Election 2016
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Home care in Manitoba best kept public

Manitoba's Home Care program was launched in 1974 under the guidance of the late Evelyn Shapiro. It is publicly funded and publicly delivered. It aims to avoid or delay the more expensive forms of chronic care such as personal care homes, and improve satisfaction and health outcomes for the client. The largest cluster of program components consists of concrete assistance such as laundry, shopping, bathing, but nursing and other health professional services may also be provided. It is universal having no fee for the client regardless of income, but it is not infinitely elastic; rather the type and level of service is based on assessed need.

The program will become ever more important as demand continues to increase. The 65+ population - the largest single group of users - is projected to increase in Manitoba from 185,300 in 2013 to 225,800 in 2020. The average monthly users of Home Care increased from 23,075 in 2009 to 27,246 in 2014 – an 18 percent increase. Expenditures have risen 26.6 percent over that same period from $265.3 million to $335.4 millon. This is in contrast to most other provinces, which have made savage cuts to their Home Care in the name of austerity.

In Manitoba, the success of the program for the system in recent years is evidenced in such measures as a diminished take-up rate in Personal Care Homes. There is general agreement among observers that better client satisfaction and outcomes are achieved, although Manitoba's Auditor General has recently criticised the lack of research which would enable planners to identify problems with the system on the front lines. Research from other provinces has identified a number of problems with home care programs which, despite creditable resourcing, could very well be present here. A common one is the rigidity of the care plan which is not subject to alteration regardless of needs which may change from day to day. Another shortcoming is the tendency to exploit family caregivers rather than support them. For example, In the U.K. family caregivers may be paid a full wage. In Manitoba, apart from some rare cases of hiring family, the most that a family caregiver will qualify for is a tax credit from both levels of government.

Finally, it should be noted that there are a number of private providers of home care active in Manitoba. It is assumed that they service those with disposable income who seek more than the public system is prepared to give. Two comments come to

telephone: 204.927.3200
email: ccpamb@policyalternatives.ca
website: policyalternatives.ca
blog:policyfix.ca
twitter: @ccpamb

Located in the
Social Enterprise Centre
205 - 765 Main St.
Winnipeg, MB
R2W 3N5

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mind. The first is that while it is difficult to quantify the extent of private services, their presence implies shortcomings in the public system, which while correctable by those able to afford the fee, may have serious consequences for the health and wellbeing of those who cannot. The province needs to explore this possibility and identify and rectify any shortcomings discovered, such as those identified by the Auditor General and others.

The second comment is that the elephant in the room in the upcoming election will be privatization. This takes many forms and disguises, but the most common in health care is contracting out delivery of a service to private providers while the public purse maintains funding. In health care this version of privatization is less offensive to the public because it maintains service based on need, not ability to pay. Nevertheless, any election hints that even this limited form of privatization is contemplated should raise some alarm bells amongst voters. (The discourse is sometimes in code using such phrasing as "alternative delivery systems"). We should remember the aborted experiment in Manitoba with contracting out Home Care in 1997. The then health minister claimed millions of dollars in savings at the outset, only to admit later that no such savings were possible despite the fact that the contractor paid low non-union wages. Claims of greater efficiencies and better quality service also melted away. Furthermore, the contractor had avoided conviction for serial fraud in the USA only by settling out of court. Well documented allegations included overbillings and billing for services not rendered, as well as selling unneeded services to vulnerable clients.

Ontario adopted a system of outsourcing most of its home care program to the private sector several years ago. An extensive consultation with stakeholders revealed serious access problems with no appeal or review process, missed visits, poor wages and poor training of staff, leading to high staff turnover and questionable service. More recently, and in addition, the Ontario Auditor General cited a system which was utterly fragmented and almost impossible to navigate. There were 260 different contracts with 160 companies. It was unaccountable with no access to company books, but evidence of large discrepancies between billings for staff costs and what staff were actually paid. Costs further escalated because of double administrations – one in the public sector and one in the private sector.

Health care is vulnerable to privatization because it is a very profitable field and the subject of intense lobbying from the private sector for it to get an ever increasing share. Home care is especially vulnerable because, together with other community based services, it does not enjoy the protections of the Canada Health Act. One USA corporation once described the Canadian system as the last unopened oyster. We need to keep the shell tightly closed and work to improve what we have.

Pete Hudson is a senior scholar at the Faculty of Social Work, University of Manitoba and a CCPA MB Research Associate.

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