A critical policy analysis of an emerging agenda for home care in one Canadian province

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Abstract
Amidst projections of the increased care demands and expectations for home care, policy in this area demands urgent attention. Home care is inherently complex as it challenges us to deliberate fundamental issues of responsibility for care, and the limits of care for people in their most immediate contexts and needs. This research takes the form of a critical policy analysis of the interaction of the context, process and content of policy proposals in home care in a regional health system in one Canadian province. The method of study includes thematic and comparative analyses of perspectives derived from policy documents, and interviews with policy actors (decision-makers, healthcare providers, public advocates) regarding their perspectives of policy problems and processes. The content and process of policy in home care interact in important ways with political, economic, social and historical contexts. This critical analysis revealed that the emerging policy agenda in regional home care is one of medicalisation, which stands in contrast to the principles of primary health care, and potentially leads to further marginalisation of the most vulnerable. This contrast is characterised by tensions between the fundamental values of equity and efficiency, choice and universality, and public vis-à-vis individual responsibility for the provision of care.

Keywords: Canadian health reforms, critical policy analysis, home care, primary health care, values

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Introduction
Canadians have experienced a decade of intense restructuring of public health services. Often referred to as healthcare reform, policy agendas associated with this restructuring of Canadian health care have included shifts to regional governance, institutional downsizing and an insidious erosion of community care and public health systems (Lomas & Rachlis 1996, Casebeer & Hannah 1998, Taft & Steward 2000, Armstrong et al. 2002, Mitton & Donaldson 2002, Rachlis 2004). As in other countries, there have been a series of commissions and reviews of Canada’s healthcare system, each affirming varying degrees of support for broad strategies to sustain public health care (Canada Senate Report 2002, Commission on the Future of Health Care in Canada 2002). The Report of the Commission on the Future of Health Care in Canada (2002) is one of the most influential and inclusive of diverse Canadian perspectives. It first and foremost has reaffirmed Canadians’ values of universally available and publicly funded health care. Most importantly, the Commission refuted the argument that additional monies are required to sustain Canadian health care. Despite these reassurances, Canadians await the deliberations of federal and provincial governments as to the future directions of public health policy.

The most recent developments in Canadian healthcare policy include what is referred to as the First Ministers’ Accord 2003, negotiated between the provincial and federal governments in what has been framed as the attempt to save Canadians’ most cherished social programme. Key features of the deal include a renewed funding commitment by the federal government to the provinces in exchange for reduced surgical waiting times,
improved home care and overall accountability for selected outcomes. Inclusion of home care as a key area of healthcare provision may be the result of hospital restructuring and the effects of early discharge, albeit often without funding to support the burgeoning needs. Because of its dominant focus on the effects of hospital restructuring and surgical wait times, there are questions as to whether the deal can also realise a vision of health reform that embodies broader primary healthcare principles in the delivery of home-care services (Motiwala et al. 2004).

Reasons for governments’ adoption of some healthcare reforms and not others are not readily exposed through traditional approaches to policy analysis. In this paper, we report on a critical policy analysis of an emerging policy agenda in home care in one Canadian province. We begin with a discussion of the Canadian context of healthcare restructuring as it relates to home care. We then explicate the method of a critical theory approach to policy analysis and provide background on the promise of primary health care as a foundation for reform of health care generally, and home care specifically. Findings of the study include a description of one provincial government’s approach to policy problems in the area of home care, and how policy actors (decision-makers, public advocates and health-care providers) perceive the policy problems and tension in values.

**Home care in the Canadian context**

An overarching question pertaining to the delivery of care in the home is how home care is situated within a public healthcare policy agenda. Whereas the Canada Health Act is the broad legislative framework for health services in the national context, the actual legislative mandate for the delivery of health services is a provincial jurisdiction. Further complexity arises in that the Canada Health Act does not refer to home-care services, therefore the standards and scope of entitlement of services is the sole mandate of individual provinces. Despite the resulting variation in the definition and mandate for care across provinces, it is generally agreed across the country, that home care constitutes ‘an array of services which enables clients, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying, or substituting for long-term care or acute care alternatives’ (Health Canada 1990, p. 10). In today’s context, McAdam identifies three main goals of home-care programmes: (a) to prevent further deterioration in client functioning, thus enabling clients to stay in their residence of choice; (b) to substitute for acute-care services; and (c) to substitute for long-term care services provided in nursing homes and other long-term care facilities’ (2000, p. 4).

The demand for access to home care in Canada is widespread across various populations including people with acute-care needs, long-term disabilities, chronic illnesses, and the frail elderly. With hospital downsizing as the main feature of a restructuring agenda, there are rising demands to provide acute care in the home.

Policy recommendations of the Commission on the Future of Health Care in Canada (2002) and the First Ministers’ Accord 2003 will likely mark the next phase of policy development for home care in Canada. Both the Commission and the Accord call for expansion of publicly funded home care with national standards to address issues of increasing diversity and disparity among programmes across the province and the country, although of limited scope and comprehensiveness. The Commission recommended that home care be covered under the legislative framework of the Canada Health Act in three priority areas: (1) coverage of care and support of people with mental illnesses, (2) coverage for post-acute home care, and (3) coverage for palliative home-care services (p. 171). The First Ministers’ Accord also advocates allocation of increased resources towards post-acute care in the home. Policy critics contend that this primary focus on acute care and professional services will further disadvantage long-term care and social services that have been associated with a comprehensive home-care programme for people who are elderly, and those with long-term or chronic health challenges and disabilities (Motiwala et al. 2004, Rachlis 2004).

At the heart of the policy deliberations over home care in provincial and national jurisdictions is the question of ‘who pays’? McAdam (2000) identifies a typology of possibilities including ‘the public provider model, the public professional and private home support model, the mixed public–private model and finally, the contractual model in which public services are contracted for delivery by a mix of for-profit and not-for-profit agencies’ (p. 4). Overriding most discussions is the discourse of the unsustainability of home care, and the inevitability of having to engage the private, for-profit sector as partners in its delivery (Government of Alberta 2001, Weatherill 2004). These unresolved questions with respect to home-care delivery involve all levels of Canadian governments (national, provincial, regional and municipal), and contribute to the dynamic context of home-care policy and the ultimate question of what policy agenda will constitute reforms in this vital and growing sector of health care.

**Primary health care as a policy agenda for home care**

Amidst these contingencies about the structure and funding of Canadian home care, has been the vision of a national home-care programme that is based on the
principles of primary health care: accessibility to services, appropriate technology, public participation, health promotion and intersectoral collaboration (National Forum on Health 1997, Canadian Nurses Association (CNA) 1998, 2000, McWilliam 2001). The National Forum on Health (1997) has provided one of the most comprehensive visions of policy reform in home care, basing recommendations on the overriding principle that ‘home care should be considered an integral part of publicly funded health services and comprehensive, including “professional services, medical supplies, homemaking and attendant care, and maintenance and preventive care’’ (p. 21). In their critique of the challenges and opportunities associated with primary health care, Ogilvie & Reutter (2003) point out particular challenges that have implications for home-care policy. They contend that a major challenge associated with the implementation of PHC includes ‘the need to balance a focus on the accessibility to health services with a greater emphasis on those determinants of health that lie outside the healthcare system’ (p. 458). As well, these authors describe how the principle of community participation poses challenges, as the emphasis should be to elicit participation in the political process of determining the basic configuration of health services and not merely in how they should be delivered.

These broader concerns of primary health care are also relevant to home-care policy. There is evidence that social determinants of health such as housing, finances and social support are germane to the policy debate in home care (Coyte & McKeever 2001, Parent & Anderson 2001, Hollander & Prince 2002). It is therefore timely for the policy analyst to assess the relationships among home-care delivery, primary healthcare principles, political contexts and policy agendas. This depth of analysis, we contend, is best approached from a critical theory perspective.

**A critical theory approach to policy analysis**

What are the tenets underpinning a critical theory approach to policy analysis? Drawing on the works of policy and organisational theorists, we propose the following. First, a critical policy analysis is directed towards exposing connections between policy context, process, and content (Walt & Gilson 1994, Collins et al. 1999). Whereas traditional policy analyses entail the deductive evaluation of the relative merit of various policy proposals, critical analyses focus on how the interplay of the processes and contexts influence the definition of policy problems (content), agenda setting, and choice of policy instruments. Second, a critical policy analysis exposes the ideologies and values underlying policy issues and their proposed solutions, and the inclusiveness or exclusiveness of the policy debate (Forester 1993, Fischer 1995). This includes an analysis of how issues are understood and framed by the various policy communities – those groups of actors from government, private sector, pressure groups, advocacy groups, media or academia who seek to influence the course of public policy (Yanow 2000, Pal 2001). Third, a critical analysis exposes the reality of organisational processes, particularly as they relate to how policies are experienced by people in their daily environments (Habermas 1973, Pettigrew 1987, 1988). In matters of health and health care, it is important to understand how clients, families and front-line healthcare providers experience the reality of policy problems and solutions. Also fundamental to policy analysis informed by critical theory in the spirit of Habermas and others, is the ultimate aim of identifying and attending to power relations inherent in policy processes (Morrow 1994, Mill et al. 2001).

Critical theory as a methodological approach to policy analysis is inclusive of different forms of knowledge. Fischer (1995) describes the essence of a critical theory approach as one of ‘integrating the normative evaluation of a policy’s goals with the kind of empirical work already characteristic of policy evaluation’ (p. 6). Therefore, findings of this study were empirically derived through interviews and documents, and interpreted in light of the methodological tenets of critical theory.

**Method**

The unit of analysis for this study is the subsystem of home care within a regional health system during the years 1993–2001. This time frame was marked by the beginning of hospital restructuring in 1991 and the release of regional and provincial policy documents related to a review of home care and long-term care in the province. Sources of data, collected during the time period June 2000 to June 2001, included 23 interviews with decision-makers at middle and senior levels of public and private organisations, healthcare providers, and public advocates in home care; government documents including programme and regional reviews and policies; and current literature depicting political, economic, social and historical contexts of home-care policy. The perspective of government was largely captured in the review of public documents. Another source of data was researcher field notes of relevant context during the year of engagement in the field. These notes referred to observations and reflections on what was happening in government at the time, observations of people and place, as well as a record of analytical decisions made about the different data sources and their relationships. For example, there was turnover in some key positions in the healthcare organisation and this was captured in field notes that
later informed the analysis of power relations in the political context of home care. Media reports of events pertaining to the restructuring of healthcare delivery in the province also informed the political context. The study underwent ethical review and received approval from the university and the health region.

Intensity sampling was used to select participants ‘who are experiential experts and who are authorities about a particular experience’ (Denzin & Lincoln 1998, p. 23). The 23 participants (15 decision-makers, 4 healthcare providers and 4 public advocates) were asked in interviews about (1) their understanding and experience of what they believed to be the most prominent policy and organisational issues; and (2) the policy processes that were most influential in home care in the regional context, including their beliefs about the issues that were and were not on policy agendas, the inclusiveness of decision-making and influences in the policy process.

Interview transcripts and documents were content analysed according to the policy and organisational concepts of context, process, and content. Analysis of interview transcripts was facilitated by the use of the qualitative analysis software program (NUD*IST 5). Themes emerged as ‘significant concepts’ that were continuous across interviews (Morse & Field 1995, p. 140). Analysis of policy texts and discourse associated with policy issues directs the researcher to the use of language and the meaning and values associated with perspectives. Yanow (2000) describes how a central question of the policy analyst becomes that of how policy issues are framed, revealed in the ‘different policy discourses – different language, understandings and perceptions – and potentially different courses of action but also different values’ (pp. 12–13). This critical analysis revealed the values-based discourse of participants, and in particular the tension in values underpinning the various perspectives. This normative analysis of ideology and values is an important element of critical theory and the understanding of policy process.

Findings

Drawing on the recent work of policy and organisational scholars, we have adapted Pettigrew’s (1987) and Walt and Gilson’s (1994) framework to guide this critical analysis of home-care policy. The framework consists of a triangle, with the three points depicting the elements or dynamics of policy analysis as context, process and content.

Figure 1

Context, process, and content of home care policy. (Adapted from Pettigrew 1987, Walt & Gilson 1994.)

Context
- Political
  - Neoliberalism
- Historical
  - Origins of home care
- Economic
  - Population
  - Public expectations
  - Family/gender

Interaction
- Actors
  - Public advocates
  - Healthcare providers
  - Decision-makers
- Values/Tensions
  - Equity/efficiency
  - Choice/universality
  - Responsibility

Agendas
- Medical model
- Social model

Process

Content
- Policy proposals
  - Integrated access
  - Continuing care reforms
- Instruments
  - Public/private delivery

Findings

Context
directs the analyst to consider political, economic, social and historical influences. Process includes the analysis of values associated with policy proposals and of the policy actors or communities who are part of the policy debate and agenda setting. The third point – Content – includes the problems and the instruments as they are proposed and implemented by governments and organisational decision-makers. The interior of the triangle represents the interaction of the three elements of context, process and content as the crux or nexus of policy analysis. We first present the findings related to policy content, as identified in the provincial and regional policy agenda with respect to home care during the period of this study. We then present findings related to elements of context and process.

In order to fulfill the requirement of anonymity, the regional health authority will not be named.
Content of provincial and regional policy agendas

The policy agenda of the Alberta provincial government with respect to delivery of health care was most clearly identified in the shift to a business model. The business plan marked the beginning of discourse pertaining to the goals of efficiency in the delivery of health services; relocation of monies to the community sector; increasing personal responsibility for health care; and increasing user fees to subsidise the funding of public health programmes (Government of Alberta 1994). In one important respect, there was a contradiction between the goals set out in the plan and what had actually transpired 5 years later in that the reallocation of resources intended for community services did not occur with restructuring (Provincial Health Council of Alberta 1998, Health Canada 1999, Alberta Health & Wellness 1999a–d).

The main policy initiative of the Alberta government with respect to home care during the period of study was the conduct of the Long-Term Care Review for the purpose of addressing the needs of an ageing society. This review process culminated in a final report that has come to be known as ‘the Broda Report’ (Alberta Health & Wellness 1999a–d). The committee that directed the review claimed to have engaged a variety of publics in its consultations. The report included ‘highlights of the various views and trends’ in four main areas including (1) increasing the ability of people to remain in their homes or ‘age in place’, (2) de-linking or unbundling social services, health and housing services to allow people more choice, (3) increasing the funding that goes directly to individuals, and (4) increasing the role of the private sector so that people can ‘age in place’ (Alberta Health & Wellness 1999a, p. 9). The discourse of increasing choice for people is evident throughout the report, as is the support for healthy ageing including health promotion and the prevention of illness. Seemingly, the ‘unbundling of services’, as referred to by study participants, could lead to a greater array of choices for clients of health and social services. Unbundling meant the decoupling of health and social services, therefore enabling clients to receive one set of services (e.g. housing support) without having to qualify for healthcare services. In this way the access to an array of services would be facilitated by not making the receipt of services in one sector contingent on qualifying for services in another sector. Increased support for home care was also identified by the committee as ‘a first priority so that more people can receive the care they need at home rather than in facilities’ (Alberta Health & Wellness 1999a, p. 22).

In their written response to the Report of the Long-Term Care Committee, decision-makers at the regional level identified improved system integration as a response to problems of access and continuity (Alberta Health & Wellness 1999d, Regional Health Authority 2000a,b). Integration was seen as the main strategy to address the need to expand home and community services with future actions towards this goal to include the ‘introduction of increased system flexibility by promoting further unbundling of care services from housing-related community supports’ (Regional Health Authority 2000b, p. 11). A regional perspective on the financing options facing the provincial government is that cost sharing for some services should be pursued, ensuring that subsidies are in place for those who cannot afford the higher fees (Alberta Health & Wellness 1999d, Regional Health Authority 2000b).

Finally, there was a trend towards increased expectations that families should assume responsibilities for home care across the programmes including post-hospital discharge, palliative care, children’s services, seniors’ service, mental health services, and long-term care. The region did acknowledge limits to the capacity of families to assume the demands of home care and also that increasing numbers of people, particularly seniors, lacked family or community support. An estimated 30% of seniors in the region live alone, the majority of whom are elderly women and this trend is expected to increase (Regional Health Authority 2000d). Policy discourse also acknowledges that, ‘prevention of caregiver burnout is extremely important in delaying entry into a care centre and thereby further increasing bed demand’ (Regional Health Authority 2000d, p. 5).

In summary, policy content related to the direction of home care in the province and the region was primarily identified within the review of long-term care. Common themes in future directions included decoupling of professional care services from personal care and home support, and increasing personal responsibility for these latter components, which had previously been a comprehensive and accessible home-care programme. On the other hand, there was no indication of a concerted policy initiative to respond to resource allocation challenges. Discourse associated with problem definition related primarily to the growing demands for home-care services and the importance of ‘unbundling services’ in order to offer greater public choice in care delivery.

Context

Elements of the historical, political, social and economic contexts of home-care policy were relevant at the time of this study. In the historical context, home care in the province of Alberta was initially conceived and developed as a programme oriented to meeting both health and social needs of people with long-term illnesses and disabilities; that is, based on a social model of care
(Alberta Health 1992). Within the context of regionalisation, however, this emphasis had shifted to a medical orientation, giving priority to meeting the post-discharge needs of clients with acute illnesses.

Political context in the delivery of home-care services involves relationships between the different levels of governments in Canada – regional, provincial and national – stemming from historical precedents that established provinces as holding primary jurisdiction over the delivery of health care. The province of Alberta is particularly opposed to federal involvement in matters related to healthcare policy. Therefore, the call for a national home-care programme and legislation that would address increasing diversity and disparity among programmes across the regions, provinces and the country was politically problematic. As well, Alberta was devolving community healthcare programmes to health regions, most often without the concomitant development of core provincial programme standards. Thus, increasing diversity among home-care programmes within the province was also identified as a relevant political contextual feature of the home-care policy agenda.

The most influential political context, however, is one of neoliberal ideology and it is interrelated with the economic context in Alberta (Government of Alberta 1994, Harrison & Laxer 1995, Murphy 1996, Cooper & Kanji 2000, Carroll & Shaw 2001). Neoliberalism is a hegemony that is rooted in capitalism and favours market solutions in all aspects of public life. It therefore endorses measures such as ‘the erosion and dismantling of public services, campaigns of state deficit – and debt reduction, and the introduction of free market principles’ (Carroll & Shaw 2001, p. 196). The Government of Alberta’s 1994 business plan with respect to healthcare delivery is congruent with the tenets of neoliberalism, and as such it is pervasive in its influence on home care and all sectors of the health delivery system (Taft & Steward 2000). Participants in this study were aware of the influences of the political hegemony and some made specific references to its influence on role expectations of families and women in the delivery of home-care services. As well, some participants noted the political sensitivity around health care generally and how this had politicised decision-making both at micro- and macro-organisational levels. Participants described the trend to for-profit business models operating in the care of seniors:

… it’s this business of the aging population, getting ready for it and wanting to get into the business. And a lot of them are starting in two places … they’re starting at the very high end, they want to service the people with money who can afford to pay. And the other group they want to service are the well elderly … so the groups who are not well served at this point in time are the low income elderly and elderly who have been well and are now starting to need more and more assistance …

Neoliberalism also relates to the social context of home-care policy. While social factors such as demographics influenced the type of care that was required in homes and the community, the political ideology also influenced a shifting balance to greater family responsibilities for providing care for family members. A relevant feature of the social context is the provincial government’s view that supportive care in the home is first and foremost the responsibility of individuals, families and communities (Alberta Health & Wellness 1999a, 2000). The relationship between political and social contexts is most emphatically seen in the impact of home-care policy on women’s roles (Scott et al. 2002). For example, as home care becomes defined as separate from personal care and homemaking, more of these latter responsibilities fall to women to assist family members who are chronically ill or aged, usually with no compensation. It is also noteworthy that unregulated care providers (e.g. personal care attendants or home healthcare aides) receive minimal pay for their services, and are often not paid for time taken to travel between home visits. In the words of one participant:

… often you think of home care being a programme that is carried on the backs of women. Because women are the primary care providers, and on the backs of low paid care providers who are primarily women, and that has been brought forward by several of our staff who can see it as a feminist issue.

Process

Major findings in the process analysis include the perspectives and values of the policy actors in relation to allocation of human and fiscal resources, the value and meaning of home care, and tensions in values.

Allocation of human and fiscal resources

The main policy issue identified by the healthcare managers, providers and client advocates related to the allocation of both human and fiscal resources for the delivery of home care. There were four main themes related to the issue of resource allocation including: supply and demand of resources within home care, boundaries of home care, efficiency-based decision-making at the level of care and a false economy.

The theme of supply and demand was described by almost all participants and their descriptions were consistent with the findings of the documents. Data confirmed a situation where the Regional Health Authority expenditures on home care had not increased substantially during the restructuring period and had therefore not kept pace with the increased demand for home-care services that had occurred during the same period due to the downsizing of hospitals. One regional manager contended that the intention to enhance
community-based services was unattainable because of lack of political will:

... going back to 1994, in the throes of cutbacks and reorganization, the health authority wanted money reserved, put into and maintained in home care and public health — but the acute care is very sexy so when you get down to the policy issues, it takes a great deal of will politically to stay the course.

Participants referred to the increasingly tighter boundaries that were drawn between health and social services. While case managers were compelled to segregate professional healthcare services, personal care services and homemaking, they also recognised how these distinctions or boundaries were not in the clients' best interests:

Homemaking is sometimes the break between someone staying at home and not staying at home, and if that's the case, it makes more sense to provide [this] than to say, 'No, we're not going to do it' and then have them go to long-term care when they maybe really don't need to be there.

There were several examples of how 'environmental' and 'social' factors influenced the health care of individuals who lacked adequate housing, basic transportation and family or other supports. Since regionalisation, home care had responded more to immediate and acute healthcare needs at home. The policy direction seemed to be towards 'unbundling health and social services' which was, in reality, a move to define the boundaries much more tightly than previously.

Participants also described how the value of efficiency was driving case management decisions. They perceived a false economy when decisions made to improve efficiency resulted in the loss of those services that supported people to remain at home and would have in the long run avoided more costly care options:

... what we're finding with the families [parents lifting children who are chronically ill at home] is that their backs break down, their shoulders break down and then they are not able to provide for their children, and they end up having to go to foster care ... it costs us all if we're jeopardizing those families' physical well being, not mention their mental well being ... the cost of that [providing additional personal care] is negligible compared to what else might happen ...

**Value and meaning of home care**

Participants also described changes in the value and meaning of home care that they had noted since regionalisation. The predominant themes related to a shift to a medical model of care; a concern for a loss of continuity in home care; a concern for the standards of care; and an expectation that families assume a greater responsibility for the care of clients who are at home. The shift to a medical model was pervasive in the discourse of participants, who characterised home care as increasingly task-oriented and focused on the immediate illness, rather than valuing continuity of care in the home over time. Once again, the participants provided vivid descriptions of the shift that was taking place in the meaning of care:

I see it [home care] becoming more of a hospital without walls, as opposed to when I started, there were a lot of services in place, homemaking, personal care, a lot of that and although that's still part of it, it seems to be less of a part of it than it used to be.

With respect to the theme of continuity of care and standards of care, participants expressed concern that some clients, especially those who were older and socially isolated, were ‘falling through the cracks’. Home-care nurses found that they could not provide ongoing monitoring or checks for people who were living at home with unstable health conditions, even when these were warranted:

... when we send the frail elderly home, they may have a frail caregiver in the home, they may be the caregiver for someone, and we don’t have the ability to have anyone to just go in and do a check, without anything specific – that to me has always been very difficult to comprehend if we are moving to community care.

Finally, participants identified that family caregiving placed a burden on families when home-care clients were unable to access appropriate levels of professional care. This concern was closely linked with standards of care. Participants referred to government expectations that families and women assume caregiving responsibilities for family members and to the growing challenge of engaging families in care or finding comparable support for those individuals who did not have family. Further, it was thought that issues related to family burden and the overall mental health of the family unit were less likely to be explored and addressed by overworked case managers.

**Discussion**

**Tension in values**

A comparison of the stories, discourse and statements of what the actors perceived as important issues and directions in the delivery of home-care services revealed tension between the values of equity and efficiency. This in turn exposes tensions between the values of choice and universality in the fundamental determinations of the boundaries of entitlement and the limits to the provision of scarce resources (Stone 1997). Finally, a further tension was identified between the values of individual self-sufficiency and public responsibility in the delivery of home care.
Equity

Stone (1997) refers to equity as ‘distributions that are regarded as fair even though they contain both equalities and inequalities’ (p. 42). Fair distribution of home-care resources depends on how fundamental questions related to individual entitlement, human rights, and the scope of health services are to be resolved as a societal determination. Tensions in determining equity therefore lead us to consider more deeply the values of universality and choice in the delivery of home-care services. Arguments in favour of shifting universally provided public programmes to user pay and private programmes refer to how these reallocations can then result in more equitable service delivery to low-income people, as well as provide a greater array of choices to those who can afford to access the programmes (Government of Alberta 2001, Romanow 2004). However, critics of this approach argue that markets developing in the wake of universal programmes eventually lead to inequities, as support for the public system wanes (Coyte 2000, Bashevkin 2002, Romanow 2004). These are vital considerations in determining the accessibility of other than direct professional healthcare services for those who are economically disadvantaged. Subsidies to low-income people for social and support services comprise a policy instrument that will likely preserve some of the equity in the system of care. However, critics also point out that over time, eligibility requirements are likely to tighten, and access to a range of comprehensive social and personal supports may be eroded (Rachlis 2000, Armstrong et al. 2002, Bashevkin 2002).

Efficiency

Political and economic contexts have been characterised by the reduction of public services, forcing an efficiency model that emphasises cost containment as the primary goal. In response, organisational and political theorists have described these tensions between efficiency, productivity and quality in both private and public organisations (Mintzberg 2002, Stein 2002) and have challenged us to consider the question of efficiency with respect to the provision of public services: ‘What are we to be efficient at?’ (Stein 2002, p. 41). Providers in this study also acknowledged the challenge of sustainability and fiscal limits to what governments can provide. However, they were more inclined to present the subtle complexities of an efficiency orientation, including the danger of a false economy when quality care issues are not considered. Policy-makers further understanding of the tension that exists between efficiency and other values might lead to policies that are characterised not only by cost containment but also equity, choice, and the provision of quality home care.

The trend towards the medicalisation of home care actually limits the provision of health promotion and prevention as part of the package of home-care services. This stands in contradiction to recent evidence that supports the cost-effectiveness of adding nursing, health promotion and preventive care to personal support services in the care of elderly clients in the home (Markle-Reid et al. 2003). These questions relate most fundamentally to how care is valued within the system and in society and the contributions of family, women and informal caregivers.

Individual and public responsibility

Another tension exists between the values of personal responsibility and communal (or community) responsibility for the provision of health services. There is a growing emphasis on personal responsibility and self-sufficiency with less reliance on government provision of services. This mandates a level of family and community support at a time when individual levels of self-sufficiency are decreased due to disability, illness or normal ageing. Critics acknowledge how this impacts families, and acknowledge gender implications of public policies that identify women as primary informal – and most often unpaid – caregivers (Gregor 1997, Brodie 1999, Armstrong et al. 2002). Policy discourse in both provincial and regional contexts identifies the need for more support for informal and family caregivers within the array of ‘unbundled or de-linked services’. However, there is less acknowledgement of those people who are isolated and lack social supports and little identification of policy options that would address the gender issues and ultimate sustainability of informal and family caregiving. In this instance, the governments’ policy is to provide resources only when voluntary instruments in the form of family and community, or market forces, do not address the policy problem (Howlett & Ramesh 1995).

Will home care be transformed as primary health care?

Central to this critical policy analysis was the question of how the emerging policy paradigm in home care did or did not relate to the principles of primary health care. In response to this question, one first observes that the vision for the development of long-term care and home care as it is laid out in the policy documents of Alberta Health & Wellness (1999a–d) correspond at least in a rhetorical sense to PHC principles. However, upon closer scrutiny, there are differences between what was happening with respect to regional home-care policy and what would be expected if policy agendas were congruent
Table 1 A Comparison of Medical and PHC Policy Paradigms in Regional Home Care

<table>
<thead>
<tr>
<th>Elements of policy content and process</th>
<th>Medical</th>
<th>PHC</th>
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| Problem definition | • Aging and chronic illness as a burden of care  
  • Potential for catastrophic costs to the public purse  
  • Need to define boundaries between health and non-health services | • Aging and chronic illness as community challenges  
  • Reduced capacity of existing health systems to evolve in the face of new challenges  
  • Health and health care must be broadly defined to realise goals |
| Goals | • Efficiency/control of public expenditures  
  • Immediate treatment/medical care needs as a system priority  
  • Health promotion and prevention are goals but not fully realised as health services | • Provision of a comprehensive and accessible range of services  
  • Health promotion and illness prevention are integral  
  • Provision of health services that are affordable and sustainable at a community level |
| Instruments | • Market efficiencies: contracting out of all but narrow scope of treatment-oriented health services  
  • Private responsibility/user pays for an increasingly wider range of services  
  • Subsidies | • Intersectoral initiatives/healthy public policy  
  • Public ownership and funding of system  
  • Develop system capacity (human resources, community resources, less costly ‘upstream’ services) |
| Values | • Efficiency: entrepreneurial initiatives  
  • Increased choice in services (health care, housing, personal care)  
  • Equity through subsidies | • Equity, including universality of access  
  • Efficiency/affordability  
  • Individual and community responsibility (social justice) |
| Actors | • Policy process dominated by policy elites and political interests | • Public participation in policy processes |

with a PHC policy paradigm. Table 1 is a summary of some of the key points of difference in policy content and process between the emerging medical paradigm and the PHC paradigm. Our delineation of a medical paradigm refers to a systems context rather than the connotation of the practice of the discipline of medicine. In this context, we refer to a medical paradigm as one that more exclusively focuses on a pragmatic and episodic treatment of illness and generally lacks the elements of health promotion and community-based care.

Problem definition in the medical paradigm is framed as a potential catastrophic burden of home care on the public purse, with the primary goal of controlling public expenditures in the delivery of services. This in turn, leads to policy instruments that favour market efficiencies, user pay options and subsidies. On the other hand, the PHC paradigm frames the care demands of the elderly and chronically ill as a community challenge. When framed as such, this challenge calls for broad-based community solutions including a comprehensive range of health and health-related services that are affordable to the community and society. Policy instruments in a PHC framework are intersectoral, legislative and regulatory to ensure public ownership and funding of the system overall.

With respect to policy process, the medical and PHC policy paradigms are distinguished by different emphases on combinations or patterns of values. The medical paradigm favours efficiency and choice in the delivery of home-care services with priority given to the acute, treatment-oriented health services over chronic or long-term care in the home. Efficiency is largely realised through the introduction of market forces, and equity is achieved through subsidies. Within a PHC paradigm, the value of equity is actualised through universality of access to a range of health services as well as efficiency in the provision of services that are sustainable and affordable to a community. Finally, actors who influence the policy process in the medical paradigm are generally characterised as policy elites such as MLAs, cabinet ministers, organisational leaders, physicians and others who may be part of an inner circle of policy-makers (Lavis 2002). The PHC paradigm is based on a principle of public participation, and this should be realised to its fullest extent in the inclusion of diverse publics in policy-making (Ogilvie & Reutter 2003).

Conclusions

We draw two main conclusions from this critical policy analysis of home care in one Canadian province. The first conclusion is that home care was undergoing medicalisation, an evolution that was not supported by primary healthcare principles. This critical analysis revealed that regional home care was not evolving in the direction of a broad definition of health services that included home support, family support and prevention services. While researchers provide evidence to support the need for comprehensive services in order to sustain people in
their homes (Forbes et al. 2003, Markle-Reid et al. 2003), influential policy positions and documents continue to identify primarily acute care substitution and professional care services in a publicly funded basket of services. At the same time policies are silent with respect to the provision of supportive services for people with chronic health conditions or the frail elderly who are at home (Government of Alberta 2001, First Ministers of Canada 2003). Governments do express some support of PHC in their policy documents. However the full potential of PHC must be actualised as a philosophy of care. It is therefore the philosophical tenets of PHC that appear to be in contradiction with the political ideology of neoliberalism which characterised the provincial government at the time of this study.

Second, we conclude that a critical theory approach to policy analysis can inform the science of influencing policy by exposing ideological tensions, exemplified in this study as a tension between neoliberalism and primary health care. Given the strength of political agendas, one must conclude that it will be very difficult to respond to a policy window for the development of a home-care delivery system that is based on PHC principles. There is research to suggest that decision-makers will ignore policy proposals that are not framed as compatible with their ideology (Bryant 2002, Sabatier & Jenkins-Smith 1999). Therefore, reformers of policy in home care must use these insights about the ideology of the dominant political discourse as the basis for influencing decision-makers of the inherent contradictions in their rhetoric of health policy reform. They must point to the reality of how policy agendas stand in opposition to values of equity, authentic choice and public responsibility.

We have identified the limitations of this study. First, we did not include recipients of care and their families as study participants and this would have enriched our findings related to the experience of home care. Further, we recognise that it would have been useful to build into the study design the opportunity for the various actors to dialogue amongst each other for the purpose of coming to a greater awareness and understanding of different perspectives, values and the impact of policy decisions on people’s lives. Finally, it may be beneficial to conduct similar studies in other jurisdictions that have different political, historical and social contexts for comparative analyses of policy process and content.

In spite of the limitations, we conclude that this study has provided useful insights into how a critical policy analysis is important to understanding the dynamics of health policy in the 21st century. Based on our findings related to the interaction of policy context, process and content, we conclude that diverse perspectives of policy actors and must be heard and honoured in the process of making public policy choices. If fully realised, a critical theory approach may hold the promise of democratisation of policy processes (Fischer 1993) by promoting inclusiveness of input and emancipation of those most affected by policy changes.

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References


Habermas J. (1973) Knowledge and Human Interests. Beacon, Boston, Massachusetts.


Regional Health Authority (2000a) Business Plan 2000/01–2000/03. Regional Health Authority, Edmonton, Alberta.
Regional Health Authority (2000b) Continuing Care 10 Year Strategic Service Plan: Response to Alberta Health and Wellness’ Phase One Expectations – Environmental Scan. Regional Health Authority, Edmonton, Alberta.

Regional Health Authority (2000c) Continuing Care 10 Year Strategic Service Plan: Vision, Mission and Values (Appendix A). Regional Health Authority, Edmonton, Alberta.

Regional Health Authority (2000d) Response to Alberta Health and Wellness’ Phase 1 Expectations. Environmental Scan Supporting Document. Regional Health Authority, Edmonton, Alberta.


