CARE WATCH
Advocating Quality Home & Community Care

1) Care Watch and Bill 175

On February 25, 2020, Ontario's Minster of Health tabled **Bill 175 – *Connecting People to Home and Community Care Act, 2020***, which significantly changes home and community care.[1] There has been little, if any, public consultation. Care Watch is concerned that when government's regular business resumes, the Bill could be pushed through quickly without clear information about how services will actually be delivered. This briefing summarizes our comments, concerns, and questions; it will be a springboard for other Care Watch communications. As the legislation and regulations evolve, our thoughts will evolve along with them.

2) About Bill 175

Bill 175 consists of three schedules addressing changes to key legislation:

- **Schedule 1 – *Connecting Care Act, 2019 (CCA)*** (Ontario Health, health teams, and funding, planning, and management). The government is moving the home and community care legislative framework to this Act.
- **Schedule 2 – *Ministry of Health and Long-Term Care Act (MOHLTCA)*** (the obligations and authority of the Minister to oversee home and community care); and
- **Schedule 3 – *Home Care and Community Services Act, 1994 (HCCSA)*** (the current foundational structure for home and community care legislation, which Bill 175 repeals).

Bill 175 also makes amendments to five other acts[2] plus regulations.

Care Watch applauds the Ministry's goal of modernizing home and community care. Many of our concerns, however, come not from what Bill 175 says, but what it doesn't say. Specifics are left to regulation and policy - a crucial distinction. Before becoming law, draft legislation is subject to all-party debate and public consultation. Regulations, in contrast, can be passed, repealed, or changed at any time by Cabinet with no public input.

Local Health Integration Networks (LHINs) are re-branded as Home and Community Care Support Services, downgraded from public crown agencies to service providers, and eventually abolished. They are governed by one board and CEO and their functions dispersed. System planning moves to Ontario Health and regional planning for home and community care to the Ontario Health Teams. The LHINs/Home Care and Community Support Services will continue to coordinate and manage admission to LTC homes, supportive housing, chronic care and rehabilitation beds, and home and community care services until the health teams and others take on those functions. Ontario's "…enduring commitment to the principles of public administration, comprehensiveness, universality, portability, accessibility and accountability as provided in the Canada Health

[1] The umbrella term now being used for home care and community support services. The Bill is available at: https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-175. A Ministry of Health summary of proposed regulations is available at:https://www.ontariocanada.com/registry/view.do?postingId=31727&language=en.

[2] *Excellent Care for All Act, 2010; Health Protection and Promotion Act, 1990; Local Health Systems Integration Act, 2006; Health Insurance Act, 1990; Health Care Consent Act, 1996.*

Act"[3] and commitment to "…equity and respect for diversity in communities…"[4] will be lost unless new legislation spells them out.

Unlike most legislation, Bill 175 has no statement of ***purpose*** or ***objects*** that reflect public interest. It also lacks definitions and descriptions. It essentially dismantles public governance of home and community care services, transferring key planning, design, delivery, and coordination functions to private (non-profit and for-profit) entities accountable to their corporate boards and not the public. Finally, there are no provisions to address access to care, equity, assessments, standards, quality, or staffing shortages.

3) Bill 175: Analysis of Some Key Elements and Changes

The Minister has made significant efforts to assure folk that nothing will change from a patient or client experience perspective and that people will continue to access services in the ways and from the sources they do now. Bill 175, however, doesn't clearly demonstrate this claim. Following are some key elements of the Bill.

Bill 175: Some Key Elements and Proposed Changes		
Issue	**What Bill 175 says**	**Care Watch perspective**
Broad service categories	• ***Home care services*** ▪ Professional services ▪ Personal support services and homemaking (when personal support services provided) ▪ Security checks and reassurance (where other home care services provided) • ***Community care services*** ▪ Remaining services in current HCCSA and Ontario Regulation 386/99 (e.g., foot care, assistance with activities of daily living, palliative care education, services to people with visual or hearing impairments), plus personal support services, homemaking, security checks and reassurance, education and training, and supplies and equipment	• Broad service categories may permit greater flexibility in defining services. • Each Ontario Health Team will determine or choose the services it will provide; no standard basket of services accessible to all Ontarians is identified. • No standards of service outlined. • Risk that wide array of organizational service choices will lead to greater fragmentation, inconsistency, and inequity.
New services included	• Education, training, and supplies. • Programming for aphasia, pain and symptom management, diabetes education, and psychological services for people with acquired brain injury. • Residential accommodation services, including funding for lodging, meals, unscheduled care needs, housekeeping, linen/laundry, safety and security checks, and social and recreational activities within residential congregate care (settings not defined).	• Includes some services previously delivered by LHINs/Home and Community Care Support Services. • Programmes such as assistance with health and personal services for vulnerable seniors in independent living settings not included. • No criteria or standards identified for residential accommodation/congregate care settings or their providers; settings could include hospices or some transitional care, but not defined.

[3] *Preamble. Local Health Systems Integration Act, 2006.*
[4] Ibid.

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Issue	**What Bill 175 says**	**Care Watch perspective**
Care settings (locations)	• Settings expanded. Supportive housing and adult day programmes included as health sector organizations. • Public hospitals added as care settings for some complex clients. • Settings to include residential congregate care; legal framework to be provided for non-licensed transitional or rehabilitative beds. • Some residential care beds operated by health service providers no longer defined as private hospitals.	• As health sector organizations, supportive housing and adult day programmes could be funded more readily. • Some hospitals (technically non-profit) already approved to deliver community care/support services, raising questions about funding duplication, professional responsibility and liability, and care standards. • Could lead to expansion of private for-profit hospitals into residential care.
Care settings (oversight)	• Regulations to allow province to create oversight mechanism for residential and congregate care models. • Congregate models currently undefined.	• Expansion of care settings generally welcomed, but standards and oversight not evident; current residential and congregate care models already operate in legislative grey zone with inadequate and haphazard oversight. • Transitional beds not legally defined; *Canada Health Act* already covers rehabilitation beds. • New, unlicensed settings could result in resurgence of private, for-profit retirement homes – not publicly funded or regulated and sites of some serious (sometimes fatal) incidents. • LTC residents could be forced into facilities providing insufficient care.
Placement and care coordination	• Will move from LHINs/Home and Community Care Support Services to Ontario Health Teams and other providers.	• Health teams may assign care coordination to a for-profit or not-for-profit health organization or to a contracted service provider. • Organizations that both coordinate and provide care can unilaterally limit numbers and types of visits and resources and then deliver (or not deliver) service – an inherent conflict of interest. • Risk that wide array of organizations coordinating and/or providing care will be increasingly privatized and will lead to fragmentation, inconsistency, and inequity.

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Issue	**What Bill 175 says**	**Care Watch perspective**
Service delivery	• Both in-person and virtual (electronic) visits to be continued as appropriate based on client's assessed needs and preferences. • Virtual visits to be expanded.	• Enhancement and expansion of virtual visits welcomed, but lead to questions about accessibility (language and culture), internet cost and access (in some communities), privacy protections, cybersecurity, equipment cost and maintenance, and response to injuries or other emergencies. • Private telehealth/virtual health providers entering market; how will quality be maintained? • No assurance that patient's rights and preferences will be listened to.
Eligibility	• Eligibility criteria (now in Ontario Regulation 386/99) expected to remain the same, but the additional qualifying criteria for each service may be updated. • Criteria not included in Bill 175; may be established by regulation or policy (currently undefined) rather than legislation.	• If each health team determines which clients receive which services, there is concern about lack of transparency and potential inconsistency of qualifying criteria for services. • No specified right to access home care (or even to be on wait list), so user fees and rationing based on funding likely to continue. • Eligibility for pharmacy and physiotherapy services (when unavailable in client's area) under consideration.
Service maximums	• Current service maximums to be removed.	• Real change unlikely; cost, funding allocations, and business models will continue to determine actual amount and duration of services provided. • People with high needs, those waiting for LTC, and the dying already excluded from maximums.
Client rights	• Current Bill of Rights repealed along with current home care legislation (HCCSA). • New, updated Bill of Rights (currently undefined) to be created in regulations, but not legislation. • Patient Ombudsman's jurisdiction (under *Excellent Care for All Act*) continued for prescribed services.	• Prescribed services not defined. • Updated Bill of Rights not currently available. • Current ability of Minister to approve or disapprove agencies depending on compliance with Bill of Rights is removed, so enforcement of Bill of Rights unclear.
Complaints and appeals	• Ontario Health Teams must establish process for reviewing complaints about home and community care service eligibility and conditions, quality, and alleged violations of rights. • Complainant may appeal health team's decision to Health Services Appeal and Review Board (HSARB), which may: 1) affirm health team's decision; 2) rescind decision and refer back to health team; or 3) substitute its own decision. • HSARB determinations final (not appealable).	• Regulations (and therefore requirements) as yet unpublished; procedural consistency and administrative fairness across health teams not guaranteed. • Lawyers generally needed for HSARB appeals, and community legal services have been decimated. • HSARB already has significant backlog, so will need more resources to increase capacity.

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Issue	**What Bill 175 says**	**Care Watch perspective**
Costs to clients	• Health teams, health service providers, and contracted service providers already prohibited from charging clients or families for home and community care services or receiving payment from them, except as allowed in regulations.	• Ministry media release states only community services may charge co-payments; appears contradictory unless applies to services that aren't prescribed services (but not defined). • Charges could be affected for services from for-profit service providers, which must serve interests of their directors and stockholders.
Funding and accountability	• Ontario Health replaces LHINs as home and community care funder; authorized to fund some service providers, including Ontario Health Teams, directly. • Ministry funds Ontario Health and some service providers, but retains right to directly enter into agreements with Indigenous organizations for home and community care services. • Health teams and other service providers may deliver services directly or indirectly through contracts with for-profit or not-for-profit providers or may fund clients/families for self-directed care. • Ontario Health can be audited annually by provincial Auditor General.	• Although Ontario Health can be audited, there are no such provisions for providers it funds. • System accountability requires consistent data reporting; providers may use their own auditors, applying generally accepted audit standards, so may not necessarily report consistent data. • HCCSA's qualifying criteria for provider agencies and penalties for failing to maintain qualifications lost when HCCSA is repealed. • Ability to regulate/ensure provider quality, practices, and integrity lost. • Concern about increased privatization of services, despite government's claimed preference for not-for-profit providers.
Government oversight	• Ministry's oversight extended, but only for prescribed home and community care services. • Minister may investigate residential accommodation, issue compliance orders, appoint a supervisor, and publicly publish enforcement information. • Current ability of Minister to approve, disapprove, or remove authorized providers eliminated, along with qualifications for approved provider status.	• Prescribed services not defined. • Lack of clear qualifications for approved providers doesn't place prospective providers on equal ground, increases likelihood of privatization, and limits ability to ensure quality, consistency, and public accountability; Minister's loss of power to approve, disapprove, or remove providers compromises system integrity. • Despite public statements favouring not-for-profit service providers, there is currently no obvious protection for non-profit service delivery (previous practice favouring non-profit community service delivery was established via LHIN service agreements, not regulation).

4) Some Questions

The government tells us that, if passed, the new legislation will make it easier for people to access home and community care in hospital, primary care, or community settings; help people connect with their care providers; and provide more choice for people with high needs to receive care in new community settings.

Bill 175 doesn't support these claims. Transferring planning, coordination, and delivery of home and community care services to Ontario Health Teams (and their delegates) raises concerns that services will be fragmented and

inequitable; inconsistent assessments will lead to inadequate care; and privatization will swallow the public interest.

Following are some key questions.

- What is the government's commitment to key public interest principles: public administration, comprehensiveness, universality, equity, portability, accessibility? Are the interests of the most powerful players in the system consistent with the public interest?
- How will prescribed services be defined? Who will have input into definitions and descriptions?
- How will Ontarians get the services they need regardless of where in the province they live and which Ontario Health Team serves their area? How will the cost of a particular service affect access?
- How will the Ontario Health Teams work? Who will do the coordinating?
- Will there be a consistent set of qualifications for all providers? How will not-for-profit service delivery be protected?
- What oversight will the government have over all service providers? How will clients be protected from rogue and dangerous caregivers? As virtual visits take on a larger role, how will clients' privacy be protected?
- Who will be accountable to the public for service quality and equity and for use of public funds? How will the public know how, and whether, the new structures are working?
- Why change the legislation now, when fewer than 50% of planned Ontario Health Teams are even in development, and they are new and still untested?