

**Contesting Expertise:
Home Care Under Ontario's Conservative
Government 1995-2003**

by

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Abstract: Using the example of home care services in Ontario between 1995-2003, this paper shows that policy problems defined through a lens of ideological understandings lead to policy remedies that can be problematic. There is a disconnect between what health care professionals and decision-makers value in the organization of service delivery. While health care professionals value continuity of care and collaboration among providers, decision-makers value cost containment and competition among providers in a quest to improve efficiency, as they understand it. Under Ontario's system of "managed competition" the role of expertise or knowledge in the delivery of health or social services has become the site of a power struggle among the actors engaged in funding, organizing and delivering these services. Expertise, knowledge and education have become commodified as each organization attempts to offload costs to the other. This is problematic with the increasing complexity of care required in the community.

1. Introduction

Using the case of the governance of home care in Ontario under the Conservative government of 1995 –2003, this paper illustrates how the imposition of policy reforms designed to remedy ideologically constructed “problems” can interfere with effective service provision when such reforms are at odds with professionally or expertly developed epistemologies. In their quest to make government “run like business”, Ontario’s newly elected Conservative government embarked on a significant structural reorganization of home care delivery by introducing a reform referred to as “managed competition”ⁱ. Managed competition is a neoliberal market reform that originated in the USA and was implemented in both Britain and New Zealand as part of their respective public health care reform initiatives. It was held that by imposing the discipline of markets onto what was seen as bureaucratic systems of health care provision “efficiency” would improve (Light 2001). In Ontario’s rendition of this reform, 43 Community Care Access Centres (CCACs) were charged with creating geographically bound home care markets.

This replaced home care systems that had emerged and developed organically, albeit unevenly, through the non-profit sector across the province in response to two

stimuli –local needs and government program funding. However the solution designed to address the “problem” of inefficiency failed to take into account the characteristics of the services and the way in which the professionals –primarily nurses- that run the system work.

Home care is defined by the federal government as a set of services that enable “individuals with major or more minor limitations to live at home or in supportive housing”(Health 2003a). Home care includes a range of services from nursing, occupational therapy, and social work to personal care (bathing, physical transfers, help with dressing) and light housekeeping such as vacuuming, and laundry (OECD 1997). Home care services are designed to achieve three main outcomes for patients: to delay or avoid institutionalization; to allow convalescence at home rather than in hospital (post-acute care); or to provide end-of-life palliative supports. Services are provided by a variety of regulated professionals (nurses, therapists) and unregulated workers (Personal Support Workers). In public policy terms, home care straddles the boundary between health and social care policy as services include both medical interventions and social and supportive care that allows clients to live at home with dignity and independence. The combination of the changes in federal transfer funding to the CHST in 1996 with the limitations of the Canada Health Act (1984) to only physician and hospital services, meant home care fell entirely under provincial jurisdiction during this period. Each province and territory has its own home care regime and only Manitoba and Ontario provide these services on the sole basis of needs (Health 2003).

This paper is organized into three parts. It begins with a discussion of the theoretical considerations that drive this analysis. An analysis of the case follows, which

is based on both secondary sources and fifteen interviews with key informants conducted as part of my dissertation research. In addition to these formal interviews, I had a unique perspective to the reform process as a participant-observer. In 1996, I joined the board of a local home care agency and witnessed the dislocation caused by the reform. My six years in that position enabled me to develop a deep understanding of both how the system previously functioned and the effect of the changes. Although I interviewed a number of key informants with a provincial perspective, the comparison of the organization of home care focuses on the system in Hamilton before and subsequent to the introduction of the managed competition reform. As service delivery is on going, studying local experience is critical, because that is where policy and practice intersect.

In the third part of this paper, the features of home care reform are analyzed and three important issues are raised. It is argued that the way in which governments define problems logically leads to the deployment of particular policy instruments. In first-past-the-post parliamentary systems where, as in home care, policy jurisdiction is watertight, majority provincial governments have the constitutional power to proceed as they choose to make policy. In this case competition was positioned as the answer to the problem of service provision by non-market actors (Jiwani 2003).

Transforming home care from a collegial policy subsystem to one based on market-relations fundamentally changed the way organizations related to one another (Light 2001; Mullet, Jung et al. 2002). Hence working in collaboration with other providers to improve service, a core value under the previous delivery regime, became problematic when organizations were in competition with each other in an environment

that structures interactions as market exchanges. This has led to a highly fragmented delivery system, which interferes with providing a continuum of care.

Finally, expertise and what were formally treated as best practices that improve efficient delivery to be shared among peers have become “proprietary knowledge” or “intellectual property” that constitutes each organization’s competitive advantage. Moreover, the complexity and rigidity of the contract relationship has been such that CCACs have no effective way of ensuring that agencies will provide sufficient education to their front-line staff to ensure new learning is incorporated into treatment. Under this regime, the education of front-line staff is treated as a cost-centre, and this cost is not directly recoverable because agency remuneration is based solely on a fee-for-service basis. This occurs in a context where increasingly complex care is provided in the community by unregulated workers who work without mandatory service standards and without a professional college to which they are held accountable. Clearly this situation can affect quality of care. However, agencies have to make “business decisions” around the level of resources to commit to staff training. The implications of this commodification of expertise and knowledge are discussed.

2. Theoretical Considerations

This paper takes a neo-foucaultian approach to unravel the conflict in belief and value systems between the Conservative government and the health care sector. The notions of governmentality, problem definition, political rationality and technologies of governance are central to the analysis. I draw from a body of literature that explores neoliberal governmentality (see Miller and Rose 1990; O'Malley 1992; Rose and Miller 1992; Rose 1993; Barry, Osborne et al. 1996; Burchell 1996; Rose 1996a; Rose 1996b; Peterson and

Bunton 1997; Petersen, Barns et al. 1999; Light 2001). I then use the Foucaultian concept of a rationality to examine the world of health care professionals

The governmentality approach embodies the reconceptualization of government in its central role “of managing and overseeing a whole population” presumably “so they flourish” (Light 2001). Recognizing the fact that to govern in a liberal democracy implicitly means governing at a distance, managing the population or a particular population - particularly during periods of social change- can require a reshaping of human conduct given that people are autonomous and sentient beings. Governments, then, use particular strategies or technologies, (re)education, rewards, punishment and social sanctions to encourage some behaviours and discourage others (Rose and Valverde 1998). Governmentality is revealed through an examination of broad political discourse.

Osborne describes the importance of problem definition or problematization in Foucaultian analysis of public policy. Problem definition involves “active ways of positing problems” that begins with an environmental scan and an analysis of what one sees (Osborne 1997: 174). This scan can operate at various levels of sophistication: from populist understandings of “common sense” or ideological interpretations of how society works to highly complex scans based on extensive or intensive research. Clearly such scans exist at all levels of analysis. I would add the processes that result in these particular accounts are critically important. As Jenson points out power privileges some voices over others and different voices will be attached to different interests (Jenson 1989). In identifying particular ways in which governments define problems one can begin to uncover particular understandings of cause and effect that inform definitions, and permits the analyst to trace these to the correctives (Stone 1989).

O'Malley et al. define political rationalities as “the ways in which programmes of government are formulated and articulated within broad discourses of rule” (501). The principal strength of the governmentality approach "stem[s] from a characteristic concern with the nexus between political rationalities and technologies of rule. ... it provides the conceptual and analytical equipment for a close critical engagement between theory and political practice" (O'Malley, Weir et al. 1997: 503). A political rationality has three characteristics. It takes a moral form; it has an epistemological character with a particular understanding of the nature of the objects governed, and it is articulated in a “distinctive idiom that is more intellectual than rhetorical”. In sum, political rationalities are “morally coloured, grounded upon knowledge, and made thinkable through language” (Rose and Miller 1992: 179).

With health care reform on the agenda of all governments in advanced industrialized nations, this policy area has provided fertile ground for a plethora of analysts and commentators with competing views of what the “problems” are. Health care delivery has been the object of reform dating back over half a century. With the emergence of neoliberal thinking and its administrative arm –New Public Management, the insinuation of market mechanisms into the relationship between purchaser and provider of services has been one technology or strategy chosen to change the behaviour of the health and social service deliverers and try to tame what is seen increasingly as an intractable policy area.

Rose and Miller observe a shift in the relations between political and non-political actors, characteristic of neoliberal governance in post-Keynesian states. They identify “a new relation between expertise and politics” wherein governments aim to discipline

experts who, at the height of the Keynesian Welfare State, had enjoyed a great deal of autonomy and authority to shape the contours of public policy in their particular realms. The imposition of a competitive model combined with a narrowing in the meaning of accountability and a highly restrictive funding model transformed the home care sector privileging government priorities and reshaping the care relationship valued by health experts, particularly the nursing profession.

3.0 Home Care Locally

A clash of civilizations

Canada's medicare program is a single payer insurance plan, publicly administered by provincial and territorial governments but delivered by a combination of individual practitioners, private for-profit firms (e.g. laboratory services, physiotherapy clinics, home care agencies) and private non-profit organizations (e.g. hospitals, community clinics, home care agencies). When health care moved out of the private market and became a public good in Canada during the middle decades of the last century, provincial governments simply took on the physician and hospital systems as they were, leaving a mixed economy of care (for more details see Naylor 1986; Flood 1999; Jiwani 2003). Generally speaking, clinical policy and practice were left to (largely) regulated health care professionals while governments footed the bill.

Regulated professionals achieve that status by meeting requirements set out by self-regulating colleges established under provincial legislation. Colleges set professional standards of practice, define scopes of practice and have the power to discipline their members (O'Reilly 2000). Physicians are paid directly by the government in accordance with a fee schedule negotiated between the Ontario Medical Association and the provincial

Ministry of Health and Long-term Care. Other regulated professionals, however, work for public, for-profit or non-profit organizations that are contracted to provide services through a variety of funding arrangements with government. The integrity of service provided by regulated professionals is protected by the bifurcation of accountability to both their professional college and their employers. Nurses, for example, must adhere to standards of practices and risk the loss of their license if they fail to meet these standards. This duality serves to mediate the relationship between employees and employers. This is particularly important when organizations are under pressure to save money or when workers find themselves under the authority of non-professionals who may not understand the importance of the standard.

When Ontario expanded its range of insured services to include ancillary services such as nursing and social support in people's homes beginning in the 1950s, the terms of service and funding were negotiated but the management of the system was left to a variety of local organizations (Williams 1996). In some cases the province contracted local branches of the VON to run "Home Care" and in other jurisdictions Public Health co-ordinated these services. Home Care was accountable for running the various programs to the respective ministries but the services were managed locally by health care professionals. Fees were negotiated between Home Care and the Ministry of Community and Social Services¹ in Toronto. Services, such as homemaking and nursing home care were both provided by the managing agencies and referred by them to other agencies - both non-profit agencies and private/for-profit service providers. Under the

¹ Home care moved from MCSS to Ministry of Long-term Care, which was later merged with the Ministry of Health (1998?) into the Ministry of Health and Long-term Care (MOHLTC).

NDP government of 1990-1995, there was a “not-for-profit preference”, which ensured that most publicly funded service went to that sector.

Former Conservative Minister (Seniors) Cam Jackson describes the sector at this time as a “patchwork”. Home care services had emerged out of the community, were “underwritten” by charitable organizations and funded on a program basis by the province and municipalities (Jackson 30 October 2003). There were different sets of standards and different eligibility criteria around the province (MCSS, MOH et al. 1991; Williams 1996).

Although unwieldy from a provincial perspective home care services looked different from a community perspective because delivery systems were integrated locally, albeit with varying degrees of “success” across the province. The shape of the institutions was less important than the practices that engaged the respective actors. Service provider agencies provided services to clients under the direction of their local coordinating agency, cobbling together funding from the various programs (MCSS, MOH et al. 1991). In Hamilton, the management of Home Care was contracted to the VON. Home Care, in turn, negotiated the terms of service provision with two other non-profit agencies. Weekend and evening work was supplemented by for-profit agencies. Locally then, Home Care made sense of the array of programs and pockets of funding. This local home care community enjoyed the high degree of autonomy afforded them by the province.

Valverde describes the mixed social economy of health and social service delivery that developed in the province of Ontario from its earliest inception. Initially charitable organizations delivered services in response to local needs and eventually on behalf of governments as they began to provide funding. As early as the nineteenth

century the province provided public funding to charitably run “lunatic” asylums (Valverde 1999). This symbiotic pattern continued well into the 1980s (Interview-a 2003). The VON, for example, was founded in 1897 and continues to deliver in-home nursing services across Canada today. Similarly religious orders, such as the Sisters of St. Joseph began to establish community hospitals, poorhouses, homes for the aged and visiting nursing organizations shortly after they arrived in Ontario in the nineteenth century. VON, as well as the organizations ostensibly still controlled by the Sisters, count among the myriad of non-profit organizations that deliver health and social services on behalf of government. Government funding is supplemented by a range of activities undertaken by non-profits that include fundraising, service innovation to fill the gaps left by discreet government programs, and the enlistment of a coterie of volunteers to both provide direct service and to support the organizations themselves. This, in addition to the contribution of this sector to energizing a robust civil society, is the “value-added” of the non-profit sector.

Valverde argues that with welfare-state scholars using the introduction of income transfer mechanisms as the indicator marking welfare-state emergence, these earlier manifestations of support for citizens from both private philanthropic and public funding have been obscured. In fact, subsidiarity, now seen as a highly effective form of responding to local needs in the governance literature (Paquet 2001), was the form of health and social service delivery that emerged in Ontario and across Canada.

Given the highly technical expertise held by regulated health care professionals combined by the institutional foundations of a mixed social economy, health care systems resemble what Salamon refers to as “third party government”. This is

[T]he exercise of discretion over the spending of [government] funds and the use of [government] authority. They thus continually place [government] officials in the uncomfortable position of being responsible for the programs they do not really control.... Instead of a hierarchical relationship between the federal government and its agents, therefore, what exists in practice is a far more complex bargaining relationship in which the [government] agency often has the weaker hand (Salamon 1981).

In other words, decisions on the appropriate care of individual patients would take place independent of fiscal concerns and would be driven by patients' needs, technological ability and the incentive structure provided by the funding regime. In the early days, funding was more fluid, treated more as a guideline than an order "cast in stone". A system mandated to provide services on the basis of need compared to a system mandated to ration services with a predetermined pool of money will inevitably mean a variance between budgeted and actual expenditures.

Third party government presents a paradox to governments. On the one hand, liberal democratic societies have relied on this type of self-governance as a robust feature of civil society (Rose 1993). With the emergence of accountability for spending as a paramount value of many contemporary governments and society, the challenge became to achieve some measure of control and fiscal accountability in the circumstances where the delegation of decision-making power means unelected decision-makers spend public funds. In Ontario, this shift in the understanding of accountability occurred with the 1995 election of Progressive Conservative government of Mike Harris. Accountability was now to taxpayers, not citizens, and the notion of accountability was simplified to mean efficient spending and prudent fiscal management. The Harris government vowed to run government like a business. The idea that government operations were analogous to

business operations was insinuated into the broad discourse of rule throughout the seven years that Harris served as Premier (Jiwani 2003).

In 1996, Ontario introduced two significant reforms to its home care system in line with this new governmentality. First was the creation of 43 CCACs to serve as gatekeepers to local home care services. CCACs were to establish the criteria that would permit citizens to receive service and how much, and contract with independent providers to deliver said services. CCACs were prohibited from providing direct service. Initially the government provided little or no direction to CCACs with respect to client eligibility criteria, but they did direct the process by which CCACs would select providers-managed competition. Funding was converted from being based on existing programs to a formula based on local age and gender data deemed to serve as proxy for need.

Managed competition is the creation of an internal market by way of a contracting process. Internal markets involve the separation of provision (funding and assessing needs) from production (providing service). The contracting body functions as a proxy for the consumer, ascertaining the most efficient trade-off between quality and price, as decided through a tendering process (Request for Proposal or RFP). This is premised on the notion that the CCAC, as a neutral body without a vested interest in a particular outcome other than the best quality-cost trade-off, would provide a cost efficient way of managing home support services (Le Grand 1993; Le Grand and Bartlett 1993; Jérôme-Forget and Forget 1995).

In Ontario, the insinuation of a market mechanism to choose providers was coupled with a belief espoused in the discourse that the private sector is inherently more efficient than either the public or voluntary sector (Jiwani 2003). Under managed

competition, the not-for-profit preference, that had been the policy of the NDP government, was eliminated and both Canadian and American for-profit firms were invited to compete for contracts. The government anticipated that bloated administration would be trimmed, and wage rates would find their natural (read: lower) rate. This reform marked a dramatic departure from an entrenched bargaining relationship that had existed between government and the third sector.

Statements in the provincial legislature paint a clear picture of the government's rationale for reform and the insinuation of a market analogy into their discourse. On one occasion, Long-term Care Minister, Cam Jackson stated,

[F]or years in Ontario we had an unregulated system of home care that was operated on a monopoly basis, administered by the government" (Hansard May 5,1998).

The new model would emulate business. CCACs would be accountable to government through the commitments laid out in their business plans (Jiwani 2003). As Health Minister Jim Wilson stated,

The idea of the business plans is to ensure that we get rid of the excessive administration in home care throughout the province. We have 73 home care and placement coordination offices today. They will be replaced by 42 community care access centres, and we want to see the business plans -- and I think it's a reasonable requirement for any business that's using taxpayers' dollars to deliver services -- so that we can ensure that they do not spend an excessive amount of money on administration -- we're trying to correct the problems of the past -- and that every dollar is driven to home nursing services, home care, Meals on Wheels, occupational therapy, physiotherapy. That's why we want to see the business plans, just to ensure that they're not building empires. We're getting rid of the empires of the past and replacing them with streamlined efficient delivery systems (Hansard February 25,1997)

The service delivery model was the central reform of the government. A key informant describes it as follows,

I think their initial focus was really on the structural reform on the system and [getting] the competitive process up and running. They were dealing with legislation that preceded the development of their model. There was the Long Term Care Act, which sets out fairly generous appeal provisions. At the same time you have a system that has very little regulation, very little monitoring in terms of who gets service, when do they get it and who gets priority. So I think a lot of what happened in the last few years [of their regime] was really responsive rather than proactive in terms of looking at ... you know ... and you got a system less and less that was responsive to [clients'] needs. It becomes quite arbitrary the farther you get into that kind of thing (Interview-j 2004).

A number of problems emerged from what was generally viewed as implementation that was poorly executed and a structural reform that addressed only a narrowly defined problem. One key informant describes the government's response as "It was really 'here's the model, like it or not'. It was really that blunt." The structural problems were compounded by the priority given fiscal accountability. Another key informant states,

We are held much more accountable for the dollars than under the Home Care program. There's definitely the structures: the reporting mechanisms are in place [and] they're tighter on the CCAC than in any other sector of health care, *by far*, from what I see, and where I sit, and who I interface with. Our accountabilities are black and white relative to hospitals. We, as a CCAC, like to think that we are expected to have, and we have a strong one in this community, a resource allocation model for the case managers. So that the concept of accountability is not just about the [Executive-Director] or the directors and managers but about everybody in the organization being clear about what their responsibilities are and how that rolls up into ultimately accountability to the board and to the Ministry for how we spend the dollars, or how we treat the clients or how we deliver the services through our agencies.

Fiscal accountability became the prime focus of the CCAC and little attention was paid to the sector subsequently by government (Jackson 30 October 2003). Anticipating that more was required, the bureaucracy had developed what one key informant considered

a fairly comprehensive set of draft regulations on service policy, prioritization criteria - a more creative look at how you manage service, that kind of thing that

was really much more responsive to the kind of needs you see in the community now. ... [but] It just never got off the table. It was on the drawing board and would bubble up every once in a while but then be overtaken by other things (Interview-k 2004).

The problem, it seemed was the management style of the government that meant such decisions went to the Premier.

I think they just couldn't get it on the bigger agenda.... Everything went to Cabinet. ... [There is] so much centralized control of government now that within the Ministry nothing can happen without the Minister's signature and the Minister has very little authority without taking an initiative back to Cabinet. So unless you can get on the Cabinet agenda and get the attention basically of the government, a lot of things, basically, can't happen (ibid.).

The only significant modifications to home care to occur subsequently were a consolidation of the hierarchical power relation that set the government at the top, the CCACs as organizations to follow their policy priorities and service providers at the bottom (O'Connor 2003).

As noted above, the restructuring exercise intersected with a period of fiscal constraintⁱⁱ. Although widely touted as an efficient solution to expensive hospital care, home care services actually decreased as a percentage of Ontario's health care budget from 5.1% in 1997-98 to 4.2% in 2003-04. Between 2000-01 and 2002-03, the number of clients served was severely reduced: nursing clients decreased across the province by 25.4% and PSW clients by 17.2% (OACCAC 10 February 2004). A number of agencies closed their doors with the ensuing volatility in the home care market (Browne 2003). A CCAC official referred to this culling as the "survival of the fittest". What it meant was adaptability to the requirements to be low-cost and flexible was the primary determinant of survival within a contract period. The contractual relationship did not give quarter for any other measure of effective service delivery.

The contract became the template for the relationship between CCACs and service providers. Contracts prohibited price increases for the duration of contracts, which typically ran three to four years. They did not link price to service volume and there were no guarantees of minimum service volumes. This is important to understand because it resulted in agencies absorbing all of the costs unanticipated at the beginning of the contract period. And there were many such costs associated with the increased complexity of care provided and the volatility in service levels. This remained the practice until a new contract template was introduced in 2003-04.

3.2 From Collaboration to Competition

The new system required a sea change in the culture of the home care community. An examination of nursing theory reveals the rationality that informed those previously organizing and delivering home care services through the non-profit sectorⁱⁱⁱ (Rogers 1970; Watson 1979; Chinn and Watson 1994; Rogers 1997; Watson 2002). The care paradigm, which extends beyond nursing into other health care relationships is described as "a caring-healing relationship that potentiates health and well-being, physical comfort, symptom management, pain control and promotes meaning, growth and harmony between provider and other". This model of care is underpinned by "carative values"^{iv} and supported by extensive research into the effects of treating patients as a whole person with health care professionals responding as whole people, not just technicians. Watson states, that "mind-body medicine and the 'soft' caring modalities affect longevity, meaningful living in the midst of suffering and healing responses at the psychoneuroimmune level of an experiencing person" (Watson 1994, 1). The importance of these soft skills was supported by a meta-analysis of over 130 studies on the care-

healing relationship (Swanson 1999). What is paramount is the wholeness of the relationship between the client and the practitioner. This literature establishes the ideational linkage between theory and practice or techniques that informed the practices of the nurses who ran Hamilton's home care community. The care paradigm includes a systematic approach to implementation, complete with an evidence-based approach to measurement and total quality management (Watson 2002).

Hamilton is perceived to have had one of the better locally integrated models of care across the continuum of health services during the 1980s and into the 1990s. The purpose of integration is to provide seamless care for patients, to improve both patient care and patient outcomes, to improve interface and information transfer among the various practitioners and institutions in the "system". The value of integration also lies in the way in which it eases the substitution of lower cost services for higher costs, such as ambulatory care (including home care) for hospital care (Davis 1999). Such systems integration remains an elusive policy goal in the health care sector, which comprises a wide range of independent service subsystems funded separately by the Ministry of Health. Ontario, unlike other provinces, did not establish regional health authorities to try to integrate local decision-making. Funding silos present in government ministries are often reproduced locally. Prior to 1996 this occurred in Hamilton in a reasonable fashion, facilitated by a series of local networks and committees that included a range of providers dedicated to improving integration of care (Interview-a 2003; interview-g 2003). It also occurred within non-profit home care providers which had cobbled together funding from a variety of programs and sources to fill the gaps in service they identified from their local vantage point (O'Connor 2004).

This effort to provide integrated care is linked to a culture of collaboration. The practice of collaborating with peers is well established as a mode of professional behaviour. Wainwright describes knowledge as a “social structure” which becomes more complete when it is shared. Knowledge is “shared in order to minimize the limitations of individual knowledge” (1993, 118). Collaboration forms the cornerstone for learning and problem solving among professionals. In addition to the reliance on professional development, journals and conferences for individual professionals, former Home Care managers and Service Providers Agencies have provided numerous examples of how collaboration, and mutual respect served as a critical piece for improving service, providing the foundation for dealing with emerging issues and problems (see for example McGeown, Rogers et al. 1995). The practice in Hamilton among those delivering home care was that as issues emerged service providers and Home Care would sit down and work out solutions. This extended to decisions about how to ration care when facing budget constraints (interview-g 2003; Interview-h 2004).

There is no doubt that market reform fundamentally transformed these relationships. One key informant describes this.

Part of the fallout from the managed competition process was that it fundamentally changed relationships. ... By necessity there is now a focus on legal risk by virtue of the nature of the process. And if you have organizations that provide similar services under competition – which is probably not the best model- instead of partnerships, it’s difficult to get people to the table to talk about sharing innovations and best practices. So it really hasn’t facilitated those kinds of cooperative relationships. CCACs tend to be nervous about – I was talking to someone at a conference the other day- and their local CCAC wouldn’t accept cookies from them at Christmas because it might be perceived as some kind of bribe... So the process creates some real funny situations in terms of people’s comforts in collaborative kinds of relations. And I think that’s a horrible loss (Interview-j 2004).

While CCACs will often refer to agencies as their “community partners”, agencies do not feel they are part of a partnership as the power relation is very clear. The CCAC- service provider relationship has been described alternately as “overbearing”, “employer-employee”, “contracted providers”, “master-slave”, and there is a sense that this pattern is quite consistent across the province with only a few exceptions. Day- to -day relations between CCAC and service providers at an operational level work smoothly, particularly between regulated professionals, but there is little interaction between most senior level executives of CCACs and service providers and no forum to address systemic problems. (Interview-j 2004; Interview-m 2004; interview-n 2004). One service provider identifies an on-going problem with communication. He states,

There needs to be a continual method for us to communicate all the positive, negative, opportunities for improvement, not just on an annual review basis or a quarterly service provider meeting. But we should have someone we can pick up the phone and call or somewhere we can present what we’re trying to do (interview-l 2004).

Individual CCACs do not have the mandate to address the problems associated with the contract or competitive process. Until 2003-04 an established process for arbitration of contract disputes was non-existent. Advocacy on systems challenges occur at the provincial level between agencies and CCACs respective umbrella groups and government (interview-g 2003; Interview-j 2004; Interview-k 2004; interview-l 2004).

Service providers feel further marginalized, at least in Hamilton, as they are left out of local discussions on integrated care. They are not invited to participate in networks dedicated to providing integrated care across the delivery continuum, and they see this as problematic as they have expert knowledge that is not transmitted to the CCACs and

therefore not represented in those networks. CCACs speak for service providers - although they provide no service (Interview-j 2004; Interview-m 2004).

Service providers and organizations representing them identify this absence of partnership as creating a significant obstacle to establishing best practices across the system and delivering effective services within a continuum of care. A CCAC official also recognizes this as a problem. She states,

There's no doubt that as we moved into the [request for proposal] process that the relationship changed both between the service providers and the CCAC but between service providers in terms of "intellectual capital" and the concept of competition versus collaboration. Those were very much challenged. And it's come a long way but it's still not easy for some of the agencies to be 'partners', to participate in sharing and developing best practices, for some of them use that as their intellectual capital. On the other hand, as a CCAC we're pretty clear with them in the RFP process that they need to collaborate with us, that our responsibility is to deliver the best care possible in the community to the clients and if that means we need to develop better ways of doing things then they need to be at the table and create best practices.

What is interesting to note is that while most key informants cite competition as the reason for the cultural change in the sector, it is the relationship with the CCACs as structured by the contract that seems most problematic according to those representing service providers. The offloading of costs to providers and workers has squeezed service providers' resources (O'Connor 2003). The narrow definition of service in the fee-for-service model reduces the opportunity to pilot new delivery models, unless the CCAC is convinced and has money. The lack of communication on any basis other than a day-to-day operational basis reduces opportunity to develop collaborative relationships and innovative service delivery. There are no incentives built into the contracts to develop best practices: the fee-for-service schedule is based on time spent with clients - not outcomes, therefore the theories of innovation associated with markets simply do not

apply. Best practices, where they occur, emerge from the values associated with professionalism- not entrepreneurship.

3.3 Commodifying Knowledge and Expertise

This care paradigm included soft concepts and incorporated a relational dimension that is not easily measured. When government's top priority became to reduce spending to eliminate deficits and "efficiency" became a new value (Gross Stein 2002) nursing changed. Rogers describes changes to nursing in the mid 1990s as follows,

Dramatic changes in the health care system were precipitated by difficult economic times. Many administrators, politicians and health care providers, as well as the public, defined nursing by the skills and tasks nurses performed, not by the knowledge they had. Even nurses themselves, regardless of where they worked, had great difficulty articulating the breadth and depth of nursing knowledge, and the unique contribution of nursing to the health of people. Consequently, a movement began to replace professional nurses with cheaper alternative care providers. Some nurses were worried about what was happening, believing that the role of the registered nurse was being eroded". (Rogers 1997: 14).

The reduction of care to skills and tasks is based on a biomedical or "body parts" model. This stands in stark contrast to the care paradigm with its focus on knowledge informed by values. The biomedical model is in many ways quite compatible with the market paradigm that reduces services to tasks stripped of the relationship dimension. Both are coolly rational and mechanistic.

One Service Provider describes it as follows,

Contracting for service has become very task-based. So that appreciation for that body of knowledge - that it's more than doing the task it's that whole collective of patterns, knowledge of the system, knowledge of the whole continuum of care, knowledge of families and building capacities, all of those things that go into doing the task - seems to get sifted out in the process. And they are just asking for the task. Over time, with that shifting of service providers back and forth [with every new round of contracting] I see that pattern of knowledge getting further disrupted (Interview-m 2004).

This idea that “care” is nothing more than a physical task, similar to assembly line work represents the way in which work has been “taylorized” (O'Connor 2003).

One of the first reforms of the Conservative government was to reconstruct homemaking services as a series of discrete tasks. Compiling those tasks into units of time became the basis for fee-for-service remuneration schedule. No time was allotted for the soft, relationship-building dimensions of care (Browne 2000; Aronson and Neysmith 2001; Aronson 2002; Browne 2003). Moreover, a series of tasks that at one time were performed by nurses were transferred to unregulated Personal Support Workers (PSWs) who have a variety of levels of skills and whose work, in the contracts with CCACs, is simply categorized as “homemaking” (O'Connor 2003). This continued to be the trend. In 2003 the province created a list of services that potentially could be shifted from nurses to PSWs (OACCAC 2003a; Interview-i 2004).

There has been an increase in the acuity of care of clients being served in community for a number of reasons. Among these are technological change that enables some procedures and post-operative care to occur safely in community and a shift to providing palliative care in people’s homes. Such change requires continuing education and upgrading of staff knowledge. When discussing education and training, one CCAC executive was quite comfortable relaying the variety of opportunities for continuing education open to her case managers as well as to the allied professionals who provide service; not so, however, when it came to PSWs, who provided service to 83,502 of the province’s 192,009 home care clients in 2002-03.

Another key informant described the situation,

I think our overall funding structure that ‘s been with us doesn’t really support that kind of thinking about how you provide support around the workers. You

basically push it so ... you know, we keep fragmenting things farther by breaking it down further into little tiny pieces of things rather than looking at how you create a system that's integrated and sustainable for the long term.

To qualify as PSWs, potential workers must complete an eighteen-week training course at either a community or private colleges which includes a job placement and there is subsequent opportunity to upgrade to three more levels of skill. However, unlike the regulated professionals, PSWs are not subject to a continuing accountability for adhering to a set of work standards established by an independent college, nor need they commit to professional developments to retain their right to work. While this may have been less important when homemaking truly was that – vacuuming and dusting –as these workers perform tasks formerly performed by nurses, this can be problematic. It must be remembered that all home care takes place in people's homes. Workers are isolated from both colleagues and supervisors. Without an ingrained set of professional standards to inform their work practices their accountability is primarily to their employer for their performance. It is only under the recent modifications to the contract template that PSW supervisors were required to be regulated professionals, although this was the practice in Hamilton. Unlike nurses, should a PSW prove unfit, there is nothing to stop her from moving from one agency to another.

A former CCAC supervisor describes the problem with continuing education under the managed competition as follows.

Historically people like VON and [St. Elizabeth Nursing] would bring their nurses in or send their nurses to us for teaching. Whereas I know that what happened after the managed competition... it is your cost per visit that you have to look at^v. They now take the teaching plan and take it into their staff and that's a very different teaching model. And I don't think you get as good a buy-in. And there isn't the opportunity for their staff to have the discussion about it. So they wouldn't have the really in-depth understanding (Interview-h 2004).

In relating an example of teaching about infection control she raised the following concerns.

PSWs are such a crucial piece of the system. These are people who haven't had a lot of education about infection control, let alone HIV. So first of all we have to make sure they understand that this is serious business. But then we also have to make sure that they understand that it's a *manageable* serious business. And I think of some of the examples we used in the teaching package- well, but did somebody else have something else on their mind? And what had been their family experience with this? And were they afraid of going and infecting their kids or transmitting it to their friends, let alone themselves. So, just getting written information is really helpful but is that everything that's needed?

The challenge is even greater with PSWs as they are often immigrant women with a variety of cultural and educational backgrounds. She continued,

And what is their cultural background around infection? And I quite frankly don't know all of that and so to put one package together, which is what we did [to] address the needs of both non-professionals and professionals was always a big challenge. And we knew that then agency supervisors would translate that for their own workers. But I know that didn't always happen. And I think that we need face-to-face communication around it. And getting people into some groups so they can ask questions is really important, and for them to be able to bring up their own examples so that the supervisor could address those. And if you do it in a group situation the question then is, are you going to then pay your workers to attend these? Is it going to be compulsory or not? Then, well one worker may hesitate to bring up their question to their supervisor. But if one person is brave enough to say, 'I've got a question'. That may then trigger some discussion that then somebody else is, even in their heads, [going to] say 'my situation is just a little bit different but that sounds sort of applicable'. Or six months from now when the situation comes up they're not going to have a total panic and think that they'll have to, you know, glove, mask, gown and put the goggles on, which our clients have told us is very concerning for them and dehumanizing.

It is important to note that in addition to the knowledge transfer issues, this key informant raised the problem that taking time out for education is, of course, a cost to agencies, to workers or to both. With the fiscal squeeze put on service providers and workers under the funding model (O'Connor 2003), education becomes yet another cost that they are

required to absorb rendering continuing staff education a short-term “business decision” (Interview-i 2004). As agencies must be financial viable to survive the contract intact, business imperatives are necessarily regularly privileged over quality of care imperatives.

To ensure that appropriate expertise is available for clients, CCACs have endeavored to create a strategy to offset this systemic shortcoming. Some have recently begun to contract for particular types of expertise, like incontinence care or palliative care (Interview-i 2004; Interview-m 2004). This is a further commodification of knowledge that takes expertise out of the public domain and places it in the realm of proprietary knowledge to be bought and sold instead of shared among professionals pursuing a common goal of improved patient care.

4. Conclusion

Returning to the Foucaultian notion of government’s role in steering the “conduct of conduct” (Light 2001), a number of things are apparent. Home care was reorganized using two governance techniques that served as the central planks of the system and were held as sacrosanct by the government. First was managed competition with its structuring of the interaction between CCACs and service providers as a market exchange relationship narrowly defined and prescribed by the terms of the contract (Taylor and Lewis 1993; Flynn 1996). Second is the transformation of the notion of accountability to mean fiscal accountability. As Jiwani argues,

For the Harris government, efficiency and cost-effectiveness were essential strategies to contain costs in the public sector. Therefore, they became an integral component of all accountability mechanisms in health care, in both the institutional and home care sectors (Jiwani 2003: 277).

Jiwani chronicles the government's narrow focus on cost-oriented numbers as indicators of policy success – numbers of clients served, cost per unit visit, cost per client per type of service (Jiwani 2003), which is revealing in light of Foucault's observation that what government's measure reveals what is important to them (source). Client outcomes are notoriously challenging to measure when it comes to chronic conditions or palliative care, however nursing theory has developed indicators to do just that.

CCACs were disciplined until they complied with the government's vision of a narrow fiscal accountability that moved in one direction - upward to government (O'Connor 2004). That this accountability was coupled with a cost-containment strategy that squeezed CCACs who, in turn, squeezed service providers led to a number of agency failures and the disenfranchisement of particular client groups (Browne 2003; O'Connor 2004) as well as a system of care stripped to its bare bones.

Implicit in the ideological bent of the Harris government was a view that markets and cost containment would control what they assumed were bureaucracies' proclivities for self-aggrandizement. With the implementation of policy designed to address these particular "problems", other problems emerged as an outcome of the increased fragmentation of local systems. Characteristics of the system logically fell into place as an outcome of those defining features.

Within the formal structures of the system, care was treated as a set of tasks devoid of its relational dimensions. Cost containment meant service providers were forced into survival mode. Service providers were to reinvent themselves as flexible and adaptive to volatile and unpredictable market conditions.

Collaborative relationships that had existed among service providers were transformed into competitive relationships. CCACs came to see themselves as the central components of the home care system, although they provide no direct service. Service providers were pushed outside of local networks organized to provide facilitate continuity of care and respond to emerging problems.

Knowledge and expertise have become market commodities to be bargained over but not freely shared. With continuing education treated as a cost centre rather than as a necessary ingredient to providing effective care - particularly in the case of unregulated workers - service effectiveness has been subordinated to a notion of efficiency measured by the ability of agencies to provide service at a fixed price and CCACs to “live within their means”. This arrangement is not conducive to providing effective services in a continuum of care.

The concept of problem definition is shown to be revealing, but the far-reaching consequences of problematizations are only evident when the related programs of government are examined. The governmentality approach is particularly useful in bridging what Pal has called the policy - implementation gap (Pal 1997). In policy subsystems entailing complex human services that play policy out on a daily basis through service delivery, it is critical to pay attention to the delivery regime. Delivery systems provide the critical link between government decision-making and outcomes for citizens. This black box needs to be opened.

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Notes

ⁱ CCACs had the autonomy to develop their own model for tendering provided it included opening the market to for-profit providers and foreign providers. There were restrictions on the type of service that could be provided i.e. in-home care and one price was to stand for the duration of the two to four year contract.

ⁱⁱ Despite the fact that home care operating expenditures went from \$812.7 million in 1995-96 to \$1.17 billion by the fiscal year 2000-01, an increase of 43% over six years the system was under enormous strain because of the influx of post-acute clients who were discharged from hospital earlier than in the past. CCACs consistently ran deficits until the province flatlined their annual budgets and made it illegal for them to run deficits. Subsequent expenditures in 2001-02 decreased by over \$100 million from 2000-01. Ontario Public Accounts. Toronto, Government of Ontario. See also O'Connor, D. (2004). Ontario's Home Care System in Neoliberal Times: Retrenched, Medicalized. unpublished manuscript. Hamilton.

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^{iv} These "carative values" are as follows. 1. a humanistic-altruistic system of values
2. the instilling of faith-hope
3. sensitivity to others
4. helping-trusting human care relationships
5. expressing positive and negative feelings
6. creative problem-solving caring process
7. transpersonal teaching-learning
8. supportive, protective, and/or corrective mental, physical, societal, and spiritual environment.
9. human needs assistance
10. existential-phenomenological-spiritual forces.

^v The contracts are such that all costs associated with doing business with the CCAC is rolled into the cost per visit. This means all costs have to be estimated three or four years forward in the proposal presented to the CCAC for consideration.