

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

Executive Summary on the results for Question 1
November 2002

Research team:

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

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
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 split 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.

The study could not have been performed without the aid of our 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

We would also like to acknowledge the M-THAC (From Medicare to Home and Community) Research Unit, funded by the Canadian Institutes for Health Research, for funding the cost of the survey. A study of this magnitude does not happen without considerable help. Our profuse thanks to Ann Pendleton and Cathy Bezic. Brenda Gamble has ably managed every step, and will well deserve the Ph.D. we expect to result from this study.