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**Managing under Managed Community Care:  
The Experiences of Clients, Providers and Managers in  
Ontario's Competitive Home Care Sector**

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## **Abstract**

In 1996, a newly elected government in the Province of Ontario, Canada, introduced a managed competition environment into the home care sector through the establishment of a competitive contracting process for home care services. Through 65 in-depth, semi-structured interviews conducted between November 1999 and January 2001, we trace the implementation of this competitive contracting policy within Ontario's newly established managed community care environment and assess the effects of competitive contracting against two sets of goals: 1) quality of care goals that consider continuity of care of paramount importance in the provision of home care; and 2) the managed competition goal of increased efficiency. In assessing the implementation of this policy against these goals, we highlight the conflicts that can arise in pursuing different policy goals in response to different formulations of the policy problem that underpin them. We map stakeholder experiences with the competitive contracting policy onto relevant contracting and managed competition literatures. When measured against the goals of quality of care and efficiency, the findings presented here offer a mixed review of the experiences to date with the competitive contracting process introduced in Ontario's home care sector and suggest improvements for managing future competitive contracting processes.

Key words: home care policy; Canada; competitive contracting; managed competition

## Introduction

The community care sector in Canada, of which home care is a major component, has expanded rapidly over the past decade in the face of a contracting hospital sector (through bed closures, mergers and facility closures) and demographic and life expectancy changes that have led to more people living longer and requiring a greater intensity and array of services as they grow old. Despite a 71% increase in inflation-adjusted home care expenditures between 1991 and 1999, home care needs in Canada have outstripped funding.<sup>1</sup> While shifts from acute care, facility-based to community and home-based care have occurred, the legislation that establishes the types of and manner in which health care services are financed in Canada, the *Canada Health Act*, stipulates that full, comprehensive coverage of medically necessary services be covered by law, but only for those services provided in hospitals or by physicians.<sup>2</sup> The absence of federal legislation governing the financing of community care is further compounded by the provincial governments' constitutional authority for the delivery of health services in Canada which gives them complete discretion to develop publicly funded services or not, as they deem necessary or appropriate. Thus, legislation governing home care systems is developed provincially, resulting in inter-provincial variations in the governance, financing, organization and delivery of home care services and opportunities to experiment with different service funding and organizational models.

Four models are currently used to deliver publicly funded home care across Canadian provinces: public provider (all providers are public employees); public professional and private home support (public employees provide professional care and home support care is contracted to private agencies); mixed public and private (public employees provide case management and services are provided by either private or public employees) and contractual (publicly funded services are delivered by a mix of for-profit and not-for-profit agencies who are awarded the right to deliver services through a competitive bidding process).<sup>3,4</sup> The contractual model is currently used in Ontario and is the focus of the research reported here.

In 1996, a newly elected government in the Province of Ontario, Canada introduced a managed competition environment into the home care sector through the establishment of a competitive contracting process for home care services. Forty three regionally-based Community Care Access Centres (CCACs) were charged with the responsibility to assess service needs, make referrals to the appropriate services and purchase of all in-home services including professional (i.e., nursing and therapy) and home support services (i.e., personal care, house cleaning and meal preparation) through a competitive contracting process within capped budgets set by the provincial government.<sup>5</sup> Under the new competitive service-contracting model, CCACs would award contracts through a Request for Proposal (RFP) process to provider agencies based on a combination of “highest quality, best price” with the balance between the two left to the discretion of local CCACs.<sup>5</sup>

We trace the implementation of this competitive contracting policy within Ontario’s newly established managed community care environment and assess the effects of competitive contracting against two sets of goals: 1) quality of care goals that consider continuity of care of paramount importance in the provision of home care; and 2) the managed competition goal of increased efficiency. In assessing the implementation of this policy against these goals, we highlight the conflicts that can arise in pursuing different policy goals in response to different formulations of the policy problem that underpin them.

## **Lessons from the Literature**

Evidence from three different literatures is relevant to the subject of this paper: the measurement of quality of care in home care; the experiences with managed competition and quasi-markets in the health sector; and the experiences with contracting in the human services field. Despite its centrality to the contract awarding process, “the measurement of quality in home care is in its infancy”.<sup>6</sup> To develop sound measures that allow their precise measurement, the processes and outcomes involved in home care need careful definition. Attempts to reach conceptual clarity about the dimensions of continuity of care have

resulted in a range of definitions and terms to describe continuity in different service delivery contexts and from different professional and patient perspectives.<sup>7-9</sup> Central to these are the elements of consistency (in provider and/or service), progression towards a defined outcome of care; coordinated information transfer and on-going relationships. Recent work in this area has identified the need to pay attention to both the management of care and its delivery to ensure continuity of home care which will, in turn, optimize care by organizing the delivery of home care services around individual client needs with an appropriate deployment of resources.<sup>6</sup>

Managed competition, or quasi-markets were introduced as a part of the large-scale reform of Britain's public sector initiated by the neoliberal Thatcher government. A feature of neoliberal ideology is the notion that where welfare functions are conceived as a political responsibility, services should be "transformed into commodified forms and regulated according to market principles".<sup>10</sup> Quasi-markets were ostensibly designed to capture the features of markets that result in efficient and innovative production by substituting private or non-profit delivery of services for production of these services by public servants.

A growing literature has examined the experiences with government-sponsored managed competition in the health sector, particularly the United Kingdom's quasi-market.<sup>11-13</sup> The emerging picture from these studies is one of "little overall measurable change"<sup>11</sup> despite fundamental, if not easily measured change in the culture of doing business (e.g., greater cost-consciousness and clarity about roles and responsibilities). Modest gains in production efficiency, as a result of a depression in wage rates, were offset by increased administrative costs with almost no improvements in patient choice of provider or service.<sup>11</sup> With respect to ensuring and enhancing quality of care, acknowledged as difficult to measure generally within the health care system and more specifically within the context of community care services, the U.S. experience with for-profit health maintenance organizations has documented the threats of "unfettered competition"<sup>5</sup> to access to and quality of care, due to risk selection (i.e., enrolling only healthy or low risk patients whose costs are kept at a minimum).<sup>15-17</sup>

Governments' use of contracting for the delivery of a variety of goods and services has increased steadily through the last decade.<sup>18</sup> Fiscal pressures, political forces, bureaucratic routines and market conditions all influence the use of contracting as an alternative to in-house production. Potential benefits associated with contracting include "cost savings through the reduction of bureaucratic inefficiencies, allowing governments to access economies of scale, by-passing costly labour and supply requirements, and generating competition among vendors".<sup>19</sup>

On the cost side, the customer focus that drives the contracting movement is thought to conflict with central tenets of democratic governance such as citizenship, civic engagement and broad conceptions of the public interest. The contracting process can also exacerbate service coordination problems that are associated with the management of a complex set of contractor-contractee relationships.<sup>19</sup> Among the most significant potential costs associated with contracting are transaction costs that may arise from service-specific characteristics (i.e., asset specificity, task complexity and service measurability); goal incongruence between contracting agencies and contractors; and non-competitive markets (i.e., contestability).<sup>19,20</sup> Where all three of these are high, the bargaining, and hence, transaction costs associated with the contracting process are also predicted to be high. This suggests that policy makers, if they were willing, might mitigate potential market failure problems that might be experienced in a contracting environment by paying greater attention to specific contracting features.<sup>21</sup>

The appropriateness of employing contracting for certain types of services has also come under scrutiny.<sup>19</sup> An examination of the nature of purchaser-provider contracts in the New Zealand health system revealed higher contracting costs for some health services, such as acute mental health services, than others.<sup>22</sup> Transaction costs were also found to increase in conjunction with increases in asset specificity, frequency of transactions, uncertainty and measurement problems. Case study research in the U.K.'s community care sector has similarly revealed that the characteristics of community health

services challenge the successful implementation of a competitive contracting process in this sector.<sup>23,24</sup> More specifically, these characteristics include the high task complexity associated with a broad array of home care activities; the different types of expertise required to perform these activities; the difficulty in precisely determining service costs and pricing; and the complexity of measuring outcomes and quality in the community health service sector which expose the contracting agency to vendor non-performance or negligence.<sup>19</sup> Furthermore, the inter-organizational and inter-personal relationships required in a sector where multiple agencies and providers service a wide range of client needs can be thwarted by the adversarial conditions imposed on purchasers and providers.<sup>23,24</sup>

## **Methods**

This study, approved by the Ethics Review Board of the Faculty of Health Sciences at McMaster University, was conducted in the City of Hamilton, a geographic area with a population of approximately 500,000 people who are served by the Hamilton Community Care Access Centre (HCCAC).

During 1999 and 2000, we undertook a qualitative study to understand how clients, caregivers, case managers and home care workers conceptualized continuity of care. Within this larger study, we examined these stakeholders' perceptions of the effects of the competitive bidding process (and the transitions that arise from the awarding of new contracts) on their experiences with continuity of care. The first competitive bidding process was initiated soon after the CCAC's establishment in 1997. The first service contracts were awarded in November 1998 for approximately one-third of all nursing and homemaking services provided in the region. A second bidding process was initiated in 1999 which resulted in the awarding of nursing service contracts for the remainder of the CCAC's client population. Our interviews were conducted following the awarding of contracts for these two bidding processes.

We sequentially interviewed 13 CCAC case managers, 19 home service providers (eight home support workers, ten nurses and one supervisor), 25

clients and 5 of their caregivers and three physicians who had a large number of patients receiving home care. Case managers were chosen from a list prepared by HCCAC case managers. To select service providers, we asked each agency to list up to five service providers who were willing to be interviewed. Clients were chosen from CCAC files to reflect differences in entry to home care (from hospital or from the community) and differences in availability of family caregivers (live alone or live with other family members).

Interviews were conducted by telephone or in person. Permission to tape record was withheld by three interviewees. In these cases, the interviewer took notes and dictated a summary shortly after completing the interview. Otherwise, interviews were transcribed from the tape recording. Interviews ranged from forty-five to ninety minutes in length, with most lasting about one hour. Case managers were asked about their experiences with the implementation of provider agency transitions that follow the awarding of contracts; the factors they perceived to be important in deciding whether a client is transferred to another agency and the types of clients who have difficulty with a provider change. Interviews with service providers explored their experiences with provider agency transitions and their perceptions of how such changes affect client care. Client and family caregiver interviews explored their direct experiences with provider and agency changes and their perceived impacts of these changes.

Transcribed interviews were entered into a qualitative data analysis program, NVivo. Four investigators read a sample of the interviews for each of the groups interviewed and developed a preliminary coding scheme for these data. Themes from these interviews led to an initial coding strategy for the overall project that included the competitive bidding process as a major coding category. This code and its related sub-codes was used to analyze the interview transcript data for this paper (see Appendix A for a list of all codes).

## **Study Findings**

In the sections below, we describe how the contracting process affects: 1) organizations, 2) relationships and individuals and 3) client care from the

perspective of interviewees who reflected on their own and others' experiences. To illuminate our findings, we describe the sequence of events from the time new contracts are awarded. This description has some generic elements that apply to all home care contracting processes; however, we give emphasis to those features specific to the process under study (i.e., the effects of competitive service contracting in Hamilton).

The awarding of new contracts in the home care sector typically alters the market share of service provider agencies. In the study community, this involved the potential reconfiguration of 10 or more major service provider agencies. A direct effect of the contracting awarding process is that some proportion of clients will be "transferred" to a different agency. In the context of our study, a client "transfer" was considered to have occurred if a client ceased receiving services from one agency and began receiving services from another. In a sample of 600 clients, 123 clients transferred from one agency to another, 21.5% when both homemaking and nursing contracts were awarded, 13.3% when only nursing contracts were awarded. While agency-to-agency client transfers are an obvious outcome of the contracting process, clients may experience provider changes within the same agency, also resulting from the contracting process.<sup>1</sup> Even if the same agency is awarded the new contract, an agency may need to alter its staffing complement and assignments to meet the terms of the new contract, such as market share or geographic service delivery area changes, or the obligation to provide a different array or intensity of services requiring a different staffing complement in that area. The consequences of meeting these contractual obligations may be new hirings, the reassignment of staff to different geographic regions or the termination of some workers. If a service provider agency loses a contract, this results in, at least in the interim, the reduction of hours or termination of some employees within the unsuccessful agency if they cannot or choose not to be redeployed to another area where the agency still holds a contract.

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<sup>1</sup> It should be noted that there are a variety of reasons for transfers that may be unrelated to the contracting process. For example, clients and/or providers may and do initiate transfers (i.e., a change in personnel) within a service provider agency while it holds a contract.

## The Effects of Competitive Contracting on Organizations

The management of the competitive bidding process and the implementation of transitions following the awarding of contracts requires dedicated staff time at the management level to oversee the competitive bidding process and requires several weeks of dedicated case manager time to communicate and oversee the changes that result from the awarding of the contracts. Case managers incur opportunity costs as they try to ensure a smooth transition between “old” and “new” agencies and for clients who are being transferred from one agency to another and experience service provider changes. Case managers find this a stressful time. One case manager spoke of her reluctance to experience another major transition in this way:

*I would just hope that there isn't another major across the board change. I don't want to think about it, I went with it the first time... I don't want to go there, it was a lot of work...*

Following the implementation of the transition, regular case management duties are constrained as case managers respond to client concerns or questions about the transition. CCACs also incur the cost of case managers who need to devote time to establishing new relationships with service providers and their agencies, minimizing the time devoted to managing their current caseload.

*... suddenly we're going to be doing less of the kind of case management we want to do which is more proactive and start doing a lot more reactive case management. It's very difficult to prepare a case load of 300 people for a transition. It's just impossible. [case manager]*

Competitive contracting also requires staff time, at the provider agency level, to prepare proposals and to implement transitions. The process precipitates a cycle of staffing instability and reorganization to meet new contractual obligations. This instability exacerbates staff recruitment and retention problems, which further threaten the agency's ability to meet its contractual obligations. Two case managers reflect on the consequences of this situation for service delivery:

*...if you look at it staff wise, you can't keep staff, you can't expect staff to stay in a community setting if every three years their employer is going to change. That's the big thing, I don't think that the government, when they turned this thing out, even thought about that because it's not like one*

*agency is covering the whole thing. ... It's the staff continuity as well as. You won't get the staff continuity if you can't keep good staff on board. [case manager]*

*It appeared that they were having a great deal of difficulty right from the very beginning meeting their obligations. Well for instance, something that happens regularly is we will call up that agency, the agency holding the contract. We have plans for service for certain clients and we want to give them two hours of homemaking twice a week. They'll call us back and say, 'we can't do it, we don't have any providers'. This is even when we leave it wide open, 'pick a day, pick a time', they often can't provide it. [case manager]*

### The Effects of Contracting on Relationships and Individuals

The introduction of competitive contracting and a purchaser/provider split alters relationships that previously existed between individuals and organizations in the home care sector. In the case of Ontario's competitive contracting model, the purchasers are the CCACs and the providers or contractees are the service provider agencies. The characteristics and effects of these relationships trickle down to employees within these organizations (i.e., case managers within the CCACs, nurses, home support workers or nurses in the service provider agencies) and, ultimately, to the provider-client level.

#### *Organizational relationships*

Inter-organizational relationships have been affected by the establishment of CCACs, and the introduction of the competitive contracting model. It has forced new, competitive relationships among provider agencies who had previously reaped the benefits of collaborative relationships. An illustration of these changing relationships in this study community was the close relationship shared between the city's largest nursing care provider agency and the CCAC's predecessor "Home Care Program". These two organizations achieved administrative efficiencies through shared management and space. More importantly, these collaborative relationships allowed for shared learning and an environment that promoted "best practices" in home care service delivery.

### *Provider-case manager relationships*

Relationships between providers and case managers are also affected as case managers, who had developed long-term working relationships with a small group of providers in a non-competitive environment, are suddenly required to establish new relationships each time new contracts are awarded. One case manager described the effect on relationships in the following way:

*I think for community case managers, too, working with one service provider in an area can be beneficial because you've come to have a relationship with that person and you can work together so that one case manager is maybe getting reports from and conversing back and forth with just several nurses instead of 40 nurses. [case manager]*

A potentially more damaging effect, depicted by another case manager, is the lack of trust that can develop within this competitive environment where contracts were awarded based on assessments of what agencies said they could deliver and were then unable to deliver what they promised.

*... we have not been able to develop that trust relationship with the new providers. Time and time again, there's too many problems in that they aren't delivering what we would be expecting them to deliver, so our faith in the next contract is a little dislodged and a little precarious at the moment. [case manager]*

### *Client-provider relationships*

Most notable among the relationship changes that have been affected by the competitive contracting process is the severing of client-provider relationships that result from the transfer of clients from one agency to another. These disruptions not only affect the professional and informal caring relationships that are established over time but also meaningful social relationships that provide clients, especially isolated individuals, with an important source of social support. Of particular concern is the disruption to homemaker-client relationships, which typically involve more personal and intimate activities that clients would prefer to have carried out by the same person.

*This is unfair. Clients are really upset because they've opened up their home, the nurse comes in and does her assessment and leaves. Well this person that comes in to do the every day, personal care and housework is in their space. You establish a relationship with somebody, you establish a trust and this person is like, in and out of your cupboard, in and out of your drawers, changing your bed, putting you in the bath and*

*all of a sudden Laurie's changed to Bob, and you don't want Bob, ....  
[case manager]*

*You know, for a long time, I've had her and you get very used to one person coming into your house. It's so much easier when it's somebody you know, the same person every week. So that's been my biggest complaint about this change over. I don't know why they couldn't have left her, and why they had to change, why two different groups can't work in one area. [client]*

After these long-standing relationships have been severed, both parties are then required to develop new relationships which reduces the efficiency of service provision. Clients and home care workers express frustration and disappointment in the wake of such occurrences.

*It changed from one firm to another firm and since that time I've had a different person just about every week until I guess two weeks ago, and that's been terrible. Now, all I get is two hours a week but they just couldn't seem to find someone to fit in with that. [client]*

*...if a new home support worker comes in, he or she is first of all going to say, 'well, what is it you'd like me to do?' And then they have to go through and explain, well this is what we need and this is where this is and it's very draining of energy and time consuming to have to be re-explaining over and over again. I think if the client is the one that's doing that, then it's hard for the client. [case manager]*

Rumours and confusion surrounding potential agency changes fuel clients' apprehensions about the potential service delivery losses or changes. Clients spoke of the poor communication about these potential changes:

*... the communication was poor. I think that they should have notified me about what was happening instead of me wondering what was going to happen because I, up until the day before, my worker was due, I hadn't heard from them ... I felt that they should have got in touch and said the worker has changed. [client]*

*if they had even said for a few weeks it's going to be sort of turmoil because we have to straighten this all out. But nobody did say that. You're just left with this sort of hanging over you. [client]*

In extreme cases, these threatened disruptions can lead the most vulnerable home care clients to exit the home care sector entirely as described by this service provider:

*... the government is talking about renewing these contracts every two to three years. I actually had a gentleman in my area downtown who was so upset with all of this, and he had a chronic illness, [he] knew he was going to be dependent on the home care system for the rest of his life and could not face every two or three years meeting new nurses, new home makers that he went into a long term care facility. [nurse]*

Home care workers are personally affected when they are forced to leave clients with whom they have established long-term relationships. The effects of the contracting process can also affect their employment and income security. Human resources in the community care sector are already characterized by low pay and poor benefits relative to the institutional sector. The competitive contracting model has the potential to further destabilize the home care workforce through job insecurity and pressure to keep wages low enough to remain competitive during the bidding process and afterwards as service agencies' rates are contained for the duration of the contract. Home care workers respond to these conditions by switching agencies to maintain income security and to ensure continuity for clients whom they are reluctant to leave. Several interviewees described the situation and its effects.

*... the new agency gets that contract as of that date. Those patients go to that new agency. And of course the staff no longer have a job because the agency doesn't have the jobs. So I think in some circumstances the new agency can hire them and they can even maybe go back to their old area and give the continuity which would be great for the client. But it's terrible for the staff person because now they're working for a new agency, different salary and that kind of thing, no benefits. I mean different benefits, no carry over benefits type thing. [home care worker]*

*... there's no stability as far as continuity for the clients or the nurses because for the client, they may have a group of nurses for so many years and then have an entirely different group. This could happen to them every two or three years depending on how long they need the service. The nurses, I think that job security is a big question there because in the next three years, what if we lose contracts in all these areas – I won't have a job. [nurse]*

Ultimately, this human resource management approach affects home care workers' job performance and satisfaction which can ultimately affect the quality of the care provided, as described by this case manager:

*So they're left working for one or three agencies, running all over the country doing their darndest to fill the hole in a very unsatisfying way, so they can't develop expertise. They can't be secure in what they're doing. They're very committed people who try very hard, but because of the structure of the hiring processes at the agencies, they don't perform well. [case manager]*

This employment instability is felt acutely by clients immediately following the awarding of new contracts as agencies are trying to redeploy their staff to meet new contractual obligations. Clients describe their experiences as follows:

*Well I thought it could have been done a little more smoothly but maybe I'm asking too much. To go three or four weeks and see a different face every day was just a bit much. I liked the first lady that was here, after a couple of weeks I phoned in and complained and I said, 'now look I like the first lady that was here very much, can I go back to her?' Well she had left the company by then. So then I said 'well just give me the same person two different days in a row'. 'Well we think the one you're getting next will have time for you in her schedule'. Well this went on and on and on and finally we got settled with the one we've got. Now since I've had her I have no complaints. But up until then I was getting awful frustrated. [client]*

*The first two or three weeks I saw a different face every day I got home care until I was getting really furious and up tight. I guess I'm a very nervous person, but meeting a new face twice a week and trying to go through the same routine of what they're to do. All this got to be a pain to me. Then finally I complained to one of the home care people that was here and I said 'I don't have any problems with anybody, I just want to see the same face twice in a row. [client]*

While clients and home care workers are the most directly affected by these conditions, case managers working within the CCACs play an integral role in the day-to-day management and delivery of home care services, and are, therefore, exposed to all elements of the competitive contracting process. Case management is a core business function within all CCACs and is the vehicle through which home care services are authorized. Key case management functions, as outlined in the *Ontario Home Care Manual* (1984), include: (i) assessment and determination of eligibility; (ii) goal setting; (iii) service plan development to achieve goals; (iv) authorization of client's initial service plan; (v) monitoring and reassessment of client needs and eligibility; (vi) adjusting service plan as required; (vii) planning for discharge; and (viii) community relations.

During the contracting process, case managers become the key points of contact and communication for managing the transition of clients and providers. While the amount of time spent on the implementation of the transition focuses attention on the effects of contracting on organizations, the process also appears to affect employee morale when they are carrying out duties that conflict with their personal or professional values. One case manager described her experience this way:

*I was involved with the transition committee. ... It created stress, anger and embarrassment. It made me do things that I didn't agree with. It made me get away from the day-to-day things that need attending to. Always explaining why I had to transfer them. It took a lot of extra time and energy. [case manager]*

Although case managers are not as adversely affected by agency changes as clients and providers, the case managers' pivotal role in the management and communication of the transition process positions them to both witness, and where possible alleviate, the effects of the transition on both clients and providers. Case managers have developed personal and working relationships with many of those who are affected by the contracting changes and they are burdened by being the "bearers of bad news":

*So on a personal basis it was hard emotionally. This was not so much related to the case management aspect as the personal aspect. I was very distressed with the fact that nurses had jobs and all of a sudden they don't have jobs. You know, you work for an agency and they work hard and then, because of nothing you've done, you don't have a job anymore. This really unsettled the agency. To have a job and then be out of a job. It has unsettled the whole workplace, the whole market place in the area. It is inhumane. And I hear that they get lower salaries now than they did before. They don't necessarily go with the cheapest bidder but that does play in. [case manager]*

*We'll be looking at identifying clients that it's not appropriate to send them a letter, that we have to go out and actually make a visit and deliver a letter and talk about the process. Kind of steel up our personal defences, as it were to handle the onslaught of, calls about the "whys", kill the messenger kind of thing, why is the Ministry doing this, ... [case manager]*

### The Effects of Contracting on Client Care

So far, we have focused on describing the effects of the contracting process on personal and professional relationships as well as on human resources in the home care sector. Ultimately, however, the rigorous evaluation of the implementation of a new policy or program in the human services sector requires an examination of its effects on program recipients, particularly one that emphasizes cost containment and quality service provision. Our qualitative interviews provide insights into the effects of contracting on client care as perceived by clients themselves, their families, service providers and case managers. These findings reflect on clients who had experienced an agency transfer as well as on what potential effects might result from agency transfers. Our results, therefore, describe reflections on *actual* as well as *potential* effects of transfers on client care.

The most significant perceived effect of the severing of client/provider relationships (through transfers) on client care relates to the lack of continuous monitoring of the clients' progress by one or a few providers. The absence of routine monitoring by the same group of people may have a harmful effect on the client's health and well-being:

*It makes it next to impossible for nurses to really judge over a time continuum a client's improvement or deterioration, because they don't have baseline on which to judge. [case manager]*

From a health system's perspective, this can lead to greater costs when an opportunity for early intervention to prevent a client's condition from deteriorating can be missed. Moreover, a transition can halt or potentially reverse the progress a client is making as observed by this home care worker:

*... my personal experience with these bids for the last couple of years, I find that we get [clients] up there and we get them built so good, in fact almost to the independent stage. When these bids come in and they have to go through the transition, I find personally, it takes them back down to where we first walked in there. [home care worker]*

Others voiced concerns about the combination of introducing new provider agencies and the lack of employment stability in the home care sector

contributing to a decline in the quality and level of specialized care provided to some client groups:

*Some of the clients who've been on care for years, a lot of the disabled group talked about caregivers who didn't know how to provide care in the home, and discontinuous, so that the caregivers didn't come in with a plan or didn't know about the plan or weren't able to implement the plan from a skill level, from a knowledge level, because the agencies hired new people that didn't have community experience, weren't comfortable with some of the client groups. So the clients found discontinuity in the capacity of the caregivers, which was very frustrating, cause that again is the need that cannot be fulfilled. That's what you're contracting for is a skill level and a functional level from the caregivers that the clients aren't seeing. [case manager]*

A related concern is the potential for “client dumping” when agencies are unable to meet the intense or complex service needs of a particular client:

*... when an agency has difficulty servicing a client because we are asking for a type of service that is often daily, twice a day, the needs of the clients get worse each year. If they can't meet that need, they find some legitimate way to dump the client rather than having the responsibility of finding the people to be able to service the need.[case manager]*

In a small minority of cases, a transfer (and the severing of the client-provider relationship), was considered a healthy option where there were concerns about clients becoming so dependent on a particular worker that their progress toward independence might be slowed.

## **Discussion**

The findings presented here describe the experiences of those who are managing within a new competitive service contracting home care environment. We offer several observations about how they are ‘managing under managed care’ and we assess the implementation of the competitive contracting policy within Ontario’s home care sector against the twin goals of: ensuring quality of care through care continuity; and increased efficiency.

As a descriptive case study of one community’s experience with the introduction of this new model, our results are instructive to policy makers and health system managers who are seeking to improve future competitive

contracting processes by identifying the challenges that arise during the implementation process. Although we recognize the limitations of generalizing from a single case study, our focus on the most generic elements of the contracting process (i.e., aspects that home care providers, managers and clients in any community are likely to experience) partially addresses this limitation. In addition, the situation of our findings within a broader managed competition and human services contracting literatures strengthen the validity of the case study findings. We also believe that by relating the experiences of those on the “front lines” of this policy change, we offer a compelling story about the qualitative effects of the implementation of policy change on these affected parties.

From an organizational point of view, our findings reveal a range of costs that are associated with competitive contracting. Purchasers and providers incur displacement and transaction costs during the competitive bidding process and the transition period immediately following the awarding of new contracts. Staff resources are required to manage the competitive bidding and contract implementation processes and case managers experience a change from active to reactive mode for at least several weeks following each transition. Our findings also reveal “human” costs associated with the competitive contracting model, evident in provider movement between agencies following the awarding of new contracts, the severing of relationships between providers and clients, in effect disrupting continuity of care, and the increased anxiety felt within the competitive environment. Our analysis did not seek to quantify these costs. Their qualitative depiction by our interviewees, however, reinforces available evidence to suggest that the competitive contracting model applied in a sector like home care, characterized by service complexity, measurement challenges and human resource uncertainties, hampers the ability to achieve efficiencies under such a model.<sup>22,23</sup> In fact, this contracting model may well contribute to the inefficient use of resources with disruptions to continuity of client care and to the collaborative relationships that promote the goals of high quality, continuous care in this sector.

### Competitive Contracting in a High-Risk Environment

The undersupply of home care workers that characterizes this sector poses considerable barriers to the successful implementation of competitive contracting and to agencies' abilities to meet their contractual obligations. "Winning" agencies are typically forced to rely on the recruitment of workers from "losing" agencies (or other agencies holding contracts) to meet their contractual obligations leading to the destabilization of the home care workforce and adverse effects on job performance. This can be a highly risky proposition as it assumes that workers will choose to chase new contracts, resulting in the loss of benefits (if they have any), over being redeployed within their own agency to an area where the agency still holds a contract, or being called upon by the CCAC to fill gaps when the agency holding the contract is unable to service their client base. This problem is further exacerbated by struggles to keep home care workers from exiting the community care sector altogether in favour of jobs in hospitals and long-term care residential facilities, where they can earn higher wages and gain greater job and income security.<sup>25</sup>

Case managers are the most vocal about the adverse effects of the reform on providers and clients. The competitive contracting model has added to their workload with the additional responsibilities for managing the implementation of the transitions that result from the awarding of new contracts. While they are committed to ensuring smooth transitions, they are concerned about and cite numerous examples of the costs associated with contracting and market competition such as: agencies' failure to meet their contractual obligations (i.e., vendor non-performance);<sup>19</sup> and the lack of specialized expertise that leads to client dumping (i.e., adverse selection).<sup>17</sup>

### Competitive Contracting and Quality of Care

When assessed against quality of care goals, the implementation of the competitive contracting model in Ontario raises concerns about its lack of provisions for ensuring continuity of relationships between providers and clients, considered essential to the achievement of quality home care provision and to

the adequate measurement of outcomes.<sup>6</sup> Concerns were also raised about the ability for contracting agencies to ensure adequate skill levels among their service providers. This suggests that there are service-specific characteristics associated with home care provision such as task complexity and differentiated expertise that pose additional transaction costs and requirements for stringent contract monitoring. These characteristics are not taken into account in homemaking contracts which do not specify any skill level for these unregulated workers.

### Implications for Contract Monitoring

Direct service recipients are considered an important source of information in the contract monitoring process.<sup>19</sup> Of the 25 clients who were interviewed in this study, only a few of these clients spoke directly about how the contracting process had affected them. Clients were aware that changes had been made to the organization and delivery of home care services but were often unaware of the specific details of the contract awarding process. Their concerns were more focused on their desire to minimize the disruptions to their lives and intrusions into their home through the establishment of long-term relationships with a small group of service providers.

If clients are to be used as information sources in the contract monitoring process in the home care sector, effort needs to be given to overcoming the numerous barriers that exist to 'hearing their views'. For example, clients may remain silent because they are afraid to complain for fear of losing service. Fear of service loss can have a significant muting effect on client views, particularly those of vulnerable populations such as the frail and elderly. CCACs need to find arm's-length mechanisms to collect "client information". Efforts also need to be made to reduce any systematic bias in the types of complaints or feedback that is gathered. For example, long and tiring patient satisfaction surveys that bias responses to those who are well enough to complete them need to be avoided or augmented by other tools.

An additional concern about the ability to adequately monitor the contracting process through client information is that home care clients, as they become socially isolated, are excluded from a range of activities, including active political participation in the decisions that directly affect them.<sup>26</sup>

For those clients who are making efforts to articulate their desire for greater choice and accountability from the contracting process, it is worth considering what recourse they have for achieving this within a managed care environment. According to Hirschman,<sup>27</sup> clients have two options available to them for ensuring accountability for service provision. The first is market accountability through market “exit” (e.g., from one agency to another or from the public to the private sector) or political accountability through “voice”. In Ontario’s current community care sector, exit options are limited as clients typically exercise little consumer choice over their purchasers or providers<sup>2</sup>. Those with resources can, in theory, exit the public system and pay privately for their services but with the needs assessment and referral functions vested in the CCAC purchasers, their financial power is constrained. Those who are able to flex their exit muscles are often those who have the greatest capacity to apply pressure for change within the existing system, leaving those remaining behind within the public system further disadvantaged. With respect to voice, examples include models of devolution which attempt to shift the locus of decision making closer to citizens; opportunities for political accountability through elected governors and public consultation; and through formal complaints processes.<sup>28</sup> At present, none of these features are adequately developed in Ontario’s community care sector. The complaints process, in particular, has been criticized for its lack of independence from CCACs who are, as managers and purchasers of care working within a system that rations care, inappropriate client advocates. Traditional complaints processes that require significant resources including energy and stamina fail to serve a vast majority of home care clients who are typically under-resourced in these areas. In considering these options,

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<sup>2</sup> The provincial government in Ontario does offer a self-managed care program in which clients seeking to exercise complete autonomy over the management of their care can participate.

Hirschman's concept of "loyalty" is also relevant. Our findings illustrate that clients are generally very loyal to their individual providers and the provider agencies they work for but are more resigned than loyal to the home care system more generally.

## **Caveats and Conclusions**

The experiences with managed community care as depicted by home care managers, providers and clients in our case study community offer several interim lessons for policy makers with respect to the implementation of competitive service contracting in the home care sector. First, our findings suggest that the contracting process and its required elements has heightened awareness of the need for greater specificity in the identification and measurement of quality service provision, particularly when service providers are assessed as potential contractees.<sup>29</sup> The implementation of the competitive contracting model has also focused attention on improved accountability relationships between purchasers and providers, consistent with findings documented in other studies<sup>22</sup> and has begun to improve accountability for meeting contractual obligations. While our study findings portray case manager concerns regarding agencies' ability to meet contractual obligations in a somewhat negative light, the accountabilities that are associated with the awarding of new contracts (i.e., the ability to determine whether contracts are being fulfilled or not) can also be interpreted as a positive feature to build on in the future. Similarly, our interviewees appeared to have learned a great deal from the initial competitive bidding processes about how to improve agency transfers following subsequent competitive bidding cycles.

What remains to be seen, however, is whether these "emerging benefits" will outweigh some of the more problematic aspects of the contracting model such as the transactions costs incurred by purchaser and provider agencies as well as the quality of care and continuity concerns raised by individual clients and providers who must establish and build new relationships following the awarding of new contracts and agency transfers. These disruptions not only translate into

inefficiencies in the provision of care; they are potentially harmful to clients, particularly in those situations where on-going monitoring by consistent providers is a crucial element of the care plan.

When measured against the goals of quality of care and efficiency, the findings presented here offer a mixed review of the experiences to date with the competitive contracting model introduced in Ontario's home care sector. These reviews also highlight the conflicts between the goals of the policy, whose goals are considered and how the problems that underlie these goals are framed. For example, provincial policy makers' overriding goal appears to be the introduction of market mechanisms to increase efficiencies in the home care sector. Consequently, their measurement of the policy's success will be driven by these goals and the underlying problem (i.e., inefficiency). In contrast, health care providers are more inclined to assess the policy against the goals of improved service co-ordination and quality of care which reflects a different construction of the problem. Our findings suggest that case managers fall somewhere in between as they straddle both levels of policy goals and consider the range of policy effects.

Despite our attempts to focus on the experiences with the competitive bidding process and between-agency transitions that resulted from the bidding process, the values held toward managed competition were perceptible and even palpable among those managing under managed care, especially among providers and case managers. We view these 'values' positions as difficult, if not impossible, to separate from direct experience and argue that they should be given greater consideration in future evaluative research in this area. At an organizational and provider level, the introduction of managed competition has imposed a profound cultural shift on the home care sector in Ontario. For some providers and managers, it has prompted their exodus from the community care sector entirely. For home care clients who do not have these exit choices, they bear the full and direct cost of changes that take place at each level, as they reverberate into their homes and their personal lives on a regular basis. Although difficult to measure, the effects of Ontario's home care reform on clients

and the quality of care they receive must be given greater attention in order to comprehensively evaluate Ontario's shift to managed competition as the method of ascertaining of "highest quality, best price".

## Appendix A

### RFP Process

- *changes in agency*
- *changes in provider*
- *boundaries*
  - geography (includes travel discussions related to facilitators or barriers)
  - type of worker (nurse or HSW)
- *competition*
  - reactions
  - bidding process
  - territory
  - capacity to compete
- *effects of transitions*
  - on clients
    - how it occurred
    - who is affected
    - nature of changes
    - nature of impacts
  - on providers
    - who
    - nature of changes
    - nature of impacts
  - on agencies
    - which ones
    - nature of changes
    - nature of impacts
  - on case managers
    - who
    - nature of change
    - nature of impacts
  - on linkages
    - between who
    - nature of changes
    - nature of impacts
  - communication
    - how are changes communicated
    - reactions to different communication
    - who communicates change
    - client awareness
      - understanding of RFP
- *exclusions*

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