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## Neoliberalizing Home Care: Managed Competition and Restructuring Home Care in Ontario

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It's filtered down – like the misery has come down from the government to the upper echelons of the CCAC has now filtered down to the coordinators and unfortunately the coordinators are having to carry out what the bosses have said and it's coming onto us (home care nurse).

This home care nurse is reflecting on the recent restructuring of the province of Ontario's publicly funded home care around the principles of managed competition. She refers to "the CCACs" or Community Care Access Centres, a governance structure first implemented in 1996 as part of this new system for administering and delivering home care in the province. The CCACs are 43 regionally based organizations that govern the delivery of home care services and admissions to long-term care facilities in their region. The restructuring of home care was introduced as part of a wider set of neoliberal-oriented social policy changes in the mid-1990s by the then recently elected Conservative provincial government. These CCACs were organized around the market-oriented

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logic of managed competition, a popular transnational health policy reform. The CCACs were required to develop business plans and issue requests for proposals from local home care service providers, not only from the nonprofit sector, which had traditionally delivered the services, but also the for-profit sector. The restructuring of Ontario's home care system is an example of introducing private sector management techniques into the public sector. It also reflects the deployment of a neoliberal rhetoric of accountability, effectiveness, and efficiency that has increasingly become the hallmark of public health care administration around the globe. Ontario is a useful case study to excavate the neoliberalization of health care services because it was unique in Canada for shifting from delivering home care mainly through the public sector to "experimenting" with privatizing home care.

Our chapter is framed around an understanding of neoliberalization as processual, and as socially constructed, contextual, and contingent rather than an external monolithic force (Kingfisher 2002). This informs our focus on demonstrating the "messiness" of, and contradictions within, a particular neoliberal project – the restructuring of home care provision – in order to emphasize the "historically specific and contradictory aspects of neo-liberalism" (Larner 2000: 20). Stressing the production of neoliberalism challenges representations of neoliberalism as all-encompassing, as a unitary, coherent, ready-made apparatus to which "there is no alternative." Moreover, by conceptualizing neoliberalization as a process, we are insisting that not only is it not inevitable, but it actually requires a great deal of hard work to create and maintain it. As John Clarke (2004b: 30) points out, "neo-liberalism tells stories about the world, the future and how they will develop – and tries to make them come true."

In this chapter we look first at managed competition as an example of transnational "policy transfer," the increasingly common neoliberal technology of extracting policy knowledge from one context to put it to work in another. We explore the conditions under which a provincial government could even, in the first instance, envision a policy where home care becomes "accountable" to the market in a political system supposedly committed to publicly funded universal health care. Second, we explore the hard work (struggles even) of the Conservative Ontario government to introduce managed competition into the delivery of home care. To paraphrase Clarke, we trace their attempt to tell a story and try to make it come true. Finally, what of the front line workers whose job it is to provide home care to "actually existing" home care recipients on a daily basis? After all, bringing "the neoliberal political project" to life needs not only the global managers, policy analysts, and politicians that

most commonly receive attention; it also needs “ordinary” workers. And in the case of home care, those workers are overwhelmingly women; a fact which underscores that the neoliberal project is brought to life in deeply gendered ways and that policy agendas and their outcomes are far from being socially neutral (Gibson-Graham 1996; Roberts 2004).

## **Neoliberalizing Health Care, Policy Transfer and Managed Competition**

For some time now, health care reform has been high on the political agendas of many countries. In some cases, especially in the global South, health reform programs are closely interwoven with the policies of the World Bank and the International Monetary Fund (among other multi-lateral lending agencies) that require, for example, the privatization of, and cutbacks in, social services as a condition for receiving loans. In other cases, mainly in advanced industrial countries, health care reform has been part of a broader “crisis of the welfare state,” where nation-states have narrowed the scope and volume of their social welfare responsibilities. Of course, there have been several waves of “health care reform” over time, including that which first ushered in publicly funded health care systems in Keynesian welfare states like Canada, Australia, New Zealand, and the United Kingdom. What marks out much of the contemporary round of reform is the erosion of health care as a public good, and the increase in market-oriented, for-profit delivery mechanisms. As these neoliberalized policies have proliferated, health and social care systems have been reconfigured to minimize public expenditures. Hospitals and long-term care facilities have either been closed or reduced in size and function, and many social care services have been terminated or reduced. In explaining the shift from welfarism to neoliberalism, Nikolas Rose and Peter Miller (1992: 189) suggested that those “aspects of government that welfare constructed as political responsibilities are, as far as possible, to be transformed into commodified forms and regulated according to market principles”. And in considering what she calls “the neoliberal mindset,” Sue McGregor (2001: 83) argues that:

The neoliberal agenda of health care reform includes cost cutting for efficiency, decentralizing to the local or regional levels rather than the national levels and setting health care up as a private good for sale rather than a public good paid for with tax dollars.

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Health care policy of any ideological persuasion reflects government decisions regarding cost, quality of care, accessibility, delivery, and program evaluation. In the growing literature on comparative health care policy, cost-cutting and cost-benefit analysis and the like figure prominently as innovative “best practices” (and some argue this is at the expense of issues of quality and/or accessibility). To be sure, many nation-states were attempting to rein in the costs of health care well before such political projects were marked as neoliberal. Since the late 1960s, at least in North America, there have been concerns about the escalating costs of health care. In their assessment of “cost containment” as a health care practice, Evans, Barer, and Hertzman (1991) point to 1970 as a watershed year for the US and Canada. Previous to then, “meeting needs” and expanding the flow of resources into health care were the principal policy concerns; whereas after that, “cost containment” became an increasingly important part of the agenda. Since then, other fiscally oriented concerns have been added to the mix: deficits, debts, and policy preoccupations with stringent cost-cutting in the public sector; and most recently, doubts about whether health care dollars are being spent wisely (McDaniel and Chappell 1999; Evans 2000). The particular mark of neoliberalization is in the reshaping of health care policy through privatization, marketization, and decentralization as the (perhaps even the only?) way to make health care more “cost-effective” and “efficient,” often with an air of “there is no alternative” rationality. From the former Soviet Bloc (see Filinson, Chmielewski, and Niklas 2003 on Polish health care reform), across Europe (see Cabiedes and Guillen 2001; Light 2001) to Latin America (see Iriart, Merhy, and Waitzkin 2001 on several Latin American case studies), cost containment, introducing purchaser-provider splits, exposure to market forces, user-fees, contracting out, and generally introducing market competition have become the hallmarks of contemporary health policy.

As part of the expansion and deepening of neoliberalization, policies and programs that can be construed (even tangentially) as delivering “best practices” often get dis-embedded from their original spatial and institutional context, get put into circulation via policy networks, and then are adopted in another context (Dolowitz 1998; Jessop and Peck 2001; Peck and Theodore 2001). The sort of “knowledge transfer” and learning from elsewhere (“elsewheres” at a range of scales, domestically and internationally) has, in recent years, spawned a multitude of national and international conferences and transnational networks of government officials and non-state actors, including think tanks and international consultants (Stone 2004a). This process of policy transfer

means that neoliberalization is also actively produced in different places through transnational networks of consultants, experts, policy makers, and the like.

A particularly popular approach to contemporary health care reform currently in circulation is managed competition. Despite its beginnings as a complex economic theory, managed competition has come to mean a loose cluster of market-oriented policies and strategies of government-regulated competition among the providers and, in some cases, insurers of health care. Donald Light (2001: 1159) suggests that “by the early 1990s, managed competition had become the leading new conceptualization of state control over health care waste and costs, not only in advanced wealthy nations but by fiat in poor nations, where market structures alone could consume much of the health care budget for treating the seriously ill.” The goal of health care policies informed by managed competition is that by creating “quasi-markets” the fabled benefits of private-sector competition can be enjoyed in the public sector, including not only cost-saving but also making providers more accountable, offering more consumer choice and higher quality care (Light 2001; Dolfsma, Finch, and McMaster 2005). Managed competition was first associated with the US-based health economist, Alain Enthoven, the “father of managed competition,” who was part of the so-called Jackson Hole, Wyoming, think tank that informed US President Bill Clinton’s Administration’s health care reform proposals in the early 1990s. Enthoven explored how health care costs could be contained within a social insurance context for health care. His theory, in its most complete form, is that in a market regulated by the federal government, the quality and efficiency of health care delivery would improve if independent groups had to compete for health care “clients” (Enthoven 1988). Enthoven’s ideas were received with great interest not only in the US, but across the world. The diffusion of his ideas owes a great deal not only to Enthoven’s busy lecture and consulting schedule, but also to the networks of international consulting firms and policy decisions by international agencies (including the World Bank, US AID, and the IMF) (Light, 2001). Variations on his ideas (often in consultation with Enthoven himself) were put to work in, for example, the Netherlands, New Zealand, and the UK, and there is now a sizeable literature documenting and assessing those “experiments” (see, for example, Le Grand 1999 on the British National Health Service; and Schut and van Doorslaer 1999 on the Netherlands and Belgium). In Canada, his ideas have been deployed at the provincial level because of the particularities of Canada’s political structure, which we describe in the next section.

## The Rise of Managed Competition in Home Care in Ontario

Our account of home care reform draws on textual analyses of a range of policy documents, position pieces by various home care provider stakeholders, Ontario newspapers, and the Ontario Legislative Assembly Hansard<sup>1</sup> that refer to the CCACs and home care restructuring. The four authors are also involved in a large ethnographic study of Ontario homes that have been receiving publicly funded services for people with chronic illness and disabilities. The “Hitting Home” project is a trans-disciplinary, multi-method study investigating various dimensions of long-term care provision in the home. We conducted 17 cases studies of homes across Ontario receiving long-term home care services.<sup>2</sup> The cases included interviews with care recipients, primary family caregivers, and paid caregivers. In this chapter we include excerpts from the 29



**Plate 7.1** Personal support worker helping with the basic activities of daily living (© Getty Images)

interviews with paid caregivers – nurses, attendants, personal support workers (also known as homemakers), respite caregivers, and in one case, a physiotherapist (see Angus, Kontos, Dyck, McKeever, and Poland 2005 and Dyck, Kontos, Angus, and McKeever 2005 for analyses of the data about care recipients and the meanings of home).

To trace the manifestation of neoliberal ideologies in government policies and programs in Ontario means addressing the regulatory framework of health care policy in Canada. The rise of publicly funded universal health care (often referred to as Medicare) occurred at a significant point in Canadian history, when many Canadians believed that welfarist measures could be instituted to address social and economic inequalities and construct a more equitable society. Several key pillars of the welfare state at the federal level were enacted in the mid-1960s. In addition to Medicare (1966) was the Canada Pension Plan (1965) and the Canada Assistance Plan (1966, basic public assistance). Canada's health care system is a single payer system, not "socialized medicine" as it is often portrayed (by those on the Right and by foreign commentators, especially Americans who oppose the application of Canadian-style health care reform to the US). While it is publicly financed, the delivery of care is not state-run. Patients can choose their physicians who are paid on a fee-for-services basis according to a periodically negotiated fee schedule (in other words they do not receive a direct salary from the province). The setting and administering of national standards for the health care system are embedded in the terms and conditions of the 1984 Canada Health Act by way of five principles: health care is to be comprehensive (covering all hospital and medically necessary care), universal (covering all citizens and permanent residents), accessible (no limits on services and no extra charges to patients), portable (each province must recognize the others' coverage), and publicly administered (under control of a public, nonprofit organization). However, the Canada Health Act is a federal law and under Canada's Constitution there is a carefully guarded division of powers between the federal, provinces/territories, and local jurisdictions of government, and the management and delivery of health care is a provincial responsibility. The federal government negotiates health plans with each of the provinces/territories and plays a critical role in terms of financing via federal-provincial cost-sharing which, in the context of the Canada Health Act, allows it to exert some pressure to harmonize standards across the provinces. Each province/territory has a public insurance program (for example, Ontario has the Ontario Health Insurance Plan, and British Columbia has Health Insurance BC) that covers all residents

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and is financed from general tax revenues. There is, then, not one single health care system in Canada, but multiple systems, one for each province and territory. So it is at the provincial level that Canadians have seen “challenges” to the principles (or perhaps more accurately the spirit) of publicly available, universal health care, such as a recent Supreme Court challenge emanating from Québec over the introduction of a so-called two-tier (public and private) health care system.

Home care is one of the fastest-growing areas in health care today, not only in Canada but elsewhere too (see Parent and Anderson 2003 for a consideration of home care in international perspective). In Ontario, there are numerous reasons for this growth. As in other global North settings, people are living longer, but for some time now there has also been a “cost-containment” strategy of hospital closures and mergers, fewer beds in those that remain open, and shorter hospital stays (Abelson et al. 2004; Cloutier-Fisher and Skinner 2006). Home care was not that common until the 1970s, but since then there has been a dramatic growth. The critical point we want to consider here is not merely the growth in home care (and therefore a growing “market”), but its place within the broader health care system. The possibility for market-oriented principles to be applied to Ontario’s home care sector goes back to the way Canada’s public health care program was designed in the very first instance. The geography of where health care took place was pivotal. When Medicare was created in the 1960s, medical care was generally provided by physicians and the principal site of care was the hospital (the numbers of which had grown enormously in the 1950s). So Medicare was formulated around that model of health care delivery, a design that continues to impact the ways in which all sorts of health care is delivered today.

Concerns about the accessibility of health care (among other things) led to the Canada Health Act of 1984 which requires that provinces provide universal health care for what are vaguely described as “medically-necessary services” provided in hospitals and by physicians. Thus the regulatory framework put in place means that services provided in the home or by health professionals other than physicians are not specifically covered by the Canada Health Act in terms of Medicare coverage. Thus the same care that is publicly financed in hospital is technically considered “de-insured” when it takes place in the home (Baranek, Deber, and Williams 1999; Armstrong and Armstrong 2003). Thus home care services are not included in the Canada Health Act, and this means the provinces and territories can decide on the extent and nature of home care provision in their jurisdictions, without federal oversight. Unsurprisingly then, there is a range of models in use



across the country (National Coordinating Group on Health Care Reform and Women 2002a). In recent years this “gray area” has offered neoliberal-inspired provincial politicians and policymakers an opportunity to choose to pursue what is often tagged “greater flexibility” (i.e., “market reform” and introducing market-oriented practices) in the ways that home care is delivered, how it is financed, and how (increasingly scarce) resources are allocated (Parent and Anderson 2001). Funding for home care can be capped, services can be based on either co-payments or user fees, and home care can be offered by for-profit corporations; in other words, provincial governments can choose to design a home care system that is privatized and marketized in ways that they cannot with services more clearly in the embrace of the Canada Health Act. And when the Ontario Progressive Conservatives (the Tories) won the provincial election in 1995, that is exactly what they chose to do. As Robert Evans (2000: 896) puts it, in the context of Canadian health care more broadly, “The strategy seems to be to use the distinction between insured and uninsured services ‘creatively’ to stay within the letter of the federal legislation while driving a truck through its principles.” Put another way, and in the words of one of the nurses interviewed for the “Hitting Home” project:

The hospital is covered by OHIP and that’s covered by the government. Why don’t they do the same thing with community? They don’t want to do that in the community. They don’t want to have that in one umbrella where the government has to pay for most of it. What they’re trying to do, what the government is trying to do is get out of there and have people in the community, more and more people in the community pay for their own services.

## Neoliberal Provincial Politics

In the spring of 1995 the Ontario Progressive Conservatives, under the leadership of Premier Mike Harris, ran a provincial election campaign promising a “Common Sense Revolution,” a neoliberal manifesto for wide-ranging social policy change and government restructuring. The following January (1996), the Minister of Health and Long-Term Care, Jim Wilson, announced the government’s plan to introduce managed competition into home care delivery. The cornerstone of the Tories’ model was 43 Community Care Access Centres which were mandated to come into effect on April 1, 1997. In the weeks leading up to April 1, Jim Wilson faced pointed questions in the Ontario Legislative Assembly

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(as he and his successors did long after the CCACs came into effect). One particularly lively exchange took place in late February 1997 regarding reports of the CCACs spending too much on start-up costs (for instance, hiring consultants and staff, signing leases, and purchasing or leasing equipment) (Hansard, February 25, 1997). In early February 1997 a memo had been sent from the Ministry of Health and Long-Term Care telling the CCACs to put a “halt to your activities” pending the development of, and then Ministry approval of, a “business plan” from each CCAC. The entire board of one CCAC had resigned in response. Marion Boyd (who, in the previous provincial government, had been a Cabinet member, Minister of Community and Social Services, and then Attorney General of Ontario) asked Wilson about this decision.

Boyd: Minister, with only one month before their mandate comes into effect, the CCACs have been ordered to drop everything to fulfill your bureaucratic requirement... Can you guarantee us here today that on April 1 the CCACs which you created to deliver these growing and vital services will actually be in place?

Wilson: I remind all members that there was great praise for the development of the community care access centres from the service providers. They're far more preferred than the multi-service agency model the previous government was trying to put in place. 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.

Boyd: You're full of fine words, Minister, but the reality is that the CCACs are in real difficulty in looking at fulfilling their mandate... There's chaos in long-term care everywhere... Now you've stopped the whole process of implementation just because of a bureaucratic requirement. Will you deny that you're considering reversing a whole year's work on long-term-care reform and will you deny that the ministry is currently considering options that would cancel the implementation?

Wilson: Again, when you're using taxpayers' dollars, it's a very reasonable request to ask for a business plan. Many of the community care access centre boards had already developed business plans, so it didn't apply to all of them, just those that had not submitted anything to the Ministry. Every dollar has to be spent on services, not excessive administration. An example is that in some communities it may be appropriate to have the offices for the community care access centres in the empty parts of the hospital buildings or in health care facility buildings where we have physical space.

Boyd: Why didn't you think of that six months ago?

Wilson: We did think of that, I say to the honourable member. It's just that some of the boards didn't quite get the message so we're asking them to submit a business plan and to make the absolute best use of the taxpayers' dollars to ensure that every dollar is available for care and not administration (Hansard, February 25, 1997).

Wilson's remarks lay bare the neoliberal agenda of the Conservatives' plans for home care. Following his barb about the multi-service agencies of "the previous government" (i.e., when Boyd was a Cabinet Minister, etc.), he proceeds to describe how his party's approach will "get rid of the excessive administration in home care throughout the province" (notice he mentions excessive administration, and its associated costs, three times in this exchange), this includes reducing the number of offices from 73 to 42, deploying business plans to make sure CCACs are "not building empires," and more generally "getting rid of the empires of the past" and introducing "streamlined efficient systems." Finally there are the references to "taxpayers' dollars" with the implication that the Tories' accountability is to taxpayers, not to Ontario residents more broadly.

Well known to the readers of this book is Jamie Peck and Adam Tickell's (2002) distinction between "roll-back neoliberalism" (the hollowing out of the welfare state, marked by deregulation, privatization, and dismantling the welfare state) and "roll-out neoliberalism" (involving active state-building in terms of new institutions and new regulatory reforms, including workfare, deepening market relations, authoritarian penal state forms, and the marketization of social life). Exemplifying the notion of roll-back neoliberalism, the Conservatives' "Common Sense Revolution" was marked by fiscal austerity and (supposedly) state retrenchment. But as is increasingly recognized now, not only in Ontario, but elsewhere too, rather than involving the much-touted "retreat of the state," neoliberalization often involves more, not less state intervention, such that there might be a quantitative decline in

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state functions, but there has also been a qualitative shift (O'Neill 1997; Peck and Tickell 2002; Mitchell, Marston, and Katz 2003). Indeed Peck (2004) argues that privatized and deregulated markets are not self-regulating and so they need to be managed. Thus rather than more market and less state, there has been market re-regulation, in other words more not less government intervention. In the case of Ontario, Roger Keil (2002: 588) argues that the Harris neoliberal Tories:

created a political environment reminiscent of Thatcherism and Reaganism... Popularist in its appellations, the Tory program was a textbook case of a neoliberal policy strategy and project. It contained many internal contradictions. Despite its embrace of a rhetoric of small government, the Harris cabinet was, in effect, perhaps the most interventionist government (Ontario) had ever seen.

Immediately upon entering office, Harris set about meeting his neoliberal "textbook case" campaign promises, introducing drastic welfare cuts and workfare reform, reducing the personal income tax rate, watering down ("liberalizing") labor laws, reducing the public sector workforce, and amalgamating local governments (Keil 2002; Bradford 2003).

Until it was reworked around the "policy transfer" of managed competition, home care in Ontario was provided through the Home Care Program (HCP), usually administered by Public Health Departments in regional municipalities. Almost all the services had been provided by nonprofit, government-funded organizations which have very long histories in the province, and were the employers of a sizable proportion of the paid caregivers interviewed for the "Hitting Home" project. Although it was a publicly funded and publicly administered system, the Home Care Program had long been a mixed system. Private, for-profit companies had always operated within in the home health care sector, albeit in a subsidiary role to the public sector<sup>3</sup> and often concentrated on "hard-to-serve" clients and less popular shifts (nights and weekends) (Ruggie 1996).

On entering office, the Tories quickly fulfilled one campaign promise by repealing the 1994 Long-term Care Act which had only recently been introduced by the previous New Democratic Party (NDP, social-democratic) government, in which Marion Boyd (quoted above in the exchange with the Health Minister) had served several roles. The Act was set to put in place the NDP's plan to amalgamate about 1,200 different home care services into 200 provincially administered "one-stop shopping" multi-service agencies (MSAs) based on public provision.

However, they were elected out of office by the Tories before they could fully implement this plan (Skinner and Rosenberg 2005). Even before the election, the NDP's plan had been criticized for making home care "too bureaucratic" and spelling the end of nonprofit organizations, and the Tories picked up on this as a campaign item. The speedy repeal of the Act by the Tories met with approval from at least some home care providers. Newspaper articles with headlines such as "Tories to scrap NDP care plan" (*Toronto Star*, July 12, 1995) and "The Mike Harris Plan: Tories kill NDP health care law" (*Ottawa Citizen*, July 13, 1995) included quotes from representatives from several nonprofit agencies describing themselves as "delighted" but wanting "the momentum for change to continue." However, perhaps subtly signaling what was to come, Premier Harris is quoted in the *Ottawa Citizen* story as saying "This decision sends out a signal to all volunteers, these agencies – profit and nonprofit – will all be welcome to continue to provide the services and be eligible to provide those services in the future. We haven't looked at it from a cost-saving angle at this particular point in time. We're looking at providing a better service and keeping the players providing the service in that field."

Mike Harris charged Jim Wilson, the Minister of Health and Long-Term Care, with (quickly) developing a new plan for home care. Wilson's response was to import the framework of managed competition and marketize home care. Once the plan was unveiled, newspapers began running stories with headlines such as, "Ontario opens home care for elderly to lowest bidders" which appeared on the front page of the *Ottawa Citizen* (January 26, 1996). This was not going to be the smooth policy transfer neoliberals dream of; there was what Anna Lowenhaupt Tsing (2004: 1) calls "the sticky materiality of practical encounter" to contend with.

The Tories' answer to the NDP's multi-service agencies was the CCACs that would replace the 38 home care programs and 36 placement coordination services. The CCACs are mandated to provide a simplified "single point of access" to "manage" and "coordinate" long-term care services in their region (this includes long-term care facilities, and schools, as well as in-home services). The CCACs employ "case managers" to assess "client" eligibility for home care services, deciding whether to "authorize" a service plan (which they subsequently monitor and may adjust), and arrange access to contracted services from a range of local community nonprofit and private, for-profit agencies. The CCACs themselves do not directly provide any services; previously the Home Care Program had directly employed nurses and homemakers,

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or contracted out (usually) to the nonprofit sector. Instead the CCACs are required to use competitive bidding via requests for proposals for contracts from local nonprofit and private, for-profit agencies to provide nursing, homemaking, personal support, and other services. There was a transition period from 1997 to 2001 to allow the nonprofit sector to adapt to managed competition (the rationale being that the for-profit sector had more experience at dealing with a competitive environment), after which “the market” would be wide open.

### **Managed Competition and Home Care Workers**

Managed competition is not only put into practice at the level of policy making, of course, it also impacts upon the experiences of those who work in the environment created by it – what several of our interviewees called the “front line workers.” Home care is a female-dominated industry, so in Canada, as elsewhere, those “front line workers” are disproportionately women, who provide more than 80 percent of the care (National Coordinating Group on Health Care Reform and Women 2002a, 2002b). Among the home care workers interviewed for the “Hitting Home” project, only one was a man (a nurse). So whether acknowledged by the architects of home care policy (and often it isn’t), the neoliberalization of home care in Ontario has a distinctly gendered complexion (National Coordinating Group on Health Care Reform and Women 2002a, 2002b). Restructuring home care in ways that emphasize market principles has produced greater burdens for women compared with men (women are also more likely to be home care recipients and family caregivers). As the National Coordinating Group on Health Care Reform and Women (2002a: 1) point out, “health care reforms have a significant impact on women as patients, health care providers, and family caregivers... (and) affects women’s health, work and financial well-being.”

Although caregiving (paid or unpaid, for that matter) can be rewarding, health care reform has meant more and different work for women, with increasing workloads and increasing stress (Aronson and Neysmith 1997; Abbott 1998; National Coordinating Group on Health Care Reform and Women 2002a, 2002b; Armstrong and Armstrong 2003). For example, in the case of nurses, so-called flexible or contingent work arrangements have become more common in health care services, whether in hospitals, long-term care facilities, or home care (Aronson and Neysmith 1997; Health Canada 1999; Williams 2001).

In this section we look at some of the ways that neoliberalized home care plays out on the ground by exploring how the work environment and experiences of nurses and homemakers have been influenced by the introduction of the competitive bidding process in Ontario.

### *Understanding competitive bidding*

In May 2001, the Ministry of Health and Long-Term Care informed the CCACs that funding for the 2001/02 fiscal year would be frozen at the 2000/01 levels; this also ended up being the case for 2002/03. The hours of publicly funded home care per capita available to clients had already been capped, and the eligibility requirements for receipt of home care were greatly tightened (Office of Ontario's Provincial Auditor 2004). Publicly funded resources were being rationed and tightly controlled. As one nurse said:

The government has said to the CCACs – first of all CCACs have been told that they are not going to be bailed out any more. They used to run out of money around Christmas time and the fiscal year would end in May. The government would bail them out for that period of time. They have now told them they are not bailing them out anymore.

As a result the CCACs had to reduce services, not only to remain within their budget, but also to offset rate increases in their service provider contracts. Across the province, between 2001 and 2003 (when funding was frozen at 2000/01 levels), the number of nursing visits decreased by 22 percent and the number of homemaking hours decreased by 30 percent (Office of Ontario's Provincial Auditor 2004). The introduction of managed competition and the new (and often shifting) rules and regulations put into place both by the province and by individual agencies produced a sense of instability and confusion for the workers (and almost certainly for the clients too). One attendant noted:

I think that when they make all these policies and procedures that they don't really understand how it is to go in every day into somebody's home and...and try to...to do your job and follow every procedure, you know, in the book. You know I find it difficult to follow all of the procedures in the book. I don't know whether any of the other girls do or not, but, I think it's pretty restrictive. I find it too restrictive.

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Describing the region of the province where she worked, one nurse commented, “there are so many nursing agencies out there now because of things being opened up for bids. There’s like six agencies, when there used to be – when I first started this job there was only two (nonprofit) agencies.” Also, the restructuring of home care took place relatively quickly, and often without sufficient public information about the changes. This left many workers to explain the new system to their clients, who in many instances they had worked with for years. Neoliberalizing home care, then, relies on the feminized “soft” skills of the workers to ease the transition for clients. The women workers are basically doing what women often do: picking up the slack and filling in the gaps left by the erosion of social services. They become the social safety net of the neoliberalizing system (Roberts 2004). For example, one nurse remarked:

There’s not enough nurses, the patients in their mind are expecting and I feel – I would say 10 years, 15 years ago – I used to go in there and the family says, “Well I’ve paid my taxes, I’m entitled to this” and I thought to myself, wait a few years, this is going to change and it’s changing... They’re going to have to pay for every single thing. They have for-profit agencies, nursing agencies, and there is gonna be a time where Home Care is going to say, “we can only provide so much and the rest is going to be up to you.”

But it is not just clients who are confused, so are many of the workers, such as, for example, one attendant who works for a public sector attendant care agency. She cares for Susan in the morning, and when she began working with Susan, she expected her agency to be sending someone for the afternoon slot, but she found out that a for-profit agency had “won” the contract that covered that slot.

I don’t really know too much or enough about any other agencies. I always thought, actually, that (the CCAC) would first contact (her employer) because the services are free to the client, and then would contact other agencies. But often I think (that if) clients have to go with the other agencies first that they might have to pay something for it, and then be on the waiting list for our agency. But then I was told that Susan got (a for-profit agency) in the afternoon and not our agency, because (the for-profit agency) costs less money for the government. But I thought, “They’re a private business!” So I’m a little confused on where the money flows and who gets what and what’s cheaper and what’s for free.



The attendant's confusion about how the delivery of home care has changed is not surprising; on the face of it did not make sense to her (nor to others we interviewed) that there would be multiple agencies servicing the same client. It does beg the question, is this "stream-lined, efficient" home care, to borrow Health Minister Jim Wilson's language? The competitive bidding environment is also eroding cooperation among agencies, as increasingly even a particular client's program of care becomes "proprietary data." As Abelson et al. (2004: 364) note, in the past collaboration among agencies had fostered shared learning ("knowledge transfer" even) and the pursuit of best practices, but with a competitive bidding model, best practices are more likely to be viewed as a competitive advantage over other agencies and jealously guarded.

### *Workloads, wage differentials, and turnover*

Previous research indicates that as home care is restructured, women face increasing workloads and increasing stress whether they are paid caregivers or family caregivers (Aronson and Neysmith, 1997; Abbott 1998; Armstrong and Armstrong 2003). This is not surprising because in an effort to be competitive, even nonprofit agencies have increased the workloads of their workers, which for many means more stress and less job satisfaction. As an attendant who participated in the "Hitting Home" study remarked: "we are a little short-staffed I guess... we kind of do extra on top of our schedule." Research conducted across different national contexts with home care nurses and personal support workers demonstrates the extraordinary stresses and extensive physical and emotional tasks they face (Aronson and Neysmith 1997; Abbott 1998; Twigg 1999) as well as the health and safety risks that this work involves (Kendra et al. 1996).

Home care nurses in Ontario generally receive lower pay and fewer employment benefits, and enjoy less social status than their institution-based colleagues (Neysmith and Nichols 1994; Aronson and Neysmith 1997; Canadian Health Services Foundation 2001). And this differential has to be located within the broader persistent pattern of the gender wage gap, especially for women in female-dominated work like nursing and other care work. A longstanding concern among feminist scholars (and activists) is the gender division of labor and the crowding of women into low-status, low-paid jobs (Fortin and Huberman 2002). The home care-hospital wage differential has been further exaggerated in a competitive bidding environment which has produced intense competition

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among agencies and driven down nurses' wages even further below those of their hospital colleagues (Baumann et al. 2001). In 2000, there was a substantial gap between the wages offered in Ontario hospitals (\$20–30) compared with home care (\$19–25) (Parent and Anderson 2001). When asked if they were happy with their work, several "Hitting Home" participants complained about their wages and benefits, most making direct comparisons with their hospital colleagues. One nurse quickly responded:

No. We're quite significantly behind the hospitals and that has to change. That's a whole new tangent. It has to change; it really does have to change. I mean, a little while ago Harris threw, I don't know, 10 billion dollars at the CCACs and what they did with that money I don't know, but we never saw a dime of it. I don't think we've had a proper raise since 1987. And what they did with that money is they created the CCACs. It used to be called Home Care, now it's called CCAC. So we didn't see any of that money either. Hospitals are always – their wages are going up all the time. I mean I have a friend who's been in nursing for eight years, she works in Emergency part-time at (a hospital) and she makes six dollars an hour more than I do. I mean that's really inequitable . . . Supposedly that's the direction it's going to go because it's cheaper, etc., etc. But just because it's cheaper doesn't mean there are cheaper nurses, you know, cheaper knowledge or cheaper (experience), I used to be in Intensive Care so I carry those skills with me.

Notice that not only does she make the comparisons with hospital nurses, but she also puts the wage gap in the context of money being "thrown" at the CCACs to create the architecture for competitive home care, but with little or none going to "front line nurses" (a point raised by a few of the other nurses too). This nurse is also well aware (as were many other nurses, homemakers, and personal support workers) that their wages were a significant factor in allowing for "cheaper" home care.

One direct outcome of the competitive bidding process was that as the home care–hospital wage differential was exaggerated, more nurses and homemakers (especially those who train on the job to become personal support workers) began leaving home care (Parent and Anderson 2001). The competitive bidding regime has resulted in a destabilization of working conditions for home care workers. One of the attendants told us:

There's been a LOT of changes, a lot of changes. Yeah. A lot of changes in policies and procedures and a lot of changes in staff, like the office staff. And a big changeover for the workers, the girls, especially up in my area, there's a really big turnover.

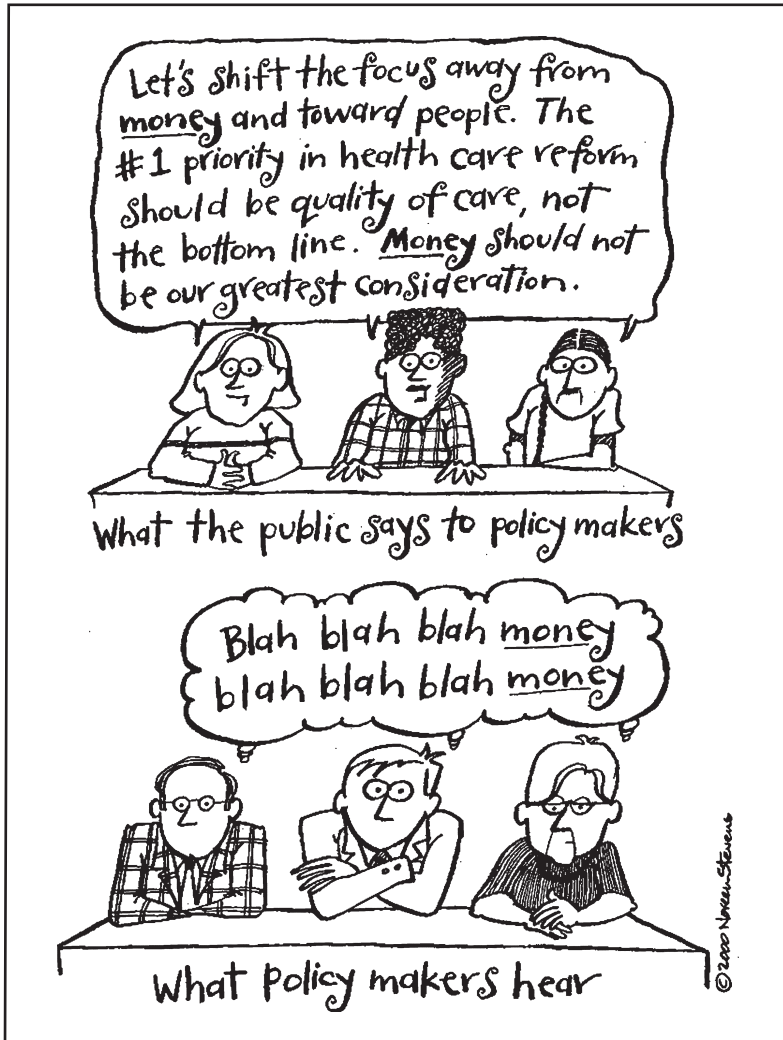
Her last comment relates to the worrisome trend towards the high turnover among home care workers, homemakers, and personal support workers that we saw being tracked by various stakeholder groups. Many of the nurses we interviewed remarked that they had seen the same thing in nursing: “The nurses have gone. I mean every time you turn around, the nurses have gone” said one. When asked about how the home care system could be improved, another nurse responded:

Give us more money. I know that sounds maybe petty, but it’s why they’re losing nurses. It’s why my case load is so heavy, is because we don’t have enough nurses; and they’re not gonna get enough nurses until they increase the pay. I mean there are registered nursing assistants at (hospitals) who make almost as much money as I do. That’s ridiculous.

This staff shortage was soon dubbed a “crisis.” Newspapers were replete with stories describing how people faced long waits for home care services or who were scheduled to be released (“sicker and quicker”) from hospitals, but had their return home delayed because there simply was not enough home care staff to care for them. “What if you can’t go home again?” asked the *Ottawa Citizen* (April 13, 2001) and included the alarming statistic that Ottawa home care agencies had lost 50 percent of their workers in 2000 alone. And in a Canada-wide survey of organizations providing home care, Parent and Anderson (2001) found that 43 percent of those employing nursing staff and 60 percent employing home support workers had difficulty retaining staff because they were leaving for better paid jobs in sectors other than home care.

### *Changing the experience of home care work*

An important theme to emerge from the interviews was how the day-to-day experiences of the workers had shifted. A number of the women complained about the increased amount of paperwork they had to manage; paperwork that went beyond the usual “charting” of the care, treatment, and progress of clients. The “Hitting Home” respondents had to fill out forms, phone the office on a regular basis, and check with the office to ensure that a client was “care coded” for a particular service, and if so, for what amount of time. Nurses are now required to get “authorized” for an unscheduled follow-up visit with a client; one said: “you’d have to call the CCAC and get authorized for another visit. That



**Plate 7.2** Quality of care versus cost-saving

would be two visits in a day and lots of times they won't pay you for two visits." Nurses responded that previously they had more autonomy and several, even some who remained very satisfied with their work, expressed frustration at what they saw as an erosion of that autonomy

and a lack of respect for their professional judgment and on-the-job experience in being able to assess their clients' needs for services. Certainly if we reflect on the neoliberal dream of less government intervention and more market, then all these interactions with "the office" are not suggestive of getting "rid of the excessive administration in home care throughout the province" as Health Minister Wilson promised in 1997. In fact this suggests more administration and more management, revealing yet another contradiction in the messiness of "actually existing neoliberalism."

Among the other changed conditions of work were less "hands-on care" and fewer, if any "tea and sympathy"-type visits that support clients who are psychologically or socially isolated. This was the sort of caring labor (and obviously highly feminized labor) that had brought some of our respondents into home care (rather than the more institutionalized hospital setting) in the first place. "Cost savings" of the financial sort are made by reducing the number of visits by home care workers and reducing the duration of those visits. Nurses who have been visiting some clients for over a decade told us they used to do so twice a week. Now they can only visit once a week and they expected in the very near future they would be visiting even less frequently. One nurse lamented:

Oh yes, that's really changed over the years. Because when we were working with Home Care previously we would be in and we would bath our people. And there was a lot more hands-on. There was a lot more hands-on. It was much more personal, and I found much more satisfying. Because what I find now is it seems like it's the dollar orientated, not the people orientated. Now that's how I feel about it. And I have a difficult time, with things now because you know we receive the (time) sheet which we never had (before). Now we have to keep track of how long we were in with the people.

Note that this nurse remarked that nurses no longer bathe their clients. This task and other supposedly "less skilled" aspects of home care work have been passed on (downloaded to use language of neoliberalized social policy) to personal support workers. Of course, that move in and of itself is a "cost-saving" measure, but further savings were made via cutbacks that mandated that long-term care clients who previously received three baths a week became entitled only to one. Dalton McGuinty, then leader of the (Liberal) Opposition, frequently asked questions about home care clients' bathing entitlements of the Premier and the Minister of Health and Long-Term Care. For instance, on December 13, 2001 (Hansard) he asked the Minister:

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Here is the case of Mrs Agnes Winterbottom from St Catharines. She's in her 80s, she's blind, and she's had her home care hours cut. She was embarrassed to have to tell us what the cuts are going to mean to her. Do you know what they mean to her? She's now only going to get one bath every seven days. She would like to get two baths a week. You have \$500 million for private schools. You have \$2.2 billion for large corporations. You tell me, . . . knowing there is that much money available out there, what directive are you going to issue to ensure that Mrs Winterbottom gets what she wants, which is nothing more than two baths a week?

In fact the number of bathing entitlements of home care recipients came to symbolize, for various stakeholders (politicians, workers, recipients, and advocates), the brutal extent and depth of the Conservative government's budget freeze and capping of home care services. It is also noteworthy that it was this particular aspect of home care that captured the public's imagination and received so much public attention, quite literally embodying competitive bidding. Almost always the body in question was a woman (like Mrs Winterbottom, and in fact McGuinty in that same narrative gave a second example, Mrs Gould, who "worked and paid taxes until she was 82 years of age" and who "wants a bath"). Social policy is not gender-neutral, and women do dominate the home care client base, and so it makes sense that they dominate heart-rending appeals for clients to be treated with more dignity. How many baths home care clients were entitled to was repeatedly employed by non-Tory politicians and paid care providers alike as a means of trying to gain political traction with the Conservative provincial government. And of course, in the broader argument of our chapter, this interweaving of the state and the body, of (multiple meanings of) the public and private, the personal and the political, as well as embodiment nicely demonstrates that the neoliberalization of home care involves socio-spatial practices and relations that are located in a lattice of processes, practices, and discourses unfolding across a range of scales.

## **Conclusion**

We began our chapter noting that emphasizing the historic specificity and contradictory features of neoliberalism call attention to neoliberalization as a socially constructed, contextual, and contingent process. So we should be very clear about one aspect of the larger argument we are making in this chapter. Even before the election of the Tories, there

had been longstanding concerns about duplication and lack of coordination in home care that resulted in confusion for clients and their families. There had even been an increased movement toward privatization by the two previous governments, especially through contracting out some services and de-insuring others. However, what the Tories did was to dramatically increase the pace and extent of the process and give it a neoliberal spin (Armstrong and Armstrong 2003). While many aspects of the Conservatives' "Common Sense Revolution" were unprecedented in Ontario, their decision to restructure home care did not appear out of thin air, but was the latest in a series of attempts by the provincial government (whatever its political persuasion) to transform home care. Since the mid-1980s, sequential governments had addressed the increasing cost of home care and recognized the need to better coordinate a "patchwork quilt" of services. Different models of reform were floated by the three provincial governments, reflecting very different political rationalities; Liberal (centrist, 1985–90), NDP (social-democratic, 1990–5) and Conservative (1995–2003) (there is now a Liberal government, which we comment on below). The ideological orientation (for instance, the relative importance of equity versus efficiency as a guiding principle) of these models, and the merits and disadvantages of each has rightly captured a great deal of attention from activists, practitioners, and scholars alike (for example, Baranek et al. 1999; Cloutier-Fisher and Joseph 2000; Skinner and Rosenberg 2005). But what we want to stress is that since the 1980s successive provincial governments (Left, Right, and Center) have proposed overhauling home care in some form. The ideological underpinning may have differed, but in each case the specifics of what needed to be restructured revolved, to a greater or lesser extent, around better coordinating services, eliminating duplication, and cost management; and each model considered the respective roles of the public, nonprofit, and for-profit sectors in delivering services. Thus home care had been ripe for restructuring for some time – it just so happened that the Tories' version was the one that ended up being put into practice; and it pivoted on neoliberal rationalities and technologies, introducing private sector management practices (in the name of cost saving and efficiency) into a system that had long been the purview of the (mostly publicly funded) nonprofit sector.

The introduction of managed competition into home care has ushered in a number of large, private for-profit corporations that in some parts of the province now control the majority of the market-share at the expense of nonprofit agencies that had provided services there for

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decades. In the past several years, the newspapers have repeatedly reported the now familiar tale of nonprofit agencies losing contracts in a particular community, closing their offices, and laying off staff. Indeed, there is evidence to suggest that Ontario's home care "market" is gradually consolidating into the hands of a few large for-profit providers. According to the Ontario Health Coalition (2005), across 40 of the CCACs in 2004, a mere six corporations held 76 percent of the contracts. In contrast, eight agencies held 66 percent of the contracts in 1995, before the introduction of managed competition. The irony is that this is a market oligopoly (and in particular, a private sector oligopoly) even though the Health Minister at the start of the Harris Government claimed the (textbook neoliberal) goal for managed competition was "getting rid of the empires of the past and replacing them with streamlined efficient delivery systems."

As is often the case, there was a mismatch between the economic myth of neoliberal policy and the lived realities of "actually existing neoliberalisms." In the rush to make home care a "streamlined efficient delivery system," a multiplicity of contradictions became apparent, including more, not less, state bureaucracy. A new crisis emerged around the exodus of health care providers, market-oriented management practices, and the burden of increased bureaucracy, which erupted into a series of strikes and public outcries over the quality of care. In October 2003, the Conservatives were soundly defeated by the Liberals. The new Premier, Dalton McGuinty, had been one of those who had asked insistent questions about how the Tories were restructuring home care (for instance, Mrs Winterbottom and her weekly baths). Campaigning under the slogan "Choose Change," the Liberal campaign promises included a commitment of new investment in home care (especially for what they called "the frail elderly") and that home care would remain an option for people as long as it did not exceed the cost of a nursing home. However, there was no promise to end for-profit home care, or to extend the principles of the Canada Health Act to cover home care that many activists had hoped for. Whereas Harris moved quickly on his campaign promises (perhaps too quickly?), McGuinty has been accused by some of dragging his feet. For example, in the summer following the 2003 election, the Ontario Community Support Association (representing 360 community support agencies such as Meals on Wheels, and personal and home support programs) issued a press release announcing "Community-based agencies continue to fall victim to the flawed home care selection process." They insisted that "Ontarians 'Chose Change' on October 2, 2003. They did not get 'Change'." They reminded McGuinty



and the Liberals that as the official opposition party they had been “adamant in their condemnation of the Tories’ home care procurement process” and called for an immediate halt to competitive bidding and an independent review of the system.

Over the summer of 2004 there were large, loud protests by providers, home care activists, and unions in Ottawa, St Catharines, and Toronto about the competitive bidding process and the increasing erasure of nonprofit providers in the home care “market.” That autumn, the Ministry of Health and Long-Term Care announced a review of the competitive bidding process. Opponents of managed competition wanted to place a moratorium on the competitive bidding process and allow the CCACs to hire staff directly. In 2005 the Minister announced that managed competition would remain for now, but that other points of concern (the erosion of community control in the CCACs, and concerns that costs trumped quality of care in the assignment of contracts) would be explored in an independent review of home care. Perhaps this is the beginning of a reversal. Or perhaps home care will be reformed (again) in line with the “friendly face” of “soft” neoliberalization and “partnering” ethos of Third Wayism described by Larner (2000) and Peck and Tickell (2002), or perhaps even in keeping with the policymaking associated with the “After Neoliberalism” political program described by Larner, Le Heron, and Lewis in this volume? That remains to be seen. Regardless, the case of introducing managed competition into Ontario’s home care sector demonstrates that importing policies and programs from elsewhere, neoliberal or otherwise; does not guarantee similar outcomes in a different place. The case of Ontario home care shows that the politics of neoliberalism do not always prevail, or may do so only for a short while; and that the creation of a neoliberal “common sense” is not smooth and neoliberalism is far from inevitable.

## Acknowledgments

The authors are part of a larger group of scholars, the “Hitting Home” research team led by Principal Investigator Patricia McKeever, and includes Co-Investigators J. Angus, M. Chipman, A. Dolan, I. Dyck, J. Eakin, K. England, D. Gastaldo, B. Poland, and Research Coordinator K. Osterlund. We would like to acknowledge the financial support provided by the Social Sciences and Humanities Research Council of Canada under the Strategic Grant Competition: Society, Culture, and the Health of Canadians, Operating Grant

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#828991018. We also thank the fieldworkers of the project, Tracy Irvine, Pia Kontos, and Karen Spalding. We benefited from the very useful feedback from Catherine Kingfisher and Kevin Ward on an earlier version of the chapter, and we would like to acknowledge the generosity of the National Coordinating Group on Health Care Reform and Women who granted permission for us to use one of their cartoons in this chapter as Plate 7.2. Most of all we are deeply grateful to the participating households, workers, and partnering Community Care Access Centers in the Province of Ontario.

**Notes**

- 1 Hansard is the official transcript record of debates in Canadian parliament and provincial legislative assemblies (as it is in the British, Australian, and New Zealand parliaments).
- 2 The households were recruited through three Community Care Access Centres (CCACs) from urban, rural, and northern Ontario. These CCACs were among the consulting community partners involved in the “Hitting Home” study (others represented service providers, family caregivers, and care recipients). Our data collection techniques were designed in collaboration with our partners. The interviews followed focused interview guides developed to minimize intrusiveness and time expenditures for participants. Three senior doctoral students (Tracy Irvine, Pia Kontos, and Karen Spalding) were trained as fieldworkers and gathered the case study data. Altogether, about 60 interviews were conducted, half of them with home care workers as several households received services from a nurse and an attendant or a personal support worker.
- 3 For a few years prior to the introduction of CCACs, regulations mandated that the for-profit sector could receive no more than 20 percent of the funding under the so-called 80/20 rule.