in the provision of such services or goods. A third rationale is that of market failure. Governments can improve efficiency by becoming monopoly providers or by regulating private monopolies. The provision of order, a fourth rationale, is ensured by the state's monopoly of force and its sovereign authority. Lastly, the promotion of social justice through government redistribution is often cited to correct unjust or unfair market outcomes.

On the other hand, the questioning of government's capacity in social welfare provision is linked to calls for deficit/debt reductions and arguments of efficiency. Distrust and loss of faith in the public sector, both in terms of motives and competence seems to be increasing.[4] Critics of government provision advocate the introduction of more market-like mechanisms in public services - such mechanisms as consumer choice, competition, and performance measurements based as much as possible on profit considerations. Calls for greater privatization and minimal public provision are other suggestions.[5] [6] [7] The guiding beacon for social policy reform is no longer "market failure" but "government failure."[8]

As a countermovement to the growth of government, privatization emerges as the most serious conservative effort to pose an alternative. Most notable efforts have occurred in New Zealand, Australia, Britain, and the United States.[9] According to Kamerman and Kahn,[10] the pro-privatization case argues that the private sector results in greater efficiency, responsiveness to clients, scope for innovation and specialization, and improved management. Despite the popularity of the movement, precision in the definitions of public and private is lacking.

Paul Starr,[11] in his essay on the meanings of privatization, states that public and private are usually paired to describe a number of related oppositions in our thought - public is to private as open is to closed, or as the whole is to the part. Public often can mean governmental or official. Private often characterizes what lies beyond the state's boundaries; that is, in the market or in the family. Saltman[12] states that "public" can refer to branches of government or to semi-autonomous agencies, which are publicly capitalized but autonomously managed and accountable to public officials for long-term outcomes. On the other hand, "private" is less precise, sometimes, but not always, including not-for-profit organizations with commercial ones which may range from small owner-operated firms to large stock-issuing corporations. The distinction between for-profit and not-for-profit is also less precise; sometimes being separated by whether an excess of revenues to expenditures is called "profit" or "surplus." One has to look not only at the ownership structure but also at the framework of incentives that determine the behaviour of these institutions. Deber et al. [13]

in their definition of public and private divide public into four levels of government (nation, province/state, region, and local), and private into five sectors (corporate for-profit, small business/ entrepreneurial, charitable/non-profit run by paid employees, charitable/non-profit run by volunteers, and family/personal).

Privatization generally means the withdrawal from variously conceived public spheres: a shift of individual involvement from the whole to the part; an appropriation by an individual or a group of some good formerly available to all; or a withdrawal from the state of assets and functions. Public policy is concerned with privatization at the latter level.

Starr cautions that public and private do not have consistent meanings in different institutional settings and that it is risky to generalize about the merits of privatization as public policy beyond a particular institutional or national context. As a result, he argues that privatization reflects a direction of change and does not denote a specific origin or destination. Critical to this change is movement from open to closed (as in access to information) or from the whole to the part (particularly in the distribution of benefits).

There are four types of government policies that can bring about a public/private shift:

1. the cessation of public programs and the disengagement of government from specific kinds of responsibilities (implicit privatization), or the restriction of publicly produced services in volume, availability, or quality, leading to a shift by consumers toward privately produced and purchased substitutions (privatization by attrition);
2. the transfer of public assets to private ownership;
3. the financing of private service (contracting out or vouchers) instead of direct government service production; and
4. the deregulation of entry by private firms into activities that were previously treated as public monopoly.

Bendick [14] defines privatization as a shift of some or all roles in producing a good or service that was publicly produced into nongovernmental hands. He differentiates between "governmental load-shedding" and the "empowerment of mediating institutions." For Bendick, load-shedding refers to arrangements where both the means of financing and the means of delivery are divorced from government; for example, budget reductions, the introduction of user fees, or increased use of volunteers. The empowerment of mediating institutions involves arrangements where government delegates production and delivery of services while retaining some or all responsibility for financing; for example, the use of vouchers, contracting out services, or public/private partnerships. Many of the policies of both the Thatcher and Reagan governments were examples of load-shedding.

The normative theories justifying privatization as a possible direction for public policy emanate from different visions of a good society. Laissez-faire individualism which accepts inequality in resources as natural and free market economics that promises greater efficiency, a smaller government and more individual choice are most influential. Another vision is grounded in a return of power to communities through a greater reliance on families, churches, and non-profit institutions for social provision. Another view sees privatization as a political strategy for diverting demands away from the state, thereby reducing government overload. Starr argues that some advocates of privatization draw on all three.[15]

Saltman[16] cautions that we not confuse privatization and competition. While privatization refers to the private ownership of capital resources and the private objective for which these resources are deployed, competition is a particular methodology for aliocating resources. Competition uses a variety of mechanisms (consumer choice, open bidding, negotiated contracts, etc.) to compare the performance of multiple players. As monopolies can exist with private ownership, competition can exist within public ownership and administration. The concept of competition will be discussed later under the allocation dimension.

LTC reform illustrates the attempts by government to shift both the financing and delivery of services along this public-private continuum. As will be documented in later chapters, the NDP shifted delivery away from for-profit provision. This was later reversed by the Harris Conservative government. In financing all three governments either intended or did put in structures that have the potential to increase the private component of LTC funding. It will be argued that this act has broader implications for health care in general.

2.2 Design Decisions: Financing, Delivery and Allocation

In examining public/private shifts in policy and their implications, Deber et al.[17] argue that clarity is gained if we differentiate the dimensions of financing, allocation, and delivery. A review of the research and analysis of private versus public financing and delivery of health services and different allocation mechanisms will provide a context for evaluating the design decisions made by the provincial governments in LTC reform. This review will highlight the range of options available to the provincial government when they turned their attention to reforming this sector.

2.2.1 Financing

A number of participants may be involved in the financing of health and social services. The public sector can take responsibility for funding some services, or some portion of the population. Private sources of funding can come from private insurance, out of pocket spending, or charitable giving. In reviewing financing of health care internationally, evidence indicates that the public share in total health care financing, on average, has increased from about 60% in 1960 to 80% at the

beginning of the 1980s.[18] Many publicly funded systems not only include hospital and physician services, as in Canada, but also drugs, dental care and long term care services. Poullier found that public financing was generally higher in hospitals and other institutional care than in ambulatory care and medical goods.

The argument for public financing is based on the evidence that single payer systems tend to have lower costs than public-private systems as in the United States.[19] [20] [21] Mixed funding sources give rise to two policy problems: first, cost control measures can be achieved through cost shifting, that is, moving costs from government to the private sector, or from one level of government to another rather than through actual efficiencies, and second, monopsony bargaining power over providers is harder to achieve with multiple players.[22]

Despite the evidence of the merits of public financing of health care and its increasing use, there are continued attempts to introduce increased private funding of health care through the use of user fees or co-payments, as a solution to increase revenues and reduce costs to the public system, and to prevent abuse of the system. Robert Evans[23] [24] refers to these attempts as "zombies", ideas that are intellectually dead, but nevertheless keep returning from the grave. Evidence shows that user fees will generate more revenue for providers, will increase not decrease the total cost of health care, and will redistribute the benefits to the healthy and wealthy, and the costs to the sick and the poor. [25] [26] Similarly, arguments for private health insurance, like those for user fees, are shown to be less efficacious. [27]

In redesigning the financing side of the LTC system, governments were dealing not only with health services, but also social support services, most of which are traditionally not considered to be part of government's responsibility; such as, housekeeping, and the provision of meals. Government intervention in these areas has traditionally been based on financial need. However, governments have had to untangle the effects of these social needs on health to the extent that their lack of provision contributed to deterioration in health of the client. With respect to traditional professional health services, provincial policy at the time fully funded them, but there was no legal requirement to do so. As a result, governments were free to privatize them. In other LTC services, there was already an ongoing practice of charging user fees.

With developments in technology and pharmaceuticals, more and more acute care provided by physicians or in hospitals was now being performed in the community. In 1995/96, it was estimated that 46% of Home Care cases was for acute home care.[28] As a result, publicly funded care was being shifted to a sector of care, which no longer fell under the protection of the *CHA* and, therefore, was no longer mandated to be publicly insured. Reform of LTC services therefore has wider implications for the future of Canadian health care.

In redesigning the financing dimension of community-based LTC, governments, although aware of the research evidence supporting public financing, were also conscious of the rising demand in care, decreasing fiscal transfers from the federal government, rising provincial debts and deficits, and the need to control and cut costs. These factors would play a part in the shifts in the public/private mix.

The design question considered in the financing dimension is how services will be financed. Financing-related "design decisions" include:

- Scope of the public dimension - what services should be publicly financed. As will be seen, there has been less disagreement about whether to fund professional and personal support services than about whether to fund community support services. Whether social supports are the responsibility of the individual or the state, whether social supports were crucial to a broader definition of health that emphasized prevention were questions considered.
- Who should be covered for these services? Possibilities included various combinations of the well elderly, the frail elderly, people with disabilities (adults and children), and those discharged from acute care hospitals. While reform began as system for providing services for seniors, it was expanded to include people with disabilities, and by the mid- to late- 1990s became more and more a substitute for acute care.
- Universality of funding; i.e., should publicly funded services be available to all, or should public funding be based on income or ability to pay? As LTC came to include more services formerly covered by the *CHA*, this issue took on special meaning.
- For what services should user charges be applied, and on what basis?
- Should budgets be capped? This question is linked to the issue of universality and whether services are considered an entitlement.

2.2.2 Delivery

The delivery dimension considers who should provide the service. Possibilities include the public sector, that is, the state, or the private sector, either not-for-profit or for-profit providers. Decisions on the appropriateness of each sector had to do with the relative efficiencies of each and from a consumer perspective, the amount of choice available.

In recent years, there has been considerable discussion in the public media and in academic research on the privatization of publicly delivered services to commercial providers. Some studies claim that the private sector is more efficient in production than the public sector. Profit motives, competition and incentives are deemed responsible for the difference. However, many of these works can be criticized on the grounds that similar goals and services were not being compared in the public and private sectors. Martin Knapp [29]compared the relative efficiency of public, voluntary, and private

producers in the provision of residential childcare in the U.K. In Britain, this service is publicly financed but may be publicly or privately provided (i.e., contracted out from the public sector). After controlling for technologies of care and characteristics of clients, the tentative conclusion drawn was that in the privatization of production the private and voluntary sector are more cost effective than the public sector. However, the study was not able to take into account the final output, particularly the long-term effects of care on children and their families. Tax concessions, low wages, long hours, and charitable giving are possible reasons for cheaper care in the private and voluntary sector.

Judge[30] compared private sector provision of residential care for the frail elderly to public provision in England and Wales. His tentative conclusion was that private provision is good value for money. Bendick[31] examined the efficacy of the privatization of publicly delivered services within a framework of public financing. He concluded that for-profit privatization tends to be more efficient in services where goals are measurable, easily monitored and evaluated, for example, garbage collection. Where problems are complex such as health and social welfare programs, and processes not well-understood, he argued that the for-profit sector does no better or worse than the public sector. As an alternative strategy, he recommended the privatizing of programs with complex goals to the non-profit sector over the for-profit sector, which he refers to as the empowerment of mediating institutions. Evidence indicates that non-profit deliverers have a better record in providing services in the interest of clients beyond what is precisely specified in contracts. Bendick also argued that the empowering of mediating institutions would draw service providers into the political constituency that advances and defends public programs.

Woolhandler and Himmelstein, in a comparison of all acute care hospitals, both for-profit and not-for-profit, in the United States, found that for-profit hospitals were 25% per case more expensive than not-for-profit facilities. More than half of this difference was due to higher administrative charges in commercial facilities.[32] These same researchers in another study found that quality of services was rated lower in for-profit HMOs over their not-for-profit counterparts.[33] Others have found that death rates and post-operative complications are lower in not-for-profit hospitals.[34] Even with services and programs for which goals and costs are easily monitored and evaluated, savings from for-profit delivery have not materialized. By March 31, 1999, under the alternative service delivery strategy, the Ontario Ministry of Transportation had entered into a number of contracts with the private sector to provide road maintenance services for approximately 6,800 kilometers or 30% of the provincial road system. The Ontario Auditor in his 1999 Report[35] found that the Ministry had not achieved the target savings of 5% on the four outsourcing contracts reviewed, which covered about 20% of the province's highway system. In health care and social support services where services are

harder to predict, monitor, and evaluate, it is difficult to argue for the delivery of many of these services by commercial agencies.

As stated, the design issue considered in this dimension is who should deliver the services? In health care in general and in LTC in particular, delivery is not so much a distinction between public and private as it is between not-for-profit and for-profit. In the acute sector, most hospital services are not-for-profit, and most practicising physicians are considered individual entrepreneurs. The *Canada Health Act* does not specifically prohibit the commercial delivery of services. However, many would argue that for-profit delivery of acute care services goes against at least the spirit of the *Act*. With LTC services, even the spirit of the *CHA* did not apply. As a result, governments had considerable latitude in the redesign of the sector. Delivery options included: the public sector, where workers would be government employees; the not-for-profit private sector using paid workers (e.g., Ontario public hospitals); the not-for-profit sector relying on volunteers (e.g., most agencies delivering Meals on Wheels); individuals and their families; and/or the for-profit private sector (e.g., many homemaking agencies). As the above indicates, one key issue in this design decision is the determination of the appropriate balance among paid workers, volunteers, and "informal care givers" (families and friends). In Ontario, another issue that surfaced in the reforms was the extent to which governments encouraged the unionization of the sector and promoted the rights of unionized workers over their non-unionized counterparts.

In redesigning the delivery side of the sector, governments, therefore, had the option of leaving the status quo which was largely not-for-profit providers with some for-profit groups in the homemaking services; shifting the not-for-profit/for-profit balance of providers to one or the other end of the continuum; or assuming responsibility for some or all services.

2.2.3 Allocation

Allocation refers to the method/mechanism by which finances are flowed to providers who may be individuals or organizations. Allocation includes resource allocation (how a resource envelope is determined and the mechanism for transferring funds to providers) and reimbursement (the formula for determining how much is to be paid to a provider for a service).[36] None of the models with the exception of the CCACs reached the stage of micro-allocation decisions concerning formulae for reimbursements of services. As a result, this aspect of allocation will not be considered.

Most models of health care contain a number of components between the funders of the system to the care deliverers. These can include third party payers (government, private insurers) as well as intermediary provider organizations. Allocation is not so much a public/private issue as it is one of control of finances and incentives for reimbursement. While it is not a public/private issue, certain forms of allocation lend themselves better to particular forms of financing and delivery.[37]

Hollander et al.[38] distinguish between partnership models and market models of funding services. In the former, government takes a more flexible approach in the development, negotiation and administration of contracts. They are more concerned about the stability of the industry and more cautious about experimenting with different service delivery approaches. Providers of care because they are not in direct competition with each other, are more cooperative, exchanging 'best practices'. Market models, on the other hand, develop criteria for measuring efficiency and effectiveness, have a specified format for negotiating and administering contracts usually based on cost and price, encourage experimentation in delivering services, and competition among a pool of providers.

With publicly financed services, Saltman and Von Otter[39] describe allocation mechanisms as lying along a continuum from centrally planned models (associated with command and control models) to pure market models. See Figure 1.1.

Client follows money			*Money follows client*	
centrally planned models	adaptive planning or regionally planned models	managed competition	public competition	market

Figure 2.1: Allocation Models for Publicly-Financed Services

Market allocation models are not to be confused with market-based financing since the allocation mechanisms being discussed here are for *publicly* financed services. Another distinction that can be made about allocation methods is whether the client follows the money or the money follows the client. At the centrally planned end, clients follow the money, that is, the planner decides where services will be provided, a global budget is allocated to the particular provider organization, and the client goes to that organization for service. Choice of provider for the patient is considerably reduced. The British National Health Service represents a model closer to the planned end. In market allocation models, money follows the client, that is, the client chooses the provider and the provider is reimbursed for services provided to that client. An example of this type is fee-for-service reimbursement of physicians in Ontario where the physician's income is largely determined by the number of patient visits and patients choose their physician. The models in between attempt to create a compromise between central planning and markets.

During the 1980s and 1990s there was considerable experimentation on allocation mechanisms within publicly financed health systems in the U.S., Britain and Europe. In their work on the publicly operated health systems of northern Europe, Saltman and Von Otter[40 41] developed a conceptual framework of "planned markets" as an option that could strongly influence reform efforts in such systems. The authors suggest that structural problems with the "command-and-control" public

delivery model were at the root of the search for alternative models. Pressures to constrain spending, for publicly operated systems to be more responsive to patient concerns, and for more employee participation in decision making have forced these countries to experiment with new organizational frameworks that rely more upon market mechanisms.

The other distinction in allocation mechanisms is the purchaser/provider split. As Hollander et al.[42] indicate a purchaser/provider split can technically only occur in one of two circumstances: 1) the client is the sole purchaser of services (there are no third party payers such as governments or insurance companies; and 2) the client has delegated his/her decision to a purchasing agent (e.g., government or private insurer) on where to receive services. In the first condition, clients are threatened by catastrophic risk. In the second condition client choice is diminished. It is argued that splitting the purchaser function from that of the provision of care can increase efficiency and removes conflicts of interests inherent in situations where the functions are combined.

With publicly financed services governments can either flow funds directly to their own employees (e.g., Ontario psychiatric hospitals); to individual private service delivers (e.g., most Canadian physicians); to private for-profit or not-for-profit provider organizations (e.g., most Ontario hospitals or nursing homes); through a mediating agency such as Ontario Home Care Programs; or to individuals who purchase their own services. There is no purchaser/provider split in the first instance, Ontario psychiatric hospitals. The funders and deliverers of services are part of the same organization. In the other four instances there is a purchaser/provider split in that the purchasing function is undertaken by government but the delivery of care is provided by non-governmental employees. With mediating agencies, there is an additional purchaser/provider split if the agency then purchases services external to the organization.

In LTC reform in Ontario, recommended allocation mechanisms swung from one end of the continuum to the other. Allocation methods varied from a very informal brokerage model close to the planned end of the continuum, to a much more centrally planned model, and then to a managed competition model closer to the market end of the continuum. All three governments also introduced pilot projects for people with disabilities to be able to purchase their own services directly.

In Chapters 4 to 7 the decisions regarding the financing, delivery and allocation of community-based LTC services for each of the five models introduced by the provincial governments and will be analyzed. Chapter 8 will provide a summary analysis and the implications that each design decision and each model had for the various interests and for health care in general. The design decisions will be analyzed using the criteria of security, equity, liberty and efficiency as proposed by Deborah Stone (see below under 2.3.1(ii) Dominant Ideas).

2.3 Framework for Understanding

Question #2 seeks to understand the forces that shaped the five different models. What were the influences that led to the development of the brokerage type models of both the Liberal and NDP governments? At a time when western governments were under pressure to downsize and to introduce more market forces into their programs, what factors can account for the NDP governments dramatic shift from a brokerage model to a more centrally planned, command and control model with a quasi-public delivery of care? Finally, what were the forces that led to the reversal of direction to the market-driven Progressive Conservative model?

Researchers have suggested a number of different frameworks in which to understand and analyze public policy.[43] [44] [45] For Doern and Phidd, the consideration of ideas, structure and process can provide an understanding of policy development. Simeon outlines five factors that influence public policy: the environment, ideas, the distribution of power, institutions, and process. Depending on the policy area, according to Simeon, some factors will be more dominant than others, and none alone provides a full understanding. Similarly, Manzer refers to the effect of political ideas, the distribution of power among participants, the organization of political interests, the structure of institutional constraints, and the influence of the socio-economic environment. The inter-relationship of factors as well as their independent contributions are important to understanding policy.

Borrowing from these frameworks, this research proposal adopts a neo-institutional approach and examines both the independent and interactive influence of ideas, institutions, and political interests on Long Term Care Reform in the Liberal, NDP and Progressive Conservative periods. Within a neo-institutional framework, the research also adopts the approach developed by Coleman and Skogstad of policy communities and networks.

Ideas, institutions, and interests are at times conceptually difficult to untwine. What follows is an attempt to define and distinguish them.

2.3.1 Ideas

Doern and Phidd[46] define ideas as "the desired end states, the sense of public purposefulness, that individuals and groups seek to obtain through state action, often through preventing the state from acting" [47] They distinguish between four levels of ideas: ideologies, dominant ideas, paradigms, and objectives.

Manzer[48] states that public policies are made within frameworks of political ideas that structure thinking about what constitutes a public problem, what means are available to deal with it, and what evaluations are made retrospectively. This definition is part of understanding ideas as policy determinants, not simply used strategically but instrumentally to understand problems and actions. He goes on to argue that political ideas can be examined as determinants of policies or as meanings of

policy. As determinants, ideas are used strategically to mobilize, persuade and manipulate other interests in support of one's own. As such, ideas are instruments of political power. Manzer argues that the understanding of participants' political ideas helps explain their actions in a particular policy debate.

Simeon[49] also argues that ideas are very closely linked to power and must be linked to the group whose interests they promote. Schattschneider[50] sees the root of all politics as conflict. Every change in the scope of the conflict creates bias and cleavages, and changes the nature of the conflict. As a result, the definition of alternatives is viewed by him as the supreme instrument of power. The way in which a policy problem is framed will determine who gets involved, the degree of conflict, and the possible solutions.

Stone[51] sees ideas as a medium of exchange and a mode of influence, ideas as object and as subject. Shared meanings motivate people into action and coalesce individual desires into collective action. However, information is interpretive, incomplete, unequally available and strategically withheld. Because politics is driven by how people interpret information, much activity is spent on controlling interpretations. She views policy making as a constant struggle over the criteria for classification, the boundaries of categories, and the definition of ideals that guide the way people behave. Boundaries are constantly contested either because they are ambiguous or because the positioning of boundaries differentially allocate benefits and costs.

Public policy is usually about the distribution of concentrated or diffuse benefits and costs. The distribution of costs and benefits of any program, whether they fall in a concentrated or diffused way, influences the type of political contest that follows. As a result, participants strategically represent programs as contests between different types of costs and benefits. The description of the problem one way or the other mobilizes different groups into actions. In these ways, ideas have a direct influence on political interests as well as on institutional arrangements.

In examining the ideas and their influence in policy formation, this research makes use of ideologies, dominant ideas and paradigms.

(i) Ideologies

Ideologies are "explicit, detailed, and politically focused ideas, which explain the political world, provide a framework for interpreting particular events, and offer a recommendation and prescriptions for future action."[52] In his study of educational policy, Manzer[53] distinguishes among three ideological traditions in Canada: liberalism, and conservative and radical communitarianism. In liberalism, the focus is on the individual and the efficiency of the market. The role of the state should be minimal and limited to facilitate fairness in competition and allow for individuals to achieve their potential. Emphasis is on the fairness of process even if it results in unequal results.

In contrast, Manzer sees communitarian ideologies as centred on communities and humans as social beings. The difference between conservative and radical communitarianism lies in their view of the political community. In the former, the community is a hierarchical order in which individuals are unequal governed by obedience to a legitimate authority. In the latter, the community is composed of equal individuals governed by cooperation and consensus.

In Canada, the distinctions across traditional political ideologies have been less clear as parties adopt aspects of each other's ideologies. As a result, Deber argues that in the health sector, it is more helpful to speak of reforms from the right versus reforms from the left.[54] Although there may be overlap in these concepts and in reality these concepts more closely represent the end points of a continuum, it is helpful to look at the overall cluster of ideas distinguishing the two positions.

Reform from the left within the health sector would include the following collection of ideas and beliefs: a belief in public administration and production to ensure social goals of equity; the need for a redistribution of goods and services by the state; universal coverage of programs; entitlement as a right to services; security as a motivating force; and a shift to healthy public policy (specific public policy initiatives which are required to improve the health of residents and which are beyond the traditional jurisdiction of the formal health care system).

Reform from the right would include: a diminished belief in the capacity and ability of the state to perform certain functions; a need to limit the responsibilities of the state and reduce spending; the importance of individual liberty; the reduction of coverage of necessary services to a minimum; a greater belief and reliance on the private and informal (families) sector in the financing and provision of care; targeting of social programs based on need and ability to pay; the debilitating impact of the welfare state on individual initiative; the importance of need as a motivating force; and the continued belief in the medical model of care.

As will be documented in the later chapters, the second LTC model (MSA) legislated by the NDP government is a prime example of 'reform from the left'; while the model (CCAC) introduced by the Harris Conservatives represents 'reform from the right.' The two Liberal models (One-stop Shop and SAO) and the first NDP model (SCA) lie in between.

(ii) Dominant Ideas

Dominant ideas, according to Doern and Phidd,[55] are a second order construct that provides shape to a particular policy issue. They are derived from broader ideologies and often conceptually difficult to separate from ideologies. Although the same dominant ideas tend to be used in public policy debates, the interpretation or spin put on the idea depends on wider beliefs and interests of the participants. Some of the dominant ideas that underlie public policies are equity (sometimes viewed

as justice = equity or fairness in the distribution of public benefits and burdens[56]) security, liberty (often synonymous with choice or freedom from state interference), efficiency, and effectiveness.

Stone[57] sees equity involving distributions, which are regarded as fair even though they may contain both equalities and inequalities. Distributions are at the heart of most public policy debates, especially those involving the goal of equity. In any distribution there are three possible dimensions: the recipient (who is included and excluded in the distribution); the item being distributed (definition of the boundaries and the value of the item being distributed); and the process for making the distribution (fairness with which the item is being distributed). In LTC policy, financing decisions often deal with equity issues, that is, the scope of services, who is eligible for service, and the determination of user fees.

Liberty embraces various notions ranging from economic freedom, to freedom of expression. Liberty is usually seen as an attribute of individuals, not of social groups. Restriction of individual action is usually justified by a reduction of harm to others. However, to define a simple criterion of harm that tells what activities are or should be forbidden is problematic because liberty, according to Stone is constructed in political life. She sees it as a matter of cultural history and political choice as to what kinds of harms are privileged and which are punished. From the consumer's perspective, liberty often refers to the freedom to choose a service or service provider. From a provider's perspective, liberty often refers to autonomy and freedom from government regulation. In LTC reform, the allocation method chosen had different implications for consumer choice, while delivery decisions had ramifications for provider viability.

The idea of security usually refers to the satisfaction of needs. It often involves conflicts over the kinds of security government should provide, the kinds of needs it should meet, and the way in which burdens making security a collective responsibility should be distributed. The idea that security can be reduced to objective and countable needs is politically problematic. The definition of security, like other policy goals, is an exercise in political claims-making. In LTC, financing decisions that dealt with service availability and quality, as well as the amount and determination of user fees were security issues from a consumer perspective. Delivery and allocation decisions had security implications for workers (job security, compensation and working conditions) and for providers (viability).

Efficiency, for Stone, is a comparative idea. It has come to mean the ratio between input and output, efforts and results, expenditure and revenue, or cost and benefit. Efficiency is always a contestable concept, and the measures used in any analysis of efficiency can also be viewed as political claims. As Stone points out, one person's efficiency can be seen as another person's waste. By offering different assumptions, sides in a conflict can portray their preferred outcomes as being

most efficient. According to Stone, conflicts over efficiency arise over three questions: who gets the benefits and who bears the burdens of a policy; how should we measure the benefits and costs of a policy; and what mode of organizing activity is likely to yield the most efficient results? As Manzer[58] argues "concepts of efficiency and effectiveness are embedded in politically contested concepts of public purpose, norms of legitimacy and justice, and theories of policy intervention." The evaluation of efficiency or effectiveness of public policies is part of the ideological context. In LTC reform efficiency permeated the debate of all three design decisions: the efficiency of public funding versus mixed financing models, the efficiency of for-profit versus not-for-profit provision, the efficiency of competition versus cooperation.

Ideas rarely stand alone but often conflict. Equality and efficiency are often thought to be in a zero-sum relationship. Equality, it is claimed, eliminates the differential rewards necessary to motivate people to be productive, or interferes with individual choices curbing experimentation and innovation, or is not productive because it requires a large administrative machinery to maintain. Security and liberty often conflict in that the redistribution of benefits to increase the security of disadvantaged individuals usually result in the infringement of the ability of more affluent individuals to dispose of their assets as they choose, as well as adversely affecting efficiency by removing the motivating force of need. In the reform of the LTC sector, there were many trade-offs as will be argued in Chapter 8.

(iii) Paradigms

"In technically complex fields of policy, ... decision-makers are often guided by an overarching set of ideas that specify how the problems facing them are to be perceived, which goals might be attained through policy and what sorts of techniques can be used to reach those goals. Ideas about each of these matters interlock to form a relatively coherent whole that might be described as a policy paradigm. Like a gestalt, it structures the very way in which policy-makers see the world and their role in it." [59] Paradigms act as prisms through which certain policy options pass easily while others do not. Shifts in policy paradigms often account for policy innovation.

In the LTC sector in Ontario, two policy paradigms were in evidence: 1) the medical model and 2) a broader determinants of health model. The medical model[60] favours the primacy of the physician, is reactive, focuses on cure as opposed to health promotion and disease prevention, centres on the individual rather than whole populations, and views health narrowly as an absence of disease rather than a state of complete physical, mental and social well-being (definition of the World Health Organization).

The broader determinants of health was informed and developed over the years by a number of national and international reports. It sees the scope of health and health care as being broader than

illness/disease and physician/hospital care. The 1974 publication of the internationally acclaimed Lalonde report, *A New Perspective on the Health of Canadians*[61], represented an important milestone in the evolving concept of health. This document outlined the Health Field Concept, which emphasizes that health is influenced by four areas, namely, lifestyle, human biology, environment, and the organization of health care. Later, the Ontario Premier's Council on Health adopted the World Health Organization's (WHO) definition of health, "Health is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is therefore seen as a resource for every day life, not the objective of living; it is a positive concept emphasizing social and personal resources, as well as physical activity."

This broader approach further focuses on health promotion and disease prevention rather than cure, where health promotion has been defined as "the process of enabling people to increase control over, and to improve their health". At the World Health Assembly in 1977, WHO resolved that "the main social target of governments and WHO in the coming decades should be the attainment by all citizens of the World by the year 2000 a level of health that will permit them to lead a socially and economically productive life". The endorsement of this resolution and the subsequent birth of the Health For All by the Year 2000 movement (HFA 2000) were significant developments for health promotion. In 1978, at an International Health Conference on Primary Health Care (PHC) in Alma Ata, USSR, a declaration was made stating that the Health for All goal was to be attained through PHC.[62] The major features of PHC were defined as health education, health promotion, community participation and inter-sectoral cooperation.

LTC reform took place in an environment that was informed by the above national and international events and reports. Much of the efforts in LTC reform had to do with realigning the sector away from a medical model to a broader determinants of health approach. The research will examine the use of ideology, dominant ideas, and paradigms as a way of framing issues to influence who gets involved in or stays out of the debate, who forms alliances, how interests are represented, why certain institutions are established, and in understanding the policy outcome, itself.

2.3.2 Institutions

Ideas in a policy debate do not bounce around in a vacuum, but are distilled and interpreted through institutions. Neo-institutionalism states that institutions, their structural characteristics, formal rules, and informal norms, play a central role in shaping the actions both of individuals and of the organizations to which they belong.[63] [64] With a neo-institutional approach state agencies act on their own preferences rather than simply responding to and mediating societal interests.

Institutions include the range of state and societal institutions that shape how political actors define their interests and that structure their relations of power to other groups. It includes both formal organizations and informal rules and procedures that structure conduct.[65] In the historical institutional approach of the new institutionalism, institutions are never the sole cause of outcomes. The emphasis on institutions as patterned relations that lie at the core of an institutional approach does not replace attention to other variables - ideas, interests and power distributions. Rather, it shows how these factors relate to one another by drawing attention to the way political situations are structured. The emphasis in this institutional approach is on relationships and interactions among a variety of variables. Change in institutions alters the constraints in which actors make strategic choices and it can reshape the goals and ideas that stimulate political action.

A critique of traditional institutional analysis has been its tendency to static and sometimes deterministic accounts, better able to explain continuity and permanence rather than change. Thelen and Steinmo[66] outline a number of sources of institutional dynamism. First, broad changes in the socio-economic or political context can produce a situation in which previously latent institutions suddenly become salient, or in which old institutions are put in service of different ends, which in turn introduce new actors. External changes can produce a shift in the goals or strategies being pursued within existing institutions. Lastly, changes occur when political actors adjust their strategies to accommodate changes in the institutions themselves, that is, acting on openings provided by the different context in order to defend or further their positions.

Considerable evidence in international contexts demonstrates the influence of institutions in policy making. Immergut[67] shows how the difference in institutional factors (constitutional rules that create different veto points, political parties and party discipline, and electoral results) accounted for the differences in national health schemes introduced in France, Switzerland and Sweden, rather than differences in ideas or in preferences, and the organization of interest groups. She concludes that no view of politics can rely exclusively on either institutions or on interests. Both are necessary.

Hall,[68] in his study of the way in which Britain moved from Keynesianism to monetarist policies shows how institutions interact with interests and ideas. For him, the following institutional factors influenced the policy outcome: capital relations of production and democratic electoral institutions; a party system characterized by intense two-party competition that gave the Conservatives strong incentives to seek a clear alternative to Labour policies; the centralization of power in the cabinet and the Prime Minister which gave the Conservatives the capacity to institute radical change; and the routines and procedures of the British Treasury which acted as filters to new incoming ideas. Institutions emerge from his analysis as a critical mediating variable, however, not as a substitute for interests and ideas.

In the LTC reform, institutional factors such as legislation, government structures, and shifts in their structure influenced the shape and power of ideas, the authority of societal interests, and the ultimate policy.

2.3.3 Societal Interests

Societal interests, according to Pross,[69] perform a number of functions within a policy community: interest promotion, communication, legitimation, regulation, and administration. They transmit demands and information from sectoral communities to public authorities, and information and demands from the authorities to their members; they build public support for programs and policies; they administer some public programs, and they engage in regulatory activity. An understanding of the reciprocal benefits provided by the state and interest groups provides insight into why some groups have more influence than others.

To achieve their goals, public officials must generate support in the policy community. If interest groups do not exist, state agencies often encourage their formation. At times governments try to break up old policy communities to create new ones. In this way, governments can try to control the agenda and to frame the scope of conflict. Schattschneider indicates that the development of cleavages is the prime instrument of power. "Every change in the direction and location of the line of cleavage produces a new majority and a new allocation of power." [70] In addition, without the support of well-organized interest groups, state agencies may find their agenda usurped by central agencies or other departments. At times, ministers use groups as a source of policy countervail to departmental advice.

To perform the above functions, interest groups must possess the attributes of organization: a formal structure; a clear definition of roles; a system for generating and allocating resources; rules governing behaviour; and procedures for reaching and implementing decisions. Pross categorizes interest groups along a continuum ranging from institutional groups to issue-oriented groups. Institutional groups possess organizational continuity and cohesion; have extensive knowledge of the sector and enjoy an ease in communications within the sector; have a stable membership; have concrete and immediate goals; and organizational imperatives are generally more important than any particular objective.

Issue-oriented groups are at the other end of the continuum and possess characteristics opposite of those possessed by institutional groups. They allow their concern with one or two issues to dominate both their internal affairs and their relations with government. Their weak base, however, does not make them ineffective. They can achieve their objectives through techniques normally shunned by institutional groups, such as demonstrations, media events and inflammatory rhetoric.

Their chief advantage lies in their flexibility. They can disrupt a policy field, breaking down and challenging its consensus.

Within the LTC sector, most groups were issue-oriented groups and some tended more towards the definition of institutional groups. The composition of societal groups and the fragmented network it formed will account for the dominance of the state in the LTC policy sector and for the volatility in alliance formation and withdrawal.

Interest group power or influence is not a property possessed by groups solely by virtue of their organizational characteristics, the number of members, or their budgets, however, as some interest group theorists would contend. Understanding interest group influence in terms of social, economic or organizational resources is not enough. According to Immergut,[71] political influence comprises the relationship of these groups to the political system and therefore, one needs to understand the receptivity of political institutions to political pressures. Institutional mechanisms structure the process and provide interest groups with different opportunities for influencing decisions. As well, new ideas as stated above change the boundaries of a debate and realign societal interests.

Interests, here, also refer to the policy preferences, motives, or objectives of state and societal actors in a policy field or policy issue.[72] Interests may be either explicit or implicit, openly declared or hidden. Groups do not only promote their own interests but also shape the reception of opposing interests by their public interpretations of them.

In the LTC reform, there were a number of policy interests that can readily be identified. The government had an interest in constraining costs by shifting publicly financed care to the private sector, by shifting care to less costly providers and agencies, to strengthen and regain their political support base, to improve access to care, to reduce or increase the involvement of the for-profit sector in care, and broaden consumer participation in program decisions. Consumer interest included ease of access, broadening the types of care provided, rights, and choice in providers. Unions were interested in successor rights, job protection and promotion, while provider groups were interested in income protection and autonomy.

Chapters 4 to 7 document the changing shape of ideas, institutions and interests, as well as their effects on policy. Chapter 8 examines the relative influence of these three constructs in reshaping LTC community-based services.

2.3.4 Policy Communities

Within the neo-institutionalist framework, this research adopts the approach of policy communities, as developed by Coleman and Skogstad,[73] in understanding the influence of the state and interest groups on public policy in a given sector over time. A policy community is that part of a

political system that, by virtue of its functional responsibilities, its vested interests, and its specialized knowledge, acquires a dominant voice in determining government decisions in a specific field of public activity. It is populated by government agencies, pressure groups, media organizations, and individuals who have an interest in a policy field and attempt to influence it.[74] [75]

Coleman and Skogstad reject exclusively state-centered and society-centered approaches to public policy. Rather, they examine the interaction between state and societal actors. This approach disaggregates the state and highlights its role in structuring sectoral demands and in influencing the organization and strategies of interest groups. In focusing on policy communities, the authors stress three sets of structures: the autonomy and capacity of state agencies, the organizational development of sectoral interests, and the relationships or networks that develop between the state and societal actors.

State autonomy is enhanced by professional bureaucracies, able to generate their own information, and backed by legal mandates and unambiguous regulations. State capacity is assisted by bureaucratic expertise and by a state's ability to coordinate and concentrate decision-making through either a single agency or inter-departmental committees. A policy network describes the properties that characterize the relationships among the actors that form around an issue of importance to the policy community. Networks are influenced by the relative strength, autonomy, and capacity of the state and societal groups. For example, a strong, cohesive group of societal actors with shared interests provides less opportunity for state actors to promote their interests than a loosely organized, uncoordinated set of societal actors.

One of the major objectives of actors within a policy community is to maintain the stable relationships that exist. Coleman and Skogstad argue that this is hard to do. New groups are added to the attentive public or to the sub-government, or groups try to move from the attentive public to the sub-government. These changes in the community spark changes in the policy networks. Changes in values associated with socio-economic change, changes in political institutions, or the addition of new state institutions foster changes in a policy community.

The concepts of policy communities and policy networks are useful in integrating and understanding the interacting and reciprocal influences of ideas, interests and institutions. The composition of the policy community (described in Chapter 3), the balance of power within it, especially between the state and societal groups, can account for the relative stability or instability in a policy sector. It will be argued in Chapter 9, that unlike the acute care sector, the composition of a strong state and a network of loosely connected societal interest groups allowed for government ideology and its interests to predominate reform.

2.4 Ideas, Interests, Institutions and the Public/Private Mix in LTC Reform

There is a reciprocal influence among ideas, institutions, and interests. Interests influence the kinds of ideas and interpretations that get expressed. In the recognition that certain interests may not have broad appeal, ideas are often shaped to be more collectively oriented in order to gain support for a group's interests. Broad ideologies shape various interests and the nature of preferred policy outputs. Interests and institutions also interact in that state interests may prefer particular state structures and institutional relationships. And institutions promote the influence and access of certain interests over others as discussed above.

Using these concepts, the analysis will show that the reform models reflect the ideology of the government of the day which, faced by a largely unorganized network of groups was able to press its own interests in reform. To the extent that government reform was impeded it was due to the attempts of societal groups to consolidate their influence through alliances. However, when government changed, the ideas put forward in their reform proposals introduced new cleavages, which favoured a different set of actors. Coalitions that found they could no longer sustain their former mutual interests dissolved.

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Chapter 3

Research Methodology

This chapter describes the type of research approach chosen, the sources of data collected, the sample selected, and the analyses undertaken. Explanation of each decision and the respective limitations underlying these decisions are also provided.

3.1 Qualitative Research

Data gathering techniques cannot be divorced from theoretical orientations.[1] Data are associated with the reasons for choosing a particular subject, the conduct of the study, and eventually the analysis. In terms of understanding the influence of ideas, institutions and interests on reform in this sector, a qualitative analysis approach was decided as the best way to proceed. This in no way is to denigrate quantitative approaches or to insist that one approach excludes the other. Rather, it was decided that a qualitative analysis would better allow for the exploration and understanding of meanings, reasons, and effects. The purpose of this analysis is to illuminate the ideas and interests that were expressed by stakeholders regarding reform and to understand their perceptions of the influence of ideas, interests and institutions on the shape of reform, and in particular, the shifting public-private boundaries in the financing, delivery and allocation of LTC services.

3.2 Case Study Design

The case-study design is now recognized according to Johnson and Joslyn[2] as a distinctive form of empirical inquiry in understanding the development of public policies, developing explanations, and testing theories. Unlike research using experimental design, a case study design is used in situations where the researcher is unable to assign subjects to different groups, manipulate independent variables, or control the context of the study. However, rather than being merely a default design option, it is used in research where in-depth understanding is the goal. "The design permits a deeper understanding of causal processes, the explication of general explanatory theory, and the development of hypotheses regarding difficult-to-observe phenomena" (p.147). Case study methods involve systematically gathering detailed and in-depth information about a person, social setting, event, or group to allow researchers to understand how it operates or functions. It can be narrow and focus on an individual or be broad and focus on an entire community. Case studies of communities involve the systematic gathering of enough information about the community to know and understand what takes place in the community, why and how these things occur, who among the members take part in the activities, and what social forces bind members together.[3]

Robert Yin[4] defines the case study as an empirical inquiry that investigates a contemporary phenomenon within its real-life context, when the boundaries between phenomenon and context are

not clearly evident, and in which multiple sources of evidence are used. For Yin, case studies are useful for answering "how" and "why" questions; that is, explaining events. It typically uses a number of data collection methods such as interviews, document analysis and observations.

A number of factors in LTC reform provide the scope for an in-depth analysis using ideas, interests and institutions and make it an appropriate candidate for the case study design.

1. The history of reform spans approximately fifteen years which allows for the possibility to see trends and changes.
2. LTC services were funded and administered by both the Ministry of Health and the Ministry of Community and Social Service which gave rise to two different cultures of care. The culture of the MOH tended towards a medical model and top down planning, whereas the MCSS culture was based more on the ethos of social services and community decision-making. This allows for the analysis of the influence of different institutions on reform.
3. Three separate parties formed the government in this period allowing for the analysis of the influence of different ideologies on reform.
4. As LTC is not constrained by the *CHA*, there was flexibility in the boundary between the state and the individual allowing governments to experiment in the development of their models. Accordingly, the Liberals, NDP and Conservative governments each proposed models, which differed in terms of the public/private mix in the financing and delivery of services, and in allocation mechanisms. These changes, as they were developing, made transparent the interests of the different participants.
5. The institutional structure of government also changed with the creation of new ministries and central agencies, and changes in which ministry led the reform. Ministers who were centrally involved in the reform or who led the reform changed a number of times. These varying dynamics make LTC particularly suited for an institutional analysis.
6. In comparison to other health sectors, the stakeholders involved in LTC were a diverse assortment of relatively small, loosely organized groups. The groups that participated represented the health sector, the social services sector, providers, consumers, labour, volunteers, charitable organizations, for-profit organizations, ethno-cultural groups, and religious groups. They varied in terms of their resources, which necessitated coalitions. There was considerable volatility in the formation and withdrawal of alliances as groups attempted to influence reform. Reflecting this diversity in groups was a similar diversity of values, which led to debate. Despite the agreement on the reasons for reform and the principles guiding reform at a general level there proved to be a lack of consensus on the application of these principles; i.e., on what the new system should look

like. In particular, there was variation in views about the role of government and the private sector. The relative influence of groups changed as new groups formed, and new alliances were created.

7. Through government consultations, which varied in terms of its depth, there was considerable written public debate amongst stakeholder groups providing a record of their concerns.

Using the case study design and through a variety of data sources, this research explores and attempts to 1) understand the five reform models and their potential impact, and 2) understand the influence and interrelationship of ideas, interests and institutions on the development and change of policy between 1985 and 1995 in Ontario. Specifically for the second aim, the research attempts to account for the changes in the design dimensions of financing, delivery and allocation in LTC policy over time. The goal of the research is not generalizability of the specific dynamics in this policy arena to other arenas. Rather, the results of this research will lend further support to a framework for understanding the nature of policy communities in general, and the influence and interrelationship of various forces on policy. However, as will be seen in later chapters, some of the findings should ring a warning bell of the potential adverse consequences to Medicare.

3.3 Boundaries for the Research

The period of time covered in this research is 1985 to January 1996. It covers the mandates of the successive Liberal, NDP, and Progressive Conservative governments. However, because of the recency of events during the NDP period, a more in-depth analysis will be undertaken of this period. The Liberal (1985-1990) and the Conservative (1995-) periods will provide not only the book-ends for the NDP reform but also allow for the analysis of trends and shifts in institutions and interests over three ideologically different governments. Only the period leading up to the introduction of the LTC model under the first Progressive Conservative government period (that is, up till January 1996) will be analyzed in order to provide closure to the reform period and a counter point to the NDP and Liberal reforms.

3.4 Data Sources

There were two primary sources of data in this research: documents and interviews. These two data sources were used to supplement the limitations in each other. Analysis of the written word affords certain advantages. It is a permanent record that permits retrospective analysis; it is non-reactive; it promotes ease of access; and despite the possible intentional bias in the presentations, it is the public representations of participants' views, perhaps strategically advanced, to promote their interests. The usual disadvantage of the accessibility of records is not an issue since all the documents in this research form part of the public record, accessible through Freedom of Information

legislation. However, because of the passage of time, availability of records was uneven especially for the earlier Liberal period and forms a limitation on the research.

Interviews allow the researcher to fill in gaps in data in the written documents, and allow for further exploration of ideas and interests expressed in the documents. Written documentation can conversely act as a reliability check to material collected through interviews based on events from the past. Interviews further allow for an exploration of the subject's interpretation of the relative influences of ideas, interests and institutions and the potential outcome of policies.

While there are implicit theoretical assumptions and limitations with each data source, each represents "a different line of sight directed toward the same point."[5] The use of multiple lines of sight or triangulation allows for a richer understanding and a means of verifying insights. The triangulation of the data is not merely a combination of different kinds of data but an attempt to relate them.

3.4.1 Documents

The following documentation was collected:

- Published government reports from the Liberal, NDP and Progressive Conservative period outlining reform models. They include *A New Agenda,* 1986[6] (Liberal - One-Stop Shopping model); *Strategies for Change*, 1990[7] (Liberal - SAO model); *Redirection of LTC,* 1991[8] (NDP - SCA model); and the multi-coloured reports on the MSA, 1993[9] and *Bill 173: An Act respecting long term care*, 1994[10] (NDP - MSA model); and *Alternatives to the MSA: A summary of discussion with key groups representing LTC consumers, providers & workers,* 1996 (PC – CCAC model).
- Hansard from the Legislative Assembly for the research period, and the Standing Committee on Social Development reviewing *Bill 173*, media releases, and speaking notes from Ministerial addresses.
- Written submissions from a sample of societal interests plus government-type agencies to the Standing Committee on Social Development reviewing *Bill 173.* Other written material from these groups on earlier reforms was also reviewed but the availability of such material was not as systematic.
- Annual reports and other reports from societal interest groups, where available.

3.4.2 Interviews

Questions for an interview schedule that was semi-structured (in terms of guideline of questions asked) and open-ended (in terms of responses provided and supplemental questions that may arise during the interview) were developed based on material gathered from preliminary

interviews with key informants and on the need for information required to test out the influence of the theoretical constructs. This schedule was pre-tested and modified accordingly. The interview schedule is included in Appendix A. Face to face interviews (with the exception of one-and-half interviews which were done by telephone) were conducted with 38 key informants. They included informants from 23 societal organizations and 15 government informants(17 were approached). This latter group included government ministers and members of the opposition parties, ministry officials from government bureaucracies and other types of government agencies. Key informants from organizations were typically the head of the organization in smaller organizations or the policy manager/analyst most involved with the reform in larger organizations.

Although it is the organization, its interests and influence that is of interest, one cannot interview organizations per se. The assumption in the research, while recognizing the precariousness of it, is that the answers of individuals represent the organizational or institutional perspective. Because the research period encompasses ten and a half years, key informants were not always involved with their organization for the entire period. While it would have been more sound to track down and interview all the key informants for each organization over the entire time period, resources and time did not permit such an approach. As a result, in some instances, the interviewee had to hypothesize and infer the answers to questions pertaining to periods when they were not with their respective organizations.

Informants were first contacted by telephone and explained the purpose and nature of the research. With assurances of anonymity and confidentiality, permission to be interviewed and an appointment were obtained. Only two individuals from the sample category 'Government' refused an interview. Interviews ranged from one to four hours in length. Because of the length of some interviews, two appointments with the informant were sometimes necessary. With permission from the interviewees, the interviews were tape-recorded and later transcribed. The interviews done by telephone were simultaneously typed on a word processor with permission of the interviewee.

3.5 Determination of the Policy Community

The data collection began with the determination of the make-up of the policy community in the community-based LTC sector. This was done by examining government LTC files during the Liberal, NDP and PC periods, government consultation documents, and information gathered from preliminary interviews with key informants.

The government institutional structures most closely associated with reform (in chronological order) included the Office for Senior Citizens' Affairs (OCSA), Ministry of Health (MOH), Ministry of Community and Social Services (MCSS), Office for Disabled Persons (ODB),

and the Ministry of Citizenship (MC) which combined OCSA and ODB during the NDP mandate. The Standing Committee on Social Development, the Premier's Council on Health and later the Premier's Council on Health, Well-Being and Social Justice, other government agencies, and local government also had key roles in the reform at specific points in time.

The societal interest groups in the community-based LTC sector number in the thousands as evidenced by the claim of the NDP government to having included 75,000 participants during their consultation.[11] Clearly, not all groups had equal input. Given the limitations of time and resources and the intent to undertake in-depth analysis of reform during this period, it was essential to focus the research to the key influential groups. In reviewing government files, certain groups tended to surface more than others did. From this preliminary review, it was clear that groups that had a provincial mandate were more influential than those with local ones. This view was further substantiated with the fact that during the NDP consultation the central LTC Division which was developing the policies conducted the meetings with provincial associations, while the 14 Area Offices undertook the consultations with local groups and only forwarded summaries of their discussions to the central Division. As a result, the policy making ear in government received a distillate condensed by the Area Offices of the input from local groups.

It was, therefore, decided to focus on organizations with a provincial mandate. However, these numbered in the hundreds. Because certain interest groups were highly influential in the reform, simple random sampling might omit them, thereby losing a rich source of data. To ensure that the different types of interests in reform were included the groups were stratified into the following categories: consumers (seniors, disability, and ethno-cultural), providers (for-profit, not-for-profit, professional services, support services, professional associations, unions) and other (e.g., charitable organizations). Using a snowball sampling technique, a purposive sample was chosen from the categorized list. In total 23 organizations were included in the final sample: five consumer groups, 17 provider groups, and one other type of organization. One "local" provider organization was included because it was suggested as important and no provincial association existed representing that interest. Because the numbers are small, a further breakdown in each category will not be done in order to protect confidentiality.

Within the government category, the 15 key informants included government ministers, members of the official opposition, political staff, members of the bureaucracy from deputy ministers to policy analysts, and representatives from municipal government and government-type agencies.

3.6 The LTC Policy Community

In order to analyze the events that unfolded over the period in question, it is important to describe the policy community involved in community-based LTC services when the Liberals came to form the government. Government agencies included the MOH and the MCSS. Societal interests included the Home Care Programs which were not-for-profit agencies fully funded by the MOH, provider groups (health and social support agencies which were both commercial and not-for-profit, and funded by both MCSS and MOH), volunteer agencies, and consumer groups (seniors, disability groups, multicultural and religious groups). Over time, the relative influence of these groups would change shifting the balance of interests. Similarly, government proposals for reform would often change the scope of policy, awakening otherwise dormant interests or bringing together disparate interests into alliances with some commonality to support or oppose the reform.

The health provider organizations were largely not-for-profit agencies providing nursing or rehabilitation therapy services. While these organizations had been in existence for some time, in terms of resources and access to government, they did not rival the more 'institutionalized groups'[12] in health care like the medical or hospital organizations. The diverse nursing and therapy provider agencies, while having their own provincial organizations (for example, the VON agencies belonged to VON Ontario) did not form either a nursing coalition or health provider coalition at the provincial level.

Although there were powerful medical associations, like the Ontario Medical Association (OMA), they were, on the whole, not much involved with LTC reform. They had other issues more important to them to fight, such as extra-billing. In 1984, the *Canada Health Act* came into effect banning extra billing but giving provinces a three-year grace period to comply with the Act. Negotiations between provinces and physicians proceeded relatively smoothly in all provinces except Ontario[13]. In 1986, the new Liberal government was embroiled in a bitter doctors' strike during which they brought in the ban on extra billing practices.[14] Similarly, hospital organizations and their associations, such as the Ontario Hospital Association (OHA), did not engage with much vigor. In the mid-1980s, LTC reform was viewed as largely involving community services and residential care, and therefore, not the concern of the OHA. As 1990 approached, these organizations would also be distracted by other pivotal issues such as hospital cut backs and restructuring.

The social and personal support service organizations provided services such as attendant care, homemaking, food preparation, meals delivery, and security checks. They were largely single, one-off, not-for-profit agencies whose services were provided by largely unskilled, low-paid workers or volunteers. Organizational resources included a small, paid administrative staff. At the provincial level, the not-for-profit agencies, which provided similar types of care, had associations; for example,

homemaking agencies belonged to the Visiting Homemakers' Association, or meals on wheels agencies belonged to Meals on Wheel of Ontario. There were a few for-profit agencies such as Extendicare and Dynacare. The support services sector as a whole, however, was not unified at the provincial level. Without a uniform voice, this was not an effective set of organizations during the Liberal reform period. Similarly, government found it more of a challenge to consult them.

In the mid-1980s, consumer groups consisted of various seniors groups (pensioners or consumer advocacy groups), disability groups, which broke down into largely disease-focused groups, diverse ethno-cultural groups separated by their ethnicity, and religious groups. During the Liberal reform period, these groups, although somewhat vocal, were not forceful.

In the context of this analysis, the research adopts the term "consumer" to refer to seniors, people with disabilities, children and other potential recipients of LTC services. Alternative terms have been suggested, such as, recipient of care, client, or patient. Clearly, none of these terms is politically neutral. "Consumer" and "client" have meanings that pertain to private markets, that is, completely informed persons, individual preferences, and choice. Many "clients" in the LTC sector are the frail elderly or the cognitively impaired for whom informed choice is not meaningful. On the other hand, the term "patients" is often associated with a medical model, that is, the authority of the physician, a narrow focus on cure and health as being the absence of disease. "Recipient of care", other than being cumbersome, has an undertone of passivity. While the latter two terms, "patients" and "recipients of care" are appropriate for patients with an acute episode of illness discharged early from hospitals, they are forcefully rejected by well-seniors and people living with physical disabilities. These latter two groups lobbied heavily during the reforms for autonomy in decision making and for an empowerment in designing not only their program of care but also the LTC system. As will be argued, well seniors and people with physical disabilities were more vocal and became more organized than other recipients. These two groups favoured the market moniker, "consumer," precisely because it implied the kind of recognition and power they were seeking. While adopting the term, "consumer," it is recognized that the term has a narrow meaning and is not appropriate for all groups receiving LTC services.

In the remaining chapters, respondents will be identified by a letter designating the type of group to which they belong followed by the number their group was assigned in the sample. For example, a member of a consumer group would be identified as C001. The letters designating the types of groups are as follows:

"C" – Consumer organizations (which includes seniors', disability and ethnocultural organizations)

"P" – Provider organizations (which includes all provider groups, both professional and support services, and for-profit and not-for-profit, professional associations, as well as organized labour)
"G" – Government officials (which includes members of the bureaucracy, members of the political arm of government, members of the official opposition, and member of other types of government agencies); and
"0" – other types of organizations, such as volunteer organizations

While it would provide greater clarity to the analysis if the sub categories in which respondents belong were further identified, ethical considerations prevent such a strategy. Clearly knowing whether it is a government minister or a member of the bureaucracy, or whether it is a respondent from a not-for-profit or a for-profit provider organization who is speaking in interview excerpts would make the analysis stronger. However, because the numbers of interviewees in each sub category are small, respondents would be readily identifiable, negating the assurances of anonymity and confidentiality given to them in return for their participation.

3.7 Analyses

There were three types of analyses undertaken on the data: historical review; policy analysis, and content analysis.

3.7.1 Historical Review

Documents were used to construct an historical account of the events, process and environment around the reform over the research period. The historical account of events and decisions is included in the chapters that analyze each government period (Liberal – Chapter 4, NDP – Chapters 5 and 6, PC – Chapter 7).

3.7.2 Policy Analysis

Government policy documents were also used to compare and evaluate each recommended model in terms of the decisions made regarding the three design dimensions of financing, allocation and delivery. Specifically, the shifts in the public/private mix in financing and delivery and the allocative mechanisms across the models were analyzed. The implications of the design decisions in each model were analyzed in terms of the role of the state in this sector, and in terms of meeting traditional policy goals of access to services, quality of services, efficiency, choice, and availability of services. This analysis for each of the five model is undertaken in the relevant chapters (4, 5, 6, 7, and 8).

3.7.3 Content Analysis

A content analysis was done using the QSR NUD*IST qualitative analysis software. The interview transcripts and the written submissions to the Standing Committee on Social Development

on *Bill 173* were systematically analyzed using this software. The purpose of this analysis was to develop an understanding of the determination of LTC policy using the framework of ideas, interests, and institutions; to answer questions of who, how, what, when, and why. The other documentation outlined above was used to inform and supplement these analyses.

QSR (Qualitative Solutions and Research) NUD*IST (non-numerical unstructured data indexing searching and theorizing)[15] is a computer package designed to aid users in handling non-numerical and unstructured data in qualitative analysis. QSR NUD*IST manages data documents, explores documents through the creation of categories and coding of the text, manages and explores ideas, searches for patterns in coding and allows for the exploration of theories about the data. This software replaces the earlier cumbersome and time consuming methods of undertaking qualitative analysis (making notes on index cards and sorting them into categorical piles), and allows for a more in-depth, faster and flexible exploration of the data. Moreover, it allows for an ongoing interpretation and exploration of the data through the creation of new codes by combining old ones.

Interviews were transcribed and documents (reports and submissions) were optically scanned into Text Format and imported into NUD*IST. Each document was divided into Headers (provides identifying information about the document); Sub-Headers (divides the document into sections); and Text Units (is the smallest piece of text which can be coded and they may be paragraphs, sentences, lines of text, or words). In this research Sub-Headers consisted of a question and its answer in the Interviews, and a paragraph in the research documents (reports and submissions). For both data sources, a line of text represented the text unit.

The selection of categories for coding the documents was an iterative process. Categories were initially developed based on the requirements of addressing the research questions. After a review of a selection of the documents and interviews, categories were further developed, refined and expanded. For example, since financing decisions was one of the issues being explored by this research, it became a major category for coding. The different issues raised under the topic of financing became sub-categories. These in turn were further subdivided to allow for more subtle analysis. Not all codes and categories were used in the analyses. Coding was done with future research in mind.

Five written submissions from stakeholder groups were initially coded by the author using these categories. The coding schedule was explained to a fellow Ph.D. student who was knowledgeable about the theoretical framework and research questions being addressed in the research. These same submissions were independently coded by this colleague using the coding schedule. The coding of these submissions done by the author and the colleague was compared and

analyzed in terms of agreement and disagreement on coding decisions. There was 42% total agreement on categories. Where there was disagreement, the decisions were reviewed and discussed. This resulted in a further 55% agreement with the author's original coding. The coding schedule was modified to clarify areas of inconsistency. A different set of three documents were then coded by the author and the colleague using the new schedule. This time there was 95% agreement on categories.

The content analysis of interviews and written submissions using NUD*IST explored the influence of ideas, interests and institutions on LTC reform. These analyses are presented in Chapters 4, 5, 6, and 7.

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Chapter 4

LTC Reform in the Liberal Period (1985-90)

This chapter documents the set of reform efforts on LTC community-based services during the period of the Peterson Government between 1985-1990. The chapter will describe and highlight the backdrop to the development and timing of key government documents, provide an analysis of the policy documents to which groups responded, outline the interests of key government and societal players involved in reform and analyze the influence of government structural arrangements and interest group strategies on reform. An analysis of the dominant ideas, interests and institutions and their shifts between 1985 and 1990 will be undertaken to help explain both the policy models that developed and the dynamics of policy reform.

It will be argued that during this period, the anticipation of an aging demographic shift, the reduction of federal funding, and the escalating costs associated with treating the elderly in a largely medical manner through prescription drugs and placement in hospitals and LTC institutions drove the need and the process for reform. The emerging view of health and well-being required looking at the needs of the whole person and recognizing that improvements in health status of populations was better achieved through avenues other than the health care system. To achieve this governments needed to re-orient the LTC system away from the medical model by promoting services that would keep seniors healthy in their own homes for as long as possible. To effect this change in thinking, the Liberals introduced various institutional structures into governing this sector.

By creating a focus for seniors' issues within government through the advocacy ministry of the Office for Senior Citizens' Affairs, the Liberals were not only able to give voice to a growing constituency who were demanding more independence in living, but also to wrest reform away from the two dominant ministries providing the majority of LTC community services, namely the Ministries of Health (MOH) and Community and Social Services (MCSS). Without allowing the self-interested biases of those two ministries to dominate, the Liberals were able to develop policy without inter-ministerial conflict which realigned the sector away from a medical orientation.

The creation of the Premier's Council on Health whose members were elites from the health and social services arena provided a powerful forum for the development of policies which also moved the system away from medical dominance to one promoting population health. The interweaving of senior members of the bureaucracy with the Council and its committees ensured that the realignment in thinking would permeate ministries.

In 1985, the Liberals were only able to form a government through an agreement with the NDP party. During this first mandate (1985 - 1987), they were not only new to governing having

followed forty years of Tory rule, but they were also under threat from the withdrawal of NDP support. Reform in this mandate was little more than the gathering of information and the suggestion of what future reform would look like. The 1987 election returned the Liberals to government, this time with a majority. The Liberal's interests in reform were largely to introduce better coordination of the system, more accountability in Home Care contracting of services, and better able to manage future costs. The delivery side of the reform model was unchanged. The reform was incremental in nature. Without major change, the Liberals left the focus of policy development largely in the bureaucracy unlike the NDP and the later Progressive Conservatives. The major impact on the system of the Liberal reform was suggested but left to the future.

During both Liberal mandates societal groups in the LTC policy community continued to consist of a large number of small independent agencies largely working on their own. No single group dominated, and neither government assistance or policy action galvanized a concerted, coordinated action on the part of these groups.

4.1 Liberal Government (1985-1987): One-Stop Shopping

This section will describe and highlight the LTC reform efforts during the first Liberal mandate between 1985 and 1987.

On May 2nd, 1985, the Progressive Conservatives won a plurality of seats (52 seats in an 125-seat Legislature) but not enough to form a majority to rule. The NDP and Liberals each had won 25 and 48 seats respectively, not enough for either to govern. The NDP had, however, agreed in discussions with the Liberals to back them in an accord to form a majority. Unlike a minority government, the NDP had indicated that they did not want cabinet seats, preferring to maintain a credible distance from the Liberals. The two had announced before the throne speech that they planned to defeat the Conservative government. On June 4th the throne speech was delivered and the government was defeated on a non-confidence vote. Rather than calling another election, the Lieutenant-Governor allowed the Liberals and NDP to form the government whereby the Liberals would govern the province with NDP backing.

4.1.1 Institutional Changes and Underlying Government Interests

One of the Liberal's first acts was to appoint Ron Van Horne as Minister for Senior Citizens Affairs with responsibility for guiding the development of a system of services for the elderly. It was believed to be the first time in Canadian history that a Minister had been appointed solely to deal with seniors' issues.[1] Seniors were not only a growing demographic group who were living longer and, therefore, would be requiring more services, but were also a much more affluent and vocal group than earlier generations. They were becoming a constituency that governments could not

ignore. They had been lobbying for some time to have a spokesperson within Cabinet to represent their interests. Without a focal point within government, seniors' groups had to approach separately each of the several ministries (Health, Community and Social Services, Housing, Municipal Affairs, Finance, to name a few) that provided programs for them. In recognition of the potential political strength of this constituency, the Liberal government created the Office for Senior Citizens' Affairs (OSCA). This new office provided an institutionalized mechanism for concentrating the resources of seniors and thereby, strengthening their voice. As one opposition MPP and one bureaucrat stated,

G095: There had been prior to .... '85, discussions and community consultations around what should happen. And there was certainly at that point, enough of a skeleton network of services and enough recognition at the provincial level that services for seniors were a growing demand because of the demographics. I think the provincial government had no choice but to say, 'Okay, we've got to show some leadership here, and it's time that something happened.'

G102: They were looking to assuage the seniors. They knew something was needed. I think there was always a consciousness that what you designed you could then look at in the context of how it would serve others. But ... the demographics spoke to the need for that population (seniors) and that population was organizing and was more vocal.

However, without a mandate or budget to deliver programs and services to seniors, it would become apparent as time went on that OSCA did not have the clout to deliver reform. Other motives would be attributed by societal groups to the Liberals for the creation of this special purpose advocacy office as will be documented later in the chapter.

On July 12, 1985, Van Horne announced that OCSA would conduct a public consultation to gather information for its review of programs and services for seniors. Unfortunately, little information on the process was available in the Ontario Archives. The consultations began with a roundtable discussion of representatives of fourteen provincial senior citizens' organizations. It then travelled to fourteen communities to hear the views of seniors and providers in a series of open meetings. At each of these meetings the government endeavoured to have a representation from the following types of interests: planning groups (e.g., district health councils and municipalities), health care providers, community service providers (home care and home support services), the housing sector, and LTC institutions (nursing homes, homes for the aged, and retirement homes). Approximately 60 site visits were paid to institutional programs and community service organizations serving seniors. Major interest groups were also invited to submit written submissions.[2]

While there was no clear-cut agreement on solutions, a consensus on the problems emerged from these consultations. Lack of coordination among the MOH, MCSS, and the Ministry of Housing was mentioned frequently. There was almost a unanimous belief that better coordination needed to begin at the provincial government level. Within the area of health and social services, seniors indicated that they preferred to remain in their homes for as long as possible. They endorsed the further development of community services and less reliance on institutional care. Furthermore, they wanted a single access point or 'problem-solving centre' in each community to provide information and referral to all services for the elderly. Major gaps in homemaker services were highlighted and the availability of these services without a physician's referral was recommended to enable seniors to remain in their home. Expansion of community supports was urged.[3]

When the government decided to undertake a review of all services to seniors, it was understandable that OSCA whose sole mandate were seniors would lead the review. Based on OSCA's first round of consultations, it was determined that health and social services, being the largest provincial expenditures on services for the elderly, would be the first programs selected for review. OSCA continued to head the review. The obvious question is why, with the review narrowed to health and social services, was the lead for reform not given to either MCSS or MOH. MCSS funded the social services, which provided approximately 80% of all community-based services to seniors. However, Home Care comprised 80% of all expenditures on services to seniors and was funded by MOH.

A government official indicated that making OSCA the lead agency for reform fitted in with the Liberal government's thinking on the need for both vertical and horizontal lines in cross cutting policy development. The Liberals had established a number of 'advocacy' ministries whose mandate was to advocate on behalf of their particular constituencies across government and to provide some coherence and coordination in policy analysis and development.

G107: They created a number of so-called advocacy ministries ... who were designed to create policy for their particular constituents. ... These were specific ministries designed to target or designed to address targeted populations and their specific needs, and to operate as a kind of matrix in government. So they had the line ministries dealing with the actual funding of the programs, and then what they tried to create were ministries that would be cross-cutting, that would be integrated between, in the case that you mentioned, Com Soc (MCSS) and Health. Senior Citizens (OSCA) was designed to be, if you like, the horizontal part of that. ... Long term care was seen as trying to bring together a full spectrum of services for seniors which

included transportation, housing, supportive housing, attendant care, specialized care in the home, and conventional, traditional medical care.

Indeed, the notion of cross-cutting matrices was introduced to coordinate policy and program development not only across ministries but also within ministries. The MOH, during the later Liberal period, introduced a number of 'coordinator' positions within the ministry to advocate on behalf of client groups (Aboriginal Coordinator), provider groups (Nursing Coordinator), or disease groups (Cancer Coordinator).

The government's decision to have OSCA take the lead was seen as a strategic one by those outside government in the policy community as well. It was viewed as a way of ensuring an impartial mediation of interests or ideas, or both. Some interviewees stated that the independence of the Office, while allowing for a neutral mediator between the conflicting MOH and MCSS, also acted as a direct and trusted conduit to consumers, a largely unheard voice.

P054: Well, because of the constant wrangling between the two ministries (MOH, MCSS) as to who should be in charge. And the view was that the Office for Seniors was more independent, was a new kid on the block, maybe more able to communicate directly with consumers, and other interested parties, wouldn't be so influenced by one or another set of provider agencies, uh, and that it could do a better job of coordinating with the other two ministries.

Others felt putting it in an Office indicated that the issue was either a priority for government or indeed, not a priority - that not giving the lead to a line ministry with a budget and authority for programs was an indication of the lack of importance of the issue to government.

G095: Oh, I think that by doing that and appointing a minister without portfolio responsible for this-that-and-the-other-thing, is a very clear way for a government to signal, it hopes, that this is now a priority and is going to have special attention.

P069: That if reform is in an Office, it isn't as strong as when it's entrenched within a ministerial mandate, and the Minister is a member of the Priorities and Planning. It just has a stronger, thrust to it. ... I didn't really think the Liberal agenda was Long Term Care.

The appointment of OSCA as the lead ministry was seen by some as a necessary institutional response to breach the schism and to reflect the shift in thinking away from a medical model that was taking place, a shift in thinking that was also becoming prominent in other areas of health care. There was no logical place within either the MOH or the MCSS, which could bridge the diverse programs, and be able to assume responsibility for reform. The MOH had been largely concerned with the Home Care Program, and more particularly, with nursing homes as its primary LTC function. MCSS

was seen as too soft and fractured in its approach for the more medically-oriented or health-oriented elements of the needs of seniors. (G079)

Rather than putting more money into a system that was already set up to deal with people who were ill, one provider organization (P061) believed that the Liberal Government's decision to have OSCA manage the reforms was intended to ensure that the preventive elements of care would be strengthened. Another respondent in answer to the question, why was OSCA given the lead for reform, replied.

G096: Just as in many other areas of health care there was a strong movement and much thinking that patients generally had been over-medicalized, that there was too much of the medical influence on their treatment programs or care programs, and that inadequate attention had been paid to other aspects of care provision. There was literature that was identifying, it hadn't been published much before that period - that identified factors other than clinical care as being important to the quality of life of individuals who were involved in a long term care situation.

All indications from respondents were that government's creation of OSCA was motivated by a desire to depart from the traditional methods of policy development, or to avoid of inter-ministerial conflict and bring about an integration of services, or to create a break from the consciousness dominating the ethos of service provision.

4.1.2 One-Stop Access and Government Interests

On June 2nd, 1986, the Minister for Senior Citizens' Affairs in keeping with Senior Citizens' Month tabled *A New Agenda: Health and Social Service Strategies for Ontario's Seniors*[4] in the Legislature. The Liberals declared that "to the best of our knowledge, this is the first time in Ontario that a government has publicly released a strategic plan for health and social services for seniors."[5] It was to be the first of a series of papers on services for seniors. The central theme of the document was to enable seniors to live active and independent lives in their own communities and in doing so to prevent unnecessary and inappropriate institutionalization. The report proposed five strategies, which represented an outline of a plan for policy and program development in health and social services for the elderly over the next fifteen years. The five strategies were:

1. to improve the health and functional status of seniors through emphasis on health promotion and illness prevention, and improvements in education and research;
2. to assist the elderly to live independently in the community by improving access to, and delivery of, community support services through the introduction of a one-stop-shopping approach; and by providing a broader range of community support services;

3. to enhance the ability of hospitals to meet the needs of the frail elderly through improvements in specialized outreach and inpatient services;
4. to provide high quality institutional care for those elderly who are unable to live independently in the community; and
5. to introduce comprehensive planning and management at both the provincial and local level.

As this list illustrates the emphasis for community-based services was on prevention through community support services, functional independence, coordination of services and the introduction of local planning - themes that had been identified under the previous Conservative government. There had been a growing awareness that the curative side of health care was not only expensive but had little effect on improving the health status of populations. The government's focus on prevention and health promotion in this report marked the beginning of a shift in thinking away from the medical model of Home Care.

A New Agenda had less of a 'program' focus. Reform in health care tends to be undertaken in program areas or levels of care; that is, hospital restructuring, primary care reform, or drug reform. Rather than focusing on community-based services as a set of services for all the clients who currently used them, the government decided to focus on a defined group of users; namely, seniors. People with disabilities would continue to be eligible for community-based services (home care and support services) but were not the target group in this agenda. By taking this approach, the government was indicating that they needed to create a system that dealt with the complete needs of the elderly from community care to acute and chronic institutional care. This approach resulted in keeping a very strong advocacy group, the disabled, out of this set of discussions, as they would be in later reforms.

G079: Some argued that it made much more sense to take a 'care group' approach, than a 'care level' approach. The government has tended to divide the health system up on the basis of care levels, not care groups. There has never been a pure model, because there have been care group entities within government, the Office of Aboriginal Affairs... But, by and large the powerful parts of the Ministry have been the care level parts .... And the concern of others, including me, was that people often use multiple levels of care and unless you create a grouping, you run the risk of losing the focus on people. You can become obsessed with care levels.

As indicated earlier, there was some awareness in the policy community at the time that the needs of the disability community were different from those of seniors as were their services. The

vocal disability community tended to be adults with physical rather than cognitive disabilities, many of whom were part of the Independent Living movement and were fairly independent. (G103)

The Liberal government's interest reflected in the second strategy of a one-stop shopping approach in *A New Agenda* was to address the need to improve access to services and to provide a more comprehensive approach to the delivery of community health and social services.[6] The government indicated that the first step in the development of this approach was the introduction of the New Homemaker Program in January 1986 which was to be delivered in conjunction with Home Care. The purpose of the IHP was to assist families to care for their members by offering homemaking, shopping, meal preparation, cleaning, laundry, ironing, mending and personal care. Although the IHP was administered by the MOH through the Home Care Program it was funded by the MCSS.[7] This strategy would begin to bring about a functional integration of the more medically oriented services with the support services and would begin to shift services towards prevention rather than cure.

Furthering the objective of access and prevention, *A New Agenda* also identified the need for more community services across the province along with enriched funding for home support services. In January 1986 the government had allocated an additional $11 million for community services for the elderly and for increased support for volunteers who assist in many of these services. The priority was to address maldistribution in these services with expansion to be given to northern, underserviced, rural and remote areas. In addition, special attention was to be given to programs responding to ethno-cultural needs (e.g., ethno-specific diets) of seniors. The increased funding was to enhance and supplement, not replace existing or potential family and volunteer support services. The government was not indicating that this group of services was a public function. Individuals would still be held responsible for meeting these needs. The government increased the maximum provincial share for home support services to 60% of agency costs, which was to rise to 70% in 1987. Through the expansion of support and volunteer services the government wanted to avoid "excessive professionalization" of programs.[8] In short, the existing system of service delivery by both formal and informal providers was not to be disturbed, and any new funding was targeted at improving geographic equity, addressing cultural needs, and securing the viability of informal and social supports. The balance of public and private responsibility in the financing and delivery of these services did not shift.

The fifth strategy was designed to address one of the structural barriers to an integrated and coordinated system of care for the elderly. The Office for Senior Citizens' Affairs, working with the Ministry of Health and the Ministry of Community and Social Services, concluded that the various

programs delivering health and social services for seniors were all components of a broad system, but they were divided among different ministerial jurisdictions, with different philosophies, legislative requirements, eligibility requirements, and funding formulas. Home Care and Placement Coordination Services resided within the MOH; and Homemaker and Nurses Services, the Integrated Homemaker Program, Home Support, Respite, and Attendant Care resided within MCSS. Diffused responsibilities made it difficult for government to plan and allocate resources comprehensively, establish priorities, and deliver health and social services on an integrated basis.

The consultations leading to the report indicated a strong consensus for services being developed and planned on a comprehensive basis. The consultations also suggested that the division of responsibility between the Ministries of Health, and of Community and Social Services contributed to a fragmented delivery system. To reduce fragmented development, government continued to place responsibility for planning and overall coordination of services for the elderly with the Minister for Senior Citizens' Affairs. This continued the efforts of trying to mitigate the institutional barriers within government to the integration of services.

While recognizing the need for comprehensive provincial planning, the report also conceded that no single agency had the responsibility or authority to plan, develop or manage services locally for the elderly. Home Care was administered by Health Units (23 by local boards, 7 by regional governments), by the Victoria Order of Nurses (4), by hospitals (3) and one by a special purpose body. A number of interviewees talked about the conflict of interests of Home Care programs being run by providers who were also eligible for contracts with the program. Others indicated that programs run by either Public Health Units or hospitals were always the poor sister to other programs run by the governing agency. (G058) The Paper[9] suggested a special purpose board responsible to the Province, a local government, or a provincial ministry should be created with responsibility delegated to local offices.

After another round of province-wide consultations with seniors, service providers and community leaders, the Minister for Senior Citizens' Affairs announced in June 1987 the creation of five pilot projects as sites for the new one-stop shopping approach, now called One-Stop Access. One-Stop Access would offer functional assessment and take responsibility for bringing community health and social services to seniors in their own homes. The pilots were estimated to cost over $5 million and were to be introduced in two phases (3 in 1987-88, and 2 in 1988-89). Local planning and management of community services, and flexibility in addressing needs were highlighted. Given the government's recognition that local needs varied across the province and that a "cookie cutter" approach was inappropriate, each of the five pilots was free to develop its own model within the

context of provincial criteria. As will be seen in later chapters, the Liberals were different from the NDP and the Conservatives in allowing the characteristics of their model agency to be more locally determined.

Funds for service provision would be transferred from the government to the local authority, which would be fully accountable for them. The local authority would not be able to reallocate funds from provincially designated programs without provincial approval. It would have a similar aggregate planning relationship to the District Health Council as did hospital boards and public health units. [10]

The One-Stop Access proposal represented an incremental change to the existing system, was categorized by a flexibility in approach, and was intended primarily to serve the needs of the elderly. The initiative was to be undertaken in close cooperation with the Ministries of Health, Community and Social Services, and the Office for Disabled Persons.[11] [12]

4.1.3 Societal Interests and Influence on Reform

Going into the consultations, the interests in the policy community around the reform of community-based health and social services at the time were fairly straightforward. There was nothing in their requests that required a major realignment of the current system.

(i) Consumers

From interviews with different "consumer" groups, the strongest perception that emerged was that there was not a single notion of a "consumer". Nor were the interests of the different consumer types uniform. Seniors wanted easier access that was independent from current providers.

C007: What we were stressing was the one point of entry, that was the big thing; so there'd be some coordination, so we could find one place where we get what we needed, rather than have to do all of this searching for ourselves and not, in many cases, consumers don't know what's available if somebody doesn't tell them. And if you're going to be possessive about your own organization, you're not necessarily going to be too helpful.

The government had heard a number of concerns from seniors: that community-based services were provided by a wide variety of agencies and that no single agency was responsible for conducting comprehensive functional (as opposed to medical) assessments of the elderly client, for coordinating the delivery of a range of services, or for monitoring changes in the individual's situation. While many agencies were actively involved in service coordination, none had the mandate to identify all the needs of elderly clients in a comprehensive assessment, bring together available resources, and provide services on a comprehensive basis. As government officials reported,

G103: Everybody was complaining. There was a lot of correspondence and groups that came forward and said, "It's so hard to find out where to go. You get passed on from one person to the next." And so it was just messy. It was inconvenient. Some services didn't know about other services. If somebody did manage to find out about Home Care and get through to a Home Care program, they (Home Care) didn't necessarily mention other supports in the community that were available, and vice-versa.

G093: If a client requires more than one service, then you're getting a lot of people walking in the door, and can sort of begin to feel like you're living in a train station. So that for example, nurses want to go in and assess before they go to a client, because they want to know what they're going to come up against on a regular basis. ... Homemaking agencies are going to look for completely different things and in fact not trust the assessment. ..If you have more than one person (provider) you're getting a lot of different assessments, which can be very frustrating if you happen to be the person receiving all of them. And then, with three or four different agencies it means that you have three or four different agencies with completely different cultures, completely different ways of going about their business, coming in and basically invading your life.

The disability community's main interest at the time was not to be included with seniors in the planning of community-based services. They saw their needs as fundamentally different from those of the elderly. People with disabilities had long been fighting to get out of the disease model of services. The more politically active parts of this community, while physically constrained, did not see themselves as ill or mentally incompetent. Their greatest need was for personal attendant services to aid in the tasks of daily living - toileting, dressing, transportation, shopping. Given the closeness of the working relationship with personal attendants, people with disabilities wanted the freedom to choose their own providers.

C010: The issues at that point from the disability community side had been pretty consistent all along. One is they don't like seeing ... long term care services as medical, and there has been a long term fight to try to get them out. The second issue that really, I think, preoccupied the community for a long time is direct funding of attendant care services. ... But up until that point I would say that the energy of the groups that were really working hardest on long term care in the disability community were primarily focused on individualized funding, and keeping disability out of (LTC reform for seniors). .... The attitude of people with disabilities is, number one, we're not seniors and there's a real difference, but more important, the real issue is the autonomy issue and the ability to choose because this is their life. I mean people

think of long term care as being illness related. But for people with disabilities it's getting out of bed in the morning and going to work, school services like special needs.

When people with disabilities talk about consumer control they talk about people like themselves who are using wheelchairs or whatever, being involved, and that's reasonable. They're healthy people who are not deteriorating mentally. So it's not unreasonable for them to be on boards, or to be involved in advisory groups. When the seniors' community talks about consumers, what they're really talking about are family members often, because the person who's using the services is often not in any shape to be on the board.

Cultural communities wanted to ensure that the ethnic-specific services they had built over the years remained intact. Whether it was the Italian, Chinese or Greek communities, access and coordination were not as pressing issues. From their perspective, care was already coordinated and easily accessed within their own communities.

C030: Someone from the Italian community is quite comfortable going through COSTI or Villa Columbo, and they've got this whole circle in which they can operate reasonably effectively. Same thing with the Chinese community.

The general feeling was that during this period, reform consisted of basically tidying-up the existing system. As such, there were no elements that would arouse consumer passion or dissent.

G058: I think the consumer movement hadn't really hit a pitch at that point. There was no real series of events that would catapult a consumer movement. You know, it's doing business as usual, hearing there's some problems, saying, 'Okay, let's clean up the system. We'll get better governance; we'll try to get rid of the conflict of interest around boards; we'll strengthen the case management role; and we'll bring about one kind of phone number approach to this.' It was relatively, now when you think about it, you know, kind of a mild approach to change.

(ii) Providers

Most provider organizations felt that there was less threat to them during this government period (1985-87) and as a result, they were not as involved in the reform.

P067: I don't think in a direct way, certainly not at the provincial level. If there was any involvement it would have been just through probably fate and circumstances at the local areas or through the home care programs. But there was no government relation strategy to influence the direction.

P050: Why weren't we as involved politically, as an organization at that point? The issues weren't of a high stake. There seemed to be more balance. I guess we felt more secure, as a provider during that interval.

As stated earlier, hospitals did not see community-based services as important to their mandate. One spokesperson, however, saw this as shortsighted, believing that hospitals should have repositioned themselves and have become the hub of all care.

P062: At that time in the mid-80s, most hospitals were not that heavily involved in the community. ... I felt that the time was coming when the hospitals should be, especially in small town rural Ontario, should become health centres, should become the leaders of new networks of health services that ranged all the way from primary care through to all forms of care ...and become something much broader than a set of institutional care givers. (Under the previous Conservative government, government had) started calling on hospitals to reduce the lengths of stay, to reduce the rates of admission, to move more into home care.

Feeling like the poor cousin, the home support service sector believed there were two crucial issues that needed to guide reform: prevention strategies and integration of health and social services. The emphasis on prevention would necessitate heavier use of support services; and the integration of health and social services could lead to more secure funding for the lesser of the two publicly-funded sectors.

P061: I think the basic input was, two issues actually. One, that prevention and early intervention were critical, absolutely critical and terribly underrated and underfunded and very marginalized. But the second piece was that the pieces should be pulled together - the pieces that were delivering treatment services through the health system and those that were delivering the more preventive type services through the home support system.

Unlike the later NDP period, which will be discussed in the next chapter, the union voice also was not activated. Their interests would have been stirred if the government had been thinking about changing the nature of work, threatening job security, merging or realigning workplaces, or changing the funding mechanism. (P043)

On the whole, many in the policy community believed that the interests guiding reform were the Home Care Programs and the professional provider groups. In answer to 'Who was most influential in this period?', the following are some answers offered.

G102: There (were) more providers as I remember. There were some consumer groups but not, not the kind that we saw develop over time.

G097: People who were involved in delivery - the provider groups, particularly those who were providing nursing care were also strongly in favour of a coordinated approach to care.

P061: I don't think there's any doubt, it was, ... the Home Care people have always been the most influential. In terms of community services, there's no contest. The health services are extremely well funded. The social services have a very small percentage of the funding. And the same goes in terms of recognition. The two (funding and recognition) often go hand in hand.

The One-Stop approach and *A New Agenda* were not radical changes to the way business was already being conducted in the sector under the preceding Conservative government. As such, these reforms did not upset the boundaries of the policy sector and, therefore, did not galvanize societal interests into action.

4.1.4 Assessment of One-Stop Access by Members of the Policy Community

The overall assessment of this first reform model by those interviewed was that it was a good beginning and a step in the right direction, but that more was needed. Their assessments reflect reasons why there was less turmoil in the policy community during this period than during the NDP and later Conservative mandates.

G095: I think it was a taking of what existed, and I suspect a commitment to create where there were no services, similar kinds of services, and then a commitment to making sure that you put in another layer which coordinated those services, which is probably the simplest thing that one would do.

P061: As far as it went, I thought it was all right. But it was only a first step ...towards more intensive integration. But certainly the idea went a long way towards dealing with the just enormous fragmentation that still exists.

Despite the incremental nature of reform, some groups did have concerns. A number of consumer and provider groups believed that One Stop either cut them out of the sector, or didn't do enough to bring them into the sector. Some ethno-cultural groups had concerns of services losing their ethnic-specific orientation. "If everybody goes through this quote, One-shop-stop, then what do something like the Federation of Italian Seniors do? And who do you volunteer with?" (C030) From the perspective of people with disability, One Stop shopping represented a model where professionals still made decisions about what you needed. Although *A New Agenda* dealt specifically with seniors, the disability community could and did access a number of these services. As such, the reform represented the antithesis of the 'consumer-created and consumer-driven' model they would

find acceptable. (C010) This was in contrast to some government interviewees who believed that what they were trying to do was to move to a consumer focus away from a provider focus. (G097)

Physicians believed that the one-stop approach to assessment was an unnecessary level since they already provided that service, and furthermore, it would cut them out of the loop. (P030) Some in government also felt that One-stop just added another layer and what was needed was a more comprehensive reform. (G092) For-profit providers believed that the brokerage system prior to *A New Agenda* never allowed them to get a foot-hold into home care contracts and that the proposed model would do little to change that.

P059: It was the current way of doing business. There wouldn't be any sets of principles. There wouldn't be a level playing field.

(I: So what was the current way of doing business?)

Just renewing contracts.

(I: But how did the contracts get started in the first place?)

You've got a contract. You keep getting a contract and the percentage that you had last year you get next year. Most communities start their contracts with VON and the St. Elizabeth got in there, and Red Cross and some of the others. So, as the need grew they always went to the not-for-profits first. That was the approach 30 years ago. And what happened about 18 years ago now, with hospitals discharging clients sooner and sicker, they needed nurses to visit Friday evening and weekends, or night. And the nursing organizations, because they were a monopoly said, 'No, we're not going to do that. Our people don't want to do that. We don't want to set up systems to do that. It's more expensive,' etc. And so Home Care Programs had to find someone to do it, so they called upon the private sector. ... It wasn't a competition process of getting (contracts). We got the leftovers. And we still get the leftovers.

Some not-for-profit providers, on the social support side also believed the reform model fell short and was not comprehensive enough.

P095: I think that it didn't address the question of 'Are the services that are already there, and that have grown in a very ad hoc way, in fact appropriate services? Is the structure appropriate to the delivery of service? How do we get, not just a coordination of those community services, but some kind of seamless transition from hospital to home and from home to hospital?' ... I think that even then the kinds of grass roots groups that I was involved with were expressing concern that the model would be dominated by the more powerful agencies: the Red Cross who was providing homemaker services at that point. And some of the hospitals were

beginning to tune-in to the fact that this might well be a growing field in the future, and beginning to talk the talk without necessarily walking the walk of community-based services.

Others found it understandable that the first Liberal model did not go far enough. The Liberal-NDP accord in which the NDP did not constitute part of the Cabinet ensured that any policy development undertaken by the Liberals would have to be incremental to avoid risking a non-confidence vote. Furthermore the inexperience of governing after forty years of Tory rule for Liberal members made them more cautious. As two respondents captured it, *A New Agenda* and One-Stop Access represented a preliminary attempt at reform during which the new government was getting its grounding.

O107: The first mandate was a relatively new government with people who had not been used to governing at all, who tried to articulate general principles. ... When they were first elected, '85 to '87, the two-year coalition government with NDP, (they) were establishing values, aims, and goals.

As a result, the first set of reforms was evolutionary rather than revolutionary.

G058: I think that it was their way of saying the Long Term Care system is evolving; it was not a revolutionary piece.

4.2 Liberals (1987-1990): Service Access Organization

In the summer of 1987, the Liberal Government, which had been gaining in popularity, called an election. On September 10th, the Liberals received a majority return having won 95 seats in an 130 seat Legislature, and no longer needed the support of the NDP to form the government. This section will describe the development of the next stage of LTC reform under the majority Liberal government. During the second mandate, there was very much a move away from the medical model towards a population health approach and non-medical and less costly means for improving the health of populations. The Liberals introduced institutional structures and processes to further this view.

4.2.1 Paradigm Shift through Institutional Change

In the first year of their second mandate, the Liberal government received three major health care reports from the Ontario Health Review Panel (chaired by Dr. John Evans), the Panel on Health Goals (chaired by Dr. R. Spasoff), and the Minister's Advisory Group on Health Promotion (chaired by S. Podborski). These reports emphasized health in its broadest sense, and refocused the system on community care, health promotion and disease prevention.[13]

As a result of these reports, the Premier's Council on Health Strategy was formed in December 1987. Chaired by the Premier, with the Minister of Health as vice-chair, the Council

adopted the World Health Organization's definition of health, which acknowledged broader social, economic, environmental and lifestyle determinants of health.[14] The Council set up five committees to examine each one of its mandates: Health Goals, Health Care System, Healthy Public Policy, Integration and Coordination, and the Health Innovation Fund.

The work of the Council and its committees was an important part of the environment during which the early reforms of LTC took place. Although the reports did not come out until 1991, the fact that the Premier, various Ministers and senior bureaucrats who provided support were involved with the ongoing work of the Council and its committees ensured that the thinking of the Council and its committees influenced and penetrated government's activities. Indeed, a senior government bureaucrat in that period believed that the Council and, not the MOH, was the guiding policy body for health and LTC reform.

G107: There were a lot of policy ideas evolving and position papers coming out of the Premier's Council that were helping to mold and establish policy. ... If you follow the sequence of the papers and the reports that came out of Com Soc on integration/coordination, particularly, you come up with a lot of the policy bases that were being implemented by the Ministry. Although the Minister had the lead influence in the beginning, as the policy evolved it was ultimately the Premier's Council on Health that had the largest influence in establishing some of the principles on integration/coordination.

The recommendations of the Council's committees would be recognizable in the evolving LTC policy. Goal 2 of the Health Goals Committee with its broad vision of health emphasized the importance of the social environment and social services to health.[15] The work of the Healthy Public Policy Committee emphasized the limited role of the medical treatment system for improving the overall health of the population.[16]

The Health Care System Committee would present a plan for the future health care system. One of the key elements was a deliberate shift in emphasis and related resources to the development of community services as an equal partner with the institutional sector in the provision of health services. It recommended the doubling of funding for community services; legislative and policy reforms to allow for the development of community services; enhanced local planning, accountability and funding envelopes, and new forms of organization and management to be tested by pilot projects.[17]

The Integration and Coordination Committee recommended the devolving or transferring of authority for budgetary allocation, service management and planning and evaluation to local levels; while responsibility for legislation, funding and standards setting would remain at the provincial

level. Transfer of authority should be phased in after corporate restructuring to integrate the Ministry of Health with the Ministry of Community and Social Services on a regional basis. Devolution was to make services more responsive to local needs and to give consumers a say in how services are planned and delivered.[18] In 1989, John Sweeney, Minister of Community and Social Services, was given lead for LTC reform. This decision reflected the prevailing direction of the Premier's Council and other organizations like the WHO: the view of health being determined also by social and economic factors and the need to diverge from a medical treatment response model to improving health status; the importance of local involvement (as noted earlier, MCSS had a less top-down management style than MOH and already had area offices for the management of programs); and the need to shift away from institutional to community services. A number of interviewees saw the move to MCSS as necessary in bringing about this shift in the prevailing thinking that dominated the policy sector.

G107: The Ministry of Health saw care as a very medicalized thing, and everyone understood after they had done their local consultations with the seniors' groups and the regional bodies, that long term care was in fact to be a non-medicalized approach to care of the elderly. Because (if) all we were going to do was medicalize the care of the elderly, then that would be considered a major step back. The view was that medicine was an adjunct to long term care, it was not the core of long term care. And that was a decision that was taken fairly high up in both ministries.

P059: There was a more generalized belief among people who had concerns about the health sector that the medical model of caring for people had adversely affected many clients of the system. And that something that was more like a social model was more appropriate.

G093: And I think that all the time it was with Com Soc, they were trying to de-medicalize the system as much as they possibly could which is in line with sort of the continuing warring cultures between those two ministries.

G103: What I'd heard was that they wanted the model to be very much a health and social service model, and that clients did not necessarily want to be treated as patients. And they didn't want a strictly medical model. And so to echo that, at the political level the lead was given to MCSS.

Placing the emphasis on prevention was also seen as a cost containment strategy. Given the projected demographics, a medical approach to care for the elderly was going to be prohibitively expensive. Home care under the Ministry of Health was an entitlement under OHIP. Furthermore, in 1986, the Mulroney government changed the formula for increasing the funding for the Established

Programs Financing (EPF). Rather than growing at the same rate as the economy, EPF growth was now linked to the growth in the Gross National Product minus two percent.[19] Because the federal funding flowed into the province's general revenues, there was no mechanism to ensure that the provinces would spend the transfers on health and education. Nevertheless, the cuts meant less provincial flexibility overall, and affected the province's overall ability to expand programs. In their second mandate, the Liberals were also becoming aware of the imminence of another recession. In hindsight, it is clear that funding for health care, which had been ever expanding, would need not only to be halted, but also to be scaled back. Disease prevention and health promotion would be justifications for the shift in the role of the state from fully-funded health care towards the more privately funded social model with its emphasis on the broader determinants of health.

P061: There were a significant group of people who felt that, the more socially oriented preventative services would be essential to strengthening the system, and to find a way to get the system working together. And to prevent just enormous accumulations of need for funding later on. In other words, to control the people getting sicker quicker, you need to find some way to strengthen the more social side of it. It was a way to control the costs because the health-oriented costs are so much more expensive, the medically funded programs are significantly more expensive than the costs of the home support social service side. There were some folks who thought that if the lead was given to Health, costs would skyrocket. In my heart of hearts I was hoping that the reason was more towards somebody thinking prevention was a good idea, but more realistically, I think there was probably also some significant thought put into the fact that if it was moved to Health, it would become very expensive.

However, others believed that the culture of MCSS reflected more of the real business of LTC and that social supports were more important in order to keep people in the community. Furthermore, if integration of services was to be achieved, MCSS had fiscal responsibility for the majority of community agencies; that is, they had the numbers in terms of agencies rather than dollars.

P043: It may have been when they first decided that the community was, you know, really where health was going, maybe they felt that in terms of being able to integrate, I mean, all of the agency type stuff, all of the other services in the community were Com Soc. So it may have been trying to figure out how to, how can you have this one system, this coordinated thing with all the agencies, all working together in a community if, if it's through three different

silos. ... And there are a whole lot of services you can't bring into health because they're not about doctors, and treatments.

P050: I think the vision (for LTC) was more that it would be in the support service area - community services, that the needs, because it wasn't seen initially, I don't think, as so much a health need as a ... more of a social support primarily, recognizing that there were health elements obviously. But that the focus of what was needed to provide this one stop access, would be really this service support system .... and that group had traditionally ...was funded through MCSS.

The Liberals intended reform to be decentralized, community-based and locally driven, echoing the recommendations of the Council's Integration and Coordination Committee. Devolution would make services more responsive to local needs and give consumers a say in how services were planned and delivered. In order to achieve this goal, some believed that the effectiveness of implementation would be best undertaken by a ministry that already shared this vision.

G079: They (MCSS) were a de-centralized Ministry, and that their offices were the ears of the community. ... And, at that point, I think the Government was looking for a decentralized solution.

G095: Com Soc was seen as the ministry most capable of working effectively with the hodgepodge of citizens' organizations and voluntary agencies that were out there doing these services. Whereas Health has no experience, the culture is totally different, and Health is very much a professional and an institution ministry.

The culture of MCSS was also seen as one that best reflected the dignity and individuality of clients, and respected their right to involvement in the decision-making about their care. The mediation of values through institutional structures, and the difference in cultures, was expressed over and over by respondents. Interviewees made reference to the difference in clothing styles, in work styles, to the detail that MOH staff wore watches and MCSS staff did not. With respect to the influence of different institutional values on reform, the following excerpt from an interview is enlightening:

P103: Com Soc staff brought a lot of influence in terms of dignity of the individual, the idea of consumer choice. Because in Health patients don't have a choice. They're sick people. You have these highly paid well-educated professionals making life and death decisions. Right? That's the headset. Coming from Com Soc, you think, 'Well, I wonder what the person will want to do about this.' ... The Health culture tends to be, pardon the pun, a bit more prescriptive. The culture comes from wanting to heal, assuming disease in the first place.

> ...Community and Social Services, I think, the culture tends to be more 'What are the consumers saying they need?' ... More of a preventative kind of emphasis, not the same emphasis on expertise, but it's more client-centred. So the client is the focus, and is very much involved in the planning. So there's certain things we've introduced into the reform that I think reflect that. For example, that the plan of care be done with the client, or the client's family; allowing for independent attendant services where people don't have to go through the system and get reassessed.

Another reason for the shift to MCSS from OSCA offered by interviewees was more practical, that it was important at this point to move it to a Ministry that administered the programs in order to be able to implement reform. The government wanted to move forward from listening to concerns and the articulation of principles.

> G097: There's no question that the process had become very cumbersome internally and it was felt that it was appropriate for the lead ministry to be not only a policy maker but an implementer as well.
>
> O106: If what they were going to do was implement real changes to the way service was delivered, it made sense to place leadership for those changes with the Ministry that was responsible for allocating the dollars for the delivery of those services.

Others saw it as reflective of internal politics, a pre-emptive move on the part of the line ministries, MOH and MCSS, to abort OSCA's attempt to gain budgetary control of services.

> G107: One of the big problems was that (OSCA) which was originally designed to be a policy ministry actually wanted to have line management responsibility for long term care, that is, to be, to have the budget, and that kind of thing. ... Health and Com Soc said, you know, 'We understand the policy role, but there's no way that we can give up whole hunks of the two ministries' budget to another ministry and still remain accountable for that budget to Management Board.'

Others in government viewed Van Horne's model as one that was not going to address the issues or get the job done. While One-Stop was going to be piloted in some areas, Sweeney, the Minister for Community and Social Services, and Caplan, the Minister of Health, decided a more comprehensive reform, which was not merely going to add another agency to the existing system, was needed. Practicality played a role in terms of which of these two ministries would take lead responsibility. One official indicated that MCSS and MOH had reached a mutual decision, based on the need for an appropriate ministerial culture to inculcate reform, and the relative workloads of the ministries, that MCSS should take the lead.

G092: Com Soc had the lead, which was Caplan's suggestion because MOH tended to medicalize everything and LTC included both health and social services. We needed something less threatening, particularly since Long Term Care was going to be community-focused. Also Caplan was embarking on major reforms in other areas and had her plate full.

While the evolving ethos in LTC dictated which ministry should spearhead the reform, the need for a better coordinated and integrated system required the participation of other ministerial players. In June of that year, Sweeney made an announcement in the Legislature of the formation of an inter-ministerial task force led by his Ministry to develop a comprehensive approach to long-term care services. The integration of LTC policy development was to begin by bringing all relevant ministries to the table. With the assistance of his colleagues, Elinor Caplan, Minister of Health, Mavis Wilson, Minister Responsible for Senior Citizens' Affairs, and Remo Mancini, Minister Responsible for Disabled Persons, the task force was to develop a plan to streamline services by early 1990, with change beginning in the 1990-91 fiscal year. The task force would report to a Steering Committee of Assistant Deputy Ministers and Directors from the four ministries as well as from Cabinet Office and Management Board of Cabinet. Most interviewees believed that during the Liberal period, the bureaucracy was very involved in the reform process and trusted to lead its development in contrast to the later two governments in which policy was much more politically controlled.

The reason behind the government's interest in reform continued to be the burgeoning of the elderly population. In the last decade, life expectancy for both sexes in Ontario had increased by three years, to 80.5 years for women and 73.7 years for men. Furthermore, based on prevalence rates generated from the Statistics Canada's Canadian Health and Disability Survey in 1983/84, it was estimated that more than 983,000 adults in Ontario had physical disabilities that resulted in some degree of function loss limiting their ability to carry out routine activities. The likelihood of disability was known to increase dramatically with age. It was estimated that by 2006, Ontario would have 1.5 million disabled persons, an increase of about 36%. Once again this was thought to be due to the aging of the population and advances in modern medicine.[20]

For these reasons, the planning in LTC reform now included all personal health and social service programs for the elderly *and* adult persons with physical disabilities. A senior government interviewee also indicated that the disability community had started to advocate inclusion because they saw the government was moving more towards population health strategies. They began to recognize that reform "was going to focus on individual need and was flexible enough to include

their preferences with respect to attendant care." (G092) Advocates in the disability community concurred with this assessment.

While those requiring acute Home Care to recover from illness, injury or hospitalization would still be covered; the emphasis would be on chronic care services for the elderly and the disabled. As documented later in this research, although the government's emphasis in the 1980s was prevention, health promotion and delayed institutionalization of seniors and people with disabilities, in the late 1990s the priority for client eligibility would become those with acute needs, the once traditional patients of the medical and hospital sector.

To bring about integration, the Liberal government undertook another institutional change in ministerial structure. In an effort to coordinate health and social services and to oversee the plan for reform, the Acting ADM, Community Health (MOH) and the ADM, Community Services (MCSS) were both to report to the Deputy Ministers of Health and of Community and Social Services. The government was considering eventually placing management responsibility for the new LTC system into a single ministry. Whether it would be the MOH or the MCSS was left unclear. Perhaps to avoid an inter-ministry conflict, it stated that this might not necessarily be accompanied by the consolidation of the funding of all LTC services in one ministry. This move was a precursor to the later establishment of a joint Division for LTC made up of MOH and MCSS staff with one ADM reporting to both Deputy Ministers.

The reform of Ontario LTC's system was now to be guided by seven principles which emphasized efficiency and cost control through cost containment, integration and coordination, emphasis on the least costly service, cost sharing and strengthening the role of the informal caregiver. The principles were designed to:

- reform the funding system to emphasize individual needs;
- support caregivers;
- encourage use of the most appropriate, cost-effective service;
- emphasize services in people's own homes;
- establish a single, integrated admissions process for both long term care beds and formal community services such as Home Care;
- strengthen the role of the local community; and
- ensure affordability and appropriate sharing of costs.[21]

The earlier One-Stop Access approach centred on a rationalized system for community-based health and social services only, which would eventually move progressively toward the inclusion of other services (e.g. institutional) and other target groups. Now, however, the government felt that a

broader approach was necessary, one that would offer a single entry system for health and social services in both the community and institutional sectors.

The task force reviewed LTC health and support programs, as well as the experience in other jurisdictions. Once again, discussions had been held with provincial organizations, consumers, advocacy groups, service providers and volunteers. Requests by these groups at the time called for communication of more reform details and wider community discussions.

The government had used structural changes to bring about a paradigm shift in the values underlying LTC services at the time. Once a different mindset was established, it would allow for the eventual integration of responsibilities at the provincial level. The shift in thinking also allayed the fears of the disability community which was more accepting of inclusion under the reform. Ultimately, the departure from a medical and health model would also permit greater cost control and cost shifting for government in the future.

4.2.2 *Strategies for Change* and the SAO

On May 30, 1990, the Minister of Community and Social Services, Charles Beer, announced the release of *Strategies for Change*,[22] a plan for reforming LTC. The paper was intended to outline the strategic directions for reform and to provide a framework for continued community discussions. The announcement was made on behalf of the Ministers of Health (Caplan), Senior Citizens' Affairs (Morin), and Disabled Persons (Collins). Beer indicated that over $52 million would be dedicated to the reform initiative in that fiscal year, and by 1996-97, new funding to improve services would increase to $640 million annually.

In this document the Government explicitly indicated an incremental approach to reform, in that it intended to work within the framework of the existing delivery network. The main purpose of the reform as outlined in *Strategies* was "to build a coherent, integrated service system on the foundation of existing in-home, community support and long-term care facility services. ... Fundamental to the reform is the fact that Ontario already has many of the components of an effective long-term care and support system. The reform builds on the current strengths and skills of successful health and social services. The strategies for developing a more coherent system, based on the existing services, are described in this paper."[23]

The reasons given for reforming LTC had not changed. They included the pressures from changing demographics; the lack of integration of planning and service delivery; the growing costs; the variety of policies, funding arrangements, eligibility criteria, and legislation that pertained to the different formal services; inadequate access to services for consumers; changing expectations of consumers to live as independently for as long as possible; the burden on informal caregivers;

variable availability of services over the day and across the province; and the changing cultural/ethnic mix of Ontario's population.

The principles guiding this new reform effort continued to reflect the thinking of the Premier's Council and the earlier announced principles with some notable additions. The announced principles were:

- individualization (services responsive to individual needs; recognition of the dignity and uniqueness of individuals)
- independence and choice for consumers
- community living
- service accessibility
- support for informal caregivers
- local planning and management within provincial standards and directions
- affordability and the cost of services should be shared fairly among levels of government and consumers.

As can be seen, added to the earlier principles was now reference to individualization, independence and choice for consumers, and community living. Now that the scope of reform was broadened to encompass the disability community, the government included principles dear to the hearts of this community, new principles, which are clearly 'liberty' values. Moreover, advocates in the disability community believed that what had happened in the interim since the publication of *A New Agenda* was a shift in the thinking of seniors as well. "There's a change in the philosophy in the seniors, who are also saying, 'We want autonomy.' There's actually now, more of a convergence again (in the interests of seniors and people with disabilities)." (C010)

The service system was to include a Service Access Organization (SAO) in each of 38 or more areas of the province, and was built upon the current Home Care Program and Placement Coordination Services. The SAOs were to have the same functions as the One-Stop Access.

Sponsoring agencies for service access could be existing or new organizations, *other than* current direct providers of service. This was to eliminate the apparent or perceived conflict of interest inherent with the management of Home Care programs by direct providers, such as the VON, as identified by some interests. "I think they wanted a more open process for service delivery. Service providers were lobbying to open up that process. It was seen as sort of a closed shop you know. Home Care had its preferred providers and there wasn't an opportunity for other groups to get involved." (P050) Criteria for the selection of SAOs were yet to be developed and were to be a subject of further consultation.[24]

The report also recognized, as one of the essential components of the reformed system, the need to plan and develop community support services more comprehensibly. Up to that point, these services were developed without overall provincial guidance, leading to a proliferation of single service agencies, regional variation in service availability, lack of coordination across services, confusing access for consumers, and a multiplicity of funding arrangements, charging policies, and eligibility criteria. As a result a policy framework was to be developed to give coherence to community planning. Resources for these services were to be enhanced and targeted to address service gaps, targeted to multi-service sponsors that addressed both the needs of the elderly and the disabled, and to underserviced areas of the province. These services which complemented both the formal in-home services and the informal services provided by family and friends would continue to be accessed directly by consumers. However, the SAO would provide information and referral for consumers to these services, and could purchase these services on behalf of some consumers. Change in this sector was to be achieved with carrots rather than sticks. While this might be a slower process it was a path of less resistance.

Recognizing that informal caregivers provide up to 80% to 90% of assistance to people who need personal support or assistance with daily living, the government outlined a number of support services for caregivers. These included respite services such as adult day programs or the use of LTC facilities for emergency or pre-planned respite care, and information services and support groups.

In terms of costs to the consumer, the government intended to develop a uniform consumer charging policy for community-based services. The principles underlying the charging policy exemplified the Liberal view of the appropriate role of government versus the individual in LTC, and the related redistribution of costs and benefits to achieve it. The new charging policy was to be guided by beliefs that people are traditionally responsible for paying their own basic living and household maintenance costs, and, therefore, these costs should not be within the scope of state responsibilities; that people should receive services regardless of their ability to pay for them; and that those who can afford to pay for services should subsidize services for those who need them but cannot afford to pay for them.

4.2.3 Integration of Services through Institutional Change

The Premier's Council had suggested that the transfer of authority to local communities should be phased in after corporate restructuring within government which would integrate the Ministry of Health with the Ministry of Community and Social Services at a regional level. For reasons stated earlier there was a need to integrate these two ministries in order to create a coordinated program of service; namely, LTC comprised both health and social services that were

under the auspices of two ministries with different cultures, legislation and regulations, and funding, eligibility and monitoring criteria. The service integration was partially to be achieved structurally through the creation of a joint division through which ideas and interests would be mediated. The aim was to arrive at a new hybrid program that not only reflected the values of both ministries but also created a new amalgamated mindset. Having already steered reform towards a broader vision of community care and involvement by giving MCSS the lead, and having partially integrated MOH and MCSS through the reporting of the Assistant Deputy Ministers from the relevant divisions to both Deputy Ministers, the government now went the next step towards integration. They created a new single decentralized division of the Ministries of Community and Social Services, and Health by merging the long term care and support services (MCSS) with the community health services (MOH). One ADM from the new LTC Division would report to both the Deputy Minister of Health and the Deputy Minister of Community and Social Services. Programs from both ministries would be structurally pulled together and would report up through the new ADM.

P054: The reality of the day, there was legislation, there was, under the purview of the Ministry of Health, and legislation under the purview of the Ministry of Community and Social Services. And often, the legislation was contradictory or, or totally unrelated to each other. So there was a decision, 'We've got to sort all this out. We've got to find a way to rationalize how money is distributed, how access is provided, criteria for eligibility or admission.' All of that had to be looked through. So the vehicle that it was seen as, as one that, to begin to sort all this out was to create this sort of, across two-ministry structure.

Government respondents saw the move as a way to get the two ministries to overcome their rivalry and work together. The progress of reform was being hampered by these structural and cultural differences. The joint division was an attempt to bring about an integration of services in the community through an institutional change within government. Not only had you to overcome the silos in the community, but you also had to overcome the territorial barriers within government. The success of the reform was not possible without it.

G092: Health doesn't give much up. And nor does Com Soc. They're both very large ministries that had very distinctive cultures, very large, very competitive with each other. Health doesn't, just didn't give up its budget, because one doesn't give up to another ministry because you never get it back. And I think the same applies to the Ministry of Community and Social Services. ... The move to a joint division came from the recognition that they couldn't move forward unless the two ministries worked together. There were bureaucratic barriers. People worried about losing their jobs. This was a signal. The merger was also necessary if you

were going to bring the services together in the community. The merged division was to be the bureaucratic structure. It wasn't just an interim step. If we were moving to integrated models such as, the CHOs (community health organizations), LTC had to be part of it. And this was going to be easier if the health and social services were together.

G105: It was a big move because until then the departments had really been allowed to, you know, at the director level, they were allowed to just fight with each other all the time and erect barriers.

G101: The purpose of the joint division was trying to balance-off the tradition that had grown up in the Ministry of Community and Social Services and the tradition that had grown up in the Ministry of Health. And at that point because they had developed, if you wish, on separate tracks, they were distinct.

G095: They were recognizing that two ministries were not able to work effectively together, particularly when they were as different as Com Soc and Health. And they needed to pull something out and create at the bureaucratic level what they had earlier created at the ministerial level with Ron Van Horne.

G103: It would have been very hard to have made the changes from outside. ...It wouldn't have been do-able otherwise. There were so many things that we needed to do that affected both ministries. Our information systems were a mess. And we were dealing with two different sets of legal services, and two different communication branches. ... There had to be some way of combining the program areas.

While not contradicting the above stated reasons, others saw the integrated division as a way of allaying the fears of societal interests. Having broadened the scope of the reform to include the disability community, one interviewee stated that the government needed to address their concerns regarding the medicalization of their services. Similary, the government was cognizant of the different cultures within the provider groups that reflected the cultures of their sponsoring ministries. An integrated division was an institutional instrument to manage potential conflict which could de-rail reform.

G101: Among consumer groups you have persons with disabilities. We definitely didn't think that they were to be lumped in with senior citizens. So when the paper came out, I would imagine that all the Health people thought it was a Com Soc document. And all the Com Soc people thought it was a Health document. And all the Disabilities people thought it was a Seniors' document. And all the Seniors thought that they were importing all kinds of concepts from the disability sector. ...

> And it was decided that it would have been, in order to ease people into the notion of a single division that you weren't going to take it out of one ministry and plunk it down in the other. Simply because, not only inside the Ministry, but also in terms of the groups they were dealing with, there might well have been some sensitivity to, for example, if they put everything in the Ministry of Health, immediately the people in the Community and Social Services side would have regarded it as a Health take-over of a part of the social service system. .... It was the idea of putting together the two sides in a division that was ..to try and retain the best of both traditions ... and to make everyone comfortable with the fact that, if you're dealing with LTC services, you're dealing with something, which is, has both a health aspect and a social service aspect.

To begin the decentralization of LTC planning, the new division established fourteen local area offices, where staff would work with local organizations and DHCs to plan the implementation of reform. While the policy function and program management remained in the division, it was intended that over time, these centralized functions would be transferred to the local offices. As a senior bureaucrat in that period indicated this step was essential to the later step of reallocating funds from institutions to the community.

> G105: One of the basic concepts ... and that I very much feel is the correct concept, is that you need to regionalize your administration, your provincial administration instead of having people in each region responsible for a program reporting to program heads in Toronto in the Hepburn building (at Queen's Park) ... and their only integration being at the level of the ADM. ... So there'd be a Long Term Coordinator in each region that would be responsible for everything, not just for homemakers, and not just for ... home care, and not just for homes for the aged, and not just for whatever, but the whole gamut. I mean that's the first step. You have to consolidate your budgets as well. That's what it means to do a reform where you're integrating, and where you have the capacity, for example, meaningfully to reduce your budgetary commitment to institutions, and instead bring some of that funding into community. You can't do it, unless those budgets are integrated. ... You can't transfer from one to another. It's better to do it at a regional level where it's more local.

The reallocation of funding from institutions to the community was essential to the overall goal of cost control and containment. Without an integration of the two divisions, the creations of a single budget envelope for LTC community and facility services would not be possible. "Anybody that was doing their homework, would do some mathematics, to see how much it cost to build

nursing homes. And they'd multiply that by the 85+ population, and from that, 'We've got to find another way to deal with this.'" (P061)

The integration of budgets was not only for the purposes of the reallocation of funds from institutions to the community, but also eventually to cap the LTC budget. Until then, Home Care services were basically a fully funded entitlement under OHIP. The government had realized that, what was initially a small portion of the overall health budget was growing exponentially each year. The integration of services at the regional level which was seen as the first move to the eventual integration of budgets meant that, in the future, the home care budget could be transferred out of OHIP to a global capped budget for all LTC community-based services. (G093) The Liberals had intended to do eventually what the NDP later did. This decision would hold the door open for the movement of more care out of the public realm to the private one of user fees and co-payments. One interviewee summarized this argument best.

G102: Home Care, which was in the hands of Health, was a universally accessible service. If you established eligibility, the service was yours and it was yours as a right, and there was no cost or cost sharing with respect to that. Comp Soc, which funded the Home Support side, the non-medical side, was a Comp Soc'ish kind of a model where there were user fees, where there was a lot of volunteer participation augmenting their services. ... Because behind all of this there was a need to cap the cost, all along, people realized that the costs of Home Care, which was the expensive pieces of the formula, were escalating all of the time. In order to cap that, there was a plan, and I don't know when it surfaced in terms of it being a conscious thing, but there was a need to cap the envelope for Home Care services, by moving it into the Comp Soc arena. As the lead they could start to look at that user-fee, shared-cost, more-use-of volunteers model as opposed to the universal right like OHIP. And that's basically what our Home Care was. If eligibility was established they had to provide service. ... So this was an attempt to shift it from that 'universally paid for, absolutely your right' to a shared responsibility which was the model that Com Soc tends to espouse, with, you know, a lot of different funders and user fee potentials.

Strategies also dealt with issues regarding workers. In terms of steering care towards the community, the report outlined the difficulty in recruiting and retaining community-based professionals to provide in-home services. The government suggested an evaluation of the work currently provided by nurses, and the ability of other professionals such as therapists or social workers, RNAs or trained attendants to perform some of their functions; ways in which to increase the number of rehabilitation therapists; and improving the wages, working conditions, and training of

homemakers. Some people with physical disabilities cautioned the government against over-professionalizing homemakers. The anticipated Health Professions Regulation Act would eventually allow greater flexibility in service provision by different types of providers, a way to further reduce costs through the use of lower skilled professionals. The government also indicated the need to train professionals in community settings.

The government indicated its intention to introduce time-limited legislation in the spring of 1991 to implement a number of critical elements of reform, with subsequent legislation to create a single comprehensive statute governing the whole LTC system. The initial legislation would provide the mandate, funding and governance for service access organizations and their facility placement committees, and the new, consolidated in-home services programs. The legislation was also to include the rights and protection of consumers.

4.2.4 Influence of Societal Interests on the Development of the SAO model

(i) Providers

The feeling among societal interests was that the Liberal government listened more to providers, both for-profit and not-for-profit groups than any other societal interest. In particular, the government was said to have listened to the Home Care Programs, and agencies like the VON that administered them. These were the agencies, which were credited with developing the idea of the SAOs. (P042, G058, PG061, PG070, PG093, PG095, O106)

Although there was an easy relationship between the Liberal government and provider agencies one interviewee felt that by the end of the 1980s, the relationship between the government and providers had begun to change. Towards the close of the decade, the government was beginning to worry about its ability to continue its past spending trend on programs. In hindsight, it would become clear that the Liberals were very aware of the coming recession. Fiscal control would formalize the relationship between the government and providers.

P054: Our relationship with the government until 1989 was quite good. It was so good that we never even thought we'd have to get into government relations and lobbying activities at all. The funding for us was open-ended. Members were able to secure anywhere from 70 to 90 cents on the dollar from the province if they felt the need was there. ... The Province began to change the funding mechanism, ... began to introduce 70% funding , and the cap was introduced in 1989. Up until '89 it was almost a partnership relationship. It was only with the sort of move towards fiscal control in '89 and '90, and that whole era in our relationship changed.

(ii) Labour

There continued to be no coordinated effort on the part of unions to influence reform. The community, unlike the institutions sector, was not a heavily unionized sector. The SAO model was introduced before massive restructuring of the hospital sector and before the recession hit the province in the early 1990s. In addition, with the incremental nature of this particular set of reforms, there was no imminent dislocation for community workers. One union spokesperson also argued that the silence of organized labour was more due to the lack of recognition afforded them by the Liberals.

P040: I don't think the Liberals thought of the union movement as a group you would consult. They were just the workers. They are irrelevant. (They would say), 'Oh, we're talking to the people because we're talking to the user, the community people, and we're talking to the employers. So we're covered.' So it was only under the NDP that we finally broke through in terms of being taken seriously as a group that had to be consulted.

(iii) Consumers

Many interviewees felt that the Liberals, as one put it, were not as "wired to the consumer."(P061) Some felt that the seniors were also not as yet a well-formed lobby group. Nevertheless, the respondent went on to say that it did not matter because the Liberals listened to spokespeople from institutions and to professionals, such as physicians.

People with disabilities, however, may have been the exception. With the second Liberal mandate, the disability community was beginning to recognize that the government's intention to reform LTC services for seniors affected the very services they used as well.

(G079) Later on when long term care reform actually unfolded, and it took in large numbers of people from two population groups, the elderly and people with disabilities, there was a fair amount of anxiety, particularly on the part of people with disabilities about being folded in the care group, that they felt they had no great kinship with, particularly if they were the younger disabled.

With the change in the senior's movement to value more independent living and autonomy, the two groups realized, as stated earlier, that they had more in common than they had in the past. During this period of reform, disability and seniors groups got together to discuss common principles for reform and to see if they could form a lobbying coalition.

C010: What we tried to do with that was to come up with a set of common principles and say, 'Look you can recognize that there are going to be differences. You can respect the differences, but is it possible to come up with a common set of goals and principles that we

can agree on to get over the hurdle and to really get the government moving on something. And then deal with our differences (when) you have to deal with them.'

However, this was a short-term coalition. As the second Liberal model developed, the disability community did not want to talk about the issues that were more of concern to seniors; namely, institutions, professional assessments and referrals. After the publication of *Strategies*, the disability community began to lobby government to be removed from the SAO reform.

C010: Again it was pretty much saying to government, 'You've got to take us out.' Even the service providers were on side. So you had the March of Dimes and Easter Seals and the MS society, Cheshire Foundation saying, 'We're different.' In a sense the Liberals never really took them out. But that was the battle, and they did get agreement in principle to get direct funding. So it was sort of an alternative plan proposed. Now, the Liberals never really followed through with it. They (disability groups) did a huge lobby campaign essentially. It was at that point in 1990, that a group which came out of the Attendant Care Action Coalition, and the Centre for Independent Living, and others were meeting on a regular basis and really lobbying hard. So all of the energy from the disability side went into direct funding. That was really what they wanted to talk about. ... Once the government sort of agreed that they didn't have to be part of it, they dropped out of the rest of the discussion. There really isn't any active discussion with the government on the other kinds of issues in the SAOs.

Although the disability community only got agreement in principle for direct funding, they felt they did influence government in other ways.

C010: I think in part that's the reason that under the Liberals, you never saw the full move of long term care into Health formally. ... I think part of that was the disability (groups), both within the government and outside said, 'We don't want to be part of the Ministry of Health. We're not sick.' ... There was a real fear of going into the Ministry of Health, because they'd been in the Ministry of Health and fought to get out, you know, during the Davis years, and didn't want to go back in. And they had their own office at that time - the Office for Disability Issues ... and a Minister for Disability was around, and I think that also played some part.

The Multicultural community was interested in retaining their own ethnic specific programs. Based on the argument that Ontario and particularly, Toronto, were made up of a very multi-cultural population, they lobbied to have diversity of services for different ethnic groups be considered the norm for the sector rather than the exception. They felt that they had most influence with this government, because "the Liberal governments traditionally at least for the last several decades in Canada have been much more attuned to the interests of ethnic communities than the other two

parties. This Conservative government (Harris), not so much the tradition of Conservative governments pre-1985, but this Conservative government and the NDP are much less attuned to, and sympathetic to the issues and concerns of ethnic communities. Frankly, they owe much less to them in terms of their electoral success." (C030)

Overall, however, during the Liberal period, societal interests were neither very vocal or active in trying to influence government. "My understanding of that era was not much of that (interest group lobbying) was going on. They weren't organized in a way that would allow for that." (G058) Many organizations did not have the necessary resources to lobby, either an Executive Director to speak on their behalf or someone within their organization who had the time to review government proposals. However, one government official indicated that, had the groups lobbied, government may not have listened. From this person's perspective, none of the groups really influenced government because they were not able to rise above their own interests to put together a model that encompassed the whole system. In answer to the question asking which groups were influential, the official answered,

G105: Well frankly, the answer's not many, or any that I could think of. Because who sees the whole system? And who conceptualizes it? And how many of them know about what it is to come in and run a huge apparatus encompassing several thousand people and have an idea of what it means to reorganize in a comprehensive way. And the answer is most of them don't. They're looking at the elephant, and they see a leg, or they see a tail, or they see a trunk, because that's what they deal with. So you ask them what to do. They say, 'Well we need a bigger trunk.' Or whatever they happen to be looking at. They don't see the whole animal.

4.2.5 The Mobilization of Interests

During the latter part of the Liberal's second mandate, there was a stirring among groups, particularly, seniors, the disability community, and the support service groups, to strengthen their positions by joining resources and forming alliances. Although it was not until the NDP mandate that the Senior Citizens' Consumer Alliance (SCCA) would form, the initiation of the idea started at the end of the Liberal period when they felt that they were not having much effect in moving the government forward.

C007: And the seniors got together because we were very unhappy. We had responded in writing, attended all of the meeting for *A New Agenda* and for *Strategies for Change*, and we had responded in brief form, and we had meetings with the Minister of Health and people ... but we were getting nowhere. We were hoping they would implement it, that they would do something. We've been talking to Ministries, we've been talking to people, service providers

and we're getting nowhere. So, we decided that the time had come when we were getting nowhere doing it this way. So we had to do something else. And we decided to talk to a consultant and see if they would help us either write a better brief than we were doing, or something. And this is where the idea came in that we would work with other organizations and we would form an alliance.

Unlike the professional health services, which had large paid staffs and were more able to lobby government, the support services relied heavily on volunteers. At the end of the Liberal period, the various not-for-profit support services, also came together to form the Ontario Community Support Association (OCSA). Not only did this alliance eventually find a greater influence with government, but government also found it easier to consult with this constituency of hundreds of small one-service agencies. This group felt a need to organize not only because they believed they were the undervalued, underpaid part of the system, but also because they felt increasing competitive pressure from for-profit agencies. Although this sector had grown from largely not-for-profit roots, increased demand was attracting commercial agencies. As spokespersons for a number of agencies that joined OCSA put it,

P093: Well, I think we felt that we actually hadn't had a voice at the Province. You know, hospitals had a strong voice, physicians had a strong voice, but the community-based services didn't. We were also feeling very threatened by ... a growing threat of the for-profit homemaking sector taking over what traditionally had been a not-for-profit sector. So it was kind of a wake-up call. (While demand was growing and the agencies were not able to keep up with the demand), we were looking at increased competition from the private sector. ... And basically, most of us had always thought that because we'd done nice things and had God on our side, that it was fine. ... Homemaking and home support and meals on wheels, we saw ourselves as the poor cousins, and we thought, 'This is silly, you know. We do hundreds and hundreds of hours. We're sort of the meat and potatoes, you know, so that everybody can whip in and do fancy stuff. And if patients don't get fed, don't get bathed, don't get their houses cleaned and so on, you know, it's impossible for a nurse to float in for 15 minutes and poke somebody in the arm. So why don't we actually do something about it.' It took three years to get those organizations together.

P096: There was a time as there is in a lot of things that happen in life, that you come to a cross-roads and it's a good thing to do. But then there's an outside force such as the government who are about to bring changes and you realize that you better get together and start to work together and start to really make sure that your voices are in unison first of all.

This group of agencies had also hired a consultant to help them write a paper and lobby government. The seniors groups would later hire the same consultant to help them form an alliance and to lobby the next government. As will be discussed in greater detail in the next chapter, it is not surprising that the two alliances (SCCA and OSCA) would put forward similar models to the NDP government.

4.2.6 Assessment of SAO by the LTC Policy Community

The Liberal period was viewed as the period of balanced reform by providers, consumers, and government officials. Balance meant that the new model would not overly disadvantage any societal interest.

P067: My sense is that it was a balanced viewpoint. It was just a balanced position of all the stakeholders to come up with something sort of mutually agreeable and seemed to balance out all of the perspectives.

A government official involved in this reform indicated that the reason that there was general support for reform was that it was principle-driven, flexible, and did not represent drastic a change from the status quo.

G092: The important feature of Strategies for Change and the SAO model was that the principles were accepted; that is, it was a principle-based reform and there was wide acceptance of the model. The model was flexible. An essential feature was that it was a partnership model without being overly prescriptive. Built into it was a strategy for dealing with conflict of interests between the manager and deliverer of services; that was the idea of community management to monitor conflict of interests. ... The government didn't believe that a large monolithic model like the NDP model proposed later would lead to innovation. It was envisaged that the model (SAO) would vary across communities. We decided on the continuation of profit and non-profit agencies in roughly the same balance as existed because we thought it would be less threatening. We recognized the difference between the two sectors and that there was value in having a balance. In many cases non-profit is more expensive, and for-profit could be more innovative. Therefore, we wanted the best of both worlds.

Service providers on the whole supported the brokerage model. One provider echoed the sentiments of the government official cited earlier, the model was viewed as non-threatening.

P102: It didn't feel like a hell of a lot. It wasn't anything that you couldn't support because what they were really talking about is creating better access, ... not developing mechanisms to have more services available in the community to support people. ... We were feeling

frustrated just because there were lots of planning and not a lot happening, but there was no negative sense of what was trying to be accomplished or any major worry about it. .... (For-profit agencies) just saw it as opportunity. They felt the demographics, you know, the aging population, they saw an opportunity to grow their business. And there was nothing that we know that was going to be created in Service Access Organizations or anywhere else that threatened that growth. We didn't feel any threat being an issue.

The brokerage model was supported because it did not endanger the viability of existing agencies. The elites in this policy community often served on the boards of a number of agencies and would not back a model that threatened another member's agency.

G079: I think a number of (our members) liked the brokerage model because it didn't blow up all of the individual local agencies.... You know Betty doesn't want to be blown up. Charlie on the (Board) won't support blowing her up. So there was a certain amount of support for the brokerage model.

Although the Liberal government's intention in incremental reform was to have a balanced approach, which would keep all happy, there were some criticisms. Senior consumers felt that *Strategies* was not a big enough step forward from *A New Agenda*. Furthermore, money was being spent on restructuring government rather than on direct care where it was needed.

C007: We were repeating what we'd done before in the *New Agenda*. Now we're spending hundreds of dollars that could be spent on services. And by now they're turning people out of hospitals early; they're sending them home, to the community; and they're not improving the community care. ... All this money being spent setting up another new office (14 Area Offices) to do what? And we had the sense that nothing was going to happen. And you realize how right we were. 'Cause I'm talking about 1985 and now we're into 1990 and we're still talking about one stop shopping. It's still a good point. It's one we want. But let's get on with it!

As might be expected, the disability community found little in the SAO model to recommend. In fact, the model reduced autonomy from their perspective, a value they were not interested in sacrificing.

C010: It's still the problem of: it's great if you fit in the mold; if you know what you need, it's a waste of time. ... If you have one provider whether it's the One-Stop Shopping that actually provides services or they broker for services, you're actually giving people much less choice and much less flexibility in what can be delivered.

Social support providers, like seniors, felt that the SAO model, while in the right direction, was merely incremental and did not go far enough.

P061: Because it was still separating health and social services. It was still fragmenting. It was not dealing with the fundamental issue, which was the difficulty of access, that's resulting from the enormous fragmentation. One-Stop Shopping was moving in that direction. The Service Access Organizations moved a little bit further along in the direction. I don't think that many people had at that point in time really believed that it was possible to really integrate the system.

Or they saw it as an insertion of an even larger bureaucracy than the current Home Care Program between themselves, the service deliverer, and the government. (P093)

Although provider organizations favoured the notion of brokerage, of independent governance of SAOs, and the stipulation that service providers could not be an SAO, they were split on the case management function of SAOs. While Home Care Programs supported this function, other service providers felt they would lose a lot of professional autonomy and control, or that it would not eliminate duplication in assessments. The function of the case manager was key to all models proposed from the Liberal period on and how it was defined was critical to its acceptance.

G058: The role of the case manager was being defined year by year. And the importance of the success of that role was significant in the eyes of, I think, those who worked in the system. There had been quite a struggle to define what case management's function would be without having to compete with the service providers on occasion. ... In the very early days of Home Care Programs ... there was a resistance from the service providers to have this new type of worker, called a case manager parachuted in on them; where the case manager was viewed as having the authority to decide who, first of all, was eligible for Home Care programs at all. And then the case manager would essentially decide who of the service providers - the nurses, or therapists, or homemakers - which service would be appropriate for this client's needs. ... So there was a fair amount of power resting in that position. And it created tension in the relationships among the other professional or paraprofessional team members.

P061: The professional social work approach is to have the same individual assessing needs and delivering the services, or the same organization assessing and delivering. Rather than an organization that does the assessment and then tells agency A or service B that is what their decision is and this what they (should) do. The problem with the latter is that then agency A does their own assessment, agency B also does an assessment. And you end up with a minimum of three assessments.

P069: The problem with brokerage is the fragmentation of the care delivery, in that the client may have the Red Cross homemaker, the VON nurse, and Paramed for the shift nursing, and someone else for something else. It mitigates to chimneys of care, as opposed to consistent, provider-driven care coordination. Now the Home Care Programs would argue, 'Well, the case manager is in effect managing all this different care.' But the reality is the caseloads with case managers may be 150-200. I mean they're not coordinating care.

Another spokesperson for one agency also expressed concern about the brokerage process where the perception was that quality would be sacrificed for cheaper services. This respondent also believed that the Liberals were trying in this way to introduce more for-profit agencies, especially into homemaking services. This sentiment would be raised more broadly from a majority in the policy community during the later Harris Conservative period.

P042: We had great concerns with the brokerage portion of it. It's the same as the brokerage concerns now, where, although the request for proposal is supposed to be based on quality and on cost, our fear is the drive will be the cost only. There'll be movement to agencies that provide a cheaper service. ... It will be of lesser quality.

Yet, some for-profits felt that the SAO model did not level the playing field for them, and that the SAO would continue to issue contracts more or less in the same informal fashion that the Home Care Programs had been doing. (P059) As the government official cited earlier stated, interests may depend on which part of the beast you focus.

Strategies for Change was intended to provide a focus for the next phase of the reform which was to review directions, resolve concerns and begin the local implementation planning process. Consultations would be coordinated by the local managers of the new division with DHCs, municipalities, and MCSS area offices. A series of information meetings, as well as issue-oriented local meetings were planned, to culminate in a provincial conference. Interested parties were invited to send in written comments on the report. Community planning for reform was to take place over the next several years. In September, a series of about 40 community meetings were to be held to discuss local planning and implementation.[25] The Liberal government pre-empted any formal response to their model by precipitously calling another election after only three years into their second mandate in the Fall of 1990.

The Liberals ran on a platform of expanding community-based care and home care, with a plan to develop these services for seniors and people with disabilities by a $2 billion, 6-year program of reform of the long term care system.[26] However, the people of Ontario were cynical about the

need for a premature election. Seeing the call as an opportunistic move on the part of the Liberals, the people voted in a majority NDP government.

4.3 Conclusions

Reform during the Liberal period was very much incremental in nature. The LTC system as designed by the Liberal government remained more or less the same, with the inclusion of a mechanism for introducing coordination of referral and assessment. Increased public financing for services was still within the existing framework for the role of the state in this sector, and was intended to improve equity of access and the strengthening of the less expensive forms of care. The existing balance of for-profit and not-for-profit organizations would continue to deliver services. As a result, the public/private mix did not dramatically shift in this period. The coordinating agency (One Stop and then the SAO) would be governed by a local board that would not be a provider organization, removing one of the issues of concern, namely, conflict of interest. The agency would issue contracts more or less in the same informal way that they had been doing in the past. Rather than changing the system in one sweep, the Liberals piloted their ideas in different jurisdictions allowing local conditions to determine the eventual shape of the model in that community. While more cautious, this approach allowed for greater flexibility.

However, at this stage the real agenda in LTC reform was the positioning of government to be able to control an increasing demand for services from an aging population. With the reduction in federal funding for health services under the Established Programs Financing, the Liberal government needed to reduce the costs of the health portion of LTC community services. The old ways of caring for seniors were too expensive and had to be transformed. New ideas were coming forward on the health of populations, their determinants, and the importance of prevention. A shift away from the medical model was launched by a growing belief dominant at the time and promulgated by the Premier's Council on Health.

The government introduced a number of institutional changes in both the structure and process of LTC reform development to ensure that reform would be guided by this new set of principles. The shifts of lead for reform to first the OSCA and then MCSS allowed for the development of a reform model that was not dominated by medical care. The creation of capped budget envelopes for LTC services would allow for the reallocation of funding from more costly to less costly services. The future transfer of the budget for the Home Care Program from OHIP to the LTC envelope would transform a universally insured service to one where eligibility criteria could limit government exposure to increased demand.

The integration of services was first brought about through the step by step amalgamation of the two different cultures of MOH and MCSS. This was first accomplished by having the two Assistant Deputy Ministers responsible for community services in MOH and MCSS report to both Deputy Ministers. Eventually the two divisions were joined with one ADM reporting to both Deputies, joined but separate. The next government would complete the transition.

Fully aware of the escalating costs of Home Care, giving the lead to MCSS and moving towards the integration of budgets were strategic moves to reduce costs by shifting them gradually from the public to the private purse. While creating the structure for potentially massive change, the Liberal government's reform in the SAO model was positioned as incremental. At the time of the election, Home Care was still a fully insured entitlement under OHIP. In their reform, the Liberals were able to continue a system that provided professional home care as an entitled service, strengthened the ability of the informal private sector to continue to provide for individuals, and retained consumer co-payments for services not medically necessary while providing a safety net for those who were unable to pay.

Although reform was incremental and did not elicit passionate response from societal groups, it did not mean that there was full support for the Liberal models. Groups, however, at that time, did not have the resources to raise the level of their concerns to an audible level. Nor were there other contingencies that would bring together disparate groups and galvanize mutual interests. The recognition of the limitations of lobbying alone started to dawn on groups as they began to mobilize into coalitions. In the next five years the new NDP government's belief in consumer and worker empowerment and their fiscal strategies to restrain spending would provide the context for the merging of interests.

Without well-organized societal interests during the Liberal period, however, government ideas on reform were allowed to prevail. Institutional changes within government reflected these ideas and were introduced in the service of those ideas to advance reform. Balance and incrementalism, the hallmarks of the Liberal reforms, would soon give way to pressures from realigned groups supported by a new order within the wall of government. The next chapter will analyze the approach to reform under the NDP government.

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Chapter 5

LTC Reform Under the NDP, 1990-93

Election of the NDP Government was as much a surprise to the party as to the rest of the province. It was the first time in provincial history that the party was elected to power. It was commonly believed that the 1990 vote reflected more an anti-Peterson/Liberal vote than a pro-Rae/NDP vote. Many New Democratic party candidates ran on the belief, and perhaps even the hope, that they would not be elected. As a result, the NDP were not well-prepared to assume the role of governors of the province. Once in office, they discovered that the finances of the province were not as healthy as the Liberals had led everyone to believe, and their first two years were marked by a deepening recession.

The election of the new government heralded a change in political ideology which favoured community participation, greater sensitivity to visible minorities, more centralized control of programs, support of organized workers and preference for not-for-profit delivery of health and social programs. These values were reflected in the organization of government institutional structures and the relative access of societal interests during this period. Formerly marginalized interests were given voice in this period. In particular, consumers, unions, and community support services were encouraged and, as some believed, became the mouthpiece for government. However, as meat was put on the bones of reform, interests became threatened and formerly supportive groups joined the ranks of the dissidents. This was a period of considerable dynamism in alliance formation and breakdown. In the end, legislation remodelling the LTC community sector was put in place which strongly reflected NDP ideology. However, nobody including the NDP government felt like winners.

This chapter will outline the reform developments during the first three years of the NDP mandate between 1990 to 1993. The first year marked a period of education for its members, many of whom had been elected for the first time to provincial parliament. At the end of the first year, they released *Redirection of Long-Term Care and Support Services in Ontario*,[1] a consultation document which recommended the Service Coordination Agency model. Developed by the same bureaucracy that had developed both *Strategies for Change* and the Liberal Service Access Organization model, there was little in the values and proposed structures in the two successive documents and models that differed. To many in the policy community, it was the Liberal model with a new name. The document, however, was to be the basis of a far reaching and intensive consultation of all members of the policy community, and, in particular, the voices that had not been heard in the past.

In keeping with their ideological values and beliefs, the NDP empowered formerly marginal groups in the sector, namely consumer and the community support sector which delivered the softer social services. These two groups would recommend a model which was adopted by the government and which represented a radical departure from the growing political ethos in most other jurisdictions. At a time when governments were promoting privatization and competition, the second NDP model, the Multi-Service Agency (MSA) was akin to the nationalization of the private LTC delivery system.

The recession in the early part of their mandate led the NDP to take certain decisions which were viewed as contrary to their own political ideology. After their first expansionary budget, they changed directions and put on the brakes to spending. They introduced a Social Contract requiring both the civil service and the broader public sector to accept wage restraints which contravened some existing negotiated contracts. This action led to the mobilization of newly formed interests which had an impact on the progress of LTC reform.

This chapter will document and analyze the developments leading up to the publication of *Redirection* and the SCA proposal, the province-wide consultation, the effect of the recession and the government's response to it on societal interests and the reform itself, and the ultimate recommendation of the MSA model.

5.1 NDP Government (1990-1992)

When the new government assumed power, MCSS retained the lead for reform, working with MOH and the new Ministry of Citizenship (MC) which now assumed the responsibilities for seniors and people with disabilities, as well as mutlticultural and anti-racism issues. This government's commitment to visible minorities went further than the previous Liberal government. They would eventually come out with a policy on anti-racism which was viewed as more proactive than the earlier policy on racism. In addition, their commitment to race would later be viewed by non-visible minorities to overtake commitment to ethno-cultural diversity.

The continuation of MCSS as lead reflected, as before, the continuing distrust of MOH, the fear of medicalizing this sector, and the need for cost control. It was an institutional solution to implementing ideas and policy interests dominant in both the government and its major constituency.

P061: It was a matter of the government of the day having the philosophy that the social services - I shouldn't put it so much in terms of social services as preventative services - needed to be considered most significant. ... The health services were much, much more expensive, and it was a never-ending thing. You could fund them and fund them and fund them and it would

never be enough. And somehow or other, something had to be done to find a way to fund services that might prevent people from getting too fast into that high-end system.

G096: From listening to people in the community, the message ... was that it had, even though the bulk of the money was in one ministry, the essence of what we were trying to do was community involvement and community-based support so that, if you have it in under Community and Social Services, it is not as frightening to people. ... I think the relationship between people who worked in Com. Soc., between the bureaucrats and the people who worked in the community was much more defined, more comfortable and more trusting than in Health, where it's envisioned that it's a Ministry of Institutions.

G102: My understanding of that (giving the lead to MCSS) is because Home Care which was in the hands of Health was a universally accessible service. If you established eligibility, the service was yours and it was yours as a right and there was no cost sharing with respect to that. Com. Soc. which funded the Home Support side, the non-medical side, was a Com. Soc.'ish kind of a model where there were user fees, where there was a lot of volunteer participation and augmenting the services that the paid agencies could receive through volunteers. Because behind all of this there was a need to cap the cost. All along, people realized that the costs of Home Care which were the expensive pieces of the formula were escalating all the time. In order to cap that there was a plan, there was a need to cap the envelope for Home Care services by moving it into the Com. Soc. arena. As the lead, they could start to look at that user-fee, shared-cost, more use of volunteers model as opposed to the universal right like OHIP. ... So this was an attempt to shift it from the universally paid for, absolutely your right to a shared responsibility which was the model that Com. Soc. tends to espouse. ... Again it was an attempt to de-medicalize that as formally as well.

The Minister of MCSS announced the intention of the government to review LTC services and programs before making any further announcements. On June 11, 1991[2] after a year of internal review, the MCSS Minister, Zanana Akande, announced the government's intention to reform LTC. Acknowledging the work of the previous Liberal government and the fiscal situation in which the NDP found the province when assuming office ("the enormous economic challenge Ontario faces in this time of recession"), she announced the investment of $647 million into LTC services by 1996-97 (the same funds announced by Charles Beer in 1990) with almost $440 million going into community programs.[3] A consultation paper for a much broader and more far-reaching consultation than any which had previously been considered was also promised. She stated that she and her colleagues, Ministers Lankin and Ziemba, "believe that the consultation process is an important part of the

product."[4] Reform itself was not the only product, how one got there was as important to this government reflecting their notions of procedural justice.

5.1.1 *Redirection* and the Service Coordination Agency (SCA) Model

In October 1991, the government released *Redirection of Long-Term Care and Support Services in Ontario: A Public Consultation Paper*.[5] The principles and goals guiding reform continued to be the same with some minor variations in emphasis and additions; such as racial equity, enhanced protection of workers, and rather than the continuation of the existing mix of for-profit and not-for-profit providers, the majority of which were non-profit, the NDP stated a preference for the latter. The difference in emphasis in the values underlying reform was at the heart of the ideological separation between the NDP and the former Liberals, and would explain much of their subsequent actions and ultimate direction in LTC. The goals of reform were:

- integration of LTC health and social services,
- improved access to quality services,
- creation of community alternatives to institutions,
- greater consumer participation and control of the services they receive,
- promotion of racial equity and cultural sensitivity,
- realization of funding equity across the province,
- enhanced protection of the rights and security of service workers,
- and continued preference for a not-for-profit service delivery system.

The reform continued to focus LTC services for both the elderly and the disability community. The government intended to establish approximately 40 new Service Coordination Agencies (SCAs) across Ontario. These agencies were to replace and consolidate the services provided by the Home Care Program and the Placement Coordination Services Program. Employees of the latter two programs would transfer to the new agencies. The SCAs like the SAOs were to act as a single point of access for Health and Personal Support Programs (see below), respite and adult day programs, and institutional care. They would assess and monitor the individual's needs, provide information and referral to community support services, and purchase services for consumers from delivery agencies. Each agency would have a local representative board of directors, the membership of which would be subject to consultation but was to reflect the racial, cultural and linguistic diversity of their communities.

Integration of services was to begin within government through the creation of new program structures. The health and personal support services provided through the Home Care Program, Integrated Homemaker Program, Attendant Outreach Program, and the Homemakers and Nurses

Services Program (which were administered by different levels of government , provincial ministries and community agencies) would be integrated into the new Health and Personal Support Program with consistent eligibility criteria and service standards. Access to these essential services would be coordinated through the new service coordination agencies (SCA). Access to support services, attendant care, social work and nutritional services were demedicalized in that they no longer required the receipt of professional services. There would be no charges for services under the Health and Personal Support Program. Homemaking services could be accessed directly by consumers if they were deemed non-essential but preferred. They would be expected to contribute to the cost of the service according to their ability to do so.

The NDP connection and commitment to grass roots organizations were reflected in their decision to expand and increase the funding to community support services. Priority was to be given to underserviced communities to improve geographic equity of access. Through guidelines, the government was to ensure greater consistency in eligibility criteria, consumer fees, service delivery and administrative standards. In recognition of agencies' varying ability to raise funds, the government changed the funding formula from 70% provincial funding and 30% local funding and consumer charges, to funding 100% of the agency's approved budget after deducting revenue from these other sources. As a result, some agencies would receive more funds and some less than previous years. Services would be accessed directly by consumers or through the information and referral service of the SCA.

Recognizing the gradual change in the site of care, the government indicated its intention to shift funds from hospitals to community-based services. It announced that it would reallocate annually for the next 5 years $37.6 million from the provincial hospital budget to LTC. Each area of the province was going to be given a funding envelope for community-based services that would be allocated by area offices under provincial guidelines with the assistance of local planning groups. While communities were not expected to have the same priorities for services, criteria would be established by the government to determine the basic level of services that must be funded in all areas. A pilot project was introduced to provide direct funding to people with disabilities to purchase their own attendant care.

A key focus of *Redirection* was the attention paid to front line workers. In the reallocation of resources from the institutional to the community sector, the government indicated that it would protect the interests of workers in institutions. They foresaw the creation of new jobs in the community and in LTC facilities, and would help institutional workers access these jobs through training and upgrading programs, and human resource planning. This decision would create some

tension between community and institutional workers in the last two years of its mandate when the LTC model would change dramatically. In recognition that most LTC workers were women and, in particular immigrant women and women from minority groups, the government intended to revise funding so that agencies could provide more secure employment under improved working conditions. It intended to extend pay equity requirements to the private sector and to public sector workplaces that weren't already covered. Wages for homemakers were also to be adjusted.

The management of the new LTC sector was to be undertaken by the integrated Community Health and Support Services Division and its fourteen LTC Area Offices as set up by the former government. The decentralization of the division into the fourteen LTC Area Offices continued to reflect the ethos of MCSS whose other programs (outside of LTC) were already administered by fourteen different areas offices. Once again, structure within government reinforced the NDP's commitment to community.

True to their principles regarding the inclusion of marginalized voices, the government made it clear that the priority groups for consultation were consumers, their families, and front-line workers shifting the emphasis on which groups it considered important in the reform. Emphasizing the importance of process as product, on September 12, 1991 there was a province-wide focus group to consult on the consultation process. The process was to be open, broad-based and comprehensive. Local consultation processes would be assisted by the 14 area offices of the Community Health and Support Services Division, and area managers would be responsible for relaying community input to the Ministry and the three Ministers. The central Queen's Park office was to lead the consultation with provincial associations.

As this chapter will document, public consultations were a strong component of this government's ideological belief in governing. The NDP would go the citizens of Ontario in a number of different policy fields such as employment equity, social assistance reform, and advocacy. In its attempt to include its citizens in policy making, the government exhausted most groups' capabilities and resources. In LTC reform alone, the government itself undertook a massive consultation. They provided funding to a number of associations to consult their own membership. One of these groups, the seniors, would mount an ambitious consultation process that would parallel the government's.

Respondents stated that consulting broadly and more inclusively was part of NDP political philosophy, a belief that would eventually be the undoing of their efforts.

G095: It (the consultations) was very ambitious. It certainly let everybody who wanted to be heard, be heard. I think it was necessary. I mean, reform of long term care had by that point been around for about ten years and there was a huge frustration. And as I said at the beginning,

nobody had ever, sort of, gone back to square one and said, that if we were starting with a brand new clean slate how would we design this. And the hearings provided an opportunity for that.

P067: I think when the NDP got in they had to prove that they were out for the disadvantaged, marginalized groups and had to have signals that reflected that. ... So I think that they probably felt they had to provide resources to these groups that previously lacked the infrastructure to have a voice or be at the right tables, or have lobbyists, or know how to participate within the whole political venue. I think some people (political) were probably driven by passion for that and feeling it is about time these people have been sort of oppressed and now there's that opportunity. I think they also were very politically naive to how this would really play out. And I don't think they realized that their own would start to eat their young.

5.1.2 Service Coordination Agency: A Liberal Model?

The fundamental similarities between *Strategies for Change* and *Redirection*, and between the models proposed by the two documents, the Service Access Organization (SAO) and the Service Coordination Agency (SCA) were striking. In order to understand the dynamics that led to the conceptualization of the later NDP model (the Multi-Service Agency) which differed significantly from their earlier model, it is important to examine the government's commitment to and development of the SCA model.

Interviewees, on the whole believed that the two models (SAO and SCA) were similar with minor variations. "It seemed to me at the time that it was just ... some minor changes to give a new government a label." (G094) "I remember at the time, we did an internal briefing note that compared them (SAO and SCA). There were some subtle differences but they were minor."(G103) The reasons given for the similarity ranged from the government was not well informed about the issues, to it being indifferent to the issues, to the similarities being purposeful. As stated earlier, forming the new government was as much a surprise to the NDP as to others. Within government, the feeling was that the NDP was not well-prepared to govern.

G092: They never expected to win the election so they weren't ready to govern. They were suspicious of the bureaucracy, even individual ministers were not trusted by the Premier's Office. It was a government in chaos.

G095: And that first year was, as you can imagine, a year of total turmoil as we came to grips with what the government meant and how it all functioned.

G103: They didn't have the experience of being an elected government before. There were a lot of things they were getting used to. And Long Term Care is a very complex subject.

Given their inexperience, many felt that the government either did not have a position on LTC (P059), did not view it as a priority item at the time (P069) or were not prepared to take risks.

G079: I think in the first year, they didn't want to change a whole heck of a lot until they understood it. And even when they understood it, they still didn't want to change a whole heck of a lot. I mean, my sense is that they were a new government. They recognized that they ran the risk of losing a whole lot of support if they changed too much too quickly. And I think the brakes were on all kinds of things ... while the new political masters and their senior civil servants, their deputy ministers began to get their heads around things.

G093: It was a government that had never been in power before, and had not anticipated being in power. And I think it was doing an enormous amount of listening to its public service, except on very specific areas where the Premier already had a pre-determined desire to do something. ... In any event, when it came to Long Term Care, the folks who were doing the changeover, said to Stephen (Stephen Lewis who was managing the transition for the NDP), 'you know, this is a program for seniors, and just leave it alone unless you want to get into trouble. And so, you know, it was just given a new spin.

Many were of the opinion that, because of their naiveté around issues, the government left the development of the LTC consultation paper to the bureaucracy. As stated in the last chapter, it was believed that the Liberals gave the bureaucracy a great deal of autonomy in the development of reform. Without a well-formulated policy of their own, the NDP further relied on the bureaucracy to develop their first model. Having already developed a policy to their own tastes and without further political instruction, the bureaucracy came up with a variant of their earlier model with elements that reflected the new political order.

C074: They were naive about the complexity of Long Term Care reform. As were all the political parties. They thought there was a model, it had been developed. ... They fine-tuned it and put their own stamp on it and named it their own name. The bureaucracy told them it was 100%, it was great. It was a 'go'. So, they went out with it.

G094: I didn't see a heck of a lot of difference between the Liberal approach (and the NDP). And I think it was because it was owned by the bureaucracy in both cases. The minor changes reflected some of the policies and principles of our party in terms of not-for-profit and those sorts of things, inclusiveness, but ... there probably would have been language around the

treatment of the workers, you know, those sorts of things. ... There was not, I think, strong support in the government for it one way or the other.

O106: There was speculation that the civil service was pretty committed to this idea, the brokerage model, and it was really hard for them to think outside that box. And the government was fairly new. And so when asked, 'what's your thinking about what needs to happen?', the civil service gave them what they'd already been working on under the Liberals.

P058: They (bureaucracy) were asked to re-write this (*Strategies for Change*) But they just re-wrote it, calling it something different, called the Service Coordination Agency instead of Service Access. They're both the same. ... The bureaucracy created the SAO, the SCA model. So it was kind of their birthchild. And furthermore, before that, they (bureaucracy) were the ones that, in years back, supported, created the brokerage model.

For the various reasons given, the general belief was that the NDP government was not committed to the brokerage model. "*Redirection* came out as a dialogue document. ... It didn't come out as, 'this is government policy'." (O106) The intention of the government, according to a Government official, was to use the *Redirection* document as the basis for community dialogue and consultation. The consultation would buy them time to develop a model more reflective of their values.

G095: My interpretation of that first document was really that it was a reiteration of the Liberals' commitment that something needed to be done and a better coordination was essential. And, 'here's our take on what the Liberals have done at a fairly preliminary level. Let's put it out, and see what the response is.' And (it) was the best that could be patched together at this point. And so the solution was, 'Okay, let's put it out there, see what the response is, and that will give us the time and the opportunity to make it right.'

Redirection and the SCA model were used as a jumping off point or a foil against which societal groups could reflect their own interests. The difference in nuances with the Liberal policy reflected the NDP's commitment to community empowerment, to the community support service sector from which many of its own ministers had come, equity for workers, greater participation for consumers, and the protection and promotion of visible minorities. The decentralization of the system and its shift to a more social as opposed to medical model was continued through the lead of MCSS.

The consultation on *Redirection* was unlike other government attempts. To ensure that professional providers would not dominate the advice given to government, the NDP would provide financial resources and access to institutionalize the participation of seniors and support service providers. The question on many lips at the time was whether the NDP's action to support these

groups was done to correct a previous wrong or to legitimate their own interests by creating a like-minded voice in the community. Both answers reflect the truth.

5.1.3 Mobilization of Interests

Recognizing that the new government had an ideological commitment to community and citizens, and that they had to create a voice to influence reform and counter the interests of providers, two consumer groups decided to hire Ted Ball, a private consultant, to advise them. The consultant working with these two organizations recommended they form an alliance with a third organization to create the Senior Citizens' Consumer Alliance for Long-Term Care Reform (SCCA). In June 1991, the United Senior Citizens of Ontario (USCO), the Ontario Coalition of Senior Citizens' Organizations (OCSCO) and the Consumers' Association of Canada, Ontario (CAC) combined their respective organizations to develop a co-ordinated response to the Government's proposed strategic plan for the re-direction of LTC. All three associations were voluntary, not-for-profit organizations whose goals were to improve the quality of life for older adults by promoting independence and participation. The interests of the CAC was specifically to create a "consumer-oriented health care system" with accompanying rights.[6] The USCO, a grass roots organization comprised solely of seniors, had never received any government funding in the past and had been self-sponsored. The OCSCO was made up of seniors' organizations and had a number of formerly unionized workers who would later inject some conflict into the Alliance.

The SCCA was intended to be a single-purpose body with a limited mandate to conduct public hearings and to respond to the Government on LTC reform. This association is typical of Paul Pross' issue-oriented group, one that has a single, narrowly-defined objective.[7] Later they would risk their relationship with government to pursue their single goal, unlike more institutionalized groups which are prepared to compromise on the issue at hand to further broader long-term objectives. The Alliance's focus was limited to those issues which affected senior citizens and their families, and specifically never intended to speak on behalf of the disability community.[8] Although an attempt had been made to bring together senior's groups and the disability community to form a broad "consumer" group to act as effective a lobby group as providers - "to be able to be a counterpoint to the doctors and hospitals" (C010), it never got off the ground.

Because seniors had felt that the Liberal government had listened more to providers they were determined to be heard this time round. One respondent indicated that the general belief at the time was that *Redirection* and the brokerage model was "owned" by the civil service and there was suspicion that a consultation run by the civil service would not be "authentic." It was this sentiment plus the distrust that the new government had of their public service that led a number of

organizations to seek funding to run their own consultations. Taking advantage of the NDP's commitment to consumer empowerment, SCCA sought and received funding from both the Ministry of Citizenship and the LTC Division to consult seniors and to respond to the *Redirection* document. One senior's organization referred to it as forming a "partnership" with the Government. "You (seniors) can probably do that better than we (government) can. You can find, as seniors asking seniors, you'll get better answers. And so we kind of formed a partnership with them (government), and they financed us to do a lot of research."(C007) Other consumer organizations also lobbied for government funding to get people out to the consultations "who will back your (government) agenda." (C010) Government officials at the time saw the funding of intervenors as inherent to NDP philosophy and their origins, creating an even playing field with other traditional health providers whose budgets allowed them to analyze policy and lobby to protect their interests. The importance of participation in government decision making would be specifically rejected by the next government under the Progressive Conservatives.

G108: I think it reflected the government's roots. When you come from advocacy organizations, the advocacy organizations needed funding to play an effective role in policy formation.

G093: Hospitals, you know did it (lobby) all the time. I mean the reason they could do that is because they had the OHA (Ontario Hospital Association). Well, the OHA gets it fees paid out of hospital funds. And hospitals are funded by the public purse. So, you either give it directly to people or indirectly. And I guess one of the things that we thought we were doing was making it a bit of a more even playing field, and we thought it would do everybody good to hear what the consumer wanted.

G095: I think there was a growing realization that the interests of the long term agencies that had served seniors and were very institutionalized and bureaucratized was not necessarily the same as the clients those people were serving. And there was no mechanism for the clients to be heard unless we found a way of providing that, and that's what the coalition's (SCCA) hearings did.

The SCCA formed a 12-member panel which met through the summer and fall of 1991. Shortly after the government released *Redirection*, the SCCA sent out their Public Hearings Paper to 6,000 decision-makers throughout Ontario outlining what they felt were the right questions about LTC reform. On January 17, 1992 the Alliance sponsored a public policy conference attended by 600 people who were consumers, providers and experts. They then proceeded to hold 16 days of public hearings before they issued their *Consumer Report on Long-Term Care Reform.*

The other alliance that would play a pivotal role in reform germinated at the end of the Liberal period. Three community support associations, the Association of Visiting Homemakers of Ontario, the Ontario Home Support Association, and Meals-on-Wheels Ontario had come together and had hired Ted Ball to help them facilitate a response to the *Strategies* document. The Visiting Homemakers Association had originally hired this consultant to help them lobby government to increase the wage rate for homemakers. These three organizations with the help of Mr. Ball looked for an alternative to the SAO. From these activities emerged the idea of the amalgamation of the provider organizations and on April 1, 1992 the Ontario Community Support Association (OCSA) was formed.

P061: It would be helpful for people who needed services, but also helpful for taxpayers from a funding point of view, to look beyond this entry level organization (SAO) that would then fan out and broker with everybody, and try to find some other way of doing things that was more cohesive, certainly a lot less expensive and more productive. ... And we started out really small and expanded, just brainstorming, "How could it look if it was different from this SAO thing? What would another idea be?" Well, the first step might be to ask each of the organizations that (would) belong to the SAO to contribute one or two members to an umbrella board. So the whole umbrella board idea, ... we all saw as being a step in the direction of a more integrated program which would hopefully happen later on.

Another interviewee reiterated that the integration of these organizations to form OCSA led to the eventual development of the integrated MSA model. When asked whether the process of LTC reform had influenced the decision of these organizations to form an alliance, one respondent stated, "I would put it exactly the opposite, that a lot of the reform initiatives evolved out of the determination of those of us that were at the front-line level in the community to amalgamate ourselves." (P061)

There were a number of reasons offered for these social-support provider groups to come together. As one interviewee who belonged to one of these groups stated it:

P056: Well they were all very small. Only one of the three had permanent staff. The other two were always struggling financially, and were able to have staff at all only through project funding, through various projects that they were able to get.. I think that they felt none of the three had a very good relationship with government. It was okay but they didn't have much impact.

P093: I think we felt that we actually hadn't had a voice at the Province. Hospitals had a strong voice, physicians had a strong voice, but the community-based services didn't. We were also feeling very threatened by - I'm speaking group not necessarily individually - by what

appeared to be a growing threat of the for-profit homemaking sector taking over what traditionally had been a not-for-profit sector. So it was kind of like a wake-up call. We were getting more and more people requiring services. Home Care service was limited and there were maximum hours. And we were finding we just didn't have enough other services for people. Our home support programs and our other programs were simply not meeting the need. We had waiting lists ... and many of our customers could not pay their shared costs, and we were absorbing it. In addition to that, we were looking at increased competition in a way that we'd never had before from the private (for-profit) sector. ... And basically, most of us had always thought that because we'd done nice things and had God on our side, that it was fine. ... We saw ourselves as the poor cousins. We do hundreds and hundreds of hours. We're sort of the meat and potatoes, you know, so that everybody else can whip in and do fancy stuff. And if patients don't get fed, don't get bathed, don't get their houses cleaned and so on, it's impossible for a nurse to float in for 15 minutes and poke somebody in the arm. So, why don't we actually do something about it. It took three years to get those three organizations together.

The professional, not-for-profit organizations, such as nursing organizations, already had either strong provincial organizations of their own, or had paid staff to lobby government. As a result, they did not see the need to come together with the support services. Unlike professional providers, during the early discussions a number of members from consumer associations had been attracted by OCSA. However, the consumers eventually broke away from the providers.

P070: Eventually, what you saw is a breakout between the consumers and the providers, which by the way, I think is quite proper. It's a much purer kind of thing when consumers are talking about needs for themselves. But when they're all tangled up with providers, you wonder if they're being manipulated. And it's, the word is bad optics. ... How does the government know that we haven't manipulated them into just singing from our song book?

Not surprisingly, many believed that Ted Ball was key to understanding the influence of consumers and community support providers during the NDP government. Many providers believed that the SCCA was actually being controlled and led by the consultant. He was viewed as key to the development of the later MSA model. Mr. Ball turned out to be the hub of many connecting spokes. Aside from initial contact with Ted Ball through the early stages of the formation of OCSA, one of the seniors' organizations that eventually joined SCCA had used Ted Ball to help them put in a brief earlier on auto insurance policy. Some political staff during the NDP period, including some Ministers responsible for the LTC reform, had previously been members of community support

associations; for example, Elaine Ziemba, the Minister of Citizenship, had run a Meals-on-Wheels program and had been involved in the formation of OCSA. Ruth Grier, the later Minister of Health, had been instrumental in the creation of a multi-service organization in Etobicoke. One government official who had been involved in hiring Ted Ball when she had worked in the community stated that the government was more than pleased when the SCCA had sought government funding to pay for this consultant.

P070: The NDP had figured out that the consumers really didn't know enough to help them answer the questions they needed to have answered. So when the consumers' group got themselves formed and they submitted to the government for a grant to pay for (the consultant), they (government) were only too happy to pay it because they realized (the consultant) was going to get them educated. .... They couldn't say, "Hire Ted Ball." They could just say, "Here's the money." But I think they knew that at that point that this was all going on, they'd (consumers) already been in quite in-depth discussions with him. So, I mean, and I think (the consultant) delivered.

Remembering that some officials in government had previously been involved with community support organizations, some provider organizations believed that the seniors were encouraged to hire Ted Ball by government because he would promote the model being developed by OCSA.

P058: There are many who believed that the management consulting group that was hired by the Seniors' Alliance really was reporting to someone other than the Seniors' Alliance. The Seniors' Alliance was the front, in a sense, for what other groups wanted, but they couldn't hire the ...firm because it would look too close for comfort. So it was the Consumer Group that was given funding and suggested, "Well, why don't you hire (name of the consultant)." .... Some believe it was the Ontario Community Support Association's key people.... There was a sense that it (the model) would be viewed like, "it's their model" and it needed to come from a more neutral grouping. And strategically if you place it with consumers, ...consumers, especially with an NDP government, are more likely to be viewed as the neutral group versus one of the players, the stakeholders.

P067: I think it was probably a match in a number of ways but clearly it was somebody directing that resource. I think Ted Ball had been in a number of different forums and I think he had some innovative ideas and some interesting ways of looking at things when people were trying to bring out other thoughts and get beyond just the party line of what was previously the Liberal party line or the Conservatives'. But I think it was clearly positioning and

supporting friends and not supporting enemies. And certainly the NDP were as corrupt as anybody else to make sure that the mouthpieces they wanted were there. And I think Ted Ball, though probably also had his own strength and his own skill at lobbying and working with groups and had demonstrated that with other political parties. So I'm not sure that it was an NDP issue versus that he had the skills that complemented what they wanted. And so they simply supported him because they knew through his manoeuvering that the Seniors' groups would be able to be the mouthpiece for the government. And they were hoping to position that voice with what they were trying to move forward with so they wouldn't be the lightning rod. And how could you yell at a bunch of senior people. So it was beautiful, you know, sort of shield to kind of walk through with some difficult decisions. But I think it backfired.

Ted Ball was also viewed by various seniors' groups as being very creative, a good facilitator, and an effective lobbyist with government.

C002: He was a very political person. He played a very strong role in influencing the development of the planning that the Alliance did. In many ways, he was a very creative person. I would never have conceived of the magnitude of the things that we did. As I say, they (activities) were historical because before we had gone when invited and participated as we were allowed to. So he was very creative in that sense, and he was very good at getting money from government for another project that we oversaw. ... There was a lot of very direct communication between the government and the Alliance through the consultant who was always reporting what somebody in the ministry had said, what they thought we should do and what we thought they should do. And they would give us money to pursue particular aspects and so on.

OCSA had argued that the government's own consultation process would not tap into the specific needs of their sector since the sector was new and underfunded. The Association furthermore wanted to do more than merely respond to *Redirection,* they wanted to suggest an alternative. With the government's financial assistance, OCSA also held their own parallel consultations facilitated by a consultant who had previously worked with Ted Ball. The fact that both SCCA and OCSA would eventually come out with the same model was, therefore, not surprising. "I don't think it's coincidental that the two models were similar." (P056) They came out with a model that integrated assessment and service delivery, the predecessor of the MSA.

Up to this point, unions were not much involved with the LTC reform. They kept a watching brief on the government's activities in this sector on a couple of key issues, in particular, the direct

funding project for people with disabilities and collective bargaining rights. However, nothing at this point spurred them to action. As one respondent from a union stated,

P043: One was the idea of how attendant care and services for disabled adults were going to fit in. And I believe that was a piece of the reform initiatives before we started calling them MSAs under the NDP. And the whole notion of individualized funding where the individual would broker for their own services. So we were interested in that. And then the other piece that we always monitored was whether it was going to be kind of a massive privatization, or de-unionizing of the units we had. It was probably primarily at that time watching to make sure our members were okay and then watching for what was going to happen to the sector overall. ... So fairly broad at that point.

Other established providers in the field such as the professional providers were not dissatisfied with the brokerage model. Most were concerned with the inherent conflict of interest of some of the former Home Care programs being run by providers which was addressed by the SCA model. Many approached the consultations as nothing more than an opportunity to promote their organizations.

P067: I remember looking and thinking, "this (another organization's submission) is saying nothing but selling (the organization). So I thought maybe this is how we lobby. We just sort of talk about what we've done, you know. We love the community and we love God and God loves us and love is beautiful and here we are and nurses are wonderful. And that was basically it.

A number of these organizations, however, were beginning to realize that the ground was shifting during the SCCA consultation. The emphasis on consumer empowerment, justice and an anti-medical approach was viewed by these organizations as metaphors for reducing provider authority. They quickly realized they would not be able to find common ground with the Alliance.

By March 31, 1992 the entire public consultation process was completed. It had been a massive undertaking. Over the five-month period, according to the government more than 75,000 people and 110 provincial associations participated in approximately 2,900 meetings held at both the local and provincial level across Ontario. When concern was expressed about funding senior consumers and not others, the government, towards the end of the consultation, provided funding to the Consumer Coalition of People with Disabilities to carry out consultation with their members.[9] [10] [11] Further to their commitment to community consultation and participation, the government had also distributed 87,000 copies of their *Redirection* plan in English, French, audio cassette, and Braille. An information pamphlet had been translated into 33 languages. The government's hot line had received more that 2,200 requests for information, and 1,800 written submissions had been sent in from

societal groups. While democratic participation in government decision making was a goal in itself for the NDP, it was one that would contribute to them not achieving their other goal of LTC reform implementation.

5.1.4 Institutional Changes within Government: The Shift from MCSS to MOH

In the Spring of 1992 the lead for reform switched from the MCSS to the MOH. Zanana Akande, Minister of Community and Social Services, was under investigation regarding her role as a landlord, and subsequently resigned as Minister. She was replaced by Marion Boyd. Frances Lankin, the newly appointed Minister of Health took over the lead for LTC reform and the new LTC Division reported to her. Given the resistance to associating LTC with the Ministry of Health, and the attempt by governments to emphasize social as opposed to medical services, the move was unexpected at this time. An exploration of reasons offered for the government's action provides some insight into the changing focus in reform. The reasons cited for the government's decision to transfer the lead to MOH ranged from the capabilities of individual ministers, to expediency, to a shift in ideas about the nature of LTC.

G097: I think it was the personalities and the way they (Ministers) were viewed. Frances was a singularly strong member of the legislature and a singularly strong member of Cabinet. And I think that she was seen as being able to cope with the additional responsibility as Minister. I think it has more to do with her than a shift in the policy itself.

G095: The Premier fairly arbitrarily handed this (LTC reform) to Frances in Health. And said for god sake, take it. And it was a product of frustration and inability to, in fact, move it at a pace that met (NDP) priority at that time. And so it was seen as, "let's put Frances in charge and get it moving." .. (It was a reflection of) confidence in her and frustration with Com. Soc.

However, this respondent also believed that with the movement of patients from hospitals and LTC facilities into the community the requirements of this growing set of LTC consumers were different. This trend marked a beginning of LTC services being devoted to a growing demand from the acute health sector as hospitals downsized. Eventually, as will be seen in the next government period under the Progressive Conservatives, home care would become re-medicalized.

G097: Well, I think all of a sudden it occurred to them that LTC is more than just providing social services, and that for a while as it was evolving both through the Liberals and the NDP there may have been far too much emphasis on the social side to the detriment of the health side. ... So many people in our hospitals who basically ought to have been in long term care facilities and people who were in long term facilities who out to have been cared for in the

community, there was no question that most of those people ... need very strong medical attention. So that more and more of the long term care was dealing with acute care.

G095: The realization was growing that whereas this started with just, sort of, community support services to keep people in their homes, there was growing need for services after people were discharged from hospitals because hospital budgets were being squeezed and that whole thing was happening. There were the disabled groups and others saying, "hold it, if you're going to reform long term care, we're going to be there too." And there was a growing understanding that this was moving more towards health than it was a social service; that if you were really to reform the system then it had to be seen as a responsibility of Health, as Health was moving more to the community. I mean, the overlap was becoming greater. The frail elderly were a constituency of Health, now sort of meeting what had been the 'well' (those who were still fairly independent and without major illnesses or disabilities) constituency of Com. Soc..

C074: There was a consensus developing both among the bureaucrats and among the service providers that what we were dealing with in Long Term Care were issues that were more health-related than they were social service-related. Whereas for decades many of the Long Term Care services were more social service based. People's healthcare requirements were less than their social service requirements. But clearly as the 80s drew to a close, it became clear that the Long Term Care issues were more health related issues.

For this interviewee the change in thinking about LTC came about because of a shift in thinking about disability and aging. These two conditions were "normalized" and were becoming perceived as every day occurrences. Consequently, the view was that meeting the needs and demands related to those conditions should be in the realm of the private market and the responsibility of individuals. Government subsidized services were therefore viewed as being reserved for conditions out of the ordinary.

P074: I attribute the change to a greater normalization of the aging process.... There are many, many people today who are physically challenged who live in the community, who live in their own homes, who go on the buses, who have jobs, who go to school, who have families, who live what we consider to be normal lives. But, who, ten or fifteen years ago did not live among the normal community. They lived in institutions. They lived in group homes. They lived in family homes but they were hidden away. But they weren't normalized within our society. And aging was a similar thing. In my view, throughout the 70s and 80s, we saw greater and we continue to see a greater normalization and acceptance of aging, and

acceptance within our broader society of aging. So a lot of the needs of seniors, the social needs of seniors and some of their other everyday needs are being met by businesses, by builders, by pharmacies, by the normalized society. They don't have to be met by specialized government funded services. So contractors renovate homes to provide wheelchair access and banks have specialized services for seniors, etc. So a lot of the reasons why people needed specialized services no longer exist. So it's less of a social service. ... So there was a consensus that these were health services, and there was no longer the pull within Com. Soc. to hold onto that portfolio.

While recognizing the steering effect of this institutional move, there was also a sense within government that the LTC Division had developed, through the straddled division, into more of a hybrid creature, dominated by neither Ministerial cultures. Therefore, the shift to MOH was no longer deemed to be detrimental to reform.

G103: There was also a sense at the time that we'd gotten past that health versus social services thing and that Long Term Care had become a more integrated kind of culture; that we weren't going to get flack from outside groups about going under Health. We talked about it. We thought that the disabled community might say, "What are you doing moving over to Health? What does that mean?" You know, "a medical model! a medical model!" We had great assurances that we were going to remain as a separate division within Health; that we were not being incorporated in the other silos. And that we were to be seen as a health and social service division. And I think it was just a feeling that probably the time was right and the bulk of the bucks was being spent on healthcare, not the social services aspect. That it was a Health Minister's problem, if you like.

Another institutional mechanism for integrating ministerial cultures and ensuring that all relevant interests were considered was the requirement under the NDP that all three Ministers involved in reform (MCSS, MOH, and MC) had to sign cabinet submissions on LTC. It was viewed as a new way of doing things in partnerships. "We were trying to get ministries to work together rather than have it isolated. And this was a little bit of a test, trying to see if we could actually get bureaucrats and the ministers to be more in partnership rather than take complete ownership and run with an issue." (G096) The dual reporting relation of the ADM, LTC Division, to both Ministers, however, was cumbersome and slowing reform down. Some believed that further institutional change was necessary to simplify process.

G108: It was a very unwieldy process with the fragmentation that was there. And we had this, in my view, quite unworkable arrangement with a shared ADM between Health and Community

Services. And what was happening was there wasn't clear accountability..... Every operational issue has multiple ministers You just can't work the process where you need three ministers to sign off every piece of paper.

Although the Premier decided to put it (LTC) in the Ministry of Health, this respondent believed that the proper place for LTC was in MCSS. The decision to give responsibility to MOH had less to do with vision than it had to do with confidence in the abilities of individual ministers. He believed, however, that the values and interests within the Health ministry would be detrimental to reform

G108: (It was) not a good fit because the main business of the Ministry of Health is paying hospitals and paying doctors, and it rarely has any intention for anything else. By the time you finish fighting with the hospitals, it's time to fight with the doctors again. ... Health exists as a highly centralized claims payment agency and a funder of hospitals. ... There's no substantial regional presence in Health. It does not have a view that it knows what's going on at the ground. Whereas Com. Soc., the power's always been at the regional office level. It's never been at head office. So what you were doing was taking a service system that essentially was quite devolved and regionalized and handing it to a Ministry that thought very much in head office terms, and in kind of universal terms. ... Lankin and (Decter) tried to give it attention, certainly way more attention than, you know, in dollar terms it merited. ... (But) it's not a mainstream thing for the Ministry of Health.

Another respondent, however, saw the switch as a good fit and a necessary institutional structural change to make the kind of adjustments necessary in moving from hospitals to the community.

O106: It made people generally feel more comfortable ... that it was being taken more seriously when it moved to Health. And one of the key reasons why people were thinking along those line was there were some real assumptions around money being released from the hospital restructuring to actually float a support for the very needed care in the community. And one of the problems had leadership for Long Term Care rested with Com. Soc. was that it was a much bigger gulf for that money to flow across. And therefore, it was less likely to happen. And I don't think it really happened anyway, but there was at least the opportunity (for it to happen).

Whether for political interests or to further evolving values, this institutional change was viewed as instrumentally necessary for the next steps in reform.

5.1.5 A New Model Begins to Emerge

On May 25, 1992, Frances Lankin, Minister of Health, spoke to OCSA's annual conference providing them with a progress report on the consultations.[12] During her remarks the Minister indicated that there had been a great deal of consensus on the government's philosophical values and overall directions. The major differences concerned the way LTC should be organized. Many felt that the 14 LTC area offices were too bureaucratic and lacked local flexibility. The financial viability of the not-for-profit community-based sector was another area of concern. People with disabilities were critical of what they saw as the perpetuation of the medical model of service delivery. Consumers were generally concerned about the lack of trained workers, and the burden this created for family members particularly women. The Minister acknowledged that she was in fundamental agreement with the five premises for reforming the system as outlined by OCSA in their own submission to government and to the SCCA consultations: i.e., not-for-profit delivery; consumer control and participation; integration of LTC health and social services; balance between health and social needs, between community and institutional services, and between prevention and treatment; and integration of assessment, care management *and* comprehensive service delivery. She acknowledged OCSA's recommendation for a multi-disciplinary, multi-service organization.

In this speech, she indicated that she and her colleagues would reform the system based on: equity in service; community control and accountability; accessibility; choice; prevention and rehabilitation; not-for-profit administration; minimum bureaucracy; and a preference for multi-service agencies.

OCSA had indeed recommended a multi-service agency model, which they called Comprehensive Community Care Organizations (CCCO). However, the association had not recommended the implementation of this model across the province, but rather that it be piloted in 10 areas; in particular, in areas that were structurally ready for this concept. Jurisdictions that had been funded under the Liberals to put in place a one-stop access model were seen as possible sites. The failure of the government to take this cautious approach would eventually lead OCSA to withdraw its support of the later MSA model. The seeds of dissent within OCSA's membership were sowed in this early NDP period. As one of the association's members put it

P056: We had some bumpy roads in the beginning around policy development. Partly it was because we were so new and we were forming at a bad time. Everything was changing. A brand new organization was expected to forward a policy paper without the kind of credibility and relationship with its members to be able to do so. So it was very difficult. There was, I think, a little bit of a difference between where the membership was and where

the leadership was. The leadership was far more progressive in terms of where they thought things should go than the membership was.

OCSA had consulted with its membership to get their views and then the leadership developed their recommendations. However, they did not have the time nor the funds to go back to their membership to gain support for the recommendations. During the consultation, most of the discussion revolved around principles. Unfortunately, as this respondent (P056) put it,

P056: What often happens is that when the rubber hits the road, there's a difference between policy and operations. Everyone agrees with the principles and the policy of being able to work more cooperatively together, and so on. But I don't think people really realize that the way you do that, or one of the ways you do that, is to actually consolidate the agencies into a larger one. And then, it was sort of like, 'Oh my God, what about us, and what about our board, and what about our volunteers, and what about our jobs.'

The Red Cross, which was the largest member in OCSA, was not able to be as involved during this phase of the reform. They were preoccupied at the time with the blood crisis. When the government later adopted the model suggested by the leadership of OCSA and by the SCCA, the membership of OCSA, including the Red Cross, would force the association to withdraw their support.

On June 22, 1991, Jane Leitch, Chairperson of the SCCA, forwarded an advance copy of the *Consumer Report on Long-Term Care Reform*[13], to Frances Lankin, Marion Boyd, Minister of Community and Social Services, and Elaine Ziemba, Minister of Citizenship. In the covering letter[14], she asked the Ministers to indicate at the SCCA's July 6th Public Policy Conference, the areas of agreement with the Alliance's recommendation. Arguing that everyone was weary of continuing debate, she further urged the government to provide some indication at the conference of how they intend to reform the sector.

In their report, the SCCA recommended that planning for LTC services must be done in conjunction with the acute care system, and that care for the elderly must focus on the continuum of services from ranging prevention to palliative care, to include primary, home, acute, extended and chronic care services, and on the linkages between those services. They believed that the fragmentation in the sector was caused by the historical schism between health services funded by MOH and social services funded by MCSS. They urged the government to abandon the concept of an SCA which they viewed as "another form of the costly, inefficient and overly-bureaucratic "brokerage model' of service delivery"[15], indicating that only two out of 100 major provincial organizations who made presentations at their consultation favoured the SCA model. Instead they

recommended a major overhaul of the sector by the adoption of "single service agencies to incrementally transform - through voluntary mergers of agencies - to form what we are calling 'Comprehensive Multi-Service Organizations' (CMSO)."[16] They credited OCSA with the development of the CMSO concept. The SCCA consumer panel believed that the separation of the assessment and delivery function distanced providers from consumers, failed to integrate services at the delivery level and maintained the distinction between health and community support services, continued duplication of assessments, and created the need for elaborate, costly bureaucratic structures like the brokerage system.

The CMSO model was described as an amalgamation of existing, not-for-profit service providers either by merging their operations or by establishing administrative linkages among them while continuing to operate under their separate auspices. Considerable thought went into anticipating objections. As a result, some of the features of the CMSO model were to include the provision of a full range of in-home and community support services, services delivered to a defined population and geographic community and responsive to the ethnic mix in the community, a multi-disciplinary approach to assessment, the integration of case management and service delivery, a process of consumer appeal, establishment of provincial standards, and funding through a global budget and/or capitation rather than a brokerage/fee for service model. SCCA rejected a "cookie-cutter" approach, preferring instead local development of models. They also encouraged efforts to ensure that the unique identity of organizations like VON, Red Cross and others be retained within the CMSO. They allowed for the time-limited external purchase by CMSOs of services provided by agencies reluctant to merge. Not wanting to take on the for-profit agencies, they recommended that these agencies be allowed to maintain but not increase their market share as the system developed. They appealed to the magnanimity of the Home Care Programs and Placement Co-ordination Services whose functions would be replaced by the CMSO. They urged the equalization of wages between institutional and community workers and recommended the unionization of workers and collective bargaining on a regional basis. Finally, while there was strong consensus that user fees should not be charged on any health or personal care services, the SCCA could not reach agreement on the implementation of user fees for community support services.

The devolution of planning and resource allocation to Local Area Offices or civil servants as recommended in *Redirection* was not viewed as an effective way of empowering communities. Rather, SCCA recommended the establishment of a permanent Standing Committee on Long-Term Care within the District Health Council to assume these responsibilities. Given that DHCs had planning responsibilities for the acute care system, the Alliance believed that this recommendation

would deal with the major structural problems that exist between the acute care and LTC systems. To overcome the view that DHCs are medically oriented, they insisted that the Standing Committee have an equal balance of health and social service perspectives. Recognizing the importance and steering effect of institutional structures, the SCCA recommended the eventual evolution of DHCs into District Health and Social Service Councils.

In keeping with the thinking at the time of the broader determinants of health and the importance of social services to health status, the Alliance rejected the artificial distinctions between health and social services. The report called for the government to define a guaranteed basket of health and social services that would be available in all regions of the province. The legislated core services they recommended ranged broadly from health promotion, education, recreation, home maintenance and support, transportation, foot and oral health care, respite care, meals, day care, counselling services, rehabilitation therapies, assistive devices, supportive housing, to in-home professional services. Reform should be guided by principles that enhanced the independence and empowerment of consumers. Consumers should not only have the "right" to alternative services and the right to make choices among them, but also the right to "take risks."[17]

On July 6, 1992, Frances Lankin addressed the SCCA policy conference to provide feedback from the government from its consultations, and in particular, to the report of the SCCA. She once again addressed her remarks in the context of the "hard economic times", and stated that reform must be "cost effective as well as quality enhancing."[18] The government agreed with the seven principles for LTC reform identified in SCCA's report but would add three more, namely, commitment to public administration and not-for-profit preference, reform must address the needs of people with physical disabilities in terms of their distinct needs and preferences, and policies must promote racial equality and respect for cultural diversity.

The minister agreed with the seniors' report that 'tinkering' with different parts of the system was not enough for reform, and acknowledged that their report was the most comprehensive of the submissions government received, addressing itself to systemic issues, and the need for greater systemic reform than envisaged in the government's consultation document. The government agreed that a new model for service delivery was needed and was seriously considering the Comprehensive Multi-Service Organization put forward by OCSA and SCCA. This model would provide a full range of in-home *and* community support services to communities based on a defined population and geography, operate under one local administration with a community-based board of directors, integrate case management *and* service delivery under one roof by providers who would be employees of the new organization, include an appeals process, and be funded on an enriched global

budget and/or capitation rather than through brokerage (fee-for-service) model. While recognizing that care must move away from the costly medical model and that there was an artificial barrier between health and social services, Lankin was pleased that the CMSO was to work under the direction of the LTC Committee of a reformed District Health Council. She was also pleased with the suggestion that wages and working conditions of community workers needed to be improved; that better wages would improve both the quality of care and the quality of work and family life not only for workers but for consumers as well.

On November 26, 1992 Frances Lankin made an announcement to the Legislature which began to put into place some of the pieces for reform. The *Long-Term Care Statute Law Amendment Act* amended several statutes affecting LTC institutional services and the *Ministry of Community and Social Services Act* giving authority to the Minister to make direct payments to adults with physical disabilities for them to purchase their own support services. Support services at the time, specifically attendant care programs, did not permit such direct funding arrangements. Government funding was provided to a service agency which received a fee for administering programs on behalf of disabled adults. [19]

She also stated that a report on the community consultation would be released in January indicating the policy directions for reform, and early in the Spring of 1993 the government would announce the implementation framework for the reform of the system. Meanwhile the DHCs were to restructure their LTC planning subcommittees to include representatives of municipalities, the social service planning and delivery sectors, and consumers. They were to assume the lead role in planning LTC in their communities.[20]

On December 2nd, she announced $133.5 of the $647.6 million for the expansion of homemaker services in 17 underserved areas of the province. Moreover, receipt of these services would be available to consumers regardless of their need for professional health services. As a result, all areas of the province would have homemaking services integrated with home care. The areas that would be receiving the new funding would be required to work with the Hospital Training and Adjustment Panel to facilitate the hiring of laid-off hospital workers. She also indicated that community-based services would "eventually be provided by comprehensive multi-service agencies, which will be created from existing agencies such as home care, placement coordination services and a range of not-for-profit service delivery agencies."[21] The purpose would be to integrate assessment, case management *and* service delivery.[22]

For many stakeholders the Service Coordination Agency model was a reasonable approach. For the professional not-for-profit providers, it maintained their expertise and market share, and it

was flexible. However, for consumers although it improved access, the SCA model was viewed as ineffective and bureaucratic, an additional layer between the provider and the client. It did not deal with the issue of multiple assessments and it did not sufficiently empower the consumer. Consumers from the ethnic communities for the most part who had access services through their own community organizations were concerned that SCAs would erode this relationship. Support service organizations were concerned the model continued to make a distinction between services in terms of essential and non-essential services. Most of their services, they feared, would be considered non-essential and therefore, less of a priority. This led some in the support services to promote an integrated model, believing that their organizations would become the hub of such a model agency. The for-profit providers were not comfortable with such a model, however, because of its stated preference for brokering to not-for-profit agencies. Many believed that the eventual goal of the NDP was to eliminate all for-profit providers from LTC.

5.2 NDP Period (1993) and the Multi-Service Agency (MSA) Model

5.2.1 The Recession and the Social Contract

As indicated earlier, the NDP, like other governments of the day, were faced with a growing recession, reduced revenues and increasing costs, rising unemployment, and mounting debts and deficits. These formed the background context for all government actions, including LTC reform. The situation for Ontario as with other provinces was exacerbated by unilateral cutbacks of the Federal Government. The federal share for spending in health and post-secondary education through the Established Programs Financing had been cut from a high of 52 per cent in 1979-80 to 31 per cent, amounting to a cumulative loss of $12.3 billion for Ontario.[23] In May 1993, the Premier and the Minister of Finance outlined the grave fiscal situation for Ontario. Without intervention, the government was projecting that total revenues would be 1.4% lower than 1992-93 levels. The debt was $68 billion, with a deficit approaching $17 billion. Unlike the early years of their mandate where the government decided to spend its way out of the recession, it now proposed an economic package that asked all Ontarians to contribute to the control of the debt and deficit while maintaining public services and an investment in jobs. They hoped to achieve savings of $6 billion in 1993-94. The measures included raising of revenues through taxes and sales of assets, reduction of expenditures in government ministries and programs, all of which made up the Expenditure Control Plan ($4 billion in savings), and finally negotiation of a Social Contract. The latter was to address the $43 billion in total compensation paid to approximately 900,000 employees who delivered the network of health, education, and public services in the public and broader public sector.[24]

Rejecting approaches that would result in massive layoffs or wage rollbacks, the government proposed negotiating with employers, employees, and bargaining agents ways to save an additional $2 billion in 1993-94. This financial target was to be met through reductions and containment of transfer payments. The Social Contract was to run for three years, starting on April 1, 1993 and ending on March 31, 1996. To achieve this saving, employees of the Ontario Public Service and the broader public sector were asked to take 12 days unpaid leave per year ("Rae" days) in each of the three years of the Social Contract; negotiated and scheduled wage increases and benefit improvements were deferred until April 1, 1996, thereby overruling existing contracts; and early retirements and voluntary exits were encouraged.[25] [26] The government's plan for the economic recovery of Ontario had two effects on LTC reform. The Expenditure Control Plan slowed the implementation of LTC because of cutbacks in the flow of funds, and the Social Contract put a major strain on the government's largest support group, labour, as well as galvanized other groups into coalitions to oppose its LTC reform.

The Social Contract did more than introduce a negotiated agreement for cost restraint. A number of stakeholder groups involved in LTC reform believed that it brought together in one room for the first time a number of disparate interests. Many credit these meetings with subsequent formation of alliances in the LTC sector that would slow the implementation of the Multi-Service Agencies.

P058: That whole notion of coalitions came after Social Contract or during the period of the Social Contract. They dragged us into a room and said, "You've got to talk to us under Social Contract." It was one of the worst things the government ever did for itself in that it showed us how to work together to fight the NDP government. Not just this (LTC reform), you know things that we didn't like about the NDP or any government. I said, "Gee, coalitions do work!" ... It was only when we came together under Social Contract that people said, "Oh, you've got an association. Look who's in that association. And this is how they conduct business. We all did things individually. And if we did anything, it was unbeknownst to most others. So literally the government brought the groups together in order to discuss Social Contract, and suddenly we developed relationships with these people. ... It provided for a huge bonding experience. You can imagine. Those people were stuck in rooms twelve, fourteen hours on end. ... And you had rooms for the health sector, rooms for education. So the health people got to know each other, got to develop relationships and understand mutual issues. "Oh this is in our best interest too. And we'll work out consensus positions." And they learned to do that.

While the Social Contract animated some societal groups to oppose reform, it also alienated public sector unions, traditional supporters of the NDP. as will become clear in the next chapter, attempts to repair this relationship led to actions within LTC reform that alienated other groups and mobilized further resistance, thereby slowing the progress of the NDP agenda.

5.2.2 The Locus of Policy Development Shifts

In February 1993 Ruth Grier had replaced Frances Lankin as Minister of Health and the NDP had decided that LTC reform was a priority issue, a "signature" priority. Since the announcement of the MSA by Frances Lankin, very little work had been done towards its development. The inaction was blamed on bureaucratic resistance to the proposed model. As a result, the development of reform initiatives was taken away from the bureaucracy and was now spearheaded by the Minister's own political staff.

G094: There was a huge struggle inside the Ministry to, to get the policy work done, to actually present through the Cabinet process. There was not a lot of support in the bureaucracy for this approach.

G095: Nothing had been done in the intervening six months (since the announcement in September of the MSA model by Lankin) The policy staff, some of whom had been with Frances were just terribly frustrated with the bureaucracy because there had been no work to put flesh on the policy announcement that had been decided in September. And so we felt six months had been lost. ... So we scrambled madly and what became known as the first of the partnership documents was driven by (Grier's) office completely, written by her policy staff and edited by her chief-of-staff who came from a social services background with some help from people within the bureaucracy, but no leadership. ... Some of the people who had been brought over from Com.Soc. and put in charge of this (LTC reform) were wary of the whole subject and were not convinced that the model (the NDP) were now trying to develop was the right one and had been wedded for a very long time to a more coordinated approach, and had been working closely with the major agencies to develop that approach, and felt very comfortable with it.

P056: Uh, well from what we've heard there was a huge battle going on within the Ministry between the bur-bureaucrats and the, um, political staff, and, I think one, was it Lynn Grist, was the policy assistant to the Minister. She had been from this sector herself before she went into the political level. -- She agreed with it and liked the idea, and she became a champion for it, convinced the Minister, ah, and there were connections between her and (OCSA), some of its board members where there was kind of a personal and, and philosophic linkage, and, uh,

combined with the um, the Seniors' Alliance which had a lot of power, um, partly cause, I, from what I understand, Ted Ball was liked by Frances Lankin and she used his consulting company quite a bit, um, so he was pushing this model.

One government official saw the battle as resulting in the erosion of the traditional role of the bureaucracy and blamed it on the shifting sands in government of ideology and Ministers.

G102: I felt the whole process of the bureaucracy became very distorted and undermined, and that the bureaucracy was not any longer in a position to give the best advice to government, but rather the government told them what they wanted and it was the bureaucracy's job to figure out a way to make it happen. ... And in fact, I remember quite clearly when there was certain advice, and saying, 'No, that's not what we want to hear. You go back and give us other advice.' ... The primary purpose which should be non-partisan, and that's not how it worked. I mean it worked for 42 years because we had one government and everyone was singing under the same tempo, and there was stability. But once we had these constant changes, it became very difficult for the bureaucrats to shift with whatever the ideology of the day is and the players of the day, and then the different ministers. All different approaches to how you make this happen.

5.2.3 The Partnership Documents

As promised, starting in April 1993, the Ministries of Health, Community and Social Services, and Citizenship released the first of the four "Partnership" documents on LTC reform which provided considerably more detail to the earlier announcement of an MSA model.[27]

(i) Policy Framework

The first of the series, the policy framework document which was developed by a planning group that included representatives of DHCs and staff of MOH and MCSS, outlined four major factors that was to shape their LTC reform:

1. *Traditional methods of planning and delivering services are not effective*: The planning and delivery of services now reflected major shifts from a medical model to an integration of health and social services; from an emphasis on institutional care to a full continuum of care and support; from brokerage models to integrated models. While the community-based sector in the past was underfunded and undervalued (in 1989-90 almost 80% of the LTC budget was spent on institutional services and 20% on community-based services), it was now to be the core of the LTC system and its key to success.
2. *Consumers want more involvement*: Consumers expressed a desire during the consultations to have a formal voice in allocating services, priorities and methods of delivery.

3. *Changing demographics*: The elderly and the frail elderly were a growing proportion of the population in the province. Meeting their needs in the community would prevent future, more costly institutional intervention.
4. *The current and future economic climate*: The cost of health care had risen 10 to 12% each year over the past decade because of the focus on medical and high-technology acute hospital care, exceeding both annual inflation and population growth. Due to the recession, provincial revenues dropped by $3 billion. The federal government steadily withdrew its funding support for both the Established Programs Financing and the Canada Assistance Plan. Since 1982, Ontario estimated it had lost more than $12.3 billion in EPF transfers.

The document summarized the major findings from the provincial consultation. While there was an agreement on the principles and goals of a reformed LTC system, there were different views of the mechanisms and models of consumer empowerment, planning and accountability, co-ordination and delivery of services, and funding and human resource strategies. The document indicated that the new system required more comprehensive system-wide solutions than were proposed in the *Redirection* report. "Tinkering" or incremental reform was no longer enough.

The framework document indicated that consumers wanted a more meaningful role where empowerment had to extend to more than shaping their own existing services. It also had to include input at a higher level in shaping the design of the LTC system and its programs. People with physical disabilities raised major concerns about equity in decisions given the relative organization and political strength of seniors' groups vis-à-vis disability groups. They were critical of the perpetuation of the medical model of service delivery and wanted to be able to plan, arrange, and manage their own services.

The document recognized that the two umbrella groups, Ontario Community Support Association and the Senior Citizens' Consumer Alliance, had rejected the brokerage model of the SCA, and had suggested instead that services be delivered through comprehensive multi-service organizations which would be planned by integrated health and social services LTC committees of DHCs. The Alliance also rejected the idea of the 14 LTC area offices. By maintaining the distinction between the Health and Personal Services Program and the Community Support Services Program, the SCA model had failed to integrate health and social services at the delivery level. Improved wages and working conditions for workers were also advanced in the consultations.

The policy framework document indicated that the new system would provide services to adults with physical disabilities, elderly persons in need of LTC and support services, and people of any age who required health services at home or at school. Not-for-profit multi-service agencies

(MSA) would provide access, offer case management services, and decide on eligibility for community support and long term health care; decide eligibility and admissions to LTC facilities; reflect the needs and features of communities (including geography, region, language and culture); and deliver community-based services funded by and accountable to government. For the first time, in-home health and personal support services, as well as community support services such as meals programs and transportation were both to be provided by one agency, the MSA. Physician referral would no longer be required. There would be no charges for health and personal care service or homemaking services considered essential to keep people in the community. Nor would there be charges for respite care services, adult day care, and support programs for family care givers. Charges for community support services would be based on ability to pay. A provincially defined minimum basket of services would be available in each community.

Concessions were made to workers in the new system. MSAs would offer potential for regular employment rather than hourly contracts. The government also proposed improved training for workers, and involvement in planning the programs, staffing and budgets of LTC facilities and MSAs. The planning of MSAs would also ensure that succession rights of workers were addressed. Hiring priority was to be given to displaced hospital workers.

(ii) Local Planning Framework

The next in the series of reports focussed on the local planning framework and described the new LTC service system, the principles for the local planning process, and the guidelines for representation on LTC planning committees. It also made suggestions for community development and roles and responsibilities.[28] As stated earlier, newly constituted LTC committees of DHCs would lead the planning process in each community. In recognition of the social service component of the LTC system, the LTC committees would include representatives of the social service side of LTC. Moreover, the membership of the committees should be representative of the community (cultural, linguistic, and spiritual) and consist of one-third consumers (people who receive or have received LTC services, their direct caregivers who were family or friends, and people with disabilities), one-third service providers, and one-third other (representatives of municipal governments, social planning councils, seniors' councils, labour groups, women's groups, multicultural groups, advocacy groups and members of the general public). The provider and other categories should also ensure equal health and social service representation.

While the role of the DHCs would be to provide advice to the government (MOH and MCSS) on the allocation and reallocation of LTC resources, the MOH and MCSS would provide policy direction, set and maintain standards, and establish LTC funding envelopes for each district.

The local planning role that had until then been done by the 14 LTC local area offices along with the resources to support that role were to be transferred to the DHCs. The area offices were to assume a supportive role to the local planning and implementation process. By 1995, many of their responsibilities were to be incorporated into the central LTC division, the DHCs and the MSAs.

(iii) An Implementation Framework

The third in the "Partnership" series, *An Implementation Framework,* was released in June 1993.[29] The intent of this paper was to provide details on how the province saw implementation proceeding so that individuals and groups could get involved. In the description of the responsibilities of the MSAs, the paper indicated that MSA purchase of services from commercial or not-for-profit agencies would be the exception to the rule. Moreover, if MSAs had to purchase service from a commercial agency, it would only be allowed to do so to a maximum of 10% of its homemaking and professional services budget by the end of 1995. Where these services were currently at less than 10%, they would be frozen at that level.

The Integrated Homemaker Program was to expand across the province from 20 sites to 38, and Placement Coordination Services would expand from 23 to 36 sites. Not-for-profit health and personal support agencies would provide all services delivered in the new Integrated Homemaker Program sites, all new service in existing IHP sites, and all new growth in the Acute and Chronic Home Care Programs and the School Health Support Program. LTC area offices were to establish a steering committee to help communities to make the shift to a new not-for-profit in-home delivery system. The government planned a three-year transition period from 1993 to 1995 to make the shift to a not-for-profit delivery system. It was expected that MSAs would be up and running by 1995. Registries were to be established to help match displaced workers from commercial agencies with not-for-profit employers.

An internal steering committee of staff of the LTC division and an external resource group with consumer, service provider and union representatives had been meeting since the spring of 1992 to advise on the development of a funding system. The new funding system was to be in place by the 1994-95 fiscal year. The government also established a resource group with consumers, workers, unions, educators and employers to look at developing provincial training and curriculum standards for workers who provide personal care and support.

(iv) Guidelines for the Establishment of MSAs

The last of the "Partnership" documents, *Guidelines for the Establishment of Multi-Service Agencies*, was released in September 1993.[30] The paper outlined provincial expectations for MSAs and topics for discussion for MSA development. The development process for MSAs was to be

public, open and inclusive. Each MSA would operate at arm's length from the provincial government and would be governed by a board of directors elected by a voting membership that included consumers, family caregivers, volunteers and interested individuals.

Because the MSA would unite existing services and provider agencies, it would affect volunteers and staff in agencies whose services were being integrated into the MSA. To ensure fairness to workers, a human resource strategy for both staff and volunteers would be developed as part of each MSA's plan prior to the establishment of the MSA. Workers transferring from existing service agencies would become employees of the MSA. Unions would have to be involved in the planning to discuss and resolve various labour issues arising from having transferred staff in the MSA with different collective agreements, benefit packages, job descriptions, and salary levels. Other issues that would need union involvement included employment and pay equity, the role of volunteers, job security, existing contracts, successor rights, and impact on non-union staff. In the summer of 1994, the government provided two years funding to the Ontario Federation of Labour to consult with all the health-related unions (not only those affiliated with the OFL) on these changes.

(v) Further Details

In August 1993, the Director of LTC Policy, released a draft manual for community-based services provided by multi-service agencies.[31] The document was circulated to approximately 100 professional, consumer and service provider associations to get their views regarding the direct services that would be provided by MSAs, eligibility criteria and service maximums. Policies for personal support and professional services were fairly well defined. For community support services, the document sought input regarding which services should be considered core, consumer fees and funding policies.

The new LTC Community Services Funding Envelope for any district was to consist of the existing base transfer payment funding for community services, and any new funds allocated on the basis of an equity funding formula to equalize regional inequities. This formula, based on population and need factors, was to form the basis for allocating new community services funding to districts. The document further identified the mandatory basket of core services that MSAs had to provide. These included meal services, homemaking services, transportation, care provider support, adult day programs, personal support services (homemaking, attendant care, respite care), professional services (nursing, occupational and physiotherapists, social work, speech and language pathology services, nutritionist services), goods and services under specified circumstances, and admission to LTC facilities. Discretionary services included social/recreational services, friendly visiting, security

checks, and wellness programs. While it did not mean that these services would not be provided, they were seen as a lower priority.

The document was clear in re-iterating a number of times that as a result of limited financial resources, eligibility did not necessarily guarantee the delivery of services. In some cases individuals might be able to receive some but not all services, or go on a waiting list, that is, the needs of all persons who require services might not be met, nor all persons receive the maximum amount of service. The next Progressive Conservative government would bring in strict eligibility criteria and limits on service maxima.

Funding for services for persons with long-term care needs would be a fixed budget for each MSA. Funding for persons with acute care needs and those with resource-intensive needs was not fixed, but resources were limited. "Receiving services is not an entitlement. Local administering agencies must provide service within the available funding. Consequently, priorization criteria have been developed for local agencies to use when confronted with difficult and competing resource allocation decisions."[32] The criteria for service priority in order were risk of hospitalization or being placed in a LTC facility within 24 or 48 hours, services required to enable individuals to engage in competitive employment or attend post-secondary schools, individuals who have moved to another area of the province who have been identified as a priority in the new area, individuals awaiting discharge from hospital, and individuals in the community with multiple personal care and or medical needs who were not at immediate risk of institutionalization. The outcome of these decisions was that the budget for Home Care, which until now was a fully insured entitlement under OHIP, was transferred to the LTC Funding Envelope, thereby diminishing its status. Cost containment through prioritization, waiting lists and denial of services was clearly going to be the way of the future. With hospital restructuring and downsizing, this decision in the term of the next government would have serious implications for health care in general.

Consumer fees based on income, not assets, were required for meal services, transportation, home maintenance, and homemaking under specific circumstances. The rationale for consumer fees for community support services was that they relate to basic costs of community living or basic community services which normally would be undertaken by individuals or their families in the course of living in their own homes in the community. The principles guiding the development of a fee system were equity (consistent fee across the province, based on consumer's income not assets, and levied for services related to usual community living costs), affordability/accessibility (reasonable, simple to administer, allow for maximum service provision), and importance of family and community (fees would not be charged for special support services to family caregivers). No

consumer fees were to be applied to friendly visiting, security checks, support services for family caregivers, hospice volunteer visiting services, programming/supervision in Adult Day Programs, and some goods and services.

These documents and the announcement of a comprehensive delivery agency mobilized societal groups as the impact on their interests began to become transparent. Concerned about organizational viability and having found each other through the Social Contract process, not-for-profit and for-profit agencies started meeting to plan a joint strategy. Volunteer organizations concerned that there would be no role for them in the new agency joined with organizations that delivered services through paid staff. Community support service agencies joined with professional health agencies. Multicultural groups feared that with the emphasis on anti-racism their ethnic concerns would be lost. Unionized workers were pitted against unorganized workers, community workers against institutional workers.

5.2.4 Anticipating Objections

On January 11, 1994, Ruth Grier was a keynote speaker at a two-day conference of DHCs.[33] In her remarks, she took the opportunity to address some of the criticisms that had been voiced about MSAs. She indicated that the government was not completely in control of the timing and development of MSAs. "I have to sound vague because that will be up to you. This really is a partnership. There isn't a cookie cutter at Queen's Park that, that this will be same all across the province....We are doing this to ensure that the system reflects the diversity, the history, the experience and the individual needs of each community."[34] She further went on to say that MSAs would be independent community not government organizations. They would not be huge bureaucratic institutions. The integration of services was to ensure primacy of the consumer and achieve administrative efficiencies. She asked the DHCs to "ensure that the citizen-consumer perspective – what we usually refer to as the public interest – becomes and remains the driving force of LTC reform."[35] She referred to the above-mentioned manual as key to bringing about a rational planning and allocation process that treated all parts of the province fairly. She reinforced the importance of volunteers, indicating that there would be an enhanced role for them, and the fair treatment of employees. She believed that due to the expansion of the LTC sector, there would be an expansion of jobs and, therefore, job security.

In a series of Questions and Answers[36] released in January 1994 the government indicated its hope that the establishment of MSAs would remove systemic obstacles to cooperation. Under the current system service agencies ended up competing with each other for government funding. The elimination of this competition was intended to be the incentive for current agencies to amalgamate

with MSAs. The government's position, however, completely ignored the reality that both existing for-profit and not-for-profit agencies would cease to exist or that they would no longer be offering those services and, therefore, competition among them was not an issue. The purpose of the not-for-profit policy was the government's commitment to the public administration of Ontario's Health and Community Service System. Especially in times of fiscal restraint, tax dollars should be directed toward service and wages rather than profit. In addition, these services should be accountable to the communities they served through volunteer boards of directors. The limit of 10% for external purchase of service for the government represented a balance between their philosophy of a not-for-profit system and the need to minimize the impact on consumers and workers. The not-for-profit policy was not to be seen as reducing consumer choice because the consumer would continue to have the choice of worker.

The government was soon to table legislation that would provide the legal framework for LTC community services. The legislation would integrate community service programs into MSA agencies designated by the Minister and would apply consistent rules, standards, and criteria; it would provide rights and appeal mechanisms for consumers similar to those for facility residents; it would limit the external purchase of services thereby enabling the shift to a not-for-profit delivery system; and it would restore takeover powers and subrogation rights which were lost in the transfer of programs from the MCSS to the MOH. More ominously, however, in terms of the government's successful execution of their blueprint for reform, the legislation once again provided a focal point for the expression of concern and attacks by societal interests.

5.3 Conclusions

LTC reform in the first three years of the NDP mandate transformed from a pseudo-Liberal incremental policy to one that more closely reflected this government's ideology – community participation and empowerment, not-for-profit delivery, support for community support services, and integration of service delivery under one agency. The NDP's first model, a minor variation on the previous Liberal model, was not one to which the government had any commitment. Busy educating themselves in their first year in the task of governing, the SCA model was developed by the same bureaucracy which had given birth to the Liberal model. *Redirection* was clearly used as a launching pad by the NDP to gather support for their own vision.

The period was marked by the mobilization of formerly marginalized groups through the financial assistance of government. Both the Senior Citizens' Consumer Alliance and the Ontario Community Support Association had concerns with the brokerage model. The former wanted health and social services to be integrated into one agency to improve access. The latter wanted to remove

the distinctions between professional and support services which always left them as the poor sister. For them an integrated model which removed the distinctions and delivered all services was the solution. Although the SCCA and OCSA had been credited with giving birth to the MSA concept, its origin was debated by most in the policy community. The entwined relationship between seniors, support service provider organizations and members of the government's political staff gave rise to suspicions that government was pulling the strings. The fact that the Partnership Documents were developed by the political staff rather than the bureaucracy gave credence to these views.

The massive public consultation on the *Redirection* document was an exercise in democratic participation. As noble a goal as it was, it would turn out to work against the NDP by considerably slowing down the process. The Partnership Documents which outlined the MSA concept and the process for implementing the model shifted the boundaries of reform. The new contours of the reform would alert provider interests who, through the Social Contract process, discovered new strategies to have themselves heard. As will be documented in the next chapter, the conflict between the NDP and labour brought about by the Social Contract would impel government to make concessions under the LTC legislation which would further alienate provider groups including OCSA, and create conflict between community-based and institutional workers.

The Partnership documents marked a divide in LTC reform and along with the Social Contract heralded new cleavages in the policy community. The events outlined in this chapter set the stage for the LTC legislation, the change in the response of societal interests and for the ultimate failure of the NDP to achieve the implementation of the MSA.

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Chapter 6

The NDP Government and the Multi-Service Agency (1994-95)

Within the context of the *Partnership* documents and the Social Contract, the NDP introduced LTC legislation putting in place the elements of their thinking and dramatically shifting the policy sector. The elements of the legislation repeatedly reflected the ideology of the NDP. There was more central control over the administration of the sector. Service delivery would be centralized under Multi-Service Agencies (MSAs) and services would be delivered by quasi-public sector employees. Unions and their members would be protected and their rights promoted. Community support services were given protected status by being included in the mandated basket of services. Consumers were given enhanced autonomy, protection and control. And the sector was being weaned away from for-profit provision. However, seemingly contrary to their political beliefs, the government transferred the home care services budget from OHIP to a capped envelope, thereby removing its universal entitlement status.

The legislation marked a second round of "consultations" with the submission from groups in the policy community to the Standing Committee on Social Development. The committee deliberations provided a forum for groups whose mutual interests were awakened by the *Partnership* documents and the Social Contract. Both the supporters and detractors of the legislation took this opportunity to make further demands of the NDP. Some of the demands were for desired changes to LTC reform itself. Others, however, represented concessions to correct wrongs the NDP had committed in other sectors.

The legislation evoked considerable opposition. Both for-profit and not-for-profit provider organizations opposed the expropriation of their business activities by the MSA thereby threatening their continued viability. While the status of community support services was elevated and protected by the legislation, the difference in structures, make-up and resources of the organizations under OCSA would split the membership in terms of their support for the reform, eventually forcing OCSA to turn against the MSA model. As a result, the NDP were confronted by opposition from all provider organizations, for-profit and not-for-profit, as well as professional and support service providers.

The legislation divided consumers into their different interests. It was evident that the interests of frail seniors differed from the well seniors. Also there were unique concerns from multicultural, religious and disability communities.

There was considerable controversy over the provisions in the Act for the workers in this policy sector. The NDP's attempt to appease the labour movement by giving their members preference for positions in the MSA over non-organized workers had both intended and unintended

effects. There was increased unionization activity within the sector with a number of provider organizations seeking union status. However, within labour itself there was conflict. Organized workers in the community sector believed that they were going to lose positions to organized workers from the institutional sector that had been displaced through hospital restructuring.

The forced amalgamation of providers under the MSA, the labour concessions, and the 80-20 rule were the parts of Bill 173 that evoked the most vociferous opposition. Meanwhile, the potentially most dangerous element of the legislation received hardly any notice. The transfer of the Home Care budget from OHIP into a capped envelope removed the universal entitlement status for those services. This act along with the gradual shifting of more and more care which is covered by the *Canada Health Act* into the community will have implications that extend beyond LTC to health care in general.

Although the NDP passed *Bill 173*, the damage had already been done. The emphasis on community participation slowed the process down and thereby prevented the government from completely implementing their LTC reform before an election was called. This would allow the Harris government to undo and ignore the legislation. Failure to address the fiscal issues early in their mandate forced the government to make unpopular decisions late in their term. The Social Contract process, while intended to have employers and workers reach an agreement with government on how to deal with the debt and deficit crisis, brought together unlikely groups which actively worked to defeat the LTC legislation. These groups also campaigned against the NDP during the election campaign and contributed to the efforts that led to their defeat.

This chapter will document and analyze the introduction of *Bill 173, An Act Respecting LTC*[1], the Standing Committee process, the submission made by interest groups to the Committee, the amendments made to the Act, and the events leading to the election.

6.1 *Bill 173: An Act respecting Long-Term Care*

On June 6,1994, during Seniors' Month, Ruth Grier introduced legislation for LTC community service, in the Legislature for first reading.[2] [3] The consumer Bill of Rights and the Appeals Process were highlighted in the statement and the press release.[4] On June 15, 1994 *Bill 173 An Act respecting Long-Term Care*, received second reading.[5] Paul Wessinger, Parliamentary Assistant, who moved second reading of the Bill, continually emphasized aspects important to the government's supporters - consumers, community support service organizations, and unions.

He referred to the Bill's consumer focus, not only in terms of its content, but also in terms of the constituency to which the government listened. In keeping with their respect for diversity, the MSA board was to reflect "the diversity of persons to be served by the agency in terms of gender,

age, disability, place of residence within the geographic area to be served by the MSA, and cultural, ethnic, linguistic and spiritual factors."[6]

In listing the mandatory services to be provided by MSAs, the NDP showed their bias for grass roots organizations. The member listed the services starting with the softer, social services - community support services - and ending with professional services. He indicated that the mandatory service scheme would put all four types of services and providers "on a level playing field." "Community supports provided by volunteer agencies such as Meals On Wheels are equal players with homemaking, attendant care and professional services."[7] However, while the government mandated the basket of services to be offered by MSAs, they made it clear that these services, while potentially on offer, would not necessarily be provided,[8] marking a shift from universal entitlement to restricted access.

MSAs were restricted to 20%, rather than 10% as stated earlier, of their approved budget in each of the four categories of services, for external purchase of service from either the not-for-profit or for-profit sector. However, the government intended that any new spending in LTC services would be directed to the not-for-profit sector. Indeed by this date there were only a few regions in Ontario, which exceeded the 10% limit of their current in-home budget in purchasing services from the commercial sector.[9] The intent to shift to a not-for-profit delivery system had begun to be put into place. To protect their volumes of business activity some commercial agencies were seeking not-for-profit status.[10] As a nod to the disability community, Wessinger reminded them that the Minister had announced a $4.4 million pilot project for direct funding to people with disabilities the night before.

The Act included a Bill of Rights which spoke of consumer dignity, respect, autonomy, individuality with respect to cultural, ethnic, spiritual, linguistic and regional differences, the right to information including written notice of rights and other matters, the right to give or refuse consent to the receipt of services, the right to raise concerns or recommend changes to services, the right to launch appeals regarding service decisions, and the right of individuals to have their records kept confidential. Rights under the *Act*, however, did not extend to all Ontario residents but only to those who were in receipt of services. The government made it clear that the Bill of Rights did "not represent an entitlement to service; the rights apply only to consumers who are receiving community services funded under the *Act*."[11] However, matters subject to appeal included the determination that a consumer was not eligible for service, exclusion of a particular service from or amounts of service in a service plan, and the termination of service.

Under the legislation, the Minister had the authority to provide community services directly, to establish and operate facilities to provide services, make agreements with others or make payments

to others to provide services, provide financial assistance regarding capital and operating expenditures incurred by others in providing service.

The Minister was given broad powers under the *Act,* which included the approval and designation of agencies as MSAs. Boards of Health and municipalities could only be designated MSAs after the suitability of other approved agencies had been considered. The Minister's powers included imposing terms and conditions on the designation of an agency as an MSA, as well as approving the premises chosen for the MSA, and setting terms and conditions on the approval. One of the factors that the Minister was directed to consider when designating an approved agency was the composition of the agency's board of directors. The board had to reflect the diversity of the community. It also had to include persons experienced both in the health services and social services fields. No employee of the MSA could be on the board, a clause that would aggravate labour. The Minister could also appoint Directors and program supervisors. The Minister had the authority to revoke approval of an agency and designation of an MSA. The Act also included take-over powers of both an approved agency and a designated MSA, and the removal and replacement of some or all of the directors of an MSA.

There was a long list of matters that were to be set by regulation which included: duties, functions, selection, composition and powers of Directors; additional services that could be added to the mandated basket of services; the development and implementation of a plan for the recruitment and use of volunteers; eligibility criteria; the amounts of different classes of services to be provided; the development of plans of services, waiting lists and the ranking of people on them; the termination of services to a person; consumer charges and how they were to be determined; and the purchase of external services. The extent of matters left to regulatory powers would concern those who wanted their rights and entitlement protected by legislation, and would concern others who felt their individual liberty encroached upon.

A number of pieces of legislation were amended by this *Act,* including the *Ministry of Health Act.* This amendment gave legal authority to DHCs to advise the Minister on health needs, make recommendations on the allocation of resources to meet those needs, to make plans for the development of a balanced and integrated health care system for its geographic area, and any other duties assigned to it. The codification of DHC powers concerned those who worried about the medicalization of the LTC system, and others who worried about giving too much authority to regional powers. The *Act* was silent on the rights of employees in existing agencies, the transfer of employees to MSAs, and the status of collective agreements. This omission was key in the conflict between labour groups and management.

6.2 Government Interests

There were a number of design decisions under the legislation that warrant inspection because of the sharp departure from the status quo and because of the response they evoked from societal interests. These decisions include those related to direct service delivery by the MSA, human resource issues, not-for-profit preference, the 80-20 external purchase rule, the inclusion of community support services into the mandated basket of services to be provided by the MSAs, the decision to remove Home Care from the OHIP vote, and user fees. This section explores government's interests in making these decisions and the perception of government motivation by societal interests.

(i) Direct Delivery

The shift from the brokerage model to the MSA by the NDP government was viewed as a pragmatic solution to the fragmentation of the existing system. The government defined "one stop" as more than an integrated information, assessment and referral nexus. One-stop was to be "achieved by a functional integration of information, referral, assessment, case management, *service delivery* and *follow-up*." By integrating these services under one agency, the government stated that they recognized the interrelationship of a person's health care and social support needs. The further integration of health and social services was to be achieved by the participation of persons from both fields on the boards of MSAs and on the LTC Committees of DHCs.[12]

P059: They thought that if you brought it all under one roof, that somehow it would be better coordinated than it was at the time.

G079: I think they genuinely did believe that the creation of a much more integrated long term care system just made more sense in terms of delivery of service than a brokerage model, that the kinds of negotiations and deal making that would be necessary in a brokerage model you could virtually eliminate if you just smooshed everybody together.

G083: When you think about it, we were in the era of one-stop shopping. And really before 1990, which was in the Liberal years, one-stop shopping was still something very private sectorish, you know. It was something you did at banks, not in the public sector. And so when you think about it, an MSA is a one-stop shopping approach to services, as opposed to the SCA just handling certain services.

G093: Well, essentially what we did is we really wanted people to have one-stop access. So you go to your local MSA which is within reasonable distance for you ... and you sit down with one person, ... that person will organize it for you, and it will be done by people who are not

racing around everywhere, but in fact, can afford to have the time to actually take care of you because they actually have full-time jobs.

One government official saw the MSA as the institutional counterpart to hospitals, in the community. The movement of seniors between hospitals, nursing homes, and community services would be seamless if there was an integrated agency in the community.

G094: All governments were trying to deal with the same thing - fragmented services. How do you coordinate the services, and the two approaches that emerged were obviously the brokerage approach where you have the single access point and the referrals are made. But it seemed that there was an incredible duplication of administration ... and you still ran the risk of fragmentation and of people's need not being completely met. The Multi-Service Agency approach, ... contrary to the criticism that arose afterwards that (they were) big bureaucracies, etc., that approach actually would allow in catchment areas, an organization to be there with all the different basket of services that either on a purchase basis or direct delivery ... and that it would be a more seamless delivery of service to relate to the institutional side. ... Seniors move in and out of hospitals, and to have the right connection back to the community for the home support. ... So integration, we thought would take place a lot better with the Multi-Service Agency approach at the community level.

G108: (The MSA) will give you one-stop shopping, whereas, service coordination didn't give you that. It gave you a funnel, you know, a smorgasbord, if you like.

Some believed that community services should be governed by the community, and that the barrier to this was the plethora of service agencies, each with their own board of directors. The shift to community governance was viewed as too difficult to obtain in a brokerage model. The only way to realize it, according to one official, was to move to a direct service delivery model. Having witnessed an earlier attempt in the 1970s while he was in the community, this official was only too aware of the resistance of individual provider agencies that had to be accountable to their own independent boards to move to an integrated delivery model in a gradual fashion.

G095: The (project) was a coalition of a whole lot of agencies, and we had naively at that point dreamed that you went from co-location, getting them all working in the same building, to coordination which meant sharing services, to integration. And here I was 12 years later ... and that (project) had never moved beyond coordination to integration because for each partner in the coalition to justify their own existence to their own funders, to their own board, they had to have their own intake, they had to have their own files; they had to have confidentiality releases, and these were barriers to integrated service delivery.

Many, however, perceived the direct delivery model as more ideological than pragmatic, and one that was calculated to promote that ideology. The ideas underpinning the MSA were inspired by social values that held that the health care sector was not a suitable arena for the market and private profit, rather public funding should go towards services for consumers and wages for workers. As one government spokesperson stated:

G093: If we were going to have a program which was provincially funded and met the sort of the basic requirements that we had for healthcare, which had to do with accessibility and equity and so on, probably the only thing we could do is to create a series of principles around which to have a program. Certainly there was a philosophical position among the whole government that did not favour competition in healthcare, that saw it as, you know, saw it as a public service, and that it was not something where profit was to be made. And so having a competition rather than regulating by criterion standards was not an option that they would be interested in. So it was a natural step to sort of just move away from brokerage because it didn't make any sense to them, I mean, philosophically.

Direct delivery was sold as a model which would further values of efficiency (integration) and equity (consumer empowerment and access). However, direct delivery had also to do with more centralized control, and securing the sector for labour.

(ii) Human Resource Issues: Unionization and Protection of Collective Agreements

Part of the ideology, some believed, was to secure the sector by unionizing it, which would be more easily accomplished if the brokerage concept were shelved. The community, unlike the institutional sector, consisted largely of non-unionized workers. There were 15 unions representing workers in community-based services. The Canadian Union of Public Employees represented almost half of them. The Ontario Nurses Association represented a further 25% of workers in home care programs.[13] The MSA structure was an attempt to institutionalize the government's ideas regarding markets, employer-employee relations, and to secure the interest of their major support group.

G092: The MSA enhanced the ability of unions to organize.

P062: I suspect that a good part of it (MSA) would have had to do with the NDP's agenda. The other piece concerned the displacement of unionized workers. The MSA model better suits the labour movement. The NDP made it very, very clear ... that one of the objectives was to unionize the entire health sector. As you know, while hospitals are heavily unionized, I forget the number, we're talking a figure of 80 or 90 per cent, it's the reverse at the community level. Most of them are not unionized. And the MSA model more easily, was a better vehicle than the brokerage model. Because the brokerage model has kept, everything is split up and

it's straight contractual arrangements. ... I think that was a conscious decision of the NDP. Fair enough, I mean, it was part of their philosophy.

P067: During the hearings when they put in the clause for, that non-unionized workers would basically be at the bottom of the rung and unionized workers would go job to job into the community, and then everyone else who wasn't within a collective agreement was basically out of luck, that's when I lost it. Because that's when I could not believe how profound the ideology had prevailed. I could not believe that that's what this was all about. ... Really it was absolutely clear that unionization was the issue, absolutely clear.

P059: I think the unionization issue was a big piece. I think there may have been deals with the union people that, "we'll organize the community so that it is basically government workers and we'll give preference to the union for positions in there." Now some say, "Well, that didn't happen till the latter end of the MSA formation." But unless you organize the structure, the sector into that kind of an entity, you can't unionize it as easily.

That the NDP was successful in convincing workers of this shift to unionization is evident in one provider's words.

P069: The reason why I'm saying this is because (the respondent's organization) underwent incredible amounts of unionization from the time that they announced the MSA to the time when the PCs got elected. Because people thought, 'If I don't get a union, I may not have a job.' So I think with the RPNs (Registered Practical Nurses), the unionization at least doubled, if not more than that. And with ONA there were a significant number of bargaining units, and some other, CUPE got a couple, and OPSEU got a couple.

While arguing that critics of the government interpreted the NDP's respect for negotiated union benefits as evidence of favouring unionization, one government official was not quite as certain of this imputed intent. This official, however, did not deny the inevitability of unionization.

G095: If the MSA was composed of predominantly unionized workforce, there is no doubt that that workforce would have attempted to unionize the others, but we were not, I may be wrong, I don't think we were requiring the non-unionized people to join that union just when it went to the MSA. But there's no doubt in my mind that that probably would have happened over time.

The creation of a unionized environment was not only viewed as part of NDP ideology, but also necessary to placate the labour, which had been alienated by the Social Contract process.

P067: The theory was the unions agreed with this (Social Contract) and went along with this because they had sold them the concept that unionized positions would emerge in the

community to offset the downsizing in the hospital system. And that's how they got them to the table to accept some of the concessions for the Social Contract. ... There was definitely a union ideology. ...Way, way back the commercial agencies had some view that a structure was going to be put in place that was certainly pro-unions and the Premier had got the hospital unions to be quiet through the Social Contract activity by guaranteeing that they would create an infrastructure in the community that could accommodate them.

P062: Its (labour issues) connection with the Social Contract was that the NDP was so out of favour with organized labour that this was one way they could say, "Hey guys, we're still your friends, we're still family."

G079: The NDP, if I recall rightly at that point, was beginning to face a whole lot of heat from public sector unions. And had to dangle some things in front of them to try to keep them relatively happy. And that seemed to be, from the NDP's point of view, a reasonable thing to say, you know, "We'll protect unionized workers."

Others in and outside government believed that the human resource issues in the MSA legislation, although perhaps not necessarily directly related to the Social Contract, were the government's attempt to make amends with unions for all of the upheaval in the public sector due to the recession, and the restructuring that was taking place in the hospital sector. However, government did not take into account that organized labour within the community felt threatened by the NDP's attention to organized labour within the institutional sector.

P061 Well, my guess is and I think it's partly true, was because of the recognition that there was going to be fairly significant restructuring in the hospital sector, and there would be large numbers of employees that would be looking for, that were already unionized, would be looking for employment.

G093: Well the labour movement was pushing really hard, of course, because they'd already had, -- I mean this was in the middle of the Social Contract stuff, you know -- and we had sort of, like appalling relationship with, certainly with the public sector unions, not so much with the private sector unions who actually really understood some of the things that Rae was trying to do...But the public sector unions, ... OPSEU at the time and a couple of others in the public sector, because it was a lot of their workers, were really concerned.

G094: There's a relationship, a bit more complicated than that. I mean a few things were happening during the Social Contract discussions. The community-based side was not very welcoming of participating, you know, with the rest of the health care sector. For example, looking at transition issues they saw themselves very separate. When we had established the Health

Sector Training and Adjustment Board to deal with layoffs and looking at transition, the community sector was very resistant to participating as part of that. ...So there were a lot of tensions at play and I think that probably did play a role with respect to Ruth's (Grier) recommendations in terms of these changes that had been brought forward around labour. I think that the strain in the relationship between the party, the government and the labour movement, the traditional relationship was very strained during that period of time. I think that there were probably efforts on all of our parts in different ways to try and reach out and rebuild.

G095: The two (Social Contract and MSA legislation) were very distinct exercises. I think it's probably fair to say that having been burned by the Social Contract we were attempting to rebuild bridges and might have been more receptive.

G094: I think that in a complicated way it is related to all of that. But the fundamental issue that, in recognizing that we were in a major way restructuring, that would cause displacement of workers and that there had to be some way of fair treatment of workers and part, recognizing that where there are unionized workers and there are rights that have been achieved through collective bargaining that there has to be a way of some recognition of that.

Of the human resource concessions under the legislation, preference for unionized workers in MSA jobs, the definition of seniority, and successor rights, were perhaps the most obvious in their intent and the most controversial. The issue of successor rights for organized labour, while less understood, caused conflict between labour groups.

P050: I think that was, again, a reflection of the ideological bent of the NDP. I think probably the pressure came from the unions, and the NDP were largely, you know, backed by that group and they had a lot of influence. And I think that's where it came from. And there was a lot of unrest about that because St. Elizabeth particularly (has) a non-unionized labour force, and VON are. And there was lot of lobby by St. Eliz, as I recall because they didn't want to take a back seat in getting work. ... And I think in the end, the inability to move beyond some of those labour barriers was what scuppered the MSAs... in the end the HR problems became too huge to overcome. And it was inter-union, you know, the fact that you had successor rights. ... You know, you could have different unions representing the same worker category and the MSA would have to inherit that.

For the "workers'" government, the perception from the outside was that not all workers were equal. The divisions consisted of, not only unionized versus non-unionized workers, but community versus

institutional workers. In this two by two grid, there were strong feelings about the hierarchy of claims.

G102: The Home Support side was non-unionized. The Home Care and the other side was unionized. So you could technically because the jobs that were going to open up on the Home Support side, you were going to be displacing people who had been working in that field in a non-unionized environment who would be second to some -- you closed Brockville Psych (hospital) -- and some orderly or some nursing attendant, I don't mean to be pejorative, who was unionized would have first dibs on that community care job over the people in that work. It was unconscionable.

G094: We thought that having less reliance on institutional care whether it be acute care or chronic care, and having more services provided in the community whether that be primary health care services or long term care services, that the workers that were going to be displaced needed to be treated fairly, and that there needed to be a process of transition, of retraining because I do believe it's very different working in the institution and in the community. And there was great resistance from the community about accepting institutional people.

In their own defence, government officials argued that unionized and non-unionized workers were not equal. Both sets of workers had made choices that structured the relationship between the employer and employee. One paid for their legislated rights through organizing and dues. This championing of labour rights, ironically, followed shortly behind the disregard of negotiated collective agreements during the Social Contract process. The recession would test many of the NDP's ideological principles.

G093: They are not unionized and they are therefore, represented by their employer. And so in terms of conditions of employment, they have by default, designated their employers. So, (government) will talk to their employers, but (government) is going to talk to the unions. And those are the two people (government) is going to deal with. And if the employers don't do very well for their workers, that was a choice that was made by their workers.

G094: Well, unionized workers have a collectively bargained set of rights. They have, you know, traded off things to get rights like job security and other sorts of things. And to simply, in my view, to simply ignore that and say that has no special status is to look at union busting. ... And so, I think, that while there was a response from people who had workplaces that were non-unionized saying, "Well, what does this mean about me?" From a trade unionist point of view, the answer would be to organize and, you know, to collectively bargain for those rights. It wasn't a diminishing of those individuals or their rights under statute, but there is a

recognition of the statutory right to organize and to collectively bargain and to ascertain rights that are above and beyond what the statutory minimum are.

G095: As a government that believes in workers' right to organize and in the advantages of that, we accepted our responsibility to ensure that in a sector where there was a considerable number of employees who were part of a union, that we could not arbitrarily remove the benefits that they had negotiated with their employer and had to find some mechanism to enable that to carry on. Now that then got interpreted by our critics as demanding or going further (by) encouraging the unionization of the entire long term care system. I don't know whether that was right or not. I suspect that the unions saw that they would have an opportunity to organize and to expand.

One government official felt that the anxiety of displaced workers over jobs was not justified, but rather was a deceit fueled by both the employers (hospitals) and bargaining agents in another arena of government activity, namely, hospital restructuring, to mobilize their own set of interests.

G108: Both the Hospital Association and the health bargaining agents had, I think, done quite a disservice to the community by advancing enormously preposterous estimates of the number of displaced workers. If I recall, in '92, both of those groups forecast job loss at 14 to 15 thousand. ... Actual job loss across the sector that year -- it was a sector of 160,000 people in it -- was about 2500. And of those, most were handled by early retirement and other measures. There were actually very few people who were displaced and needed employment. The consequence of that was to convince the government that it needed to make significant efforts on labour adjustment -- the HTAP (Hospital Training and Adjustment Board), later expanded to the whole sector. And the bargaining agents made a forceful case that there were going to be massive shifts out of institutions into the community. The community sector was absolutely resistant to accepting anybody that worked in an institution to the point of saying even if their skills were equivalent, you know, ... we don't want them. So, I think, the government was pushed from one side by the bargaining agents, but also found the attitude of the community sector, and I would say personally, I found the attitude of the community sector somewhat startling.

If the sector was expanding and there would be enough jobs for all workers, the natural question is why the NDP created a distinction.

G108: Well, I don't think they were convinced that that process would happen smoothly. And so, I think they were determined to force those bridges rather than presuming they would be -- I

think a real reaction to how much the two solitudes were there between the community and the institutional sector, that you presumed that a community agency looking to hire someone, and the local hospital is laying someone off that they would be willing to sort something out. But it was very clear they wouldn't. ... The government felt that it should be more forceful in the issue.

One aspect of the legislation that did not receive much attention, but whose intention the government made clear was the ability of MSAs to substitute lower-cost workers. The *Act* did not specify what professional or trained non-professional had to be employed to provide a particular service. Because of the greater flexibility under the *Regulated Health Professions Act*, lower cost personal support workers or attendants could provide some highly personal procedures and treatments rather than employing higher-cost nursing services. This was presented as a mechanism for freeing nursing staff to be able to provide care for which only they were qualified.[14] Once again, the NDP displayed an inconsistency in its own ideological position. The substitution of lower cost workers while being fiscally prudent had the potential to exploit already low-paid workers and to erode the wages and benefits of higher skilled workers.

(iii) For-Profit versus Not-for-Profit Delivery

The not-for-profit preference of the NDP for service delivery was strongly rooted, as stated earlier, in their ideology; the belief that public dollars should go towards service and not end up in the pockets of a minority. Nor should the misfortunes of others be used to actualize profits. The commercial sector was also viewed as exploiting easy markets rather than meeting needs in unprofitable locales.

G096: The service should be provided so that all of the funding that you're going to be using from government will go directly to the service and not-for-profit, and what profit means is that one person or two people will end up making a lot of money and will be taking it away from the service that needs to be provided. ... There's only so many dollars for any service that you're going to provide. ... Nobody should be gaining money, it's the philosophy of (the NDP) party, nobody should be gaining on the ill health of an individual.

G094: (There was) absolutely a very clear preference for not-for-profit and a desire not to see the for-profit sector grow. That's both ideological and, in terms of our commitment and also from my point of view, quite practical - what I saw in terms of the for-profit sector was a lot of skimming of the easiest sort of patient to take care of, and the high density markets where volume could produce profit and sort of a claim of efficiency. Compared to the not-for-

profits that were servicing the longer distances, the more difficult cases, etc. I think there was both a practical and a very strong ideological reason for that.

The bias against the for-profit sector was viewed by one government official as the factor motivating the elimination of the brokerage model in favour of direct delivery of services. Elimination of the for-profit sector could more easily be achieved if all service providers were brought into one not-for-profit agency. However, for political optics, the MSA model was sold as anti-brokerage rather than anti-profit.

G102: That's a big part of their platform. There's no room or very little room for the private (for-profit) sector. When the NDP started to think through this and they looked at the brokerage model, they realized that it was very difficult. The private sector was there. They were (developing) an increasing market share. And they (NDP) didn't know how to keep them out. So one of the ways of keeping them out was to say no brokerage. If you say no brokerage, you have to provide service directly. From my perspective that was the driving force for the MSA model. Okay. Because if you didn't have brokerage, and you weren't buying service, but were engaging or employing everybody, then the private sector's gone. Now originally when they came out with that, it became an anti-brokerage model, was what it looked like. Okay. But the driving force was because you were buying services from the private sector. ... So for me, my sense of what the drivers were that influenced the shaping of the MSAs was the attempt to drive the private sector out of health care and that arena.

Another government official supported this view - that the MSA was a vehicle for removing the for-profit sector.

G108: It (MSA) was seen as a great deal more complex than service coordination. I mean you have a mixed market place, public/private provision which had been fine with two previous governments. You had a new government elected that, among other things, didn't like private provision, but couldn't afford to get rid of it either politically or financially. Service coordination leaves your service system, you know, essentially in place. You're just going to direct traffic better, and maybe drive some efficiencies over time. The Multi-Service Agency (was) much more massive reform.

The commercial sector responded to this direct threat by launching a lawsuit rooted on the premise that the MSAs amounted to expropriation of their business without compensation. At the time the for-profit sector received in total 33% of all government funding for in-home services. While most of the funding went for homemaking services, a smaller proportion was directed to nursing and the therapy services. According to one government official, a potential defence against

the lawsuit was that the government in creating the MSA did not discriminate against the commercial agencies. The services provided by both the commercial and not-for-profit agencies would be subsumed under the MSA. " So they had a law-suit. That was a good lawsuit. It was going to be very expensive. It was going to be very embarrassing. So that's how they got around it, you see. You employ everybody! 'We're not discriminating. We've got a bottom line - there's only so much you can buy outside of the MSA, whether it's private or not-for-profit.'" (G102)

(iv) External Purchase of Service

The restriction on the external purchase of services became known as the 80-20 rule, the percentage of an MSA's budget that could be used for the purchase of external services. The government's rationale for allowing external purchase ranged from (a) pragmatism,

G093: Well actually, that (20% external purchase) was because we knew that we'd need to do things like vacation coverage, emergency coverage -- you know, what happens if we didn't have enough employees. There w(ere) all kinds of bits and pieces that we felt we would need to do. Or something where we required a service but only needed it for a few clients and it would have been economically unfeasible to hire a full-time person. ...If you're in a small MSA, you may not get much call for physiotherapy, but you might have a couple of people who need it. So, it would be a smart idea to actually allow people to be able to do that.

G094: It was simply a question of had there been ... no sort of, restriction on it (external purchase) we felt that we would not have achieved a fully integrated service delivery agency.

G108: There are substantial quantities of service currently provided or were provided at that time by other than not-for-profit agencies. And I think the Ministers were convinced that to move to eliminate that would place an unreasonable burden on clients and patients; that is, although philosophically they wanted to see a 100% not-for-profit system, it was clear that there were areas where the private sector was providing because nobody else would. And that was going to, I think in their view, put the reforms in significant jeopardy. That is, if the net result of the long term care reform was somebody who was getting service would stop getting service that was clearly going to be the headline. And so the 80-20 was their best guess or their best calculation of what, kind of, left the status quo in place.

... to (b) restricting for-profit growth,

G096: I think (the NDP) were trying , worried very much as we did see surrounding jurisdictions around us going towards privatization and going more for the profit sector, and trying to see that there was some way that (they) could build into legislation that would stay after (they) left, that would protect, ensure that the dollars that were being spent would be staying for

services. ... And at the time, people were really working hard on the issue, coming back with different formulas and just trying to see how this all would work out and tried to project into the future what this would really mean.

... to (c) a political balm to soothe the growing discontent in the service delivery sector.

G079: My sense is that the NDP would have been just as happy if there was no outside purchase of service. But they recognized that there was probably a need for some political salve. I don't think the 80-20 was calculated on any particularly sound methodological basis. It was just a kind of salve that allowed some purchase of specialized or unusual services, ... but still preserved a large enough chunk for the MSA to control. And as salves go I don't know that it made anyone horribly happy.

Both direct delivery and the related 80-20 exception clause, however, would unleash the combined efforts of both the for-profit and not-for-profit providers to defeat the MSA. While the government's intent was to create a not-for-profit model, its mechanism for achieving this would be through the indiscriminate elimination of both the for-profit and not-for-profit service agencies currently providing care in the sector.

(v) Mandated Basket of Services

The more ideologically rooted elements of public delivery, the labour issues and the preference for not-for-profit delivery were not the only distinguishing features of the NDP model. The inclusion of the community support services, like meals-on-wheels and transportation, into the basket of mandated services along with the traditional home care services was unique to the MSA model. The government's action was to operationalize their belief in the broader determinants of health, that keeping people in their homes was dependent on good health which in turn was dependent on more than health care. It was also dependent on good social supports.

G083: When you think about what people need to keep themselves in the home, well, meals-on-wheels and friendly visiting somebody just to check that you're okay, and supportive ... And (Britain has) done a lot of amalgamation of health and social services, and it was really successful because you don't know where health stops and social service begins. And so (the government was) really trying to make an effort to sort of put them together so that, in fact, if you're the client you don't care which Ministry funds you. You just want to make (sure) that you've got it. ... So we were trying to do that kind of continuum, and trying to think more about the customer than sort of established cultures.

Funding all LTC services under a single funding source (Ministry), however, did not require the inclusion of community support services in the mandated basket of services.

G093: The problem is, you know, with what is perception. And the reality is that those (services) in, get to be the services, and those outside, get to be the add-ons that can be pushed away. And we wanted to ensure that if we're going to have a continuum of services, it was all going to be in one place. ... So you didn't end up in a situation where because this was meals-on-wheels and it was off on the side (outside the basket), it got under-funded and marginalized. Because our concern was that a lot of the literature was telling us that very small interventions were really important to maintain people in their own homes.

Other government respondents also saw the inclusion of community support services as a way of protecting them. It is important to remember that two ministers involved in reform, Ruth Grier and Elaine Ziemba, as well as a number of their political staff had been involved with community support services before they came to government. Their loyalty and concern for these providers was evident.

G095: I think (there was) the whole need for a seamless transition as one's need increased or diminished, and the desire to maintain those community-based services as entities rather than see them squeezed out by the behemoth might have arisen out of sort of just a homemaking, home care kind of health entity taking over. ... The whole basis of this which was integration of service delivery, and rather than chopping up different pieces of the service and then necessitating separate intakes, separate statistics, separate budgeting. ... there was some administrative savings (to integration), but I think, as much as that, it was the whole question of, 'we don't want to make a judgement between a support service to keep someone independent in their home and an essential service that keeps them healthy when they've been discharged from hospital.'

As to whether being integrated with traditional home care and homemaking services would better protect support services was viewed by one government official as a rhetorical debate that took place both inside and outside government. Whether there was any basis in fact, however, is almost irrelevant in the political sphere where illusions of fact and the power behind claims are what counts.

G108: I think there were varying views on that. I mean, on every move of funding you get both arguments being advanced. One that, by combining things you were permitting shifts that were more sensible; that is, people would tend to allocate the resources to their highest and best use. You'd also get the 'defenseless program' argument, that you would get the stronger programs cannibalizing the weaker ones, and that would disadvantage clientele of those programs. That debate raged on certainly the whole time I was there. I don't think I ever saw

a single shred of evidence either way on it. So it was a very strong rhetorical debate but with, you know, nothing underneath it.

(vi) Entitlement to Home Care

Because direct delivery, the not-for-profit preference and the labour issues more directly affected the interests of most groups, and were the focus of most of the debate around *Bill 173*, the elimination of Home Care as an entitlement by removing it from the OHIP vote went almost unnoticed. This step by the government would in reality have more profound effects not only for LTC services but also for health care in general.

This ideologically inconsistent act was justified by government by reasons that were ideologically pure. The transfer of the home care budget to a LTC funding envelope was deemed necessary by government officials in order to rectify the geographic inequity in funding allocation across the province. (G093) Some government officials saw the move as necessary to effectively achieve integration of services and flexibility in resource allocation. As one pointed out there were multiple avenues to the same service resulting in multiple assessments leading to services that were totally publicly funded or services that entailed a user fee. Often which scenario prevailed depended less on the need of the client than on the luck of the draw and the knowledge of either the client or her physician, of navigating the system.

G096: There had to be a continuum of care. And as service providers we discussed this so many different times that it just was not realistic for the person in the home to have to go through all of these different barriers. And also to see some people not getting the service because of lack of information or whatever, but they just didn't get it.

This official went on to say that the move out of OHIP was actually a decision to protect the Home Care budget.

G096: Under OHIP the funding was starting to diminish. There was starting to be a concern that it could be something that could be eliminated eventually. Again, going back to, people do not think that the people living in their own homes, require essential services. ... There was always the concern that under OHIP, that at some point in time there might be a decision that this isn't essential. And they only provided those services to a small segment of the population, and unless you came through the hospital structure and you had a doctor that was advocating for you. But as I said when we had people who came out of an institution, out of a hospital and with the same medical problems as another neighbour and they couldn't get OHIP funding. So it really didn't seem to be a fair way. And you really have to bring it

together if you really want to have an amalgamated way, a source of funding in the community.

Another government spokesperson was more cynical and saw it as a cost-saving manoeuvre to counter the projected growth on the community side because of restructuring and demographic growth. Under the *Health Insurance Act*, denial of service either because of priority setting through eligibility criteria or a limit on total amount of service gave consumers the right to appeal the decision to the Health Services Appeal Board and to the courts. Home Care as an entitlement greatly reduced the government's flexibility in limiting the projected growth in costs. Relatedly, community empowerment through community boards was viewed as a way for government to shift both the responsibility and accountability for making rationing-type decisions away from it onto others.

G102: An important driver aside from the brokerage was a sealed envelope. Nobody realized that the Home Care dollars that were going to put on the table were going to be a closed envelope. And that those (MSA) boards would be really working hard to make decisions, somehow it would be allocated, that that was a huge driver that wasn't talked about. Hospitals didn't realize when they were, all of a sudden, having to look at shorter lengths of stay and all of a sudden in 1993-94 they are waking up and discovering Home Care. Excuse me! ... So the fact that you're planning to send many more people, we're going to have closed dollars. We've got to plan this together. You can't shorten your length of stay. Because if we've got waiting lists, or we don't have capacity, people are going to go home, they're going to be back in emerg. But we couldn't get their attention ... Everybody tried to hush-hush the fact that it was a closed envelope, you see, with fixed funding. And then you'd make tough decisions, whereas before, on the Home Care side of it, it was just the more demand, the more you had to supply. ... Budgets grew by 11% a year. So that was sort of a hidden step. ... I mean if it grows a bit by population, you're talking about a closed envelope which is why they need these independent boards who are going to make these decision on how they allocate the money. And it's basically a managed system as opposed to an open universal system. But that was very hush-hush. But it became critical to do something to stop the growth and growth and growth.

One government official, recognizing the short-sightedness of this decision indicated that at the time that the decision was taken, the MSA designers naively believed that with government's proclaimed financial commitment to this health sector, there was little to worry about.

G095: As we began to discuss eligibility guidelines it became clear that having very specific eligibility rules for the part that was funded by OHIP and the ability to construct our own

eligibility criteria for the rest would be very difficult. And because we were fully committed and had Cabinet and Treasury approval for a great deal of new money going into long-term care, we certainly believed that there was in fact going to be more money available through our model than the proportion that was guaranteed under OHIP. ... And in the current climate where everything is being cut there isn't a commitment or a firm budget, then I can understand the criticisms that are now emerging from saying, 'Well, at least we were sure of money under OHIP. We've lost that now.' But it (the decision to remove the budget from OHIP) was (a) to facilitate the implementation of our model, and (b) because certainly in our commitment we were talking more money not less, in doing this. And I think that we were all in the euphoria of believing that there would be more money for long term care. That as hospital budgets were constrained there would be even more freed up, and as hospital restructuring and health reform began, some of that money from Health would move into that.

The notion that there would be more money for LTC services was contradicted by the prevailing fiscal pressures of the time. Providers were having to deal with reduced transfers from the province because of the Expenditure Control Plan. They had to achieve further cuts in their budget due to the Social Contract. This was difficult to fulfil for providers funded on a contract or a fee-for-service basis. The mechanism of taking unpaid days off was not available to them since they were only reimbursed if they performed a service. Similarly, these providers were also facing the costs of pay equity adjustments required of all government transfer agencies.

(vii) User Fees

The other related debate that did not get resolved while the NDP were in government was whether there would be co-payments or user fees for support services. While some favoured the notion of entitlement, others saw this as unrealistic and were more persuaded by notions of affordability

G095: I'm not sure that that had been totally sorted out. The preference, and I wasn't sure I agreed with it, had been for no user fees from any of those community-based services. ... I had assumed that we had yet to have the discussion about eligibility and that it would depend to a certain degree on what the level of need was at the point when you became eligible. And if you were totally dependent on the service then I didn't think a user fee was required. If it was perhaps a bit of an option, then I had seen there might have been room for user fees. But I haven't seen that discussion as being finished.

G108: I don't know how much realism there was to it. There was certainly Ministers who held the view that that's (no user fees) what should happen. But the same Ministers also accepted budget numbers that wouldn't permit that to happen.

Ideology, with the injection of fiscal reality, was undoubtedly the driving force behind the MSA design – not-for-profit centralized delivery by quasi-public sector workers, preference for unionized workers and the creation of an environment more conducive to unionization, the elevation of importance for support services, and consumer empowerment and protection. The government, based on their notions of community involvement had consulted broadly and had, from their point of view, listened to the people. Their design had, however, adversely affected a number of groups who had, at least before the legislation was tabled, no common interest. Even the groups representing "the people" would turn on the NDP.

6.3 Policy Interests of Societal Groups

Hearings for the Standing Committee on Social Development were held between August and October 1994, with amendments to the *Act* considered in November. The Committee travelled around the province listening to and receiving submissions from a large number of groups. Some of the public submissions to the Standing Committee from various interest groups will be used to illustrate the kinds of issues expressed by the different types of societal interests. Concerns and support for the MSA legislation will be highlighted by reference to submissions made by (i)consumers (seniors, disability community, multicultural seniors, and religious community), (ii)providers (not-for-profit versus for-profit, and professional versus support services), (iii)labour, volunteers, and (iv)other types of interests. It is important to note that many of the associations representing the consumer communities, aside from being advocates for their members, are themselves providers of services largely delivered by volunteers; for example, Alzheimer, Ontario provides day programs, respite programs, counselling services, family support groups, education programs and information services for seniors who are cognitively impaired. The expression of policy interests by these four types of societal groups will be further supported by material garnered through interviews. With reference to the policy goals of security, equity, liberty and efficiency, the analysis will demonstrate the way in which competing interpretations of these values are used to bolster different policy interests.

6.3.1 Consumers

As discussed in the first chapter, although the thesis makes use of the term, "consumer," it is problematic. The term has connotations of choice of services by informed clients who through their decisions promote competitive environments for markets. These conditions, however, do not apply to health care services in general or to most home care services. Moreover, the term implies that choice

has the same meaning for all consumers and that all consumers are equally competent and able to inform themselves of their needs, to assess the necessary services required, and evaluate their quality. As will be evident from the submissions from, and interviews with representatives from seniors, disability, multicultural and spiritual groups this is certainly not the case. The ability to assess information and make decisions vary between well and frail seniors and between cognitively and physically disabled people. For seniors, access to services when needed and the choice to refuse services were a higher level of importance than choice of provider, which was paramount for the physically disabled person. For both groups the ability to participate fully in the decisions involving their care was highly relevant. The availability of ethno- and spiritually specific services was most important for those respective communities. The representation on MSA boards and to whom MSAs were accountable were also contested by groups within the 'consumer' category.

(i) Seniors

This section will outline the briefs submitted by the Seniors' Citizens Consumer Alliance, the Ontario Coalition of Senior Citizens' Organizations, the Canadian Pensioners Concerned, and the Advocacy Centre for the Elderly. While supportive of the legislation overall, these groups as will be shown, varied in their concerns which largely reflected their organizational roots or mandate.

In their brief[15], the *Seniors' Citizens Consumer Alliance* strongly endorsed the MSA model as an alternative to the then current system with some minor recommendations. They were convinced that incremental reforms, while politically expedient and capable of making modest improvements in the system in the short term, were not in the best interests of the system or the province in the long term. They believed that individual agencies would not be able to adjust to pressures brought on by federal budget cuts and demographic pressures; that comprehensive reform through the integration of agencies was the only way to avoid the collapse of the community-based sector and the development of a two-tiered system. They believed that the MSA was the only model that dealt with service fragmentation, the integration of health and social services, assessment and case management, and the inefficiency of 30 to 40% expenditures on administration and overhead by agencies.

They became the voice for government in their submission by addressing what they considered to be common public myths about MSAs. As will be recalled by the previous chapter, SCCA had a very close working relationship with the government, had been viewed by many other interests as being the government's mouthpiece and had proposed in their earlier report an MSA-type model. The first myth they addressed was that MSAs would not be more cost-effective. They had commissioned a paper by Price Waterhouse, which found that the integrated delivery model was more cost effective than brokerage. This report would come under attack from provider agencies and

would eventually lead to its withdrawal by the consulting firm. The second public myth, MSAs would be large government bureaucracies accountable only to Queen's Park. They believed that MSAs would be no different from other transfer payment agencies, such as, hospitals or community health centres, that they would be independent not-for-profit organizations governed by representative community boards. Third public myth, MSAs would limit consumer choice. The SCCA argued that choice of agency never existed within the brokerage model since it was dictated by Home Care Program contracts. For seniors, choice of individual provider was more important than choice of agency, which the MSA would still protect. The fourth public myth addressed was that MSAs would undermine volunteerism. The SCCA responded that volunteer involvement would increase under MSAs because of better coordinated recruitment activities, that volunteers identified with the consumer they served rather than the agency, and that experience in other sectors did not support the claim. Fifth public myth, MSAs would devastate fundraising activities. The SCCA addressed this allegation by stating that MSAs through their community boards and integrated structure would be able to mount comprehensive campaigns and eliminate the current competition for donor dollars. Sixth, MSAs, as both purchaser and provider, would be in a conflict of interest. They dismissed this concern since the dual responsibility was already prevalent in public hospitals.

While strongly endorsing the passage of the legislation, the SCCA expressed some concerns, which focused on access/equity and security issues. To begin with, they felt the legislation fell short of addressing issues of fragmentation. Dividing MSA services into four programs, with separate rules for the purchase of external services and user fees mitigated against the integration of health and social services. They believed that the legislation did not address the continuum of care by not including supportive housing, wellness and health promotion, primary care physicians and regional geriatric programs.

The Alliance recognized that funding was key to the success of the reform and that the legislation was silent on this issue. Their concerns around financing addressed issues of equity and security. They strongly recommended that the Bill clearly state that MSAs would be funded on a global and/or capitated basis. The removal of Home Care from the OHIP budget was seen as important for the goal of integrating services. However, they recognized that this act threatened those services and recommended that the legislation be amended to continue to insure under OHIP those home care services that were previously insured under the Health Insurance Act. They also focused their energy on removing mention of user fees from the legislation. The Alliance was against user fees within the reformed long term care system on the grounds that 1) they produced inequitable access to care deterring those at the lower income scale, 2) were inefficient in that they were often

more expensive to collect than the amount generated, and 3) continued the distinction between health and social services negating the increasing belief in the essential preventive effect of social services. Other issues raised regarding security were the call for establishing and monitoring of explicit provincial standards for quality, and an explicit process for monitoring waiting lists.

With respect to consumer empowerment, the SCCA was concerned that the governance structure of MSAs would emerge as federated structures dominated by provider organizations. Indeed, the not-for-profit provider organizations would put forward such a model to the Progressive Conservative Government after the defeat of the NDP in June 1995. They recommended that consumers and members of the community make up the majority of board members, that employees of provider organizations be prohibited from sitting on the boards, and that health and social service expertise be provided by a professional advisory committee to the board. They further wanted more sanctions against agencies that violated the Bill of Rights.[16]

Although the *Ontario Coalition of Senior Citizens' Organizations* (OCSCO) was a founding member of SCCA, they made a separate submission to the Committee. They claimed to represent 66 organizations and 500,000 seniors across Ontario including the Older Women's Network, the United Steelworkers of America Retirees, Ontario Public Service Employment Union, and Canadian Pensioners Concerned. Their submission to the Committee reflected concerns about liberty (choice), equity (access), and security (availability of service, quality of care). In their submission, they supported Bill 173 but expressed concern that some services were legislated into the basket of services provided by the MSAs while others such as attendant care and supportive housing were left to regulations. They recommended that the legislation, which they believed was too detailed and therefore rigid, leave the operational details of reform to the regulations. They strongly rejected user fees on the grounds that they were demoralizing and a disincentive for service. They called upon government to ensure that funding for MSAs be secure so that there would be no deterioration in service through waiting lists. Fees, where they existed, should not be means tested or targeted. They requested more assurances that the Bill ensure that consumers have the "right of choice" of service, whether it be to remain in the home or to seek placement in a LTC facility. In keeping with their view of consumer empowerment, they asked that consumer representation on MSA boards not be tokens and recommended that half of the board's representatives be comprised of consumers. They defined consumers as an individual who is or will be in a position to receive LTC services. They asked that government establish an Independent Review Board for appeals and that Bill 173 incorporate an enforcement mechanism for monitoring care.

Not surprisingly given the inclusion of organized labour in their membership, OCSCO saw the introduction and expansion of "generic workers" and unregulated, non-professional care as an issue threatening the quality of care and the safety of seniors and the disabled. They demanded stricter regulation of providers, which included proper pay scales, pension plans and other benefits. They asked for recognition, support, and payment of services provided by family caregivers. Recognizing that patients were being discharged from hospitals "quicker and sicker" than before, they pressed for an assurance that services would be available in the community before discharge. They denied the government's claim that it did not have the funds to pay for the original vision of an accessible, equitable and high quality long term care system, and suggested that government reorder its priorities to do so.[17]

The *Canadian Pensioners Concerned* (Ontario Division) which advocates on behalf of seniors on health, financial and social issues also submitted its own brief, despite being a member of OCSCO. Unlike OCSCO, they were concerned that too many important decisions such as fees, eligibility criteria and hours of service were being left to regulations. They asked that the regulations be tabled at the time of third reading of the Bill or before so that there might be an opportunity for public input. They expressed concern about the commonly held, yet untested, assumption that care in the community was less costly than institutional care. With cutbacks in facilities, they feared that without the necessary funding and expansion of services in the community, consumers would be facing at best inadequate care and at worst no care. They called for a definition of consumer to be incorporated into the Bill and that they (consumers) be fully involved in decisions about their own care as well as in policy and planning decisions. They echoed OCSCO's recommendation that at least half of board memberships should be made up of "real" consumers and that social services be equally represented as health services. They feared that the government had oversold the idea of people wanting to remain in their own homes and asked for the option to choose other forms of care. Despite the government's commitment to health and well-being, they noticed no reference to wellness in the Bill. Rejecting the medical model, they indicated that social and recreational programs played as important a role. Their parting words in the brief reflecting the frustration of all consumer groups was "Let's get on with it!"[18]

The *Advocacy Centre for the Elderly*, a legal clinic for low income seniors funded by the Ontario Legal Aid Plan, put in a brief on September 15, 1994. They framed their submission around security/social justice issues based on the kinds of complaints they typically received regarding community-based services, that is, issues of quality, eligibility, accessibility, and adequacy of service types and volumes. ACE argued that MSA consumers are not typical market consumers in that they

are often either cognitively, emotionally, or financially unable to exit if dissatisfied. Voice is their avenue of redress and hence the legislation needed to ensure a tight complaints/appeal procedure, a quality management system that included consumer input, and an alternate dispute resolution mechanism. To address these issues, they recommended that the government make explicit in the legislation changes to the Bill of Rights, eligibility criteria, fee issues, limitations on service, rules regarding termination of services and waiting lists.[19]

(ii) Disability Community

The briefs from the Citizens for Independence in Living and Breathing, Ontario March of Dimes, and Alzheimer Ontario will be used to distinguish the interests of those in the disability community living either with a physical or cognitive impairment. Groups that represented people with physical disabilities rejected any attempt to medicalize their conditions by referring to them as illnesses or diseases. They lobbied for greater independence and autonomy in decisions regarding their own care. Groups representing the cognitively impaired called for more support for family caregivers and representation on MSA boards.

The *Citizens for Independence in Living and Breathing* was a consumer organization representing ventilator users and potential ventilator users with neuromuscular conditions whom, because of muscle weakness or paralysis, require breathing assistance. They considered themselves not to be ill but to be living with a disability. As might be expected from earlier accounts, their interests focused on classical liberty issues of independence, choice, and rights protection. While being pleased with the Bill of Rights under the MSA legislation, they recommended stronger expressions of rights and entitlement, for example, that access to services be guaranteed for all persons meeting eligibility requirements, and that contravention of the Bill of rights be grounds for the revocation or suspension of an agency's approval. Concerns about independence included the recommendation of a *guarantee* rather than the *opportunity* for the consumer or his/her agent of the right to full participation in the development, revision, and evaluation of any plan of service. From their perspective, an opportunity to participate left the provider clearly in control, rather than promoting equal partnership and participation. Fearing the loss of independence and the medicalization of their condition, they recommended that hospitalization for initiation of long-term ventilation be avoided. They also requested representation of a ventilator user on the board of the MSAs on the assertion that their needs were unique.

With respect to choice, they "endorsed with enthusiasm" the phrase in the legislation recognizing the importance of a person's needs and preferences. However, they were concerned that service options for minority groups like ventilator users would be seriously reduced, resulting in

"ghettoizing" them. They further recommended that the direct funding option be available to all consumers who are capable of directing their own care and that the option be included in the legislation. Choice and independence were seen as inextricably linked with the loss of choice seen as leading to an erosion of control and independence.[20]

The *Ontario March of Dimes* assisted adults with physical disabilities to live independently in the community through the provision of programs and services that included the Attendant Services Program, Support Service Living Units, and Outreach Attendant Services. While they supported *Bill 173*, they too wanted stronger wording ensuring independence, choice and empowerment of the disabled consumer whom they viewed as unique in their requirements. They unequivocally rejected any medically oriented service philosophy that perpetuated the notion of disability as illness and promoted dependency. They requested greater consumer involvement in establishing service standards, service plans, and on governing boards. They feared that the promotion by government of generic workers in the legislation would encourage the use of least costly options over best quality and appropriate options. They recommended that their programs not be included under the MSA but continue to be directly funded by the government because of their uniqueness. They recommended that the direct funding pilot legislated under the LTC facilities legislation be a permanent option under *Bill 173*.[21]

Alzheimer, Ontario, which according to their estimates represented the second largest group of consumers of LTC services, generally supported the legislation. However, they felt that the true providers of most LTC services were not recognized and recommended specific reference to support for family caregivers in the purposes of the Act. They feared that the translation of the goals of LTC into legislation gave way to a "'health model' of rules and criteria driven by the system rather than by the needs of the consumer or even the local community." They asked that the focus on consumer need and quality of life be recaptured in the legislation. Unlike other consumer groups whose members are not cognitively impaired and who, therefore, wanted direct rather than mediated representation on governance structures, Alzheimer, Ontario protested that the legislation while spelling out inclusive criteria for board membership (gender, age, disability, geography, cultural, ethnic, linguistic and spiritual factors) left their members without a voice. They requested the legislation be amended to require representation by family caregivers of people with Alzheimer Disease and related dementias on all MSA boards. Finally, they recommended that adult day programs, which are crucial for their members to remain in the community, be added to the mandatory basket of services provided by MSAs.[22]

(iii) Multicultural Community

The *Multicultural Alliance for Seniors and Aging* was an association of more than 40 organizations representing the interests of multicultural communities with respect to the needs of older adults and their families. As might be expected from the demographics of the province, their members came largely from Metropolitan Toronto and Hamilton. The focus in their submission was on choice and consumer empowerment. While supportive of the MSA and the requirement in the legislation of the recognition of a person's individuality and respect for cultural, ethnic, spiritual, linguistic and regional differences, they wanted the empowerment of ethnic seniors through their community and the designation of an MSA as a lead agency for a particular ethnocultural community. They further wanted a formal process for soliciting and appointing ethnic representation on MSA boards. They wanted plans of service to take into account the unique needs of their members and staff to be trained and sensitized to their needs. They also demanded the establishment of Multicultural Services Committees in DHCs, which they viewed as notoriously insensitive to their needs.[23]

(iv) Religious Community

The *Catholic Women's League of Canada, Ontario Provincial Council* was an organization with 65,000 members who volunteer time and raise funds to support local organizations. They estimated that, in the Toronto Archdiocese, over 100,000 hours were spent by members working with organizations such as the Arthritis Society and Meals on Wheels. Their major objection to the legislation concerned the potential loss of volunteer workers and the impact that would have on consumer security. Because MSAs would absorb many community agencies into large government-mandated bureaucracies, they would not be able to attract volunteers. Volunteers, they argued, needed to identify with an agency and needed to feel that if they were not doing the job, it would not get done and someone would suffer. With the existence of MSAs, however, the belief would be that government is providing their service and volunteer help was not needed. The loss of volunteers, they argued, would have financial implications for government that would have to replace them with paid workers. They estimated that it would cost $6 million alone to replace CWL volunteers in Ontario. Added to this would be the loss of revenues raised by volunteers through fundraising activities which they estimated would run over $800,000 from their organization. Without these funds, services would be cut.[24] Although the CWL has been placed as an organization representing consumers with particular spiritual needs, they are also a provider organization and echoed, as will be seen below, many of the same arguments expressed by providers.

(v) Insights from Interviews with Consumer Groups

Excerpts from interviews with a number of representatives of consumer organizations reiterate and reinforce some of the above concerns and support. This section breaks down comments under the various issues raised.

- Medicalization of the system

C002: In our discussions ... we wanted the District Health Council, not just the long-term care committee but the total District Health Council, to become a District Health and Social Council. That represented the social agency groups and consumers as well as the health groups. So that the Long Term Committee of the District Health Council would not be responsible to an over-all Health Council but would be responsible to again, a marriage of the two.

- Governance and representation

C010: When the seniors' community talks about consumers, what they're really talking about are family members often, because the person who's using their services is often not in any shape to be on the board. And that was, it's a huge battle. I mean it seems, at first glance not important but during each of the stages and particularly because the NDP got farther along than most did. Our final meetings with the NDP Bill had to with the governance because the seniors were saying, 'Well, if you say it's one-third consumer, you have to have a broad definition.' And of course people with disabilities say, 'I don't want my family making decisions. It's me.'

- Consumer empowerment

C002: We wanted to be sure that these things that we had been talking about, the combination of social and health services the one-stop shopping easy access, the right to be involved in choosing your service, and in choosing what kind of service you're going to get (were included). The big issues I think with the consumers' groups were how complaints would be dealt with and would there be a procedure for that that would protect the complainant and get some action. Those kinds of issues became the larger issues. ... It was a community responsible and responsive proposal because it was to centre in a community. And the board would be a community board with strong representation from the community and strong representation from the volunteers and the consumers.

- For-profit provision

C010: The disability community is somewhat different in that it actually, except in the area of health care, doesn't oppose privatization because what they prefer is choice. ... So I think

they couldn't care less to be honest about whether the MSA had the not-for-profit restrictions or not. They weren't prepared to go and fight in the same way the seniors were saying, it has to be 80-20 and all of that.

C007: Our final position was that not-for-profit is the way to go because for-profit at this time does not have the same rules as not-for-profit, and they can hire people with less training and are cheaper as a result than the not-for-profit.

Insufficient flexibility in the model to reflect ethnocultural differences

C074: What unifies the services for seniors in an ethnic community is the ethnic community. So you will have these services developed under one umbrella. So you don't need to worry about the issue of having to merge organizations and do away with existing organization. It was not a major issue with the ethnic communities. They were already Multi-Service Agencies. ... But where there was an issues was that we were opposed to a strict geographic definition of MSA boundaries. And we wanted boundaries that could be identified on the basis of communities of interest as well as geographic. We were successful in getting the legislation amended, but we had a lot of intense fights and disagreement with District Health Councils.

Other consumers, however, saw ethnocultural concerns as unwarranted

C007: Under the MSA they would respond to cultural sensitivity to the best of their ability, but not set up ghettos of Italians or Jews or whatever, you know. But try to meet the cultural needs to the best of their ability. And if everybody worked together there should be in the collection of people, they should be able to cater to the religious, and ethnic, cultural things. Somebody should be able to help them. But we could not see that everybody that was Italian no matter where they were, ... they should be serviced within their communities with help from the Central Area, rather than setting up particular multicultural, ethnic groups (MSAs).

Another consumer group felt that diversity did not mean setting up multiple systems but rather ensuring access to the system by all groups.

C030: I always believed that all you do is you say, 'You've got a million dollars for heart programs. I don't want, you know, $950,000 for heart programs, and $50,000 for cultural communities. I want a million dollars for diversity.' So you show me who's getting the benefit of those programs.

On the whole the concern for consumers was to get the reform implemented quickly. Governments had been talking for far too long about reforming the system.

C002: We were having meetings with the Minister of Health saying, "Get on with this! Do something about home care and these organizations that are putting so much opposition to it. Go ahead. Do it!

(vi) Summary of Consumer Interests

It is clear from these submissions that all consumers are not alike. Indeed, reference to 'consumers' by SCCA and government, each in their own way seeks to create a homogenous group. The SCCA by referring to 'consumers' seeks to claim broad representation and, therefore, power to speak on behalf of such a large interest group. Government's intention is ease and support of policy and program development. As will be recalled, one of the organizations comprising SCCA was the Canadian Consumer Association of Ontario. As is typical in private markets the reference to the recipients of care as consumers also conveyed notions of accountability of providers to the person who pays for the service. While indirectly paying for care through tax dollars, seniors wanted providers to answer to them directly.

Disability, multicultural and religious interests had more interest in promoting their differences than any similarities. Their very existence is predicated on these differences. These subtleties explain the varying recommendations for consumer empowerment and consumer representation on governance structures.

Seniors' organizations which are run and populated by the well-elderly are interested in having "people who will require services in the future" to be part of the consumer constituency, and want wellness programs to be part of the mandated services. Some members of the disability community view their own disabilities as unique and not comprehensible by others, requiring direct board representation. Cognitively capable people living with physical disabilities have no desire to have family members as representatives on MSA boards; whereas, those representing Alzheimer patients clearly do. From the multicultural communities' perspective, the requirements of Chinese elderly differ from those of other ethno-cultural groups having different languages, recreational activities, spiritual practices, culinary tastes, and healing practices. Similar arguments are made by different religious orders.

Notions of liberty also varied, but not surprisingly reflected the interests that made each type unique as a group. Seniors were more interested in being able to choose their preferred type of service, that is, in the home, community or in an institution, or an individual provider, and less interested in choice of a provider agency. People with disabilities were concerned about being able not only to choose their own individual provider but also to have direct control over the terms and

conditions of their employment. The multicultural and religious communities were more interested in choice of provider agency or an MSA that would cater to their unique needs.

With respect to security and equity, the consumer groups had similar interests. Security issues dealt with adequacy and protection of funding, quality of services, the establishment and monitoring of services, an enforceable complaints procedure, and the establishment of standards of care and eligibility requirements under legislation rather than regulation. Those consumer groups that either also provided services or had a substantial labour component to their membership expressed concern on behalf of the security of workers. Equity issues dealt with availability of services and no user fees. However, each group depending on their own requirements requested the inclusion of certain services. Well seniors wanted quality of life supports. Cognitively disabled groups wanted adult day care and caregiver supports. Seniors and the disability community preferred that security be achieved through not-for-profit provision but the disability community became uninterested if it affected choice.

6.3.2 Providers

At the time when the MSA was proposed there were approximately 1,100 community-based service agencies that were directly funded by the government, most of which were going to lose their autonomy through the amalgamation of agencies into the MSA. As stated earlier, these organizations could be divided into for-profit versus not-for-profit, and professional (nursing, rehabilitation therapy) versus support services (homemaking, meals-on-wheels). The submissions from the Ontario Home Care Programs Association and St. Elizabeth Visiting Nurses' Association of Ontario will be used to highlight professional provider interests. The Ontario Community Support Services and the Ontario Red Cross will highlight the interests of support service providers. These four will also illustrate issues raised by not-for-profit providers. The submission of the Ontario Home Health Care Providers Association will illustrate some interests expressed by for-profit providers. Finally, excerpts from interviews will illustrate and reinforce many of the same points raised in the submissions.

(i) Professional Providers (not-for-profit)

Submissions from the Ontario Home Care Programs Association (OHCPA) and Saint Elizabeth Visiting Nurses' Association of Ontario (St. Eliz.) will be use to highlight the policy interests of not-for-profit provider organizations. These two organizations, however, differed in their concerns. The OHCPA in most jurisdictions with the exception of Metropolitan Toronto expected that their staff would simply slip into comparable positions within the MSA, that is, instead of working for Home Care they would be working for MSAs. Whereas St. Eliz. was facing the

elimination of their organization through amalgamation. This underlay the difference in their concerns.

The *Ontario Home Care Programs Association* (OHCPA) represented all of Ontario's 38 Home Care Programs and had over 4500 staff including case managers, therapists, homemakers and nurses. The program was established under the *Health Insurance Act* as an insured benefit to Ontario citizens and provided approximately 90% of the total provincial spending for community-based health and personal care. While in most locations, the Home Care Program would turn into the MSA with a new board of directors, in Metropolitan Toronto the one Home Care Program would be decentralized into a number of MSAs.

The OHCPA, like most other organizations, were able to support the abstract principles and goals of the legislation, the integration of health and social services, and the standardization of eligibility criteria and assessment process. However, they raised a number of concerns of a more practical nature: the "de-insuring of Home Care Program Services", the overly prescriptive nature of the legislation, the implications of amalgamating most existing agencies for volunteers and workers, the need for greater flexibility and local determination around the development of the model, and the recognition of case management as a mandatory services. In their recommendations, aware of the growing pressures on the system from the acutely-ill, they asked government to reallocate funding so that care for the acutely ill did not come at the expense of LTC consumers. As an employer, they asked for the seamless transfer of employees to the MSAs with no break in employment, and that current community workers be given priority for positions over other socio-health (institutional) sector employees.[25]

Saint Elizabeth Visiting Nurses' Association of Ontario provided community-based nursing care on a not-for-profit basis. While also supporting the goals and principles of reform, St Elizabeth was adamantly opposed to *Bill 173*. They believed the legislation would lead to the destruction of community-based, non-profit agencies like theirs. MSAs were viewed as regional monopolies that would stifle innovation, be cost-ineffective bureaucracies, would eliminate consumer choice and volunteerism, and be insensitive to ethnocultural needs. MSAs were seen as a way for government to control and constrain community services.

Many of their arguments were couched in efficiency terms and liberty arguments were sometimes used to buttress these claims. "Consumers want choices. The freedom of choice promotes innovation and excellence." They believed that the government would fund MSAs according to levels that they, government, deemed appropriate regardless of the need in the community. Furthermore, they believed that the cost of services for government would increase because of the

inability of the MSA monopoly to attract private donations. They felt it was inevitable that the MSAs would become unionized workplaces. As such, they would further drive up costs through the negotiation of enhanced salary and benefits packages and because services currently provided by volunteers would have to be provided by salaried workers. They argued that the savings in administrative costs through the reduction in duplication of agencies would not be realized in Metropolitan Toronto since that single home care program was to be split into approximately 20 MSAs.

The agency believed that the government through the legislation would be destroying one of the major functions of not-for-profit organizations, namely, filling gaps that neither the government nor the for-profit sector would fill. "Under Bill 173, the government is tearing down service structures that are proven to be efficient, effective and sensitive to the changing needs of the community, in the hope that the government itself can do a better job. Many non-profit agencies in this province arose out of the fact that the community recognized the need to fill the service gaps that governments had allowed to develop in the first place."[26] The link of the origins of their agency to the "community" aligned them with goals and interests, which were widely seen as influential on the government.

In a sample letter for interested persons to send to their MPPs, which was attached to their Fact Sheet, Saint Elizabeth revealed what they viewed as the government's intentions. "The government has gone beyond addressing the issues of ease of access and the coordination of existing services. Instead, the government has chosen to destroy existing community-based agencies and to scrap the excellent services that are already in place because they hope that the government and the big public sector unions can do the job more efficiently and effectively through a large bureaucratic monopoly."[27]

Many of their arguments were couched as being in the best interests of consumers. Failures of liberty (loss of consumer choice of provider agency), security (not meeting needs of consumers and communities), and equity (destroying organizations that improve consumer access to services in non-profitable areas) were used to buttress claims of the inefficiency of the MSA model. The elimination of existing agencies (security from the provider perspective) was motivated by government in the interests of their powerful ally, labour. Although arguments are expressed altruistically on behalf of the consumer and the community, the bottom line issue not surprisingly was the viability of the organization. Claims that are based on more than self-interest are more successful in drawing in other potential advocates such as consumers and their communities.

(ii) Support Services (not-for-profit)

Through the examination of submission from the Ontario Community Support Association and from one of its constituent member, Red Cross Ontario Division, the following section will outline the issues raised by the not-for-profit support service sector in LTC. The section will also illustrate the difficulty an alliance made up of organizations with different resources and organizational complexities has in coming to and maintaining consensus.

The *Ontario Community Support Association* (OCSA) made two presentations to the Standing Committee; one on August 17th and one on October 3rd, 1994. OCSA claimed to be a grass roots organization with 300 member agencies across the province, over 10,000 staff and over 45,000 volunteers. In their August 17th presentation[28], they indicated their support like many others of the principles, values and purposes enunciated in the legislation, that is, not-for-profit service delivery, community-based planning, equity of access, a delivery mechanism driven by consumer needs and responsive to cultural diversity, the Bill of Rights, alternative models to the MSA that are the result of local planning and which meet the requirements under the Act, the functions of the MSA and the integration of health and social services. They, however, expressed six areas of concern.

First, OCSA was concerned that a policy document released by the Ministry in September 1993, gave preferential treatment to unionized workers in the MSAs. Moreover, *Bill 173* was silent with respect to the protection of not-for-profit community-based employees in the implementation of LTC reform. OCSA recognized that the development of MSAs in the context of Social Contract reductions and constrained finances would have an adverse impact on employment in the health care sector. Fearing the transfer of staff from institutions that were largely unionized, it argued that the skills of community and institutional workers were not comparable, and therefore the government could not simply transfer one into the other. The community support sector employee who had largely been exploited through low wages and long hours of work, precisely because they were not organized, was now going to be disadvantaged because of their lack of voice. Arguing for the security of consumers through continuity of service worker, OCSA recommended that community support service workers from not-for-profit agencies be guaranteed comparable positions in the MSA without loss of seniority and be given priority over other socio-health sector employees (i.e. institutional workers). This clearly put them in opposition to organized labour who had negotiated terms and conditions of employment and for whom seniority was a bargained right that did not exist outside of negotiated contracts.

Second, OCSA was concerned that the legislation was too prescriptive and at the same time not detailed enough leaving too much to regulation. While the province was moving to implement

MSAs, major regulations regarding eligibility criteria, program standards, MSA guidelines and regulations were not in place. OCSA demanded active involvement in producing and approving the regulations and that caution be exercised in setting retroactive dates for application of the regulations.

Third, they were concerned with the lack of effort and planning spent on the recruitment, support and maintenance of volunteers who were the backbone of their organizations. They argued, as others did, that without active volunteers, both the amount of service and the private revenue needed to support these services would be jeopardized. They called for formal recognition, support and planning for volunteers.

Fourth, OCSA was concerned that the government was too rigid in their model of the MSA. They argued that the form of the agency should emerge from the community planning process and, and accordingly, might vary from one locale to another. They stated that MSAs must not be allowed to develop into large bureaucracies that they believed could not be responsive to local community needs.

Fifth, the separation and distinction made among the services included in the mandated basket of services (that is, community support services, homemaking, personal support services and professional services), they believed reinforced the existing hierarchy which was based on medical need, the split between health and social services, and between cure and prevention. This distinction they argued mitigated against the development of a "generic worker" who would perform many of the functions such as personal support and homemaking. If a client needed both a bath (personal support service) and shopping, housecleaning (homemaking), it was unclear if that would involve two workers, or one worker with separate billing items. Furthermore, they argued that the legislative categories did not allow for flexibility in the community planning process in meeting different local needs, or enough flexibility for changing future practices and innovations. They recommended that homemaking and personal support services be combined and that community support services, homemaking, personal support services and professional service be further combined into one category. Although not explicit, OCSA did not favour the separation of workers into, what they saw, a hierarchy of skills, which would result in an unfavourable comparison for their workers.

Sixth, they pointed out that while many services, such as their own, were defined in the Act, many, in particular, professional services were not. They recommended the development of these definitions and OCSA's involvement in their development. They ended with applauding the government in its leadership and looked "forward to working in continued partnership" in bringing about the new system.

Because of a number of intervening developments within its own organization, OCSA requested another opportunity to address the Committee. While supporting the government in August and willing to work with it in partnership, on October 3rd, OCSA informed the Committee that without amendment to the legislation, it would not support *Bill 173*.[29] Reiterating their earlier concern that the Act was too rigid in the specification of MSAs, OCSA argued that alternative models that resulted from a community planning process should be allowed. A one-model approach was not flexible enough to respond to different local needs. They objected to the promulgation by government and other organizations of the view that OCSA recommended the MSA model. They clarified that in 1992 they had recommended the Comprehensive Community Care Organization (CCCO) and the establishment of a fund to foster development in a phased-in approach of no less than 10 demonstration models of CCCOs over a period of years. *Bill 173* demanded too much of a change in too short a period. Communities were at different levels of readiness for change.

OCSA indicated that they supported the recommendation of a number of other organizations that Section 13 of the *Act* restricting the purchase of external services to 20% be removed. They argued that restriction on external purchase of services needed to be relaxed on the condition that community boards provide or obtain their services from the not-for-profit sector unless this sector was unable to provide them. They once again reiterated their concerns and recommendations regarding workers and volunteers in their sector.

OCSA pointed out that since the NDP government had begun its reform the focus had shifted from an emphasis on simplified, equitable access, a reduction in fragmentation, an expansion of services, and consumer-centred care to a focus on cost cutting as a primary argument for organizational change. This change in focus, they argued, was due to the pressures of cost-shifting from a downsized institutional sector to the community and the added costs associated with pay equity. As a result the pledge of $647 million by the government was now meeting pressures not originally envisaged. OCSA took this opportunity to discredit the report released by SCCA and prepared by Price Waterhouse Management Consultants on the savings that would result from the reduction in administrative costs in the MSA model over the existing community-based system. The report had implied that community-based programs were administratively top heavy and inefficient. OCSA accused Price Waterhouse of using unexplained assumptions and for burying in the appendices, the data showing that the administrative costs of community support programs were already on average below the administrative costs projected for MSAs. OCSA's fear was that the government would argue that the administrative savings from MSAs would be sufficient to

compensate for the increased service pressures. OCSA argued that the shift to the community needed to include a shift of funds as well as clients.[30]

Although OCSA's shift from qualified support to not supporting the legislation without change may seem subtle, it was a blow to the government that had described its MSA as a model developed by the Association. Given its commitment to consumers and grass roots movements, OCSA's seeming defection was bad optics. The undercurrent of OCSA's change of heart had to do with its own internal politics, of managing consensus among 300 agencies across which there was a considerable power imbalance. OCSA's largest member was the Canadian Red Cross Society (CRCS), Ontario Division.

The *Canadian Red Cross Society, Ontario Division* was/is a not-for-profit charitable corporation incorporated under federal law. As a member of the International Red Cross which only allows one Society in each country, the Red Cross's Divisions, Regions and Branches are prohibited from being separately incorporated or from having their own Boards. Because the Society is precluded from entering into any arrangement that will diminish the authority of its Board, it alleged that the *Act* prevented its Regions or Branches from becoming an MSA or even providing services as part of an MSA. The legislation required each MSA to be incorporated under the *Corporations Act, Ontario* or the *Co-operative Corporations Act, Ontario* and to have its own board of governors; these requirements were incompatible with the Society's Fundamental Principles and corporate structure.

The Ontario Division, at the time, operated 78 branches with 10,000 volunteers and 6,000 staff (3/5ths of staff employed by all OCSA member agencies) who provided community-based services to more than 130,000 Ontarians. The Society provided community support services which included homemaking (about half of the service provided in the province), meals-on-wheels and wheels-to meals, transportation services; home maintenance programs, and friendly visiting. In fact, their Ontario zone was close to one-third to three-fifths of their national non-blood budget.

While supporting the principles underlying the reform and the Purposes in the *Act*, Red Cross did not support the creation of MSAs. The Society felt that the legislation went too far, ignoring many strengths of the existing system. Furthermore, the legislation addressed "systemic problems through the creation of a corporate structure," and did not, in its view, reform the sector in the context of the whole system. As a result, the organization saw occasions for gaming the system by which the powerful institutional sector through various strategies could shift their costs to the less powerful LTC sector. In addition, the *Act* was too prescriptive and inflexible, running the danger of quickly becoming dated. The Red Cross recommended that service categories in the MSA be defined by regulation rather than legislation to allow for emerging practice patterns. The division between

homemaking and personal support services devalued the former services reinforcing the stereotype that homemakers were little more than cleaning ladies. This belied the reality of the evolving nature of the job which included more complex activities such as transfers and mobilization, training clients in activities of daily living, assistance with self-medication and care of the dying, and ignored the way in which the boundaries between homemaking and other services were blurred.

The Society further stated that the problem with the existing system was not brokerage but rather coordination and access. The limits on external purchase of service by MSAs did not allow sufficient volume of services to be provided by agencies outside of the MSA to keep them viable. In some communities, the Red Cross was the only provider. If the Society was not able to continue, it warned that clients would face waiting lists, a decline in service quality and severely limited or no choice with regard to provider. The Red Cross recommended that the limits on the amount of external purchase of service be removed and each community be allowed to choose its own delivery model and mix of provider agencies.[31]

The friction within its own membership was evident in memoranda sent by OCSA's Executive Director to its Board. The Chair of OCSA's Policy Committee had resigned indicating that she "could not advocate for the Board's position regarding the MSA and *Bill 173*, when she cannot personally support this position."[32] As one respondent said, the Policy Director was one of the architects of the MSA model with very close ties to the Minister's Office and responsible for getting SCCA to hire Ted Ball.

P058: When her own board came out against the model, she was fit to be tied. She had been a prominent creator of the MSA. And to this day, I think, is still pushing for it, or trying to create it in local communities were she lives.

In an October 19th memo[33], the Executive Director refers to the "varying levels of support for and against Bill 173 and the 80/20 section in particular" within the Association and the Board. "This has been a difficult time for OCSA, ... to have had to balance the various, sometimes competing, perspectives." He recommends that members of OCSA be given the choice to proceed individually when approached by the Ad Hoc Group (described below) in a media campaign. He reminds the Association that its creation was the result of a successful amalgamation "which resulted from three groups negotiating and coming together ... Let's not forget this part of our history during these troubling times!"

As one member organization of OCSA put it,

P056: Every group that was opposed to this approach, that felt threatened by it, gave us a pretty rough time. So we had some difficult times through the first couple of years. And within our

membership, the membership was split, and even after they, the government, decided to call it an MSA and enshrine it in legislation, we had a significant number of our members in favour of it, and a bigger more significant number that were against it.

Another OCSA member organization described the split within the parent organization in this way,

P049: (Red Cross) could not continue to be a very large member of OCSA at the same time that the two organizations appeared to be taking a divergent role in terms of the creation of the MSA. I am probably over-simplifying, but it seemed to me that people who had been involved in the process from the beginning did not realize that the concepts coming out of the NDP policy position were incompatible with organization survival.

A respondent from an organization outside of OCSA saw the decision to pull out as quite self-serving.

P058: They didn't realize it (MSA) was going to put them out of business too. They initially thought that they would be served by it because they would somehow arrive at being in charge of the system. Because they all wanted to become MSAs, themselves. When they discovered that no one was going to be having their own board of governors. It was all, 'we were all going to be workers under one system. Holy smokes!' The board of OCSA said, 'Wait a minute! What are we doing here? We're committing suicide by endorsing that.' So they backed out, too.

Not surprisingly, support for and concern about *Bill 173* dealt with those issues in the legislation that had a direct impact on these organizations. They favoured the inclusion of support services in the basket of services which increased their importance, but not the continued distinction of service categories which would foster a hierarchy of care, thereby detracting from their programs. They supported the notion of a generic worker, which would increase opportunity for their employees. However, they opposed the preference for unionized workers, which would disadvantage their largely non-unionized workforce. Understanding that the 80-20 rule would affect their membership in varying degrees, they called for greater flexibility.

The internal discord within OCSA emanated from the disparate beginnings, institutional structures and interests of its members. The Red Cross was a large agency of long standing, a complex governance structure, comparably more resources, a large pool of paid staff, and heavily vested in home support services. During the reform, it was involved in a dispute over its blood bank, which threatened a substantial portion of its business. It had a lot more to lose than the other members of OCSA. The others were small grass roots organizations with a small paid staff and

budget, and whose services were provided by a bank of volunteers, for example, individual meals on wheels programs. Although they formed their own provincial association that joined OCSA, they did not match the Red Cross in resources or longevity. The power differential within its own membership would account for OCSA's withdrawal of support for *Bill 173*.

(iii) Professional and Support Services (for-profit)

The *Ontario Home Health Care Providers' Association* (OHHCPA) represented for-profit (commercial) home care agencies in Ontario. Through 115 offices across Ontario, they employed over 20,000 staff including nurses, home support workers, occupational and speech therapists, physiotherapists and administrative staff. They claimed that 40 to 45% of publicly-funded homemaking services in Ontario were provided by OHHCPA members.

In their submission to the Standing Committee on August 16, 1994, they opposed *Bill 173* on largely efficiency grounds for the system, liberty for consumers, and security for themselves. They argued that it would destroy rather than reform the system. It would be more costly and less responsive to consumer needs because it would put in place a monopoly that would be both administrator and provider. They drew to the Committee's attention the fact that the legislation originally limited external purchase of services to 10% from for-profit agencies only. The government later increased the limit to 20% but now applied it to both commercial and not-for-profit agencies. They argued that the limit on external purchase would cripple an agency's ability to retain the critical mass necessary to survive, driving almost all of their member agencies as well as others out of business. The legislation threatened both commercial, not-for-profit and volunteer agencies, workers, and ultimately consumers. One-stop shopping through the MSA would remove all choice. The lack of competition, they argued, would discourage innovation and choice, remove consumer safeguards and rights (consumers would not complain about service because the people who provided the care were the same ones who determined eligibility and amount of care), erode quality and increase costs. Not surprisingly as proponents of the market, they saw the legislation as micro-management of the system from the centre at Queen's Park. They saw the legitimate role of the provincial government as developing overall policies, defining core services, determining the level of funding and letting the local communities determine priorities for home care.[34]

(iv) Providers under the Canada Health Act

This section documents the submissions from the providers typically associated with Medicare, namely the physician and the hospital. For hospitals, the role of DHCs in the legislation along with activities undertaken by the MOH in other policy areas were warnings of the government's intent to weaken their autonomy. The case management function of the MSAs was

viewed by family physicians as undermining one of their most important roles in the care of their patients.

Speaking on behalf of acute and chronic care institutions, the *Ontario Hospital Association and the Council of Chronic Hospitals of Ontario*, (OHA/CCHO) put in a joint submission to the Committee on September 12, 1994.[35] While supporting the principles of reform, they stated that they could not support *Bill 173*. Appealing to values of liberty and efficiency, they argued that the legislation was too prescriptive and introduced a "top-heavy structure of centralized control" representing an unnecessary and unwarranted intrusion on the autonomy of individual organizations, volunteers and providers. Furthermore, they believed that the proposed MSA model would "usurp the management and governance responsibilities of community-based organizations, including hospitals." While supporting one-stop access to services, the two bodies did not support one-stop shopping which restricted consumer choice.

They believed that hospitals were an integral part of the community, already providing community support services such as outreach palliative care programs, home care services, respite services, and meal programs. Because *Bill 173* would threaten hospitals' abilities to continue these programs, they asked that the restriction on the amount of external purchase of services be deleted. The legislation and the provincial government were presenting institutional and community-based care as mutually exclusive systems rather than as "common pathways" to meet needs. They called for an interim strategy which could be a federation of long term care agencies agreeing to work together to provide services for a given area.

While supporting the planning function of DHCs, the OHA/CCHO were concerned about the blurring of the distinction between the functions of planning and management in section 62 of the Act ("the allocation of resources to meet health needs in the council's geographic area; and ... plans for the development of a balanced and integrated health care system...") which would undermine the autonomy of individual institutions. Furthermore, section 62 allowed the DHCs to perform any other duties as assigned. For the OHA/CCHO, this section was a red flag when viewed in conjunction with the June 1994 final report of the Ministry's Regional Planning Steering Committee for Southwestern Ontario which recommended a Regional Health Council for the area. From their perspective yet another layer of bureaucracy was created without public or stakeholder input.

The *Ontario College of Family Physicians* that represented approximately 5,000 family physicians submitted their brief on August 17, 1994. From their perspective, the government had successfully de-medicalized LTC and written the family physician out of the loop of care. The legislation as written did not allow for medical input into decisions regarding services for a patient,

did not allow physicians to access services on behalf of their patients, and did not provide for a communications link between the physician and the MSA. In the government's rush in shifting care to the community, the organization felt that it was de-institutionalizing care in areas or instances where it might not be appropriate, for example, rural areas where community services were not available or for patients who did not have a family support structure. From their perspective, the family physician must be involved in the decisions regarding his/her patient. They asked that many of the rights under the Bill of Rights be extended to individual providers.

(v) Provider Alliances

Threatened by various aspects of the legislation, a set of unlikely interests came together to form the *Community Providers Coalition*. The Coalition consisted of both professional and support service providers as well as not-for-profit and for-profit providers, namely, the Ontario Home Care Programs Association, Canadian Red Cross, Ontario Community Support Association, the Ontario Home Health Care Providers Association, Ontario Home Respiratory Services Association, Saint Elizabeth Visiting Nurses' Association of Ontario, and the Victorian Order of Nurses. The contentious aspects of the legislation for the Coalition were the amalgamation of agencies into the MSA and the 80/20 restriction, both of which would affect the viability of provider organizations, potential loss of jobs for non-unionized community workers to unionized, institutional workers, and loss of independence in governance. The Coalition was united in its opposition to the government's intent in offering positions in the newly-constructed MSAs to unionized staff in order of priority before offering them to non-unionized staff. The majority of the Coalition's staff were non-unionized. They decried the 'one-size fits all' approach of the government in mandating the MSA model, the basket of services, and the forced transition of thousands of workers into "yet another enormous bureaucratic structure."[36]

During 1994 and particularly during the Standing Committee meetings the Coalition expanded its membership in an attempt to have broader based representation and appeal. Although it mostly added provider groups (Association of Ontario Physicians and Dentists in Public Service, Catholic Health Association (Ontario), Federation of Non-Profit Organizations Working with Seniors, Ontario Association of Medical Laboratories, Ontario Association of Non-Profit Homes and Services for Seniors, Ontario Hospital Association, Ontario Medical Association, Ontario Nursing Home Association and Villa Charities) to its membership, it also recruited a few consumer groups (Catholic Women's League, Council on Aging, Ottawa-Carleton, and the Ontario Association of Residents' Council).

The Coalition began a campaign opposing the legislation including writing to the Premier seeking his personal intervention in the reform arguing that the reform would result in less but more costly services for consumers, decreased volunteerism, and less empowerment of local communities.[37] It issued press releases and held news conferences.[38] [39] The coalition hired a consultant who advised it on media relations[40] and on the procedure and behaviour for being in the legislature during debates.[41]

It got a legal opinion on the amendments to Bill 173 dealing with staff transfers that the government tabled in November following a meeting with the Ontario Federation of Labour. It issued a media release stating that the amendments would force MSAs to offer available jobs to unionized workers before they were offered to non-unionized workers. Despite the government's assurances that the non-unionized worker would not have reduced job security and that the community care sector was expanding, the coalition stated there would be fewer jobs. "The announced purpose of MSAs is to reduce duplication and increase the efficiency of service delivery. This is typically done by reducing jobs. Thus, in the MSA former employees of service providers will compete for fewer jobs than formerly existed. These MSA jobs will be given first to unionized workers and then to non-unionized workers. The result is that non-unionized workers will have reduced job security. ... This means that a non-unionized long term care worker with twenty years of experience could be pushed out of the system by a unionized worker who has been on the job for four months." Leaving the media to draw its own conclusion, the Coalition stated that the government "amendments have nothing to do with improving the delivery and access of long term care to the people of Ontario."[42] [43]

An interviewee from one of the organizations that joined the coalition indicated that it was very easy to form the alliance when the union issues surfaced.

P067: Yep, it was easy. It became really easy when the union ideology came out of the whole thinking. And that's where ideology really started to prevail and that is when all the forces came together. That is when the commercial agencies provided resources for all of the community agencies, that's when the OMA came into the thing, and that's when we created the LTC Reform Group. ... They got enough people angry all across the board, from physicians to commercial agencies to not-for-profits. Just everybody they alienated. So we all banded together, got two or three really good government relations people and that when it was going through hearings and all of that. There was tremendous, just tremendous momentum.

This amendment late in the day prompted the Executive Director of OCSA to recommend reversing OCSA's previous position of not "going high-profile in opposition to the Bill." He justified

his recommendation as follows, "I feel that we need to make an exception in this instance and speak out, because the government has clearly backed away from its previous amendment, which protected unionized and non-unionized employees equally. Our Association represents 12,000 employees, of which, 94% are non-unionized, and I feel that all employees should be treated equally under the law during the transition to MSAs. ... Therefore, I have agreed to be listed as a contact on the attached news release, which is being circulated today to the press."[44]

After the passage of the legislation, the activities of the Coalition continued under the name *The Group for Long Term Care Reform*, and its membership expanded to include: Alzheimer's Society of Ontario, Association of Ontario Care Therapists, Association of Local Official Health Agencies, Catholic Charities, Lambton Alliance, Ontario Home Care Case Managers' Association, and the Ontario Home Care Medical Advisors. Red Cross, OCSA, OHHCPA OHA, OMA, Saint Elizabeth's and the VON committed either financial or in-kind support.[45] The Group mandated four roles for itself: to act as an advocate on behalf of change in LTC, a clearing house for information, a resource for the media and the public, and a liaison with other stakeholders. One of its intents was to raise LTC reform as an election issue by providing information to the media, being a resource for politicians, and working in concert with the Ontario Health Providers Alliance in its election strategy. It planned to increase consumer participation in its organization and to "minimize the apparent government strategy of 'divide and conquer' by explaining our position and our activities to consumer organizations, and listening to their views and concerns."[46]

(vi) Insights from Interviews with Provider Groups

Excerpts from interviews with some provider groups also reinforce the above concerns.

- Organizational viability

P049: Survival was the central them. For some it was preservation of their mandate. For some it was, it was the ability to serve their own client population in a way that they had done so successfully over time.

P050: The issues were loss of identity, organizational identity. ... We would no longer exist.

One provider agency, however, felt that loss of organizational viability and identity was of concern only to the larger organizations.

P067: I think some of the stronger not-for-profits who actually had a corporate identity in addition to a public service identity, wanted to hold onto their corporate identity. And it was mainly the smaller community support agencies that had been struggling to death to get funding that I think, that within the MSA structure a lot of that detail would be eliminated and they could become part of this phenomenon and not have to worry so much about the day-to-day

financing and didn't really mind transferring who they were and what they were into an MSA.

As one government spokesperson put it, for some large organizations, not unlike the Red Cross, their national viability was at stake.

G093: I mean the problem for the VON in particular was that Ontario was, as 40% of the population, was an important part of it's national, otherwise provincial, base. It had major problems in other provinces. You know, there was basically nothing left in B.C. I can't remember if there's anything left in Alberta, but in a lot of other provinces, the VON no longer had a role. ... And so Ontario with the funding that we were providing, because it was the mass of their work, was not only funding the provincial organization but it was doing a good bit to funding the national organization too. So it was a serious problem for them. Much more serious for them than it was for St. Eliz.

P061: It was difficult for (organization) just as an example to consider dissolving and becoming part of an MSA, it was equally difficult for community 'xyz' that had it's own board of directors, that had worked so hard to develop its own world to even conceive that it could fold and become part of something else. We knew that that was going to happen.

Another agency, in contrast however, commented on the ability of some not-for-profit agencies to put the needs of the consumer above their own organizational viability and thereby support the legislation.

P056: They had the most to lose. Which is interesting, they had the most to lose in going in to an MSA because they're the biggest corporations, but they were the biggest proponents because they felt, ... 'the mission of the organization is more important than your organization itself.'

- External purchase (80-20 rule)

Closely linked to organizational viability was the restriction on external purchase of services.

P056: If a lesser percentage than 80% came under the MSA then it meant that not as many organizations would have to be folded under it.

P059: You couldn't sustain a business on dividing up the work on that basis (20% of MSA services).

P058: Out of 100% case-load, they were going to insist that the MSA employees provide 80% of that business. Twenty percent of the business or the case load would be serviced by outside service providers. None of us could survive on that 20%, divided among us. I t wouldn't be possible from a viability, fiscal viability point of view. So it essentially, you know, rang the death knoll for all the agencies.

- Not-for-profit provision

Some saw the not-for-profit preference to be related to the amalgamation of agencies and the 80-20 rule. The government's real intent was not-for-profit provision and the 80-20 rule was viewed as a concession on the part of the government to gain the support of providers for the MSA.

P061: I mean the concept was to have all of the not-for-profit together in one organization. I think one of the other things that I think that really put that whole idea off-kilter was the size that the NDP were suggesting that these MSAs should be. Much, much too big. ... We fought against that quite fiercely, but they just didn't understand that we didn't really need to be so huge. And that created an awful lot of the anxiety for the small agencies. And that's why some of them said that they wouldn't be part of it. .. And so that whole idea of 'well, you can stay outside if you like, you know, we'll purchase, the 20% idea, we'll purchase from you.'

P083: We always knew that there were some areas in the province that had already had a high level of for-profit providers. And others that didn't. Well, I mean you've got to sort of work to provide the right incentives if you wanted them to move to non-profit. Give some start up allowance to non-profit agencies. There's lots of room here folks! We're expanding this sector. There could have been lots of ways to do it, I think, rather than saying you know, 'Thou shalt not operate.'

- Government intrusion into service provision/ too bureaucratic/too inflexible

P059: Where you've got Multi-Service Agency, you've got government employees providing health care.

P067: MSA is an attempt to really 'governmentize' if there's such a word, and do away with all of the governing structures. ... This whole MSA concept ... was the slippery slope that, you know, first start in the communities then you'll start in the hospitals. Then you'll start to erode all of the separate governance of agencies.

P058: It's too large. There's too much influence, there'll be too much influence from the government because the stakes are far too high to let that off the rail for too far. So I don't think that it would have ever been that removed from the government. ... I just saw the government sitting on top of this thing like a hen on an egg. (P030)

There was a lot of discussion about the merits of a, what we viewed as a post office style delivery of health service versus one where you had a more brokerage model style.

P069: It was really Ministry-driven. The Ministry was establishing the initial Board. And they were defining the terms of reference for the Board. ... I mean the MSA was very much, a very,

very dedicated model. ... Because it was so circumscribed by government regulation, it was a defacto extension of the government in the mind of the providers.

P083: We're community organizations and we're run by, you know, like we're community-based. We don't want to be what you're (government) telling us – we have to join together because it's not who we are. And because you (government) fund a program or arrange it or even the bulk of it doesn't mean that you still run the organization. We're not a wing of the government. That fundamental, world view difference. That was always at the heart of the problem.

P062: What I kept saying to the government was, 'Tell us what the funding model is going to be, or let us help you develop it. And then get out of the way! Let the managers manage!' There isn't a person in the Ministry of Health today that I can think of, who would know how to run any of these programs, community-based or institution. That's a big change from 20 years ago when there were people in fact who had very successfully run many programs and were brought into the Ministry. They couldn't do it, and yet they are more and more trying to take control of all of these facilities, of all of these programs. And we the taxpayers, are going to pay a heavy price for that. ... The belief was that these bureaucrats ... had an agenda whereby they would, in effect, tell them (MSAs and their boards) what they could and couldn't do, and so box them in. These boards would be nothing more than window dressing.

P049: I think that the approach they were taking was a good one but it was very troublesome to agencies who had not had that very, almost legalistic, and very much defined approach before. For the agencies that had brokered services through the Home Care Program it was not such an issue. ...For the community supports that are used to getting a global budget, and then doing the best they can in their community, it was a huge departure from where they had been. ... And particularly under Bill 73 the legal obligations, it was quite ominous for them. The expectation was that a number would then not be able to survive in that environment, and those that would, would have to put more money into overheard or whatever else required services.

P061: You'd get a huge monolith and everybody gets a feeling they're being swallowed up. If you keep it smaller, it's easy to do this in the rural areas, because the communities define themselves very, very nicely, I think in a rural area. And then they don't have any difficulty with where they think the boundary should be ... In the metro areas, it not as easy, but it's still quite doable to define communities. .. The whole idea of the economy of proximity versus the economies of scale. I mean there has to be a reasonable amount of people to make

the economies of scale idea work. But ... any organization that gets too huge, it becomes very cumbersome, very top—heavy, tendency to being very opportunistic and bureaucratic.

- Human Resource Issues: Unionization of a largely non-unionized sector; institutional versus community workers.

P069: This is a government take-over of the health sector. This is a union-driven take-over.

P059: What was characterized as post-office style healthcare provision was not going to serve customers well, not the tax-payer. Where you've got Multi-Service Agencies, you've got government employees providing health care. And unionized ones too. Because people believed that the NDP move was to unionize that whole home care sector; because within the MSA human resource policies there was favouritism for unionized workers to get the jobs in the MSA. So that was a threat to all of the home care sector, from the point of view of the employers, because most of the workers are not unionized.

P050: At that point in time we weren't unionized. And it was really fascinating but our workers unionized during that period because again they saw themselves as having an advantage. ... They felt that if they weren't going to have a union that some other group would come in and provide the work, ... that they wouldn't even be guaranteed the succession into the MSA.

P061: So it was a very hot issue with them, with OCSA (the parent association of this respondent's agency) because in most by far the majority of the agencies in OCSA were not unionized. So most of them felt that it was a non-issue until we were all of a sudden faced with it, and realized that all of these agencies that they would be amalgamating with were unionized. And there were huge issues involved with, you know, how those employees were going to be treated. ... And we were saying, 'Well, you know, maybe someday it will be (unionized) but that will be the role of the employees, to make that decision. That's not something that we should be making. It's not a decision that we need to make in formation of these organizations.'

P056: (One of our concerns was that displaced hospital workers would get preference for MSA jobs). And they're a very different type of worker. Their whole approach is completely different and often times the client, patient population is dealt with in a very different way. And hospital workers will admit that when they go on working in the community, you don't have all this high tech stuff. You're kind of out there on your own.

P083: The community sector -- here I mean community health centres, the smaller community agencies not so much the nursing homes or even the public health units, but the smaller

agencies -- have very strong belief that you can't move, you can't automatically move workers from hospitals over to the community because they're too institutionalized.

- Conflict of interest

P054: The only concern we had, and that's a continuing theme throughout, was that conflict of interest will become an insurmountable problem; that there will be an agency that will be delivering 80% of services, buying 20%, and at the same time deciding on each individual case what service this person should get.

- Too much, too soon

P083: I thought it was kind of like taking one major leap, wiping out everything and thinking that the next day you were going to set up something new. I thought that was absolutely insane. And of course, you would need some human resource strategy and so on if you were going to be that devastating. I had always thought that the way you would approach it would be in steps ... before you actually sort of just decided to create one employer that would take over everything.

Even those organizations, which favoured most aspects of the MSA model, thought it would not succeed because it was too dramatic a departure from the status quo.

P054: We had said, initially, 'we're not sure about this, but we think it's a good idea. Try it, you know, in say ten demonstration projects and then you can adopt it elsewhere.' Senior's Alliance said, 'Forget pilots, they never work.' ... And the government opted with that approach. ... They were getting battered so much on so many different issues that they wanted to have something that would be a good news story. ... Only as it turned out, it wasn't such a great news story.

P061: They said, 'let's do it everywhere.' And we said, 'start with 6 to 10.' ... We had the benefit of knowing how difficult it had been to amalgamate these three organizations. ... And I don't think the politicians really understood how enormous that was going to be and how difficult it would be for the VON to say, 'okay, we'll fold when we become part of the MSA.'

- Non-implementable model, ill-thought out model

P083: I just think that this big leap to the MSA was absolutely absurd. I just think that the NDP was very, very weak on implementation, and didn't know how to go to the bureaucracy to help them to work that out. I do think they had a lot of good, you know, policy ideas, and even initiatives. But when it came to implementation, it was sort of like they never were able to think through the detail and how to get from A to B and carry everybody with you.

P089: They were announcing stuff before they even knew what they were going to do in the next day. You know, 'Now let's announce this.' Well what does it mean? 'We'll work that out next week just announce the God damn thing!' ... It was a juggernaut. ... And they'd come out with these manuals this thick, and draft lines for how your MSA will function. They had just come out, Womp! And people ... 'Where the hell did this come from?' And you start reading it and it is a nightmare. And one abomination after another. ... It was just like everybody had ripped out their favourite 20 pages of nightmares.

- Efficiency

P049: Bringing together of a number of different agencies had significant HR implications for the workers because the diversity of the services provided was so extensive that you had hourly workers with very, very comprehensive benefit plans side by side with workers like homemakers that were hourly workers paid somewhat above minimum wages. (Our organization) was very concerned first of all, that the system could not sustain an equalization that would move up the cost of all the service providers. At the same time they did not want the more lowly paid and less professional workers to be disadvantaged in the process. Because throughout the creation of the MSAs it was always argued that 'Oh well, no one would lose any jobs. It would be more efficient." And in a system that's primarily staff driven and all the funding goes for staff, at least 85%, you can't achieve a lot of efficiency without having implications on the staffing.

P054: We felt that while the governments are trying to control costs, at the same time they're putting in place provision which will drive the costs up significantly. We saw some of that happening by that time ... in the facility sector, was the constant ratcheting of labour agreements. And we felt that the same process will happen as soon as MSAs are created. All the costs will go up to higher, whatever the highest cost element is. All the wages will go up to that level. ... In creating a new agency and bringing staff from four or five different workplaces, no one's going to take a pay cut.

- Financial burden on providers

P059: There had been a long history of commercial relations between the Home Care programs and the providers that initiated the suit for which there was no compensation for the fact that an arbitrary cessation of the relationship was being put into effect.

P056: There would be huge costs to the not-for-profit sector around severance and terminations. It was very clear. ... We bore the responsibility and I recall having a legal opinion done at the

time in terms of what would be the burden, the financial burden, to our organization around the costs of devolving. And it was huge. (P050)

There (was) some stuff around succession rights with pensions and the pension wraps up because of the fact that it's gone over and it folds. Then there's a huge liability (for the transferring organization).

- Concerns about quality

P067: I think our key concern was that this new structure would not have the same standards, approach, responsiveness to the current delivery profile we had. So by creating government type structures that that the actual diversity and responsiveness of our current home care system with its complications would be simplified to the point of lack of services and actually less responsive to the home care needs.

- Loss of volunteers and private giving

P030: What about our volunteers? They're not going to join this massive MSA. They just won't do it.

P089: And for some of these agencies like VON or some of these neighbourhood services, you know, these groups have been going for 80 or 100 years. They have this whole identity, this whole community persona, this whole tradition. And people who have been loyal supporters for generations and stuff. And they're like, 'If you get rid of us, these volunteers aren't going to go over there.' You know, like they're going to be so mad that you destroyed their organization that they loved that they're not going to want to waltz over and become your volunteers there. And the people who give money to a community-based local neighbourhood organization aren't going to feel the same way about giving to this kind of quasi-governmental creature that you've created. ... You know, it's hard enough to get enough resources focused in here. What you're going to do is you're going to drive away some of them. ... They got really concerned when we started talking about, when they found out how many volunteers were actually involved. And they didn't have any clue how many volunteers were involved in delivering services. 'You mean, like to deliver all these things, you need all these people? And it's all contingent on the good will of these organizations?'

- Medical model orientation

P061: When somebody or other sold the Ministry of Health on the idea of giving the development of the Multi-Service Agencies to the District Health Councils. Quite frankly, when that happened, I knew that it was doomed. .... It was because the District Health Councils were perceived by the community support agencies as being very health focused and they saw

> themselves as being marginalized from that. Being considered insignificant by that organization. ... The community support agencies didn't find themselves interested in any part of it. They didn't trust it.

Like consumer groups, there is no single version of provider reaction to the legislation. There was one aspect of the legislation, which would bring the majority together. While different provider organizations raised issues of quality of service, of inefficiencies of the MSA model, or the unwieldiness of the model, they were almost all united figuratively and literally against the model because it threatened their very organizational existence. Security of the consumer, choice for the consumer, efficiency of the system were heralded in support of their arguments but the bottom line was the security of the organization, whether professional or support service agency, health or social service provider, or for-profit or not-for-profit.

6.3.3 Labour

Although the government had provided funding in the summer of 1994 to the Ontario Federation of Labour (OFL) to consult with health-related unions on LTC reform, most of these unions put in their own briefs to the Standing Committee as did the OFL. This section documents the issues raised in submissions from the Ontario Federation of Labour, the Ontario Nurses' Association, and the Ontario Public Service Employees Union.

The *Ontario Federation of Labour's* submission[47] to the Committee on October 3rd claimed to represent the position of the labour movement. In its brief, the strong ties with consumers were highlighted. It stated that it had over 650,000 members from all spectrums of the workforce representing both the users and the front-line workers in the health care system. It made clear that it joined with the Ontario Coalition of Senior Citizens of Ontario (a member organization of SCCA and which had union roots) and the SCCA to urge the NDP to move the legislation in this term of their mandate. They indicated that the opposition was mainly coming from self-interested provider organizations. "The opposition to the Bill is really about power. What is being played out is turf wars among over 1,000 agencies who want to keep their control over their piece of the long-term care delivery system."

Aside from advocating consumer choice in being treated in either the home, the community or in long term care facilities, the OFL submission focused on the protection of labour's interests. It asked that home care services currently funded under OHIP continue to be insured without user fees when transferred to MSAs. Underfunding of the system would, from their perspective, result in low-paid workers, over-burdened family members, and exploited volunteers. The OFL expressed grave concern that the government increased the potential purchase of external services from 10% to 20%

and did not state a preference for not-for-profit agencies. It recommended that the government revert to the 10% limit without exceptions and a not-for-profit preference. The OFL strongly opposed the use of volunteers to do work that should be done by full-time trained staff and asked that *Bill 173* be amended to reflect this, prohibit the use of volunteers to do work previously done by any employees in the health sector (not just the LTC sector), and that the MOH develop a protocol on the role of volunteers in consultation with organized labour.

With the downsizing of the acute care sector where most of their members worked, the OFL asked that a mandatory redeployment protocol be enshrined in Bill 173. The protocol would include a guaranteed transfer of workers in the community to MSA jobs without loss of salary or benefits, the development of a central registry of laid-off workers with the requirement that employers hire from this registry, and a mandate for the Health Sector Training and Adjustment Program (HSTAP) to administer the registry. They asked that the Standing Committee urge government to develop a redeployment system ensuring jobs for workers displaced by health care restructuring. Because HSTAP was administered under a Board with equal labour and management representation, this was a way for labour to have direct input into job transfer policies. Institutional workers on the whole had better salary and benefit packages than their counterparts in the community. Institutional (and unionized) workers who were transferred into community jobs were in jeopardy of poorer compensation packages. As a result, the OFL recommended that the *Act* enshrine the goal of equalizing the wages and benefits in the two sectors.

They rejected the *Act's* prohibition of MSA employees as Directors of the agency and asked that the offending section be deleted. In the continuing battle to have labour representation on District Health Councils, they asked that Bill 173 be amended by allowing labour to nominate four appointees (two labour consumers, and two labour providers) to DHCs and by allowing for the remuneration of board members of MSAs and DHCs for lost wages and expenses incurred in attending meetings.

The *Ontario Nurses' Association* which claimed to represent 50,000 registered nurses working largely in institutions fully endorsed the goals of the legislation in their submission[48] but had two major areas of concern: human resources and governance and accountability. With respect to human resource issues, the brief pointed out that community health agencies tended to use lower-paid staff than institutions because these staff were less qualified and tended not to be organized into unions. ONA feared that the option of using alternative, lower-cost workers cited in the Compendium of the *Act* in conjunction with the provision under the *Regulated Health Professions Act* for regulated health professionals to delegate controlled acts, would tempt agencies to control costs by using

lower-paid staff. With approximately 1,700 Home Care Case Managers, most of whom were registered nurses, ONA urged government to make use of these skilled professionals rather than employ cheaper labour. The reduction of the high turnover rates in some agencies through job security and proper compensation packages would contribute more to quality of care from their perspective. To further protect their members, they recommended that paid work not be performed by volunteers. They asked for successor rights (continuing rights of unionized employees to be represented by their union and to be governed by a collective agreement). Because of the complexities of amalgamating many agencies with different labour affiliations under one organization, they also asked that union representation be included on MSA boards.

The *Ontario Public Service Employees Union* (OPSEU) which claimed to represent 110,000 workers and whose members were also educators, consumers, predominately women, informal providers, community activists, volunteers and taxpayers made their submission[49] on August 16, 1994. They noted the same ground covered by the later OFL and ONA submissions. They expressed concern over the discrepancies between the "myth" and the "reality" of *Bill 173*. The shift to the community, despite the rhetoric, had more to do with cutting costs by creating a cheaper system based on downsizing of a well-trained, fairly compensated workforce. The "affordable community means low-paid, unorganized workers, over-burdened family members and exploited volunteers. The inappropriate use of volunteers would undermine the "efforts, and successes, of pay equity and employment equity legislation" and "erode the quality, accessibility and continuity of services." They saw government "offloading the responsibility for negotiating employment adjustment strategies onto communities" and called for a labour adjustment strategy enshrined in the legislation and for labour representation on boards.

(i) Insights from Interviews with Labour Groups

Excerpts from interviews with representatives of various labour groups reinforce the issues raised in their submissions.

- Not-for-profit preference

P043: Our position across the health sector has always been that with increased demand and the so-called fiscal crisis and rising cost, we did not want to see any dollars going out of the system. And there are an increasing number of examples, you know, where that's happening now with the private sector coming in to deliver health care. ... We didn't want Extendacare and Paramed and Compucare and Columbia Health Care Rehab Services. That's what we had a problem with. We didn't have a problem with the VON or the Red Cross. ... One of the things that we were certainly interested in was having workers remain, you know, having

direct service providers being employed by the MSA, but ... our position was not that everybody who's providing service has to now be a direct employee of the MSA. ... We just wanted the service to be purchased from not-for-profit providers.

- External purchase of services, the 80-20 rule

P040: (We wanted) zero contracting out. If the Multi-Service Agencies were going to do it, they should do it, right? MSA Workers would be there, there'd be no contracting out and no user fee. ... It (legislation) allowed people to contract out for different reasons, and it just was really like an open gate because you could have contracted out for almost anything the way that the wording was. And we wanted these exceptions be stipulated and this was the maximum limits in terms of how much they could contract out. We wanted to make sure that it didn't include things like short-term absence of employees due to illness, vacation or other unplanned events or from a self-employed individual. ... It (contracting out) was supposed to be used for special, a new service or something else but not for ongoing regular business which a vacation would be seen as ongoing regular business. They should, their human resources plan should include that.... The research shows that, and the numbers are there, private sector people who work in the private sector, tend to make less, their working conditions tend to suffer because the profit has to come from somewhere. There's only so much efficiency you can get out of a small agency. ... And the agencies are really very efficient anyway. And in order to crank a 20% profit out of an operation, just because you move it to the building next door (MSA), it's either got to come out of the workers, their conditions, or it has to come out of care.

- Use of volunteers

Labour often expressed their fears regarding the use of volunteers as either exploitation of volunteers or reduced quality of service for clients.

P040: We see it in the Long Term Care facilities right now with funding cuts. One day a worker gets laid off, the next day they've got a volunteer coming in to feed people. We're saying, 'No, that's a workers job.' ... And our position on volunteers was we wanted them to supplement things that workers couldn't do, like writing letters, doing the social stuff, you know, doing the extra things for people. But not doing the daily work that's required to provide the ongoing (care). So more the support work as opposed to the cores services. And we were saying that the Minister of Health should have a protocol of role of volunteers with organized labour.

P040: They (volunteer associations) were very concerned around using volunteers inappropriately for doing things that they weren't covered and WCB. They weren't trained properly for expecting them to do more and more. And it's no longer being a volunteer. If you're going to feed somebody, you have to be there every day at 12:00. It's like a commitment for work. You can't miss it.

P043: I also sat on a consultation group on the role for volunteers and long term care. In the training group, what I was really concerned about was that with a little bit of training what they were doing was just widening the scope (of the use of volunteer service) to the point where it was going to be dangerous, using less skilled workers.

- Job security for community workers versus hospital workers

P040: (We wanted) a framework for, that workers who are displaced in health system restructuring are placed in comparable jobs, at comparable wages, in other parts of the healthcare system. ... So as they downsize the hospitals that those workers should, and this was a major bone of contention for the community, that they should have rights to go at comparable pay and benefits in other parts of the health system. ... See Labour never had their head in the sand and said we don't want change. We said we want change within these principles. And we want change in such a way that workers who aren't trained and have the skill are moved within the new system. And are part of the new system in a comprehensive planned way. ... And it would have gone a huge way in dealing with even the issues around the Social Contract if this had, if they had dealt with this thing first. But did not deal with it. They did not want to give it to us. They were too worried, well as we're seeing Metro, ... 10,000 fewer people in the hospital system. Where do you put them? ... The union movement has far more institutionalized workers. ... We wanted a system-wide restructuring which would have made these hospital restructurings a lot less chaotic than they are in some of the communities that have done them. ... They wanted the communities under the Employment Security (legislation) to do community negotiations of how they're going to do labour adjustment. Well, it's the same thing happened is what we knew would happen. Windsor was the first deal, negotiations. So then the next one would take Windsor (deal) and try to make and improve it better. But huge amount of resources expended, going over and over the same issue, and in the end getting basically the same deal as was the first one. So we wanted some province-wide criteria saying, these are certain given criteria. Then you go and apply it to your situation but don't have to start over again from the beginning.

- Successor rights, terms and conditions of work, seniority

P040: We really wanted ... to secure employment and working conditions for employees and have as part of its approval process (for designating an MSA) a human resource plan. How are they going to make this transition.

(Wage parity) is a non-starter. But we had to put it in as a principle. And it's still an ongoing fight. And I don't think, until we get the community health workers unionized, we (will) get it equalized. It's atrocious what community workers earn. And mostly because their agencies have been underfunded. ... You're taking the skills and in this case even demanding more of the community workers than ever before because they're taking care of sicker and more complex people in the community and yet you're paying them a third of the salary.

P042: Our concern was more from that perspective that we wanted to be sure that registered nurses were providing the nursing care and that they did have the support of a union as they moved from one to the other (agency). Under successor rights through the Labour Board that law is in place, but then when it actually happens, you have to see whether it would really happen or not.

P043: So we had drafted into the legislation that it would be considered a sale of business, which we could have probably have argued at the Labour Board anyway. But right in the legislation it said it would be deemed to be a sale of business and so therefore everybody would have successor rights. And we wanted the seniority to be recognized in terms of these job offers. So it got very complicated. What we were saying was the unionized member would be given job offers and if there was any paring down of jobs, then it would be done in terms of seniority. (Interviewer: How would seniority have been determined with non-unionized members?) Non-unionized members don't have seniority. They have length of service, which can be recognized for certain employers for certain thing. But the only way you actually have seniority is through a collective agreement that defines how your seniority is counted. ... And then your contract goes on to define in what cases your seniority applies and the foremost obviously is lay-off and recall. .... The other thing we wanted in the legislation was that (if) unionized members were a minority that (there) wouldn't automatically be a de-certification vote. So it wasn't a massive unionization strategy. What we were concerned about was that it could be a de-unionization of the sector.

- Substitution with lower skilled workers

P043: It's not good for occupational therapist and it's not good for the clients. We have a professional now whose speciality is looking at the whole person's life. And to have a homemaker who has, you know, has basically had a slide show, is what it was going to be. I

mean the training program, the stuff that they wanted to have the personal support workers learn, you know, it was adding up to be a three-year program, but they were looking at like 16 weeks or 40 hours (of training) or something. And it was just ludicrous.

- Governance and representation on boards

P043: And we did not come up with a model that we were preferring in terms of, you know, how the governance of this new agency would work, but we were fairly steadfast in saying, 'You have to allow labour representation on the board. (Were you successful?) No. ... I think anyone who actually works for the agency can't sit on the board, But our argument was, 'Well, we could have someone from the labour council, the local labour council.' He could be a CUPE member who works for the city or power worker who works, you know, it doesn't matter. We want somebody there who has an understanding of how decisions will affect people's working lives, and who will, you know, have some accountability.

- Funding of LTC services

P040: (We wanted) the MSAs to provide services without user fees, ... and the guarantee that the Home Care Programs services wouldn't get de-listed under OHIP. We wanted all the traditional community support services to be fully funded under OHIP. If we're going to try and keep people out in the community longer and it's still going to be a lot because a lot of things that used to be provided in hospitals, they're being sent home. We're keeping them (patients) out there (in the home) longer. If you fund those things properly, why should they be eligible for it under a hospital or a facility and not in the home when it's cheaper to keep them in home.

Labour's interests in job security and transfer of negotiated rights and working conditions were directly contrary to the interests of for-profit providers. Even though Labour favoured not-for-profit delivery, their stand on union rights, the imposition of legally defined seniority, restricted use of volunteers, and the elimination of generic worker concepts were contrary to the interests of many not-for-profit providers.

6.3.4 Volunteers

On October 4th, the *Ontario Association for Volunteer Administration, the Ontario Association of Directors of Volunteers in Healthcare Services, and Volunteer Ontario* put in a joint submission[50] to the Committee. The primary mandate of these organizations was the promotion of volunteerism and the promotion of the professional management of volunteer programs. Basic issues that they felt needed to be addressed directly in the legislation included the need for adequate resources in the core operating budgets for agencies and programs to recruit, train, recognize and,

support volunteers "all of which should be managed by competent, professional, paid staff," professionals in the management of volunteers and volunteer programs must be at the planning table, and the confusion and disagreement about the appropriate roles of volunteers and paid staff must be addressed. After recommending assurances for managers of volunteers, the associations asked that volunteers be treated with some dignity rather than "warm bodies" that can be moved around on a board to suit the needs of the system and that they be given the same kinds of protections as primary caregivers. They criticized the view that volunteers be seen either as a cheaper alternative to paid labour or as the tail-end of a welfare state. The decision of 'who does what', from their perspective, must be discussed with labour, management and volunteers. The issue should not be left to regulations or the decision-making of individual communities. Their fear was that decisions would be driven by the availability of dollars rather than rational planning. Volunteers viewed as cheap labour would be an insult to them and a legitimate concern to labour.

(i) Insights from Interviews with Volunteer Groups

- Exploitation of volunteers

P040: And one of the examples (that volunteer organizations used) that I always remembered because it was so stark for me was, 'Should volunteer organizations get involved with Workfare? But the example that they gave was when New Brunswick started doing Workfare, the Ministry of Natural Resources hired Workfare people or accepted Workfare people. And the person was very excited and happy to be working and he was doing whatever his job was in the Ministry of Natural Resources outside work. And he realized about 3 days into the work that like he's getting paid, like I don't know what four or five bucks an hour, or whatever it was on Workfare. And he realized the day before it was a unionized position; it was full benefits and a decent wage; that he could have been supporting his family. Now, he says, 'I'm capable of working I'm capable of doing this. And now on Workfare – the same work – and now it's not worth it anymore. ... And I can't support my family on this.'

6.3.4 Other Interests

The *Association of Municipalities of Ontario* (AMO) which was a not-for-profit organization made up of approximately 700 of Ontario's then 817 municipal governments, claimed to represent over 95% of the province's population. They focused their submission on the impact of reform on the role and status of local governments in the new system, in particular, a municipal role on the planning and service coordination functions. AMO strongly believed that municipalities should ultimately make the decision on the local authority for health and social services. DHCs, as unelected

intermediate advisors to the provincial government on resource allocation and the planning of services, they argued, were special purpose bodies which were being given the responsibility of setting priorities for LTC services at the municipal level without the accountability. *Bill 173*, from their perspective, by-passed municipal councils as the representatives of local communities and introduced a new appointed body (DHCs) to perform functions appropriate for municipal governments. AMO believed that the over-prescriptive nature of the legislation was necessary to monitor unelected and unaccountable agencies. They called on government to conduct a formal review of the DHC mandate and structure. AMO recommended that, in the spirit of empowering decision-making at the community level, municipalities should ultimately make the decision on the local authority for health and social services.

AMO also believed that the province ignored their long history in the funding, management and delivery of services and programs in LTC. Rather than being a last resort option for designation as an MSA, AMO recommended that municipalities be given the right of first refusal to serve as MSAs. Furthermore, ever-watchful of cost shifting, they pointed out that while the provincial government mandated the basket of services that must be provided by MSAs it did not also commit to fund these services. In summing up and appealing to values of liberty and efficiency, AMO argued that the legislation would "not achieve the following objectives: greater community empowerment, decentralized decision-making, integrated local programs and services, accountability, reduced government bureaucracy, or an efficient allocation of limited government resources."[51]

6.3.5 A Babel of Values

A review of expressed societal interests clearly highlights the clash in meanings attributed to values or goals. Ideas were appropriated and repackaged to serve different policy interests. This section analyzes the ways in which the four policy goals, security, efficiency, equity, and liberty, were pressed into service by different groups in support of their own policy interests.

Security expressed as quality or service availability can best be achieved through guaranteed government funding without user fees (consumers, labour); can best be achieved through a competition of providers (providers); can best be achieved through good salary and benefits packages (labour); through the use of trained staff rather than volunteers (labour); or through elected and accountable versus appointed officials (municipalities). Security was also expressed as the need to mandate eligibility criteria, amount of service, user fees, etc. through legislation rather than regulation (consumers), or to prescribe labour adjustment and human resource plans in legislation (labour, not-for-profit providers).

Efficiency can best be achieved through amalgamation of agencies into one stop-shopping delivery model (consumers); can best be achieved through one-stop access and referral and competition among agencies (providers); can best be achieved through job security and compensation packages which would reduce turnover (labour); and can best be achieved through volunteer participation which reduces costs by providing services and an additional source of revenue.

Equity can best be achieved through a publicly funded mandated basket of services throughout the province without user fees (consumers, labour); can best be achieved by encouraging and supporting not-for-profit agencies which respond to community needs (not-for-profit agencies); can best be achieved through comparable salary and benefits packages between community and institutional workplaces, or the recognition and respect for negotiated contracts (labour); or can best be achieved through a levelling of the playing field for both the for-profit and not-for-profit organizations (for-profit agencies).

Liberty expressed as choice had a number of meanings: choice of type of service-community, home, or facility (seniors, labour); choice of individual worker (seniors, disabled); or choice of provider agency (ethnocultural and spiritual communities, providers and volunteers). Liberty was expressed as rights protection and varied only in terms of whose rights needed protection (consumers, providers/workers, or volunteers) and the development of an enforcement mechanism, or through the requirement versus opportunity to be involved with the development of a service plan and the development of programs and policy (consumers).

Community empowerment can be best achieved through representation of particular constituencies on governing boards of the MSAs or DHCs (well-elderly, frail elderly, family caregivers for disabled consumers with cognitive impairments, ventilator users, people with physical disabilities, volunteers, consumers and workers appointed by labour); or through the planning and allocation of resources done by local elected officials (municipalities).

Groups displayed a number of strategies to promote their credibility. Most interests inflated their voice by claiming to speak for a large number of people or groups, or a diverse set of groups. They strengthened their claims by putting forward recommendations based not on self-interest but for the protection of the vulnerable groups in the sector: seniors, disabled, workers. They hired management, policy and media consultants. They held news conferences and issued press releases. They provided letter templates for their members to lobby government. They approached opposition members and forced LTC reform on the election campaign. Finally, they formed and dismantled alliances to further changing interests.

As will be discussed later in this chapter, whose interests were heard depended more on ideological compatibility with the government's own ideology and policy interests, and historical support. In the end, the NDP did not go far enough for their supporters and too far for their dissenters.

6.4 Amendments to Bill 173

On November 17th, the government forced closure on debate, and third reading was in December. The *Long-Term Care Act, 1994* was proclaimed on March 31, 1995. The proclaimed *Act*[52] differed from the one introduced in June in a number of ways. Other than general housekeeping changes, the amendments reflected concessions made to consumers and to labour.

The purposes of the *Act* were now expanded to include the provision of support and relief to informal caregivers; the integration of health and social services to facilitate the provision of a continuum of care; the recognition of needs and preferences of consumers based on ethnic, spiritual, linguistic, familial and cultural factors in the management and delivery of services; the promotion of not only the efficient, but also the effective management of human, financial and other resources; the involvement of volunteers in all aspects of the MSA except the management of them; the promotion of cooperation and coordination between providers of community services, and of health and social services; and the coordination of community services provided by MSAs with other health and social service agencies, such as, hospitals, LTC facilities, etc.

The Bill of Rights was amended by adding protection from financial abuse by service providers along with mental and physical abuse. The agency was to develop and implement a plan for the prevention, recognition and addressing of mental, physical and financial abuse. The consumer's right to participate in the assessment of his/her requirements, the development of their plan of service, the review and revision of their requirements was also specifically codified in the Bill. Approved agencies were also to establish a process for reviewing complaints. Among the grounds for complaint, ineligibility for services, amount of service, and termination of service were added to the quality of service or violation of rights set out in the *Act*.

With respect to the designation of approved agencies as MSAs, the Minister was given the added authority to designate MSAs for specific geographic areas, or for persons in a specified geographic area who could be identified by their membership in a particular ethnic, cultural, religious or linguistic group, or any other prescribed characteristics. This allowed for MSAs to cater to particular groups, such as the Chinese or Jewish community.

The Board representation was broadened to reflect not only the community it served, and to include persons experienced in the health and in the social services field, but at least one-third of the

Board had to also include persons who were receiving or had received community service from the agency. Past and current consumers, and not just potential consumers, were empowered to advise on the direction of the agency. The section prohibiting employees of an approved agency from being a Director was deleted.

The *Act* now included specific sections dealing with labour issues. It now defined "previous employer" and "successor employer." The transfer of the provision of a community service or a part of community service from a previous employer to a successor employer was deemed to be a sale of a business under the *Employment Standards Act,* the *Labour Relations Act,* and the *Pay Equity Act.* Employees were to be given a notice of 60 days before the transfer. A number of sections dealt with job security issues such that a successor employer made reasonable job offers first to employees with the previous employer in descending order of each person's length of service. However, not all employees of the previous employer were equal. The successor employer was to make job offers first to employees of the previous employer who were in bargaining units in order of seniority before making offers to employees of the previous employer not represented by the bargaining agent. The successor employer did not have to offer positions to people who were not qualified to perform the services required or who could not become qualified with a reasonable amount of training. The position offered was to consist of the same work or comparable work, and was not to represent a break in employment.

The criteria for the exception to the rule of 20% restriction for external purchase of service were now to include the absence of employees due only to unforeseen, unplanned events. As a result, amended to further restrict the private sector, absence due to vacation was deleted. And to appease labour, absence due to a strike or lockout was specifically stated not to constitute a criterion. A specific section was added to require MSAs to develop plans for the recruitment, training, supervising, retaining and recognition of volunteers.

6.5 Perceived Influence of Societal Interest Groups

This section will review the perceptions of government and societal interests of the relative influence among societal groups during the NDP mandate. Consumers were viewed as a very powerful group throughout this government period. The interests of labour, although always important to the NDP, became particularly more relevant in the latter half of their incumbency. Support service providers lost any cache with the government when they withdrew their support from the legislation. Whether these groups influenced government or whether government exploited their mutual interests was contested. Certainly, not all consumer groups were given the same access to Cabinet Ministers as the Seniors Citizens' Consumer Alliance. Certainly, the SCCA did not even

represent all seniors. Was their preferential access to government motivated by an NDP ideological belief in empowering consumers or seniors? Or were the NDP orchestrating their voice?

Driven by their ideology of grass roots/community empowerment and democratic participation in governing some interviewees felt that the NDP tried to, and did, listen to all interest groups. However, while all groups may have been given voice, not all were necessarily influential. Consumers were given priority.

P050: There was a lot of consultations, many more consultations. This whole consultation bingeing took place through then. And multiple rounds of consultation so the interest groups gained more power. (They listened to) the provider groups, but not to the same extent, I mean, the consumers really reigned supreme and there was a great investment in consultation.

However, amongst consumers, some felt there was a hierarchy for the NDP. The NDP ideological shift from multiculturalism to anti-racism shifted the balance within the cultural communities.

C030: Multicultural community as a whole kind of just, collapsed. Maybe towards the last part of the NDP's terms. Much because there was a bit of a faction growing between the anti-racism and the multicultural contingents. You had a split in the ranks and as they say, a house divided against itself. ... When Anti-Racism hit, anything with any concept of Muticulturalism was past and you had to start from scratch with Anti-Racism.

By the time the amendments were released, many in the policy community had little doubt which societal interests government was favouring. However, the direction of influence between government and these groups was contested. For some, it was collusion between the two while for others; the government was controlling the situation.

P040: I think they were listening to seniors, big time. I think they met a lot with them and with the senior organizations. I think they did listen to Labour.

P059: There was something else brewing there. And there were sides being drawn. And if you were on the side of the Seniors' Alliance and Ted Ball and the Eunice McGowan group, you were, you know, you power broker with, access to Frances Lankin and then after, Ruth Grier. But those lines got drawn very early in the reign of that MSA model. ... I don't know why but that triumvirate kind of got formed, and those were the power brokers for the stay of the NDP government. ... During the MSA stuff, when you talked to consumers, or consumers being represented, it was Jane Leitch, through the Seniors' Alliance group. And there are those who believe that it really was, they were a puppet for Ted Ball's group who was funded to promote a policy that the government wanted.

One respondent believed seniors were manipulated by government in coming up with the MSA model, a design whose main motivation was cost control and reduction.

P043: I think the seniors. I think the consumers' groups ... the whole direction of the reforms speaks to that. I mean, on the one hand, you can say, 'no, the direction of the reforms speaks to the budget stuff, because it's driving costs down.' You can see that everywhere in the health sector. It's not always about improvement to access. The model they came up with was easily sold as improvements to access and care and a simplifying of the system. And I think that speaks to the involvement that the seniors had.

Government officials, however, did not share the conspiracy theory that the NDP were using the seniors. Rather, the government was helping an unorganized group to participate in the political process.

G093: Although the seniors' groups didn't seem to me to be as well defined or as well organized then, they got much better organized under the NDP. Can I tell you why? 'Cause (government) funded them. Government actually funded them, to attack them. 'Cause that's what you're supposed to do in a democracy. ...They're unfortunately not funded now (under the Conservative government) which is why they're so silent. They simply don't have the money to have the voice.

The independence of the seniors' groups, according to another government official, was evident in their dealings with them, which were not always smooth. As the reform proceeded, the seniors were more of a barrier to helping government get the job done. However, what is evident from this excerpt is that government gave this group considerable time and energy.

G095: I wish they had been (a government mouthpiece). They certainly weren't, they enjoyed a close relationship with the Minister and her office, but as I say, they certainly didn't agree. They took a lot of persuading around some of the details, to trust us and to let us go. We had huge, hours and hours and hours of consultations around various aspects of it with them, where they were very leery that we could be trusted to do it right. And their consultant became a barrier in a way as opposed to an aid in moving forward because of his particular mode of operating and commitment to a particular model. ... They lost the ability to be flexible and to just allow us to get on with it as time went on.

The NDP's affinity to the seniors and more broadly to consumers was viewed as ideological. In this environment, unlike under the Liberals, providers were odd-man-out. Rather than trying to right an imbalance in voices, the NDP's affinity to consumers was seen as a bias towards the underdog.

G097: The were listening to Jane Leitch (Chair of SCCA) and the coalition of senior citizens. They were listening to people within their own party, which is not atypical. ... I think they listened less to provider groups. They certainly did not hear what the VON or Red Cross, Home Care were saying. They did not hear what the nursing home people were saying.

G092: NDP had always been the party of special interests and unions. NDP weren't balanced in who they listened to. The special interests they listened to were all the disaffected, the most radical advocates, the disabled, the mental health groups, the consumer advocacy groups. It was a mentality of us against the establishment. This is our government and they are going to do what we want.

While the SCCA was viewed as most influential, they were not, however, seen as the voice of all seniors or consumers. They represented a very particular and narrow subgroup of consumers. As one respondent from a senior's organization and two from provider organizations put it:

C001: That to me was not a real consumers' group, at all. It was run by Ted Ball and a bunch of people who were, I thought, manipulating the whole thing. I'll be honest. We tried to make submission before that (SCCA consultations), I was ordered by Ted Ball only to present certain things. I couldn't present what we wanted. I never bought it that that was a real consumer group.

P049: One of the challenges we faced throughout, was that the government had the Seniors' Alliance on their side, and we were never able to clearly define the fact that those were not our consumers. If you're able to drive to a meeting in downtown Toronto and hold press conferences and write articles, you aren't the people we're serving. The people we're serving we can't get out, or they wouldn't be using our services. And I think there was a real concern among a number of groups that the MSA was being driven to provide service for the people represented by the Seniors' Alliance. And more specifically, within the Group for Long Term Care, and more specifically within the Ontario Community Support Association, I think there remain two realities: one, there (are) ... service providers that are providing service to people who need it because they are significantly functionally impaired, and then there are the groups that are providing service for quality of life and preventive issues. And you can work harmoniously when there's lots of money, but when funds become really tight, it really creates a wedge because the money goes to where the need is the greatest. And that creates a real dichotomy and a real division.

P050: The consumers and the community groups ... with the ethos of community, grass roots, that whole ideology. And they were being listened (to) by the government. They had priority over

the Health (agenda). And it got to be a battle. Well, it shouldn't have been a battle. But it was 'we' against 'they'. The health providers were seen as the 'they'. And we (consumers) were the good guys and we were going to get all these home supports and we were going to look after our own, and we were going to do Friendly Visiting, and Shopping. And not realizing that, "Oh my God!" Do you realize,... I remember coming together with Home Care and that 75% of the health Home Care dollar goes to these high need (clients) ... I mean a failure on the part of consumers to be aware of the (data). I mean the money and the supports that were needed to maintain people in the community. Well when they were sick elderly, they weren't at this planning table. ... But they were well elderly planning services based upon what they perceived their needs to be. ... That describes for me, sort of, where things were going. They had a voice, they were listened to.

G108: How much broad-base support (for the MSA), it was never really tested. But I'd for one be kind of surprised if you could have found one in a thousand seniors that could, you know, had the vaguest idea of what an MSA was, or what a Service Coordination Agency was. So it was that, you know, a debate confined to a rather narrow group who on one side purported to speak for the government, and on the other side purported to speak for all seniors in the province.

Some respondents felt that the real power brokers were the groups in the OCSA, rather than the seniors. And if anything, it was OCSA who was using the seniors as a front for their ideas.

G083: The Ontario Community Support Association was the most, by far the most influential organization I would say.

P058: It was the seniors' group, but within the seniors' group there were members who belonged to the Ontario Community Support Association and they had the ear of the government. They had the ear of the Ministry of Health and the Minister of Health. ... (There were) a couple of key people who influenced her (Minister of Health) to think about moving to another kind of model, away from the Service Coordination Agency model. ... Eunice is the person who was on the board of the OCSA, friend of Frances Lankin. Some believed (she was) the chief architect of the MSA type model that was then moved forward. And (she) helped also to get Ted Ball the contract with the Alliance. And had close ties with all of that, and right until the end of the NDP era, (she) carried a lot of weight with the Ministry of Health.

While a number of respondents felt that the not-for-profit support sector, namely OCSA, was most influential in the beginning, they believed that changed as the reform progressed, resulting in the government aligning itself more with the seniors.

P049: I believe it was OCSA who really detested brokerage. The Home Care Programs are, I think, reviled is probably not too strong a word by many of the community support associations.... The relationship with Home Care Programs across the province, there was very much a perception, it's a servant-master (relationship). ... It was very, very controlling, very arbitrary and very difficult to accept. And the OCSA membership was very, very frank and very outspoken in its desire not to continue with that. ... Originally, they (government) had been listening very closely to OCSA. They had a very strong, OCSA had a very strong contact with Ruth Grier in the person of Lynn Grist. But as OCSA shifted its approach, I will tell you, it permanently eroded some of their relationship with the senior bureaucrats and some of the political staff and the politicians. And that I think drove the NDP to cement their relationship with the Seniors' Alliance more tightly.

A respondent member of OCSA believed that labour became more influential as the model developed, as OCSA changed allegiance.

P054: In view of the degree of attention paid to job security and level of pay, I'd say unions (were most influential). Secondly, I think the NDP in general wasn't feeling too comfortable with most of the provider side. So I think outside of the OCSA for a period of time, because then there was parting of the ways between the Minister and OCSA, the feeling was that OCSA was the only group that was supporting them, the Ministry direction. We (OCSA) were seen as sort of wishy-washy on one hand because of some continuing different views within the Association, and not falling in line with the government direction or view. Saying on the one hand, we like this and this, but we don't like the other part of what you're doing. ... (Seniors' groups had influence) very much at the beginning, and I think there was a shift between consumer, sort of as consumer influence waned, labour influence grew over a period of time.

The disability consumer groups believed the real conflict for the NDP was in keeping a balance between consumer and labour interests. From their perspective, labour's interests were contrary to the disability community's desire to control the recruitment and management of their own care workers.

C010: The real conflict with the NDP came between their balance of labour and consumers. I mean just as we had had the problem, you know, in the sense of the Liberals on the provider side . You know the agencies are the good guys. And if you like the agencies, link the not-for-profit. Labour took a huge role and that probably had more of an impact on what happened than anything else in terms of the development of the MSAs and where the NDP eventually went with long term care. And it created some of the problems from the perspective of

people with disabilities in terms of the lobbying and where we had the battle and where we didn't have the battle. ... It (MSA) focused on labour issues and it was union driven, and making sure that people had jobs but not a whole lot of accountability back to the people who are getting services. And it affects a lot, the direct funding model. It was a really clear funding split by this point we had two tracks going. There was the independent living group that was working on the direct funding. It had gotten pretty far. The government said, you know, 'we agree in principle.' And at the last minute labout stepped in and said, 'No you don't.' Because from labour's perspective direct funding is a huge threat. ... (with direct funding), I hire the person. I'm a single employer and they blocked it for a year. ... What labour said is, 'We want the agencies. I mean, we want to still have employment standards and contracts.' People can understand that they're concerned that wages would get pushed down, but there also is a really serious problem between labour and consumers, to be honest. ... It's not that people don't like the attendants, and it's not they don't like labour, but you've got it set up right now where the person who's getting service and who should be directing ... has literally no power.

Quite a few groups felt labour had direct influence. As will be recalled from earlier sections of this chapter, the NDP were viewed by many groups as trying to create an environment in the community conducive to unionization, and also trying to placate unions for actions they took on other fronts (hospital restructuring and the Social Contract).

P049: It was from other work that I did when I was at (particular organization), I know that labour was, had an open door. They could access the Minister of Health, particularly. And possibly also other very significant Cabinet Ministers at will.

P050: And I think through Frances Lankin and all those connections, ... unions were very powerful. And very powerful with the Premier himself, Bob Rae at the time, and the Cabinet. I think the union movement was very influential.

P059: Networking and favouring the position your allies, friends, supporters (labour) take, influences the government on which way it's going to go. And the NDP had friends that were very influential around the MSA stuff. Once they made a commitment to pursue the MSA stuff, I think they weren't going to turn back on their friends.

P050: I think that was again a reflection of the ideological bent of the NDP. I think probably the pressure came from the unions and the NDP were largely, you know, backed by that group and they had a lot of influence. ... And I think in the end, the inability to move beyond some of those Labour barriers was what scuppered the MSAs. ... In the end the HR problems

became too huge to overcome. And it was even inter-union, you know. The fact that you had successor rights so that unions came into an MSA and you could have multiple unions for the same provider. You know, you could have different unions representing the same worker category. And that the MSA would have to inherit that. And different wage scales for the same work. And it was horrific.

In their rush to get the legislation out before their mandate ran out, the NDP had not worked out the labour issues. They had hoped to clarify them in regulation. They did not anticipate a problem because they viewed the sector as expanding and being able to accommodate all workers, both unionized and non-unionized, in both the community and displaced from institutions.

G095: Some of those issues (human resource issues) really just began to surface during the hearings because we really were sort of on two tracks. We had the legislation going through ... had to get it through before other things could happen. And in our development of policies and issues we were moving ahead of the legislation in some ways. ... It was a case of, we haven't got to that issue before we drafted the legislation and so, yes, it would have regulations and I suspect labour was saying we want some greater (assurances) ... and, you know we're back to our regulations versus legislation debate at that point.

We were talking about a growing system and we were talking about the creation of MSAs in areas of the province where there were very few services. On a provincial level, you were certainly looking at far more jobs for nurses, in home support services. But if you're laid off from a job in Kingston and it's Timmins that is setting up for the first time a nursing service, you know, it doesn't quite fit. So there would have been huge problems in adjustment, but I think overall the number of jobs would not have been less.

G096: I still believe that in the future there's going to be probably more need than there will be workers. So probably the issue of who's going to get the jobs will be really redundant.

This, however, was a miscalculation on their part because labour required greater assurances in this recessionary environment.

G102: Labour was very unhappy with the MSA model because labour wanted a guarantee. See, in fact you were going to take people employed in many, many organizations. Home Care programs, much of the staff in those programs were unionized. Home Support organizations were not unionized. These little agencies tended not to be unionized. Labour wanted an assurance that union people who were displaced from place A would have first dibs on the new jobs.

As mentioned in the previous chapter, the government provided the OFL with 2 years worth of funding in the summer of 1994 to consult with labour groups. The perception was that labour woke up to their interests during the Standing Committee hearings on Bill 173.

G095: And the discussions around Bill 173 were, I think, the first time the committee hearings, was probably the first time when labour woke up to the impact this might have on some unionized members. And I think that that was part, what was happening was not only long term care but also the whole squeeze on hospital budgets and nurses were being laid off in hospitals and weren't buying the bland statement that okay there will be jobs in the community because they know how different those jobs were going to be. The Social Contract had happened or was happening and so labour was certainly watching with great interest anything the government did.

Although the seniors and particularly labour were most supportive of the MSA and were very influential in its development, their attempts to tinker with the legislation and press their concerns not only delayed the passage and implementation of Bill 173, fueled the disaffection of a formerly supportive interest (OCSA), it more importantly gave dissenters an opportunity to gather momentum and launch a powerful counterattack.

6.6 Conclusion

When the NDP took office, they put in a structure for developing LTC reform that reflected and would further their ideology (more centralized control of programs, not-for-profit preference in delivery, and preference for support services over medical services). Wanting to strengthen social supports in LTC, they gave MCSS the lead, and to ensure the voice of marginal consumers, they involved the Ministry of Citizenship, which now included disability, seniors, as well as multicultural issues.

With this government, formerly marginalized or ineffective groups found or were given a voice. In keeping with their ideological principles, the NDP strengthened consumer groups through the funding of the Senior Citizens' Consumer Alliance, and not-for-profit grass roots organizations, namely the Ontario Community Support Association. Under the rhetoric of giving Ontarians a say in the reform through an ambitious and all-inclusive consultation process, they gave preference and financial aid to those who would support their vision. The lead for reform switched to MOH after the consultations were over and the Senior Citizens' Consumer Alliance had made their recommendations known, a recommendation which well suited the Government.

Although the government's first model was a minor variant of the Liberal SAO model with an NDP spin on it - preference for not-for-profit providers, support of workers, and rights of

consumers - it was clear, that the government was not committed to this model. Rather, it used the *Redirection* document as a discussion document, a foil for its later reform. Because members of the government and their political staff had roots in the not-for-profit support services LTC sector, when the NDP formed the government, they brought with them the ideas that had been percolating in this sector towards the end of the Liberal period, namely, a comprehensive multi-service organization. Both the SCCA and OCSA had used consultants that had ties to the same firm and had received similar advice on recommended models. Given the common roots in the support services sector of key ministers, the government was open to the model suggested by both SCCA and OCSA. However, many felt for political optics, it was important that the MSA model be perceived to be the birth child of the seniors.

Recessionary events of the early 1990s took over their agenda. Trying to spend their way out of the recession in their first two budgets, they left the hard decisions too late in their mandate. With a little more than a year and a half left in their term, they changed their budget strategy. Although the Social Contract was an attempt to protect labour by saving jobs, the strategy went against one of their strongest principles, the sanctity of negotiated collective agreements. The Social Contract along with hospital restructuring left the NDP beholden to the labour movement. As a result, they made concessions in the MSA legislation which further alienated dissenters and estranged one of their staunch supporter groups, OCSA. The Social Contract and its process created new political cleavages. It provided the unintended opportunity for groups to learn about each other's concerns about LTC and to forge a common strategy against the NDP in this policy sector.

The MSA model raised much opposition based on fears that included lack of choice especially for the disability, ethnic and religious communities, viability of provider organizations, decline of voluntarism, loss of jobs, loss of negotiated rights and benefits. In the heat of this dissent all groups buttressed the nobility of their interests with arguments of improving security, equity, liberty or efficiency. The debate over the merits of the MSA model made visible the contention that the interpretations of these goals are highly contested and constitute political claims to garner support and redraw boundaries in the policy community.

Although the *Act* was proclaimed in early 1995, it was not implemented because an election was called in the early summer of that year which resulted in the defeat of the NDP government. The NDP's belief in consultative governing and their attempt to listen to their supporters brought together disparate groups which had one common purpose, that is to defeat the NDP reform. The dissension managed to delay the passing of the legislation and ultimately its implementation. MSAs had been an election issue, with the established not-for-profit and for-profit agencies vehemently opposing a

model that would diminish or eliminate their role. The Progressive Conservative Party had promised that, should they be elected, they would abolish MSAs. They were true to their word. Without many of the structures of the MSA in place, it was not difficult to achieve. Broad consultations, which slowed down progress, were hard lessons for the NDP, ones that the Progressive Conservatives learned to their advantage when they formed the new government. As one of their supporters put it,

P040: There was a lot of pressure on the NDP from all sides. And one of the things that in the NDP's era of wanting to please everybody, they pleased no one. They consulted so much, and they tried to bend over backwards to meet the VON, the Red Cross who were major fighters of this. And in the end they didn't get their support. I mean, now the VON, the Red Cross are probably saying, 'We should have supported the NDP!' Because what's coming down is a lot worse for them than this.

NDP ideology influenced the institutional structures that were put in place to fashion reform, favoured particular political interests and processes, and ultimately shaped their LTC model. In the end, that ideology could not stand the test of its own convictions.

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Chapter 7

LTC Reform in the Progressive Conservative Period (1995-96)

This Chapter will touch upon the key changes in LTC reform brought in by the Progressive Conservative (PC) government elected in June 1995 on a platform that advocated less government and more reliance on the private market and market mechanisms. Having learned from the mistakes of the NDP government, the Conservatives decided to act quickly and decisively. While the political and policy interests of societal groups did not change in this period, previously influential groups like the seniors and labour lost ground in this period. With the change in government, the provider groups saw a new opportunity to influence reform. The underlying differences in values and interests between the for-profit and not-for-profit agencies, however, resurfaced. These differences split the Group for LTC Reform as not-for-profits and for-profits re-positioned themselves with this government. The subsequent reform, the Community Care Access Centre model, which brought in managed competition among providers shifted the allocation dimension from a heavily command and control model to the market end of the continuum and favoured for-profit provision. In the end, the notion of competition for contracts shattered the already fragmented and ineffectual policy community.

The Conservative model, ultimately, could have ramifications beyond the goal of increasing efficiency for community-based LTC services. The competitive contracting process could eventually alter the balance of not-for-profit and for-profit provision of care in the LTC sector, with care shifting over time to the commercial agencies. In an age of international trade agreements and global markets, LTC services in Canada could eventually be provided by American multi-nationals. The next and final chapters will outline the potential implications for Canada that this trend may have on health care in general.

7.1 The Progressive Conservatives in Campaign

Before the election campaign, the Progressive Conservative Party released *The Common Sense Revolution.* [1] The document clearly outlined an ideological shift in the way government would operate and the Party's priorities should it be elected. Less government, the superiority of markets, and emphasis on individual effort were to be the order of the day. The Conservatives planned in their mandate to cut the provincial income tax rate by 30%; reduce non-priority government spending by 20%; cut barriers to job creation, investment and economic growth through such actions as the elimination of "red tape" and regulations and the repeal of *Bill 40*, the NDP's labour legislation; and cut the size of government by reducing the number of MPPs from 130 to 99 and eliminating 13,000 civil servants. They planned to introduce "workfare", a program which would require "all able bodied recipients – with the exception of single parents with young children – either to work, or to be

retrained in return for their benefits", on the grounds that "the best social assistance program ever created is a real job."[2] The Party stated that many of the things that government does could be done "cheaper, faster and better if the private sector is involved". For those things that government should do, it should do them like any other business that provides goods or services. Efficiency would dominate and the public would no longer be citizens, recipients or patients but customers.

> *The Common Sense Revolution* will have a significant impact on the way in which the government and its employees do business on a day-to-day basis, because it will demand that government does business *like* a business. In other words, in an efficient and productive manner that focuses on results and puts the customer first.[3]

Jim Wilson, the Health Critic for the Progressive Conservative Party while in opposition, indicated in an election campaign speech[4] his party's position on health care and LTC. Reflecting the new provincial order and ideological tenor should they be elected, the speech clearly laid the blame for Ontario's lagging economic condition on too much government, ineffective bureaucrats, conflict in all sectors produced by the NDP's governing style, and inefficient management and excessive spending by government.

Unlike the NDP that argued that a strong health care system was good for business and a strong economy, the Conservatives believed the causal order was the reverse. The *Common Sense Revolution* promised a 30% tax cut, which was to lead to "more jobs, more taxpayers and more growth." "A vibrant economy means a better, more sustainable health care system."

Participatory democracy in their mind was equated with special interest lobbying. Wilson characterized the province under the NDP as a war zone and said that a new Harris government would end the hostilities plaguing the health care system. He referred to community-based workers "warring" with institutional sector workers, "seniors who support *Bill 173* skirmishing with providers who are justifiably concerned with it," MOH bureaucrats "turning on their bosses", and to an overall anti-professional attitude throughout government. All this "bickering and back-biting" had prevented effective health care reform. Solutions were to be found through cooperation, not confrontation, and through a leaner, but not meaner, bureaucracy. Although the NDP belief in consultation may have been its undoing in this policy sector, Wilson's depiction of a province in a state of anarchy was laying the foundation for a much more autocratic style of governing. The Conservatives believed government was plagued by special interest lobbies and vowed this would end under their government.

Wilson promised that the new government would discontinue the "ratcheting down of the institutional sector until adequate supports are in place," namely community-based services. The impression was left that the NDP was merely interested in cost cutting and was incompetent at it. *Bill*

173 while legislating better access and coordination did so "at the expense of volunteers and long-standing community-based organizations who will soon be driven from the system." It was no doubt intentional that for-profit agencies were not mentioned in the losing equation of the MSAs. Their strategy to spend "smarter" included "empowering people to assume more responsibility for their individual health needs and for the overall management of the health care system." For critics of this approach, this pledge translated into shifting public costs to the individual and laying blame for the costs of the system on patient demands. They promised to stop "payment on cheques which the government has dangled to bribe communities to set up MSAs." The latter strategy was to save $5million in start up funds and scrapping the MSA model would save $37 million in volunteer services annually.

7.2 The Progressive Conservatives and the Community Care Access Centres (CCAC)

The Progressive Conservatives won a majority of seats in Ontario's 36th Parliament. On June 26, 1995 Mike Harris was sworn in as Ontario's 22nd Premier. Jim Wilson, the former health critic for the PCs, was made Minister of Health and given responsibility for Long Term Care. Their immediate announcements and the structuring of government in this policy sector would position the Conservatives for the easy dismantling of the MSAs and the quick introduction of their own model.

On July 12, 1995, following the election, Premier Mike Harris announced that in keeping with his election promise, his government was immediately halting implementation of the MSAs, thereby "undoing the damage imposed on long-term care services by the previous government." Health Minister Jim Wilson in the same press release revoked the 80-20 rule and the labour adjustment provisions. These decisions would remove the impediments imposed by *Bill 173* that affected all providers but especially the for-profit providers.

Harris indicated that over the next 60 days, Wilson would be meeting with key people in the policy community to get their advice on how best to coordinate the LTC system. In fact, Minister Wilson would meet no one. The government tried to distance the Minister from any attempts at lobbying by hiring a private consulting firm to conduct the sessions. LTC reform no longer involved the Ministry of Citizenship, which had been amalgamated with Tourism and Recreation, nor the Ministry of Community and Social Services. By centralizing reform in the Ministry of Health, the Conservatives weakened the lobby of interest groups who were client populations of the other two ministries. The consultation, according to Qs and As prepared by the MOH, was designed to be "tightly focussed. Anyone who is not invited to attend these meetings is welcome to make their views known by writing to the ministry." [5]

While not implementing sections dealing with MSAs, the 80-20 rule, and labour adjustment, the government was generally satisfied with the other provisions of the *Act.*[6] In fact, it was not so

much satisfaction with the NDP legislation but rather that *Bill 173* did not prevent them from pursuing their own model. Repealing this legislation would delay implementation of their own preferred model and would re-open debate, which they wanted to control. There were indications in this press release what sort of model would be acceptable to this government. Allocation based on competition was clearly indicated in the Premier's statement that his government would ensure that Ontarians received "the highest quality services for the best price."

Discussions were to take place within the context of the following principles, which echoed those of previous governments with some exceptions. Added to improved access, consistent eligibility requirements, and consistent and equitable funding for services was highest quality of services at the best price, cutting duplication and red tape to put more money into front-line services, and provider accountability for how money is spent on services.[7] These principles were indications of an ideological shift in focus towards business (highest quality/best price and provider accountability) and against government (elimination of red tape).

7.2.1 The PC Consultation

In its request for proposal (RFP) for the consultation, the government indicated that they wanted to move quickly with the expectation of announcing their model by the fall of that year. To achieve this end, they were going to avoid the mistakes of the NDP government, which had engaged in comprehensive consultations, by holding a limited consultation with approximately fifty provincial associations in eight discussion sessions. Seven sessions were to include representatives from various sectors (providers, users, and workers listed in that order), and the eighth session was for providers and users in the disability community (workers were not included). As will be recalled, under the NDP government the labour movement was not in favour of the direct funding approach for people with disabilities. Their exclusion from this particular session may have been intended to avoid conflict, which might have further delayed the process.

The RFP also indicated that the consultants were to meet with Ministry staff prior to the discussion sessions. In this meeting the consultants were to be briefed on the proposed content of the sessions, as well as the preferred format and process for the discussions. Government intended to control not only the process, but also the areas in which they wanted input.[8]

The ARA Consulting Group was awarded the contract. As an indication of the abbreviated nature of the consultations, the sessions were all conducted over two weeks in August 1995, each one five hours in length, which included a lunch break. Helen Johns, Jim Wilson's Parliamentary Assistant, attended each session. The reasons offered for the government's decision to have Johns rather than Wilson in attendance was varied but not necessarily incompatible. While some viewed the decision as practical, others saw another agenda.

G103: When the new Ministers came on, they had agreed to approximately half the staff of the previous government. They didn't have the office staff. ... And then we're (MOH) dealing with so many issues. So they had one Parliamentary Assistant and asked her to do that (consultation). It was just a matter of workload.

The consultation was viewed as a formality in that the government already knew where they wanted to go.

P049: I'm not sure how much change came out of the consultation in terms of policy. I think the majority of the input from the consultation was in process.

Another respondent saw the choice of Johns as purposeful in terms of keeping the consultations on the right ideological track. She had a business background and a tie to the Home Care Program, which supported the eventual government model.

P069: The first sign that all was not well was the fact that Jim did not take the lead on the Long Term Care (consultation). Helen Johns took the lead. ... I think that the lobbying by the for-profit sector had continued all along. And that, Helen Johns, when she came on, – first of all she's a business person, so there was an openness to the idea of private sector involvement. ... Additionally, her campaign manager, I remember, was a Home Care administrator. I have to check that out but I think so if I recall. Now the Home Care people were very much in favour of maintaining a brokerage model, because of course, that maintains Home Care and it maintains the case manager role. ... Remember I said about the role of the nurse versus the role of the case manager? So they had it in with Helen, and Helen was the lead. So between Harris' own, and this government's overall idea that maybe there's nothing wrong with having private sector involvement, and it might, in effect be good, to improve the system. Helen's link into Home Care. What that all leads you to is favouring a brokerage model competing on best quality, best price.

While the choice of Johns may have been either practical or ideological or both simultaneously, it also created an institutional barrier to the ultimate policy decision-maker for this reform, namely, Jim Wilson. In this way the Conservative government was able to protect Wilson from special interest lobbies which could slow down reform.

The discussions at the consultation meetings were organized to discuss the following four questions:

1. What are the major access and coordination problems with the current long term care system?
2. From a consumer's perspective what characteristics should the new system have vis-à-vis access and coordination?
3. How should the new system be organized to ensure access and coordination?

4. To what extent should government prescribe a model or models?

The first three questions were ones on which the previous two governments had already collected copious information. The last question was the opening for all provider groups who felt that the NDP model was far too government-controlled and intrusive. In sessions dominated by providers, the consumer and union voices, which favoured the all-inclusive MSA model, were relatively muted.

The compressed time frame, the participation by invitation, the shortened invitation list, the selected and well-managed agenda, and the institutional barrier to the Minister created by hiring ARA Consulting to run the consultation, and the selection of the Parliamentary Assistant to lead the consultation allowed the Conservatives to orchestrate a report which supported the model they intended to develop and to move expeditiously. Institutions, in terms of government structures and processes, were used to constrain societal interests and to further government ideology and interests.

7.2.3 The Consultation Report

In their report[9] to the government, ARA Consulting indicated that there was agreement on the problems with the current LTC system, namely, poor access and coordination, inconsistency and inequity of services, inflexibility, fragmentation, duplication, multiple assessments, inadequate accountability, provider domination, inadequate complaints and appeal mechanism, lack of continuity of care, lack of recognition of special needs populations, and inadequate staff training. Not surprisingly, given the Conservative government's commitment to eliminate the MSA model, the report indicated that participants cited current service organizations, staff who provide services and volunteers as the strengths of the current system.

According to the report, the features of an ideal system for participants included, among others, minimal layers of bureaucracy, recognition that people with disabilities needed services and not care, provision of service choice, and encouragement of family solutions. Adults with disabilities particularly wanted a system that provided individualized direct funding and provided an agency which brokered needed services, maintained choice (and not all under one roof), and a separate system for seniors. Participants in fact stated that a parallel system was needed for adults with disabilities, children with disabilities, and aboriginal people.

The report indicated that with a few exceptions, most participants were reluctant to recommend a model that would be suitable for all areas of the province. The consultants state that most participants wanted government to allow communities the flexibility to develop local models suitable to their own needs. The exception was "a few seniors' organizations and most labour groups, who favoured having one model prescribed for the province." In most cases these latter groups supported an integrated model.

In terms of organizing the system, there was general agreement that the screening function should be combined with the information function. With the exception of special situations, assessments should be independent of provider organizations. While there was no consensus on funding approaches, three were suggested with the last one having the most support: brokerage (an independent MOH-funded organization would purchase services from agencies); Ministry-approved budgets (MOH would fund agencies directly); and a local non-Ministry authority funded by the Ministry, which would in turn fund agencies.

Models presented by participants had a common basic structure, which included a local board, an independent assessment and resource management entity accountable to the board, and a range of independent service providers. Three models emerged from the discussion according to the consultants: the Federation/Partnership Model, the Augmented Home Care/Managed Competition Model, and the Municipal/Public Health Model. In fact there were four models suggested. The fourth model was the amalgamated model (MSA) favoured by seniors and labour, but the Progressive Conservatives had already indicated this model was not on the table. The only reference to this model in the report was in passing that a few participants supported an integrated model, and it was buried under a different section of the report. In this consultation, opinions were only counted if they stayed within the bounds of what was ideologically acceptable.

The Federation/Partnership Model would be a new local, incorporated, not-for-profit organization with a local community board made up of providers, consumers and other representatives. The organization would purchase services and administer contracts, maintain a management information system and coordinate assessments. Service providers could authorize services for consumers with straightforward needs and for consumers who would approach them directly. The Federation would work cooperatively with the network of providers and its board would determine which providers would be recognized.

Under the Municipal/Public Health Model local health units would manage resources and care and either provide direct service or contract with others for service. This model was similar to the existing brokerage system in some areas of the province where the Home Care Program was operated by Public Health Units.

The Augmented Home Care/Managed Competition Model (which would eventually become the Conservative government's preferred model) consisted of a single local authority which would merge Home Care, Placement Coordination Services, and Community Information Centres. Having the same functions as the Federated Model, it would, however, also house case management and assessment. Services would be purchased from approved providers. Without providing details as to how services would be purchased from providers, the consultants indicated that consumers would be

involved in the choice of their providers thereby fostering competition, and quality standards would be used to encourage competition among providers to achieve high quality care. Curiously, the only aspects of managed competition that were mentioned were the ones that are traditionally raised as concerns, namely, consumer choice and the maintenance of quality where price is often the criterion on which contracts are awarded.

With regard to implementation, the consultants indicated that the participants had advanced a list of criteria for the development of local models but were reluctant to specify these criteria or how they should be implemented. The participants' list included predictable criteria: clear access points, accessibility, accountability, consumer/community involvement, consumer control and choice, a defined set of mandated services, evaluation, case management for those who required it, simple assessment process minimizing duplication, provision for the unique needs of special populations, continued participation of volunteers, complaints and appeals procedure, human resource planning, standard training, information systems, sharing of resources where possible, cross-boundary access, linkages across providers, and flexibility to create new services. It was now up to government to create a new community-based model, and the report of the consultations, which were highly orchestrated, gave the Conservatives carte blanche.

7.2.4 Assessment of the Consultations

The consultation was not generally viewed as an honest attempt to entertain recommendations from societal groups, but merely a strategy of "smoke and mirrors" (P067) or "meaningless" actions (G097). G097 believed that the Liberals and NDP were both committed to public consultations as process as well as product. "But you see, you're dealing with a different mind set with the Tories. To them the consultative process is far less important than getting the job done. The consultative process has far less meaning to them."

One respondent indicated that the reason for the focus groups was "to tell us what they were doing was the right thing and that we would agree with it." (C002) The constraints put on the consultation were evident in not only the participation by invitation, but also by the number of representatives each organization was allowed, and the tight control on the agenda for discussion.

C007: We were told when we walked in the room there were two representatives only could go from each organization. And they had two different days so all the organizations were consulted. Johns ... was there, and she started off in the morning by saying that now, 'we want to talk about reforms. There's some things we don't want to talk about. There's no point in bringing up anything about the MSA because we're not talking about that today.' ... There must have been 25 of us, and there was a consultant hired to do this and they went through their questions and answers and all this sort of stuff. And we all had about four minutes for one

person of the two to make our point. And since we couldn't talk about the MSA, what could we talk about?

C010: The problem with them, of course, was, they said, 'Here's what you're going to talk about. And here are the issues.' And we said, 'These aren't really the issues.' And it was such a narrow consultation. For all intents and purposes, it was not a consultation. ... Basically there were consultants who said, 'Here's what we're allowed to talk about.' Helen Johns listened. I will give her credit for sitting through every single session all day, asking questions. But it was pretty clear they knew what they were going to do, and what they wanted to do. And it wasn't going to matter very much what we talked about doing.

P040: We didn't bother (putting in a submission) because every sense of the issue that we had was that this wasn't a serious consultation. They'd had their mind made up. And they told us it was going to be determined by best quality, best price.

P054: It was very staged. The consultation was, 'Here are the four questions ... This consultation is going to be basically, tell us what your answers are to these questions, and thank you very much.'

C074: It was a selected consultation of selected individuals representing selected organizations and selected interests. So when you stack a room ... .

Some groups, which disagreed with the government's direction, accused the government of distorting their position. For example, one respondent felt that the government purposefully misrepresented the consumer position by indicating that consumers had not supported the MSA model and wanted a different model. This was offered as further evidence that the consultation consisted of mirrors, that is, the government was only interested in views that reflected their own.

C002: Contrary to the records from the government, we were very disappointed with the cancelling of the MSA. But the focus groups tend to be where you come and you say your piece and then you get your report saying, 'Seniors all agreed', which is whatever way the government wishes it to be.

The fact that Helen Johns ran the consultation was seen as evidence of the slant the Conservatives were going to take and that the consultation was merely for political optics.

P056: She was from the business community ... And it was very obvious that she had very much a commercial marketplace-driven philosophy to everything and that she felt that the health care system needed to be more business-like. So we kind of knew that the game was over even before we began, especially with her.

There was a feeling, however, that the Conservatives did correctly read the mood of interest groups by consulting quickly.

C074: Now what they were right about, however is that people were sick and tired of consultation. ... so they were right to fast-track it.

The tight reins put on the consultation and its product narrowed the participation of groups in the policy community to a selected number, constrained the discussion to permissible topics in a foreshortened time frame, and distanced them from the policy makers. The Conservatives were intent to bring the market to LTC and did not want to be distracted. With the exception of a few supporters, the attempt to give legitimacy to their policy model through the consultation failed in the eyes of most of the policy community.

7.2.5 The CCAC Model

On January 25, 1996 Health Minister Jim Wilson announced the LTC reforms which were billed as simplifying access, preserving existing organizations and reducing administration. Rather than creating over 100 multi-service agencies, the government was going to amalgamate the Home Care Programs with the Placement Coordination Agencies to create 43 Community Care Access Centres (CCACs). The CCACs would purchase services from existing providers and volunteers based on best quality, best price. [10] With the exception of Metropolitan Toronto, service areas would be generally defined by the current home care boundaries. In Toronto, up to six CCACs would be established.

In making his announcement Wilson remarked that the NDP had developed a model that "was not supported by consumers or providers." MSAs would have eliminated choice, favoured organized labour at the expense of volunteers, and would have hurt quality of care by driving provider organizations out of business. Through *Bill 173* the NDP would have established approximately 130 MSAs throughout the province compared to the 43 CCACs, increasing costs and adding far too much bureaucracy.[11] The announcement clearly emphasized the Conservative's preferred interpretation of values: liberty through consumer choice, increased efficiency through less government and duplication, and improved quality from greater competition.

CCACs would be a simplified service access point and be responsible for service information and referral to all LTC services including the volunteer-based community services. They would coordinate service planning and monitoring, determine eligibility, undertake case management and placement coordination services for LTC facilities. They would not deliver services directly except during a three-year transition period; the purchaser of services and providers of service were to be split. Consumers could access community support services directly. People with disabilities would be allowed to deal directly with their attendant services and would remain independent of the CCACs. They could, however, opt to apply for personal services through the CCAC. "Clients" could access volunteer programs such as meals on wheels directly.

CCACs would be governed by independent, incorporated not-for-profit boards of directors accountable to the MOH through service agreements. Board membership would be a mix of the broader community LTC consumers and their caregivers, and a balance of health and social services perspectives. The board would not include service providers under contract with CCAC.[12] A draft job description for board members stated that members were expected to have a commitment to act in the best interest of all persons served by the CCAC, and not as spokesperson for any particular geographic area or special interest group.[13] The first board would be selected by the Minister and subsequent boards would be elected by the membership of the CCAC.

According to the government, all providers would have equal opportunity to provide their services on a competitive basis. A transition period would allow providers (namely, the not-for-profit agencies) to "adjust to the competitive system." Provider agencies would retain their own identities, governance structures and volunteer bases. CCACs would administer the RFP process within provincial guidelines, and funding would be based on both appropriateness and affordability. Objective ways to measure quality would be developed in collaboration with providers, consumers and the Ministry but would include consumer satisfaction, worker continuity, staff training and hours of service provision.[14] The Ministry would monitor service contracts on an ongoing basis and provide feedback to providers on their performance.

Bill 173 would still provide the legislative framework for managing and delivering LTC community services, but sections pertaining to MSAs, the 80-20 rule and the labour adjustment strategies would not be used and would eventually be repealed. CCACs, supportive housing, attendant outreach, and community support services would probably become approved agencies for funding under the *Act*.[15] However, later in its mandate the Conservative Government, in response to a complaint brought by a consumer concerning a denial of service, would argue that CCACs were never designated as approved agencies and, therefore, clients could not appeal service decisions to the Health Services Appeal Board as set out under the Bill of Rights in the *Act*.[16] As agencies not approved under the legislation CCACs could restrict consumer access to services through eligibility criteria or impose maximum allowable hours of service without recourse for the consumer. The intentional move not to designate CCACs as approved agencies and the fact that Home Care services were de-insured by the NDP (removing these services from OHIP) would allow the government to shift formerly public costs onto consumers. With the movement of more publicly insured services out of hospitals into the community, the effect of these actions by successive governments was to passively privatize, not only services formerly under Home Care, but potentially also services under the *Canada Health Act*.

In August 1996 the Premier announced the appointment of Cam Jackson as Minister without Portfolio, with responsibility for Seniors Issues removing this function from the Ministry of Citizenship, Culture and Recreation (MCCR). While the MOH would retain the budget and policy setting functions for LTC, Jackson was responsible for overseeing the implementation of the CCACs.[17] A few respondents believed that Jackson's appointment was to ease the workload of the Minister of Health by taking over the implementation of LTC, and also to ensure that the initial momentum and visibility were sustained. (P049, P056, G103) Hospital restructuring had begun, and Jim Wilson had to step down while allegations of impropriety against him were being investigated. David Johnston had been appointed on a temporary basis while he continued his heavy responsibilities in Management Board. Others saw Jackson's appointment as a Minister without Portfolio rather than as a full-fledged Cabinet Minister as the price Jackson had to pay for running an energetic campaign earlier against Mike Harris for the leadership of the party. (P059)

Although the decision to move responsibility of seniors issues to a Minister without Portfolio may have given these matters higher profile or eased the burden of the Minister of Health, it did once again create an institutional wedge between the policy maker and budget holder for LTC services and the implementers of the reform. Once again, restricted access to the decision-maker allowed implementation of the Conservative vision to move forward with few obstacles. However, the decision to move only seniors' issues and not disability issues, which remained in MCCR, turned LTC into a seniors' reform. As will become clear in a later section, the disability community was more or less content with the CCAC model and did not require managing.

7.2.6 Assessment of CCACs

This section deals with the assessments articulated by interest groups at the time of the introduction of CCACs. The evaluations of the model by groups help to underscore their own values and interests, but also provide insights into the potential future impact of reform. Because the CCACs were not as yet up and running, these assessments are not based on actual experience with the reformed system. As with the previous two governments, respondents' views reflect theoretical or hypothetical appraisals of the workings of the model when eventually implemented. This section will include insights provided by consumers, labour, not-for-profit, and for-profit providers.

(i) Consumers

Seniors strangely enough saw the model as a government-run program as opposed to being community-driven. Here they focussed on the fact that in Toronto there were going to be 6 CCACs as opposed to 16 MSAs. As such the fear was that the larger catchment area of these CCACs would not allow for sensitivity to local issues. They were concerned that the system would be more fragmented because the community support services would be outside of the CCACs. As the opposition to the

MSAs focused on too much being left to regulations, seniors had similar fears about CCACs. The irony was that although the CCAC was a Conservative government model, it was developed under the NDP legislation. While *Bill 173* would have created an institutional constraint on the sector had it been implemented, the failure of the legislation was that it did not prevent a government with a very different agenda from moving it forward.

The disability groups were more concerned about some aspects of the model and less with others. The inclusion of for-profit provision and market mechanisms did not worry this group. From their perspective, consumer choice and independence in decision-making was what they wanted. With the continuation of the direct funding pilot projects, the most vocal disability groups were content. The one area of concern was whether the Bill of Rights under *Bill 173* and an effective complaints' procedure would be implemented.

The ethnocultural communities feared that, although their agencies were no longer threatened by the MSA model, they would not be as successful at winning contracts because of the nature of the services they provided. Similarly, they believed that the Progressive Conservatives with their focus on the bottom line were not interested in supporting diversity or providing a provincial framework to support it. Rather each CCAC would be allowed to determine whether and how they would address these issues.

However, those supporting the CCAC model, such as for-profit providers believed that consumers wanted to get on with reform because this time there was a different set of consumers represented at the consultation airing their views.

P059: They (consumers) said, 'Let's get on with it. You know, we can't go back to more consulting, more reviewing, any of that, because we're just stalling.' ... You had a very broad spectrum there, of consumers' groups, which I've never seen in the room before. During the MSA stuff, when you talked to consumers or consumers being represented, it was Jane Leitch through the Seniors' Alliance group. And there are those who believe that it really was, they were a puppet for Ted Ball's group who was funded to promote a policy that the government wanted.

Ironically, this respondent did not recognize that both governments, the NDP and the Progressive Conservatives, had legitimated their own reforms through the seemingly autonomous support of societal interests.

(ii) Labour

Organized labour favouring non-profit service provision saw the Conservative model as a threat to this sector. Not-for-profits would not be able to compete with for-profits in a public market based on quality and price where quality was so ill-defined. The fear was that eventually the delivery dimension of LTC community-based services would switch from largely not-for-profit to for-profit. Lurking beneath the surface of this concern was the eventual take-over by U.S. nationals and the inevitable Americanization of health care in Canada.

P042: (We're very frustrated) with the fact that the choice for the provider will be based on cost and quality. Because we don't think that quality will continue to be a key force but rather, cost will be. Also a concern that, while initially, let's say in a community you have VON. You have several small for-profit companies and maybe they're pretty well equal. They're sitting ducks for an American Company coming in and undercutting the whole lot, and then getting that contract because with free trade, and so on, we don't have anything that would prevent that.

P033: There is a real danger that care will be provided by the lowest bidder, the way that the proposals are set up and the contracts will be applied. Although they say that quality of care will receive equal attention as the amount of money that agencies are asking for. I don't believe in the long run that that's going to have as much hold, as much sway as cost. So I do think that there's a real danger that our quality of care is going to hit the tubes.

The other issue and sort of related to that also, is that there are some very large concerns, very large organizations, very large companies who are coming in and underbidding like crazy and are able to, and willing to take a loss for the first three or four years in order to get their foot in the door, get contracts, and then slowly, you know, the price will increase. The cost to the Ontario public will increase. ... Also concerned too that for-profit entities are going to be providing probably a lion's share of the care, just because of the way it's structured.

We have heard, and other work I'm doing and have been doing, is the American health care companies see Canada as the unopened oyster, and Home Care as the foot to get in to the door. And we're already seeing it in long term care facilities (that) are being bought up by, in Peterborough, Omnicare. Huge American corporation who has just bought up six nursing homes. And this is supposed to be an area they're losing money (in). Then why are these American corporations so interested in buying up our nursing homes here? And a lot of people say that they're getting a foot in the door to provide the other Home Care services. And I think that this Home Care, without these kinds of protections that's in the MSA, we're

going to move into a for-profit Americanized health care system with user fees. And this is the way it's going to be done. And the CCACs provide no protection against it.

For one labour organization, the CCAC model, on its own, would not have been so ominous. However, given the decisions that this government was taking in other sectors, it was yet another nail in our tradition of public health care.

P043: When we were doing the MSA stuff, we ... didn't have this commission (Health Services Restructuring Commission) running around the province closing hospitals. We didn't have deregulation of, ah, the removal of standards in long term care facilities. We didn't have the user fees for drugs for seniors and low-income families. We didn't have the sell-off of ambulance services to American firms. You know, it might have been more innocuous, you know, except that they stripped away those two significant pieces of the legislation (80-20 rule and labour adjustment). It might have just been seen as "same as, different name" with a slightly different spin, and they're not going to have the direct service providers. But given the context and the shifting ground in all the other areas of the health sector, it's a little more ominous, I think.

The labour movement saw that workers, their compensation packages, and work standards were going to be the elements in the contracting process that would be manipulated to produce a competitive bid.

P043: Contracting out workers in competition with each other and therefore their wages and benefits become, you know, cards that are kind of dealt on the table and goes to the lowest bidder. And often what they're bidding with is the quality of somebody's work. Workers are constantly hearing that they have to be more flexible. Those workers, (who) are more flexible, they'll get your work if you're not more flexible. They can do it cheaper. ... It means you don't have a contract language that protects you from a two-hour week this week and a fifty-hour week next week, you know. We know what they're doing to employment standards. (You don't have) a contract that says, or a health and safety legislation that says one-person lifts are not safe and you can refuse to do that work. And ... you de-regulate a work environment to make it so-called flexible.

(iii) Not-for-profit Providers

Provider agencies, not surprisingly, were split in their support of the Conservative model along for-profit and not-for-profit lines. Inherent in this split was the difference in the values they held which were reflected in the ways that they conducted their programs. For example, responsiveness to community needs and workers' well-being rather than the ability to satisfy

shareholders. There was a view that the Conservative model would ultimately erode the values underlying not-for-profit service provision.

P050: I find this (Conservative model) is cut throat. ... There's clearly conflict in values between the not-for-profits and the for-profits. Well, they'd (for-profits) like to think that that isn't the case but there still is a bottom line; there still is profit going to the owners of the organizations. And that's got to come out of service, or off the backs of the workers. ... And I think, the winners at the end of the day, -- and there are some not-for-profits who have decided to take on the sort of the business mantra. So it's leading to conflict, too. I think the people have had some value dissonance within their own organization because they're again weighing survival versus staying solid to our values. ... I think at the end of the day, what it means for everyone is less service for people and less quality service.

Not-for-profit providers also believed that the government was naïve in thinking that managed competition would be more cost effective. Recalling that their model was a federation of existing agencies, they saw the CCAC as an additional level of bureaucracy. Moreover, they believed that there were considerable costs in managed competition, contrary to the notions of efficiency that were not considered or talked about.

P067: I've argued there's a cost to have managed competition and we need to know that. And that conversation has never really been had. And there's a reason and that's because of the whole politics. So it's clear to me that's what the whole agenda is behind it is to really have the commercial sector play a role. Because if it was to really create a more cost-effective system, people would be looking at what (we've) talked about. Because it doesn't take anyone a great deal of difficulty to know that that's (CCAC) an infrastructure layer in the system that's redundant.

Echoing the labour movement, the privatization (meaning commercialization) of the sector was seen as the real danger of the CCAC model. Managed competition would eliminate the not-for-profit sector, leave Ontario open to U.S. nationals, and ultimately, result in increased prices and costs to Ontarians which would not be reversible. In this scenario, both indigenous not-for-profit and for-profit agencies would lose out.

P069: If you want to go the one next step after that, after we're (not-for-profits) gone, and after all the mergers and acquisitions have come in so that commercial organizations are basically now in control of our community-based services. ... We've got multi-service, multi-national, and there's maybe two or three of them, that have literally bootlegged our entire community-based services, guess what they're going to do? Push the prices up. And what's going to happen? Regardless of the stripes of the government of the day, what is going to happen is

the same exact thing as with nursing homes right now. ... The government isn't able to move on them because if they kicked them out they'll have to take over. But imagine, you know, ten years out. We might have to buy back the long term care system from three multi-national corporations, one in Belgium, and one in Japan, and one in America. And the government's going to look at it and say, 'We're stuck with this because we can't afford to buy that back. Our not-for-profit partners are gone.' Too bad. There's nobody out there.

P096: Strangely enough this has been shared to me by Canadian for-profit agencies. They are very concerned that a lot of multi-national private companies are coming up from the States to undercut, because it is going to be competitive and they can undercut at the beginning. They'll have backing from their own companies, ... and will come in at very cheap rates. And both the for-profits and not-for-profits will be lost. ... And if we were to look to south of the border and visited several of the various agencies around, the quality of standards and the quality of service that is provided to the seniors is not what I would say would be the quality in Canada (we want). ... And I worry about even the for-profit agencies that are here, and have struggled and worked, and built up their own businesses, and will be losing their businesses.

One critic in government echoed these concerns. For this interviewee, Canada did not have the market base to sustain agencies without CCAC contracts in a managed competition environment. Moreover, the for-profit motive in driving down costs from his perspective would erode quality and safety by encouraging the substitution of health care workers with less qualified, lower skilled, and cheaper workers. Ironically, once again, the NDP legislation made provisions for exactly this scenario.

G097: What they're saying is that they believe that we have an adequate size, first of all a population and secondly potential provider agencies who could even without the government contracts stay alive and provide the service. That won't happen. We don't have an adequate sector base for an organization that doesn't get the contract to stay in business. We're just too small.

They haven't defined quality. What you get is what you pay for. And they are going to, under the tendering process, get the lowest bid. Now what that means is that there may be lower qualifications for nursing care. And we're seeing that happening in our hospitals now where the R.N.s are the ones being displaced and it's the nurses' aides who are less qualified, have a different function but now are taking on more and more responsibility in the hospital structure. That is clearly going to happen in Home Care ... because so much of the cost of any health care delivery is the human resources cost. And what you will also find are general

health workers, or whatever it's called, which are people who basically have extremely little training, they'll be delivering a lot of care.

One respondent from a not-for-profit organization, while believing that the not-for-profits could and would successfully adjust to managed competition, believed that one of the beneficial aspects inherent in a not-for-profit environment, the cooperative spirit, would deteriorate. Information which up to now had been shared freely to improve services was now a strategic resource that had to be well-managed in a competitive environment.

P079: They recognized that they have to change a lot of their perception of how they operate – a simple thing like openness. This happens to be a fairly open organization. It recognizes, however, that if it's competing with other people, it cannot do the equivalent of revealing trade secrets or trade strategies. It might have got up at an annual meeting, two years ago, and said, 'This is what we plan to do for the future.' They're now saying, 'Can we afford to do that because our competition's going to be at our annual meeting? Do we want them to know what our game plan is?' So I think there'll be a real change in how non-profits perceive their role. I mean they've always been competitive, but it's been a different kind of competition. It hasn't been so much a bottom-line, we can do it cheaper competition.

Indeed the competitive environment was viewed as being responsible for dissolving the coalition of the four not-for-profit organizations that had formed at the beginning of this government mandate.

P069: (Interviewer: Does the group of four still exist?) I would say its life probably ended pretty much when we finished the transitional support (period). Because now that that's finished, we're now into a competitive model, and everyone's competing for market share.

One respondent believed that not-for-profits, through the elimination of waste and inefficiency, were up to the task of becoming more competitive. He described strategies that could be employed to keep these organizations viable; strategies that may go against their value of developing services to meet needs rather than to generate profits or lower bids.

P079: They will go in two directions in the course of becoming competitive. One is they'll try to produce the lowest cost product for the public dollar. They'll do it by controlling wages within their organizations, by trying to cut other kinds of administrative overhead within their organizations. Many of the really big non-profit services are administratively heavy. So, I think that those are ways they'll try to cut their costs. And I think they'll be largely successful in that regard. I think they'll try to bid on things where they know they can be low cost, and will worry less about providing the things that they'd like to provide, (that) they feel in their hearts they ought to provide or that they can't be competitive at. And I think the second thing

they'll do is they'll try to go after the non-government dollar market much more than they have over the last 20 years. We non-profits have gotten pretty comfortable sucking at the public trough. When the public trough gets smaller, they'll see if there are any other troughs out there. ... Those could be through insurance companies, it could be through user-pay, it could be through appealing to markets that aren't even in the province.

(iv) For-profit Providers

The for-profit organizations who had promoted the managed competition model, not surprisingly, thought that the values underpinning not-for-profit and for-profit agencies were not as different as the non-profit providers alleged, that lack of business acuity not competition threatened the viability of an organization, and that Canada was not under siege by the Americans.

P060: The quality of the service had nothing to with the tax status of the organization. It had to do with management. Good managers produce good care; bad managers produce bad care. It had nothing to do with profits. The next question is, 'What is profit?' ... Profit is simply a cost. It's got a name, 'profit', but it's simply a cost of an organization being able to stay in business for their future and to continue what they're doing. ... They (not-for-profit organizations) have inefficiencies versus profit.

P059: If you're a company, you're foolish to put all your money, all your service into one contract. You've got to diversify. ... Agencies who haven't thought through a business plan, good business strategy are not economically viable, and that's because they're mismanaging themselves.

P060: I've personally watched, this is many years ago in the nursing home sector – the largest American company providing nursing home care would come into Canada and be gone in less than a year because they didn't understand the environment. They thought it was another America. ... I watched them do this. They didn't understand the environment. They didn't understand the governmental level of administration of the system. And it was not an experience they enjoyed. And they got out as fast as they could. ... Because Canada is different. Canada is a public health care system that's publicly administered.

The CCAC model represented an ideological shift away from NDP values. Market principles of competition and efficiency became pre-eminent. Equity and security for consumers and labour were trumped by equality between for-profit and not-for-profit providers (even playing field) and security for all providers (no longer forced to amalgamate into MSAs). No longer were special interest consumers (ethnocultural, persons with disability, and seniors) or labour allowed to represent their interests directly on CCAC boards. These interests were to be expressed by the general board membership.

Consumer choice was said to increase with this model since CCACs had to contract, where possible, with more than one agency for particular service contracts. However, real choice of provider agency was more or less pre-determined by the CCAC through the competitive process. Consumers had argued earlier that choice of the individual provider was more important than choice of provider agency. Managed competition would further threaten this notion of choice for consumers, should the provider agency whose worker the consumer preferred not be successful in the next round of competition. People with disabilities continued to be allowed to opt out of the LTC model through direct funding. Direct funding for people with disabilities was very much in keeping with a conservative agenda where the consumer/client has control and money follows the client. Ethnocultural consumers were notionally allowed choice if their preferred agency were successful in gaining a CCAC contract.

Labour was the big loser in this model. The compensation packages and working conditions were directly threatened by the race to the bottom line in managed competition. With provider agencies no longer being transferred to MSAs and the privilege unionized workers received under Bill 173 no longer in force, the union movement was denied the growth they were promised in the community sector.

While all existing provider agencies would now have the opportunity to remain in business, the new managed competition process was thought to advantage for-profit over not-for-profit agencies. In a competition based on best quality at the best price where quality is ill-defined, and where most of the costs of agencies are salaries, it was believed that price would win out. For-profit organizations had a competitive edge on the price dimension since they tended to pay poorer salary and benefit packages to their workers than not-for-profit agencies. Furthermore, it was doubtful, that agencies that were unable to win a contract would be able to stay viable until the next competition. The balance in the LTC market could shift over time to commercial agencies and, in an era of global markets and trade agreements, to American multi-nationals.

7.3 Government Interests in the Development of the CCAC Model

This section deals with interviewees' views of the government's motives driving reform. Their comments are consistent with the interest-group assessments of the CCAC model considered in the preceding section. There was very little disagreement amongst respondents, from consumers to providers to government officials, concerning the Conservatives' interest in its reform of the community-based services. The Conservatives, true to their *Common Sense*, wanted less government, more competition and other market mechanisms, adherence to the bottom line, the involvement of the commercial sector, and to distance themselves from the NDP. For many, the reform now took on a market liberal ideological bent as it had taken on a more socialist leaning under the NDP. The

Conservative government's interest and the ideology underpinning them were, to these respondents, transparent.

G093: I think that this government needed to distance itself enormously from the NDP. I think that it needed to send a strong signal to the business community that the healthcare system in Ontario was open for business.

G095: (Their interests) are a) not to do the NDP model, and b) to encourage the private sector to take over the provision of these services.

P067: So it became clear that in my judgement we were just talking another shift in ideology. And I don't think there was much clarity to what that really looked like other than it wouldn't – the structure would not be MSAs. So I think the next step to that was if not MSAs, then what kind of a structure accommodates the private sector? And that brought in the ideology. ... They wanted to transfer or re-invent, something a bit different than Home Care and that's where the CCACs were created with placement and Home Care coming together and the opportunity for the private sector to compete for all of the services. So in essence, there was almost a de-regulation, if you want to use that term, of home care services in the community. Because previously under the Home Care Programs the mandate was always that the Home Care programs could and should provide the services, or they could purchase the services. ... With this new model ... the market becomes open and you compete for the work. And that whole conflict of interest, arm's length governance piece is actually quite foreign in the not-for-profit or hospital sector. We really don't worry about conflict of interest and what is the profit of health care. I mean that's just not a language of any other sector of the health system. In the community that language has now come about, and I think, because of the whole role for the private sector in this service delivery component.

C001: They're trying to get more private sector business involved.

C002: Privatization – they don't believe in providing any services. Everything must be on a business basis, which means it has to make money. ... They want to do away with public services.

P083: Ideologically it's (CCACs and managed competition) quite compatible with their direction – privatization of services and a cheapening of services. ... Much less interest and emphasis on the role of government in the provision of services. I mean they don't really believe in a social security net in the way I think that Ontarians have been used to.

G079: A couple of things. One is that they wanted something that didn't look like it was designed by the NDP. I think they wanted something that would allow private enterprise to play on a competitive basis.

C010: I think it's (Conservative agenda in LTC) two things; one is money. I mean whatever they do, it's always money first, to save money first. I think the second thing is they want to make it, - the private sector has been pushing them to privatize as much as they can of health. I think they have contributors who they owe big time. They're trying to get the government out of doing things.

P040: Well, I think it's the same model that's behind all of their fundamental philosophy of this particular, so called Common Sense Revolution. They're more in the business of getting government out of delivering services than they are of anything else. And this tax thing is actually, you know, giving taxes to people is really , everything they've done, deregulating anything, not just in health care, environment, whatever it is. There's the deregulation moves, the privatization moves, the open for competition is to get government out of the business of delivering service and leave it open to market. And I think we're just going to see it full force here in Home Care.

The government's decision to move the community support services outside of the realm of the CCAC's responsibility was seen as yet another way of focusing on the bottom line, a way of keeping tight control over spending and reducing government's responsibility in the future. In October 1994, the federal Liberal government established the National Forum on Health[18], which travelled across Canada consulting Canadians. It commissioned papers, and was to advise the federal government on ways to improve the health care system and the health of Canadians. One of the issues that was being explored was the changing nature of care, the shifting locus of care from hospitals to the community, and the potential de-insuring of formerly insured health services. It was anticipated that one of the Forum's recommendations would be to publicly fund Home Care. One respondent believed that the Ontario government did not include community support services under the CCACs for this reason, to ensure that Ontario would not be liable for publicly providing a wider range of services under Home Care.

P043: If the federal government comes up with a national Home Care funding program, you know, if they actually decide to include drugs and Home Care in the *Canada Health Act* provision, then those (community support services) are services that they don't want to have included.

For another respondent (G103), the government did not need to control access to community support services as much as they did professional, homemaking and personal support services. These latter services which were to be purchased by the CCACs were far more costly. Costs were to be controlled by CCACs purchasing them on a competitive basis based on quality and price and by determining eligibility of consumers to access them.

Many respondents believed that unlike the two earlier government periods, the locus of policy development under this government was highly centralized in order to ensure that their agenda as articulated in *The Common Sense Revolution* was pushed through quickly. Once again institutional constraints were put in place to promote government interests and ultimately the ideology underlying them. These respondents represented this view well.

G096: The government seems to be run out of the Premier's Office by a handful of people and they tend to direct what is going on. I don't see the Ministers playing the same role as under the previous three governments. ... It's a way that a lot of governments work when they want to make sure that their agenda is going to get through without any hitches and without any sidelines. If you have a government that wants to be really focused and they have certain things they want to have done, if you start to let other people have their ideas, your agenda can be de-railed. And that happened in (the NDP) government. ... So if they are focussed entirely on privatization, cutting the deficit and bringing in tax reforms, if you have ministers that are given a full reign to do what they want to do and start consulting and going out. And their bureaucrats have been working on issues for the last 10 or 15 years ... If central control is taken away, then they're just not going to be able to get their agenda done.

C010: Decisions are not made by policy people, not made by bureaucrats, not made even in some cases by Ministers. They're coming out of a central point – from the Premier's Office.

P062: (The Premier's Office) because they were determined to make the CSR into a real agenda. ... And someone sits and ticks off boxes as each thing gets done. And that person sits in the Premier's Office.

One variation on this was one respondent who believed that reform was not as centrally controlled but was being developed in the Minister of Health's Office.

G095: My suspicion is that because Jim (Wilson) was clearly on the record as knowing what he opposed and what he would do, that he is in fact probably driving this one. Because they moved fairly quickly even though in almost all policy aspects this government is driven in the Premier's Office. I said earlier that most Premiers would question the wisdom of putting a critic in as Minister. And I suspect Mr. Harris has had cause to question putting Jim in as Health Minister for that very reason. There are hostages out there, things that you said in opposition that you now have to follow through on. But he came to office with a clear sense of direction and the Ministry has been following that.

The almost unanimous view was that, under this new regime, Ontario had indeed gone to market. Conservative ideology – more market provision (preferably for-profit provision) of services, less government, cost cutting, and a removal of the vestiges of an NDP model -- was underlying the

government's interest in LTC reform. Policy was more centrally controlled and driven to ensure that this agenda moved forward.

7.4 Societal Interests

This section outlines the policy interests of societal groups under this reform period. The data indicate that the policy interests of groups did not change under this government. However, because of the new government mindset, previous commonalities were no longer sufficient to maintain alliances. Underlying differences amongst allied groups which were submerged under the NDP, resurfaced. The government's highly structured consultation and institutional barriers to Ministerial access left little time or opportunity for groups to influence the reform. Alliances shattered as distrust grew and groups re-positioned themselves under the new order. Other groups merely faded away.

7.4.1 Changing Structure of Societal Groups

Without their special status and government resources and with a clear message from the Conservatives that the MSA model was out, consumers had very little to say under this government.

P049: They're (SCCA) still there, but they certainly don't have the linkages they had before. They were seen as a very strong NDP group, (and) had a very adversarial relationship with, particularly, Jim Wilson when he was in opposition through the Standing Committee hearings. And they taught me, you always be nice to people.

O106: The members of the SCCA still stay in touch with each other but they are not as active as they once were. There have been some deaths in the leadership group. Sad that they would die or get ill before they could see any change from all their efforts.

With the Conservative agenda across many diverse policy sectors (for example, downsizing of hospitals and the civil service and cutbacks in the broader public sector) in full force, the labour movement was fighting many other battles and was spread too thin.

Most of the input of interests came from provider organizations. While the for-profit and not-for-profit agencies were united in their opposition to the MSAs and the desire to defeat the NDP, once the Conservatives came into power, the commonality that these groups shared started to come apart. As it turned out their shared interest under the NDP was in what they did not want rather than in what they wanted. When the Conservative consultation asked for alternatives to the MSA, the different factions in the Group for LTC Reform started to meet separately to develop models. With the shift in government ideology and direction in this policy sector, the balance of power between the for-profit and not-for-profit organizations transferred to the former. The for-profit organizations saw that their time had come. This respondent describes the shift.

P049: When it came time to try and do something constructive as opposed to destructive in terms of objecting, -- the Conservative government had come into power and there was already a

divisiveness in the group (Group for LTC Reform), the commercials were pulling further away from the not-for-profits. Originally the not-for-profits had held all the power because the NDP did not favour the commercial sector. So I think the commercials found it very helpful (under the NDP government) to be part of a group that was this involved and it gave them relationships and some respectability they didn't have. That shoe switched. ... OHHCPA (the for-profit providers association) got together under the very capable direction of Vida Mazza and started to develop their model. Their model in many ways is very much similar to the one that the Home Care Program Association developed, and in part probably because Vida had been the President of the Home Care Program Association so she knew that system. And it was really almost what you see as the CCAC. The not-for-profit group which was VON, St Eliz., OCSA and Red Cross got together and spent a lot of time trying to come up with an alternative model.

A couple of organizations described the way in which not-for-profits sensing the change in the ideological wind started to meet quietly apart from the other organizations in the Group for LTC Reform.

P058: At the same time, there was a group of four they were called within the Long Term Care Reform Group who had put together some thoughts about what they might propose (to the PC consultation). But they had not let the rest of us know. But we found out. And at one of our meetings of the Group for Long Term Care Reform, it became clear they were meeting in the hallway. ... I thought we had agreed we'd all be proposing one approach and we were (not) going to go off and do our own thing. But it became clear that they were going off to do their own thing. And at that meeting I remember very clearly talking about hidden agendas. And it was the OHA who cottoned on to this. ... And we questioned them (the group of 4 – VON, St. Elizabeth's, Red Cross and OCSA). And they said, 'No, there's no model. We've just put some thoughts together.' But in a group that (had) worked so hard together, and all of a sudden a smaller group was going off, doing things that they weren't prepared to share with us. (It) felt like they were going off to present, to develop something to present to this government. And there we'd be sitting without a counter proposal. So this all happened very quickly because we had a 60 day time frame. ... The group of four said, 'Don't worry, we'll look after you.' ... The break up of the Group came essentially with that chasm where you saw a sub-group going off to do, serve its own interest without informing the rest of the Group. So the rest of the Group said, ... 'If they're going to put forward a proposal, we're certainly going to have to protect our interest and put forward a proposal.

P059: (T)he four not-for-profit service providers got together without anyone's knowledge to develop its own proposal. We caught wind of it ... and asked for an accounting of what was going on given that we had committed to working as a group. And then we heard that the four went off to do their own thing. And they essentially said, 'Well, trust us. We can't reveal everything to you right now but trust us, and we'll make sure your interests are served in our proposal.' ... So we developed our own proposal. We felt we had to. We had been left with no choice but to do that.

P060: The government was asking about alternatives to MSA. But we didn't know at the time, and we know now, that some of the more major non-profits got together and went to government with something else, long before we did.

P056: I remember ... saying, 'We need to talk. You know. We've got to come up with something as an alternative.' Because we didn't have anything. I felt that what the group was doing was just a sham. All they were doing was opposing Bill 173 and we knew the NDP weren't going to be elected, but as soon as someone else gets elected they're going to say, 'Okay, now what's your model?' And we knew there wasn't anything. ... The commercial sector had lobbied really hard during the election campaign and had helped finance their election campaigns too, so now you know, was payoff time and that's the way politics works. So we knew that there was going to be a lot of pressure. We had to come up with an alternative. So we met over the summer and then came up with this partnership model ... So we had agreed by prior decision that each of our four organizations when we presented at these hearings would present not necessarily a final model but the beginning of that model. And it actually got refined a little bit as it went along because I think the very first time it was presented by (one of the organizations), the first plan was that no 'for-profits' would be allowed on the board of this partnership organization. And it got lambasted by other people in the room.

One respondent from a not-for-profit agency indicated that even within the informal coalition of not-for-profit groups, there was dissent between the professional service providers and the support service providers. However, in the end the feeling was that it was better to submit one model from their side than multiple ones.

P049: We really felt strongly that the future particularly was going to be more of a commercial/not-for-profit tension, that it was going to be that old sort of, health and community and social services but we weren't successful in selling that. Anyway, it wasn't one of the happier moments in my career. We had an opportunity and we threw it away. ... We were told it would be unacceptable to submit ... two not-for-profit models. It was one or none.

With distrust among the members of the Group for LTC Reform, organizations began to line up on sides.

P069: You've got Home Care, that is the Public Health Units, and the for-profits lined up to support the model (CCAC). On the other side you've got the not-for-profits lined up against the model. The sector's essentially split.

The government effectively changed the power balance amongst societal groups in this policy community. They marginalized formerly powerful groups under the NDP, either by removing their resources or by creating multiple battle fronts. The Conservative ideology bred distrust amongst former provider allies, and along with the highly constrained consultation led to the splitting of groups. With societal groups shattered into their own corners of interests, the government was in full control of the agenda.

7.4.2 Interests Advanced by Societal Groups at the Consultation

There were no surprises in the different groups' interests in a reformed system. A government respondent best characterized the models advanced by societal groups, now realigned into four camps. Consumers and labour, the favoured interests under the NDP government, wanted the MSA model. Municipalities and the Public Health Units wanted to consolidate their power by continuing the status quo with them taking over the management of the Home Care programs currently not in their control. The for-profit providers and Home Care staff wanted a separate case/care management split, a competitive purchaser/provider split, and a governing board without providers which would give the for-profit providers unfettered access to the home care market and the Home Care staff a continuing role to play in the new system without the Public Health Units draining Home Care resources for their own purposes. Finally, the not-for-profits wanted a partnership or federation of provider organizations which would be directly funded by government and where care and case management were performed by these organizations. They did not want others performing their assessments or managing their cases, nor did they want to have to compete with the for-profits for contracts.

G101: One model was very close to the one they (government) chose. It was the Community Care Access Centre, obviously, that was supported by the Ontario Home Health Care Providers Association. And (it) had sort of a parallel ... in the submission that was made by the Home Care programs themselves, but not the sponsors (municipalities, Public Health Units) of Home Care. Obviously it was couched very carefully because they (Home Care staff) didn't want to tell their bosses (Public Health Units) that they wanted a different model. But obviously it was also a case management model. So that was one model.

> You had a second model that was principally put forward by the municipalities and Boards of Health, that said that the current method of running Home Care was perfectly fine. And if there were any problems with it the municipalities could look after it, and that municipalities should have the first right of refusal in terms of the system. And of the 30 they ran, that they probably want to continue to run, and that in the other 8 areas of the province that would give them an option of taking over those too if they wished to.
>
> And then you had a third group of people who came in and said that they wanted, thank you very much – these are the consumer groups and the labour groups – they came in and said, 'Gee, we want the MSA. We know you've ruled it out but we still think that's the one we want.'
>
> And then you had a fourth group which was the major non-profit providers who came in and said, 'No, we don't think we should have a model that separates out case management from care management. We think that in fact, the system should be run by a partnership arrangement among the service providers and that they should be funded directly by government rather than through an intermediate agency such as Home Care or the CCAC. And that they could work together to develop efficiencies by integrating the functions of case management and care management and eliminating some of the duplications involved at the separate care, case management level. And so that was the fourth model on the table. And considering those four models, as you know, which one won.

Another government interviewee (G103) expanded on the interests of the various groups and described the process to reach a solution. The municipalities and the Association of Local Health Professionals "didn't want to lose Home Care programs nor the administrative dollars that went with that." The not-for-profit sector "had no doubt they could provide the highest quality. In fact they argued that their quality of service would be way and above most of the providers because their wages were higher, that their staff were less transitory, had more stability. They had training. They did research. They did a lot that commercial agencies, they claimed, didn't do. So they said, we have no problem providing you with the highest quality at the highest dollar. But we can't do it at the best price because we know the commercial agencies can undercut us. ... the concern about the Wal-Mart of health care." The for-profit agencies "realized that the charitable organizations had been able to do things over the years that somebody in business for themselves simply can't do. They don't have the fat to do it. ... They felt that the non-profits could be more competitive. And they were willing to concede that the non-profits might need a chance to become competitive. So negotiations occurred. ... And what was finally decided on was a three-year period of decreasing protections for current service providers. And so it guarantees 90%, 80%, 70% of volume. In other words, VON who says,

'we've been in business for a hundred and some odd years or whatever, weren't going to just go bankrupt overnight. It also meant that new commercial agencies couldn't just move in from the get-go and take over the whole market. That there would be a gradual effect. ... To have it more of an evolutionary effect than revolutionary."

While not-for-profit and for-profit providers would not disagree with the above depictions, their own words highlight some nuances. The interests of the not-for-profit group were largely to maintain dominance over the system. One non-profit provider said it was very difficult putting forward a winning model in a "managed competition" environment. The argument that the not-for-profit motive is nobler and does not require safeguards against conflicts of interest would have no sway in a climate where efficiency ruled supreme over equity and security. Their arguments would have to be phrased in the new discourse to get an audience.

P067: They (the not-for-profits) had to either argue it two ways: to say not-for-profits are better so just use us; or they would (have) to say, well because we don't need this arm's length relationship and because we are not-for-profit, we could govern and we could deliver. ... And a few of us in a softer way started to put together this federation model where everyone would be positioned in a partnership and each one may or may not deliver the services and we may out-source some of them. Now of course it wasn't going to fly ... and this government was not going to have not-for-profit preference. Now if it was a Liberal government, this partnership model would have been, I think, a potential opportunity. But it was clear to me that wasn't going to fly. So the best attempt was to try to influence the OHHCPA's model. So much of our argument was ... that you don't need the home care case manager, and that that's a cost in the system ... that's where the duplication and added cost is. That any professional going into the home is making an assessment determining the care treatment, and in essence should be the resource manager, because they are there functioning in that role in the hospital system.

A not-for-profit provider indicated that, unlike the commercial agencies, worker protection had been one of their main concerns. They had negotiated the protection of volume in the transition period not so much out of self interest but to protect workers

P049: Because when you have competition which drives price down, and you have all your money's going to pay the workers, you know, what's going to be driven out. So we really wanted to make sure that where there was competition, the compensation to the worker was moved outside and you competed on another piece. And we had come up with a very simple mathematical model ... and it just allowed competition on what was overhead. ... It's not quite the way it ended up.

Similarly, the protection of workers and efficiency arguments were used as the justification to rethink managed competition leaving the door open for a model which combined the case management and care function.

P067: And the argument of the managed competition is simply – it really is exploiting the workers who are non-unionized, in the short term to be paid as low as possible with no benefits. So your leverage of how to get more out of the system is really lower the worker pay. Or our argument was really look at the system. Look at some of the duplications and functions and figure out another approach.

When government agreed to the transition period of protected volumes, not surprisingly, the for-profits wanted a much shorter period. The sooner they could compete on an even playing field, the quicker they could increase their share of the market. However, one not-for-profit provider indicated that it was clear that the longer transition period would benefit the for-profits as much as the not-for-profits.

P056: (T)hey did recognize that it (a shorter period) wasn't in the best interest of them either. They probably didn't admit that to the government, but privately I'm sure (they) could realize that they couldn't pick up the volume that quickly. Like if the whole of the non-profit sector failed, especially in nursing, and they had to pick up the business, they couldn't handle it, couldn't handle that large an increase (in volume).

The volunteer community support sector within the not-for-profit sector were more concerned about not having to compete for contracts having had no experience with it or resources for it. They were relieved that support services were excluded from the mandate of the CCAC, and would be directly funded by government.

P056: They haven't had to do business with Home Care in the past. They haven't had the same kind of familiarity with them. And I guess (they) were a little bit concerned about losing out, and so losing a contract.

There was a number of overriding issues that were important for the commercial agencies that made their model incompatible with the one proposed by the not-for-profits and that shaped their model. Their interests dealt with features of the current system that led to conflicts of interest: namely, governance, the lack of separation of case management and care provision functions, and the purchasing of services through informal agreements. The old governance structure when Home Care was under the Public Health Units, they argued, led to the misuse of funds.

P059: You (shouldn't) be on the Board making decisions about who gets contracts, or be privy to information that would give you an advantage in the contract. So there would be no conflict of interest. That was a key principle as well for us. There were decisions made, for instance,

> under Public Health around purchasing items through the Home Care programs' budget that were unnecessary for Home Care. Hundreds of thousands of dollars were spent on automated equipment that was placed in the Public Health Units. We're talking about lots of money that was diverted from the mission of that Home Care Program to purchase (things) for the Public Health Units. ... So that was one key principle, get the Board straightened out.

The commercial agencies wanted to separate out the case management and care functions so that staff of the CCACs would only perform assessments, eligibility determination and quality control. The provision of all care should be purchased from outside providers. They believed that if the two functions were combined in the same organization, it only lead to conflict of interest situations.

> P059: When the Home Care Program made decisions it sometimes favoured the provider, the therapist, rather than the client. So when case manager had complaints from clients saying, 'I don't know when my therapist is coming', the Home Care Program wouldn't say, 'Oh, we'll fix that.' They'd say, 'Too bad! Our therapists needs come before yours.' So we felt we've got to get rid of that. If we're really going to move to an accountable, customer focused system, we've got to get the providers out of there.

Lastly, they needed a structure that allowed them to provide service on at least an equal footing with the not-for-profit sector.

> P059: We wanted the opportunity to compete in a fair and competitive environment. So we promoted, -- we felt that to get there, we needed to have some sort of structure. That was the request for proposal process where you'd bid on a contract based on the quality that you could provide at the best cost.

Although it was a not-for-profit organization, the Home Care Programs' interests were to retain brokerage and case management. As such, their staff would easily slide into place in the new structure. Their interests, therefore, coincided with the for-profits. (P058)

In the end, for most of the societal interests, especially providers, fatigue and a desire to move on took over, of which the government took advantage. One provider captured this sentiment.

> P067: I think everybody was so profoundly tired and we had all got to the point where we simply said, 'Just give us some kind of opportunity to stay alive and we'll be happy. And I think they (the government) capitalized on that emotional sense that all of the providers had, -- it was like, you know, I don't have any more time to worry about the detail of things (anymore).

With the viability and independence of provider groups no longer being threatened by the amalgamated model of the MSA, interests of provider organizations split, and the Group for LTC Reform fell apart. Any opposition to the increase of for-profit provision and market mechanisms was

effectively silenced under the Conservative agenda; the interests of consumers and labour groups were simply ruled out of order. The not-for-profits' efforts to forestall the inevitable failed. Managed competition came to Ontario.

7.5 Influence of Interests

Having now laid out the interests of groups, the question becomes whether they had any influence on this government. This section attempts to determine whether, and which, societal interests, if any, influenced government, or whether the interests of particular groups merely lined up with the plans government had already formed. Was what was perceived as influence merely preferred access for certain groups paved by a belief in similar ideologies?

From the perspective of most respondents ideology determined access to government and potentially, influence over government. Those groups that had supported the NDP, namely the SCCA and labour, were in disfavour with the Conservatives. While the NDP spoke of consumer empowerment in terms of consultation and authority in decision making, the Conservative government spoke of consumer voice in terms of consumer satisfaction being one of the factors considered in the competition among providers. As respondents indicated earlier, the Conservatives in this policy objective were driven by a number of objectives, two of which were to run this sector like a business and to distance their model from the NDP (both positions being compatible with each other). Consumers, as strong supporters of the MSA model, were no longer therefore able to access this government.

C074: They did include the Senior Citizens' Alliance (in their consultation), but they didn't give them the same platform that the NDP gave them because it was an NDP group. Or perceived to have power within the NDP, so they wouldn't give them the same voice.

Having spent all their resources (they were no longer funded under the Conservatives) and energies promoting the MSA, the SCCA was more or less beaten down. From their perspective, any reform was preferred over more delays. As one government official (G103) said, "Haven't heard from the Alliance at all."

The disability community was less involved with the Conservative position. Their objective of direct funding and control over the hiring and managing of their own providers was more in keeping with Conservative ideology. That is, the principle of allocation being more towards the market end of the continuum where money follows clients. Therefore, there was less need to mobilize and be active in this policy arena. (C010)

Because the Conservative government was bent on undoing many of the protections that the NDP had brought in for labour in all sectors, the attention of unions was now diverted as they fought for their interests on many fronts. They mounted mass demonstrations against government through

their Days of Action. Without the financial support that had been provided by the NDP government, labour was no longer able to give LTC reform their attention.

P040: The funding ran out. ... The person who was, quote, assigned to it (government relations staff) is doing WCB (Worker Compensation Board), doing health and safety. There's huge amounts of legislation on that right now, running campaigns. (The staff member) has been pulled in to do the Days of Action. They need another body to do the work. ... The WCB and the health and safety stuff are huge changes that are happening to all workers not just healthcare workers. It includes healthcare workers, but the changes that are coming down on that are just enormous. And I don't think it was a decision of choosing one over the other. The person who got assigned to, to add health to their list was already overwhelmed.

P043: We don't have an opportunity to just sit and talk about mutual interests. And they're (the Conservative government) profoundly anti-union. And they're driven to privatize, you know, to put as much of the delivery of health care into the private sector as possible. So we don't really have a starting point because those are fairly important things for us.

While ideology silenced the consumer and labour voice, it responded to the provider voice. However, not all providers were given the same audience with this government. It was widely believed by respondents, including those from the for-profit organizations, that the for-profit agencies were most influential in reform.

C010: The private providers are playing a big role in the back room. And they're certainly the people who are playing a role in the regulation issues, the Red Tape Commission.

P033: Private owners of private entities. I think that's who is mostly speaking to this government. ... Business has a very strong ear of government. They certainly had access where I think a lot of other people haven't.

P040: The for-profits got whatever they want.

P043: I believe the for-profit sector has a huge influence.

P056: For-profits – And they, what was interesting is, they've become the equivalent of the Seniors' Alliance I think with the NDP. ... They seemed to have had a fair bit of access with the government ... They seem to have assumed a new ascendance.

P067: Certainly it was pretty clear that the commercial group had the ear of the government. It was clear to me. I mean, I was absolutely convinced that it was going that way. So how do we influence that?

The old Home Care program was also seen as influential with the Conservatives. Because the Home Care programs along with the Placement Coordination Agencies in all parts of the province, with the exception of Metropolitan Toronto, were going to become CCACs, the Ontario Home Care

Programs Association was in favour of this model. The case managers would transfer to the new agency. The direct providers (e.g. rehabilitation therapists) would be employed by the CCAC during the three-year transition period by which time they were to become private contractors bidding for service contracts.

A number of groups believed that the Ontario Home Health Care Providers Association (OHHCPA) and the Ontario Nursing Home Association (for-profit facilities) were particularly influential. According to one respondent, the ONHA had targeted Mike Harris about ten years ago and had provided financial support. (P067)

P083: Oh they're certainly listening very strongly to the nursing homes, the private nursing home association (ONHA). I also know they're listening very closely to the private Home Care Providers Association (OHHCPA). I know both the executive directors in those organizations ... have the ear of the Minister quite closely.

One respondent who concurred with this view, also understood that the Conservative government was able to move its agenda forward quickly and decisively precisely because the societal groups in this policy community were not cohesive and, therefore, not an organized force to be reckoned with.

P050: There was a sense at the time, very strong, that the interest group, that the for-profits were very strong in support of the Conservatives through their campaign. And that to a large extent moving to the managed competition in the community sector versus anywhere else in the health system, was a pay-back to the privates who had underwritten the costs of some of the campaign or were very strongly in support of the Conservatives. They (government) owed it to them. And it would be easier to implement it in the community because after all it was pretty fragmented. There weren't power players like hospitals, CEOs, you know committed to the not-for-profit and Boards where the money really was. That this would be a good place to get an inroad. You know, it's sort of fragmented and they could very surreptitiously sort of move in and win contracts and gain market share and grow and change.

One respondent indicated that because of the beliefs of this government and preferred access they gave to the for-profit sector, his organization changed its approach to government in hopes if they spoke the same language, they could fool the government.

P033: How we changed from the NDP to this government. I think that when you're speaking to this government, you need to ensure that there's a cost-effectiveness comment. You know, that you have to take on the issue of cost effectiveness. What we've tried to do is broaden this government's conception of cost effectiveness by talking about the concept in broader terms, like investing in people's health is an investment, really is definitely cost effective as opposed

to the alternative. You don't talk a lot about equity and equal access. You don't emphasize that to the same degree. Our central message hasn't changed but the way it's packaged certainly has.

There were, however, a few respondents who believed that little would influence this government. The Conservative's ideological belief in market, market mechanisms, and adherence to the bottom line predetermined the shape of the reform. As such, they were not particularly influenced by any interest group.

G097: I'll bet they didn't pay attention to anybody. I believe that the Tories had a set point of view about introducing a managed care approach to long term care and that's what they did.

P070: They are not interested, I mean the sand and gravel lobby would be saying the same thing (that they had no access to government), I would suspect. ... They care about cost. That their entire, - what they call the common sense revolution is about getting the cost out of running Ontario. And so anything else that you want to talk to them about except new and different ideas to get costs out, they're not interested. So it's even the next plateau from being locked out. It's – they don't want to know. ... They've said , 'we're not even going to listen to people because we know what they're going to say. Change is tough. We're going to have to just do it for people, and they'll thank us hopefully afterwards. Pray to God we get a second term, and by the end of the second term, people will see that there's significant benefit being derived from all this.'

Regardless, of whether respondents believed particular groups were influential or not, ideology influenced reform either directly or gave the appearance of influence through the alignment of interests or the preferential access given to like-minded interests.

7.6 Conclusions

Before the Conservative Government assumed power, it was clear to the LTC policy community how they intended to reform this sector. Through the publication of *The Common Sense Revolution*, the Party's ideology was evident – less government, market mechanisms that focus on efficiency and cost reduction, a disempowerment of unions, and empowerment of the for-profit sector. Their first act in this policy field was to halt the implementation of all aspects of *Bill 173*, which went against their agenda of competition and for-profit provision, namely, the MSAs, the 80-20 rule and the labour adjustment strategy. Ironically, the NDP legislation allowed the Conservatives to develop a model that would have been anathema to the earlier government.

The Conservatives put in institutional structures and constraints that would make it difficult to de-rail their agenda. They organized a quick and highly-focussed consultation which foreclosed any discussion about MSAs and which impeded the ability of societal groups to organize their

thoughts or resources. They distanced the Minister of Health from both the consultation and the implementation of the CCACs by giving the responsibility for the former to Helen Johns, Wilson's Parliamentary Assistant, and the latter to Cam Jackson, Minister without Portfolio Responsible for Seniors Issues. Finally, they centralized policy decision-making in the Premier's Office.

The coalitions and alliances that the NDP had either directly fostered, indirectly created through the bringing together of disparate interests to fight a common enemy, or inadvertently gave birth to through the Social Contract, quickly unravelled. The thin veneer of common interests rubbed off, as groups attempted to influence the reform. Labour and seniors were silenced because of their previous associations and because their interests were antithetical to this government's. If this government was influenced by any group at all, it would have been the for-profit providers which had either provided campaign support or had a common agenda.

The CCAC model differed from the earlier models in the opportunity it provided the for-profit sector to increase their market share. Managed competition moved allocation to the market end of the continuum, disadvantaging not-for-profit agencies. The only way for them to compete in this environment was to become more like the for-profits. In their efforts to stay viable, they were adopting strategies typically associated with commercial enterprises. Whether or not agencies would be able to survive if they lost a contract bid to compete again was in doubt. Through the mechanism of competition, one of the Harris government's achievements in this sector has been to further fragment an already loosely connected sector.

The restructuring of the health care system, the shifting of care into the community and outside the constraints of the *Canada Health Act,* the de-insuring of Home Care by removing it from the OHIP budget, and the opening of the community sector to competition and more for-profit provision, and particularly, by American multi-nationals, will have major consequences for Canadian health care in the years to come.

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Chapter 8

Analysis of the Design Decision[1]

Between 1985 and 1996, there were three politically different provincial governments in Ontario that developed five community-based LTC policies in succession. Rather than being evolutionary, some of these models not only marked a clear departure from earlier models but from the prevailing political and economic environment of the time.

This chapter will address the first set of questions posed in the research regarding policy content. How did the financing, delivery, and allocation dimensions along with the public/private mix differ across the following models: One-Stop Shopping, Service Access Organizations, Service Coordination Agencies, Multi-Service Agencies, and Community Care Access Centres; what were/are the implications of these differences from a public policy perspective; and what are the implications for the welfare state? In examining the design dimensions of each model analysis will focus on the shifts in the public/private role in financing and delivery, and the shifts along the allocation continuum from control by the government at one end to market forces at the other end. Each model will be assessed using Deborah Stone's four policy values or goals of equity, security, liberty and efficiency as evaluative criteria. The evaluation of each model against each of the four criteria depends on whose perspective (consumer, worker, provider, or government) is taken.

While the role of the private sector, especially in the financing of medically necessary services provided by physicians and hospitals, is constrained by the Canada Health Act, the same did not apply for LTC services. Provincial governments had considerable latitude in the design of their reforms. However, as the nature of LTC changed to include more patients from the acute sector, the attributes of the reform in this sector took on an added importance. Policy design decisions are rarely neutral given the nature of the political process. As will be argued in the next chapter, the political leanings of each of the three governments shaped the reform they proposed. The decisions in this policy sector have the potential to alter the shape of the Canadian health care system in general.

8.1 Design Decisions

The following section will summarize the financing, delivery and allocation decisions made by the provincial governments for each of the five models: One-Stop Shopping, Service Access Organization, Service Coordination Agency, Multi-Service Agency, and Community Care Access Centres. The analysis will highlight the potential and actual shifts in the public-private divide in the financing and delivery dimensions, and the relative shifts along the allocation continuum.

8.1.1 One-Stop Shopping (Liberal, 1987)

Financing

Scope of Services:

The services would include the following provincially-funded community programs: home care, integrated homemaker, homemaker and nurses services, home support, and placement and coordination services (where available). Publicly funded services could include other services, such as volunteer services, community health centres, specialized geriatric services (Day Hospitals), community information centres, community and neighbourhood support service programs, and other community services for the physically handicapped. The distinction between formal in-home services and informal community support services was maintained.

Public Role:

In-home professional and homemaking services were to be fully funded by the Home Care Program (which remained within the Ontario Health Insurance Plan, and accordingly continued to be considered an entitlement). Public funding for community support services was to be expanded, but would remain within MCSS, and would continue to be financed by a mix of public and private resources (with the publicly-financed portion often being means tested).

Eligible Clients:

One-stop access primarily intended to serve the needs of the elderly but could also include other groups such as the disabled, who were eligible for Home Care and the Integrated Homemaker Program.

Delivery

The existing system of not-for-profit and for-profit providers would continue except that access would be coordinated by a new group of local agencies which would provide comprehensive functional assessments, provide services under its direct control or arrange for the provision of necessary services. The local authority would rationalize and integrate existing organizational structures; for example, the case management component of Home Care and the Integrated Homemaker program were to be fully integrated with the comprehensive case management approach.

Allocation

Funding for in-home services would be brokered by the single access agency either to other agencies through contracts that would take into consideration quality assurance, cost, volume of service, catchment area, hours of service and reporting requirements, or would be provided directly. Community support services would be funded directly by government. Brokerage referred to informal contracts, purchase-of service, and referral agreements. On the allocation dimension, this

model was more towards the centrally planned and cooperative end. There was a purchaser/provider split for all services, and for in-home services the provider was once removed from the purchaser through the one-stop agency.

8.1.2 Service Access Organizations (Liberal, 1990)

The second Liberal model, Service Access Organizations (SAO), was very similar to the One-Stop Shop approach with a few variations.

Financing

Scope of Services:

The scope of services remained the same as under the One-Stop model.

Public Funding:

Public funding would cover SAO administration, service coordination, and the facility placement committees, as well as the SAO budgets for the purchase of formal in-home services. Government was going to increase public funding for community support services to 60%, and eventually to 70% of their budgets. There would be no consumer charges for treatment (usually provided by nurses or therapists) or for personal support and care services (assistance with bathing, eating and toileting). Charges for cleaning, cooking, laundry, shopping, home maintenance and meals services would be based on ability to pay assessed on income, not assets. Agency charging policies would be coordinated with the overall consumer charging policy.

Eligible Clients:

Clients under this reform model were to include both seniors and persons with disabilities.

Types of Budget:

Government was going to create an integrated regional funding envelope for all services. Eventually, the Home Care budget would be removed from OHIP and would be combined with the budgets for LTC facilities and community support services under one capped envelope.

Delivery

Services would continue to be provided by the mix of not-for-profit and for-profit providers. The SAO, like One-Stop Access, would act as a single point of access, referral, assessment and service coordination, as well as purchaser of in-home professional and homemaking services. It would also control entry into LTC institutions. Community support services would continue to be accessed directly by consumers or by referral from SAO. Sponsoring agencies for service access could be existing or new organizations, other than current direct providers of service.

Allocation

Community support services would be funded directly by government. SAOs would purchase in-home professional and homemaking services from budgets received from government. Although the nature of the contracting process for in-home services was not made clear, government sources indicated that it would be more or less on the same informal, cooperative basis as it had been up to that time. For both in-home and community support services, there would be a purchaser/provider split with funds going through a mediating agency (SAO) for in-home services.

This reform model represented minor tinkering with the earlier model. Aside from formally including persons with disabilities and increasing the public funding of community support services, this new model did not move the financing or delivery dimensions along the public-private continuum. The government's stated intention to remove Home Care from the OHIP vote represented a major threat in the future that could shift costs to the private purse. The future creation of a single capped budget would allow for the allocation and reallocation of resources to reflect the changing needs of community. It would also provide the government with greater flexibility in controlling costs. Aside from removing the conflict of interest inherent in the brokerage model of the day, the allocation mechanism of the SAO did not shift towards either the market or centrally controlled end. The Liberal's second policy model had more to do with re-aligning LTC community services away from costly medical services. At this point in time, change was incremental.

8.1.3 Service Coordination Agency (NDP, 1991)

Financing

Scope of Services

The scope of services under the SCA model would be the same as the SAO model, except that services under the Home Care Program, Placement and Coordination Services, Integrated Homemaker Program, Attendant Outreach Program and the Homemakers and Nurses Services Program would be integrated within government into the Health and Personal Support Program. Access to non-professional services no longer depended on the receipt of professional services. Community support services would be expanded with consistent eligibility criteria and user fees, and priority would be given to underserviced areas. While each area of the province would have flexibility in developing their own services, the government would establish criteria to determine a basic level of mandatory services.

Public Role

Health and Personal Support services were to be fully funded by government. Consumers could access homemaking services directly and contribute to cost if the service was not essential.

Public funding for community support services would increase from 70% to 100% of their approved budget less revenue from other sources. These services would include a co-payment by the consumer.

Eligible Clients

Both the elderly and the disabled were included under the reform proposal.

Delivery

Forty Service Coordination Agencies would be established across the province to replace and consolidate services provided by the Home Care Program and Placement Coordination Services Programs. Personal health and support services would be accessed through the SCA, while community support services could be accessed directly.

Preference for funding and contracts in this model was to be given to not-for-profit providers. Government was to extend pay equity requirements to all providers in the community, increase homemakers' wages, and assist displaced hospital workers access jobs in the expanded community sector.

Allocation

Funding envelopes would be established for each area of the province.

Funding for personal health and support services would be brokered by the SCA while community support services would continue to be funded directly by government. Direct funding pilot projects were introduced for people with disabilities to purchase their own attendant care.

The design decisions inherent in the SCA model were similar to the Liberal SAO model with the following exceptions: expanded public funding for community support services, a preference for not-for-profit agencies in the brokered SCA services, the same allocation mechanism except for the piloting of market-type mechanism for people with disabilities (direct funding and hiring of their own personal care attendants).

8.1.4 Multi-Service Agency (NDP, 1993)

Financing

Scope of Services:

Community support services for the first time were included in the basket of services to be provided by the MSA, that is, funding for both in-home and community support services would flow to the MSA.

Public Role

Health and Personal Support services would be fully funded by government.

Co-payments for community support services would be based on income and not assets as under the SAO model. Funding for In-home Health services was removed from the OHIP vote and combined with funding for support services to form the Community Services Funding Envelope.

Eligible Clients

The elderly, adults with physical disabilities, and people of any age who require health services at home or at school were included under this reform proposal.

Delivery

All community-based services would now be directly provided by the staff of MSAs which would be new not-for- profit agencies. The government through *Bill* 173 would exert considerable control over MSAs making them more or less quasi-public agencies. MSAs were restricted to 20% (originally 10%) of their budgets for the purchase of services external to the agency (the 80-20 rule). Preference for jobs in the new agencies was to go to unionized workers.

Allocation

Public funding of all community-based LTC services would now be administered by the MSAs, with approval required from government for allocation changes. With all service providers being employees of the agency and therefore no competition involved in the purchase of services, the allocation decision was moved even further towards the centrally planned end of the continuum than in the previous three models. Although there was technically a purchaser/provider split, with the MSA being a quasi-public agency, the distinction between purchaser and provider was blurred. While there was the limited potential for purchase of services from external providers, it was not clear on what basis this would be, that is, informal brokerage or competitive contracts.

The design decisions of the MSA model reflected in more ways than one the ideology of the NDP. Although financing actually moved no further towards the public end of the continuum, it did so in spirit through the inclusion of community support services in the basket of mandated services. The transfer of the home care services budget from OHIP to a capped envelope, however, would ultimately have grave consequences for the LTC consumer and appears to be an aberration in the NDP vision. Delivery of services moved heavily towards the not-for-profit end provided by quasi-public sector employees, with for-profit being marginalized by the 80-20 rule. Unions and their members would be protected and their rights promoted. The flow of funds from the funder to the provider took a decided turn toward the central command-and-control end of the allocation continuum.

8.1.5 Community Care Access Centres (Progressive Conservative, 1996)

Financing

Scope of Services:

The CCACs would determine eligibility and purchase the following services on behalf of consumers: professional services (nursing, rehabilitation therapy, medical supplies, etc.), homemaking services (housecleaning, laundry, shopping, etc.), and personal support services (physical assistance with those activities of daily living a person cannot perform on their own because of a permanent disability or illness). They would determine eligibility and manage access to Adult Day programs and placement in LTC facilities. The CCACs would also provide information, and if requested, refer consumers to community support services which are largely volunteer driven (meal services, transportation, home maintenance, and friendly visiting).

Public Role:

Funding for professional and personal support services arranged by CCACs would be allocated by the provincial government through envelope funding to the CCACs. These services would involve no user fee. Community support services which were once again outside of the CCAC envelope would be accessed directly by consumers and would be directly funded by the provincial government. Community support services and homemaking services might involve a user fee.

Eligible Clients:

The elderly, adults with physical disabilities, and people of any age who require health services at home or at school were clients of this reform model.

Delivery

The existing system of not-for-profit and for-profit providers would continue to provide services. Access to professional, homemaking and personal support services would be managed by CCACs. If requested, these centres would provide information and referral to community support services. However, consumers could access these latter services directly. Staff from the Home Care Programs and Placement Coordination Services would largely transfer to the new CCACs. Although these new agencies were required only to provide assessment, case management, placement coordination and referral services, during the three-year transition period staff of the CCACs could deliver other services directly.

Allocation

Funding for professional, homemaking and personal support services would be provided by government to CCACs through envelope funding. Rather than brokering or providing these services directly, CCACs would purchase them from both for-profit and not-for-profit agencies through a

managed competition. After an initial three-year transition period during which the market shares of existing providers would be protected in decreasing amounts, contracts were to be awarded based on best quality/best price. As a result, all existing service providers would have 90% of their 1995/96 Home Care volume protected in year one, 80% in year two, and 70% in year three. Thereafter, the not-for-profit and the for-profits would have to compete on an even playing field, including against out-of-country agencies who are currently poised at the border. The three-year transition period was intended to allow all providers, especially the not-for-profit agencies, to reach a level playing field in terms of competition based on best quality/best price. Quality, however, was tied to structural and process criteria rather than outcomes.[2]

Community support services were once again outside the envelope for the agency (CCAC) and were to be funded directly by government. The direct funding of pilot projects for people with disabilities would continue. There were still purchaser/provider splits for both types of services. While there were still centrally planned elements to the allocation dimension with respect to community support services, managed competition and direct funding for people with disabilities shifted allocation towards the market end of the continuum.

The Conservative model was similar in most respects to the second Liberal model, the SAO with a couple of notable exceptions. Unlike the earlier model, a competitive process replaced the informal brokerage method of allocation. In a sector where quality is hard to define, cost would be the variable that would determine successful bids. In this sort of environment, where workers' wages were the highest costs and where not-for-profit agencies paid better compensation packages, for-profit providers had the competitive edge. Workers and not-for-profit agencies were the big losers. If quality was sacrificed to competitive pricing, consumers were the ones who would ultimately suffer. In the long run, having widened the opening for commercial provision of services, even the Canadian for-profit providers may be pushed aside by American companies. But perhaps just as significant was a shift to the private domain in the financing dimension which was the result of action taken, not by the Harris government, but by the former NDP government.

Table 8.1 summarizes the differences across the models in financing, delivery and allocation. While there are differences in financing across the models, most of the differences across the models lie in the allocation and delivery dimensions. However, in the long run, it is a change in the financing of services that may have the biggest impact on the consumer. The transfer of the Home Care budget out of OHIP under *Bill 173* done for the purposes of integrating budgets and hence services, allowed the more market-driven Conservative government eventually to limit and contract the provision of publicly funded community care. Actions by the current Conservative government, occurring after

Table 8.1: Summary of Key Policy Design Decisions in LTC Reform				
Gov't	**Model**	**Financing**	**Allocation**	**Delivery**
Liberal (1987)	One-Stop Shop	*Who:* persons over age 65 *Public-Private Funding:* a) fully provincially funded services: in-home services (professional, homemaking), functional assessments, placement services b) public/private financing: community support services	new agency to broker (informal contracts and purchase of service agreements) in-home services from external providers; direct provincial funding for community support services; cooperative model; purhaser/provier split.	existing mix of for-profit and not-for-profit providers; One-Stop Access would provide information for all services, coordinate access to, deliver or purchase in-home services, and coordinate access to institutions.
(1990)	Service Access Organization (SAO)	*Who:* persons over 65 and disabled population *Public-Private Funding:* a)fully provincially funded services: in-home services; b) public/private financing : community support services (co-payments based on income rather than assets). c) regional funding envelope; d) capped budget for Home Care	SAO broker in-home services from external providers; direct provincial funding for community support services; cooperative model; purchaser/provider split.	existing mix of for-profit and not-for-profit providers; SAO would provide information for all services, coordinate access to, deliver or purchase in-home services, and coordinate access to institutions.
NDP (1991)	Service Coordination Agency (SCA)	(same as SAO) except community support services receive 100% of approved budget after revenues.	(same as SAO)	(same as SAO) except not-for-profit provider preference

Table 8.1: Summary of Key Policy Design Decisions in LTC Reform (cont'd)				
Gov"t	**Model**	**Financing**	**Allocation**	**Delivery**
(1993)	Multi-Service Agency (MSA)	*Who:* elderly and disabled population *Public-Private Funding:* a)fully provincially funded: in-home services, case management, placement. b) public/private financing: co-payments for community support services based on income c)MSAs must provide a defined basket of services which include community support services d) home care/support services in single capped budget	Regional planning; Government allocate all funding for both in-home and community support services to MSAs who pay salaried employees; cooperative model; no purchaser/provider split. People with disabilities funded directly to purchase their own services; market model; purchaser/provider split.	single not-for-profit agency (MSA) to provide *all* care; upto 20% of MSA budget for purchase of external service from for-profit and not-for-profit agencies
P.C. (1996)	Community Care Access Centre (CCAC)	*Who*: elderly and disability population *Public-Private Funding*: a) in-home services provincially funded; b) public/private financing: community support services; c) capped budget for home care	Government provides CCACs with budget to contract in-home services from external providers through competitive process; competitive market model; purchaser/provider split. Government fund community support service agencies directly; cooperative model; purchaser/provider split	Mix of for-profit and not-for-profit providers but managed competition contract process will likely give preference to for-profit agencies.

the period of time covered in this research, have in actuality placed eligibility restrictions on home care turning it from a fully insured service based on need to one that now has maximum hour limits. Those who have used up their allowable allotment will either have to do without or to pay for these services privately.

On the delivery dimension the differences among the models spanned the public-private continuum. The Liberal models left the balance between the private not-for-profit and private for-profit providers in place, thereby not moving the fulcrum along the continuum. The NDP models heavily favoured not-for-profit delivery with the MSA model approaching a quasi public agency. In the NDP reforms, the interests of organized labour were both protected and promoted. The impact of the Conservative model will likely favour the for-profit agencies at a cost to organized labour.

Allocation moved from the centrally planned end of the continuum under the Liberals, to even further down that extreme under the NDP, and then was shifted to the market end under the Conservatives.

8.2 Analysis of Design Decisions

Before evaluating each model along the three dimensions of financing, delivery and allocation, it is useful to revisit the values inherent in policy design; namely, equity, efficiency, liberty and security.

Equity, while often defined as equality, implies distributions that are regarded as fair even though they may contain both equalities and inequalities. In arguments about equity, one has to consider who the recipient of the benefit will be, what benefit is being distributed, and the process by which the benefit is distributed.

Efficiency is often defined as a comparison of inputs to outputs, costs to benefits. In arguments of efficiency, one needs to examine what is being included as an input versus an output, or a cost versus a benefit, and how it is being measured.

Liberty is often defined as choice. Here one needs to consider whose liberty or freedom of choice is being supported or promoted at whose expense.

Security is often defined as the satisfaction of minimum human needs. Here the issues include what needs should be met, who should be responsible for meeting these needs (the government or individuals), and how the financial burden of meeting these needs is distributed.

In analysing the three dimensions (financing, delivery, and allocation) of each government's proposed reforms of the community-based LTC sector, we draw upon the different interpretations of these values and the trade-offs, often implicit, amongst them for the various affected parties.

8.2.1 Financing

Financing issues were first of all focussed on the value/goal of security. Which services would be included in the basket of services, who would be eligible for these servies, which services would be publicly funded, and how would user fees be determined. When considering what services will be publicly funded, certain programs are considered "merit goods", in that they will be provided to everyone deemed to "need" them, regardless of ability to pay. This has been Canada's decision with respect to physician and most hospital services As has been pointed out by many economists,[3] market forces are not effective mechanisms for controlling costs if people cannot be priced out of the market as you have in situations where it is the responsibility of the individual to pay for their health care with the government funding services for those below a certain income. In such circumstances, multi-source funding serves to raise total costs, since there is a floor price (what government is willing to pay), but no ceiling. A public-private mix for services deemed "necessary", then, does not contain costs, but shifts them, either to consumers directly or to other insurers (and therefore to employers, who pay for most private insurance, and to their employees, who often pay for such coverage in foregone wages). In the long run, the total costs to society may stay the same but more likely increase, if the shift occurs to more expensive programs (e.g., foregone preventive care leading to emergency room visits or to institutionalization), or if providers are allowed to inflate charges to those able to pay. Those in between who can neither afford to purchase private insurance nor qualify for government coverage, end up doing without, often with adverse health implications. Financing issues in LTC thus become intertwined with the determination of which, if any, in-home and community services are deemed to be "merit" goods.

If one extends the principle of comprehensiveness of publicly funded services which is available to hospital and physician care under the *CHA* to all community-based services, including community support services, one risks evoking expectations that all services will be treated as merit goods. Many people with LTC needs require social supports, such as homemaking services or the provision of meals to continue living in the community. These are normally considered services which individuals are expected to take responsibility to provide for themselves. Realistically, however, needs for formally provided non-medical services, in particular, vary as a function of the individual's available social supports. An individual with strong family supports will have less need of homemaking or meals on wheels (although such families may require respite care). However, clients without family supports may deteriorate quicker without these services and require more expensive interventions that could have been prevented had community support services been

available. Nevertheless, simple acceptance of the *CHA* principles for community-based services might be a prescription for uncontrollable cost escalation.

In that connection, it is important to note that community support services were outside the rubric of all of the model agencies except the MSAs indicating clearly that these services were not to be treated like in-home services. Nor are they fully publicly funded in any other province's LTC system.[4] Within the MSA model, it was envisioned that there would be co-payments for these services. However, the inclusion of them in the mandated basket of services led many consumers and providers to believe that they would eventually be fully funded by government.

The meeting in Halifax in 1998 which was convened to discuss the possibility of a national home care program based on the recommendations of the National Forum on Health made it clear that it will be difficult to balance the expectations of the community-based sector (who are while hostile to a medical model wish full public financing for social support) against those who take a more limited view of public responsibility.

The five LTC models with respect to the financing dimension can be displayed schematically along a public/private continuum as follows:

Financing in LTC Models along the Public/Private Continuum

Public | ---------- | Private

MSA SCA One-Stop/ CCAC

SAO

It is important to note, as will be argued below, that the MSA model had the potential for being as close to the private end of the continuum as the Conservative CCAC model because of the decision to remove Home Care from the OHIP budget.

Whether budgets were capped or open-ended is a financing design decision which has implications for security. For services insured under the *Canada Health Act*, insured persons are entitled to receive all medically necessary services without extra charges. Providers therefore cannot respond to constrained budgets by refusing service to people seen as needing care, nor can they charge additional private fees. The *Act* speaks of "reasonable access" which it does not define. However, the legislation establishes a relatively clear barrier to denial of necessary care on purely budgetary grounds.

Not bound by the provisions of the *CHA*, Ontario had chosen in the past to provide many professional and homemaking services through its medical insurance plan (OHIP), thereby giving

home care the status of a quasi-entitlement. Under this system, Home Care Programs provided care to all eligible clients and the MOH covered budget over-runs. The NDP legislation, *Bill 173*, however, removed home care from the OHIP budget, and made it legally explicit that there was no longer any requirement that care must be provided. (The law mandated assessments, but not services.) Under the MSA and CCAC reforms, although it was intended that there would be no private charges for professional and homemaking services, it was/is explicit that budgets for home care services would be capped. If care is an entitlement as it used to be with professional and homemaking services, how do you reconcile entitlement with capped budgets? While services would be fully funded when provided, they may not necessarily be provided when needed. Indeed the Conservative Government provided CCACs and other approved agencies guidelines for setting service maximums.[5] In the summer of 1999, the Harris government quietly introduced regulations setting service maximums for home care services. The justification by government for removing home care from the OHIP budget and placing it within a capped LTC budget originally had been couched in efficiency terminology, that is, it is easier to integrate health and social services, to administer and deliver a continuum of care, as well as to reallocate funding among different types of services if all the budgets are in the same envelope. While integration and coordination may have been their intention, the NDP did not anticipate the eventual consequences when the Harris government took advantage of this decision and limited service. Security had been traded for efficiency by the new government.

This turned out to be a decision that not only affected universal access to home care services for the elderly and the disabled. As pointed out earlier, due to a number of factors, more and more acute care has been shifting from the hospital to the home. Long Term Care reform originally began as a reform of health and social services for seniors to help them maintain functional independence and to continue living in the community. It was later broadened to include people with disabilities. By the mid-1990s, the client population for LTC services included a high proportion of patients of all ages with acute care needs. Care, which was covered under Medicare and funded by OHIP, has now moved under the rubric of home care. Because CCAC budgets for in-home services are capped, clients with acute care needs have explicitly been given priority over those who were traditionally considered LTC clients, the frail elderly and the disabled.[6] With capped budgets and service maxima, care that was once under the protection of the *CHA* has moved to a sector where it can be de-insured or subject to user charges. The principles of universality and accessibility under the *CHA* are clearly compromised. The frail elderly and people with disabilities who do not have an acute care need and who are placed further down the priority list, will either do without service or purchase these services

privately if income permits. This situation is a clear example of privatization by attrition as described by Starr.

As described earlier, a number of committees from the Premier's Council on Health under the Liberal Government to the Health Services Restructuring Commission under the Harris Conservatives recommended a further allocation and reallocation of funds from the institutional sector to the community-based sector. Although each government promised an infusion of funds for community-based services, neither the amount or the timely flow of these resources was sufficient. Comparing the recommendations of the Health Services Restructuring Commission for the increase in funds to community-based services to the funds promised by the Harris government, Kushner showed that, in the worst case scenario, the Toronto CCAC would receive $14.5 million less over seven years from the provincial government[7]. The amount of funding clearly has implications for quality and volume of services. To the extent that either goal is deficient, the security of seniors and perhaps equity in their access will be affected. To the extent that insufficient community care leads to more expensive interventions, efficiency declines.

As a result, the government's efficiency in capping budgets, setting maximums, and underfunding of this sector is done at the expense of the consumers' security and equity, and more than likely at the expense of the efficiency of the health care sector, and often of the total economy via its impact on employers and on total health expenditures.

Equity in funding was an issue for all of the governments. Each government intended to address geographic inequities in the province by giving preference in the allocation of new funding to underserviced areas, and sector inequities by reallocating funds from hospital to community services budgets. The relative inability of community support agencies to raise private revenues through fundraising activities was recognized by the NDP government when they increased public funding of these agencies from 70% to 100% of their budgets less private revenues. All governments intended a uniform consumer co-payment for community support services, based on income and not assets.

Although accountability is a goal in itself perhaps closely linked to liberty and the freedom to participate in decision making, it can also be considered one that potentially promotes security. Through the political process, governments must answer to the populace for the actions they take. On the other hand, the decisions made in the private sector are held accountable to a much smaller constituency, the investors. When the financing of services is privatized, they are further removed from the scrutiny of government. In such circumstances, accountability for actions, which includes the maintenance of standards and quality, shifts from the public or political sphere to the private sphere dominated by investors who seek to maximize the rate of return on their investments. As

Tuohy[8] indicates when services are privatized, the effect of markets is to make technical efficiency the predominant objective, not to be sacrificed to other objectives such as allocative efficiency, equity or security. Decision making in the private sector is narrowly concentrated in closed boardrooms and not held to public scrutiny and possible consequences as it would be in the public sector. Security for the population in terms of accountable, open decision making is sacrificed to goals of efficiency and the security of a few.

8.2.2 Delivery

With respect to the public/private mix, the variations in the models had more to do with the balance between the for-profit and not-for-profit organizations within the largely private delivery system. Some researchers[9 10 11 12 13] have argued that not-for-profit delivery of complex services is inherently better in terms of both efficiency and quality than for-profit delivery. In health care and social support services where services are harder to predict, monitor, and evaluate, it is difficult to argue for the delivery of many of these services by commercial agencies.

Part of the reason for the failure of markets in health care has to do with risk selection and the profit motive. For-profit agencies, in order to generate profits, tend to provide service for low risk clients leaving the high risk ones for others; this is known as cream skimming or cherry picking. They also tend to enter markets that have a critical volume and therefore would not find it attractive to enter many rural or remote communities. It is also believed that they may sacrifice quality and workers' wages to remain competitive on price. Some have suggested that commercial agencies also indulge in gaming (manipulation of the rules to further an organization's own interests not intended by the rules) of the system and in inflating costs. As Woolhandler and Himmelstein have articulately argued, "Investor-owned hospitals maximize profits rather than minimize costs."[14]

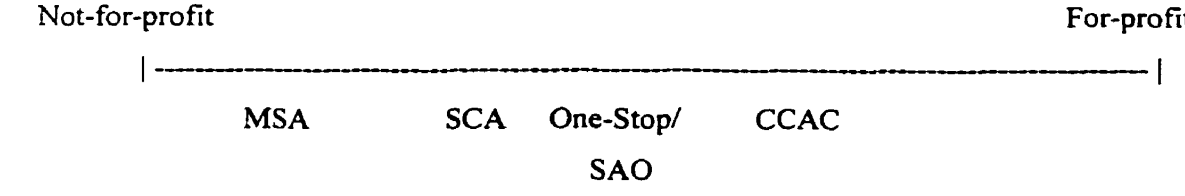
Researchers argue that not-for-profit providers often enter markets because they see a need as opposed to an opportunity for gain. In addition, not-for-profit providers are said to offer better employment packages for their employees (full-time employment with better salary and benefit packages, better training) and hence may be more expensive. Policy preferences favouring not-for-profit versus for-profit delivery appear to be linked to the ongoing debate about whether it is a public policy goal to ensure higher wages, better training, etc. or whether the goal is to get the most services for the lowest price.

The Liberals more or less intended to continue with the balance of for-profit and not-for-profit providers that existed at the time. The NDP in both their models designed their system as a not-for-profit one, severely limiting the for-profit providers, as well as bolstering organized labour. The MSA model however, had the potential to eliminate existing provider agencies (both for-profit and

not-for-profit) by making all workers employees of the MSA and to favour unions by encouraging the unionization of workers. The CCAC model employs competition to seek "best quality at best price"; however, without clear definitions of quality, some argue that the result is a strengthening of for-profit providers who undercut not-for-profit providers by paying lower wages and employing less skilled (and non-unionized) labour. Clearly, policy needs to balance costs and quality; to date, the relative performance of various providers has not been evaluated.[15]

Schematically, if one considers the eventual impact of the delivery design decisions on the make-up of the sector, the five models could have lain along a not-for-profit/for-profit continuum as follows:

Delivery in LTC Models along a Not-for-profit/ For-profit Continuum



Once again, this display is notional and based on speculation since at the time of the research all five models including the CCAC were theoretical models.

In the delivery dimension, efficiency was the policy goal most often invoked by all three governments. While competition in the CCAC model is seen to encourage the best price, lack of duplication in administering bodies under the MSA was viewed as the most effective way of reducing costs. Efficiency under the CCAC model, however, may be made at the cost of quality if the latter is not well-defined and given at least equal status with price. As a result security of consumers, as well as the security of not-for-profit providers(viability) and workers (wages) are in jeopardy. Efficiencies under the MSA model would have been made at the cost of security of all existing private providers (both not-for-profit and for-profit providers).

With respect to workers, the models have different implications. The question revolves around who should have first right to jobs in the new coordinating agencies. Should it be open to all health care workers, only displaced health care workers including those in the institutional sector, only displaced workers in the community sector, or only organized labour? Also should the existing wages and working conditions of workers be protected or enhanced in the reform?

The Liberal model more or less did not change the situation for workers.

However, through the preference for organized labour in the transfer of workers to the NDP MSA model, security for unionized workers was enhanced at the expense of equity and security for non-unionized workers. Moreover, the MSA was seen as a model, which would enhance the ability of labour to organize the entire sector. With the pendulum swing back under the Conservatives, organized labour is now threatened, as agencies in their drive for efficiency reduce their wage and benefit costs to remain competitive in the contract process.

While for-profit delivery in health care has not stood the test of empirical studies on either efficiency or quality, many view the generation of profits on the backs of the sick abhorrent. Objections to commercial delivery are based on the replacement of the traditional value system with a new one "that severs the communal roots and Samaritan traditions of hospitals, makes doctors and nurses the instruments of investors, and views patients as commodities."[16]

8.2.3 Allocation

In analyzing design decisions regarding allocation, there was one major issue which predominated the reforms- the mechanism for flowing public funds to service providers. As indicated none of the models with the exception of the CCACs ever got implemented and as a result, decisions on reimbursement methods and amounts were not made. Rather, decisions focused on whether it would be direct allocation from government to either provider organizations or individual providers; or whether government would allocate it through a mediating agency. If the latter, the basis on which this agency would allocate funds to providers was the decision point, that is, whether allocation would continue on an informal cooperative basis (brokerage) or through a formal competitive process (managed competition); or on the ability of providers to attract clients. In the first two methods clients follow money and in the last one money follows clients.

In each government's model, allocation of resources for some or all services would go through a mediating agency. With respect to in-home services, the funding was flowed to all the model agencies for these services. The difference lay in how the money was to be allocated to the service providers. Under the NDP MSA model, the purchaser and provider of services were the same, that is, all providers would be salaried employees of the MSA and funding would be allocated directly as a global budget by the provincial government to the MSA. On the allocation continuum, this was towards the centrally planned end.

Under the Liberal SAO or NDP SCA models, purchasers and providers were separate and allocation was on an informal contractual basis, and moved further along the continuum toward the market end.

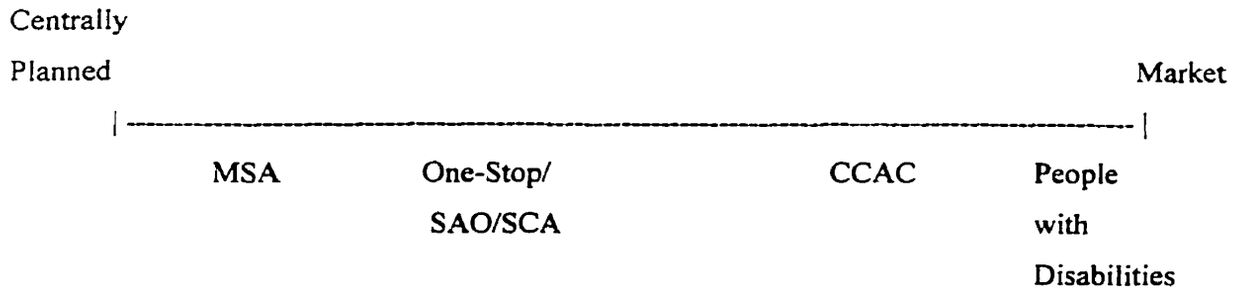
Under the Conservative CCAC models, there is also a purchaser/provider split but allocation is based on a formal competitive request for proposal (RFP) process; thus moving the model further along the continuum towards the market end. In all the models, clients follow the money.

Community support service providers were to be funded directly by government in all models. With the brokerage and managed competition models, these services lay outside the responsibilities of the model agency. With the MSA model, government flowed the funds to the agency since these service providers were their direct employees. In the former situation governments would decide on any reallocation between in-home and community support services. In the latter situation, the agency would make these decisions based on advice from its board and within government regulation.

While in all the services so far discussed, clients followed the money, there was one exception; namely, under a pilot project, people with disabilities were given direct funding to purchase their own services. In this instance, money followed the client.

Schematically, along a continuum from centrally planned allocation mechanisms at one end and market allocation mechanisms on the end, the five models would have lined up as follows:

Allocation in the LTC Models along a Continuum



In analyzing allocation policy decisions with respect to efficiencies, one has to look at the administrative costs of the process of allocation versus any savings that could accrue from the process. Transaction costs of formal contracts (staff time and resources needed for the process and to develop smooth working relationships with new providers) will probably be highest under the CCAC model, but efficiencies could be gained from competition on price as long as quality is not sacrificed. We have to remember that the highest costs associated with these services are labour costs. So any reduction in price will probably be achieved through a reduction in wages. These are already, comparatively speaking, low paid workers. In the interpretation of efficiency claims, those who argue for the efficiencies achieved through cost cutting of this nature consider wages as an input in the

cost/benefit analysis. Organized labour and social action groups, however, tend to see wages as an output. Efficiency for government gained through a competitive contractual process may be exacted at the expense of equity for and security of workers.

For service providers, losing a contract bid may threaten their viability, and accordingly, government's efficiency is gained at the cost of provider security. In a competitive process, information is an organization's private resource.[17] While competition may be viewed as a process that opens up the market, in other ways it closes it down. Efficiencies that could be attained through the cooperative sharing of information under either the Liberal or NDP model, are likely to be lost under the CCAC RFP process as agencies view their strategies as trade secrets for producing lower costs. This reflects a movement in the public/private dimension from open to closed. Or as others have indicated a movement in the privatization of policy information.[18] [19]

While the CCAC model might gain efficiencies on price, consumers are not interested in this type of efficiency if it results in a reduction in the quality of services and therefore, their security. While the MOH was to provide criteria and guidelines for quality in the contract process, the provincial Auditor's Report[20] of 1998 found that CCACs did not have to use them in the RFP process and could determine the weight assigned to any quality requirements in evaluating proposals. Without quality as a criterion, the only other dimension for evaluating contracts is price. As already stated, price can be cut by lowering workers' wages or by using lower skilled workers, both of which can affect quality. The Auditor's Report went on to recommend that the Ministry develop and implement standardized methods that CCACs could use to assess whether the quality of service requirements in their RFP are being met; evaluate its implementation and consider how often RFPs should be issued.

Choice is most relevant to the allocation dimension. The questions here are: What kind of choice are we talking about – choice on the part of consumers of provider agencies or individuals from those agencies who provide the care? How much choice is enough? Is choice more important than continuity of provider? Who gets to choose - the client or some mediating body? In LTC, choice may be more of a red herring. Consumers are largely made up by the frail elderly who lack the ability often to "voice" their interests or to "exit" from services that do not meet their needs.[21]

The NDP model most constrained choice of provider agencies since the MSA was the provider of all services. The amount of choice for the consumer under either the brokerage or managed competition models depends on the number of different providers of the same service that would be under contract with the coordinating agency, the frequency of the tendering process, and the amount of consumer input into the actual contract decision. With the managed competition model

of the Conservative Government, providers who are not successful in winning the contract, may not be fiscally viable in the future and therefore, choice of provider agencies for consumers over the long run may actually diminish.

In recognizing that people with disabilities had different needs from the elderly, all governments agreed, based on arguments of liberty (choice), to pilot a direct funding model whereby the disabled could hire and train their own attendants. Only in this latter instance does the client make the actual choice of provider.

8.3 Broader Implications of LTC Reform

What has and will happen in the LTC sector is indicative of pressures being exerted on services under Medicare and has implications for the future shape of our universal, publicly financed and largely not-for-profit delivered system. As stated earlier, cost shifting is occurring from the acute care sector to the LTC sector. As this care shifts, it is moving into a sector where for-profit financing and service provision have and will have a greater foothold. Furthermore, the private sector share of financing and for-profit delivery of services under the *CHA* has been increasing. This trend along with the movement of more and more acute care into the home and the changes in the LTC sector may alter the characteristics of health care in Canada.

The shift in the last decade of the twentieth century in the public/private mix in Canada's health care system is documented by evidence. The role of the private sector in health care financing has been increasing. From 1990 to 1997, the private share of total health expenditures increased from a little over 25% to 30.6%, the highest level since 1970. Since 1992 the increasing share of private expenditure has been due mainly to a leveling of public sector expenditure as a result of government fiscal policies. Canada was the only country compared to France, Germany, UK and US in which public health expenditures decreased as a share of GDP between 1990 and 1997.

In 1996, private spending for hospitals represented only 9.7% of total hospital expenditure, and private spending on physicians represented 1.1% of total spending on physician services. However, between 1991 and 1996, private expenditures for physician services increased at a rate of 5.9% annually, slightly higher than the average rate of increase in all private health expenditure during that time. By 1997, the private share of physician services had reached its highest level since 1986. This has been largely due to de-insuring of services formerly considered medically necessary and to the levering of annual service fees by approximately 4% of Canadian physicians. The private share of hospital expenditures has not grown much in the same period. That is probably due to the fact that public and private expenditures in hospitals are complementary rather than supplementary, that is, private spending in hospitals is dependent on public capacity. However, early discharge and

other strategies to produce efficiencies in acute care have created an increased reliance on private uncompensated sources of care.[22 23 24]

In an area of health care with mixed public and private sources of financing, namely drugs, total spending from both public and private sources, has escalated faster than any other sector. In 1997 drugs became the second largest category of total health expenditure, second only to hospital spending and overtaking spending on physician services. It is expected this growth and rank will continue in 1999. Moreover, the share of prescribed drugs financed from private sources has increased steadily since 1991, reaching an estimated 59.0% in 1997.[25]

While private sector expenditure for health care increased in all jurisdictions during the 1990s, Ontario experienced the steepest growth. Public sector spending decreased most sharply in Quebec and Alberta, but the decline in Ontario was the most protracted. In 1997, while 69.4% of Canadian health expenditure came from the public sector, in Ontario and Alberta, provinces with similar political ideologies, the public sector share was the lowest at 66.2% and 68.8% respectively. In 1999, Ontario is expected to have the lowest ranking. [26]

With respect to delivery, the Canadian health care system is predominantly private but largely not-for-profit. However, the pressures to increase the for-profit portion of delivery as stated in earlier sections do not necessarily result in poorer service. There are some areas where public financing of private, for-profit services may be both effective and efficient. Many Canadian hospitals have formed creative partnerships with the for-profit sector in areas such as cleaning and laundry services where cost-cutting is not done at the patient's health, although it may certainly be done at the cost of workers' wages and jobs. There are, however, examples of for-profit delivery of publicly-funded acute care services; e.g., cataract surgery in Alberta, hernia surgery in Ontario, and abortion services, to name a few. Despite the lack of evidence supporting the superiority, in terms of quality and efficiency, of for-profit over not-for-profit provision of acute care, the pressure for more is increasing. Actions, such as that proposed by Ralph Klein, the Premier of Alberta, to publicly fund for-profit clinics to perform certain surgical procedures is a recent example. Because of international trade agreements, these decisions may have important consequences not only for our not-for-profit delivered system, but also for our publicly financed system.

As Appleton[27] has indicated a number of measures such as the de-listing of publicly funded services, private companies that provide in-house patient medical evaluation for life or disability insurance, and shorter hospital stays that have shifted care into the home and to private deliverers, have increased the private component in Canada's health care system. What once used to be 'niche' markets for the private sector now has the potential to bleed into mainstream health care. These

changes allow interested parties, such as NAFTA investors like American-style HMOs, to force government's hand and allow them to operate in Canada. Once this occurs, it becomes difficult for the Canadian government to alter this course of action. Once ensconced in Canada, these market-based organizations will, as evidence shows, increase the cost of health care and slowly erode our single payer financed system through efforts to maximize profits and to increase market share. Given Klein's constant attempts to re-open the *Canada Health Act* to introduce private financing, one can only conclude that his current strategy is a back door approach to achieve his unsuccessful front door foray.

Along with the shifting site of acute care into a sector with private sector involvement, the Harris government's successful implementation of their LTC reform with its limits on formerly publicly financed home care services, the creation of a favourable environment for increased commercial delivery of care, and its focus on market allocation mechanisms has further increased the private component in Ontario's health care. What happens in LTC, therefore, may not just have implications for the traditional clients of this sector, seniors and people with disabilities, but also for the general population.

8.4 Conclusions

LTC Reform by each government shifted the balance of the public versus the private in both financing and delivery, and the allocative dimension towards either more centralized control or towards market instruments. As these shifts occurred, decision making and public accountability entered the closed doors of boardrooms. An era of cooperative sharing of best practices has been replaced by one where providers guard their successes. The lot of workers has worsened as their wages and working conditions become inputs into the cost-benefit equation. The restriction on service limits, eligibility criteria, and measurable quality criteria in the contracting process have threatened the safety of consumers. In the long run, the Harris reform may jeopardize the viability of Canadian not-for-profit and for-profit LTC providers as American companies find a more welcoming environment in Ontario.

The design decision in LTC reform were buttressed with calls to policy goals of equity, efficiency, security, and liberty. The reform models were buttressed by different meanings of these goals and inevitably, the promotion of one goal had impacts on the others. Which trade-offs prevailed depended on the relative influence of ideas, interests and institutions in the policy formation process. The next chapter will analyse the prevailing ideas, interests and institutions during the period of reform and the effect these constructs had in the LTC policy determination process.

[1] A version of this chapter appeared in Patricia M. Baranek et al. 1999. "Policy trade-offs in 'home care': the Ontario example." *Canadian Public Administration*, 42 (1): 69-92. and is reprinted with permission.

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Chapter 9

Ideas, Interests and Institutions

The reform of community-based services in the Ontario Long Term Care sector since the mid 1980s provides an excellent case study of the role of ideas, interests, institutions in providing insights and understanding of policy development and change. The argument of some academic traditions to champion one construct as having exclusive explanatory power of policy outcomes is intellectually weak. It is not that only ideas, or institutions, or interests matter. Rather, all three constructs are necessary. However, within different policy sectors or over time, the predominance of either ideas, interests or institutions varies. In this way, these three constructs and their relative influence provide understanding as to why certain forms of policy are possible within one policy sector and not another, and can also account for the dynamism in policy change over time. Furthermore, these constructs do not operate in a vacuum. Each can be either muted or made stronger by contingencies in the environment.

This chapter will use the constructs of ideas, policy interests and institutions, their interaction and influence relative to each other over time, to account for the shifts in the policy decisions in LTC reform over the eleven-year period. It will be argued that on the whole because of a weak network of societal interests in the community-based LTC policy sector, government ideology and government interests were able to predominate in the reform process. Societal interests that were supportive of the government's directions were reinforced and given preferential access. It was not only the internal resources or political power of these groups that allowed their interests to be furthered or protected. Rather, the promotion and acceptance of their interests was more dependent on the prevailing ideology and interests of the government in power. It was precisely because of the dominance of government ideas and policy interests that unlikely alliances among societal groups were formed. However, the permanence of alliances and their mutual interests were difficult to sustain given the shifting scope of reform when each new government introduced yet another model, which addressed a somewhat different set of societal interests. These coalitions, however, were not completely ineffectual. As will be shown, during the NDP period coalitions did slow the process down, contributing to the failure of the NDP reform. The new ideological mindset of the Conservative government would, however, reduce the ability of any societal interests in this sector to have either meaningful input or influence.

Institutions either facilitated or failed to constrain interests or ideology. Institutions in the form of existing legislation did not constrain any of the governments. Even *Bill 173* passed by the NDP government, the only LTC legislation introduced in this period, did not constrain but, rather facilitated the succeeding Conservative government in their reform efforts. Other institutions, such as

ministerial processes, were often shaped by prevalent ideas and allowed government to forward its interests. These new institutional structures were used to make certain actions possible and to shape new ways of thinking.

Ideas, interests and institutions are not deterministic. Policy is not developed in a vacuum, and even within a policy community of weak societal interests, governments are not entirely free to enforce their will. As Weir[1] has argued, they are bounded by contingencies in the political and economic environment which remove flexibility of action, make certain choices more feasible, close off other alternatives, and make different ideas more attractive.

9.1 Ideas, Interests and Institutions

In analyzing the reforms that took place in the LTC community-based sector, we need to account for marked swings in policy decisions. Rather than continuing on the Liberal or their own early path of incremental policy change in this sector, the NDP government designed a reform model which would have dramatically altered the existing service system. At a point in history when governments were responding to the calls of a neo-conservative agenda and the invocations to reinvent themselves by scaling back, de-regulating and privatizing services, the NDP government proposed a model which concentrated control and services under a government-type agency. One possible explanation is that the MSA reform was an aberration or fluke in Ontario's history of LTC reform. However, if the NDP model were merely an anomaly in an otherwise smooth unswerving trajectory of policy reform, we need to explain why the Progressive Conservative model introduced in 1996 was not a reversion to the earlier Liberal model. Rather it was a Liberal model with a definite pro-market twist.

Tuohy[2] theorizes that the relative structural and institutional stability of the Canadian health care system is due to its own distinctive logic in which collegial mechanisms and medical influence predominate. She contends that the *Canada Health Act* and the oversight control of the federal government through fiscal transfers as well as broad public support introduced institutional stability to our system not experienced in the US or Britain. This internal logic of the Canadian system worked to maintain its institutional mix and structural balance. The second-level agency relationship between the state and the medical profession, in particular, ensured the provision of services within considerations of cost and appropriateness. The accommodation between the state and the profession allowed the profession clinical control and the state budgetary control. According to Tuohy, despite the economic slowdown of the early 1990s, which gave rise to the creation of internal markets in health care in Britain and to merged markets of health insurance and health care delivery in the US, in Canada the system remained relatively unchanged.

Tuohy's analysis, however, does not take into account the changing nature and site of care, which involves a different policy community with a different relational network between the state and interested societal groups. The protection of medical and hospital services afforded by the *Canada Health Act* was never extended to home care and community support services. As argued in the last chapter, hospital budget constraints, which have resulted in shorter lengths of stay, and technological advancements, which have allowed for more care to be provided outside hospitals, have shifted publicly insured care from the protection of the federal legislation to an arena of greater volatility and provincial variation. Not only is more and more care shifting from the public to the private sector in both financing and delivery of health services, it is moving from open arenas of decision making, accountability and scrutiny to closed board rooms of private business.

The logic and professional-collegial systems dominant in physician and hospital care as described by Tuohy do not apply in the LTC policy sector. As Coleman and Skogstad[3] indicate, a policy community is shaped by three sets of structures: the autonomy and capacity of state agencies; the organizational development of sectoral interests; and the relationships or networks that develop between the state and societal actors. In the LTC community-based sector societal interests were diverse, loosely connected agencies and advocacy groups, largely without stable funding, large sources of revenue, administrative bureaucracies, or shared interests. The professional bureaucracy within government was knowledgeable and well informed in this sector. Without a strong force like a medical or hospital association as a counter-balance in the sub-government, the state was able to push forward its own agenda. Societal interests were privileged only if their agendas were in concert with the state's. As a result, this policy network consisted of a strong government and a weak, fragmented set of societal interests.

Existing state institutions such as the *CHA* and its associated fiscal penalties did not apply in this sector. While provincial legislation in LTC could have created an institutional context, which would further the interests of the government in power and constrain future governments, this was not the case in LTC. The Liberal government's model was not legislated, and hence it imposed no institutional brakes for the NDP government. Despite the passage of the NDP MSA model in *Bill 173*, it did not restrict the Harris Conservative government from furthering its agenda. The CCAC market model was established under the NDP legislation. Ironically, the transfer of the Home Care budget out of OHIP under *Bill 173,* done for the purposes of integrating budgets and hence services, allowed the more market-driven Conservative government eventually to limit and contract the provision of publicly funded community care. Actions by the current Conservative government, after the period of time covered in this research, have in actuality placed eligibility restrictions on home care turning it from a fully insured service based on need to one that now has maximum hour limits and is reserved

for the acutely ill. Those who have used up their allowable allotment will either have to do without or to pay for these services privately. As a result, the intended consumers of LTC reform are no longer seniors or the disabled with long term needs, but people of all ages with acute care requirements.

While legislation was not able to constrain the provincial governments, this does not mean that institutions did not play a role in shaping some aspects of reform. The weak sub government in the LTC policy community also does not mean that interests were not meaningful. Within context of economic and political contingencies, each had a varying role to play in accounting for the changes in policy. Moreover, the prevalence of a set of ideas, interests and institutions in one period had an influence on the meanings and dynamics of the three in the next period. The remaining sections of the chapter will summarize and analyze the role of each construct throughout the history of this period.

9.2 Summary of the Dynamics of Ideas, Interests, and Institutions between 1985-1996

9.2.1 Liberal Period

The two Liberal government mandates marked a period of measured incremental change in the LTC policy sector. Spurred by concerns of an aging population and the potential call on future spending given the existing mode of caring for seniors in institutions, the new government decided, as had the previous Conservative government, that keeping seniors in the community for as long as possible was more cost-effective. Moreover, if the prevention of deterioration and institutionalization of seniors was the goal, social supports were at least as important as health care. This approach was in keeping with the growing awareness of the importance of prevention versus cure and health as being more than the absence of disease. Community and home care, and health as well as social supports were, therefore, going to be important in the new approach.

Community-based services were fragmented, uncoordinated, and difficult to access. The majority (80%) of the provincial budget for community services was spent on home health care, whereas the majority of care was provided by either the volunteer social support sector or families. Reform of this sector was necessary if its emphasis on health care was to change to social services, and if access and efficiency were to improve.

The Liberal's main policy interests were to de-medicalize the community sector and to integrate and coordinate access to these services. These interests were achieved through institutional structures that were put in place within and outside of government. The former they achieved by channeling the process for reform away from the Ministry of Health, and giving the lead for reform first to the Office for Senior Citizens' Affairs and then to the Ministry of Community and Social Services.

It was further recognized that integration of services at the community level would first require structural changes within government. This was achieved through the dual reporting

relationship of the Assistant Deputy Ministers in MOH and MCSS responsible for LTC community services to both Deputy Ministers. This structure was eventually replaced with a single division for LTC services with one Assistant Deputy Minister who reported to both Deputies.

Integration and coordination of services at the community level was to be achieved through the One-Stop Access agency, which was superseded by the Service Access Organization. In both instances, institutions were designed to further the Liberal's policy interests and their belief in the necessity to shift away from the medical model of care for seniors.

Two environmental contingencies influenced Liberal decisions. Constrained by a coalition with the NDP in their first mandate, the Liberal's first model (One-Stop Access) was little more than tinkering with the existing system. They cautiously introduced pilot projects to test out the new model and allowed the flexibility for each model to be developed according to the needs of the particular community.

Although they obtained a majority for their second mandate, by 1989 when the Liberals introduced their second model, SAO, they were becoming aware of an impending recession. As a result, they knew that there would be hard and unpopular decisions to make in the near future. Their decision to call an early election in this mandate based on their desire to take advantage of their present popularity would allow them to ride through the recession. Hence, their second LTC model was as cautious as their first one, again proposing incremental changes, leaving the hard actions, such as the transfer of home care from the OHIP budget to a capped envelope, to some unspecified future date in their next mandate.

Societal interests during the Liberal period were most fragmented. Home Care programs and not-for-profit professional agencies were perceived to dominate. However, the not-for-profit support agencies recognized the need to pool their resources to gain a greater influence in the policy community. At the end of the second Liberal mandate, they formed the Ontario Community Support Association and a capability to respond more coherently to policy issues on behalf of this sector. Advocacy groups for seniors, persons with disabilities, or the ethnocultural community at this stage remained largely as single disparate agencies. The large health associations such as the OMA and the OHA either felt they had little interest in reform or were otherwise occupied, for example, fighting the physician extra-billing issue. Given the gradual and minimal approach of the government, there was little in the reforms to arouse societal interests. Even had they wished to oppose the Liberal reform, societal groups were too fragmented to mount a coherent opposition. As a result, the shape of the sub government and the relative power balance of groups within it did not alter to any great extent during this period.

9.2.2 NDP Period

With the Liberal call for an election in 1990, Ontarians elected an NDP majority government. Their election as a government was a first in Ontario history and a surprise to everyone including their own candidates. Not well-prepared to govern, their first LTC model was very similar to the second Liberal one, no doubt because it continued to be developed in the bureaucracy. It had some elements, however, that were more in keeping with NDP beliefs; namely, it increased funding for community support organizations from 70% to 100% of an agency's approved budget after deducting revenue from other sources, it made a number of concessions to workers, and it indicated a preference for not-for-profit delivery. Although the lead for reform continued with MCSS, in 1992 it was switched to the MOH and the amalgamated LTC division now reported only to the Minister of Health. This move was probably sparked more by the relative strength of the Minister of Health, Frances Lankin, versus the new Minister of Community and Support Services, Marion Boyd. With LTC as a 'signature priority' of the NDP government, Frances Lankin was believed to be able to get the job done. With their elaborate public consultations, the NDP had bought some time to formulate their own unique approach. To ensure no resistance from the bureaucracy, their second model, the MSA, was drafted in the Minister of Health's office and represented a marked departure from the SCA model. The MSA reflected more their political ideology and policy interest in that it gave preference to organized labour and community support services. More importantly, it centralized delivery under one administrative structure and gave the Minister of Health considerable powers over the new model agency.

Their massive public consultation, as well as the funding of the SCCA, OSCA and the OFL, were all in keeping with NDP beliefs in participatory democracy and community empowerment, and their ties to the social support sector and labour. Moreover, preference in the consultations was given to consumers and frontline workers. These actions were viewed with considerable skepticism by most groups in the policy community. It was believed that when these favoured groups spoke, rather than being empowered to voice their own beliefs, they were merely puppets mouthing the government's mantra.

The constraining factor during the NDP period was the economic position in which the province found itself. The deficit was rising, the recession had hit by 1992 thereby reducing government revenues, and Ontario was losing its credit rating status. Unlike other provincial governments including the later Harris Conservative government, the Rae government did not make its spending cuts early enough in their mandate, which might have given them time to try and build support for the necessity of the cuts, and possibly to increase spending towards the end of their mandate. For example, the new Romanov government in Saskatchewan, discovering when they took

office that the province's deficit was $850 million and not the $265 million they were led to believe by the previous government, appointed a Royal Commission to look into the economic state of the province. The inquiry helped convince the public that urgent and drastic actions were required.[4] The NDP took the approach of a 'Keynesian deficit" in their first budget, that is, to spend its way out of the recession. However, they quickly discovered they could not maintain this level of spending with the drop in revenues due to cuts in federal transfers and the recession.

The Expenditure Control Plan, which included raising taxes and reducing government expenditures, along with the Social Contract both introduced in 1993, were to save the province $6 billion in that fiscal year. There were other impacts, however, other than government savings. Both sets of actions alienated the public sector unions. Although the government's intent in their action was to preserve jobs, employees had to take unpaid days off which meant breaching existing negotiated agreements. The labour movement did not forgive their party for this action and withdrew their support during the 1995 election. Needing to appease labour during their tenure, the government made concessions to them in *Bill 173*, which redrew boundaries and the scope of conflict[5], awakened other opposition and turned formerly supportive groups, such as the OCSA, against the legislation.

The Social Contract also had the other unintended effect of bringing together in one room societal interests who rarely had a chance to meet. The amalgamation of agencies under the MSA provided common interests to otherwise disparate groups, namely, the for-profit and not-for-profit providers, and the Social Contract process gave them the opportunity to recognize each other and their commonalities.

In the end the NDP was able to push their legislation through but it was slowed down considerably by processes and decisions that reflected their beliefs in community empowerment, participatory democracy and the preservation of jobs. The public consultation broadened the scope of conflict and meant that legislation was not introduced until the last year of their mandate. The deficit reduction plans were also undertaken too late in their mandate. The Social Contract process provided an avenue for societal interests to coalesce and further slow down passage of the legislation. Despite this opposition, the NDP were able to legislate a model which gave the promise of increasing public, as opposed to private, financing and delivery, and a top-down, command-and-control allocation mechanism. However, although the NDP were able to press through their reform, it was a Pyrrhic victory. They did not have an opportunity to implement their reforms before the election was called. Without administrative structures in place, the Harris Conservatives were given broad latitude.

9.2.3 The Progressive Conservatives

The Conservatives were clear before they were elected that their agenda was going to be retrenchment, less government and more market mechanisms. Their ideology was very much

coloured with an anti-political, anti-government brush. Within LTC, their policy interests were to dismantle the ideologically offending pieces of *Bill 173* – the MSAs, the labour adjustment policies and the 80-20 rule for external purchase – and bring the LTC sector to market.

Every action they took was to speed the implementation of their vision for reform of this sector and to eliminate or put up barriers to special interest lobby groups, which could slow the process down. Both of these strategies, had they been taken, could have ensured greater success for the NDP in their reform efforts. But these were actions that would have offended core NDP beliefs.

The Conservatives conducted a quick and highly circumscribed (in terms of who was invited to participate and the agenda for discussion) consultation and announced the implementation of CCACs within months of assuming office. They centralized policy decision-making within the political arm of government, so much so that most respondents believed policy was being formulated in the Premier's Office. The involvement of the Premier's Office was believed to ensure that policies were in keeping with the spirit and letter of the *Common Sense Revolution.*

On the whole, in keeping with their anti-political and what some would believe their anti-democratic ideology, they insulated themselves from the pressure of interest groups. They created a barrier between societal interests and the Minister of Health's Office by giving responsibility for the consultation to a Parliamentary Assistant and by giving implementation of reform to a Minister without Portfolio. The withdrawal of funding support from government and the reduced access to government decreased the ability of all groups, including those formerly favoured under the NDP (the SCCA, OCSA and organized labour) to have an impact. Moreover, the actions of government in other policy sectors, which were perceived as more deleterious by organized labour, diverted their attention away from the reform of LTC. The coalition of providers that had formed under the NDP mandate, the Group for LTC, dissolved when competition rather than cooperation was the order of the day. Although the government did have the support of some groups, namely the for-profit providers, opposing interests were not able to mobilize an effective counter-attack.

The legacy of the Harris government's reforms is being played out. Their reform, aided by institutional structures they introduced, will shift financing and delivery to the private, market side of the public-private divide, and allocation to the market end with its emphasis on price and undefined quality.

9.3 The Explanatory Capability of Each Construct

As stated throughout, ideas, interests, and institutions are together important in understanding policy formation and change. Their relative influence varies depending on the policy sector and over time. In the community-based LTC sector, although societal interests and institutions had a role, government ideology was predominant in reform in this eleven-year period. This section considers

the alternative possibilities if institutions or societal interests were to dominate reform and, finally, lays out the argument for the predominance of government ideology to explain LTC policy.

9.3.1 If Institutions Were to Predominate

If institutions were the *predominant* influence in LTC reform, they would need to be able to account for more of the actions taken than they do.

In the federal/provincial context, the *Canada Health Act* and the associated penalties did not confine the contours of reform as it had and has in hospital and physician care sectors. Rather, the absence of any restraining effect in the *Act* gave each government considerable latitude in putting forward reform models that reflected their different ideological perspectives.

Furthermore, none of the reforms introduced by each government constrained the next. As stated earlier, only the NDP MSA model was drafted into legislation. However, it did not foreclose any avenues for the Conservative government. In fact, it made possible actions the NDP government may not have intended, such as restricting home care budgets and transforming home care into a substitute for acute care after the closure of hospital beds. In this policy sector, each government was able to ignore or negate the actions of the previous one and put forward policy models that were markedly different.

It is not that institutions had no effect. Rather, they can account for less than ideas. They are a second order influence shaped by government ideology and government interests to further the latter two. Particular federal and provincial institutions in some instances did reduce governments' abilities to manoeuvre and in others, did allow certain actions. While the *EPF* transfer pertained only to post secondary education and hospital and physician services, the fact that the federal grant flowed into provincial general revenues meant that federal cuts indirectly reduced the provincial government's flexibility in introducing program changes in other areas. In the economic environment of the early 1990s and with health being the largest provincial expenditure, the Ontario governments needed to ensure affordability and predictability of expenditures. With less ability to institute cost saving measures in acute and primary care due to strong restraining institutions and societal interests in those respective policy sectors, the provincial government turned to other sectors, such as LTC. The transfer of the home care budget into capped envelopes either intended or actually carried out by the three governments is one such instance. Whether the intention was cost control or the ability to integrate services and reallocate funds based on local needs is hard to answer. Only the current Harris government has made its motive clear by introducing eligibility criteria and service maximums to contain costs. There were no federal levers available to penalize subsequent reduced access. The actions of the Liberal and NDP governments in other areas of community-based LTC reform would suggest that their motive for this decision had more to do with integration. The creation of a budget

envelope for community-based services was an example of an institutional measure whose size, make-up, and subsequent effect will depend on the belief system of the government of the day regarding the appropriate role of the state in the provision of these services.

Consultation, as an institutional process was once again more reflective of government ideology, the result of which was not always intended. The NDP consultation, while intended to increase participation by all groups, especially formerly marginalized groups, resulted in delays that were critically damaging in their attempt to launch the MSA. The Harris mini-consultation while critical in controlling the scope of conflict and quickening the implementation of reform, reflected an ideology of the need to minimize special interest lobby and public participation in the governing process.

Government interests were also put in place through institutional means. The de-medicalization of community services was effected through the channeling of reform away from the Ministry of Health. Integration of services was reinforced through the incremental steps of bringing together, first within government and then within the community, the LTC community services some of which were under the Ministry of Community and Social Services and others of which were under the Ministry of Health.

Like the strategies for de-medicalization and integration, the extent of each government's direct management of policy development was dependent on their need to further their own interests and beliefs. Under the Liberals, policy was developed within the bureaucracy because beliefs about the shape of a reformed system between the government and the bureaucrats were mutual and did not differ markedly from the one that had evolved through the years. During the early NDP period, policy development remained within the bureaucracy, accounting for the similarities between the SAO and SCA model. This was not so much a result of mutual interest but rather the fact that the new government was in a steep learning curve phase on how to govern and was not prepared for action in this sector. In time when their own ideas were better formulated, the development of reform was taken away from the bureaucracy and handled within the Minister of Health's office by her political staff who drafted the MSA policy documents. Under the Harris Conservatives, reform was shaped either within the office of the Minister of Health or even more centrally within the Premier's Office. The *Common Sense Agenda* was the blueprint for everything that happened in the Harris government and the Premier was micromanaging his cabinet to ensure compliance with the overall Conservative agenda.

In the LTC policy sector there were no government institutions in place or that were introduced that could forcibly check future government direction. Clearly, the fact that governments, because of the absence of institutional structures, were largely unconstrained in reforming LTC as

they were in other sectors provides evidence of the importance of institutions. Institutions did, however, have a supporting role to play in this sector. They were strategically introduced by each government to facilitate the shape of some aspects of reform, which were in keeping with their own interests and visions for a new LTC sector.

9.3.2 If Interests Were to Predominate

If societal interests were the predominant influence in the development of LTC policy, why did the seemingly dominant groups during each government mandate not prevail in the others? Why was there so much volatility in alliance formation and breakdown during this period? As already stated in this research, the community-based LTC policy community consisted of a number of small agencies, a few larger more stable organizations such as Victorian Order of Nurses and the Red Cross, and numerous advocacy groups representing one-off consumer interests. There were no well-funded provider organizations like the Ontario Hospital Association or professional organizations like the Ontario Medical Association.

Under the Liberals the Home Care Programs and professional provider agencies such as the VON were viewed as most influential. Under the NDP, it was the not-for-profit home support agencies under the Ontario Community Support Association and seniors under the newly formed Senior Citizens' Consumer Alliance. Later on, organized labour was viewed as having an influence. Under the Harris Conservatives, it was the for-profit provider agencies. Each was given preferential access under different governments and each lost their access when governments changed.

Access and the perceived influence of groups had more to do with the interests and vision they shared with the government of the day. The NDP funded OCSA, SCCA and labour to form alliances, and to consult their members. These organizations shared a belief with government in a strong labour movement and grass roots organizations. The fact that the power of societal interests to sway government was more virtual than real is evident in the fact that when OCSA withdrew its support from the MSA legislation, it was not successful in getting the NDP to change its model. The SCCA turned out to be a one-interest group which, when government support evaporated, so did they. Ethno-cultural organizations which had a voice, even if a rather small one, under the Liberals and NDP found it diminished under the Conservatives who rejected special interest groups looking for a leg up.

The instability of coalitions also illustrates the relative ineffectiveness of societal groups to further their policy interests. Groups, such as the VON and St. Elizabeth's which were influential under the Liberal government had to form unlikely partnerships with the for-profit providers in an attempt to overturn *Bill 173* which would have resulted in their expropriation. This partnership died with the election of the Progressive Conservatives when mutual interests evaporated. Similarly,

OCSA's inability to maintain its support for the NDP legislation had to do with its inability to come to a consensus position for its association given the differing structures, resources and markets of its individual members.

The distinction between saying interest groups were not powerful and saying that the concept of interests is powerful is key. Once again, it is not that societal interests were not important but that they were not the predominant force in this sector. Their relative weakness allowed governments to be more forceful. Governments supported groups that held common ideas and interests. Ultimately, the support of groups that were perceived as dominating in each mandate was used by government to legitimate their own interests and reforms. That governments require external validation to promote their credibility lends support to the importance of societal interests in policy formation. That governments could act despite the withdrawal of support from its allies indicates the relative strength of the government with respect to the sub government in this policy sector.

9.3.3 Ideas Did Predominate

The reform of LTC was largely dominated by ideas about health care current in the period and by the ideological stripe of the government. However, ideas did not run rampant. They were, as stated earlier, modified and advanced somewhat by interests, institutions and contingencies in the environment. Nevertheless, ideas are the critical factor in explaining LTC policy development and change.

The paradigm shift in health care away from the medical model to a population health model, which emphasized health promotion and disease prevention, can account for some of government's decisions. While the interest in cost saving was certainly a factor given the aging of the population, the shift away from a medical model was driven by the belief in the diminishing returns of any further investment in medical interventions. The involvement of government ministries and the decision of which ministry would have lead responsibility for LTC reform was guided by these ideas. The expansion of community support services by the Liberal and NDP governments in particular reflects the conviction of the role of these services in promoting health and preventing further deterioration and more costly interventions down the road. Certainly these ideas were promoted through institutions, such as the Premier's Councils and the internal processes of government.

Beliefs in participatory democracy and the empowerment of the public, especially marginal groups prompted the NDP government to undertake one of the most ambitious consultations in Ontario history and to provide funds for the mobilization of formerly less heard voices. These same beliefs were reflected in the Bill of Rights and the representation of marginalized groups on planning and administering bodies under *Bill 173*. Conversely, the suspicion of government and the belief that every interest was a special interest lobby led the Harris Conservatives to orchestrate a highly

constrained and time limited consultation and to drop the funding of special interest groups. The mistrust of interest groups inspired this government, as argued in Chapter 7, also to create institutional barriers to these groups.

The not-for-profit preference in the delivery of services in both NDP models, the amalgamation of most providers of care under the MSAs, more centralized planning structures and the increase in funding for community support services to 100% of their approved budgets less revenues were consistent with the NDP belief in an expanded role for government, the role of community grass roots organizations, and a distrust of the profit motive. Conversely, a mistrust of government and a strong conviction in the efficiency of competitive contracts and market mechanisms prompted the Conservative CCAC model, along with the halting of those aspects of the NDP legislation that were offensive to the new ideology, namely, the not-for-profit preference, the labour adjustment sections, and the 80-20 rule.

The support or non-support of organized labour was also highly ideological. The NDP even in their first model, the SCA, were going to introduce measures to further or to protect the position of workers. Certainly, the adjustment measures in the MSA legislation and during the policy development process, for example, jobs for unionized workers, representation on boards, and the funding of labour groups, favoured organized labour over other workers. In fact, there was considerable consensus in the policy community that LTC reform under the NDP had more to do with creating an environment and context which was favourable to the unionization of the sector than correcting the ills of the system. Although these measures may have been recompense for the enactment of the Social Contract, the need and inclination to support labour was undeniable. Even the Social Contract was motivated not only to reduce the government deficit, but also to preserve jobs. The Harris Conservatives reversed these policies, developing a model which would seriously disadvantage all workers. In the competition for contracts where only price is well-defined, the only area for driving costs down is in compensation packages and working conditions for workers. Without a doubt, non-unionized workplaces are better able to achieve this.

All the examples given above come from the more ideologically extreme governments, the NDP and the Conservatives. Many in the policy community have argued that the Liberal government's reforms and the way in which they went about it, were incremental because the status quo more closely represented a liberal ideology. Basically a middle-of-the road approach resulted in a model which was a modest tinkering of the existing system of for-profit and not-for-profit providers, and a flexible, cooperative process to the issuing of contracts.

9.4 Implications and Final Conclusions

This research provides two important insights and conclusions. One concerns the policy process and the other, policy content. The two, however, are inextricably linked. First, the research brings further understanding to the nature of policy development in general and provides evidence into the nature of policy development in the particular policy sector of community-based LTC services. Through the examination of LTC reform as a case study, this work tests and lends support to the theoretical framework that highlights the importance of all three constructs, ideas, interests and institutions, in understanding policy development. Although empirically the relative influence or configuration of the three may vary across policy sectors or over time in one policy sector, none alone is sufficient in explaining change. Indeed, within LTC, policy change is elucidated by the difference in strength of influence of one factor over the other two. Only a consideration of all three, however, can explain the different dynamics in this policy sector in the eleven-year period.

Unlike other health policy sectors such as hospital care and physician services, the influence of ideas and interests of the state predominated over societal interests and institutions. Because of a network of loosely connected and fragmented societal groups not strong enough to check the state's actions, and the lack of institutional constraint from the *Canada Health Act*, each government was able to introduce reforms reflecting their own interests and ideology. Institutions had a steering effect for implementing the interests and ideology of the government in power but not constraining the next. Unlike the policy sectors protected by the *CHA*, this sector experienced extreme volatility in reform when the ideological stripe of each new government changed. However, if the future of the LTC sector is dominated by for-profit delivery and in particular, large American nationals, the dynamics of the three constructs in this sector are likely to change. The power balance between the government and the subgovernment will alter, as these commercial agencies become a force with which governments must contend. The theoretical framework, furthermore, is promising and useful in understanding future changes in Canadian health care, which will witness shifts across policy sectors.

Second, the research documents the need to examine the decisions on the three design dimensions of financing, delivery and allocation along a public-private continuum for the first two, and along a continuum between central and market mechanisms for the last. In LTC reform, the bottom line issue was about drawing boundaries between public and private and the appropriate role of the state in the financing and provision of these services. Where the line was drawn along the three dimensions was not neutral and largely reflected the ideology of the government of the day.

When the Ontario government began looking at remodelling community-based LTC services in the early to mid 1980s, they were mainly concerned with reforming services for the elderly. In the late 1980s, reform was expanded to include people living with disabilities. Between the mid 1980s to

today, but especially under the current Conservative government, hospital restructuring and medical and technological advancements have shifted more and more acute care and the associated costs from the hospital sector into the community sector. As a result, the home care population is changing to include a larger proportion of acute care patients.

The reform of LTC community-based services has implications for the future pattern of Canada's health care system. The movement of more acute care from hospitals to the home is leading to a passive privatization of formerly insured services either to private payer systems or by increasing the burden on family caregivers, and from a not-for-profit delivered system to one that will favour for-profits. That this is already occurring is supported by data. As this shift occurs, the accountability for an effective health care system shifts from the public sphere of government to the private and closed boardrooms of Canadian and offshore companies.

Ironically, the pursuit of governments and interest groups to de-medicalize community-based care in the 1980s and 1990s may end in a debate to re-medicalize it in order to include it within the definition of insured services and the protection of institutional mechanisms. As Aaron Wildavsky[6] argues, you don't solve complex policy issues, you replace one set of problems with another. If you are successful, you will prefer the new problems to the old ones. In LTC reform, we may not have been so lucky.

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[1] M. Weir, 1992. *Politics and Jobs: The Boundaries of Employment Policy in the United States.* Princeton, N.J.: Princeton University Press.
[2] Tuohy, C., 1999. *ibid.*
[3] Coleman, W. & G. Skogstad, (eds) 1990. *Policy Communities and Public Policy in Canada: A Structural Approach.* Mississauga: Copp Clark Pitman Ltd.
[4] A. Blakeney & S. Borins, 1998. *Political Management in Canada.* 2nd Edition. Toronto: University of Toronto Press.
[5] Schattschneider, E. 1960. *The Semisovereign People: A Realist's View of Democracy in America.* N.Y.: Holt, Rinehart, & Winston.
[6] A. Wildavsky, *Speaking Truth to Power: The Art and Craft of Policy Analysis.* (Boston, Mass: Little Brown and Company, 1979).

Appendix A

Interview Schedule

Long Term Care Reform in Ontario
Interview Questionnaire

I am a Ph.D. candidate in the Department of Health Administration at the University of Toronto. My doctoral thesis is an examination of Long Term Care reform in Ontario beginning with the reforms proposed by the Liberal government under David Peterson (1985-1990), and those proposed by the NDP government under Bob Rae (1990-1995), and those proposed by the Conservative government under Mike Harris. I wish to ask you questions about your involvement in the reforms, your views about the different government proposals, and the process of reform. The information you provide will be confidential. Any reference to the information you provide in answer to these questions will not be attributed to either you or your organization.

1. How long have you personally been involved in the LTC reform? *Probe if personal involvement spanned the different reform periods.*

2. With which organization were you involved during the Liberal/NDP/Conservative reform periods?

Liberal Reform

As you may recall, the Liberal government released two documents outlining their proposals for reforming the LTC sector. In 1986, they released *A New Agenda* which came up with the model called One-Stop Shopping. Then, in 1990, they released the document, *Strategies for Change*, which proposed Service Access Organizations (SAO).**(Card 1)**

1. What do you consider to be the most important features of the SAO model?

2. What did you *(your organization?)* like about the model? What did you *(your organization?)* dislike about it?

3. What do you think the government's main interests were in reform and in proposing the SAO model?

4. Was your organization involved in the reform of LTC under the Liberal government? When and Why did your organization decide to get involved in the reform?

5. What actions did it take? **(Card *2)***

6. What was your organization trying to accomplish with these actions? Which strategies were most effective? Why?

7. If your organization formed alliances with other groups during this period, when and with whom? What were your group's interests in forming the alliance? What interests did you share in common with the other group(s)? What influence, if any, did this alliance have on the reform? Does the alliance still exist? If not, when did it cease to exist, and why?

8. During this period of reform, if your organization tried to meet/have contact with the government, with whom did you try to meet? Were you successful in meeting with the intended party? If not, with whom did you meet? *Probe whether the contact was in the political or bureaucratic side of government and the level of the contact.* Were you ever approached by government? For what reason?

9. Which organizations do you feel were most influential in the reform during this period? Why? What were their interests?

10. Overall, do you feel your organization had any influence on the reform? In what way? Was your organization's views on LTC reform altered by its participation? In what way?

11. How successful do you feel the government was in meeting its own interests?

NDP Reform

In October 1990, the NDP formed the government. During their tenure, they released a number of policy documents on LTC reform. In 1991, they released *Redirection of Long Term Care and Support Services in Ontario* which proposed the Service Coordination Agency (SCA). After a lengthy consultation, they released in 1993 a set of four documents outlining their proposed reform model, the Multi-Service Agency (MSA). ***(Card 1))***

1. What do you consider to be the most important features of the MSA model?

2. What did you like about the MSA model? What did you dislike about it?

3. What do you think were the government's main interest in reform and in proposing the MSA model?

4. Was your organization involved in the reform of LTC under the NDP government? When and Why did your organization decide to get involved/stay involved in the reform during this period?

5. What actions did your organization take to try and influence this reform? ***(Card 2)***

6. What was your organization trying to accomplish with these strategies? Which strategies were most effective? Why?

7. If your organization formed alliances with other groups during this period, when and with whom? What were your group's interests in forming the alliance? What interests did you share in common with the other group(s)? What influence, if any, did this alliance have on the reform? Does the alliance still exist? If not, when did it cease to exist, and why?

8. During this period of reform, if your organization tried to meet/have contact with government, with whom did you try to meet? Were you successful? If not, with whom did you meet? *Probe whether the contact was in the political or bureaucratic side of government and the level of the contact.* Were you ever approached by government? For what reason?

9. Which organizations do you feel were most influential in the reform during this period? Why? What were their interests.

10. Overall, do you feel your organization had any influence on the MSA reform? In what way? Was your organization's views on LTC reform altered by its participation? In what way?

11. How successful do you feel the government was in meeting its own interests?

Conservative Reform

In June 1995, the Progressive Conservatives formed the government. When they took office, they halted implementation of the MSA model. After a brief consultation, they proposed the CCAC model. **(Card 1)**

1. What do you consider to be the most important features of the CCAC model?

2. What do you like about the CCAC model? What do you dislike about it?

3. What do you think are the government's main interest in reform and in proposing the CCAC model?

4. Is your organization involved in the reform of LTC under the Conservative government? When and Why did your organization decide to get involved/stay involved in the reform now?

5. What actions did your organization take to try and influence this reform?**(Card 2)**

6. What was your organization trying to accomplish with these strategies? Which strategies were most effective? Why?

7. If your organization formed alliances with other groups during this period, when and with whom? What are your group's interests in forming the alliance? What interests do you share in common with the other group(s)? What influence, if any, has this alliance had on the reform? Does the alliance still exist? If not, when did it cease to exist, and why?

8. During this period of reform, if your organization tried to meet/have contact with government, with whom did you try to meet? Were you successful? If not, with whom did you meet? *Probe whether the contact was in the political or bureaucratic side of government and the level of the contact.* Were you ever approached by government? For what reason?

9. Which organizations do you feel were most influential in the reform during this period? Why? What were their interests.

10. Overall, do you feel your organization has had any influence on the CCAC reform? In what way? Is your organization's views on LTC reform altered by its current participation? In what way?

11. How successful do you feel the government is in meeting its own interests?

General Questions

As you may recall, during the Liberal, NDP, and current Conservative governments, the Ministry and Minister which led the reform changed a number of times. In addition, other ministries were involved with the lead ministry during different periods of reform. I would like to ask you some questions about the possible effect this had on reform. **(Card 3)**

1. Did the change in government, i.e. which political party formed the government affect the influence of your organization on the reform or the way in which you thought of LTC reform? In what way? *Probe for the change in government contacts and the change in groups which had access.*

2. Did the change in lead Ministry affect your organization's influence/ideas on the reform? In what way? Why?

3. Did the change in Ministers affect your organization's influence/ideas on the reform? In what way?

Now I would like to ask your views and opinions on a number of policy goals. In addressing these questions, it is important to recognize the difference between the financing of LTC and the ways in which these services can be delivered. **(Card 4)**. To begin with:

1. If I asked you to freely associate, what comes to mind when I say the word, "public"? and "private"? What types of organizations are included in each sector?

2. What do you believe is the appropriate role of the government/ the for-profit sector/ non-profit sector/ individuals in LTC services?

a) what LTC services should be fully funded by government, what services should be partially funded by government; who should be covered by these services?

b) what LTC services are best delivered if any, by government/ the for-profit sector/ the not-for-profit sector; i.e., which LTC services should the different sectors provide; should there be any restrictions?

(Card 5)

3. What does the value or goal, *equity,* mean to you? Which sector, government/ for-profit/ not-for-profit, is better at achieving *equity* in Long Term Care services? Why?

4. What does the value or goal, *efficiency,* mean to you? Which sector, government/ for-profit/ not-for-profit, is better at achieving *efficiency* in Long Term Care services? Why?

5. What does the value or goal, *liberty/choice,* mean to you? Which sector, government/ for-profit/ not-for-profit, is better at achieving *liberty/choice* in Long Term Care services? Why?

6. What does the value or goal, *security/need satisfaction,* mean to you? Which sector, government/ for-profit/ not-for-profit, is better at achieving *security* in Long Term Care services? Why?

I would now like to ask you questions directly about the ability of each of the different reform models proposed by government to address each of these goals. **Card 6**

1. To begin with, which model do you prefer? Why? What are the factors most important to you in recommending this model?

2. Which model do you believe would have had the greatest amount of government involvement? Why?

3. Which model do you believe would have resulted in the greatest equity? Why?

4. Which model do you believe would have resulted in the greatest efficiency?Why?

5. Which model do you believe would have resulted in the greatest liberty/choice? Why?

6. Which model do you believe would have resulted in the greatest security or fulfillment of need? Why?

Card 1 **Public Documents and Models released by Each Government**

Peterson Liberal Government	Rae NDP Government	Harris P.C. Government
1985-1990	1990-1995	1995-present
A New Agenda 1986 One-Stop Shopping Model	***Redirection of Long Term Care and Support Services in Ontario***, 1991 Service Coordination Agency (SCA)	Community Care Access Centres (CCAC), 1996
Strategies for Change, 1990 Service Access Organization (SAO)	Four government documents, 1993 Multi-Service Agency (MSA)	

Card 2

Strategies or Actions

1. letter writing
2. report/submission to government
3. submission to the Standing Committee
4. meetings with government
5. alliances with other groups
6. media events (press releases, press conferences, demonstrations)
7. holding workshops/conferences/meetings

Card 3 **Ministries/Ministers Involved with LTC under each Government.**

Liberal Government	**NDP Government**	**Conservative Government**
1985-87 Office for Senior Citizens' Affairs (Van Horne)*	**1990-92** **MCSS** (Akande) MOH (Gigantes/ Lankin) MC (Ziemba)	**1995-96** **MOH** (Wilson/Johnson)
1987-90 **MCSS** (Beer) MOH (Caplan) OSCA (Morin) ODP (Collins)	**1992-95** **MOH** (Lankin/ Grier) MCSS (Silipo) MC (Ziemba)	
1990 **MCSS**/MOH- Community Health and Support Services Division		
		bold print indicates lead ministry

Card 4 **What should the role of each of the sectors be in financing and delivering LTC services?**

	Government	Non-Profit	For-Profit	Individuals
Financing LTC Services				
Delivering LTC Services				

Card 5 **Which sector is best at achieving each of the four goals?**

Values	Government	Non-Profit	For-Profit
Equity			
Efficiency			
Liberty/Choice			
Security			

Card 6 **Which model would have been best at achieving each of the four goals?**

Values	One-stop Shop	SAO/SCA	MSA	CCAC
Government Involvement				
Equity				
Efficiency				
Liberty/Choice				
Security				