

Medicare to Home and Community Research Unit

funded by the Canadian Institutes for Health Research



“What’s in, What’s out”: Stakeholders’ views about the boundaries of Medicare

Report on the results for Question 1
November, 2002

Research team:

Raisa B. Deber, PhD
Earl Berger, PhD
A. Paul Williams, PhD
Brenda Gamble, MSc

“What’s in, What’s out”: Stakeholders’ views about the boundaries of Medicare

Report on the results for Question 1
November 13, 2002

Research team:

Raisa B. Deber, PhD
Earl Berger, PhD
A. Paul Williams, PhD
Brenda Gamble, MSc

With the assistance of the following research partners:

Canadian Medical Association
Newfoundland and Labrador Medical Association
Medical Society of Prince Edward Island
L’Association médicale du Québec
Saskatchewan Medical Association
Alberta Medical Association
British Columbia Medical Association
Yukon Medical Association
Canadian Nurses Association
The Registered Nurses Association of British Columbia
The Alberta Association of Registered Nurses
Registered Nurses Association of Ontario
Ordre des infirmières et infirmiers du Québec
Nurses Association of New Brunswick
Association of Nurses of Prince Edward Island
Yukon Registered Nurses Association
Canadian Pharmacists Association
Conference Board of Canada
The Canadian Federation of Independent Business
Ontario Chamber of Commerce
Medical Reform Group
Canadian Home Care Association
Canadian Healthcare Association
Ontario Hospital Association

Acknowledgments:

M-THAC for funding
Ann Pendleton for survey mailing and data entry
Cathy Bezic for coordination and survey mailing

Contents

Executive Summary i
 The Rationale for the Study i
 The Participants i
 The Question iii
 The Key Findings iv
 Discussion and Conclusions viii

Introduction 2
Report on Specific Survey Findings for Question One 4
 Views on support for “insured hospital services” 5
 Views on support for “insured physician services” 6
 Views on support for certain services “currently out of Medicare” 6
 Views on support for “additional new services in Medicare” 7
 Views on support for “co-payment of services” 9
 Views on support for “insured hospital services delivered at a non-hospital site of care”
 9
 Views on support for “insured physician services delivered by non-physician
 professional” 11
 Views on support for “some form of public payment” 13
Discussion and Conclusions 15

Appendix A: Comparison of the Views on Coverage by Stakeholder Group 16
Appendix B: Overall Responses on the Extent of Coverage for each Service 23
Appendix C: List and Description of the Partners 26
Appendix D: Sample Size and Response Rate 29
References 32

List of Figures

Appendix A (separate file)

- Figure 1: Views on coverage for: Acute Hospital Care (In-patient)
- Figure 2: Views on coverage for: Palliative Care in Institutions
- Figure 3: Views on coverage for: Day Surgery in Hospitals
- Figure 4: Views on coverage for: Diagnostic Services in Hospitals
- Figure 5: Views on coverage for: Laboratory Tests in Hospitals
- Figure 6: Views on coverage for: Professional Rehabilitation Services in Hospitals
- Figure 7: Views on coverage for: In-patient Pharmaceuticals
- Figure 8: Views on coverage for: Physician Office Visits
- Figure 9: Views on coverage for: Psychological Counseling by Physicians

- Figure 10: Views on coverage for: Out-patient Pharmaceuticals Non-prescription Drugs
- Figure 11: Views on coverage for: In Vitro Fertilization
- Figure 12: Views on coverage for: Cosmetic Surgery
- Figure 13: Views on coverage for: Complementary/alternative therapies (Chinese medicine)
- Figure 14: Views on coverage for: Complementary/Alternative Providers -e.g. herbalists
- Figure 15: Views on coverage for: Travel Health-immunization, etc prior to foreign travel
- Figure 16: Views on coverage for: Palliative Care at Home
- Figure 17: Views on coverage for: Telephone-based Advice from your Doctor(s)
- Figure 18: Views on coverage for: Transportation by Ambulance for Emergency Care
- Figure 19: Views on coverage for: Immunizations (e.g., polio, mumps, measles, etc.)
- Figure 20: Views on coverage for: Long Term Care Facilities (e.g. nursing home)
- Figure 21: Views on coverage for: Home-based Personal Support Services
- Figure 22: Views on coverage for: Homemaking (cleaning, laundry, shopping, etc)
- Figure 23: Views on coverage for: Supportive Housing
- Figure 24: Views on coverage for: Community Support (meals on wheels, transportation, etc)
- Figure 25: Views on coverage for: Adult Day Programs (supervised activity in a group)
- Figure 26: Views on coverage for: Day Surgery in Private Clinics
- Figure 27: Views on coverage for: Diagnostic Services in Private Clinics
- Figure 28: Views on coverage for: Laboratory Tests in Private Clinics
- Figure 29: Views on coverage for: Professional Rehabilitation Services in Private Clinics
- Figure 30: Views on coverage for: Professional Rehabilitation Services at Home
- Figure 31: Views on coverage for: Out-patient Pharmaceuticals (prescription)
- Figure 32: Views on coverage for: Medical Supplies and Equipment at Home
- Figure 33: Views on coverage for: Midwifery
- Figure 34: Views on coverage for: Office Visits to Nurse Practitioners
- Figure 35: Views on coverage for: Psychological Counseling by Non-physician Professionals
- Figure 36: Views on coverage for: Telephone-based Advice from Non-physician Professionals
- Figure 37: Views on coverage for: Chiropractic Services
- Figure 38: Views on coverage for: Pharmacist Counseling re: Disease Management (asthma)
- Figure 39: Views on coverage for: Pharmacists Monitoring and Counseling re: medication
- Figure 40: Views on coverage for: Home-based Nursing
- Figure 41: Views on coverage for: Transportation to Receive Care at Out-of-region Centre
- Figure 42: Views on coverage for: Respite Support for Family Caregiver
- Figure 43: Views on coverage for: Stipend to Family Caregiver
- Figure 44: Views on coverage for: Dental Care - Prevention /Check Ups
- Figure 45: Views on coverage for: Dental Care - Restorative (filling cavities)
- Figure 46: Views on coverage for: Genetic Tests for Pre-natal Screening
- Figure 47: Views on coverage for: Genetic Tests for Adults (Disease propensities)
- Figure 48: Views on coverage for: Experimental Medical Treatments

Executive Summary

There is currently a heated debate about what should be “in” or “out” of Medicare. This project arose from our belief that this debate requires focusing to highlight the areas where consensus exists, and those where there is still disagreement. Discovering areas of agreement may enable us to identify where we are ready to move beyond discussion to action. Areas of disagreement, in contrast, require ascertaining the rationale for the contending views and seeing whether consensus may then be reached. There have been decades of discussion; it is hoped that this report may assist in finding areas where policy action can finally progress, and moving the policy dialogue forward on those areas where views have not yet cohered.

This report accordingly presents the views of 2,522 individuals who are “policy elites.” They come from a number of key stakeholder groups, both providers (including physicians, nurses, hospital/health authorities, home care providers, and pharmacists) and business (both large and small) from across Canada. Although public views are critical, they tend to be less specific about what particular items should be “in” or “out”; obtaining meaningful responses would thus require more efforts to clarify exactly what was meant by particular services, and would not work well in a mailed survey format. This survey thus represents the views of people who both represent individuals “in the trenches,” but also must actively deal with these policy issues, either as providers, or as business (who are often asked to pay the bills). Views of additional groups would, of course, be valuable. Nonetheless, in some areas, there is a remarkable consensus in the views on what should be ‘in’ and ‘out’ of the publicly-funded system.

The Rationale for the Study

Medicare is widely seen as the most popular Canadian social program; however, there is increasing questioning of its sustainability.¹⁻⁸ As the debate about the sustainability of Medicare heightens, many observers have called for updating the determination of what should be paid for from public funds⁹⁻¹⁸.

The Participants

To date the debate about what should be “in and out” of publicly financed health care has largely been based on tradition and rhetoric rather than evidence. To help clarify the issues, the Medicare to Home and Community (M-THAC) Research Unit and its partners conducted a national survey of policy elites of such key stakeholder groups as physicians (Canadian Medical

Association, collaborating provincial medical associations and the Medical Reform Group), 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 1 below provides a list of the policy elites included in the study along with the designation used to identify each stakeholder group. A complete list and brief description of each association can be found in Appendix C of the full report.

Table 1: Policy Elites Surveyed, by Stakeholder Group

Stakeholder Group	Who is Included
Doctors	Board members from the Canadian Medical Association and participating provincial medical associations
Medical Reform	Members of the Medical Reform Group
Nurses	Board members from Canadian Nurses Association and participating provincial nurses associations
RNAO Board	Board members of the Registered Nurses Association of Ontario
RNAO Members	Random stratified sample of members from the Registered Nurses Association of Ontario
CHA	Chief executive officers of member institutions of the Canadian Healthcare Association
OHA Chairs	Board Chairs from member hospitals of the Ontario Hospital Association
OHA CEOs	Chief Executive Officers from member hospitals of the Ontario Hospital Association
CHCA	Members of the Canadian Home Care Association
Pharmacists	Members of the Canadian Pharmacists Association

Stakeholder Group	Who is Included
OCC	Members of the Ontario Chamber of Commerce
Small Business	Members of the Canadian Federation of Independent Business
Big Business	Members of the Conference Board of Canada

The Question

The 12-page survey (available upon request), constructed in consultation with our partners, available in both French and English included items about overall sustainability issues. This report focuses upon the replies to a detailed question asking about what our respondents thought should be “in” or “out” of the publicly-funded system. Rather than ask about universal versus a “two tier” health care system in general, we compiled a list of 48 services, assembled with the aid of our research partners. Some of these services are required to be covered under the terms of the *Canada Health Act (CHA)*. Others represent similar services, delivered in different locations or by non-physician professionals, which may or may not receive public funding from various provincial health plans. In addition, a list of other services such as a number of home care services and preventative services were included. For each, we asked respondents to assume that the potential recipient of care both “needs” and wants the specified service, and to then indicate whether they think that 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.

We compared the views by stakeholder groups to identify areas where there was agreement and disagreement in order to assist in the debate of what should be included in the publicly-funded system. Detailed survey findings can be found in the full report.

The Key Findings

Under the terms of the *Canada Health Act (CHA)*, all medically necessary services delivered within hospitals must receive full public payment. Hospital expenditures still represent the largest category of total health expenditures (at about 32%), but this share has fallen dramatically over the last 25 years as care is shifted from hospitals into home and community.¹⁹ We asked about:

- Acute hospital care (Figure 1);
- Palliative care in institutions (Figure 2);
- Day surgery in hospitals (Figure 3);
- Diagnostic services in hospitals (Figure 4);
- Laboratory tests in hospitals (Figure 5);
- Professional rehabilitation services in hospitals (Figure 6); and
- In-patient pharmaceuticals (Figure 7).

These results make it clear that there is overwhelming support, across all groups, to continue to provide full public payment for these insured hospital services. ***We can thus conclude that there is little need for debate on this area; all groups surveyed concur that hospital services should continue to be “in”.***

The other major category assured full coverage under the *Canada Health Act* is physician services, which receive virtually all of their funding from public sources. We asked about:

- Physician office visits (Figure 8); and
- Psychological counseling by physicians (Figure 9).

Here, views are more mixed. Although support was evident across all groups to keep such services within Medicare (with virtually no support for removing them altogether), our results revealed some support for allowing co-payments by insured persons, along with strong opposition to this idea from others. This is most pronounced for psychological counseling by physicians, where approximately 40% of the respondents support some form of co-payment. ***These findings suggest that there is some room for debate both about the extent of public payment for certain physician services, and about the role of mental health within the publicly-funded system.***

Another group of services evoked a consensus that they should be ‘out’ of Medicare. We asked about:

- Out-patient pharmaceuticals non-prescription drugs (Figure 10);

In-vitro fertilization (Figure 11);
Cosmetic surgery (Figure 12);
Complementary/alternative therapies (Figure 13);
Complementary/alternative providers (Figure 14); and
Travel Health-immunization, etc prior to foreign travel (Figure 15)

In general, these are not currently part of the core basket; there was little support across all groups for adding them.

In contrast, there was fairly strong support for extending coverage to certain services which currently are not required to be insured:

Palliative care at home (Figure 16);
Telephone-based advice from your doctor(s) (Figure 17);
Transportation by ambulance for emergency care (Figure 18); and
Immunizations (e.g., polio, mumps, measles, etc) (Figure 19).

There would thus appear to be some justification for moving debate into action, and incorporating these services into the basket.

Another group of services were in an intermediate zone - there was support across all groups for bringing them in, but with some form of co-payment:

Long term care facilities (Figure 20);
Home-based personal support services (Figure 21);
Homemaking (Figure 22);
Supportive housing (Figure 23);
Community support (e.g. meals on wheels) (Figure 24); and
Adult day programs (Figure 25)

Clearly, there is need for a debate as to how to bring such services into Medicare, and the extent of coverage deemed appropriate.

An interesting question relates how to manage services which would be insured if delivered within hospitals, but move outside of the provisions of the *CHA* if they are moved into the community. Here, health reformers often argue that the services should be treated in the same way, regardless of where they are located. However, not all of our stakeholders agree. Support for full public payment often drops precipitously when we specify that the site of delivery has changed. We asked about:

Day surgery in private clinics (Figure 26);

Diagnostic services in private clinics (Figure 27);
 Laboratory tests in private clinics (Figure 28);
 Professional rehabilitation services in private clinics (Figure 29);
 Professional rehabilitation services at home (Figure 30);
 Out-patient pharmaceuticals (prescription) (Figure 31); and
 Medical supplies and equipment at home (Figure 32).

In stark contrast to responses for the same services within hospitals, there was stronger support for some form of co-payment for these services, with approximately 20% of the respondents indicating that they did not think private clinics should receive any public payment. ***For many of those who responded, the site of care for these services matters.*** It is not clear whether the reaction is to the term “private”(e.g., interpreted as private for-profit), or represents other reasons for preferring hospital-based delivery. However, these issues must be addressed if health care reform is not to become a synonym for de-insurance.

Similarly, views about how services which would be fully insured if delivered by physicians should be treated when delivered by non-physician professional also vary, depending on the type of professional under consideration and the stakeholder group responding. Overall the majority would support full coverage for:

Midwifery (Figure 33);
 Office visits to nurse practitioners (Figure 34);
 Psychological counseling by non-physician professionals (Figure 35); and
 Telephone-based advice from non-physician providers (Figure 36).

Here, not surprisingly, responses vary by group, with doctors particularly unenthusiastic, and nurses particularly supportive. Between 30% and 40% of the Doctors support no public payment for nurse practitioners and midwifery. All groups except Big Business are supportive of some type of public payment, be it full coverage as is the case for Nurses, RNAO Board, RNAO Members and the Medical Reform or some form of a co-payment as illustrated by Small Business, Pharmacists, OHA Chairs, CHA and Doctors for psychological counseling by non-physician professionals. While the majority of groups support full public payment for telephone-based advice from non-physician professionals Big Business, Small Business, Pharmacists and Doctors demonstrate either support for some type of co-payment or no public payment.

The majority of the respondents across all groups would support some form of co-payment for:

Chiropractic services (Figure 37).

The key exception is Doctors, who overwhelmingly support no public payment for chiropractic services. Currently chiropractic services are partially funded by provincial health insurance plans in British Columbia, Alberta, Saskatchewan, Manitoba and Ontario.

The issue of where pharmacists fit into the health care system was very contentious. Views are spilt between support for full public payment, co-payment and no public payment for:

Pharmacists counseling for disease management (Figure 38); and

Pharmacist monitoring and counseling medication (Figure 39).

Further debate is clearly needed about the role of pharmacists. For example, Pharmacists, the Medical Reform Group, and all nurses are most likely to think they should be included within the health care system (albeit sometimes with co-payments), with support also arising from hospitals and home care. In contrast, Doctors and business appear to be far more resistant. ***Further debate is needed to determine if it is feasible to extent coverage of insured services delivered by a physician to include public payment of these same services delivered by non-physician professionals.***

The last group of services reviewed included uninsured services for which group variation existed. Most groups supported some form of public payment for:

Home-based nursing (Figure 40);

Transportation to receive care at out-of-region centre (Figure 41);

Respite support for family caregiver (Figure 42);

Support is also evident for some form of co-payment for the following services. However, there were strong minorities thinking that there was no room for public financing at all for:

Stipend to family caregiver (Figure 43);

Dental care prevention/check ups (Figure 44);

Dental care restorative (Figure 45);

Genetic tests for pre-natal screening (Figure 46);

Genetic tests for adults (Figure 47); and

Experimental medical treatments (Figure 48).

While there is no clear consensus on the type of public payment for each of these services it was evident that support exist across all groups for some form of public payment. The ambiguity of the findings suggest that while those surveyed saw these services as important other factors may have influenced their decision on the extent of support for public payment. ***Clearly***

debate is needed to reach a consensus on the potential role and impact of these services in maintaining health and well-being. Only then can dialogue proceed to establish the extent of public payment if any for each of these services.

Discussion and Conclusions

Our results suggest that it is time to move the debate from what is already “in” the basket of services to an examination of those services currently “out” of Medicare. In particular, there is overwhelming support for keeping those insured hospital services currently guaranteed full public payment under the terms of the *Canada Health Act (CHA)*. There is more question about the role for user fees for physician services, which clearly will be related to the on-going debate about how best to organize and reimburse physician services.

In particular, although much of the debate has focused on pharmacare and home care, the results pointed to a number of critical services currently in an ambiguous zone, with some provinces fully covering them, and others not. These included palliative care at home (Figure 16); telephone-based advice from your doctor(s) (Figure 17); transportation by ambulance for emergency care (Figure 18); and immunizations (e.g., polio, mumps, measles, etc.) (Figure 19). There was strong consensus that these services should be “in” the basket.

Neither does the time seem ripe to discuss expanding the basket to a host of services not currently included, such as out-patient pharmaceuticals non-prescription drugs (Figure 10); in-vitro fertilization (Figure 11); cosmetic surgery (Figure 12); complementary/alternative therapies (Figure 13); complementary/alternative providers (Figure 14); and travel health-immunization, etc., prior to foreign travel (Figure 15).

There also appears to be strong agreement that certain services, while extremely important, might legitimately employ co-payments. This view seems particularly common with respect to the home and community-based social services, including long term care facilities (Figure 20); home-based personal support services (Figure 21); homemaking (Figure 22); supportive housing (Figure 23); community support (Figure 24) and adult day programs (Figure 25). Again, a “in-out” debate appears too simplistic, and may delay action.

A more complex debate is clearly needed about a few issues, including the role of non-physician professionals, and the issue of how to treat services delivered in private clinics. There are also strong issues about the roles of pharmacists on the health care team, and the place for mental health treatment.

Introduction

There is currently a heated debate about what should be “in” or “out” of Medicare. This project arose from our belief that this debate requires focusing to highlight the areas where consensus exists, and those where there is still disagreement. Discovering areas of agreement may enable us to identify where we are ready to move beyond discussion to action. Areas of disagreement, in contrast, require ascertaining the rationale for the contending views and seeing whether consensus may then be reached. There have been decades of discussion; it is hoped that this report may assist in finding areas where policy action can finally progress, and moving the policy dialogue forward on those areas where views have not yet cohered.

This report accordingly presents the views of 2,522 individuals who are “policy elites.” They come from a number of key stakeholder groups, both providers (including physicians, nurses, hospital/health authorities, home care providers, and pharmacists) and business (both large and small) from across Canada. Although public views are critical, they tend to be less specific about what particular items should be “in” or “out”; obtaining meaningful responses would thus require more efforts to clarify exactly what was meant by particular services, and would not work well in a mailed survey format. This survey thus represents the views of people who both represent individuals “in the trenches,” but also must actively deal with these policy issues, either as providers, or as business (who are often asked to pay the bills). Views of additional groups would, of course, be valuable. Nonetheless, in some areas, there is a remarkable consensus in the views on what should be ‘in’ and ‘out’ of the publicly-funded system.

Medicare is widely seen as the most popular Canadian social program, however there is increasing questioning of its sustainability.¹⁻⁸ As the debate about the sustainability of Medicare heightens, many observers have called for updating the determination of what should be paid for from public funds⁹⁻¹⁸.

To date the debate about what should be “in or out” of publicly financed health care has largely been based on tradition and rhetoric rather than evidence. To help clarify the issues, the Medicare to Home and Community (M-THAC) Research Unit and its partners conducted a national survey of policy elites of such key stakeholder groups as physicians (Canadian Medical Association, collaborating provincial medical associations and the Medical Reform Group),

nurses (Canadian Nurses Association and collaborating provincial nurse’ 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). A complete list and brief description of each association can be found in Appendix C. The response rate and a general description of the respondents can be found in Appendix D. Table 1 below provides a list of the policy elites included in the study along with the designation used to identify each stakeholder group.

Table 1: Policy Elites Surveyed, by Stakeholder Group

Designation	Stakeholder Groups
Doctors	Board members from the Canadian Medical Association and participating provincial medical associations
Medical Reform	Members of the Medical Reform Group
Nurses	Board members from Canadian Nurses Association and participating provincial nurses associations
RNAO Board	Board members of the Registered Nurses Association of Ontario
RNAO Members	Random stratified sample of members from the Registered Nurses Association of Ontario
CHA	Chief executive officers of member institutions of the Canadian Healthcare Association
OHA Chairs	Board Chairs from member hospitals of the Ontario Hospital Association
OHA CEOs	Chief Executive Officers from member hospitals of the Ontario Hospital Association
CHCA	Members of the Canadian Home Care Association
Pharmacists	Members of the Canadian Pharmacists Association
OCC	Members of the Ontario Chamber of Commerce

Small Business	Members of the Canadian Federation of Independent Business
Big Business	Members of the Conference Board of Canada

The 12-page survey constructed in consultation with our partners, available in both French and English, includes items about overall sustainability issues, and a detailed question asking about coverage for a list of 48 potential services. The components of this question includes a determination of what should be ‘in’ or ‘out’ of the publicly-funded system, by service type: Rather than ask about universal versus a “two tier” health care system in general, we compiled a list of services based upon the *Canada Health Act (CHA)*, provincial home care legislation, and other reform proposals, which might be included within a healthcare system. Some of these services are required to be covered under the terms of the *Canada Health Act*. Others represent similar services, delivered in different locations or by non-physician professionals, which may or may not receive public funding from various provincial health plans. In addition, a list of other services such as a number of home care services and preventative services were included. For each, we ask respondents to assume that the potential recipient of care both “needs” and wants the specified service, and to indicate whether they think that coverage should be:

Universal - falling under the same terms as the *Canada Health Act*; 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

We asked respondents for their views on what should be ‘in’ and ‘out’ of the publicly-funded system, by service type and then compared the views by stakeholder group. Areas of consensus, and areas which require further debate, were then identified.

Report on Specific Survey Findings for Question One

The specific survey findings on each service type for are presented in 8 parts. Each service was categorized by asking the following questions:

Is the service an insured service under Canada Health Act (CHA)?;

*What are the views on coverage for the service?;
Was their agreement on the type of public payment?; and
Is debate needed to clarify whether it should be covered by public funds and to what extent? .*

Charts comparing the views for each service by stakeholder group can be found in an attached file (see Appendix A - Draft Report on the results for Question 1). A summary of the overall results for each service can be found in Appendices A and B of this report.

Views on support for “insured hospital services”

Insured hospital services as defined under the *Canada Health Act (CHA)* include medically necessary in- and out-patient 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. Under the terms of the *CHA*, all medically necessary services delivered within hospitals must receive full public payment. Hospital expenditures still represent the largest category of total health expenditures (at about 32%), but this share has fallen dramatically over the last 25 years as care is shifted from hospitals into home and community.¹⁹ We asked about:

- Acute hospital care (Figure 1);
- Palliative care in institutions (Figure 2);
- Day surgery in hospitals (Figure 3);
- Diagnostic services in hospitals (Figure 4);
- Laboratory tests in hospitals (Figure 5);
- Professional rehabilitation services in hospitals (Figure 6); and
- In-patient pharmaceuticals (Figure 7).

As illustrated by Figures 1 through 7 all groups overwhelmingly support full public payment for insured hospital services. There are some notable differences between groups, for example business is less supportive of covering the full costs of palliative care in institutions (Figure 2) when compared to the views on coverage for acute care in institutions (Figure 3). At least 35% of business would support some form of co-payment for palliative care in institutions.

Support for fully funding rehabilitation services in hospitals (Figure 6) and in-patient pharmaceuticals in hospitals (Figure 7) is somewhat less than for acute hospital care (Figure 1),

day surgery in hospitals (Figure 3), diagnostic services in hospitals (Figure 4) and laboratory tests in hospitals (Figure 5) across all groups. One third of the respondents would support some form of co-payment for professional rehabilitation services in the hospital. In addition, approximately 40% of business supports co-payment for in-patient pharmaceuticals (figure 7). These differences aside, the results make it clear that there is overwhelming support, across all groups, to continue to provide full public payment for these insured hospital services. ***We can thus conclude that there is little need for debate on this area; all groups surveyed concur that hospital services should continue to be “in”.***

Views on support for “insured physician services”

The other major category assured full coverage under the *Canada Health Act* is physician services, which receive virtually all of their funding from public sources. We asked about:

physician office visits (Figure 8); and

psychological counseling by physicians (Figures 9).

Here, views are more mixed. Although support was evident across all groups to keep such services within Medicare (with virtually no support for removing them altogether), our results revealed some support for allowing co-payments by insured persons. For example 49% of Big Business, 42% of Small Business and 35% of Doctors support some type of co-payment for physician office visits. This is most pronounced for psychological counseling by physicians, where approximately 40% of all respondents support some form of co-payment. In fact a small minority view that this service should not be covered by public funds at all. For example 20% of both OHA CEOs and the Canadian Home Care Association support not publicly funding this service. Insured health services are subject to the two provisions relating to user charges and extra-billing. These two provisions of the *Act* discourage against user charges or extra-billing. There is more question about the role for user fees for physician services, which clearly will be related to the on-going debate about how best to organize and reimburse physician services. ***These findings suggest that there is some room for debate both about the extent of public payment for certain physician services, and about the role of mental health within the publicly-funded system.***

Views on support for certain services “currently out of Medicare”

Another group of services evoked a consensus that they should be ‘out’ of Medicare. We asked about:

Out-patient pharmaceuticals non-prescription drugs (Figure 10);

- In-vitro fertilization (Figure 11);
- Cosmetic surgery (Figure 12);
- Complementary/alternative therapies (Figure 13);
- Complementary/alternative providers (Figure 14); and
- Travel health - immunization, etc., prior to foreign travel (Figure 15).

Figure 10 demonstrates that all groups ranging between 58% to 84% support not funding out-patient pharmaceuticals non-prescription drugs. Support for some form of co-payment ranges between 18% to 38% across all groups.

As illustrated by Figure 11 support for no public payment of in vitro fertilization varies from between 43% to 76% across groups. Support for some form of co-payment is evident and varies between 22% and 44%.

Support for no public payment for cosmetic surgery (Figure 12) is strong across all groups ranging between 59% to 91%. However, one third of all nurses would support some form of public payment for this service.

Approximately 11% of the Canadian population seek services from complementary/alternative providers. In addition natural health products have become an extremely important part of self-care decisions. Over 50% of Canadians now consume natural health products in the form of traditional herbal products, vitamins and mineral supplements, traditional Chinese and other medicines and homeopathic preparations. The majority of those who responded would support no public payment for both complementary/alternative therapies and providers. However there is support in most groups for some form of co-payment for alternative providers most notably RNAO Board (59%), Small Business (47%), Nurses (45%), RNAO Members (44%) and the OCC (42%). Doctors are the most resistant to publicly funding alternative providers with 92% of the Doctors supporting no public payment. A comparison of support for providing some form of public funding for Figures 13 and 14 demonstrates that there is slightly more support for providing some form of public payment for complementary/alternative providers than for complementary/alternative therapies.

While there is group variation ranging between 19% to 79% overall 59% of the respondents support no public payment for travel health - immunization etc., prior to foreign travel.

There is little support from all groups to provide full public payment for these services with the majority supporting no public payment. ***In general, these are not currently part of the***

core basket and we can conclude that there was little support for adding them.

Views on support for “additional new services in Medicare”

There was fairly strong support for extending coverage to certain services which currently are not required to be insured:

Palliative care at home (Figure 16);

Telephone-based advice from your doctor(s) (Figure 17);

Transportation by ambulance for emergency care (Figure 18); and

Immunizations (e.g., polio, mumps, measles, etc) (Figure 19).

There were some notable differences. For example, Big Business and Small Business are less supportive of full coverage for palliative care at home (Figure 16) with approximately 50% supporting some form of co-payment. A comparison of palliative care at home (Figure 16) to palliative care in institutions (Figure 2) demonstrates overall there is less support for full public payment for palliative care at home but the difference does vary depending upon the group. For example, 19% of Small business, Pharmacists and OHA Chairs and only 5% of Nurses and RNAO Members are less supportive of full coverage for palliative care at home.

Telephone advice from your doctor(s) (Figure 17) is not insured under many provincial and territorial health insurance plans, in fact patients may be charged for this service. Overall 60% of the respondents supported full payment of this service. However there is variation in responses, at least 46% of Doctors, Pharmacists and Big Business and Small Business support full payment for this service with at least 30% supporting some form of co-payment.

As illustrated by Figure 18 all groups overwhelming support transportation by ambulance for emergency care. Doctors (56%) and pharmacists (59%) are the least supportive of full payment with 41% of the Doctors and 38% of the Pharmacists supporting some form of co-payment

Virtually all respondents across all groups fully support full public payment for immunizations (e.g., polio, mumps and measles vaccinations) (Figure 19) ranging from between 83% to 100%. A comparison of Figures 19 and 15 demonstrates that the same support does not exist for immunization services prior to foreign travel. In fact many would support no public payment (ranging from 19% to 79%) for immunization services prior to foreign travel. Both immunization services address the boarder concerns of a population health perspective yet there is more support for full public payment for immunization services involving routine vaccinations than for protection during foreign travel.

Differences aside, overall these findings suggest that there would thus appear to be some justification for moving debate into action, and incorporating these services into the basket.

Views on support for “co-payment of services”

Another group of services were in an intermediate zone - there was support across all groups for bringing them in, but with some form of co-payment:

Long term care facilities (Figure 20);

Home-based personal support services (Figure 21);

Homemaking (Figure 22);

Supportive housing (Figure 23);

Community support (e.g. meals on wheels) (Figure 24); and

Adult day programs (Figure 25)

The majority of respondents (61%) support some form of co-payment for long term care facilities (Figure 20). Few would support no public payment for this service. However a closer look at the data reveals that there is group variation on the extent of public coverage. Medical Reform, Nurses, RNAO Board and RNAO Members are more supportive of full coverage than of some type of co-payment. The reverse is true for all other groups.

67% of all respondents support some form of co-payment for home-based personal support. Figure 21 demonstrates that views vary on the extent of public payment for home-based personal support. Medical Reform, RNAO Board, RNAO Members and CHCA are more supportive of full public payment, while all other groups support some type of co-payment over full public payment.

The views on the extent of funding for homemaking (Figure 22), supportive housing (Figure 23), community support (Figure 24) and adult day programs (Figure 25) are somewhat similar. There is little support for full payment of these services with most groups supporting some form of co-payment. Some variation does exist between groups. For example, overall 70% of the respondents support co-payment for homemaking (Figure 22), while only 49% of Big Business support some form of co-payment with 46% supporting no public payment.

Viewed within the context of a population health perspective all of these services are factors that could influence health and well-being. *Clearly, there is need for a debate as to how*

to bring such services into Medicare, and the extent of coverage deemed appropriate.

Views on support for “insured hospital services delivered at a non-hospital site of care”

An interesting question relates to how to manage services which would be insured if delivered within hospitals, but move outside of the provisions of the *CHA* if they are moved into the community. Here, health reformers often argue that the services should be treated in the same way, regardless of where they are located. However, not all of our stakeholders agree. Support for full public payment often drops precipitously when we specify that the site of delivery has changed. We asked about:

- Day surgery in private clinics (Figure 26);
- Diagnostic services in private clinics (Figure 27);
- Laboratory tests in private clinics (Figure 28);
- Professional rehabilitation services in private clinics (Figure 29);
- Professional rehabilitation services at home (Figure 30);
- Out-patient pharmaceuticals (prescription) (Figure 31); and
- Medical supplies and equipment at home (Figure 32).

For example a comparison of Figures 3 and 26 demonstrates that support for full public payment for day surgery in private clinics drops more than 46% across all groups a difference that ranges between 46% to 74%. Results are similar for diagnostic services in private clinics (Figures 4 and 27) and laboratory test in private clinics (Figures 5 and 28).

A comparison of Figures 29 and 30 to Figure 6 reveals that for all groups greater support exist for fully funding rehabilitation services in hospitals than in private clinics or at home. However when a comparison is made between rehabilitation services in private clinics (Figure 29) to rehabilitation services at home (Figure 30) it is evident that there is greater support for funding rehabilitation services at home.

A comparison of Figures 7 and 31 demonstrates that there is greater support for full payment of in-patient pharmaceuticals than for out-patient pharmaceuticals- prescriptions, a difference that ranges between 27% to 64%. In fact there is greater support in all groups except for the Medical Reform for some type of co-payment over full payment for out-patient prescribed pharmaceuticals.

Hospital patients are not charged for medical supplies and equipment while in the hospital. Overall 61% of the respondents would support some type of co-payment for medical supplies and equipment at home. However, as evident by Figure 32 group variation does exist for

example, Medical Reform, all nurses and CHCA support full public payment.

In stark contrast to responses for the same services within hospitals, there was strong support for some form of co-payment for these services, with approximately 20% of the respondents indicating that they did not think private clinics should receive any public payment. ***For those who responded the site of care for these services matters.*** It is not clear whether the reaction is to the term “private”(e.g., interpreted as private for-profit), or represents other reasons for preferring hospital-based delivery. However, these issues must be addressed if health care reform is not to become a synonym for de-insurance

Views on support for “insured physician services delivered by non-physician professional”

Some provinces have regulated and publicly funded fully or partially the delivery of health care services by health care practitioners other than physicians. For example Ontario, Quebec, Manitoba and British Columbia currently publicly fund midwifery services. A strict interpretation of the *CHA* indicates that these services are not required to be publicly funded and are left to the discretion of the provinces and territories. This section contains the views on services delivered by non-physician professionals, services if delivered by a physician would be fully covered under the *CHA*.

Views on services delivered by non-physician professionals vary, depending on the type of professional under consideration and the stakeholder group responding. Overall the majority would support full coverage for:

Midwifery (Figure 33);

Office visits to nurse practitioners (Figure 34);

Psychological counseling by non-physician professionals (Figure 35); and

Telephone-based advice from non-physician professionals (Figure 36).

Some variation between groups does exist on the views for coverage for midwifery services (Figure 33) with some groups demonstrating support for full public payment. While other groups including Doctors (at 26%), Pharmacists (at 30%), Small Business (at 40%) and Big Business (at 35%) do not support full public payment. In fact 40% of the Doctors surveyed were not in favour of providing any public payment for midwifery.

Nurse practitioners are nurses who are trained to provide primary care and are allowed to dispense certain drugs. Currently, new or amended provincial/territorial legislation allows for an expanded role for nurse practitioners in eight jurisdictions including Newfoundland and Labrador, Nova Scotia, New Brunswick, Ontario, Manitoba, Saskatchewan, Alberta and Yukon.

Other areas are working on implementing similar legislation. Figure 34 demonstrates that there is support in all groups for either fully or partially funding office visits to nurse practitioners. However 32% of the Doctors view that this service should not have any public payment. Support for full public funding of nurse practitioners is greater than for midwifery in all groups except for OHA Chairs where the support for full public payment is about the same for both professions. The extent of support for full public payment for office visits to nurse practitioners (Figure 34) and physician office visits (Figure 8) is about the same for most groups. The exception being Pharmacists and Doctors who are more supportive of full public payment for physician office visits than for office visits to nurse practitioners.

As illustrated by Figure 35 views on the support for public payment of psychological counseling by non-physician professionals varies between groups. The Medical Reform and all nurses support full public payment while all other groups support some form of co-payment with the exception of Big Business where the majority at 41% support no public payment. A comparison of Figures 9 and 35 indicates that for most groups there is greater support for full coverage of psychological counseling by physicians than for psychological counseling by non-physician professionals. There is some variation between groups with Nurses and RNAO Board equally supportive of both services.

Support for full public payment of telephone-based advice from non-physician professionals (Figure 36) is evident across most groups with the exception of Big Business, Small Business, Pharmacists and Doctors who either support some type of co-payment or no public payment. A comparison of Figures 17 and 36 demonstrates that most groups equally support full public payment for telephone-based advice by physicians and telephone-based advice from call centres staffed by non-physician health professionals. There are exceptions for example, 47% of Doctors support full payment for telephone-based advice by physicians while only 29% of Doctors support full coverage for telephone-based advice from call centres staffed by non-physician health professionals. In addition, Big Business and Small Business also demonstrate greater support for full public payment of telephone-based advice by physicians over support for telephone-based advice from call centres staffed by non-physician health professionals

Chiropractic services are partially funded by provincial health insurance plans in British Columbia, Alberta, Saskatchewan, Manitoba and Ontario. The majority of the respondents would support some form of co-payment for:

chiropractic services (Figure 37).

However, overwhelmingly 75% of doctors support no public payment for chiropractic services.

Views are spilt between support for full public payment, co-payment and no public payment for:

pharmacists counseling for disease management (Figure 38); and

pharmacist monitoring and counseling medication (Figure 39).

There is no clear consensus for pharmacists counseling for disease management and for pharmacists monitoring and counseling for medication. Further debate is clearly needed about the role of pharmacists. For example, Pharmacists, the Medical Reform Group, and all nurses are most likely to think they should be included within the health care system (albeit sometimes with co-payments), with support also arising from hospitals and home care. In contrast, Doctors and business appear to be far more resistant. *Further debate is needed to determine if it is feasible to extent coverage of insured services delivered by a physician to include public payment of these same services delivered by non-physician professionals.*

Views on support for “some form of public payment”

The last group of services reviewed included uninsured services for which groups would support full public payment and/or some form of co-payment, including::

Home-based nursing (Figure 40);

Transportation to receive care at out-of-region centre (Figure 41);

Respite support for family caregiver (Figure 42);

Support is also evident for some form of co-payment for the following services. However, there were strong minorities thinking that there was no room for public financing at all for:

Stipend to family caregiver (Figure 43);

Dental care prevention/check ups (Figure 44);

Dental care restorative (Figure 45);

Genetic tests for pre-natal screening (Figure 46);

Genetic tests for adults (Figure 47); and

Experimental medical treatments (Figure 48).

The majority of respondents at 51% support some type of co-payment for home-based nursing (Figure 40). However group variation does exist. The CHCA, RNAO Board, RNAO Members, Nurses and Medical Reform support full public payment with the reminding groups supporting some form of co-payment..

Similarly the views are mixed for transportation to receive care at out-region-centres with some groups supporting full payment and other groups supporting some form of co-payment (Figure 41). A comparison of Figures 18 and 41 reveals that all groups are more supportive of full public payment for transportation by ambulance for emergency care than for transportation to receive care at out-region-centre.

Generally there is support from all groups for some form of public payment for respite support for family caregivers (Figure 42). However, the majority of groups are more supportive of some type of co-payment (ranging between 31%-69%) over full public payment (ranging between 17%-66%). A comparison of Figures 42 and 43 demonstrates that there is greater support for some type of public coverage for respite support for family caregivers (ranging 77%-99%) than for a stipend to family caregivers (ranging between 49%-81%). In fact support for not funding a stipend to family caregivers ranges between 19% to 51%.

As Figures 44 and 45 illustrate all groups are supportive of providing some form of public payment for dental care that involves both preventative/ check ups and restorative care (e.g., filling cavities) However the extent of support varies, with some groups supporting full payment and other groups more supportive of some type of co-payment. The strongest support for no public payment comes from Big Business, OHA CEOs, OHA Chairs and Small Business.

There is a general consensus that some form of public payment should be provided for genetic tests for pre-natal screening (Figure 46) and for adults (Figure 47). The extent of support for public coverage does vary but most groups would support some form of co-payment. Overall most groups demonstrate greater support for coverage for genetic test for pre-natal screening than for genetic tests for adults. Approximately one third of Big Business, Small Business, Pharmacists, CHA and OHA CEOs support no public payment for both genetic tests for pre-natal screening and for adults.

As illustrated in Figure 48 the majority of respondents in most groups would support some form of co-payment for experimental medical treatment with the exception of Doctors and the Medical Reform. The majority of Doctors (at 43%) would support not funding experimental treatments, with only 22% supporting full public payment. Contrast that to the Medical Reform where 44% support full public payment for this service and 34.9% would support no public payment.

While there is no clear consensus on the type of public payment for each of these services it was evident that support exists across all groups for some form of public payment. The

ambiguity of the findings suggest that while those surveyed saw these services as important, other factors may have influenced their decision on the extent of support for public payment. ***Clearly debate is needed to reach a consensus on the potential role and impact of these services in maintaining health and well-being. Only then can dialogue proceed to establish the extent of public payment if any for each of these services.***

Discussion and Conclusions

Our results suggest that it is time to move the debate from what is already “in” the basket of services to an examination of those services currently “out” of Medicare. In particular, there is overwhelming support for keeping those insured hospital services currently guaranteed full public payment under the terms of the *Canada Health Act (CHA)*. There is more question about the role for user fees for physician services, which clearly will be related to the on-going debate about how best to organize and reimburse physician services.

In particular, although much of the debate has focused on pharmacare and home care, the results pointed to a number of critical services currently in an ambiguous zone, with some provinces fully covering them, and others not. These included palliative care at home (Figure 16); telephone-based advice from your doctor(s) (Figure 17); transportation by ambulance for emergency care (Figure 18); and immunizations (e.g., polio, mumps, measles, etc) (Figure 19). There was strong consensus that these services should be “in” the basket.

Neither does the time seem ripe to discuss expanding the basket to a host of services not currently included, such as out-patient pharmaceuticals non-prescription drugs (Figure 10); in-vitro fertilization (Figure 11); cosmetic surgery (Figure 12); complementary/alternative therapies (Figure 13); complementary/alternative providers (Figure 14); and travel health-immunization, etc., prior to foreign travel (Figure 15).

There also appears to be strong agreement that certain services, while extremely important, might legitimately employ co-payments. This view seems particularly common with respect to the home and community-based social services, including long term care facilities (Figure 20); home-based personal support services (Figure 21); homemaking (Figure 22); supportive housing (Figure 23); community support (Figure 24) and adult day programs (Figure 25). Again, a “in-out” debate appears too simplistic, and may delay action.

A more complex debate is clearly needed about a few issues, including the role of non-physician professionals, and the issue of how to treat services delivered in private clinics. There

are also strong issues about the roles of pharmacists on the health care team, and the place for mental health treatment.

Appendix A: Comparison of the Views on Coverage by Stakeholder Group

Attached in a separate file are 48 charts that compare the views on coverage for each service by stakeholder group. Table 3 below, provides a summary of the results for the 48 services listed in question 1 of the survey *Views about the boundaries of Medicare*. Each service was categorized by asking the following questions:

1. *Is the service an insured service under Canada Health Act (CHA)?*

Yes; or No

2. *What are the views on coverage for the service?*

Full public payment (Full); Some form of Co-payment (Co-pay); or No public payment (None).

3. *Was their agreement on the type of public payment?*

Yes or No

4. *Is debate needed to clarify whether it should be covered by public funds and to what extent?*

No or Yes with specific comments.

Further verification of our findings was accomplished by determining the mean score for each of the 48 services. We first assigned a number to each of the four potential responses to each service in question 1 as follows:

Universal - 2; *Partial coverage* - 1; *Subsidized* - 1; *Not included* - 0.

Next, a mean score was calculated for each service. The mean score for each service was then interpreted based on the following parameters found in Table 2.

Table 2: Interpretation of the Mean Score

Mean Score	Majority of respondents support
0.5 or less	No public payment
0.6 to 1.0	Co-payment but with some support for no payment
1.0 to 1.5	Co-payment
greater than 1.5	Full public payment

For example, a mean score of 0.4 indicates that the majority of respondents support no public payment for a particular service. At the same time a mean score of 1.2 would indicate support for some form of co-payment; and a mean score of 1.8 would indicate that the majority of respondents would support full public payment. The mean score for each service is listed in Table 3.

Table 3: Summary of the views on coverage for the 48 Services

Service	Required by Canada Health Act?	Mean Score	Coverage	Debate Needed?
1.Acute hospital care	Yes	1.9	Full	No
2.Palliative care in institution	Yes	1.8	Full	No
3.Day surgery in hospitals	Yes	1.8	Full	No
4.Diagnostic services in hospital	Yes	1.8	Full	No
5.Laboratory tests in hospital	Yes	1.8	Full	No
6.Professional rehabilitation services in hospital	Yes	1.6	Full	No
7.In-patient pharmaceuticals	Yes	1.6	Full	No
8.Physician office visits	Yes	1.7	Full	Yes (role for co-payments)
9.Psychological counseling by physicians	Yes	1.4	Full	Yes (role for co-payments)
10. Out-patient pharmaceuticals - non-prescription	No	0.4	None	No
11. In-vitro fertilization	No	0.4	None	No
12. Cosmetic surgery	No	0.3	None	No
13. Complementary/alternative therapies (e.g., Chinese medicine)	No	0.5	Co-pay/ None	No
14. Complementary/alternative providers (e.g., herbalist)	No	0.5	Co-pay/ None	No

Service	Required by Canada Health Act?	Mean Score	Coverage	Debate Needed?
15. Travel Health - immunization etc., prior to foreign travel	No	0.5	None	No (although public health considerations might suggest consensus not an appropriate one)
16. Palliative care at home	No	1.6	Full	No - consensus that this should be incorporated into insured services
17. Telephone-based advise from your Doctor(s)	No	1.5	Full	No - consensus that this should be incorporated into insured services
18. Transportation by ambulance for emergency care	No	1.7	Full	No - consensus that this should be incorporated into insured services
19. Immunizations (e.g., polio, mumps, etc)	No	1.9	Full	No - consensus that this should be incorporated into insured services
20. Long-term care facilities (nursing home)	No	1.3	Full/Co-pay	Yes: Majority support for bringing this into Medicare, but dispute about role for co-payments.
21. Home-based personal support services	No	1.2	Full/Co-pay	Yes: Majority support for bringing this into Medicare, but dispute about role for co-payments.
22. Homemaking	No	0.9	Co-pay/None	Yes: Majority support for bringing this into Medicare, but with co-payments.

Service	Required by Canada Health Act?	Mean Score	Coverage	Debate Needed?
23. Supportive housing	No	0.9	Co-pay/None	Yes: Majority support for bringing this into Medicare, but with co-payments.
24. Community support (meals on wheels)	No	0.8	Co-pay/None	Yes: Majority support for bringing this into Medicare, but with co-payments.
25. Adult day programs	No	1.0	Full/Co-pay	Yes: Majority support for bringing this into Medicare, but with co-payments.
26. Day surgery in private clinics	No	1.0	Full/ Co-pay/None	Yes: What is the role for private clinics?
27. Diagnostic services in private clinics	No	1.1	Full/Co-pay	Yes: What is the role for private clinics?
28. Laboratory tests in private clinics	No	1.2	Full/Co-pay	Yes: What is the role for private clinics?
29. Professional rehabilitation services in private clinics	No	1.1	Full/Co-pay	Yes: What is the role for private clinics?
30. Professional rehabilitation services at home	No	1.2	Full/Co-pay	Yes: What is the role for home-based care?
31. Out-patient pharmaceuticals (prescription)	No	1.1	Co-pay	Yes
32. Medical supplies and equipment at home	No	1.3	Full/Co-pay	Yes

Service	Required by Canada Health Act?	Mean Score	Coverage	Debate Needed?
33. Midwifery	No	1.3	Full/Co-pay	Yes: role of co-payments
34. Office visits to nurse practitioners	No	1.6	Full	Yes: Consensus that this should be incorporated into insured services, but there remains some opposition from Doctors
35. Psychological counseling by non-physician professionals	No	1.1	Full/Co-pay/None	Yes. Major disputes about role of mental health.
36. Telephone-based advice from non-physician professionals	No	1.4	Full	Yes: Consensus that this should be incorporated into insured services, but there remains some opposition from Doctors
37. Chiropractic services	No	0.8	Co-pay/None	Yes: Some support for inclusion with co-payments, but others do not think it belongs in system at all.
38. Pharmacists counseling re: disease management (asthma)	No	1.0	Full/Co-pay/None	Yes: Role of pharmacists needs clarification
39. Pharmacists monitoring and counseling re: medication	No	1.1	Full/Co-pay/None	Yes: Role of pharmacists needs clarification
40. Home-based nursing	No	1.4	Full/Co-pay	Yes: Consensus should be in system, but variation in role for co-payments

Service	Required by Canada Health Act?	Mean Score	Coverage	Debate Needed?
41. Transportation to receive care at out-of-region centre	No	1.4	Full/Co-pay	Yes: Consensus should be in system, but variation in role for co-payments
42. Respite support for family caregiver	No	1.2	Full/Co-pay	Yes: Consensus should be in system, but variation in role for co-payments
43. Stipend to family caregiver	No	0.8	Co-pay/None	Yes: Responses vary with most groups supporting some form of public payment.
44. Dental-care-prevention/check ups	No	1.0	Full/Co-pay/None	Yes: Responses vary with most groups supporting some form of public payment.
45. Dental care - restorative (filling cavities)	No	0.9	Full/Co-pay/None	Yes: Responses vary with most groups supporting some form of public payment.
46. Genetic tests for pre-natal screening	No	1.0	Full/Co-pay/None	Yes: Responses vary with most groups supporting some form of public payment.
47. Genetic tests fro adults (disease propensities	No	1.0	Full/Co-pay/None	Yes: Responses vary with most groups supporting some form of public payment.

Service	Required by Canada Health Act?	Mean Score	Coverage	Debate Needed?
48. Experimental medical treatments	No	1.1	Full/Co-pay/None	Yes: Responses vary with most groups supporting some form of public payment.

Appendix B: Overall Responses on the Extent of Coverage for each Service

Table 4: Overall Responses on the Extent of Coverage for each Service

Views on coverage for:	% Full	% Co-payment		% No
		Partial	Subsidized	
1. Acute Hospital Care (In-patient)	90.69	5.64	3.35	0.32
2. Palliative Care in Institutions	77.68	13.21	7.84	1.26
3. Day Surgery in Hospitals	82.26	10.46	6.68	0.60
4. Diagnostic Services in Hospitals	84.00	8.87	6.62	0.51
5. Laboratory Tests in Hospitals	85.45	8.01	5.85	0.69
6. Professional Rehabilitation Services in Hospitals	66.57	16.83	13.79	2.81
7. Views on coverage for: In-patient Pharmaceuticals	68.28	15.70	11.34	4.69
8. Physician Office Visits	67.22	16.00	15.08	1.71
9. Psychological Counseling Physicians	50.60	23.14	16.73	9.53
10. Out-patient Pharmaceuticals (non-prescription drugs)	4.07	15.06	12.86	68.01
11. In Vitro Fertilization	5.81	15.13	17.05	62.01
12. Cosmetic Surgery	1.82	11.00	11.6	75.59
13. Complementary/alternative therapies (Chinese medicine)	5.47	13.20	21.15	60.18
14. Complementary/Alternative Providers -e.g. herbalists	6.13	16.06	23.17	54.63
15. Travel Health-immunization, etc prior to foreign travel	12.59	14.76	13.70	58.95
16. Palliative Care at Home	62.94	21.07	13.64	2.34
17. Telephone-based Advice from your Doctor(s)	59.51	13.30	13.58	13.62

Views on coverage for:	% Full	% Co-payment		% No
		Partial	Subsidized	
18. Transportation by Ambulance for Emergency Care	70.18	16.84	10.68	2.30
19. Immunizations (e.g., polio, mumps, measles, etc.)	88.56	5.47	3.86	2.11
20. Long Term Care Facilities (e.g. nursing home)	35.49	39.32	22.06	3.13
21. Home-based Personal Support Services	28.74	40.18	26.41	4.67
22. Homemaking (cleaning, laundry, shopping, etc)	8.15	38.27	31.76	21.83
23. Supportive Housing	9.75	37.97	33.73	18.55
24. Community Support (meals on wheels, transportation, etc)	9.46	31.98	32.49	26.08
25. Adult Day Programs (supervised activity in a group)	21.68	31.96	28.67	17.69
26. Day Surgery in Private Clinics	27.2	27.24	22.55	23.01
27. Diagnostic Services in Private Clinics	32.56	26.81	21.94	18.69
28. Laboratory Tests in Private Clinics	34.98	26.21	21.04	17.77
29. Professional Rehabilitation Services in Private Clinics	24.09	29.92	28.53	17.46
30. Professional Rehabilitation Services at Home	33.75	30.01	26.96	9.28
31. Out-patient Pharmaceuticals (prescription)	25.14	38.16	23.03	13.67
32. Medical Supplies and Equipment at Home	34.42	36.76	24.29	4.53
33. Midwifery	48.95	17.88	17.14	16.02
34. Office Visits to Nurse Practitioners	61.13	16.84	16.61	5.41
35. Psychological Counseling by Non-physician Professionals	29.67	26.88	23.86	19.59

Views on coverage for:	% Full	% Co-payment		% No
		Partial	Subsidized	
36. Telephone-based Advice from Non-physician Professionals	56.38	10.49	13.41	19.72
37. Chiropractic Services	14.61	24.73	28.01	32.65
38. Pharmacist Counseling re: Disease Management (asthma)	33.41	15.39	18.16	33.04
39. Pharmacists Monitoring and Counseling re: medication	36.82	14.82	17.87	30.49
40. Home-based Nursing	46.63	30.57	20.69	2.11
41. Transportation to Receive Care at Out-of-region Centre	45.51	29.20	18.82	6.47
42. Respite Support for Family Caregiver	29.19	36.06	26.16	8.59
43. Stipend to Family Caregiver	12.32	30.09	26.12	31.47
44. Dental Care - Prevention/Check Ups	31.54	21.67	19.13	27.66
45. Dental Care - Restorative (filling cavities)	23.54	26.18	21.26	29.02
46. Genetic Tests for Pre-natal Screening	33.43	16.48	19.20	30.89
47. Genetic Tests for Adults (Disease propensities)	28.77	20.34	21.47	29.43
48. Experimental Medical Treatments	33.29	20.48	22.83	23.40

Appendix C: List and Description of the Partners

Hospitals/regional health authorities were surveyed with the assistance of the Canadian Healthcare Association (CHA) and the Ontario Hospital Association (OHA). The CHA is a federation of provincial and territorial hospital and health organizations. Its membership represents a broad continuum of care, and includes regional health authorities, hospitals, long-term care facilities, home and community care agencies, community health services, public health, mental health, addiction services, housing services, and professional and licensing bodies. The Ontario Hospital Association (OHA) is a voluntary organization representing approximately 160 public hospital corporations, or 225 sites, in Ontario. Among its members are all the public hospitals in Ontario as well as the province's psychiatric hospitals. Many other health-related organizations are among OHA's approximately 200 associate and affiliate members.

Home and community support organizations were surveyed with the assistance of the Canadian Home Care Association (CHCA), a national membership organization representing the entire scope of home care and community support, including all disciplines of professional and paraprofessional providers. Membership is primarily comprised of all providers, including the new structures resulting from health systems renewal, such as regional and community health boards; community-based and hospital/facility-based home care programs; and the providers involved in delivery of both publicly and privately funded home care.

Physicians were surveyed with the assistance of the Canadian Medical Association (CMA) and a number of the provincial/territorial associations across Canada. The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 42 affiliated medical organizations. The provincial/territorial provincial associations are all voluntary professional associations and divisions of the CMA. Participating provincial/territorial associations included the:

- Newfoundland and Labrador Medical Association;
- Medical Society of Prince Edward Island;
- L' Association médicale du Québec;
- Saskatchewan Medical Association;
- Alberta Medical Association;
- British Columbia Medical Association; and
- Yukon Medical Association.

Nurses were surveyed with the assistance of the Canadian Nurses Association (CNA) and provincial/territorial nurses associations. The CNA is a federation of 11 provincial and territorial nursing associations representing more than 110,000 registered nurses. Participating provincial/territorial nurses’ associations included the:

The Registered Nurses Association of British Columbia (RNABC) which is the professional organization of all registered nurses and licenced graduate nurses in the province.

The Alberta Association of Registered Nurses (AARN) which is the professional association and regulatory body for registered nurses in Alberta

Registered Nurses Association of Ontario (RNAO) is a professional association representing over 16,000 registered nurses in Ontario.

Ordre des infirmières et infirmiers du Québec is a professional association for nurses in the province.

Nurses Association of New Brunswick (NANB) which is the professional association and regulatory body for nurses in the province

Association of Nurses of Prince Edward Island (ANPEI) is the professional organization of all registered nurses in Prince Edward Island.

Yukon Registered Nurses Association is the professional organization of all registered nurses in Yukon.

Pharmacists were surveyed with the assistance of the Canadian Pharmacists Association (CPhA), the national voluntary professional association of pharmacists that represents close to 10,000 pharmacists across the country.

Business were surveyed with the assistance of the Conference Board of Canada (CBOC), The Canadian Federation of Independent Business (CFIB) and the Ontario Chamber of Commerce (OCC). CBOC is a leading not-for-profit research institute, with over 400 member organization, which develops and exchanges knowledge about emerging economic and social trends, key public policy issues and organization strategies and practices. CFIB is a national political action

organization for small and medium size businesses across Canada. The OCC represents over 56,000 members through a network of 156 community Chambers of Commerce and Board of Trades.

Medical Reform Group (MRG) is a voluntary association of socially-concerned physicians and medical students. The majority of the members are from Ontario and 90% are practicing physicians.

M-THAC - Medicare to Home and Community - Research Unit brings together community partners and a wide variety of academic researchers from an eclectic assortment of disciplines to focus on the policy implications of the shift to home and community. M-THAC is funded by the Canadian Institutes of Health Research (CIHR).

Appendix D: Sample Size and Response Rate

Sample Size

The sample is made up of policy elites across Canada from key stakeholder groups. We developed the sampling frame for this survey with the assistance of 24 associations, who helped by identifying individuals meeting the sampling criteria . Table 4 provides information on the sample size and the response rate for each group.

Table 5: Sample Size and Response Rate: Overall and for each Stakeholder Group

Group	# of Surveys Sent	# of Surveys Completed and Returned	% Response Rate
Doctors	159	65	40.9
Medical Reform	125	71	56.8
Nurses	123	46	37.4
RNAO Board	50	32	64
RNAO Members	250	110	44
CHA	1646	353	21.4
OHA Chairs	155	76	49
OHA CEOs	162	49	30.2
CHCA	419	150	35.8
Pharmacists	686	228	33.2
OCC	265	31	11.7
Small Business	5200	1240	23.8
Big Business	894	71	7.9
Total	10134	2522	24.9

The survey was sent out to 10,134 individuals with 2,522 individuals responding resulting in an overall response rate of 24.9%. As demonstrated by Table 3 the sample size for each group varied as well as the response rates which ranged from 7.9% to 64%.

Description of the Respondents

The demographic characteristics of the respondents were as follows:

Sex: 41.4% of those who responded were female and 58.6% were male.

Age: The mean age was 50 years, with a range of 21 to 81 years.

Education: 67% have completed some type of university education.

For-profit/Not-for-profit: This question was not answered by the small business group. Of the remainder of the sample, 51.1% of the respondents indicated that they worked in a not-for-profit organization, and 34.6% indicated that they worked in a for-profit organization.

Involvement with professional associations: 74.4% reported that they were very or somewhat involved with their provincial/ national professional associations/ organizations.

Perceived knowledge: 89.2% reported that they were very or somewhat knowledgeable about the health care system.

Region: The geographical distribution of the respondents was as follows:
31.3% from western Canada;
47.1% from Ontario;
9% from Quebec;
11.8% from eastern Canada; and
0.7% from the territories.

References

- 1 Donelan K, Blendon RJ, Schoen C, Davis K, Binns K. The cost of health system change: public discontent in five nations. *Health Affairs* 1999;18(3):206-16.
- 2 Ekos Research Associates Inc. *Rethinking Government IV*. Presentation to the National Conference on Home Care, March 9, 1998.
- 3 Berger E. *The Berger Population Health Monitor: Policy Report Survey #20*. With The Hay Health Care Consulting Group, October Survey, 1999.
- 4 Hay Group. *Public Behaviour, Perceptions and Priorities in the Health Sector: An Overview*. The Health Services Restructuring Commission, January 14, 1999.
- 5 Canadian Medical Association. *In Search of Sustainability: Prospects for Canada's Health Care System*. Discussion document, 2001 (downloaded from <http://www.cma.ca/> on June 20, 2002), 2001.
- 6 Canadian Healthcare Association. *CHA's Framework for a Sustainable Healthcare System in Canada*. Discussion paper, November 1999 (downloaded from <http://www.canadian-healthcare.org> on July 31, 2000), 1999.
- 7 Alberta Association of Registered Nurses, Canadian Nurses Association, Ontario Nurses' Association, Registered Nurses Association of Ontario, United Nurses of Alberta. *Towards a Sustainable, Universally Accessible Health-Care System: A Discussion Paper Prepared for the National Nursing Forum*. May, 2000.
- 8 Mendelsohn M. *Canadians' Thoughts on their Health Care System: Preserving the Canadian Model through Innovation*. Paper prepared for the Commission on the Future of Health Care in Canada, June, 2002.
- 9 Premier's Advisory Council on Health for Alberta. *A Framework for Reform*. Report of the Premier's Advisory Council on Health, December, 2001.

- 10 Standing Senate Committee on Social Affairs Science and Technology. *The Health of Canadians: The Federal Role: Volume Four: Issues and Options*. Interim Report on the state of the health care system in Canada, 2002.
- 11 Commission on the Future of Health Care in Canada. *Interim Report: Shape of the Future of Health Care*. (Roy J. Romanow, Commissioner), February, 2002.
- 12 Flood CM, Choudhry S. *Strengthening the Foundations: Modernizing the Canada Health Act*. Discussion Paper No. 13, Commission on the Future of Health Care in Canada, 2002.
- 13 Maxwell J, Jackson K, Legowski B, et al. *Report on Citizens' Dialogue on the Future of Health Care in Canada*. Prepared for the Commission on the Future of Health Care in Canada, June, 2002.
- 14 Shiell A, Mooney G. *A Framework for Determining the Extent of Public Financing of Programs and Services*. Commission on the Future of Health Care in Canada, Discussion Paper No.6, July, 2002.
- 15 Ramsay C. *A Framework for Determining the Extent of Public Financing of Programs and Services*. Commission on the Future of Health Care in Canada, Discussion Paper No.16, August, 2002.
- 16 Canadian Health Services Research Foundation. *Medically Necessary: What is it, and Who Decides?* Prepared for the Commission on the Future of Health Care in Canada, Issue/Survey Paper, July, 2002.
- 17 Commission on the Future of Health Care in Canada, Canadian Policy Research Networks, Viewpoint Learning Inc. *Report on a Citizens' Dialogue on the Future of Health Care in Canada*. Backgrounder, June, 2002.
- 18 Canadian Institute for Health Information. *National Health Expenditure Trends (1975-*

2000): *Executive Summary*. National Health Expenditure Data Base, 2000.

- 19 Deber RB, Narine L, Baranek P, et al. The public-private mix in health care. In: National Forum on Health, ed. *Striking a Balance: Health Care Systems in Canada and Elsewhere*. v. 4. Sainte-Foy, Québec: Éditions MultiMondes, 1998:423-545.