The Cost of Privatization: A Case Study of Home Care in Manitoba

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summary

In 1974, Manitoba was the first province in Canada to implement a province-wide Continuing Care program. Its model has since been adopted by most other Canadian provinces. This program provides coordinated medical, rehabilitation and support services at home to anyone assessed as requiring them to expedite their return home from hospital or to avoid placement in a nursing home. Older elderly and physically disabled adults are the major beneficiaries.

The per person cost to government of providing community care services to Manitobans is modest (see Tables 1 and 2) and the program consumes only about 4% of Manitoba's health care costs. However, in Manitoba, as elsewhere, the total costs of the program have been rising. Reasons for this increase include earlier discharge from hospital as a result of bed closures, the reduction in nursing home beds relative to the aging population and the introduction of new treatment approaches and technologies which make it possible for persons to be cared for at home rather than in a facility.

In April 1996, several months after a leaked Treasury Board document revealed the government's plan to privatize the delivery of community care services, the government announced its intention to privatize 25% of its personal care workforce in Winnipeg. In response, the unionized personal care workers went on strike. A public debate about the government's privatization plan followed.

During this debate, the government's estimates of the potential savings associated with privatization varied, ranging from $10M by the Premier to no saving but reduced future growth in costs by the Minister of Health. No evidence was produced to support either of these claims. However, information which the government already had received showed that the hourly wages of personal care workers in Winnipeg were the lowest of any major city. Moreover, British Columbia research indicates that labour turnover rates, an important factor in providing continuity of care, are lower for unionized workers than for those employed by non-profit agencies or for-profit companies. And, the turnover rate among Manitoba's unionized personal care workers, according to the Minister of Health, is even lower than that of unionized workers in B.C.

Furthermore, does privatization really reduce health care costs? Recent U.S.research reports that for-profit companies spent about 25% more than non-profit agencies and 40% more than government agencies to provide home care. Similarly, administrative costs are highest in for-profit hospitals and lowest in public hospitals. And overall, Canada spends just over 9% of its Gross National Product on health care in contrast to the 14% spent by the U.S., where 40 million people are uninsured.

Given Manitoba's already low labour costs for community care services, how can a company make a profit without charging the government more than it is now paying for services of equal quality? It can lower the wages of workers already earning relatively low wages and it can employ more part-time workers to reduce fringe-benefit expenditures – practices already prevalent among private health care companies in Manitoba and elsewhere. This in turn would probably increase staff turnover, putting continuity of care in jeopardy. Companies can also cut management costs by reducing staff training and supervision, thereby jeopardizing the quality of care delivered to vulnerable recipients. As cases reported during the strike also demonstrated, consumer protection legislation and careful government auditing is needed to protect those receiving services from private companies, especially the elderly, from company pressure to buy additional but unneeded services.

The contract which ended the strike called for maintaining the current workforce for the life of the contract, the privatization of 20% of the personal care services and an evaluation of the "experiment" within two years. Privatized services were scheduled to begin in June 1996. However, it was not until March 1997

that the Minister of Health announced that Olsten Health Services, a U.S. company, had been awarded a government contract to provide community care services (but not all specialized services) to all new long-term care clients living in some areas of Winnipeg. Notably, the Minister revealed that the government was forced to reduce the 20% experiment to 10% because "only one bidder could do the job as cheaply as it was currently done".

Why then did the government proceed with privatization and why is it still planning an evaluation when it already knows that the savings will be minimal at best, especially if audit costs are included? Also, why did Olsten Health Services agree to a contract which other eligible companies rejected? Olsten is the largest private home care company in the U.S. and a sister company to the giant Olsten Staffing Services. Could it be that a large multinational company can afford a "loss leader" in order to gain a foothold by shutting out its competitors with a view to then raising its prices? If costs then rise, will the government, as the leaked Treasury Board document suggests, introduce user fees for support services? Or will it cap costs by restricting its support only to persons requiring medical services, thereby excluding many of the disabled and the elderly with dementia who do not require such services? Might it also respond to increased costs by reducing its vigilance in ensuring that standards of care are maintained?

The recent National Forum on Health concluded that Medicare accurately reflects Canadian values of fairness and collective responsibility, and recommended that community care be included in the provisions of the Canada Health Act. It remains to be seen whether the government has learned important lessons from its recent experience and whether it is ready to apply what it has learned in making its future plans.

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In the spring of 1996, the issue of home care captured public attention in Manitoba. A provincial government decision to privatize home care service delivery, then provided by employees of Manitoba Health, provoked a five-week strike by personal care workers and prompted a public debate about the role of the private sector in health care delivery.

This study describes the history of community care in Manitoba, the context in which the strike took place and the available evidence pertaining to the privatization initiative. It concludes with a discussion of a key provision of the strike's settlement contract and an update on the current status of the government's privatization experiment.

In 1996 a provincial government decision to privatize home care service delivery provoked a five-week strike by personal care workers and prompted a public debate about the role of the private sector in health care delivery.

background

In the late 1960s and early 1970s concerns about the organization and delivery of health care led to a spate of federal and provincial inquiries. The reports, published between 1969 and 1974 (including the 1972 Manitoba White Paper), concluded that:

- Health care delivery relied far too much on hospital care.
- The organization and delivery of health care was fragmented, inefficient and wasteful.
- Insufficient attention and resources were focused on preventing preventable diseases and improving health.
- The provision or expansion of alternate care, especially community care, was essential to reduce reliance on hospital or nursing home care and to meet the needs of an aging population.

The provinces had the political authority to respond to these issues. Furthermore, as the sole payer for publicly-funded health care services, they had the control and the tools to reduce fragmentation, inefficiency and dependence on hospital care. Yet almost no serious, sustained attempt was made to address these problems.

However, during the 1970s and the early 1980s, the provinces began to respond to the recommendations on alternate care. Manitoba was the first province to act. In 1973, it co-insured nursing home care. Under this system the government paid the cost of care, and residents paid a flat room-and-board per diem charge. This allowed even the poorest elderly to retain $90.00 a month for personal use. The following year, Manitoba implemented a province-wide, coordinated Continuing Care program.

The Manitoba Continuing Care model had several features which were unique at that time.

the model

- Crossed community, hospital and nursing home boundaries.

figure 1

- Provided that referrals to the program could come from any source, including referrals from individuals who sought help on their own behalf.
- Provided both short-term and long-term community care without charge based on assessed need, bringing community care services in line with insured hospital and nursing home care.

• Employed public sector workers to assess need and provide services to ensure equitable access, cost control and quality care.

• Used community care assessors to determine the need for both home and nursing home care. This created a single-entry system linking the assessment of need for community care to the assessment of need for nursing home admission.

• Limited nursing home admission (via this single-entry system) to persons who could not be safely and/or economically maintained at home.

Initially, only B.C. followed Manitoba's lead. In 1979 British Columbia implemented a single-entry system, and restricted nursing home admission to those assessed as requiring institutional care. Most Canadian provinces have since adopted these two features of the Manitoba model.

Most Canadian provinces also followed Manitoba's lead in using public or quasi-public (e.g. Quebec Community Local Service Centres) sector workers to assess need. However, some provinces employ workers from the public, non-profit and/or for-profit sectors to deliver services at home.

manitoba's continuing care program

The Office of Continuing Care is part of Manitoba Health and is mandated by government to plan, budget and ensure that policy and program standards are maintained across the province. However, to ensure responsiveness to regional needs, each Health Region has a Senior Continuing Care Coordinator who reports to both the Office of Continuing Care and to the Regional Director, and all Regional staff and service delivery workers are hired by the Region.

The objectives of the Continuing Care model are: to enable individuals requiring help to return home from hospital or to remain at home in the community; to delay or avoid nursing home admission; and to place individuals in a nursing home if necessary.

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To accomplish these objectives, the role of the program's professional assessors/coordinators (now commonly referred to as case managers) is to:

1) assess the functional and social status of individuals referred to the program and to reassess their status from time to time until they are discharged from the program;

2) assess their family's capacity and availability to provide support;

3) develop a mutually-agreed upon care plan;

4) arrange for the delivery and the coordination of the type and amount of services required from the program. If resources are limited, assessors can also give priority in access to services (at home or in a nursing home) on the basis of need.

The functions of coordination are to avoid duplication or fragmentation and to ensure the delivery of the right services in the right place at the right time in line with the goals of the care plan. In response to wishes among some physically disabled adults to control the timing of their own service delivery, the Continuing Care assessors continue to assess need, but provide direct payments, instead of services, to persons who want to self-manage their own care.

The program's Resource Coordinators recruit, train, assign and supervise direct service workers. They also plan and arrange staff development opportunities. The main objective of these functions is to maximize the quality of the services delivered.

The community care services available from the Continuing Care program to persons returning to, or living at home, range from those provided by professionals such as nurses, social workers, physiotherapists and occupational therapists, to those provided by paraprofessionals and lay workers such as Licensed Practical Nurses, personal care workers and home helpers. Most of these services are provided at home, but adult day care and some respite care are also made available in alternate out-of-the-home settings.

The government, the public and community care recipients benefit from publicly-provided home care services. The most important benefits to government are that a single-payer system, in contrast to a tendering system, gives it the power and the tools to control the total cost of the program's services, the ability to make reliable forecasts of future expenditures and the assurance that its policies on equity, standards and continuity of care will be enforced. The public also benefits from these assurances. In addition, and perhaps more importantly, the public benefits by having the opportunity to hold its government accountable not only for the program's policies, but also for equitable access and service delivery.

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Publicly funded and provided community care services, in combination with an established appeal mechanism, also benefits the consumers by ensuring that they have access to equitable decisions about the type and the amount of services they receive, and to quality care. Another, but less often noted, advantage to consumers is that the presence of case managers, resource coordinators and direct service workers in the same office permits informal as well as formal communication between them about the clients they serve – an invaluable asset in helping individuals and their families cope as soon as possible with any change in their circumstances. Finally, consumers, especially those receiving long-term community care, benefit by not having to adapt to new workers as a result of high turnover rates or a change in the companies which win annual tendering races.

research findings

Published studies on community care in Canada are scarce when compared to studies on other health care sectors such as hospital, physician or nursing home care. Comparisons between provincial programs are difficult to make because community care programs vary from province to province and there is no interprovincial agreement on nomenclature, definitions or what a community care information system should record. Therefore, even the results of attempts to simply compare expenditure data are notoriously unreliable.

Manitoba home care workers have a significantly lower turnover rate than non-unionized private sector home care workers in British Columbia, half of whom leave their jobs annually.

Province-specific studies are limited by the absence, scarcity or adequacy of province-wide computerized information systems. Studies using Manitoba data are especially limited because the Continuing Care program has neither a computerized information system nor a built-in capacity to link the use of community care with the use of other health care services, making research almost prohibitively time-consuming and expensive. Despite these serious problems, the key findings from studies and data from Manitoba Health on the Continuing Care program as well as relevant information from elsewhere indicate that:

- the vast majority of home care clients are senior citizens;

- the service supplements the help provided by family members, most of whom are women, but does not lead to families providing less service;

- nursing home care is ten times more costly than home care;

- Manitoba home care workers have a significantly lower turnover rate than non-unionized private sector home care workers in British Columbia, half of whom leave their jobs annually.

About 20,000 Manitobans use community care during the course of a year. In Winnipeg, three-quarters of these consumers receive long-term services; one quarter receive services for a short period of time, mostly for post-hospital care. In Manitoba, as elsewhere, the primary users are the elderly. Only 10%-12% of the elderly use home care in the course of a year, but they constitute about 75%-80% of service recipients. About 20% of service users are non-elderly, adult post-hospital patients and the disabled, and about 5% are severely handicapped or chronically-ill children. Canadian and U.S. studies consistently show that families provide 80%-90% of the care required and that most of this care is provided by spouses and children, mostly women. Research from both countries also indicates that the

table 1

cost per person served - manitoba 1988/89

services only[2]	$1,667.00
assessment[2], coordination, services and administration	2,102.00
personal care home bed[1]	22,051.00

[1] Annual Report, Manitoba Health Services Commission
[2] Office of Continuing Care

provision of community care does not encourage families to provide less care than before they received formal services.

Manitoba research shows that advancing age is by far the most powerful predictor of community care use. Other predictors of use by the elderly include poor health, functional disability, being poor and being female (Shapiro, 1986).

The cost per user of providing community care services by the Continuing Care program in Manitoba is modest. 1988/89 data from the Office of Continuing Care (see Table 1) indicate that the annual cost per user was $2,102/year: $1,667 for direct services and the remainder for the assessment, coordination, service worker management and administration functions. The average annual cost per user of a nursing home bed during the same year was $22,051, or about ten times that spent on a community care user.

Results from a recently completed study using 1992 data are shown in Table 2 (Shapiro and Tate; in press). They indicate that the average annual cost for direct services per elderly user continues to be relatively low and varies by their mental functioning (cognitive)

table 2

cost per elderly person served - manitoba 1992

cognitively unimpaired	$1,101.82
cognitively impaired	1,822.44
persons with dementia	2,343.05

capacity: about $1,100 for those with no cognitive impairment; about $1,900 for those with cognitive impairment but no dementia; to about $2,300 for an elderly person with a diagnosis of dementia. The study also found that the type and amount of services provided to these three groups are different, with the first two groups using less but more expensive services, and those with dementia using more but largely less expensive services. The differences in the types, amount and costs suggest that the assessors appear to be responsive to the different needs of the three groups in making service decisions.

Independent evaluations of implementing a single-entry system into community and nursing home care in Alberta and New Brunswick found that it was cost-effective in reducing nursing home use. A Manitoba study reinforces their findings (Shapiro and Tate, 1989). In fact, almost all the Canadian provinces have now adopted this system. Furthermore, research by the Manitoba Centre for Health Policy and

table 3

turnover rates for british columbia and manitoba home help/personal care

b.c. private for profit	50%
b.c. private non-profit	37%
b.c. unionized workers	32%
manitoba public workers	15%-25%

Evaluation (DeCoster et al., 1995) shows that the use of a single-entry system and uniform assessment criteria provide Manitobans with equitable access (i.e., fair access based on need) to nursing home care. A Manitoba study on one component of community care, adult day care, reported that its use reduced hospital admissions (Chappell and Blandford, 1983).

Research using B.C. and Toronto data found that both short and long-term community care are cost-effective (Hollander, 1994). This study also reported (see Table 3) that the turnover rate of the direct service workers in B.C. is highest (almost 50% a year) among those who work for private companies and lowest for unionized workers at 32%. High turnover rates make continuity of care by the same personnel almost impossible.

At a public meeting in April, 1996, Manitoba's Minister of Health stated that the turnover rate among Manitoba's public sector workers is about 25%, even lower than that of British Columbia. However, the Assistant Deputy Minister, in a private communication, later indicated that the turnover rate of its unionized workers was closer to 15%. Finally, recent U.S. research (Abt Associates, 1996) reports that for-profit companies spent about 25% more than not-for-profit agencies and 40% more than government agencies to provide home care.

Recent U.S. research reports that for-profit companies spent about 25% more than not-for-profit agencies and 40% more than government agencies to provide home care.

In sum, current research shows that Manitoba's home care program has been effective. Operating costs have been less than for the additional nursing home beds which would otherwise have been required. Moreover, the Continuing Care program also provides services at a low per person cost. Lastly, and just as importantly, it is better able to retain its service workers than programs which use for-profit companies or non-profit agencies – a key factor in delivering continuity of care to those who require long-term help and who constitute a majority of home care users.

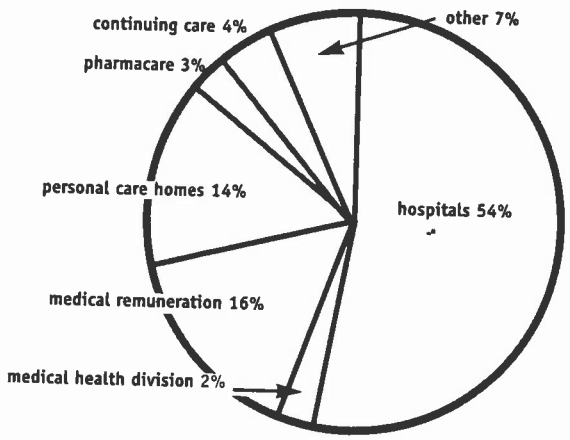
current cost and future trends

Continuing Care currently consumes about 4% of Manitoba's health care budget (see Figure 2). However, the cost of Continuing Care here, as elsewhere in Canada, has been steadily increasing and will continue to rise. The main reasons for the rise in the community care cost are:

- the growth in the number of elderly Manitobans;
- the increase in the intensity of services;
- the introduction and use of new technologies, some of which are costly but permit persons to return to or remain at home;
- the growing number of disabled adults choosing to live in the community;
- the elimination of the Canada Assistance Plan.

figure 2

manitoba health expenditures 1993/94



While the percentage of Manitoba elderly using community care has remained stable over the last decade, the growth in numbers has increased service consumption. As Table 4 indicates, the proportion of elderly in Manitoba has been rising faster than that of most other provinces between 1971 and 1991, and now stands at over 13% of the province's population – a higher proportion than every other province in Canada except Saskatchewan (Statistics Canada, 1993).

The reduction in hospital stays and the reduction in the ratio of nursing home beds per 1,000 elderly aged 75 or more (who constitute about 85% of the facilities' residents) are leading to an increase in the amount of services individuals require to recover or remain at home.

New technologies are allowing the people who previously required hospital or nursing home care to be cared for at home. One example of the effect of new technology is the current maintenance at home with community care of people requiring oxygen. This was previously provided only in hospital because even most nursing homes were not equipped to provide oxygen.

A growing number of non-elderly disabled adults are choosing to live in the community. With community care, they can be maintained at home with the new equipment and new technologies available to make this possible.

table 4

population aged 65+ in canada, by provinces and territory
(estimated for 1951-1991 and projected for 2011)

	1951	1971	1991	2011
newfoundland	6.5 %	6.2	9.7	15.1
p.e.i.	9.9	1.0*	13.2	16.3
nova scotia	8.5	9.2	12.6	15.5
new brunswick	7.6	8.6	12.2	16.0
quebec	5.7	6.9	11.2	15.3
ontario	8.7	8.4	11.7	14.3
manitoba	8.4	9.6	13.4	14.3
saskatchewan	8.1	10.2	14.2	14.5
alberta	7.1	7.3	9.1	12.4
b.c.	10.8	9.4	12.9	15.4
yukon	5.1	2.8	4.0	9.6
n.w.t.	2.7	2.2	2.8	6.6
canada	7.8	8.1	11.6	14.6

*note: this may be a typographical error and should be 10.0
source- statistics canada, 1993

The federal government shared some of the cost of community care in Manitoba under the Canada Assistance Plan (CAP). However, CAP has been folded into the new Canada Health and Social Transfer and the total transfer payment has been reduced. The province's expenditures for community care are, therefore, rising to make up for the virtual elimination of CAP.

The province's expenditures for community care are rising to make up for the virtual elimination of the Canada Assistance Plan.

the initiative to privatize

In February, 1996 a leaked Treasury Board document disclosed that the province planned to move quickly to privatize the delivery of community care services in Winnipeg. The plan was to start on June 1, 1996 with the privatization of 25% of the services provided by its personal care workers. These workers are trained to perform personal tasks (e.g. bathing, grooming) which community care clients cannot perform for themselves.

When questioned about the document, the Premier's public response was that privatization would save the government about $10M dollars a year. However, this statement was almost immediately amended by an Assistant Deputy Minister of Health who stated that the $10M savings was simply an estimate of possible savings. Even this correction was subsequently contradicted by the Minister of Health at a public meeting convened in April, 1996 by a coalition of community care consumers and representatives from organizations of the disabled, seniors and other community groups. At that meeting the Minister indicated that privatization was not expected to produce immediate savings, but was intended to reduce future increases in community care costs. However, such a reduction would happen in any case if age were the only factor affecting the need for community care. This is because, as Statistics Canada figures (Table 4) show, the rate of increase in the proportion of elderly in Manitoba will slow considerably in the two decades between 1991–2011.

No evidence was presented by the Health Minister at that meeting to support privatization. Questions from the audience after his presentation elicited no further explanations. Furthermore, questions from service consumers produced no reassurance from the Minister on two key concerns: the maintenance of the quality of care; and the continuity of care, with the same workers providing personal care to specific individuals.

One question, however, produced an interesting and carefully worded response from the Minister. When asked what the leaked Treasury Board document meant by its reference to "core" and "other" community care services for which charges could be levied, he responded that the term "core" services applied to the services now being provided without charge, but he would not identify or give any examples of what services were being referred to by the term "other". This reluctance raised concerns about the possibility of the imposition of user charges where none were previously levied for home help and personal care

services, the two most critical needs of frail elders and the disabled who require long-term care at home.

There is substantial evidence to question the government's privatization initiative. Data collected for the Steering Committee of the review of Continuing Care conducted by Connie Curran in 1992/93 indicate that the average hourly cost of public sector home help /personal care workers is lower in Winnipeg than in other Canadian cities. Furthermore, as already indicated, the higher turnover rate among direct service workers in the private sector makes continuity of care by the same worker difficult if not impossible to achieve.

The government has failed to produce evidence to support its privatization initiative, to take account of the evidence available to it on the benefits of retaining public sector service delivery, or to use any other policy options it has... This suggests that the decision to privatize was made on ideological grounds and/or in response to political pressure from the business sector.

The government has failed to produce evidence to support its privatization initiative, to take account of the evidence available to it on the benefits of retaining public sector service delivery, or to use any other policy options it has, as the single payer of publicly-funded health care, to reduce future increases in community care costs. This suggests that the decision to privatize was made on ideological grounds and/or in response to political pressure from the business sector. The latter explanation is not unwarranted. The Final Report of the National Forum on Health (1997) notes that "the private sector is pressing to gain access to new business opportunities in a sector that, up to now has been beyond its reach." Furthermore, mailings from major businesses and financial institutions indicate that they are sponsoring or co-sponsoring workshops to stimulate interest among entrepreneurs in what they refer to as an opportunity to get into a profitable business.

the problems with privatization

If Manitoba's current policies on eligibility, access, service delivery based on assessed need, and quality and continuity of service delivery personnel are maintained, privatization is unlikely to produce substantial cost savings. Privatization is also unlikely to reduce the rate of cost increases if the province continues to close hospital beds and to reduce the ratio of nursing home beds to the population aged 75 or more. (The cost impact of the growth in the elderly population will, as indicated before, be modest). The impact of new technologies is difficult to assess because some may allow persons to be cared for at home less expensively while others may involve higher costs.

Privatization is, however, likely to lead to lowered wages and increased staff turnover.

Since Manitoba's costs for service delivery labour are among the lowest in Canada, one way companies can make a profit without charging the government more than it is now spending is for the companies to lower the wages of service providers. This consequence is not hypothetical: private Manitoba companies are now paying substantially lower hourly wages and providing fewer opportunities for full-time employment for their home care workers. The advisability of reducing the wages of lower-paid workers who probably spend all of their wages on other goods and services is questionable on economic grounds.

Private Manitoba companies are now paying substantially lower hourly wages and providing fewer opportunities for full-time employment for their home care workers.

If the Manitoba experience is similar to that of B.C. and elsewhere, the combination of lower wages and lower take-home pay will result in a much higher turnover rate. Therefore it appears almost inevitable that privatization would mean that the government would be unable at the current cost to meet one of the key demands of persons receiving long-term care – continuity of care by the same personnel. It is important to note that the demand for continuity by long-term service consumers is warranted: the workers perform very personal tasks which require not only training and experience but the adaptation of workers to client preferences in the performance of these tasks. At the April public meeting and at the public hearings in the Legislative Building in May, 1996, a number of participants receiving company services during the strike complained about having different people arriving to provide the same help

and, therefore, having to deal with workers unable to meet their individual needs. In addition to the concerns expressed by service consumers, higher labour turnover rates also increase a company's cost of doing business by increasing the time and money it spends to recruit new workers.

Privatization could also lead to a number of other serious problems. These include:

• Companies can respond to the pressure to lower their price or to keep their price low on the tenders they submit by lowering their profit margin, or by further lowering wages, or by reducing the cost of service management which includes recruitment, assignment, traffic management, training and supervision of their workers. However, there are limits to reducing wages and working conditions below which it would be difficult to maintain an adequate labour supply even with constant recruitment efforts. The danger is, therefore, that companies could try to maintain profits by reducing the training and supervision required to provide the quality of care delivered to the vulnerable people they serve.

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• The province is responsible for ensuring that quality of care standards are maintained. Quality of care standards must be high enough to protect vulnerable persons who receive care at home where there may not be the continuous presence of family and when there may be only sporadic, if any, employee supervision. The government is, therefore, obligated to provide companies with explicit standards related to training, supervision and on-the-job performance and to establish and pay for the processes needed to audit compliance and handle complaints. One concern must be whether the government's standards will include specific criteria on the training, supervision and job performance of company workers. Another concern must be whether the government will assume the not inconsiderable cost of setting up the processes and hiring the staff required to audit compliance with the quality of care standards, and will account for these costs to the public as part of the cost of privatization. A third concern is how the government will respond to complaints from service recipients and/or their families about the quality of the services delivered. This latter concern is warranted: complaints during the 1996 strike centered on untrained and unsupervised service workers and on the often inadequate response by the companies involved to service complaints.

• The government will have to go beyond auditing standards of care to implement and audit consumer protection standards which do not permit for-profit companies to exploit service recipients. Some consumer complaints during the 1996 strike of personal care workers centered on company workers or company representatives trying to persuade elderly service recipients or members of their family to purchase additional services from the company which were not needed. It is difficult to assess whether such practices were widespread or just isolated incidents, but the elderly have traditionally been the likeliest victims of such "sharp" practices. And the vulnerable and older elderly who are already receiving needed care at home are even more susceptible to being persuaded to purchase services they do not need at a price which most of them, especially the women, cannot afford. According to Statistics Canada (1994) over half of Manitoba's elders have incomes below $15,000 a year and the majority of these elders are women.

The vulnerable and older elderly are even more susceptible to being persuaded to purchase services they do not need at a price which most of them, especially the women, cannot afford.

• The tendering process itself raises concerns about the effects the choice of company or companies will have on the future costs of community care services. Large, well-financed companies have been known to underbid rivals even if it initially means minimum profits in order to eliminate competition. They can later raise their prices when the competition disappears and when it is difficult to resurrect it. Companies have also been known to fix prices (as the City of Winnipeg past experience with tenders to supply cement has shown), a practice which also raises

the price of goods or services over time. Such concerns about tendering are particularly warranted when the price for the delivery of community care services is already relatively low. Finally, tendering is usually not a one-time event. This means that, even if enough competition survives to offer the government a chance to make future choices other than the present provider(s), the resulting changes in the workforce again reduces the possibility for persons to receive care from the same workers to whom they have become accustomed. In other words, this is not just a matter of providing care but also the quality of care.

• Another particularly serious concern about privatizing public services is that rising prices charged by the companies, or the high cost of auditing the quality and continuity of care, could lead the government to change its policies in regards to eligibility, access and service provision on the basis of assessed need rather than revert to using public sector workers. The terms "core" and "other or non-core" services used in the leaked Treasury Board document, and the repeated use of the term "charges" in the recently passed legislation setting up the province's Regional Health Authorities, could be laying the groundwork for policy changes which would see the imposition of user fees for some or all community care services. If user fees were imposed, the likeliest prospect is for the imposition of user fees for home help and personal care – the most needed and most used services by older, frail or demented elders and by non-elderly seriously disabled adults. This would produce serious inequities in responding to the needs of persons requiring care at home.

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• Another possible policy response by the government to increases in community care costs resulting from trends already outlined and from possible further increases in costs as a result of privatization could be to " cap" community care expenditures. Beyond questions about the wisdom of capping the expenditures of community care per se, there are other important issues in regards to how the cap would be applied. A cap applied without government-initiated, explicit criteria as to who would then be eligible to receive services and who would get priority access to services could signal a move away from the principle of equity in the treatment currently provided to all who seek help. A cap applied by explicitly excluding those who do not require medical services would mean that most frail elders and other adult disabled persons would not be eligible for formal care at home. Families, who already provide most of the care, would have little option but to seek nursing home placement for a relative, and persons with little or no family resources would require institutional care. This latter concern may appear far-fetched in the context of the program's operation over the last twenty years, but the experience of the Continuing Care program just after its implementation was that a majority of persons on the waiting list for nursing home admission chose to remove their names from that list when they became eligible to receive community care services. If the cap results in a waiting list for admission to the program on the basis of assessed need, what would be the criteria for deciding whether the admission should be treated as emergent or urgent, as distinct from one which can wait?

the 20% experiment

The contract between the personal care workers and the government which ended the 1996 strike included the retention of the current workforce for the life of the contract, the privatization of 20% of the personal care services and an evaluation of the experiment within two years. It is important to note here that the contract applies only to personal care workers, not to other service delivery workers such as nurses or home help workers. The government is, therefore, not restricted from privatizing any other community care services.

The privatization experiment was originally announced by government to begin in June, 1996, but the starting date was postponed to September, 1996. However, as of February 28, 1997, the experiment had still not been implemented. No reasons were given for the delay. One possible reason is that the province wanted to put its best foot forward for the evaluation even though private companies who do this work are likely to bear in mind that, "he who pays the piper, calls the tune."

However, two aspects of the available information on the government's implementation plans for the experiment are noteworthy. First, it plans to use private company workers to deliver personal care services to new admissions; persons already being served by the program will continue to receive care from their current workers. This arrangement will make it very difficult if not impossible to compare the quality, continuity and outcomes of services provided by public sector workers and those provided by company workers. Second, it plans to use some of the Continuing Care's experienced case managers exclusively with new admissions. This will place the experiment in a preferred position because its case managers will likely have far more reasonable caseloads for a considerable length of time than the remaining case managers who are now experiencing problems because of the large caseloads for which they are responsible.

A concurrent, recent development has been the publication of a newspaper advertisement inviting applications for a Chief Executive Officer (CEO) of Winnipeg Home Care. Interestingly, the advertisement provides no indication as to which branch of government placed the advertisement, who is charged with selecting the CEO, or to whom that person would be responsible. Furthermore, the job qualifications listed for applicants demand a strong business background but describe training in a health-related discipline simply as "advantageous". Neither the advertisement nor any public statement sheds any light on the organization or structure of the new office. Although no one can argue with the premise that community care must be as efficient and as cost-effective as possible, the business orientation in the wording of the advertisement and the accent on business qualifications appears to presage a turning away from the values which underpin Medicare – an ominous development in regards to the public and to community care recipients.

what's so important about values?

Values define the kind of society we want to live in and, consequently, the kind of role we expect the state, as the instrument by which societal values are translated into policy decisions, to play.

The Great Depression of the 1930s and the Second World War transformed Canadian values and thereby significantly changed the role played by the state. As the result of our experience during the Depression with intolerable inequities, high rates of unemployment, hunger and misery, we rejected our pre-war total reliance on individualistic values by which "market forces" and "every man for himself" beliefs predominated. We opted instead for collectivist values which, while rewarding individual initiative, recognized that we all have a collective stake in sharing the cost of health and social resources which must be available should we need them since none of us knew when we ourselves might require them. In order to enshrine these values and make sure the results were fair, just and economical, we agreed that the state has a role to play in collecting and dispensing the monies required to make services available, and we charged the state with the responsibility of ensuring equity in access, quality of service and respect for both providers and consumers of services.

As the very recent Final Report of the National Forum on Health points out, Medicare accurately reflects Canadian values of fairness and collective responsibility. The Final Report goes on to recommend that home care be included in Medicare as an insured service. After rejecting user fees and stressing the importance of maintaining our single-payer system, the Report notes that the single-payer system "provides more consistency and bargaining power in dealing with health care providers", and that "the profit motive in financing health care is both inconsistent with a view of health as a public good and moreover leads to high administrative costs and inequities in access and quality." A very recent research report in the New England Journal of Medicine (Woolhandler and Himmelstein, 1997) strongly supports the Forum's position on both issues. The study found that the proportion of total hospital costs spent on administration in the U.S. was almost twice that of Canadian hospitals and that this proportion was rising. In addition, it found that the proportion of costs going for administration was highest for for-profit

National Forum on Health: "the profit motive in financing health care is both inconsistent with a view of health as a public good and moreover leads to high administrative costs and inequities in access and quality."

hospitals (34.0%), followed up by non-profit hospitals (24.5%) and lowest for public hospitals (22.9%). Furthermore, whereas our collectivist values have resulted in our spending just over 9% of our Gross National Product (GNP) on health care, the individualistic values of the U.S. have resulted in costs which consume about 14% of its GNP and in 40 million persons who have no health insurance. In general, the OECD countries that have contained costs better have greater government control of health spending and a larger public share of total expenditures (World Bank, 1993).

The values underlying the issues involved in the strike of the personal care workers, and the support they received both from consumers and the public-at-large, echo the values expressed by the Canadian public to the blue-ribbon committee which authored the Report of the Health Forum. The government of Manitoba's plan to privatize services without providing any evidence to back up its decision, demonstrates a rejection of these widely-held Canadian values. The readiness to lower the wages of relatively low-paid providers to ensure company profits, the failure to make a public commitment to ensure quality of care and the Treasury document which presages the end of universal access without charge based on assessed need are further signs of this rejection. All of these measures hit at the core of Canadian values, and at the role that Manitobans expect the state to play in providing quality community care to its vulnerable citizens. The care of the sick, the disabled and the frail elderly is too vital to be left to the market place.

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update

This Report was completed on February 28, 1997 when the 20% Experiment was still not underway. On March 29, 1997, the Minister announced that a private company, Olsten Health Services, had been awarded a government contract, beginning April 1, 1997, to provide nursing, home attendant and home support services to new long-term care clients in some areas of the City of Winnipeg. However, new long-term care clients who require specialized services will still be served by public service workers.

The report of the announcement and press conference in the *Winnipeg Free Press* (March 29, 1997) was remarkable for three reasons. First, the Minister conceded that the government was forced to reduce the 20% experiment to a 10% experiment. Second, he admitted that this reduction was due to the fact that "only one bidder could do the job as cheaply as it was currently being done". Third, the Minister was quoted as saying that he would have looked "silly" if he had gone ahead with more privatization because "one of the things this has demonstrated is that generally speaking, our home care system is fairly well run on the cost side across the province." He also added that "when people talk about the privatization of the home care system, I just think that isn't going to happen."

The responses to the Minister's comments from representatives of organizations of long-term home care consumers and from individual caregivers as reported in the same newspaper article ranged from a simple "we told you so", to obvious relief, to a lingering suspicion of the government's future intentions.

However, the newspaper report omitted any mention of several important questions raised by the Minister's announcement. Olsten Health Services, a subsidiary of the U.S.-based multinational Olsten Corporation, is the largest home care company in the U.S. Its sister company, the giant Olsten Staffing Services, recently opened an office in Winnipeg. Why did Olsten Health Services agree to a contract which all other eligible companies rejected? Could it be that a large multinational company has the financial resources to afford a "loss leader" in order to gain a foothold in what might be a lucrative business when other competitors are shut out and prices can then be raised? Such tendering practices are not unknown in the United States

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where the goal of such companies is to reduce or actually wipe out potential competitors before raising prices. Also, no information was provided on the cost of the evaluation. That one-time cost may well equal the minimal savings associated with this experiment. And why was there no accounting for the ongoing cost of auditing adherence to standards and quality of care – auditing which is normally required when any company delivers services to vulnerable persons at home? Surely, these ongoing monitoring costs must be regarded as part of the cost to government of using private companies to deliver health care services.

Finally, the government's only stated reason for privatization was saving money. Since it already knows that other companies chose not to compete for the contract and that savings will be minimal at best, especially if its audit costs are included, what is the purpose of the projected evaluation?

It now remains to be seen if the government, which earlier neglected to heed the available evidence, has learned an important lesson or if it will remain steadfast in its decision to privatize despite the additional evidence which this experience has provided. ■

It now remains to be seen if the government, which earlier neglected to heed the available evidence, has learned an important lesson.

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