Canadian Stakeholders’ Views about the Boundaries of Publicly Funded Health Care: What are the Consequences for Women Caregivers?

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The debate about the sustainability of Canada’s health care model has focussed on updating what services should be publicly funded. Full public coverage is only guaranteed for services delivered in hospitals or by physicians. Many reports have recommended expanding public coverage to include community-based services. A national survey of 2,523 policy elites demonstrated that implementation of this policy direction will be difficult. The inability to implement policy that supports publicly financing community-based services could result in a shift of the delivery of care from the formal sector to the informal sector. Moreover, a shift of this nature will undoubtedly result in a higher reliance on the unpaid work of women caregivers. Consequently, there is a need to explore the impact that economic and social restructuring has on the well-being of women caregivers within both the formal and informal sectors.

The Canadian health care model known as Medicare is a popular social program that embodies Canadian values (Mendelsohn, 2002). These values include ones that support a publicly funded model where it is believed that all Canadians should have access to health care services based on medical need rather than on the ability to pay (Commission on the Future of Health Care in Canada, 2002a). Over the last decade there has been considerable debate about the sustainability of Medicare (Commission on the Future of Health Care in Canada, 2002a; Marchildon, 2005; National Forum on Health, 1997a, b), including a focus on the determination of what services should be included in the publicly funded basket of services (Canada. Parliament. Standing Senate Committee, 2002a; Canadian Health Services Research Foundation, 2002a; Commission on the Future of Health Care in Canada, 2002b; Flood & Choudhry, 2004; Premier’s Advisory Council on Health for Alberta, 2001; Quebec commission d’étude sur les services de santé et les services sociaux, 2000; Ramsay, 2004).

Federal regulation only guarantees full public funding for ‘medically necessary’ hospital services and/or physician services (Government of Canada, 1984; Madore, 2003). Current health care reform recommends the implementation of public policy that supports the public funding of services regardless of where (e.g., hospitals) and who (e.g., physicians) delivers medically necessary services

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(Commission on the Future of Health Care in Canada, 2002b). As well, a number of different factors (including the development of new technologies, new medical therapies, fiscal restraint and patient choice) have contributed to the shift of the delivery of hospital-based services to the community and home (Canada. Parliament. Standing Senate Committee, 2002b; Canadian Health Services Research Foundation, 2002b; Commission on the Future of Health Care in Canada, 2002b; Deber, 2004; Hollander et al., 2000; Lewis et al., 2001). At the same time, a number of national and provincial reports support a shift from the pure medical model (e.g., hospitals and physicians) to a more holistic approach that includes the determinants of health (e.g., population health) (Canadian Health Services Research Foundation, 2002b; Canadian Public Health Association, 2001; Epp, 1986; Evans, 1987; Glouberman, 2001; Government of Canada, 1994; Lalonde, 1974; National Forum on Health, 1996; Ottawa Charter for Health Promotion, 1986; Podborski, 1987).

While provinces and territories are not required to publicly fund services beyond those stipulated by federal regulation, they do fund additional services (e.g., home care, public health, prescription drugs, etc.) partially or fully, universally and/or for certain populations (Health Canada, 2002). As a result, the debate on the sustainability of Medicare involves the determination of what services should be included and to what extent under the publicly funded model. The Medicare To Home And Community (M-THAC) Research Unit and its research partners conducted a survey of policy elites from key stakeholder groups from across Canada to assist in this debate. The results presented in this paper are based on the data collected from this 2002 national survey. Results demonstrate that the public funding of community-based services is a contentious issue.

**Why are the Views of Policy Elites Important?**

Governments are not the only actors involved in the formulation and implementation of public policy. Pluralist theoretical models are based on the observation that interest groups can influence government policy (Brooks & Miljan, 2003). A number of different organized interests can be identified in the health care arena, including doctors, nurses and other health care professionals, as well as business (Tuohy, 1992). Those included in the M-THAC survey were health care providers and business. While approximately 70% of the funding for health care comes from public (i.e., government) sector sources (Canadian Institute for Health Information & Statistics Canada, 2003), almost all of the delivery of services is provided by the private sector (including physicians, hospitals, laboratories, clinics and other health care providers) (Deber, 2004; Deber et al., 1998). This often leads to tension between government and providers as to whether there is enough money put into the health care system (Evans, 1984). Furthermore, health professionals enjoy a great degree of professional autonomy (Coburn, 1993; O’Reily, 2000),

and make decisions that influence the allocation of health care services at the micro level.

The activities of business can also influence policy (Harmes, 2004; Lindblom, 1977). Not publicly funded health care services are financed privately, both in the form of group or individual health care insurance and as direct out-of-pocket payments. Business plays a key role in providing employee benefits (e.g., private health insurance) to cover health care services not funded under the public health insurance models. Consequently, the activities of business can also potentially influence the activities of government.

If key stakeholder groups (in this case health care professionals and business) disagree with policy goals, successful implementation of policy is made more difficult (Garn, 1999; Pressman & Wildavsky, 1973). In fact, a specific policy direction may stray from the original plans due to the involvement of certain stakeholders (Horev & Babad, 2005). As a result cooperation and leadership from various stakeholders are needed in order to implement health care reform and to move talk to action (Canadian Healthcare Association, 2001; District Health Boards New Zealand Inc. & Ministry of Health, 2006; Québec Ministère de la Santé et des Services sociaux, 2000; Segal, 2000).

Table I: Policy Elites Surveyed, by Stakeholder Group

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Who is included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>Board members from the Canadian Medical Association and participating provincial medical associations</td>
</tr>
<tr>
<td>Medical Reform</td>
<td>Members of the Medical Reform Group</td>
</tr>
<tr>
<td>Nurses</td>
<td>Board members from Canadian Nurses= Association and participating provincial nurses= associations</td>
</tr>
<tr>
<td>RNAO Board</td>
<td>Board members of the Registered Nurses’ Association of Ontario</td>
</tr>
<tr>
<td>RNAO Members</td>
<td>Random stratified sample of members from the Registered Nurses= Association of Ontario (as requested by the RNAO Board)</td>
</tr>
<tr>
<td>CHA</td>
<td>Chief executive officers of member institutions of the Canadian Healthcare Association</td>
</tr>
<tr>
<td>OHA Chairs</td>
<td>Board Chairs from member hospitals of the Ontario Hospital Association</td>
</tr>
<tr>
<td>OHA CEOs</td>
<td>Chief Executive Officers from member hospitals of the Ontario Hospital Association</td>
</tr>
<tr>
<td>CHCA</td>
<td>Chief executive officers from member institutions of the Canadian Home Care Association</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>Members of the Canadian Pharmacists Association</td>
</tr>
<tr>
<td>Small Business</td>
<td>Canadian Federation of Independent Businesses</td>
</tr>
<tr>
<td>OCC</td>
<td>Representatives of Member corporation of the Ontario Chamber of Commerce</td>
</tr>
<tr>
<td>Big Business</td>
<td>Members of the Conference Board of Canada</td>
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Accordingly, partnerships were established with 13 key stakeholder groups including physicians (Canadian Medical Association, collaborating provincial medical associations and the Medical Reform Group, a voluntary physicians’ association with the majority of the membership consisting of practising physicians in Ontario), nurses (Canadian Nurses’ Association and collaborating provincial nurses’ associations), hospital/health authorities (Canadian Healthcare Association and the Ontario Hospital Association), home care providers (Canadian Home Care Association), pharmacists (Canadian Pharmacists Association), and business (Conference Board of Canada, Canadian Federation of Independent Business and Ontario Chamber of Commerce). Table I below provides the list of the policy elites included in this study along with the designation used to identify each stakeholder group throughout this paper.

**Does Canada Have a National Health Care System?**

The simple answer to this question is ‘no’. Canada is a federalist state (Bird, 1980; Oates, 1972; Rocher & Smith, 2002) with the division of powers between two main levels of government; (Government of Canada, 1982) the national level or federal government and sub-national governments or the ten provincial and three territorial governments. Provincial/territorial governments are considered to hold primary jurisdiction over health policy, precluding a single national system (Atkinson & Chandler, 1983; Maioni, 2004). Therefore, the Canadian health care model is more accurately described as a series of thirteen separate provincial/territorial health insurance plans that are responsible for the funding of publicly insured services. Nevertheless, this is not to say that the federal government has not played a significant role in the determination of what health care services get publicly funded.

**What Services are Currently Guaranteed Full Public Funding?**

The provincial/territorial plans are funded in part by the federal government. The federal government ties receipt of federal transfer payments to a requirement that the provincial/territorial health insurance plans comply with the principles and conditions of the *Canada Health Act* (CHA). The Act distinguishes between two types of services: insured services and extended services. The comprehensive principle of the CHA (Government of Canada, 1984) defines publicly insured services in terms of where they are provided (hospitals) and who provides them (doctors). Insured health care services are denoted as including medically necessary hospital, physician and/or hospital-based surgical-dental services. Hospital services include medically necessary in and outpatient services, such as standard or public ward accommodation, nursing services, diagnostic procedures such as blood tests and x-rays, drugs administered in hospital, and the use of operating rooms, case rooms
and anaesthetic facilities (Madore, 2003). Insured physician services are defined under the Act as medically required services rendered by medical practitioners (Government of Canada, 1984). Provisions in the CHA discourage against the introduction of user charges or extra-billing for insured services (e.g., medically necessary hospitals and/or physician services).

Extended services are defined by the CHA to include intermediate care in nursing homes, adult residential care service, home care service and ambulatory health-care services (Madore, 2003). Unlike insured services, (e.g., hospital and/or physician services) the extended services are not guaranteed full public coverage. These services do not fall under the provisions against user charges or extra-billing. As a result, individuals may be required to pay for such services, either partially or fully.

Provincial/territorial plans may also include a number of other services, such as optometric services, dental care, assistive devices and prescription drugs (Madore, 2003). The rate of public coverage for these services varies from one province to another depending on the type of service, location, age, income and type of disease (Madore, 2003). The CHA does not require provincial/territorial governments to fund publicly additional services including those delivered in the community outside of hospitals. Accordingly, there is considerable variability across Canada in how services are delivered (since the CHA says nothing about delivery), as well as in coverage for services beyond the Medicare requirements.

The national report *Building on Values: The Future of Health Care in Canada* recommended revising the CHA (Government of Canada, 1984) to include full public coverage for a number of community-based services (e.g., post-acute home care). This recommendation was endorsed by provincial/territorial Premiers in 2003 and 2004 (Canadian Orthopaedic Foundation, 2005; Health Canada, 2003). Clearly, it would seem that there is support for publicly funding additional services in the community.

**Definition of Community-based Services**

Community-based services are defined as services delivered by both the informal and formal sectors (Baranek, Deber & Williams, 2004). The informal sector is comprised of family, friends and volunteers who provide support and care. This sector is estimated to include more than 3 million Canadians (Canadian Association for Community Care, 2001). The majority of this unpaid work is provided by women (Cancian & Oliker, 2000; Statistics Canada, 2004), who provide care and support to individuals who have chronic illnesses or disabilities (Commission on the Future of Health Care in Canada, 2002b). Furthermore, the rate of volunteering in Canada is positively related to the level of public expenditure on health care (Luxton, 1998). Individuals are more willing to commit if some level of service is available in the formal sector. This
gives individuals the sense that they do not have to do it all.

The formal sector includes both medical services and social support services provided by non-professional and professional health care providers. Moreover, it is also interesting to note that women provide the majority of care in the formal sector in the form of paid work (Canadian Institute for Health Information, 2005). Subsequently, in both the informal and formal system, women make up the majority of caregivers.

Those needing medical services in the community can be divided into two groups. One group of individuals require short-term acute services that otherwise would have been delivered in the hospital (e.g., home-based nursing, rehabilitation, etc.)-termed as post-acute home care services. A second group of individuals require services on a longer-term basis (e.g., chronic care), but may also require social support services such as homemaking. In terms of public funding, community-based services (e.g., medical services and social support services) fall under the category of extended services and by definition are not guaranteed full public funding. As noted above, many provinces/territories do publicly fund these services for certain populations, but the rate of public coverage for these services varies from one province to another. Services not publicly funded in the community are provided by the informal sector, which is often comprised solely of women performing unpaid work (e.g., homecare). Consequently, economic and social restructuring in health care has a significant impact on the well-being of women caregivers within both the formal and informal sectors.

**Boundaries of Medicare Survey**

The research design employed for this study was a non-experimental, cross-sectional survey design. The self-administered 12-page questionnaire was distributed between January and April 2002. It included the questions about what should be in or out of the publicly-funded systems by service type; priority setting across sectors and within health care; general views about public and private, views about the role of government, individuals and corporations; views on the health care model and demographic items. The sample design was a purposive (non-probability) sample of policy elites who were defined as leaders from key stakeholder groups from across Canada. The partner organizations helped to establish the sampling frame by identifying within their memberships these policy elites. This paper presents the views of 2,523 policy elites on the extent of public coverage for services delivered in hospital and in the community based on the characteristics of the service and/or the characteristics of the recipients of care/client.

Those surveyed were asked if publicly financed coverage should be:

**Universal:** Falling under the same terms as the Canada Health Act (i.e., no user fees to insured persons)
**Partial coverage:** Public payment on a sliding scale only for those who cannot afford it with others paying some or all of the cost, depending upon their incomes  
**Subsidized:** Partial public payment on another, non means-tested basis, such as capped payments with user fees allowed, or  
**Not included:** No public payment, those who want it and/or their insurers pay the full cost themselves  

Another question asked about priority setting within the publicly-funded system, based on the characteristics of the recipient of care/client. A number of hypothetical patients were briefly described, with a list of services that they might receive. For each person, respondents were asked to indicate what priority they would give for universal publicly funded care for each of the services. Respondents were asked to rate the priority of each based on the following categories:  
**Highest:** Must be done, regardless of other demands on resources  
**Medium:** Should be done, if possible, assuming all high priority demands dealt with  
**Low:** Should be done only if resources are available and not otherwise being used, and  
**No:** Should not receive public funding at all  

One vignette included Clients P and Q who are both frail 87-year-old widows. The only distinction made between the two clients was that Client P lived alone and Client Q lived with a married daughter. The services listed for each of these clients included:  
- Pharmacists monitoring of and counseling of medication therapy  
- Home visit(s) by pharmacists to assess drug therapy and adherence  
- Homemaking Adult day programs, and Respite care (only for Client Q who lives with her married daughter)  

The results indicate that the views of policy elites varied based on the characteristic of the service and generally do not vary based on the characteristic of the client with one very important exception. The exception was homemaking services, which were given a higher priority for the 87-year-old frail elderly widow living alone than for the 87-year-old frail elderly widow living with her married daughter.  

*What Are the Views of the Policy Elites?*  
The results demonstrate that the majority of policy elites support the current funding model that guarantees full public coverage for medically necessary hospital services under the terms of the *Canada Health Act* (see Figure 1).
When asked about funding these same services in the community (e.g., private clinics and/or the home), the views were more mixed (see Figure 2). While there was agreement that these services should receive some form of public payment, there was no consensus on the extent of public coverage. For some, the site of delivery did not matter. These policy elites would support full public funding of medically necessary hospital services delivered in the community. However, for the majority, the site of care did matter! There was little support for full public payment of medically necessary hospital services delivered in private clinics and/or the home.

A higher priority was given to publicly funding medical care services in the hospital with little or no support for fully publicly fund-
ing these same services in the community. While reform may recommend funding regardless of the site of delivery, these policy elites did not agree. What this survey demonstrates is that policy elites are not convinced of this point, and subsequently, this may be one of the reasons why reform in this area may remain stalled.

Unlike support for community-based services with a medical component, there was less support for full public payment and more support for no public payment for social support services (see Figure 3). The majority of elites supported the use of co-payment/user fees for: stipend for family caregiver (56.2%); respite support for family caregiver (62.2%); adult day programs (60.6%); supportive housing (71.6%); community support (69.4%) and homemaking (70%).

Figure 3: Views on social services in the community

Clearly, the ideas of the policy elites are heavily linked to the medical model rather than a more expanded model that would include the determinants of health. For many reformers, focusing on funding medical care services may address immediate medical needs, but does not take into account services that address ongoing or future needs. That said, the analysis shows that key policy elites are not convinced, and thus reforms in this area also remain stalled. This tendency to view social services differently was shown in the views about whether or not priorities should be influenced by the characteristics of the recipient. In general, the answer was ‘no’. The exception was homemaking services, where 60.7% of the policy elites (including both female and male) gave a higher priority for the 87-year-old frail elderly widow living alone than for the 87-year-old frail elderly widow living with her married daughter. Some respondents appeared to have assumed that the married daughter
should take responsibility for her mother’s homemaking needs regardless of the costs (personal, time, etc.) to the married daughter. Here, gendered values have clearly played a role for some in the decision-making process and did not support the extension of the limits of social solidarity to publicly funding services that could potentially be provided by family members, especially female family members.

**What Are the Implications from a Policy Perspective?**

The inability to implement reform that supports the funding of services regardless of the site of delivery could result in the passive privatization of currently insured hospital services. Services that are currently publicly insured under the terms of the CHA will become de-insured as the site of care shifts from hospitals to the community. Why? Health care services such as nursing and rehabilitation services fall within the provisions of the CHA only when delivered in hospital; provincial/territorial governments can, but are not required to insure them if delivered in the community. A situation that currently exists with the funding of dental surgery (Deber, 2004). The CHA lists dental surgery as an insured service when delivered in the hospital, however in reality, the site of delivery is often in community dental clinics where it is no longer a publicly insured service. Rather than medical need determining who has access to services, the ability to pay or market principles will determine who has access to medical services delivered outside of the hospital.

As noted, the majority of policy elites supported the use of co-payments and/or user fees for social support services. However the introduction of co-payments and/or user fees reduces the access for those with low incomes and increases access for those with high incomes (Evans, 2004).

As services fall outside of the publicly funded basket in the formal sector many unable to pay for care will increasingly rely on volunteers, family, and friends in the informal sector to fill the gaps. Not only will there be a shift in the financial costs of care (from publicly insured services to privately financed care), but there is also the potential to shift the burden of care from women who are paid in the formal sector to women who are not paid in the informal sector. The inability of the government to take action supports an inherent bias against women. Thus, the failure to implement economic and social restructuring within the health care arena can have a negative impact on the well-being of women caregivers within both the formal and informal sectors.

Identifying barriers to change is only the first step. Strong leadership is needed from government to make hard political choices that are based not only on facts (i.e., what is currently funded) but also on values that support access to care based on need rather than the ability to pay. Part of that decision-making framework should include recognition of the economic impact for women as well as the well-being of
women caregivers. Failure to do so will result in the assumption that women will provide care to family and friends regardless of their own circumstances, as evidenced by the policy elites who responded to the Boundaries of Medicare survey.

The debate about the sustainability of Medicare should not only focus on what to include in the publicly funded basket of services, but also on the implications for not including certain services. As this analysis has uncovered, the failure of the government to act can result in unintended consequences. The inability to implement policy that supports the funding of services regardless of the site of care will have consequences for the recipient of care as well as for women in the community who provide support and care in the informal sector. The debate needs a re-focusing that not only includes the consideration of the implications for the informal system and the unpaid work of women, but also the consideration of how this shift of care affects the paid work of women within the formal sector.
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