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Lobbying Queen's Park: The CCAC Lobby

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Immediately after an election expected by the end of May, there will be a plethora of health policy papers and advocacy campaigns unleashed on yet another fragile minority government (NDP or Liberal) by gangs of screaming banshee warriors that we refer to as "healthcare interest groups".

The proposals they make will mostly be structural in nature -- each one largely reflecting the narrow self-interests of the group, while masquerading as being "in the public interest". But this is a game about "power" and "money".

I know about this stuff.

I taught courses on interest group strategies and tactics in political science at Carleton University in the early-'70's. In the mid-'70's, I was a lobbyist at the *Canadian Book Publishers' Council* advocating on behalf of publishers. I was so effective at bugging the government that **Bill Davis's** Office reached out and brought me into their inner circle -- as a speech writer/policy-wonk/strategist -- which I joyfully did for 12 years.

I was then employed by the President of the *Canada Post Corporation* in the mid-80's -- helping to transform the old Department of the Post Office (with its billion dollar annual deficit) into the modern, smooth-running, small-profit, strike-free and lovable crown corporation that it has been up until just recently.

Trapped in Ottawa from Monday to Friday, I wrote a book in my spare time in the evenings called: "***Lobbying Queens' Park: Strategies & Tactics For The Peterson Minority Government***". The book sold like hot-cakes. A Liberal government? What's that? A minority government? What 's that? Lobbying? Influencing the way government thinks through strategic communications and coalition-building? How do you do that?

In those days, in terms of healthcare interest group power, there was just the OMA/OHA -- and then everybody else. Not anymore. Today a variety of healthcare interest groups have evolved over the past ten years as sophisticated, highly-strategic, "power players" who know the buttons to push in the GR (government relations), policy advocacy and strategic communications business. So, it is not just the two "dancing dinosaurs" at the party anymore. There are many. And some of them are good at it.

However, as I would warn students taking my *Interest Group Politics* course at Carleton University: people with weak stomachs should always avoid watching two horrible and sickening processes: the making of sausage, and the making of public policy. Because, you see ... you have no idea about the kind of crap that goes into both of those products!

For the next few weeks, I'm going to blog on the various lobby campaigns that will be launched this year -- starting with the most active interest group -- the CCACs.

Ontario's fourteen CCACs are playing an expanding role in health services delivery.

They provide vital services to 650,000 patients/clients in a much more cost-effective way. It costs \$384 per day less to care for a patient with high needs in the community. It costs \$50 per day less to care for a senior with moderate needs in the community, as compared to a long-term care home.

Indeed, by supporting people at home and in the community, our \$2.2 billion CCACs and community support services together have created cost avoidance savings of \$210 million over the last three years by shifting care from more expensive parts of the system.

The *Ontario Association Of Community Care Access Centres* was headed-up by former Deputy Minister **Margaret Mottershead** for several years. She was replaced on an interim basis by another retired MOHLTC Deputy, **Dan Burns**.

Dan hired the consulting firm of *Deloitte Inc* to research and help prepare a series of four policy discussion papers on "serving the needs of our aging and diverse population over the long term" -- most likely with the "evolving and expanding role" of the CCACs as a concluding theme throughout their papers.

The four discussion papers were guided by a Public Affairs Committee, with coaching from Dan. Dan's successor at OACCAC is another former Assistant Deputy Minister, **Catherine Brown**. She will have a mandate to convince her former colleagues -- who will be the policy-makers -- about the wisdom of the policy positions that have been articulated in their four papers.

Given that the OACCAC has mostly been run by former senior public servants, several groups express concern about the actual status of the CCACs.

Are they "**Helpers**" -- like the LHINs and the MOHLTC; or, are they "**Doers**" -- like the CHCs, nursing homes and hospitals?

While they can't be both, many sense that the CEO of OACCAC may in fact function as "an external ADM". **Catherine Brown** now has her chance to put her stamp on what should be the future of the CCAC sector by marketing the four *Deloitte* policy papers and pushing for government funded expert panel who will let the government "off-the-hook" in the same way the *Drummond Report* enabled the government to sail through the last election being able to say: "We're studying that."

While the language of these papers contain lots of references to "patient-driven healthcare", by definition and function, the bottom-line purpose of these policy advocacy papers is to position the CCACs to play an ever-expanding role as a direct service provider within the evolving health sector.

There is nothing wrong with that. This is what self-interest groups do. They operate in their self-interests -- while making it sound as much as possible like it's really all about "better patient care". All groups do this. That's the game. That's how it is played.

But I think the CCACs are becoming more aggressive now because over the past several years, they have not had much respect/support in the delivery system, nor in the government. I don't know why the delivery system and senior public servants don't hold the CCACs in higher regard professionally. They certainly are well experienced at complex change management challenges.

They underwent significant restructuring from 43 CCACs to just 14 a few years ago. Today there is a critical mass of demonstrated managerial talent and innovative capacity in this too often undervalued sector. Indeed, a number of CCAC CEOs and their senior directors are often more experienced, competent and innovative than some of our hospital CEOs and vice-presidents -- who are, nevertheless, paid a great deal more money.

Of course there are also some CCACs (as well as LHIN and hospitals) that operate as command-and-control bullies with their suppliers, staff and clients. There are also several that have demonstrated a genuine focus on patient/clients; a zest for innovation; and, for truly being "great community partners" -- focused on the community's best interests.

In many communities, the CCACs have been the "connective tissue" that holds much of the local healthcare services delivery system together -- in very constructive and helpful ways. For many CCACs, true, pragmatic, results-oriented "partnership skills" are a strength. In others, not so much.

The CCACs have been invaluable as relationship-builders with their multiple partners across the delivery system. A well-managed CCAC truly strengthens the whole system.

While the same could be said about other sectors, the mindset at Queen's Park is that the Health Science Centres, large community hospitals, CCACs, home support agencies, mental health service providers, and illness prevention services are somehow a pecking order of descending "hierarchy" -- rather than the flexible components of a health service delivery system that can be reconfigured to meet the emerging needs of the population served.

Lots of people also say that our hospital boards are much more sophisticated than the CCAC Boards. However, in my experience, the CCAC Boards that I have facilitated, are just as good as, and perhaps even more reflective of the community than many hospital boards.

There is also about the same number of dysfunctional organizations in both the CCAC and acute care sector. Nevertheless, despite their actual level of managerial and

governance competence, the CCACs seem to feel they need to step-up to the sometimes mean-spirited criticisms and political threats that they face from the Tories and NDP -- who say they would "get rid of them, and the LHINs", if they come to power.

Indeed, the **Hudak Tories** say that under a PC government, the work currently done by CCACs, would be done under the guidance of the local hospital. They propose that additional people be added to the existing hospital board to represent the CCAC perspective -- along with other agencies that would be managed by the PC's "*Hospital Hub Model*".

But it's not just politicians who want to eliminate the CCACs.

The ***Registered Nurses' Association Of Ontario*** suggests that the CCAC *Case Managers* be located in primary care, and then eliminate what they say is "unnecessary bureaucracy". So the CCAC's face some tough challenges in the public policy/political arena right now. There are many complex and threatening dynamics that are at play. The stakes are very high.

Joining the debate about health system design is **Patients Canada** Board Chair **Michael Decter** who, on behalf of patients, is advocating for a single bureaucratic structure by merging the LHINs and CCACs.

To help them in their public affairs and lobbying efforts, the OACCAC has hired the professional government relations firm of **Strategy Corp** -- which has both Liberal and PC party senior operatives who will help them "sell" their version of health system reform to the two mainline political parties, while keeping the government's partner (the NDP) fully informed.

"There is no question, the CCAC's efforts to lobby has paid off big time. The Minister does not treat them like any other *Health Service Provider*. One prominent healthcare leader told me recently that she ignores the significant criticisms of some CCACs -- who the Minister and government treat as more significant allies than their sister crown agencies, the LHINs.

This is system redesign by stealth. "As the Minister pushed CCACs into the direct services business, nobody wanted to speak up. They were afraid of the "inner circle", says this respected CEO. The opposition parties kept raising the policy question: are CCACs in a "conflict-of-interest" if they are both healthcare service suppliers, and care coordinators who contract out the work?

The answer of course is "yes" -- a system design flaw that will create unintended outcomes.

Several other *Health Service Providers* have been quietly grumbling. They kept waiting for some sort of open and transparent public policy development process that would have given them a chance to challenge, or offer more cost-effective ways to delivery services - - rather than the unilateral decision to simply shift direct service provision to the CCACs without an open policy process.

So the CCAC sector has gained power and influence as part of an "inner circle" that influences Queen's Park.

When you strut on the field to play hard-ball politics, the draw-back is that you become the target.

Last week's *Toronto Star* article by **Bob Hepburn** reports on the gathering storm of critics of the CCAC's and their mentor, the **Hon Deb Matthews** ([Wynne Ignores Looming Health-Care Disaster](#)).

According to insiders, the MOHLTC and the OACCACs have discussed the need for a sector-wide policy debate about the future of the community sector's growth, management and governance and what that transformation journey might look like.

That's why the OACCAC has created their four discussion papers. Indeed, we should thank the OACCAC for their leadership in kicking off what I hope will be a truly open and honest dialogue about our future healthcare system. The OACCAC's policy papers are entitled, "**Health Comes Home**". The four policy papers are available @ [OACCAC Web-Site](#).

In these papers, the CCAC sector advocates that Ontario introduce point-of-care user fees and expand the role of the private sector and "use private-sector interests and investment to complement the public health-care system".

Their goal, says their first paper, is: "to begin an earnest dialogue about how we come together to create a high performing health system that optimizes home and community care." Good idea! We need these dialogues at the LHIN and *Health Link* levels -- among boards, CEOs managers and clinicians.

However, to begin the dialogue, we all really need to be aligned on our basic non-negotiable fundamental high-level principles and values -- the ones supported in public opinion polls for decades. "Values" like our future health and community support system will have **universal/equal access** -- a system with "**no user-fees**".

The OACCAC tackles the issue of resources head-on saying that "given rising expectations for choice and flexibility in their care options, Ontarians may well increasingly need to assume more financial responsibility for the cost of their care." In their fourth paper, these are called "means-tested private pay" options.

While we already have a mixed public sector healthcare delivery system, the CCAC seems to be advocating for a more expanded role for the profit-focused companies to deliver healthcare services.

The issues that the OACCAC has put on the table is the need for "more money" for care services in the community system from consumers/patients -- which would mean less money would need to be reallocated from acute care to community care and less money would have to come out of the estimated 30% waste in the system -- if people simply "paid extra" for some services.

So, the healthcare system would be "off-the-hook" -- if taxpayers and patients simply paid more.

When I asked five or six people what they got from these OACCAC position papers, they replied that the CCACs were advocating for "co-payments" and "user fees" and wanted a public/stakeholder debate on the subject.

There has of course been considerable scholarship and numerous studies conducted over the past decade in this country on the costs/benefits of healthcare *user fees*. So really, what's to debate -- if we believe in evidence-based decision-making? We know from these many studies that *user fees* are sub-optimal, and don't work. They are dead and have been buried.

Health economist **Bob Evans** refers to "user fees" as "zombies". "We kill them off with research, bury them, and then, a few years later, here they are again, risen from the dead yet again", says UBC's Evans.

By "putting all the issues on the table", has the OACCAC unintentionally become a "stocking horse for the advocates for co-payments and user fees"? Since all three political parties have -- up until now -- rejected "user fees" as an option for obtaining the revenue for expanded seniors' services, it would be helpful to learn if the OACCAC would propose to shift resources from the acute care sector to community care. Now that would be putting the elephant on the table!

From a senior citizen taxpayers' perspective, they want to shift their healthcare investments from acute care to chronic care/home care, and to home support services.

Having paid handsomely for their entire lives for health services, seniors and taxpayers have consistently rejected *user fees* as an option -- which explains why no political party is prepared to publically call for user fees.

This might be a great idea in Utah, but it will not be very acceptable in Ontario.

Rather than considering *user-fees* as the first option to generate "more revenue for the same services" offered by the CCACs, why not instead put the CCACs best thinking about how to reduce the estimated 30 percent waste in our healthcare delivery system -- by even just a modest amount? That would certainly generate considerably more revenue than "**user fees**" would ever raise.

I think these **Health System Future Dialogues/Stakeholder Debates** that the OACCAC wants to encourage, could indeed generate a lot of sparks -- if they include asking patients/taxpayers for even more money for the services they having been paying for all these years. Most taxpayers don't have the type of rich pension plans enjoyed by most of the health sector. Baby boomers want to shift resources from services they require less of (i.e. acute care), to services they require more of (i.e. home support/care).

Patients -- as taxpayers and "owners" of our healthcare system -- want the high-quality services that they have already paid for. So, as we approach the Spring election, let the *Earnest Dialogue* begin!

I don't understand why the OACCAC thinks it is a good idea to infuse the issue of "**user fees/co-payments/or means-tested private pay**" into the Spring election, but good for them: let each political party explain how they will pay for increased home care -- by reducing the 30% waste in our \$48 billion system; shifting resources from acute care; to community care; or user fees? Or, combinations?

Next week I'll blog on the *Nurses and CHC Lobby*.

FORWARD THIS BLOG TO PEOPLE YOU THINK WOULD GAIN SOME DIFFERENT INSIGHTS ON OUR CURRENT CIRCUMSTANCES.

