HEALTHCARE

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Adolescent Access to Abortion Care in Canada: Age, Capacity and Parental Consent

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Conceiving Policy Design: Perspectives From Women Pursuing IVF in British Columbia

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Healthcare Policy/Politiques de Santé seeks to bridge the worlds of research and decision making by presenting research, analysis and information that speak to both audiences. Accordingly, our manuscript review and editorial processes include researchers and decision makers.

We publish original scholarly and research papers that support health policy development and decision making in spheres ranging from governance, organization and service delivery to financing, funding and resource allocation. The journal welcomes submissions from researchers across a broad spectrum of disciplines in health sciences, social sciences, management and the humanities and from interdisciplinary research teams. We encourage submissions from decision makers or researcher–decision maker collaborations that address knowledge application and exchange.

While *Healthcare Policy/Politiques de Santé* encourages submissions that are theoretically grounded and methodologically innovative, we emphasize applied research rather than theoretical work and methods development. The journal maintains a distinctly Canadian flavour by focusing on Canadian health services and policy issues. We also publish research and analysis involving international comparisons or set in other jurisdictions that are relevant to the Canadian context.

* * *

Politiques de Santé/Healthcare Policy cherche à rapprocher le monde de la recherche et celui des décideurs en présentant des travaux de recherche, des analyses et des renseignements qui s'adressent aux deux auditoires. Ainsi donc, nos processus rédactionnel et d'examen des manuscrits font intervenir à la fois des chercheurs et des décideurs.

Nous publions des articles savants et des rapports de recherche qui appuient l'élaboration de politiques et le processus décisionnel dans le domaine de la santé et qui abordent des aspects aussi variés que la gouvernance, l'organisation et la prestation des services, le financement et la répartition des ressources. La revue accueille favorablement les articles rédigés par des chercheurs provenant d'un large éventail de disciplines dans les sciences de la santé, les sciences sociales et la gestion, et par des équipes de recherche interdisciplinaires. Nous invitons également les décideurs ou les membres d'équipes formées de chercheurs et de décideurs à nous envoyer des articles qui traitent de l'échange et de l'application des connaissances.

Bien que *Politiques de Santé/Healthcare Policy* encourage l'envoi d'articles ayant un solide fondement théorique et innovateurs sur le plan méthodologique, nous privilégions la recherche appliquée plutôt que les travaux théoriques et l'élaboration de méthodes. La revue veut maintenir une saveur distinctement canadienne en mettant l'accent sur les questions liées aux services et aux politiques de santé au Canada. Nous publions aussi des travaux de recherche et des analyses présentant des comparaisons internationales qui sont pertinentes pour le contexte canadien.

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EDITORIAL

Provincial Leadership and Green Shoots: Where to Look for Innovation

The recent federal election highlighted an unfortunate fact: the national political parties were not able or willing to prioritize and champion the needed health reforms to be enacted by provinces. Each of the national parties offered few innovations beyond spending more money in the same way to buy access to family physicians.

There are many serious problems with provincial and territorial healthcare systems beyond accessing a family physician – there is palpable disappointment among healthcare experts with national parties' lack of thought leadership in healthcare.

The federal parties have shown that they are unable to articulate innovative ideas to meaningfully address the complex problems of provincial and territorial health systems. For everyone, this state of affairs should crystallize the idea that the federal government will not be leading solutions to the country's most pressing healthcare problems anytime soon.

Where does this leave Canadians looking for meaningful reform to healthcare delivery? In the short and medium terms, provinces and territories will have to develop and lead with innovative solutions that fit the context of their province or territory.

Provincial Innovation

There are green shoots that suggest some optimism for beleaguered healthcare-consuming Canadians and their families.

The premier of Alberta recently announced an overhaul of Alberta's policies used to fund acute care (Province of Alberta 2025). Alberta's new policies of funding hospitals based on their activities are consistent with how Ontario and many European countries with health systems similar to ours fund their hospitals (European Observatory on Health Systems and Policies 2011), though the devil is in the details.

Transforming the way hospitals are remunerated is a profound shift for the acute care sector, which is unaccustomed to competing for revenue or matching costs with prices

(C.D. Howe 2013). The downside risk to Albertans is low, as inefficient hospitals are unlikely to be allowed to fail by the government. The upside risks to Albertans are increasing the volume of hospital care and decreasing the cost per case (Province of Alberta 2025). The Province of Quebec also appears poised to further implement the same policies in its push for better access to hospitals, referred to as "financement axé sur le patient," or FAP (Province of Quebec 2023).

Large-scale health system innovation is also slowly progressing in Ontario. The Ontario Health Team model is a nascent policy initiative, which has long-term goals that include creating incentives for preventive health, aging at home, longitudinal care coordinated by multidisciplinary teams and reducing congestion of hospitals (Ontario Health 2024). The Ontario Health Team model preserves options for future governments to implement capitation-type payment models for Ontario Health Teams, funding healthcare providers for the health of the population in their region.

Ontario proceeding with these policy objectives may represent the "holy grail" of healthcare funding by creating financial incentives for addressing vertical and horizontal inequities in health. Ontario's experiment with Ontario Health Teams presents a bold vision – there are few international settings where population- and team-based longitudinal healthcare models are successful, and there are many legislative, policy and workflow-related barriers to progress that Ontario will need to overcome to succeed.

There are also provinces bereft of meaningful innovations addressing their healthcare systems' problems. British Columbia, Saskatchewan and Manitoba are examples where voters should reflect on their governments' barely sufficient reform-oriented policies. Without change, these provinces should expect more of the same.

As provinces increasingly claim ownership over healthcare transformation – without the encumbrance of standardization coordinated by Health Canada – it is entirely predictable that provinces' health systems will forge ahead in disparate directions. The new policy initiatives of Alberta, Quebec and Ontario highlight that there are few commonalities between them. While differences between provinces' health systems are not inherently "bad," it is worthwhile to note that what is recognized as public healthcare services in one province may not be considered public healthcare services in another.

On the whole, provinces and territories are clearly in the driver's seat regarding healthcare transformation. With several provinces' governments pushing forward with innovation-based agendas and some electing to stand pat, it is worth reflecting on the potential impacts of whether there is value in provinces and territories moving in the same direction.

In This Issue

This issue of *Healthcare Policy* is led by a Discussion and Debate article focused on adolescents' access to abortion care across Canada (Cattapan et al. 2025). The interprovincial policy comparisons reveal instances of unclear or contradictory provincial legislation that result in differences in youth's ability to access abortion care. The editorial concludes with a number of recommendations for reducing barriers to abortion care, including revising legislation and consenting processes.

A rejoinder by Haley and Motamedi (2025) extended the preceding article's focus on access to abortion care. Applying an intersectional framework to the healthcare needs of adolescents, the authors provide different insights into barriers to equitable access to abortion care among marginalized groups. The authors provide clear recommendations for reducing barriers, including creating welcoming spaces, a sense of safety and fostering personhood and autonomy that destigmatizes abortion access.

A second Discussion and Debate article focuses on interactions between health services and policy researchers with senior policy makers (Paprica et al. 2025). Framed as a researcher's balancing act between advice and advocacy, the article highlights the risk that health services and policy researchers bear through their research activities. The authors offer a number of strategies for reducing researchers from being perceived as issue advocates.

A rejoinder to the preceding article provides a different perspective on interactions between health services and policy researchers with senior policy makers (Forest 2025). The article proposes that the impact of health services and policy researchers on government policy is lesser than expressed by Paprica et al. (2025), since researchers are rarely involved in government's core policy tasks led by political leaders and decision making processes that incorporate input from a range of input channels beyond researchers, including public opinion polling, platform commitments and lobbying campaigns.

A Data Matters article by Contandriopoulos and Bertoni (2025) analyses recently released Canadian Institute for Health Information data regarding the proportion of Canadians who report having a regular healthcare provider. Variability in the prevalence of nurse practitioners (NPs) across provinces is highlighted. The article concludes that there is building evidence that NPs are granted more autonomy within their scope of practice only when access to care becomes critically constrained, and that the *Canada Health Act* (1985) also applies to NP-delivered services, potentially affecting NPs' ability to privately bill patients for their services.

Using a survey-based design, Quelch (2025) reports on themes associated with accessing fertility services, such as at fertility clinics or online support groups. The study summarized women's perceptions and experiences associated with accessing in vitro fertilization (IVF) in British Columbia. The results revealed important barriers to IVF, including regional variation and patient-borne costs. The author concludes that British Columbia's recently announced fertility program should reflect the barriers reported by women seeking IVF services.

In the setting of Alberta, Jajszczok et al. (2025) conducted a retrospective analysis of anonymized homecare costs and homecare utilization. The authors report that increased spending and utilization of home care were associated with decreased acute care utilization. The authors conclude that similar analyses are needed in all provinces to provide new insights into how healthcare resources should be allocated across sectors and how healthcare services are consumed by residents based on where they live.

JASON M. SUTHERLAND, PhD
Editor-in-Chief

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ÉDITORIAL

Leadership provincial et pousses vertes : où chercher l'innovation

Les récentes élections fédérales ont mis en évidence un fait regrettable : les partis nationaux sont incapables ou peu disposés à établir des priorités et à promouvoir les réformes nécessaires que doivent mettre en œuvre les provinces dans le domaine de la santé. Chacun des partis a proposé peu d'innovations au-delà de dépenser plus d'argent de la même façon pour acheter l'accès aux médecins de famille.

Les systèmes de soins de santé provinciaux et territoriaux présentent de nombreux problèmes graves, au-delà de l'accès à un médecin de famille – il y a une déception appréciable parmi les experts quant au manque de leadership éclairé de la part des partis nationaux.

Les partis fédéraux ont démontré leur incapacité d'articuler des idées novatrices pour aborder correctement les problèmes complexes des systèmes de santé provinciaux et territoriaux. Pour tout le monde, cet état de choses devrait cristalliser l'idée que le gouvernement fédéral n'apportera pas de solutions, dans un avenir proche, aux problèmes les plus pressants du pays en matière de santé.

Que peuvent donc faire les Canadiens qui veulent voir prendre corps une réforme significative de la prestation des soins de santé? À court et à moyen terme, les provinces et les territoires devront élaborer des solutions novatrices qui s'adaptent à leurs contextes.

Innovation provinciale

Quelques pousses vertes laissent entrevoir un certain optimisme pour les usagers de soins de santé en difficulté et leurs familles.

La première ministre de l'Alberta a récemment annoncé une refonte des politiques albertaines servant à financer les soins de courte durée (Province de l'Alberta 2025). Les nouvelles politiques de cette province en matière de financement des hôpitaux, fondé sur leurs activités, sont analogues à la façon dont l'Ontario et de nombreux pays européens dotés de systèmes de santé semblables financent les hôpitaux (Observatoire européen des systèmes et des politiques de santé, 2011), bien que le diable soit dans les détails.

Transformer la rémunération des hôpitaux constitue un changement profond pour le secteur des soins de courte durée, qui n'est pas habitué à la concurrence pour les revenus ou au rattachement des charges aux produits (C.D. Howe 2013). Le risque de perte pour les Albertains est faible, car il est peu probable que le gouvernement laisse les hôpitaux inefficaces faire faillite. Les chances de gain pour les Albertains se traduisent par une augmentation du volume des soins hospitaliers et une diminution du coût par cas (Province de l'Alberta 2025). La province de Québec semble également prête à mettre en œuvre des politiques similaires dans son effort pour assurer un meilleur accès aux hôpitaux, appelé « financement axé sur le patient » ou FAP (Province de Québec 2023).

L'innovation à grande échelle dans le système de santé progresse aussi, lentement, en Ontario. Le modèle des Équipes Santé Ontario est une initiative politique naissante dont les objectifs à long terme sont, notamment, la création d'incitatifs pour la santé préventive, le vieillissement à domicile, les soins continus coordonnés par des équipes multidisciplinaires et la réduction de la congestion dans les hôpitaux (Santé Ontario 2024). Le modèle des Équipes Santé Ontario prévoit des options pour les futurs gouvernements afin qu'ils mettent en œuvre des modèles de paiement par capitation pour les Équipes, en finançant les fournisseurs de soins de santé pour la santé de la population dans leur région.

Le fait que l'Ontario poursuive ces objectifs stratégiques pourrait représenter le « saint-graal » du financement des soins de santé en créant des incitatifs financiers pour remédier aux inégalités verticales et horizontales en matière de santé. L'expérience des Équipes Santé Ontario présente une vision audacieuse : il y a peu d'exemples internationaux où les modèles de soins de santé continus axés sur la population et les équipes sont couronnés de succès, et il y a bon nombre d'obstacles liées à la législation, aux politiques ou au flux opérationels que l'Ontario devra surmonter.

Il y a aussi, dans certaines provinces, un manque d'innovations pour résoudre les problèmes du système de santé. La Colombie-Britannique, la Saskatchewan et le Manitoba sont autant d'exemples où les électeurs devraient réfléchir aux politiques de réformes à peine suffisantes de leurs gouvernements. Sans changement, ces provinces devraient s'attendre à ce que rien ne change.

Alors que les provinces revendiquent de plus en plus de pouvoir pour la transformation des soins de santé – sans le fardeau de la normalisation coordonnée par Santé Canada – il est tout à fait prévisible que les systèmes de santé iront dans des directions disparates. Les nouvelles initiatives stratégiques de l'Alberta, du Québec et de l'Ontario soulignent le fait qu'il y a peu de points communs entre elles. Bien que les différences entre les systèmes de santé ne soient pas une chose intrinsèquement « mauvaise », il est intéressant de noter que ce qui est reconnu comme services publics de soins de santé dans une province peut ne pas être considéré comme tel dans une autre.

Dans l'ensemble, les provinces et les territoires sont clairement aux commandes de la transformation des soins de santé. Étant donné que plusieurs gouvernements provinciaux mettent en œuvre des programmes axés sur l'innovation et que certains choisissent de se tenir debout, il convient de réfléchir à la qualité de l'impact de cette approche dans les provinces et les territoires qui vont dans la même direction.

Dans ce numéro

Le présent numéro de *Politiques de Santé* commence par un article de la section Discussions et débats qui traite de l'accès des adolescentes aux services d'avortement au Canada (Cattapan et al. 2025). La comparaison des politiques entre provinces révèle des cas de législation provinciale peu claire ou contradictoire qui se traduisent par des différences dans la capacité des jeunes à accéder aux services d'avortement. L'éditorial se termine par un certain nombre de recommandations pour réduire les obstacles aux services d'avortement, notamment par une révision de la législation et des processus de consentement.

Une réplique à cet article, par Haley et Motamedi (2025), développe l'accent mis sur l'accès aux services d'avortement. En appliquant un cadre intersectionnel aux besoins des adolescentes en matière de services de santé, les auteurs proposent différents points de vue sur les obstacles à un accès équitable aux services d'avortement parmi les groupes marginalisés. Les auteurs formulent des recommandations claires pour réduire ces obstacles, y compris la création d'espaces accueillants, la mise en place d'un sentiment de sécurité et la promotion d'une identité et d'une autonomie qui déstigmatisent l'accès à l'avortement.

Le deuxième article de la section Discussions et débats porte sur l'interaction entre, d'une part, les chercheurs du domaine des services et des politiques de santé et, d'autre part, les décideurs de haut niveau (Paprica et al. 2025). Conçu comme un jeu d'équilibre entre conseils et défense d'intérêts, l'article met en lumière les risques que les chercheurs peuvent induire dans leurs activités de recherche. Les auteurs proposent un certain nombre de stratégies pour réduire la perception des chercheurs en tant que défenseurs d'intérêts.

Une réplique à cet article donne un point de vue différent sur l'interaction entre les chercheurs et les décideurs de haut niveau (Forest 2025). L'article propose que l'impact des chercheurs sur les politiques gouvernementales est moindre que ce qu'expriment Paprica et al. (2025), puisque les chercheurs sont rarement impliqués dans les tâches stratégiques essentielles menées par les dirigeants politiques et régies par des processus de prise de décisions qui intègrent des intrants provenant d'une gamme de canaux en plus des chercheurs, pensons aux sondages d'opinion publique, aux plateformes électorales ou au lobbying.

Un article de Contandriopoulos et Bertoni (2025), dans la section Questions de données, analyse les données publiées récemment par l'Institut canadien d'information sur la santé concernant la proportion de Canadiens qui déclarent avoir accès à un professionnel de la santé régulier. La variabilité de la prévalence des infirmières praticiennes (IP) entre les provinces est mise en évidence. L'article conclut que de plus en plus de données montrent que les IP obtiennent plus d'autonomie dans leur champ de pratique seulement lorsque l'accès aux soins est sérieusement limité. Ils notent également que la *Loi canadienne sur la santé* (1985) s'applique également aux services fournis par les IP, ce qui pourrait influer sur leur capacité de facturer les patients pour des services privés.

Au moyen d'un concept fondé sur des enquêtes, Quelch (2025) présent un rapport sur les thèmes associés à l'accès aux services de fertilité, par exemple, dans les cliniques de fertilité ou les groupes de soutien en ligne. L'étude résume la perception et l'expérience des femmes dans le contexte de l'accès à la fécondation in vitro (FIV) en Colombie-Britannique. Les résultats mettent en évidence des obstacles importants à la FIV, notamment la variation régionale et les coûts assumés par les patients. L'auteure conclut que le programme de fertilité récemment annoncé en Colombie-Britannique devrait tenir compte des obstacles signalés par les femmes qui ont recours aux services de FIV.

Dans le contexte albertain, Jajszczok et al. (2025) ont effectué une analyse rétrospective des coûts et de l'utilisation anonymisés des soins à domicile. Ils signalent que l'augmentation des dépenses et l'accroissement de l'utilisation des soins à domicile sont associés à une diminution du recours aux soins de courte durée. Les auteurs concluent que des analyses similaires sont nécessaires dans toutes les provinces pour fournir de nouvelles connaissances sur la façon dont les ressources en soins de santé devraient être réparties entre les secteurs et pour savoir comment les services de santé sont consommés par les résidents en fonction de leur lieu de résidence.

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DISCUSSION AND DEBATE

Adolescent Access to Abortion Care in Canada: Age, Capacity and Parental Consent

Accès aux services d'avortement pour les adolescentes au Canada : âge, capacité et consentement parental

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Abstract

For adolescents seeking abortion care in Canada, clear information about age and parental consent requirements is not always available. This article details the state of age of consent law and policy across Canada, focusing on access to abortion care. It identifies three key concerns, namely, challenges with unclear or contradictory information, obstacles presented by having additional requirements for minors' consent and difficulties posed by restrictions that require parents and/or guardians to be involved in decision making. The article concludes with recommendations to reduce these barriers to care.

Résumé

Les adolescentes qui veulent obtenir des services d'avortement au Canada n'ont pas toujours accès à des renseignements clairs sur l'âge et les exigences en matière de consentement parental. Cet article décrit en détail l'état des lois et des politiques sur l'âge du consentement à travers le Canada, en mettant l'accent sur l'accès aux services d'avortement. On y relève trois préoccupations principales, à savoir les défis liés à des renseignements ambigus ou contradictoires, les obstacles que représente l'imposition d'exigences supplémentaires en matière de consentement pour les mineures et les difficultés posées par l'obligation que les parents ou les tuteurs participent à la prise de décision. L'article se termine par des recommandations qui visent à réduire ces obstacles.

* * *

Introduction

There continues to be a relatively small number of adolescents in Canada – people who have not yet reached the age of majority in their province or territory – who become pregnant each year and who may face significant challenges in procuring abortion care. More than 80% of pregnancies among adolescents are unintended (Black et al. 2015), with approximately 1,500 to 2,200 people under the age of 17 successfully procuring an abortion in Canada each year (CIHI 2015–2024). While there are many documented barriers that people experience in seeking abortion care (Hukku et al. 2022), adolescents face additional challenges, including, but not limited to, the uncertainty of familial and social supports, confidentiality concerns and limited access to resources as well as unclear information (Assifi et al. 2020; Downie and Nassar 2008).

Since the 1988 Supreme Court decision in *R v Morgentaler*, consent to abortion in Canada is subject to the same legal requirements as other medical interventions and is largely under the purview of provincial and territorial governments (Jackman 2000; Shaw and Norman 2020). Consequently, the age of consent for abortion is the same as other health services and subject to the same laws and policies. Yet, available information varies widely: some websites indicate that anyone in Canada over the age of 12 can access abortion care; others state that there is no age of consent, and it is also relatively rare to find details about differences between jurisdictions or clear information about when parent (or guardian) consent is required. Confusion about the age of consent is particularly concerning because abortion care is time-sensitive and often stigmatized; hence, adolescents seeking care may be doing so covertly or under stress. It is critical that adolescents have access to clear and effective information about how to obtain abortion care.

Age of Consent for Abortion Care Across Canada

There is significant variation across Canada in how the age of consent to medical treatment is governed. Many provinces do not have a specific age of consent, operating instead on the presumption that patients – regardless of whether they have reached the age of majority – can consent as long as they can reasonably understand the nature of their treatment and its consequences. In each of these jurisdictions – Nova Scotia, Ontario, Prince Edward Island, Saskatchewan and the Yukon – there is specific legislation that defines capacity for medical treatment, although healthcare providers can rebut the presumption of capacity if they have reasonable grounds to determine that the patient cannot consent (Table 1) (Coghlin 2018).

Other provinces have their own statutory provisions to aid in determining capacity in minors, and within them, the common law's mature minor doctrine typically governs how the provisions are interpreted by the courts. The mature minor doctrine in the common law recognizes that people under the age of majority can consent to medical treatment but that their consent may require particular scrutiny to assess whether they are able to consent in a specific context. In New Brunswick, for example, patients who are younger than 16 must demonstrate to their healthcare provider that they understand the nature of the treatment, and their healthcare provider must believe that the treatment is in their best interest. Similarly, in British Columbia, a minor can consent to care without the involvement of a parent or guardian, but the healthcare provider must believe that the minor understands the treatment and its potential benefits and risks, and the healthcare provider must also have taken "reasonable efforts" to determine that the decision is in the patient's best interest. The legislation in both British Columbia and New Brunswick does not, however, clearly set out what a decision in the child's best interest means. Furthermore, in the Northwest Territories and Nunavut, there is no legislation addressing consent to treatment and no specific minimum age for consent. It is likely that in the absence of legislation, questions of consent to treatment in these territories, if considered by courts, would rely on the mature minor doctrine.

In Manitoba and Newfoundland and Labrador, there is a presumption in legislation that persons under the age of 16 cannot consent, although in both cases, this presumption can be rebutted with "evidence to the contrary" (*Advance Health Care Directives Act* 1995; *The Health Care Directives and Consequential Amendments Act* 1992). In Alberta, the approach is similar, but it is policy established by Alberta Health Services (rather than legislation) that sets out a presumption that those under the age of 18 cannot consent to treatment, although this "presumption of incapacity can be rebutted" if the patient is deemed to be a mature minor (AHS 2020).

In Quebec, those younger than 14 require consent from their parent or legal guardian to access abortion care. Minors aged 14 and over also require consent from their parent or legal guardian "if care entails a serious risk for the minor's health" (CCQ 1991, art 17).

TABLE 1. Minimum age of consent to treatment in legislation/policy by province/territory

	Province/territory	Minimum age of consent to treatment	Legislation/policy
No minimum age for consent; same tools to assess consent for everyone	Nova Scotia	None. All persons must understand the nature of treatment and its consequences.	*Personal Directives Act*, SNS 2008, c 8.
	Ontario		*Health Care Consent Act* SO 1996, c 2 (Sch A), s 4.
	Prince Edward Island		*Consent to Treatment and Health Care Directives Act*, RSPEI 1988, c C-17.2, ss 3–10.
	Saskatchewan		*The Health Care Directives and Substitute Health Care Decision Makers Act*, SS 2015, c H-0.002, s 2(1).
	Yukon		*Care Consent Act*, SY 2003, c 21 (Sch B), ss 5–6.
No minimum age for consent; additional precautions to assess consent in minors	New Brunswick	None. Minor must understand the benefits and risks and healthcare provider must conclude that healthcare is in the best interests of the minor.	*Enduring Powers of Attorney Act*, SNB 2019, c 30, s 2; *Medical Consent of Minors Act*, SNB 1976, c M-6.1, s 3.
	British Columbia		*Infants Act*, RSBC 1996, c 223, s 17.
	Northwest Territories[a]	None. Mature minor doctrine.	None.
	Nunavut[a]		None.
Rebuttable presumption that minor cannot consent	Alberta	Rebuttable presumption that person under 18 cannot consent.	Alberta Health Services, "Consent to Treatment/Procedure(s): Minors/Mature Minors" (last modified January 16, 2020) at 1.
	Manitoba	Rebuttable presumption that person under 16 cannot consent.	*The Health Care Directives and Consequential Amendments Act*, SM 1992, c 33, s 4(2).
	Newfoundland and Labrador		*Advance Health Care Directives Act*, SNL 1995, c A-4.1, s 7.
Minors require parental permission	Quebec	Persons 13 and under require consent from parent or legal guardian. Minors 14 and over require parental consent if care entails "serious risk."	Civil Code of Quebec, CQLR 1991, c CCQ-1991, arts 14–18.

a Given that there is no legislation in Northwest Territories and Nunavut, additional precautions may be taken in assessing a minor's ability to consent to treatment.

It is important to note, however, that the legislative approaches (and policy in the case of Alberta), as detailed above, have been addressed by a body of case law that addresses consent to medical treatment for minors. Importantly, in *A.C. v. Manitoba* (SCC 2009), the Supreme Court found that those under 16 in Manitoba can indeed rebut the presumption of incapacity in the legislation if they are sufficiently mature. In this case, the Supreme Court also found that the degree of scrutiny applied to a minor's decision making should be aligned with the extent to which "a treatment decision is likely to seriously endanger a child's life or health." Since abortion care is generally very safe (and indeed much safer than continuing a pregnancy), the level of scrutiny would be low. Some of this case law has also found that determining the "best interests" of an adolescent patient might occur with help of other adults who know them rather than engaging with parents, although others have found that taking "reasonable efforts" to determine an adolescent's best interest may – in cases where the child themselves are not capable of consent – require consultation with their parents (*Ney v. Canada* [Attorney General] 1993).

Ultimately, legislation and policy do not provide the last word on consent to care, and where abortion care is denied to adolescents, the case law suggests that there is a good chance that the courts would find in their favour (see discussion in ARCC 2017; *J.S.C. and C.H.C. v. Wren* 1986; SCC 2009). Yet, when adolescents are seeking information about abortion care, they are unlikely to encounter case law, but rather sources online – clinic websites, legislation, policy and other sources – that may contradict one another, making it unclear whether they will need parental approval or whether they may have to rebut the presumption that they are incapable of consent.

Problems with the legal landscape of age of consent around abortion

While the requirements for consent to abortion in all Canadian jurisdictions are the same as other health services, there are three important concerns that the review of the legislation (and policy) above raises in relation to adolescent access to abortion care. First, information about the circumstances in which adolescents can access abortion care in their province or territory may be unclear or contradictory. Some clinics provide very clear information online about access and age, but there are also some that establish a more restrictive minimum threshold for parental consent than their provincial or territorial law. Furthermore, the legislation (and policy) in some provinces (i.e., Alberta, Manitoba and Newfoundland and Labrador) that presumes that minors cannot consent without evidence to the contrary stands in contrast with information on clinic websites stating that they do not restrict access on the basis of age and/or that parental consent is not required (e.g., Kensington Clinic, Women's Health Clinic) as well as the relevant case law. Contradictions between the language of the relevant legislation (and policy) and clinic policy introduce unnecessary uncertainty about how consent processes will go and whether the legislation (and policy) will be an impediment to care (ARCC 2017).

Second, the requirements for minors to demonstrate a capacity to consent that does not exist for others inherently works to make access to treatment more difficult. The presumption of incapacity in some legislation puts an onus on young patients to actively rebut the presumption and to prove that they are capable of consenting to treatment. These extra steps are not inherently problematic, insofar as healthcare providers typically work hard to ensure that minors seeking any form of care understand and can agree to their treatment. However, it is possible that extra consent requirements may delay or otherwise impede adolescents seeking already difficult-to-access treatment. Abortion care needs to be obtained in a timely manner, and extra requirements can have negative physiological and mental health impacts (Foster 2021; Jerman et al. 2017).

Finally, there is potential harm associated with consent laws that require parental/guardian consent. Requirements for parental consent to abortion are problematic for a variety of reasons, including that they may deter people from accessing care entirely, or people may feel a need to travel elsewhere to seek care (with or without the resources to do so), or they may engage in self-induced abortions. For people who are in abusive family relationships, the requirement to access parental consent can also result in "serious physical injury or emotional harm" (ARCC 2017).

Reducing barriers to access

While Canada is often understood as having no legal restrictions that limit access to abortion, our analysis presents a more nuanced view. Adolescents seeking abortion care may be impeded by unclear information about the age of consent and/or parental consent requirements as outlined in legislation and policy that contradicts case law or clinic policy. This is true both of procedural abortions and medication abortions, although there may be additional concerns in the case of medication abortions in some settings where adolescents are tasked with getting a prescription filled.

There are a number of ways to reduce these potential barriers to care. Most importantly, in jurisdictions where there is a presumption of incapacity in the legislation or policy, or where the legislation indicates additional precautions are needed, provinces should revisit their legislation to reflect both the case law and clinical practice. Given anti-abortion and "parental rights" mobilization advocating for increased parental intervention in consent to healthcare for adolescents, including abortion care (*CBC News* 2018; The Canadian Press 2015), it is especially critical that information about what services are provided, to whom and in what circumstances (including when parental consent is required) is accurate, up to date, consistent and accessible.

Healthcare providers and policy makers should also work to ensure that assessments of capacity do not create delays or undue barriers to care. Again, healthcare providers are typically committed to ensuring that patients understand and can agree to their treatment in a timely manner, but the additional provisions in legislation and policy around determining consent in jurisdictions such as British Columbia, New Brunswick, Alberta, Manitoba and

Newfoundland and Labrador may add extra steps to consent processes that introduce more opportunities for scrutiny, delays in care and the denial of services.

Finally, and wherever possible, requirements for parental involvement in consent processes should be removed, namely in Quebec, where the legislation is clear that there is a need for parental consent for those under the age of 14. While most adolescents involve a parent or guardian willingly, some may be driven away from seeking care by this requirement, or they may feel the need to travel for care or may seek unsafe alternatives (ARCC 2017). The conditions requiring parental consent in Quebec for those under the age of 14 should be reconsidered.

Ultimately, capacity to consent matters and it is critical that healthcare providers continue to be given the discretion to determine whether someone seeking care can consent to their treatment. Yet, the persistence of unclear and contradictory information about the circumstances in which adolescents in many jurisdictions can consent to abortion services, and requirements for parental consent, collectively introduce uncertainty about access and, as a result, unnecessary obstacles to care.

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DISCUSSION AND DEBATE

Commentary: Adolescents, Marginalization(s) and Abortion Care in Canada

Commentaire : Adolescentes, marginalisation et avortement au Canada

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Abstract

Abortion access in Canada has improved in the past 37 years. However, as healthcare delivery is primarily a provincial/territorial responsibility, there are divergences in the administration and operation of abortion care, including coverage in rural areas, access to telemedicine for medication abortion and the laws and policies governing medical consent for minors. In addition, the access and experience of care are often conditioned by raced, classed and gendered inequalities. When considering abortion care in Canada, it is vital to consider the complexities of federalism, the realities of rural and semi-rural life and intersecting forms of marginalization impacting service users, especially adolescents.

Résumé

L'accès à l'avortement au Canada s'est amélioré au cours des 37 dernières années. Cependant, puisque la prestation des soins de santé relève principalement de compétences provinciales ou territoriales, il y a des divergences en matière d'administration et de fonctionnement des services d'avortement, notamment la disponibilité en milieu rural, l'accès à la télémédecine pour l'avortement médicamenteux ainsi que les lois et politiques au sujet du consentement aux soins des mineurs. De plus, l'accès et l'expérience des soins sont souvent conditionnés par les inégalités de races, de classes et de genre. Lorsqu'on examine les services d'avortement au Canada, il est essentiel de tenir compte des complexités du fédéralisme, des réalités de la vie rurale et semi-rurale ainsi que des formes croisées de marginalisation qui touchent les utilisatrices des services, en particulier les adolescentes.

Introduction

From the Morgentaler decision to the widespread medicare coverage for Mifepristone, abortion access in Canada has changed significantly in the past 37 years (Carson et al. 2022; Lebold and MacDonnell 2020), no doubt, for the better. What remains unchanged, however, are interprovincial/territorial differences in the administration and operation of abortion care. Key areas of difference include care coverage in rural and urban areas, access to telemedicine for medication abortion (Abortion Access Tracker n.d.) and, as Cattapan et al. (2025) point out, the laws and policies governing medical consent for minors. These differences are the result of both governmental and non-governmental factors, including, but not limited to, provincial/territorial responsibility for healthcare in Canada, service delivery across vast, sparsely populated geographical areas and uneven abortion training opportunities for medical professionals (Abortion Access Tracker n.d.; Carson et al. 2022). This is not to suggest that abortion is largely unavailable in Canada but rather that there are interprovincial/territorial differences (and even sometimes intraprovincial/territorial differences) in what is available, how care is provided and what barriers to care individuals might encounter. For example, a lack of rural coverage for procedural abortions (Schummers and Norman 2019), coupled with a lack of telemedicine medical abortions in some provinces and territories (e.g., Yukon [Government of Yukon n.d.], Northwest Territories [Government of Northwest Territories n.d.], Prince Edward Island [Government of Prince Edward Island 2024]) can require patients to undertake significant travel to access care (Abortion Access Tracker n.d.; Lebold and MacDonnell 2020; Paynter 2023). At the same time, a lack of trusted and accessible information, for example, in the province of New Brunswick, can create uncertainty and stress (Hughes et al. 2023). Within Canada's complex healthcare system, the experience of accessing an abortion, similar to any other healthcare service, is clearly conditioned by the availability of the service in a given geographical area (Carson et al. 2022). It is also often conditioned by persistent raced, classed and gendered inequalities, which can compound "disparities in abortion access and family planning services," although research on the impact of these social inequalities is "under-researched in Canada" (Carson et al. 2022: 56).

When considering the healthcare needs of adolescents, including abortion, an intersectional framework (Hankivsky 2011; Motley et al. 2023) can support a deeper understanding of barriers to care. It is recognized that for adolescent patients, organizational factors impacting healthcare access generally, such as long wait times and uncoordinated youth care, alongside individual-level factors such as low health literacy, cultural beliefs and the need for parental consent, can produce barriers, leading to poor health outcomes in adolescents (Garney et al. 2021). Marginalized adolescents report an overall lower health status and are more likely to experience multiple chronic conditions than non-marginalized youth (Robards et al. 2020). A meta-analysis of Canadian, American, British and Australian studies (Kearns et al. 2021) found that gender minority youth, for example, can fear that disclosure of gender identity may lead to negative, complex family dynamics, resulting in avoidance and fear when seeking care.

When it comes to reproductive healthcare needs – including abortion care – adolescents are at a heightened risk of unintended pregnancies and sexually transmitted infections arising from a lack of knowledge/developing knowledge of safer sex (Louie-Poon et al. 2021). An adolescent's gender, age and sexual activity change their perception of care; similarly, social support and resources determine care-seeking behaviours (Salehi et al. 2014). Immigrant youth seeking reproductive healthcare have a heightened sense of mistrust surrounding confidentiality, as familial, intergenerational, cultural and religious stigmas exist within many communities (Louie-Poon et al. 2021). Seeking appropriate reproductive healthcare is harder for youth who have poor access to sexual health information and services, often encountering cultural biases and language barriers; this highlights the need for further education and consultation on sexual health and services for newcomer adolescents (Louie-Poon et al. 2021). Youth living with lower socio-economic status in the suburbs and rural areas may struggle to travel to clinics, often located in urban centres, therefore creating barriers to abortion care (Salehi et al. 2014). These barriers for adolescents are likely compounded by ambiguity in the public information about rules governing the age of consent for healthcare (Cattapan et al. 2025) in Canada's diverse abortion landscape. Welcoming spaces that create a sense of safety and accessibility to adolescents while respecting their personhood and autonomy are needed to destigmatize abortion access (Lowik 2025), as there is clear and easily accessible information about what services are available and what (if any) third-party consent might be needed.

While Canada has fully decriminalized abortion, there remains much to be done to ensure equitable access, especially with the growing anti-choice sentiment in North America (Gordon and Johnstone 2024). The overturn of *Roe v. Wade* in the US (Supreme Court of the United States 2022) and the rise of right-wing populism in Canadian politics (Budd 2021; Graves and Smith 2020) will likely result in even greater abortion stigma, making young people in Canada feel less secure in talking about and accessing abortion care. In this context, it is vital that the inconsistent information about minors' medical consent in Canada be swiftly addressed and laws and policies requiring parental consent for reproductive healthcare be eliminated so that young people have access to autonomy over their reproductive lives. These changes are especially important when we consider the additional barriers to reproductive healthcare, especially abortion care, for marginalized youth.

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DISCUSSION AND DEBATE

Advice or Advocacy – Varying Perceptions of Health Services and Policy Researcher Activities

Conseils ou défense des intérêts – Perceptions variables de l'activité des chercheurs du domaine des services et des politiques de santé

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Abstract

The line between objective advice and advocacy may be blurred for health services and policy researchers who work closely with policy makers. Our study of 22 participants' perceptions of a five-part fictional scenario in which a researcher has increasing involvement with the ministry of health found extensive variation in what participants perceived to be objective advice or advocacy. Based on this variation, we believe that health services and policy researchers cannot completely avoid the risk of being perceived as issue advocates, whether by peers or by policy makers, and suggest some possible ways to mitigate risk.

Résumé

La frontière entre conseils objectifs et défense des intérêts peut être floue pour les chercheurs du domaine des services et des politiques de santé qui travaillent en étroite collaboration avec les décideurs. Notre étude, qui porte sur la perception de 22 participants à l'égard d'un scénario fictif en cinq volets dans lequel un chercheur s'implique de plus en plus dans le ministère de la Santé, a révélé une grande variation dans ce que les participants considèrent comme des conseils objectifs ou des activités de défense d'intérêts. Compte tenu de cette variation, nous croyons que les services de santé et les chercheurs ne peuvent pas éviter complètement le risque d'être perçus comme des défenseurs d'intérêts, que ce soit par leurs pairs ou par les décideurs, et nous suggérons certaines façons d'atténuer ces risques.

* * *

Introduction

For more than a decade, there has been debate about the roles scientists ought to take in policy making. In his oft-cited 2007 book, Roger Pielke Jr. identifies four potential roles for scientists: the issue advocate, the honest broker of policy alternatives, the pure scientist and the science arbiter (Pielke 2007, 2015). According to Pielke's framing, pure scientists and science arbiters serve as information resources and are not concerned with specific policy decisions. In contrast, issue advocates and honest brokers both aim to inform policy making but in different ways. Honest brokers seek to expand decision alternatives, while issue advocates seek to narrow them, often to a single choice or policy option (Pielke 2007, 2015).

As noted by Goodwin (2012), there is debate in the literature regarding whether advocacy is a legitimate role for scientists, for example, some argue that scientists' special and deep knowledge imparts an obligation for them to advocate, while others view advocacy as incompatible with scientific objectivity and impartiality. Pielke contends that the four roles he identifies are each "critically important and necessary in a functioning democracy," but that scientists must choose, i.e., "whether a scientist admits, accepts, or is aware of it, a choice must be made on how he or she relates to the decision-making process" (Pielke 2007: 7). On a related point, Oliver and Cairney's systematic review identifies "decide if you want to be an issue advocate or honest broker" as one of eight themes from the "how to influence policy" literature aimed at researchers (Oliver and Cairney 2019: 1).

Assigning the issue advocate role may be straightforward when scientists are transparent about their advocacy for broad topics such as the legitimacy of climate change, increasing the diversity of clinical trial participants and open data policies for research. However, the role that health services and policy researchers take may be less clear when their values are embedded "in the choice of question to study, the mode of study, and in the inferential gap between findings and conclusions reached" (Gluckman et al. 2021: 2). Put another way, the act of studying an intervention or policy approach because of its potential benefits or harms is unavoidably a value-laden decision regardless of whether the researchers involved in the work identify themselves as issue advocates for the object of their study. Furthermore, as Oliver and Cairney note, in order to have an impact, scientists may need to "engage with policymakers to such an extent that the division between honest broker and issue advocate become blurry" (Oliver and Cairney 2019: 6).

Notwithstanding strong incentives for academic researchers to work closely with policy makers in order to have an impact, including some research funder requirements (e.g., see Academy Health n.d.; CIHR 2023, 2024), the literature identifies potential negative consequences of the practice. Possible consequences include threats to researcher identity and autonomy (Boaz et al. 2021; Chubb and Reed 2018; Henkel 2005); insufficient yield from extensive researcher time invested in developing and maintaining relationships with policy makers (Oliver and Cairney 2019); emphasis on short-term, smaller, responsive research projects over the larger and longer-term pursuit of generalizable knowledge (McGrail et al. 2022); research evidence being used selectively and inappropriately by policy makers to add legitimacy to a policy position (Innvaer et al. 2002; Oliver and Cairney 2019); reputational damage and questions about researcher bias, independence and credibility (Oliver et al. 2019); and the politicization of research (Douglas 2015; Pielke 2007).

In practice, negative perceptions about advocacy may influence with whom peer researchers collaborate and with whom policy makers choose to work. For example, a policy maker may be hesitant to work with a researcher who previously worked on initiatives closely associated with one policy or political position. Given the potential ramifications of the roles that researchers take, we designed a study to explore whether there is consistency in the perception of specific activities of health services and policy researchers on a spectrum from objective advice to advocacy.

Twenty-two reactions to a five-part fictional scenario

We developed a five-part fictional scenario in which a researcher has increasing involvement with the ministry of health (MOH) and used it as the basis for a 45-minute real-time qualitative study at the Canadian Health Services and Policy Research Conference (CAHSPR) in May 2018 (University of Toronto Human Research Ethics Board Protocol 00035941). We began our CAHSPR session with brief oral presentations about the multiple expectations of applied health researchers, noting how this can lead to researchers being drawn into advocacy-like activities. "Advice" was defined as a "recommendation regarding a decision or course of conduct" and "advocacy" as "the act or process of supporting a cause or proposal" based on dictionary definitions (Merriam Webster n.d.). After participants provided informed consent via live electronic polling, we collected participant responses to the five parts of our scenario, which, in abbreviated form, were as follows:

- *Part 1*: A fictional researcher presents preliminary findings from a study of an intervention the researcher's team developed to improve the coordination of care for rural residents with multiple chronic conditions to MOH representatives, including an assistant deputy minister (ADM).
- *Part 2*: At the ADM's request, the researcher prepares a revised diabetes-focused version of their intervention.
- *Part 3*: In response to the ADM's request, the researcher provides information about the anticipated strengths and weaknesses of the diabetes-focused version of their intervention compared with an alternative US-based diabetes intervention that the MOH is considering.
- *Part 4*: The researcher conducts a pragmatic trial of the diabetes-focused version of their intervention with MOH funding, then joins the ADM in presenting the findings to the deputy minister and other MOH senior officials to help the ministry make an informed choice between implementing the diabetes-focused intervention at scale or a program aimed at increasing childhood vaccinations in hard-to-reach sub-populations.
- *Part 5*: The MOH chooses to implement the diabetes-focused version of the researcher's intervention across rural Ontario, and at the MOH's request, the researcher agrees to lead the evaluation of the implementation.

Participants used anonymous live polling to record their perceptions of the researcher's activities at each part of the five-part scenario using a 6-point Likert scale from "Completely, or almost completely, objective ADVICE" to "Completely, or almost completely, ADVOCACY" and provided open text comments with their reasons (see Table 1 noting that participants are numbered in order of increasing perception of advocacy). Participants' responses and the information provided to participants, including more detailed descriptions of each part of the scenario, are available in Appendix 1, available online at longwoods.com/content/27519.

Overall, participants perceived a shift toward increased advocacy as the five-part scenario unfolded, that is, as there was greater involvement of the researcher with the MOH policy process, there was, in general, greater likelihood of perceiving advocacy. At the same time, there was variation in participants' views about what constituted objective advice or advocacy. Individual results were highly variable, with 14 of the 22 participants entering responses that did not show a consistent trend toward perceiving increasing advocacy while often identifying different parts of the scenario as having the highest perceived advocacy and for different reasons. For example, participant 3 perceived the presentation of preliminary findings to the MOH in part 1 as "Completely, or almost completely, objective ADVICE" while participant 22 perceived the same activity as "Completely, or almost completely, ADVOCACY."

Some participants emphasized that the MOH, not the researcher, was not acting objectively. For instance, for part 2, participant 8 commented, "This feels like ministry advocacy not researcher advocacy." Most participants seemed to draw the line between objective advice and advocacy based on whether there was potential for conflict of interest for the researcher,

TABLE 1. Participants' perceptions of whether a researcher's activities constitute objective advice or advocacy in a five-part fictional scenario

Participant	Part 1 Researcher presents preliminary findings from their chronic disease intervention to MOH	Part 2 Develops diabetes-focused version of intervention at MOH's request	Part 3 Compares their diabetes intervention to US-based alternative at MOH request	Part 4 Conducts MOH-funded trial of their diabetes intervention; compares benefits to childhood vaccination	Part 5 Agrees to lead and evaluate large-scale implementation of diabetes intervention
1	1	1	2	3	NO RESPONSE
2	1	2	3	3	3
3	1	2	6	4	4
4	1	4	5	6	4
5	2	2	4	3	4
6	2	2	4	4	3
7	2	3	2	2	1
8	2	3	4	4	5
9	2	3	4	4	5
10	2	3	4	6	6
11	2	4	4	4	4
12	2	4	5	NO RESPONSE	6
13	2	NO RESPONSE	4	5	6
14	3	1	4	4	4
15	3	1	6	6	2
16	3	2	4	4	4
17	3	2	4	4	NO RESPONSE
18	4	2	NO RESPONSE	3	6
19	4	3	6	6	6
20	4	3	6	6	6
21	4	6	3	6	6
22	6	2	1	3	3
Total ≤ 3	17	17	5	6	5
Total ≥ 4	5	4	16	15	15

1	Completely, or almost completely, objective ADVICE
2	Mostly objective ADVICE
3	More objective ADVICE than advocacy
4	More ADVOCACY than objective advice
5	Mostly ADVOCACY
6	Completely, or almost completely, ADVOCACY

MOH = ministry of health.

particularly in part 3 of the fictional scenario where the fictional researcher compares their own intervention to another intervention being considered by the MOH. Participant 16 expressed this sentiment as "Researcher is naturally inclined to work in self-interest because of funding. Scenario also speaks to need for ministry knowledge users to know how to handle these relations with researchers."

This study has some limitations. There were a small number of participants, and even if more people had participated, the results from a convenience sample of policy conference attendees may differ from those if other participants were engaged (e.g., researchers and policy makers who did not attend the conference). Furthermore, some consented participants had technical difficulties that prevented them from responding to all questions, and we could not collect reliable data about participants' roles (i.e., researcher, trainee, patient, policy maker or decision maker). Even so, we do think the study findings have important implications.

Mitigating risks

Foremost, the study findings show that common health services and policy researcher activities, such as sharing preliminary results with policy makers, may be perceived as advocacy. In the context of guidance that recommends health researchers work with policy makers and decision makers to achieve impact (Cairney and Oliver 2017; CIHR 2015; Evans and Cvitanovic 2018; Oliver et al. 2022) and research funding competitions that require deep involvement of knowledge users in research (e.g., see Academy Health n.d.; CIHR 2023, 2024), it would be very hard for any health services and policy researcher to completely avoid advocacy-like activities. Accordingly, researchers and policy makers may want to mitigate risks.

In our view, mitigation starts with awareness. Consistent with Cairney and Oliver's guidance, health services and policy researchers need to "recognize that their decisions about how far they will go to influence policy are value-driven and political, not just 'evidence-based', choices" (Cairney and Oliver 2017: 1) and be transparent about the fact that they are not disinterested parties when it comes to the policy options and interventions that they develop or co-develop (Oliver et al. 2019). Transparency could be aided by researcher positionality statements, both at the start of presentations to policy makers and in publications (Jafar 2018). Fulsome positionality statements that describe a researcher's relationship to their chosen research topics – for example, if they have advocated for specific policies or have focused their careers on specific approaches – could help peer researchers and policy makers understand the nature of the space that a researcher usually operates within, and potential limits to the researcher's objectivity, thus decreasing the likelihood that a researcher will be negatively perceived as what Pielke terms a "stealth issue advocate" (Pielke 2015).

However, while positionality statements may serve to identify potential researcher conflicts of interests, they do not mitigate the real risk of conflict of interest where it exists, such as when a researcher is asked to advise about an intervention or policy that they have a strong interest in (e.g., see parts 3, 4, and 5 of the fictional scenario). In such cases, we suggest that risks could be mitigated by involving people who do not have personal stakes in the decisions under consideration, for example, by having independent scientific advisors or a steering committee provide impartial strategic advice and recommendations. Notably, this would be aligned with Pielke's recommendation that science arbitration and honest brokering of policy alternatives are best done by committee, ideally, by legitimate, authoritative bodies that are well-connected to policy makers (Pielke 2015).

Conclusions

Multiple factors naturally lead health services and policy researchers to undertake activities that are likely to be perceived as advocacy, at least by some people. The findings from our study can help health services and policy researchers and policy makers understand that some common activities in health services and policy research may be perceived as advocacy and reflect on where their own activities fall in the spectrum of advice to advocacy. Researchers should be aware that they may be perceived as issue advocates, even when their aim is to provide objective advice. Awareness, combined with transparency, for example, through researcher positionality statements, and good research governance practices, may help mitigate negative risks when researchers work closely with policy makers.

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Commentary: Risk and Causality: The Contribution of Policy Researchers to Public Decisions

Commentaire : Risque et causalité : l'apport des chercheurs aux décisions publiques

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Introduction

In his introduction to the translation into French of Max Weber's famous conferences on science and politics, Raymond Aron makes the insightful suggestion that public decisions must start with two distinct *conjectures* (Aron 1963: 11). One concerns the risks arising from policy action, or inaction, in a situation or context that is always unique and peculiar, and the other, the uncertainty attached to the results of the action. Greatly simplified, because a decision is rarely made by only one person, outside an institution and the constraints that follow, a decision maker's first order of business is to consider the many consequences that may stem from intervening (or not) to change a situation or solve a problem (Tong 1987). In parallel, the decision maker will want evidence that the measures that are considered can succeed, based on experience or by default, on some plausible "theory" of social action (Edenhofer and Kowarsch 2019).

Encounters

The paper by Paprica, Wodchis and McGrail (Paprica et al. 2025) focuses on the sort of encounters between researchers and decision makers in which policy action is considered and decided. The scenario of the virtual experiment that is reported is plausible. Most of the interactions depicted in the story are, in effect, centred around the second of the two conjectures postulated by Aron – the arguments used to promote the (fictional) researcher's intervention are based on an explicit causal model, which emphasizes dimensions such as experience, impact and predictability. Aron's first conjecture, the one associated with the appreciation of risks and consequences, is also referred to more briefly in part 4 of the scenario, in which we are made to understand that the senior decision maker (a fictional deputy minister) had to arbitrate between two possible yet exclusive programs, aimed at distinct health issues. The main features of the story are coherent with the notion that intense policy activity took place upstream, and that the decision framework is largely settled at the time of the exchanges. Such meetings happen all the time, with a few significant variations but, quite evidently, many inflections, depending on the topic and the number and level of players.

The encounters that are described in the paper are mostly working meetings with mid-level bureaucrats. It is a fact that encounters between experts and *senior* decision makers (those with the actual responsibility to do something about something and facing consequences in case of failure) are sparse and fewer, despite sincere efforts on the part of both groups. The reasons for this situation are well known: busy schedules, social and geographical distance, diverging time horizons, differences in language and, of course, as underlined by our authors, dissonant political and ideological agendas.

To be honest, however, tangible benefits to participants are probably somewhat limited, aside from some symbolic outcomes consequential to the aura that emanates from esoteric scientific activities (quantum computing someone?) or reciprocally, from political activities shrouded in secrecy. It is unusual for individuals from the wider research community to be associated with core policy tasks such as the weighting of risks conducted by political or bureaucratic leaders, with its many nuances and aspects. This would require a panoramic vision of social and economic factors that is often lacking in subject specialists. Moreover, as John W. Kingdon showed a long time ago, political systems tend to segregate "problem" and "solution" experts, which complicates their involvement in conversations regarding probable causes and possible solutions to public issues (Kingdon 2011). To put things differently, and as we see in the paper, researchers' engagement usually comes late in the policy process and happens mostly when decisions have passed the framing stage on elements such as aims, means and resources.

A Case of Severance

One issue with the paper, however, is that it is written primarily from the perspective of the expert, with her or his interest in mind. Involvement must be a precursor to influence. Advice is a prelude to action. Decision is a synonym of validation. In fact, what truly bothers Paprica and her colleagues is the interference of advocacy in these processes, which, otherwise, our authors seem to approve and support (Paprica et al. 2025). Their goal is to have more decisions based on (or informed by) sound research and valid results, and therefore, more fruitful interactions between academic experts and political or bureaucratic actors. They would like open exchanges to happen and are convinced that ideology and hidden agendas constitute a major obstacle to most kinds of productive outcomes. Those researchers who only seek specific policy decisions from governments, leading decision makers to dismiss their advice beforehand, put the full system at risk (Doremus 2006).

At first, following Roger Pielke Jr. (2007) and his large cohort of epigones, who use the term and concept of "honest broker" as if advocacy were just a moral issue that could be resolved with a behaviour change, the paper takes a normative perspective. Similar to the characters in the series *Severance*, waiting for their personal and professional memories to be surgically divided, researchers are expected to leave their convictions at the door and to adopt (or fake?) a posture of objectivity and neutrality for the duration of their interaction with decision makers. Fortunately, in their conclusion, the authors abandon this absurd position and present a solution based on a broader combination of institutional and functional criteria, which may improve the situation.

A Thought Experiment

If only as a thought experiment, imagine now what the scenario presented in the paper looks like from the perspective of those in charge of the decision. As we suggested previously, the three or four substantive interactions between the researchers and the bureaucrats that are described in the scenario are only a small portion of the policy process. An assessment of government priorities from multiple angles was surely conducted already, and the allocation of marginal dollars to a new health program ought to be the product of a complex appreciation of social, economic and political risks. It is highly probable that these two processes were informed by factors such as public opinion polling, platform commitments, lobbies and policy campaigns, without mentioning fiscal constraints and election cycles. Political advisors have been whispering in the minister's ear. Think tanks of all sorts have made proposals. In this real world, it would then be very unlikely that the choice between diabetes and childhood vaccination proposed in the scenario is the mere product of competing health researchers' representations. It is also very unlikely that ideology would play a large role in the final decision, positive or negative, as most filters have already played their part.

Morris Rosenberg had a distinguished career as a deputy minister with federal departments such as Justice, Health or Global Affairs. His advice to young policy staffers was simple but enlightening.[1] The government dislikes hearing about problems without hearing about solutions at the same time – do not bring an issue forward before you have an idea about how to solve it. To build support for the initiative beyond the ranks of the converted, solutions must (also) come with quick results and not only promises of impact in the long term. Results must translate into tangible gains for our political masters, because in a democracy, their support is a necessary condition for action. Finally, though it was the most difficult to accept, some problems take care of themselves; prudence and patience are policy virtues.

There are few studies that look at the questions raised by Paprica and colleagues from the perspective of the Rosenbergs of the world. It is not a new problem. In 1646, in one of his letters to Princess Elisabeth of Bohemia, René Descartes stated that "the principal motives and actions of princes are often such particular circumstances that one can imagine them only if one is a prince oneself, or perhaps if one has been party to their secrets for a very long time" (Pellegrin and Raymond 2024: 227–46; Princess Elisabeth of Bohemia and Descartes 2007: 143). It is not so much that the world of decision makers is opaque than the fact that it would require a distinct *anthropology* to elucidate how public decisions are "constructed" – more or less along the lines of Latour and Woolgar (1986) in their famous study of laboratory *strangeness*. When working beside Morris Rosenberg, we did not have issues with the few advocates who had worked their way through the bureaucracy up to the deputy, but with willing contributors struggling with the decision making process and underwhelmed by our pedestrian questions and our objections.

To go back to Max Weber and his vision of the science and politics dyad, the policy world has room for advocates guided by an "ethic of ultimate ends" (Gerth and Mills 1946: 115 et. sq.). Most of them, however, will be politicians, dedicated lobbyists or professional "public intellectuals" such as columnists and influencers. The process leaves limited space for academic improvisers, who may or may not be perceived as the unwanted intruders portrayed in the paper but without much impact. All the other players are expected to follow the norms suggested by the "ethic of responsibility," with its focus on perspective and consequences. If one wants to join the policy conversation, there is no need to worry so much about "transparency and (value) awareness." It is essential, however, to be prepared to contribute to the definition of the problem, considering as many dimensions as possibly relevant in that context, and to provide options for solving it, with some probability of success.

Note

1. What follows is a coarse attempt to synthesize many private discussions. Morris's thinking was (and still is) way more subtle and its expression, more elegant. I hope he will forgive me, as he had so often when I was learning the trade under his wing.

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DATA MATTERS

What Explains Interprovincial Differences in the Uptake of Autonomous NP Primary Care Practice?

Qu'est-ce qui explique les différences interprovinciales dans l'adoption de la pratique autonome des IP en soins primaires?

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Abstract

This paper examines trends in the evolution of the primary care nurse practitioner (NP) workforce in Canada. Specifically, it focuses on two linear regression models. One, unsurprisingly, shows that the number of NPs per capita is positively correlated with the proportion of people declaring having an NP as their regular provider. The second shows that the proportion of patients without a regular provider in a province is very strongly correlated with the proportion of people declaring having an NP as their regular provider. In our view, this analysis supports the hypothesis that NPs are granted more autonomy only when access to care becomes critically constrained.

Résumé

Cet article examine les tendances de l'évolution de la main-d'œuvre des infirmières praticiennes (IP) en soins primaires au Canada. Plus précisément, il se penche sur deux modèles de régression linéaire. Le premier montre, sans surprise, que le nombre d'IP par habitant est positivement corrélé à la proportion de personnes déclarant avoir une IP comme fournisseur de soins régulier. Le second montre que la proportion de patients sans fournisseur de soins primaires dans une province est très fortement corrélée à la proportion de personnes déclarant avoir une IP comme fournisseur régulier. À notre avis, cette analyse appuie l'hypothèse selon laquelle les IP obtiennent une plus grande autonomie seulement lorsque l'accès aux soins est sérieusement compromis.

Introduction

The Canadian Institute for Health Information (CIHI) recently released data on the proportion of Canadians reporting having a regular healthcare provider. The data reveal a notable decline – from 88% in 2019–2021 (CIHI 2023b) to 83% in 2023 (CIHI 2024). The decrease is particularly concerning given the significant federal and provincial investments made during that period to improve accessibility and continuity of care, including efforts to train and retain more healthcare professionals.

In this context, we want to focus on the role of nurse practitioner (NP). NPs are the fastest-growing group of healthcare professionals in Canada (CIHI 2023a). An increased reliance on NPs has also often been put forward as having the potential to trigger a broader transformation of primary care delivery models (Contandriopoulos et al. 2016). In Canada, NPs work within a variety of primary care delivery models. Almost all these models are interprofessional, and most (but not all) include physicians. In this paper, we use the term "autonomous NP practice" to describe models where the NPs' role is defined in a manner that enables them to serve as the main primary care provider for the patients they follow. The article uses linear regression to analyze the interprovincial variations in primary care NP uptake and discusses potential explanations as well as their policy implications.

Data and Methods

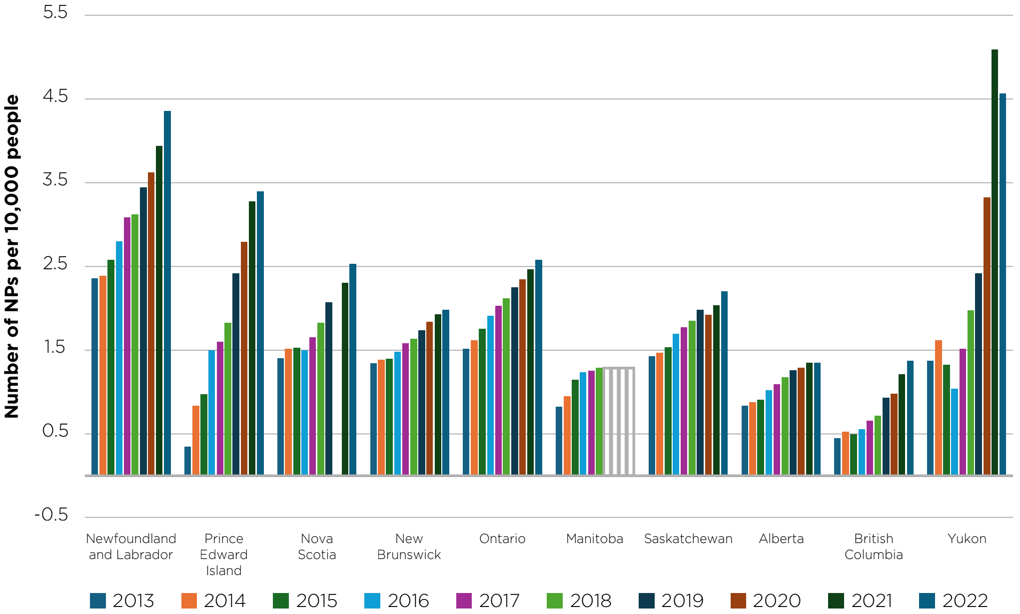
This analysis draws on publicly available CIHI data and did not require ethics approval. Data on the number of NPs from 2013 to 2022 were extracted from CIHI's "Health Workforce in Canada, 2022 – Quick Stats" (updated June 2024) (CIHI 2024). Missing data for Manitoba were estimated using linear trends from previous years. Population figures for calculating the ratio of NP per 10,000 people were obtained from the "National Health Expenditure Trends, 2023 Data Tables" (CIHI 2024c). Data on regular healthcare provider access and the professional background of those providers were sourced from CIHI's "Canadians With a Regular Health Provider, 2023 – Data Tables," (CIHI 2024b), which are derived from Statistics Canada's Canadian Community Health Survey. The analysis only includes provinces and territories for which data were available from all sources, namely, all provinces except Quebec and only Yukon among the territories. Analyses were conducted in Microsoft Excel.

Analysis

In the jurisdictions analyzed here, the NP workforce grew by over 8% annually (approximately 360 new NPs per year) from 2013 to 2022. As the number of NPs grew at a much faster pace than the population, the number of NPs per capita also grew significantly. The average annual growth rate of the number of NPs per capita was 6.7% and almost perfectly linear ($R^2 = 0.99$).

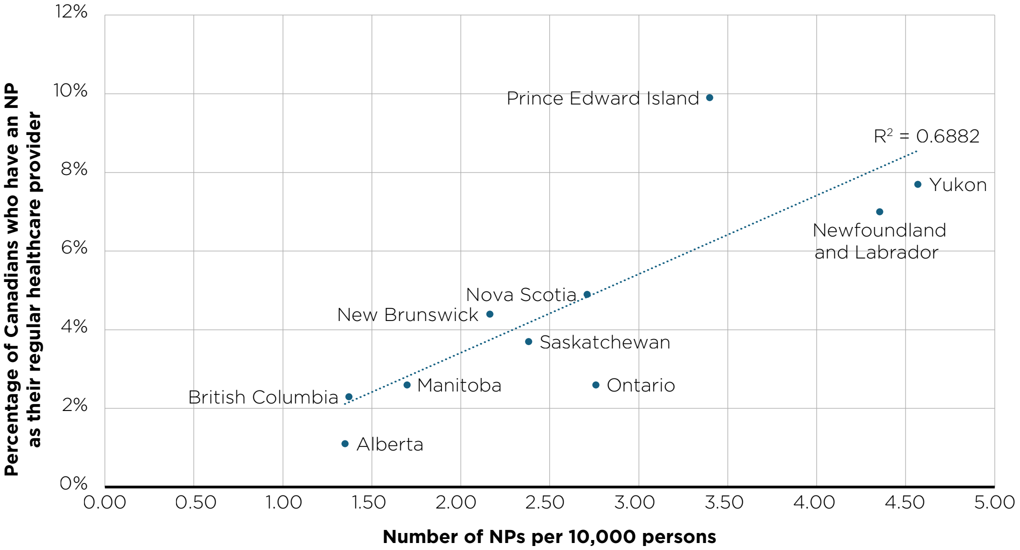
However, as Figure 1 shows, while all provinces and territories are investing significantly in their NP workforce, the number of NPs per capita and its growth rate vary widely across jurisdictions.

FIGURE 1. Number of NPs per 10,000 people (2013–2022)



Unsurprisingly, a strong correlation exists between the number of NPs per capita in 2022 and the proportion of residents reporting an NP as their regular healthcare provider in 2023 ($R^2 = 0.69$, $p = 0.003$; Figure 2). It is also interesting to have a look at the way each jurisdiction is positioned in relation to the regression line in Figure 2. Some provinces manage to have a higher proportion of their population declaring having an NP as their regular healthcare provider than it would have been expected given the size of their NP workforce. In other words, more people are cared for by NPs than one would expect given the number of NPs working in that jurisdiction. Prince Edward Island is the clearest example of such a deviation. Other provinces, such as Alberta and Ontario, are at the other end of the spectrum, having less people declaring having an NP as their regular healthcare provider than what could have been expected given their NP workforce.

FIGURE 2. Proportion of Canadians who have an NP as their regular healthcare provider (2023) as a function of the number of NPs per capita (2022)

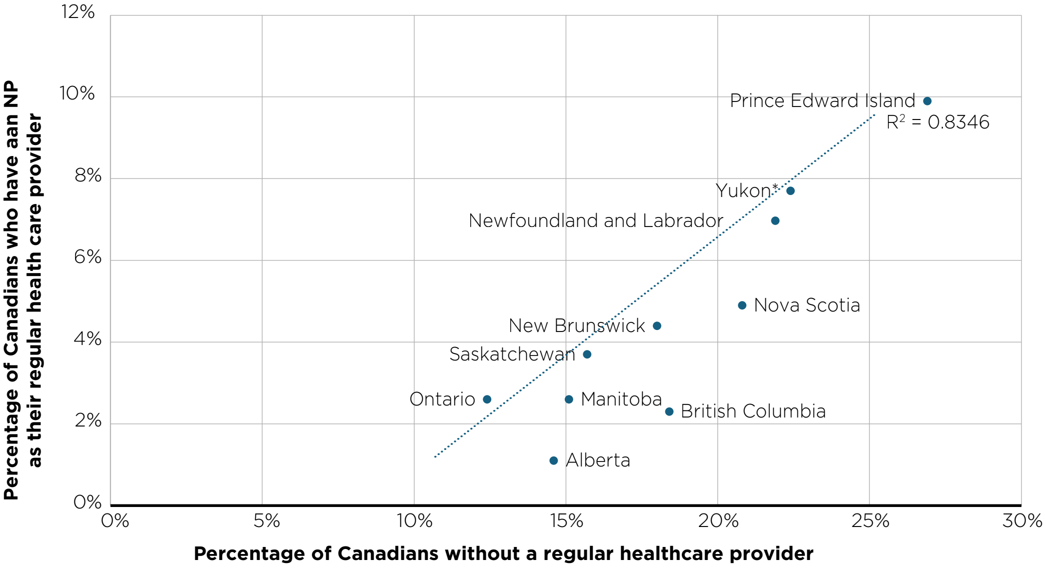


There is also a very strong correlation ($R^2 = 0.83$, $p < 0.000$) between the proportion of Canadians who declare not having a regular healthcare provider and the proportion declaring to have an NP as their regular healthcare provider (Figure 3). Otherwise said, there is a direct relation between how many people are left without a regular provider and the level of reliance on NPs as regular providers. This relationship becomes even stronger ($R^2 = 0.96$, $p < 0.000$) if data from the Northwest Territories and Nunavut are included.

Again, it is interesting to analyze how individual jurisdictions are positioned in relation to the regression line. Some provinces, such as British Columbia, rely less on NPs than expected given the number of residents without a primary care provider, while others, such as Ontario, rely more heavily on NPs than predicted.

While regression analyses cannot provide insights on causation, we would like to venture the hypothesis that jurisdictions with the poorest access to primary care are also the most motivated to implement primary care models that support autonomous NP practice. As the number of patients without a regular provider and unmet needs rise, barriers to autonomous NP practice seem to melt away. To be fair, critics might also argue that increased NP reliance reduces accessibility and continuity for all patients – a perspective akin to claiming, for example, that Japan's higher investment in earthquake preparedness somehow causes more seismic activity.

FIGURE 3. Proportion of Canadians who have an NP as their regular healthcare provider as a function of the proportion of Canadians who do not have a regular healthcare provider



Conclusion and Policy Implications

This analysis has two key policy implications. First, it supports the hypothesis that NPs are granted more autonomy only when access to care becomes critically constrained. In this perspective, more attention should be given to provinces where NP reliance is markedly lower than anticipated. For example, British Columbia, Alberta and Nova Scotia have higher proportions of the population without regular providers, yet the level of reliance on autonomous NP practice is lower than expected in those provinces. Could there be a stronger influence of medical associations in these regions, or are there other factors at play?

Second, we would like to mention that regression coefficients of determinations as high as those found here are quite unusual to encounter in the wild. While we cannot affirm that the number of patients without a regular provider and level of unmet needs really are the explanatory factor behind interprovincial variations in the uptake of autonomous NP practice, we believe that the data make this a robust hypothesis to explore. Ultimately, citizens deserve timely policy action to prevent crises rather than relying on them to drive change.

This leads us to our final point. In an effort to curb the growth of NPs privately billing patients, the federal government recently clarified that the *Canada Health Act* (1985) applies to primary care services, regardless of the type of professional delivering them (Health Canada 2025). While it remains to be seen how this clarification will influence the dominant model of NP practice, the data analyzed here suggest that empowering NPs to work autonomously holds greater potential than restricting them to support roles.

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RESEARCH PAPER

Conceiving Policy Design: Perspectives From Women Pursuing IVF in British Columbia

Conception de politiques : point de vue des femmes qui ont recours à la FIV en Colombie-Britannique

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Abstract

People experiencing infertility often face challenges accessing treatment, such as in vitro fertilization (IVF), especially in contexts where treatments are not funded by government or public health insurance plans. Using an original survey, this paper examines barriers to accessing IVF in British Columbia (BC), a province that recently announced that it would start funding IVF, beginning in fiscal year 2025/26. The survey findings highlight the financial, geographic and personal barriers that limit access to treatment. BC's new publicly funded IVF program should address patient challenges related to upfront costs, regional variation in the unaffordability of treatment and existing research related to embryo transfer limits in other provinces.

Résumé

Les personnes souffrant d'infertilité ont souvent du mal à accéder aux traitements comme la fécondation in vitro (FIV), en particulier là où les traitements ne sont pas financés par le gouvernement ou par les régimes publics d'assurance maladie. À l'aide d'un sondage original, ce document examine les obstacles à l'accès à la FIV en Colombie-Britannique (C.-B.), une province qui a récemment annoncé qu'elle commencerait à financer la FIV à partir d'avril 2025. Les résultats de l'enquête mettent en évidence les obstacles financiers, géographiques et personnels qui limitent l'accès au traitement. Le nouveau programme de FIV financé par les deniers publics de la C.-B. devrait répondre aux défis que rencontrent les patients en matière de coûts initiaux, de variation régionale du caractère inabordable du traitement et de recherches existantes liées aux limites de transfert d'embryons dans d'autres provinces.

Introduction

Canada is experiencing a decrease in its average fertility rate while also seeing increasingly older first-time parents and growing rates of age-related infertility. Alongside these changes, advances in medical technology since the 1980s have made access to fertility treatments a possible solution for those living with infertility. For those living with infertility, in vitro fertilization (IVF) is one such medical intervention that can help make parenthood a reality. This development in reproductive technologies and changing fertility patterns has spurred an increased demand for fertility interventions and services, where IVF pregnancies and births have increased by 20% since 2013 (CARTR-Plus and BORN Ontario 2024). However, the costs of IVF (ranging from $10,000–$20,000 per cycle) can be prohibitive, and as a matter of healthcare, the decision whether to cover the costs of the service falls to individual provinces.

While the federal government provides funding through the Canada Health Transfer (Tiedemann 2019) and requires provinces and territories to uphold the principles of universality, as outlined in the *Canada Health Act* (1984), provinces and territories are empowered to choose what is covered in their health insurance programs and whether they fund health services through other means, as Ontario does with its IVF program that operates outside of the Ontario Health Insurance Plan (Cantor et al. 2023). This results in variation not only in what patients have access to but also in how provinces and territories determine what health policy agendas to adopt and how best to implement them. This process, namely, policy divergence and incoherence in the context of federalism, is well documented in the literature (Béland et al. 2024; Marchildon and Bossert 2018; Palley and Forest 2004). However, there is little research that seeks to understand the actual impacts of policy variation from the perspectives and lived experiences of the users impacted by these differing policy approaches, especially as they relate to healthcare decisions in provinces *without* funding or policy intervention.

While several provinces offer some form of funding for IVF, ranging from funded cycles to tax credits, others provide no public coverage for the treatment (Austin and Apold 2023; Snow 2018). As a result, accessing treatment in provinces without funding coverage can be difficult (Mounce et al. 2022). Barriers to accessing IVF may vary, and understanding what affects the accessibility of IVF can offer insight to provincial policy makers as they continue to develop IVF and other related fertility treatment policies. To this end, this study asks what barriers prevent people in British Columbia (BC) from accessing IVF services and what challenges they face when they do access treatment. The objective of this paper is to highlight the challenges faced by those experiencing infertility in BC at a time when the province was not yet funding IVF or other fertility treatments. BC has recently announced that it would begin funding "one cycle of IVF for eligible B.C. residents" in the 2025–26 fiscal year. As the policy is still being developed, understanding the barriers that have limited access to those experiencing infertility can support improved policy design while encouraging policy makers to account for variable barriers across different regions in the province.

Methods

Study design

To study the barriers that affect people in BC trying to access IVF services, this study includes an anonymous, online survey of more than 200 self-identified women engaged with either fertility clinics or online support groups for those experiencing infertility. The themes and design of the survey are informed by a preliminary literature review where both academic literature and clinical reports inform survey questions and capture considerations for policy design, such as access, barriers, outcomes and demographics with the goal of better understanding the lived experience of those seeking IVF. The survey is designed to identify demographic trends, variable barriers to access, average costs to patients, presence of insurance coverage, regional gaps in access, etc. Furthermore, the survey includes questions related to patterns in embryo transfers and multiple births to provide policy makers with the experience of those who have been able to access IVF in BC ahead of the funding rollout in 2025. Participants were asked a total of 28 questions (Appendix A, available online at longwoods.com/content/27545) with the option to provide open-ended text responses to allow respondents to identify barriers or policy considerations not otherwise raised throughout the survey. In order to ascertain specific answers from those participants who have *not* undergone IVF, compared with those who *have* undergone the process or who may have been undergoing IVF while participating, a skip logic function is used, meaning that depending on a respondent's answer, they were redirected to specific questions.

Recruitment

Survey participants include self-identified women in BC experiencing infertility who are pursuing IVF and those who are not able to pursue it due to barriers. To ensure regional representation, the survey was distributed in partnership with three fertility clinics across the province, including in areas without IVF clinics, such as Northern BC. The clinics displayed the recruitment poster (Appendix B, available online at longwoods.com/content/27545), which featured a QR code, in their offices and waiting rooms, allowing clients/patients to complete the survey while accessing these services. Recruitment was also done in partnership with two BC-specific fertility support groups on Facebook with permission from the groups' moderators. One of the groups had upwards of 900 members while the other had just under 300 members. Lastly, several fertility coaches posted the recruitment poster to their web pages and social media platforms, including Facebook and Instagram.

DATA COLLECTION AND ANALYSIS

The data were captured via SurveyMonkey, an online survey platform, in the winter of 2020. The survey was open for approximately two months. Data were analyzed using descriptive analysis in Excel to capture trends and create data visualizations. In addition to the multiple-choice survey questions, qualitative responses were captured via a single open-ended question: "Should you wish to expand on any responses or general themes as they relate to this survey, please do so in the text box below". These responses, of which there are more than 100 across subgroups, were coded manually via the constant comparison method (Strauss and Corbin 1990) for thematic analysis to capture similar responses and better understand access barriers and perceived policy preferences among survey participants.

Results

Sample description

While 253 respondents accessed and consented to the survey, only 203 completed it in its entirety, including all demographical questions. Given the importance of understanding demographical trends and how access to IVF varies by socio-economic status, region, marital status, etc., only complete surveys are included in the analysis, resulting in a sample of 203. Table 1 highlights respondents' socio-demographic characteristics and their general experience with IVF and infertility.

Respondents who have not undergone IVF

Examining the 42 respondents who have not yet undergone IVF reveals key access barriers for policy makers to consider. First, regional variation exacerbates the inaccessibility of IVF; of all respondents from the Thompson-Okanagan region, 37% indicated having not undergone IVF, with all of these respondents indicating that it was due to cost and geographical constraints. Similarly, 32% of Northern BC respondents indicated not having undergone IVF. These figures for these two regions exceed both the sample average of 21% and the Lower Mainland respondents' figure of only 14%.

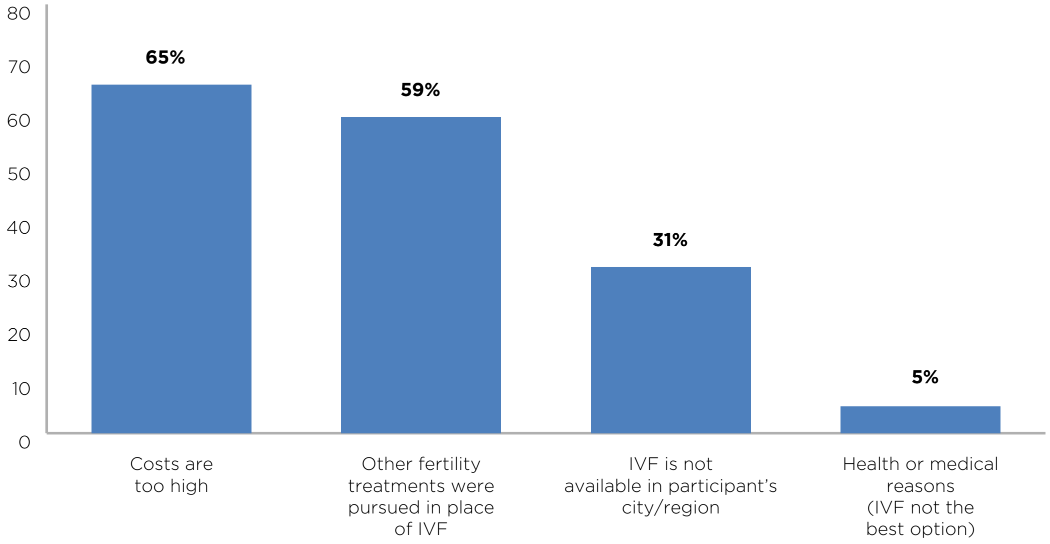
Beyond geographical barriers, the reasons for respondents not pursuing IVF point to important policy considerations around patient costs and what the impact of alternative funding options may hold. For instance, of all respondents unable to pursue IVF, 79% indicated that if the service were publicly funded, they would have undergone the procedure. When asked to indicate all reasons for not undergoing IVF, meaning participants could select more than one answer, 64% of respondents indicated that the costs were too high, while 31% indicated that IVF is not offered in their city or region (Figure 1).[1]

Participants who indicated having not undergone IVF are also provided with the opportunity to expand on what factors limit access and how policy might address these gaps. The qualitative results also demonstrate that, beyond costs being a determining factor in not pursuing treatment, they also impact a respondent's decision to pursue other medical interventions. As demonstrated by the respondent quotes below, the financial aspects of IVF can push patients to alternative treatments, such as intrauterine insemination (IUI), with the view being that it is less effective. This has important implications not only for patient autonomy but also because the pursuit of less effective treatment may result in even older patients requiring assisted reproductive technology, having not had a pregnancy through initial, less expensive interventions.

TABLE 1. Characteristics of survey participants

Sample description	All respondents (*n* = 203)
IVF access	• 57% (116 respondents) have previously undergone IVF • 22% (45 respondents) are currently pursuing IVF • 21% (42 respondents) have not undergone IVF
Infertility	• 85% (173 respondents) indicated experiencing medical infertility. Note that "Other" responses describing unexplained infertility or medical conditions or treatments related to infertility such as polycystic ovary syndrome, chemotherapy or recurrent miscarriages were included in the count for medical infertility. • 4% (8 respondents) indicated experiencing "circumstantial" or "social" infertility • 6% (12 respondents) indicated experiencing both medical and "circumstantial" or "social" infertility • 5% (10 respondents) indicated not experiencing any type of infertility
Age groups of participants	• 2% (4 respondents) are between the ages of 18 and 24 years • 11% (22 respondents) are between the ages of 25 and 29 years • 24% (49 respondents) are between the ages of 30 and 34 years • 41% (83 respondents) are between the ages of 35 and 39 years • 14% (28 respondents) are between the ages of 40 and 44 years • 8% (16 respondents) are 45 years of age or older
Combined household income	• 1% (2 respondents) earn less than $30,000 • 5% (10 respondents) earn between $30,000 and $59,999 • 14% (29 respondents) earn between $60,000 and $89,999 • 25% (51 respondents) earn between $90,000 and $114,999 • 27% (55 respondents) earn between $115,000 and $149,999 • 19% (39 respondents) earn between $150,000 and $199,999 • 9% (18 respondents) earn $200,000 or more
Education	• 3% (6 respondents) hold a high school education or less • 28% (57 respondents) hold a college or trade diploma/certificate • 34% (69 respondents) hold a bachelor's degree • 31% (63 respondents) hold a master's degree • 4% (8 respondents) hold a doctorate's degree
Employment	• 10% (20 respondents) indicated not being employed • 15% (30 respondents) indicated being employed part-time • 75% (152 respondents) indicated being employed full-time
Partnership status	• 4% (8 respondents) indicated being single or separated • 96% (195 respondents) indicated being married or in a domestic/common-law partnership. Of these, 97% indicated being in a heterosexual partnership compared with only 3% who identify as being in a female-female same-sex partnership.
Community type	• 48% (97 respondents) indicated living in urban areas • 38% (77 respondents) indicated living in suburban areas • 14% (28 respondents) indicated living in rural areas
Regional representation	• 6% (21 respondents) indicated living on Vancouver Island or the coast • 63% (128 respondents) indicated living in the Lower Mainland/Southwest • 13% (26 respondents) indicated living in the Thompson-Okanagan • 3% (6 respondents) indicated living in the Kootenays • 15% (30 respondents) indicated living in Northern BC

FIGURE 1. Reasons for not pursuing IVF (*n* = 42) (respondents select all that apply)



IVF = in vitro fertilization.

> We are pursuing IUI before IVF because it [IVF] is too expensive even though it's more successful.
>
> I have stage two endometriosis and my partner has Male Factor Infertility. We have been recommended to pursue IVF + ICSI but the base cost is $8,500 plus medications, and we don't have that amount saved up … We have been devastated by our diagnoses and the lack of funding for medical treatment.

Respondents Pursuing IVF or Who Previously Underwent IVF

The 161 respondents who either previously underwent IVF or who are pursuing IVF were asked about access and, similar to the challenges that restrict access for those who have not pursued IVF, 81% of respondents indicated experiencing financial barriers. This is also reflected in participants' reported total costs of IVF, with nearly 40% of respondents having spent upward of $28,000, some of whom indicated spending up to $150,000–$200,000. It may be the case that for these extremely high-cost figures, some patients may be including associated expenses such as egg freezing, egg or sperm donations, surrogacy, etc. Furthermore, 63% of these respondents indicated that they would have undergone additional cycles if IVF was publicly funded. A summary of findings for this group of respondents can be found in Table 2.

With minimal insurance coverage available for treatment, as noted in the survey responses, these costs have important implications not only for those who cannot afford IVF but also for how those who can afford it choose to pay for it. Beyond the sheer cost of

TABLE 2. Findings for those who have undergone or who are pursuing IVF

Sample description	Respondents pursuing or who have undergone IVF (*n* = 161)
Reported costs for IVF	11% (18 respondents) have spent between $7,000 and $13,999 30% (48 respondents) have spent between $14,000 and $20,999 20% (32 respondents) have spent between $21,000 and $27,999 22% (35 respondents) have spent between $28,000 and $49,999 17% (27 respondents) have spent more than $50,000, with some respondents indicating total costs of up to $150,000 and $200,000
Reported insurance coverage for IVF medications	34% (55 respondents) have no insurance coverage for IVF medications 58% (93 respondents) have partial coverage for IVF medications 8% (13 respondents) have full coverage for IVF medications
Reported insurance coverage for IVF	96% (155 respondents) have no insurance coverage for IVF 4% (6 respondents) have partial coverage for IVF
Barriers (respondents select all that apply)	81% (130 respondents) indicated experiencing financial barriers 55% (89 respondents) indicated experiencing emotional barriers 35% (56 respondents) indicated experiencing workplace challenges 25% (40 respondents) indicated experiencing geographical barriers 16% (26 respondents) indicated experiencing health and physical barriers 9% (14 respondents) indicated experiencing no barriers to accessing IVF

IVF = in vitro fertilization.

treatment, respondents also indicated that the associated financial barriers often required them to delay treatment to save, or that they look to other options such as support from parents, remortgaging their homes, lines of credit or online fundraisers such as "GoFundMe" to cover the costs, as evidenced by the qualitative responses below. This raises important questions regarding not only income equity but also what other decisions may be impacted by the high upfront costs of IVF, including whether to pursue other forms of treatment, impacts on other health concerns or whether a patient may have to stop treatment altogether due to costs.

> Due to financial restrictions, we had to wait six years to be able to afford to do the second transfer of our final frozen embryo.
>
> Because of the financial barriers, we tried multiple rounds of IUI before moving to IVF.

While only 25% of respondents in this subgroup indicated geographical barriers, it is noteworthy, though unsurprising, that when isolating for regions, geographical barriers are selected by 96% of Northern BC respondents and 48% of Thompson-Okanagan respondents compared with only 9% of Lower Mainland respondents. As evidenced by the following quotes, the travel time and costs can be burdensome, adding additional barriers to those living in regions without full-service IVF clinics. It is also important to consider the fact that as IVF is not a one-time "procedure," but instead a series of consultations, monitoring appointments, transfers and check-ups, the scheduling challenges can exacerbate geographic barriers.

> No clinics are located in Northern BC, so we had to relocate to Vancouver for two weeks while undergoing stims/retrieval/transfer.
>
> My husband and I can't afford to both travel for the procedure, so I will be going alone.

Looking at outcomes for those respondents who are either pursuing or who have previously pursued IVF, 34% indicated having completed more than two cycles, which includes all retrievals and transfers. When looking more specifically at embryo transfers, we see that experiences vary for those respondents who have undergone different numbers of transfers. For this aspect of the survey, respondents were first asked how many transfers they had undergone, then asked the maximum number of embryos transferred. Of those participants who have only undergone one transfer, 37% indicated having had a multiple embryo transfer during that initial cycle compared with 47% for those who have undergone two transfers (Table 3). Of all 141 respondents who have undergone IVF, only 14% (20 respondents) indicated having given birth to multiples. When looking at these births of multiples among only those 75 respondents who have experienced the birth of one or more babies as a result of IVF, this figure climbs to 28% (Table 3).

TABLE 3. Summary of embryo transfers and birth outcomes for respondents who have undergone at least one IVF cycle

Sample description	Respondents who have undergone IVF (*n* = variable depending on the number of transfers)
IVF outcomes	Of the 141 respondents who have undergone at least one IVF cycle: • 53% (75 respondents) have experienced the birth of one or more babies as a result of IVF • 47% (66 respondents) have not experienced the birth of one or more babies as a result of IVF
Birth outcomes	Of the 75 respondents who have experienced the birth of one or more babies as a result of IVF: • 72% (55 respondents) gave birth to a singleton • 25% (18 respondents) gave birth to twins • 3% (2 respondents) gave birth to triplets
Embryo transfers	Of the 51 respondents who have completed only one embryo transfer: • 59% (30 respondents) had one embryo transferred • 27% (14 respondents) had two embryos transferred • 2% (1 respondent) had three embryos transferred • 8% (4 respondents) had more than three embryos transferred • 4% (2 respondents) did not know how many embryos they had transferred Of the 30 respondents who have undergone two embryo transfers: • 47% (14 respondents) had one embryo transferred during their second transfer • 37% (11 respondents) had two embryos transferred during their second transfer • 12% (4 respondents) had three embryos transferred during their second transfer • 4% (1 respondent) had more than three embryos transferred during their second transfer Of the 69 respondents who have undergone more than two embryo transfers: • 36% (25 respondents) had a maximum of one embryo transferred at one time • 52% (36 respondents) had a maximum of two embryos transferred at one time • 6% (4 respondents) had a maximum of three embryos transferred at one time • 6% (4 respondents) had a maximum of more than three embryos transferred at one time

Discussion

As shown in the survey data, there are significant and inequitable barriers limiting access to IVF in BC. While BC has announced that it intends to launch its program, which will provide funding for one cycle of IVF for eligible BC residents, beginning in the 2025–26 fiscal year, there are ongoing considerations that policy makers should review. In particular, three considerations evidenced in the survey data should be examined in program design: perceptions around infertility as a medical concern and patient perspectives on funding; demographic and equity considerations for accessing IVF; and regulatory considerations as they relate to embryo transfer policies.

Looking first at infertility as a healthcare issue and the associated demand for eligibility, policy makers might consider the medicalization of infertility and the perception of those undergoing IVF. In particular, the thematic analysis reveals a consistent view of infertility being a medical condition with available treatment options. As is, private funding models contribute to the continued financialization of reproductive care and limit access by social status, income, and region and, as some have argued, delegitimize infertility as a *medical* issue worthy of funding (Bell 2016; Jain 2006; Shanley and Asch 2009). While some respondents have the option of pursuing alternative interventions such as IUI, which can be effective for male factor infertility, those experiencing more complex forms of infertility are faced with fewer choices. As such, the cost of IVF can act as a prohibitive barrier for those requiring more specialized treatment, such as intracytoplasmic sperm injection (ICSI), a treatment typically used in association with severe male factor infertility (Khatun et al. 2018).

These financial barriers faced by respondents also differ by region, with housing prices and workplace opportunities effectively preventing those with some types of medical infertility from accessing the necessary treatment or from putting money toward savings or other areas. As such, policy makers might consider funding options that ensure demographical equity. As the purpose of this paper was to identify barriers to accessing IVF, it follows that there are unique barriers to account for within BC. In particular, regional barriers and the challenges of upfront costs are likely to continue barring patients outside of the lower mainland from access. Given the laboratory infrastructure and massive investments required, developing complete IVF services in Northern BC, the Okanagan and the Kootenays remains unlikely and perhaps, unnecessary. Instead, policy makers might consider funding options that facilitate travel to those areas offering IVF. Though BC has recently confirmed that its program will provide funding for one cycle of IVF for eligible residents, policy makers should consider additional funding coverage for those outside of the lower mainland or those in areas without IVF clinics. Otherwise, the program risks continued exclusion based on region and costs associated with travel. Options such as a fertility grant or special assistance fund could alleviate some of the regional barriers while enabling pre-treatment allowances, thereby reducing some of the obstacles associated with the upfront expenses. The strength of this funding model lies in the certainty of costs for the government compared with a rolling fertility program, similar to that seen earlier in Quebec before the province replaced funded cycles with a refundable tax-credit model (Shaulov et al. 2015). Furthermore, the income and regional equity delivered via ex-ante funding coverage coupled with the ease of implementation, as demonstrated by New Brunswick's success with its earlier special assistance fund, is another highlight of this type of funding model.

Finally, beyond considering barriers to accessing IVF and which funding model might best meet budgetary needs, policy makers might consider regulatory reform once IVF is funded by the government. As noted throughout the literature, there are health risks to both pregnancies and births associated with multiples, including premature delivery, jaundice, low birth weight, preeclampsia, gestational diabetes and peripartum hemorrhage, among others (Attawet et al. 2022; Bergh et al. 2020; El-Toukhy et al. 2018; Sazonova et al. 2013). This highlights a critical aspect of policy consideration, where at a national level, there are calls for reducing multiple births associated with IVF (CARTR-Plus and BORN Ontario 2024), yet provinces without such regulations, chiefly those without publicly funded IVF, may continue to face challenges associated with multiple births (El-Toukhy et al. 2018; Lanes et al. 2020; Van Voorhis and Ryan 2010). While the scope of this study is relatively narrow, and the results related to multiple births should not be overstated, the survey findings suggest that this aspect of IVF policy development is an area for further research and monitoring as BC develops its funding model. BC could consider reviewing existing provincial policies across Canada to examine the impacts of attaching a single embryo transfer guideline to its program, as is the case in other provinces.

Conclusion

By bringing together patients undergoing IVF and those hoping but unable to access treatment, this study has sought to identify barriers that affect British Columbians looking for IVF. These results are particularly timely as they highlight critical considerations for BC's recently announced fertility program. In particular, the lived experience of those dealing with infertility reaffirms the need for such a program while highlighting critical policy considerations such as ex-ante financial barriers, regional inequities and pregnancy and birth outcomes that merit further research. Though BC has until recently been an outlier among its peer provinces for its lack of funding for IVF, the province now has the opportunity to learn from jurisdictions with both successful programs and those that struggled with earlier rollouts. In developing this new program, policy makers should be cognizant of the critical access barriers that go beyond costs and ensure that the funding instrument alleviates barriers related to BC's geography, the upfront costs and treatment, the challenges of lottery or waitlist systems managed by private clinics and the previously identified risks associated with an elevated multiple births rate.

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Ethics Approval and Consent to Participate

The study was approved by the Simon Fraser University Office of Research Ethics. Informed consent was obtained from all individual study participants.

Note:

1. It should be noted that for the 5% (2 respondents among 42) who indicated not pursuing IVF due to health or medical reasons where IVF is not the best option, it may be the case that they are pursuing IUI with the view they may pursue IVF later, or perhaps they had previously undergone IVF and have discontinued. In both cases, this subset of respondents presents a limitation to the paper as further probing is not feasible. It may be the case that they participated in the survey given other conditions related to infertility and reproductive healthcare (e.g., while visiting a clinic for other services).

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RESEARCH PAPER

Impacts of Homecare Investments in Alberta: Ecological and Economic Trend Analysis

Impacts de l'investissement dans les soins à domicile en Alberta : analyse des tendances écologiques et économiques

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Abstract

No standardized cost-based homecare-specific indicators are used provincially or nationally in Canada. We trended and portrayed Alberta's homecare costs and health system usage between 2015–16 and 2019–20. In addition, we conducted a cost-effectiveness ratio analysis. Total avoided acute care utilization was estimated at 346.2 thousand in-patient days. With $240.3 million in homecare investments above general growth, our cost-effectiveness ratio is 694:1. Application of these cost-based indicators reveals that homecare programs improve system cost-effectiveness. These indicators can assist health-system policy makers in understanding how systems are structured, specifically in achieving the goal of sustaining the publicly funded health system.

Résumé

Au Canada, aucun indicateur normalisé fondé sur les coûts n'est utilisé à l'échelle provinciale ou nationale. Nous avons établi une tendance et brossé un portrait des coûts des soins à domicile et de l'utilisation du système de santé en Alberta entre 2015–2016 et 2019–2020. De plus, nous avons effectué une analyse du rapport coût-efficacité. L'utilisation totale des soins de courte durée évités est estimée à 346,2 milliers de jours d'hospitalisation. Avec 240,3 millions de dollars en investissements pour les soins à domicile au-dessus de la croissance générale, notre rapport coût-efficacité est de 694:1. L'application de ces indicateurs fondés sur les coûts révèle que les programmes de soins à domicile améliorent le rapport coût-efficacité du système. Ces indicateurs peuvent aider les décideurs à comprendre la façon dont les systèmes de santé sont structurés, plus particulièrement pour atteindre l'objectif du soutien du système de santé financé par des fonds publics.

* * *

Introduction

To date, publicly funded health system-provided homecare and community care costs comprise 4.2% of Canada's publicly funded healthcare costs (CIHI 2023a). It is estimated that nationally, a lack of publicly funded and available homecare services accounts for 2,000 people daily in hospitals waiting for homecare services (CIHI 2024a). This shortfall of homecare availability represents $15.6 million in potentially avoidable daily costs (CIHI 2024a).

Canada's healthcare system's Commonwealth Fund quality ranking has dropped from 9th to 10th (out of 11 Organisation for Economic Co-operation and Development [OECD] high-income countries), only besting the US system (Commonwealth Fund 2021). Acute care in Canada makes up 25.6% of overall costs (CIHI 2023a, 2023b; Commonwealth Fund 2021). In 2022, hospital care cost Canadians about $81 billion nationally, with the standard cost per hospital stay in Canada at $7,803 (CIHI 2023a). Furthermore, the standard cost per hospital stay per province and territory varies drastically based on local policy decisions, with Alberta having the highest cost among the provinces at $9,341 (CIHI 2023a).

Homecare services are a fundamental lever in supporting the sustainability of Canada's publicly funded health system (Romanow 2002). People in Canada receive homecare through a variety of means. Homecare services can be provided by informal caregivers, through private homecare providers (paid out of pocket or through private insurance) or as publicly funded services from local healthcare systems. It is estimated that caregivers provide an economic value of over $97 billion per year, much of this supporting individuals at home (Research on Aging, Policies and Practice 2022). Across Canada, publicly funded services are provided based on individual assessed unmet needs to support people and often their caregivers at home as they recover from illness and injury and/or to support aging in place. As per national expenditure data (CIHI 2024b), the majority of homecare and community care services (which includes homecare expenditures) not provided by caregivers are those services that are publicly funded and provided through local publicly operated health systems.

It is estimated that if investments in publicly funded home care do not keep pace with the increasing demand due to the growing and aging population, it could lead to a decrease in the quality and quantity of services each client receives (Health Canada 2023; Romanow 2002). Without adequate publicly funded and accessible home care, more seniors might require hospitalization or admission to long-term care facilities, which are more costly than home care (Government of Canada 2017; Health Canada 2023; Romanow 2002; Statistics Canada 2023).

Recognizing the need for increased homecare services, in 2017, the federal government created a new provincial and territorial health transfer payment structure. Specifically, in partnership with provinces and territories, the federal government distributed $11 billion for community-based programs, with the majority of transfers ($6 billion) being allocated to support publicly funded and provided homecare services (Government of Canada 2017, 2022a, 2022b). Each province and territory invested their allocation of homecare-specific transfers to meet the unique needs they identified.

In Alberta, these federal investments resulted from policy makers announcing provincial homecare service investments totalling $200 million (Alberta Health 2018; Government of Alberta 2017; Government of Canada 2022a). Alberta Health Services (AHS) is the service provider/allocator of publicly funded homecare programming in Alberta. Based on AHS annual financial reporting, homecare costs increased less than 3% over the five previous fiscal years (AHS 2016, 2017, 2018, 2019, 2020, 2024a) for the five years before 2015–16. Examining the five years leading up to the COVID-19 pandemic, the 2015–16 fiscal year homecare cost was approximately $585 million, which rose to $716 million for the fiscal year 2019–2020 as part of these new investments (AHS 2016, 2017, 2018, 2019, 2020; Alberta Health 2018). For policy makers and health system leaders, the question remained: How can we examine if these investments made an impact when viewing shifts in health system utilization?

Through a multi-phased research project (international scoping review and a modified Delphi approach), financial indicators were explicitly identified for application within a balanced scorecard approach to health system quality and performance measurement (Jajszczok et al. 2023, 2024). Building on that research, this paper provides a health system ecological and economic trend observational study of homecare clients in Alberta, including those in acute care spaces/beds. The study aims to assess the impact of increased homecare funding on acute care utilization and overall health system costs in Alberta from the health system and policy maker perspective.

Methods

We conducted an ecological aggregate observational study that examines trends over time for homecare clients in Alberta, including those in acute care beds/spaces. We assessed the increased funding made available as announced in 2015–16 over the following years ending in 2019–2020 and applied new financial quality and performance indicators. We conducted a cost-effectiveness analysis (CEA) of acute care utilization changes against increased publicly funded homecare costs in Alberta. We studied publicly funded homecare costs and population trends in health system utilization in Alberta, applying the new financial indicators against other system measures. We compared and observed the ecological trends in health system utilization and costs before and after the increased funding. Trends in publicly funded homecare costs, population health system utilization and the impact of investments in home care on acute care utilization. We were careful not to infer causality in our approach to avoid the facility this creates in examining complex populations and correlating changes in trends through tests for significance (Freedman 1999; Levin 2006; Schwartz 1994; Smith 2020). Applying scientific trend testing to ecological trend data can create the assumption among those interpreting the data of causality in the observation (Freedman 1999; Levin 2006; Schwartz 1994; Smith 2020).

Costs are measured in Canadian dollars and adjusted for inflation where applicable. These expenditures do not include private, out-of-pocket costs borne by homecare clients or Albertans receiving private services outside of the services provided by AHS. There is no tracking or repository of those who purchase private home care. Private homecare expenditure data development is underway but not yet available nationally or by province through Canadian Institute for Healthcare Information (CIHI 2025).

Analytic methods: CEA and ecological trend analysis

We applied a CEA to calculate the unit ratio change over time and the total over the five years (CDA 2017). A CEA is a way to compare costs and system outcomes. CEA provides a framework for comparing multiple interventions' relative costs and outcomes (CDA 2017). We analyzed the impact of homecare investment-based interventions by comparing them to the baseline year of 2015–16 and estimating how much it costs to gain a unit of a health outcome, such as reduced acute care utilization (CDC 2021). We compared utilization changes specifically for homecare clients in three main areas: the number of days people were in a hospital waiting for a continuing care living option (CCLO) (long-term care space or a designated supportive living space) (Y1); average acute care days in the last 30 days of life for homecare clients (Y2); and hospital acute care days (excluding those waiting in acute care for CCLO or within their last 30 days of life) (Y3).

Cost-effectiveness ratios (CERs) are calculated by taking the total net new costs calculated for each year and the five-year study period and dividing this by the utilization changes in the three main areas and as a total (CDC 2021). The CER is beneficial for policy makers as it helps in resource allocation decisions by comparing the cost-effectiveness of various health interventions, and the CER can be applied to a wide range of health outcomes and interventions, making it a versatile tool for health economic evaluations. We chose the CER over other methods, such as an incremental cost-effectiveness ratio (ICER), due to several factors, including the nature of the study as our study is an observational ecological trend analysis rather than a direct comparison of two interventions. ICERs are typically used in comparative studies to evaluate the additional cost per unit of health benefit between two specific interventions. The CER analysis provides a holistic view of the intervention's impact on health system utilization and costs, which aligns with the goals of our study. The CER method provides a precise measure of the cost per unit of health benefit for the increased funding in home care. This can be more useful for policy makers interested in understanding the overall value of the intervention in isolation rather than comparing it to another intervention.

A primary limitation of the information available is that we cannot delineate the amount of homecare investment applied explicitly to specific clients. Data does not exist that ties cost to the client specifically, costs do not follow the clients and cost per client type, such as those who require short-term home care (post-illness, injury, surgery), long-term home care (medically complex, frailty), those palliative and/or at the end of life or those waiting at home for CCLO versus overall homecare funding growth.

Due to the nature of the data, and similar to other trend analyses, we chose not to conduct scientific, statistical analyses or a scientific trend analysis on the trend findings due to the understanding that at a system/population level, there are too many variables in a complex health system to appropriately assign causality or even assumed causality (Chao et al. 2018; Schwartz 1994; Shahzad et al. 2019; Twells et al. 2014). For example, within our data, within our trends, we witness a 15% increase in the number of homecare clients who died year over year, a decrease in the average days in acute care in the last 30 days of life and an overall increase in the cost per day per home care client. We cannot identify the causality of the mortality increase for homecare clients as the factors are endless. These investments promise that as more funding is applied to homecare, more enhanced palliative homecare services become available, leading to more individuals feeling safer receiving palliative homecare services versus through other means, such as within a hospital setting. These are concepts and assumptions that policy makers and healthcare operational leaders need to weigh based on their expertise, experiences and the trends portrayed through this research.

Data sources

We used publicly available deidentified homecare cost data for Alberta and AHS' linked to health system utilization data provided to the research team via Tableau Software© (2022) (Tableau Server Version: 2023.1.7 [20231.23.1011.0410]) visualized analytics. Tableau-based visualizations were constructed by AHS analytics teams from admission, discharge and transfer (ADT), discharge abstract data (DAD), Alberta continuing care information systems (ACCIS) and national ambulatory care reporting system (NACRS) data between April 1, 2015, and March 31, 2020. We used the Canadian Institute for Healthcare Information's (CIHI 2024a) cost data to estimate acute care utilization costs (Canadian currency, unadjusted) by location and year, and this is unadjusted costing (CIHI 2024c). From the previous Delphi study, we inserted the two identified indicators for measurement: homecare costs as a percentage of overall health costs, cost per client over time and annual homecare costs per client comparing years utilizing (Jajszczok et al. 2024). These indicators are "home care funding as a percent of overall health care budgets" and "average cost-per-day per home care client."

We created visualizations comparing key system indicators to these two identified homecare financial indicators using Microsoft Office 365 Software© such as Excel© and Powerpoint© (Version 3202 [Build 16130.20846]). We used Stata/IC 14.0© (StataCorp. 2015) statistical software for Windows (Version 15) to conduct the Mann–Kendall trend test for the demographic data in Table 1.

We compared utilization patterns over the five years to a conceptual model assuming funding growth remained the same as the initial year (2015–16). We compared actual outcomes to the conceptual model built on standardized estimates for each activity. A comparison of the actual and conceptual models was used to portray the estimated system utilization differences.

We excluded homecare clients who were assessed and waiting for facility-based care in acute settings to estimate homecare clients' acute care utilization to ensure that we are not double counting. For the estimated utilization of those CCLO in acute care, we calculated two scenarios, a 2015–16 baseline data (unadjusted) and a second adjusted model that includes a modification to accept 2017–18 peak levels of individuals waiting for CCLO in acute settings and applying those for 2018–19 and 2019–20 fiscal years. The adjusted model provides a more accurate estimate of acute care utilization, allowing for the average peak levels of 787 people waiting for CCLO in acute care settings to be maintained versus using the much lower 2015–16 baseline rate of 686 daily people on the annual average for the conceptual model.

We calculated the cost per homecare client by counting the number of unique home-living clients (not in a CCLO) per year per the criteria set by AHS divided by the annual homecare costs reported for each year in AHS's financial statement. In addition, we calculated the percentage of homecare costs compared with global AHS costs from the same annual financial statements.

Data assumptions

We assume that the health system structures, access to primary care physicians or other community-based services outside of home care has remained stable throughout the study period for conducting the demographic-based (age and sex) trend statistical analysis. Due to the nature of the data, we cannot test the distribution and assume that it is not standard. Each trend used data from the AHS analytics program, and it is assumed that the data is generally factual and that errors (missing values, incorrect entries and other artifacts) within the raw data have been addressed. Lastly, it is assumed that the financial data is accurate as reported by AHS for each year without significant changes in the financial data coding methodology or assignment of expenditures during this period.

Results

Table 1 describes the demographic profile of home living homecare clients, outlining clients by age, sex and rural living location for each year within the study period.

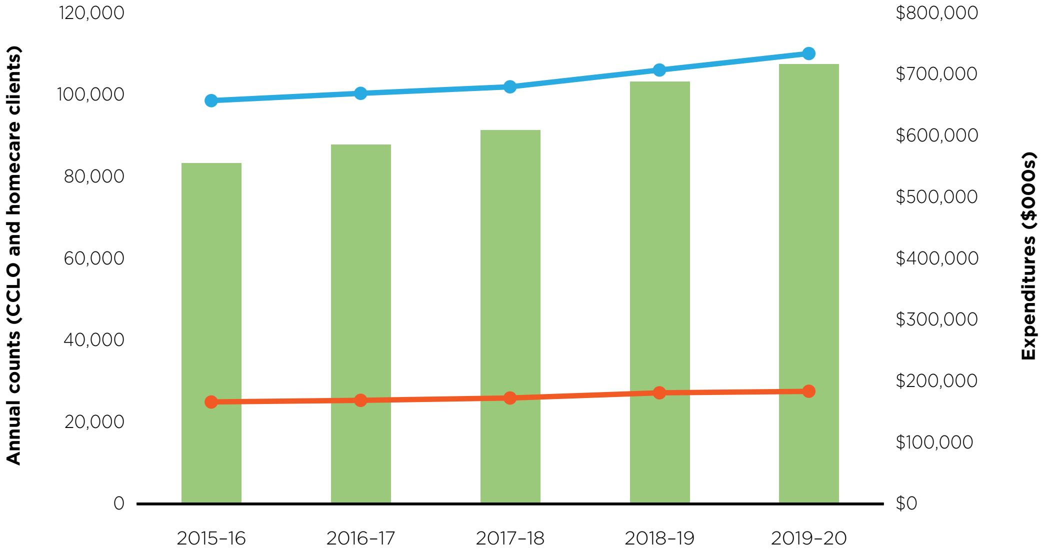
TABLE 1. Homecare client demographic profile by age, sex and rurality, comparing year over year

Homecare client demographics	**2015–16** ***n*** **= 98,618**	**2016–17** ***n*** **= 100,398**	**2017–18** ***n*** **= 101,998**	**2018–19** ***n*** **= 106,099**	**2019–20** ***n*** **= 110,135**	******p***-value**
Mean age all	68.3	68.6	68.9	68.9	68.8	0.3122
Mean age, male	65.9	66.1	66.5	66.5	66.6	**0.043**
Mean age, female	70.2	70.6	70.9	70.8	70.6	0.6134
	Frequency (thousands)/ per cent	**Frequency (thousands)/ per cent**	**Frequency (thousands)/ per cent**	**Frequency (thousands)/ per cent**	**Frequency (thousands)/ per cent**	
Males, age 20–64 years	14.8 (15.1%)	15.0 (14.9%)	15.1 (4.8%)	15.8 (14.9%)	16.5 (15%)	0.651
Females, age 20–64 years	15.7 (15.9%)	15.7 (15.5%)	15.3 (15%)	15.6 (14.7%)	16.4 (14.9%)	0.086
Males, age 65–74 years	9.1 (9.2%)	9.4 (9.3%)	9.7 (9.5%)	10.7 (10.1%)	11.1 (10.1%)	**0.042**
Females, age 65–74 years	10.2 (10.3%)	10.4 (10.4%)	10.7 (10.5%)	11.2 (10.6%)	11.5 (10.5%)	0.13
Males, age 75–84 years	10.4 (10.5%)	10.4 (10.4%)	10.9 (10.7%)	11.2 (10.6%)	11.6 (10.6%)	0.613
Females, age 75–84 years	14.8 (15%)	15.0 (14.9%)	15.0 (14.7%)	15.3 (14.4%)	16.1 (14.6%)	0.084
Males, age 85+ years	6.9 (7%)	7.2 (7.2%)	7.7 (7.5%)	8.0 (7.5%)	8.3 (7.5%)	0.096
Females, age 85+ years	13.7 (13.9%)	14.3 (14.2%)	14.6 (14.3%)	14.9 (14%)	15.1 (13.7%)	0.81
Per cent, rural	28.6 (29%)	29.0 (28.9%)	29.5 (28.9%)	30.7 (28.9%)	31.6 (28.7%)	0.096
Per cent, rural, female	15.5 (28.5%)	15.7 (28.5%)	15.7 (28.3%)	16.1 (28.2%)	16.6 (28%)	**0.043**
Per cent, rural, male	12.1 (29.5%)	12.4 (29.4%)	12.8 (29.6%)	13.6 (29.7%)	14.1 (29.6%)	0.312

Note: AHS analytics define rural as client home postal code upon last assessment from within communities/geographies smaller than 25,000 population (as available via CIHI). *Mann–Kendall trend as a test, alpha level is set at 0.05, meaning a *p*-value less than 0.05 is considered statistically significant (as bolded).
AHS = Alberta Health Services; CIHI = Canadian Institute for Healthcare Information.

As per Table 1, we applied the Mann–Kendall trend test for this population-based data as it does not assume a specific data distribution. We observed that while most of the trends and changes in the mean age for homecare clients over the years of the study period, and the distribution among age and sex has not significantly shifted, the mean age of male homecare clients has grown substantially year over year from a baseline of 65.9 in 2015–16 to 66.6 in 2019–20. Of this growth in mean age for males, the proportion of homecare clients that are males between the ages of 65 and 74 is the only age grouping to show a significant growth in mean age from 9.2% or approximately 9,100 unique homecare clients to 10.1% or approximately 11,100 unique homecare clients. The percentage of overall rural homecare clients has remained stable at 29–28.7%. More males live in rural areas than females, and this difference increases from 1% for fiscal year 2015–16 to 1.6% in fiscal year 2019–20. However, even though the number of unique rural female homecare clients increased from approximately 15,100 in 2015–16 to 16,600 in 2019–20, the trend of the proportion of female homecare clients decreased at a significant rate from 28.5% in 2015–16 to 28% in 2019–20.

FIGURE 1. Annual clients/bedded community-based capacity compared with homecare costs

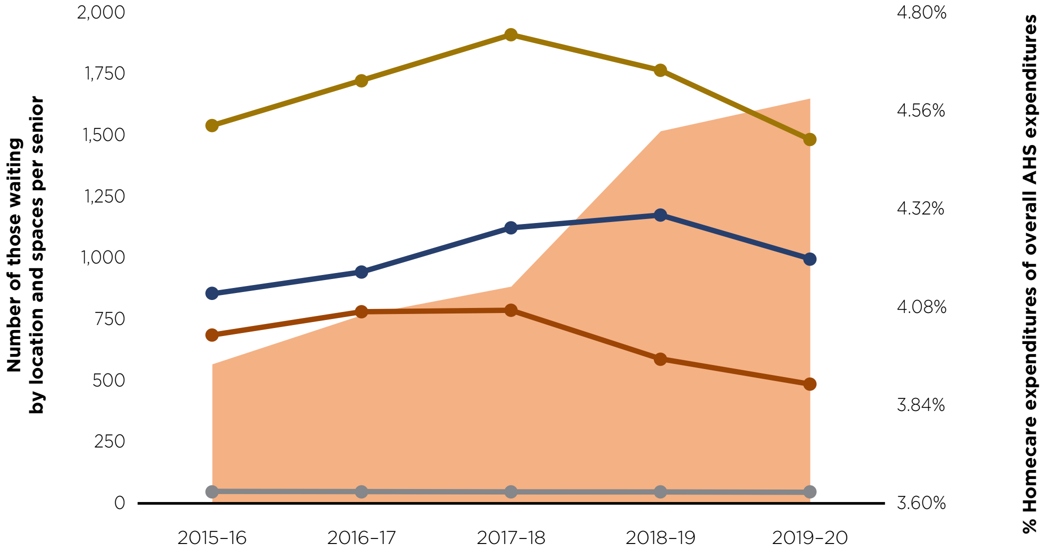


	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
🟩 Homecare Expenditures (AHS) ($000s)	$555,831	$585,313	$609,579	$688,295	$716,561
🟠 Facility-Based Continuing Care Living Option (CCLO) Bedded Capacity (End of Fiscal Year Count)	24,938	25,324	25,896	27,163	27,518
🔵 Unique Home Living Homecare Clients (Fiscal Year Annual)	98,618	100,398	101,998	106,099	110,135

AHS = Alberta Health Services; CCLO = continuing care living option.

Over the five years, homecare clients increased year over year from 98,618 clients in 2015–16 to 110,135 clients in 2019–20, an 11.9% increase from baseline. Homecare costs increased from $555.8 million to $716.5 million, a 28.91% increase from baseline. CCLO capacity increased from 24,938 spaces to 27,518 spaces (10.35%). The fiscal year 2018–19 had the largest gains in homecare costs.

FIGURE 2. Assessed and waiting for facility-based care compared with homecare costs as a percentage of overall AHS costs



	2015–2016	2016–2017	2017–2018	2018–2019	2019–2020
■ Homecare Expenditures as a Per Cent of Overall Provincial Health Authority Healthcare Expenditures	3.94%	4.06%	4.13%	4.51%	4.59%
● Waiting for CCLO in Acute Care – Annual Fiscal Quarter Snapshop Average	686	781	787	589	486
● Waiting for CCLO Total – Annual Fiscal Quarter Snapshop Average	1,540	1,724	1,910	1,765	1,483
● Waiting for CCLO at Home in community – Annual Fiscal Quarter Snapshop Average	854	943	1,123	1,175	997
● CCLO (LTC+DSL) spaces per 1000 Seniors	48.90	48.02	46.86	46.55	45.30

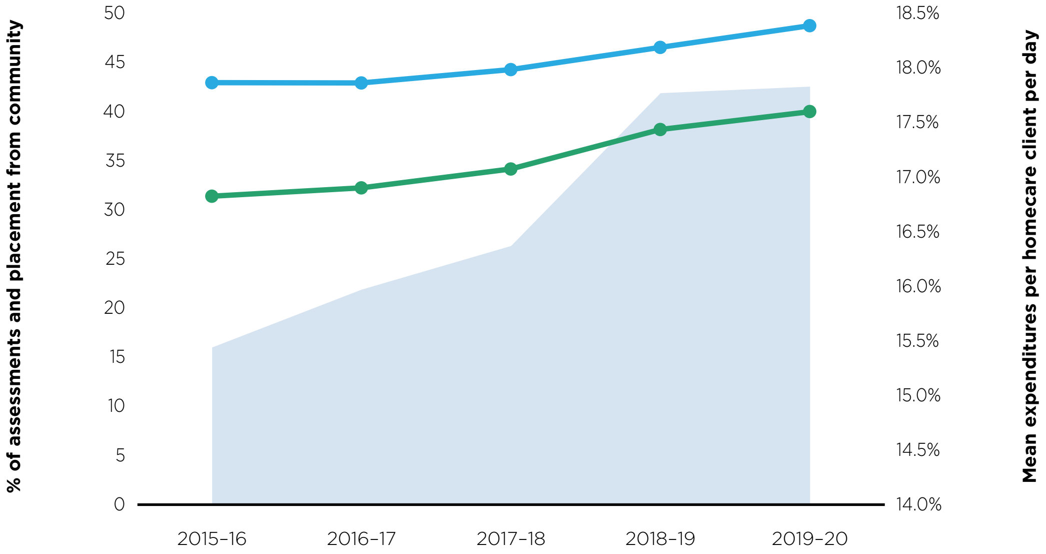
AHS = Alberta Health Services; CCLO = continuing care living option.

In Figure 2, we compare the overall homecare costs as a percentage of global health system costs against indicators that measure the number of people waiting for access to CCLO by their location. We observed that homecare costs as a percentage of AHS global costs increased from under 3.94% to 4.59% over the five years.

From 2015 to 2018, we observed an increase in the annual average daily number of individuals waiting for a CCLO, peaking at 1,910 in 2017–18 and decreasing to 1,483 in

2019–20, when most growth in homecare costs, as a percentage of overall health system costs, was observed. Furthermore, we observed that the annual average daily number of people waiting for a CCLO in hospitals follows the same trend, with a peak of 787 in 2017–18 and a reduction to 486 in 2019–20, with accelerated increases in homecare expenditures. This decrease equates to an average of 301 fewer people daily waiting in hospital settings for facility-based care. Lastly, we observed that the number of CCLO spaces per senior in Alberta during these five years decreased yearly from a high of 48.9 spaces in the fiscal year 2015–16 to 45.3 in the fiscal year 2019–20.

FIGURE 3. Fiscal year annual percentage of assessments/placement from community compared with mean costs per homecare client per day per fiscal year



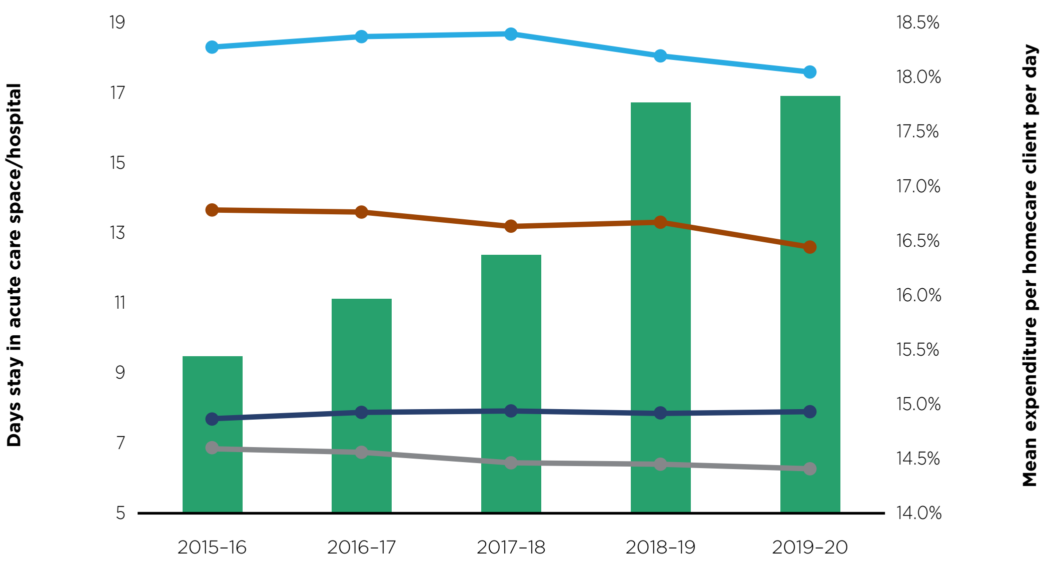
	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
🟦 Mean Fiscal Year Expenditures Per Day Per Homecare Client (AHS)	$15.44	$15.97	$16.37	$17.77	$17.83
🟢 % of Individuals Placed into CCLO from Community	31.40%	32.25%	34.17%	38.19%	40.00%
🔵 % CCLO RAI Assessment in Community (the Latest Assessment Prior to Placement)	42.96%	42.93%	44.29%	46.55%	48.76%

AHS = Alberta Health Services; CCLO = continuing care living option.

Costs per homecare client per day increased from $15.44 in fiscal year 2015–16 to $17.83 in fiscal year 2019–20, an increase of 15.48%, with the sharpest increase between fiscal years 2017–18 and 2018–19. As the costs per homecare client increased, the percentage of individuals assessed for a CCLO and waiting at home/community (not acute/hospital) increased from 42.93 to 48.88%. Furthermore, individuals placed into a CCLO from community settings (instead of being placed in a hospital setting) increased from 31.4 to 40.0%

between fiscal years 2015–16 and 2019–20. The sharpest increase occurred between fiscal years 2017–18 and 2018–19, with the increasing momentum nearly equal between 2018–19 and 2019–20 fiscal years, even with the trend in homecare costs per day for homecare clients plateauing between these fiscal years.

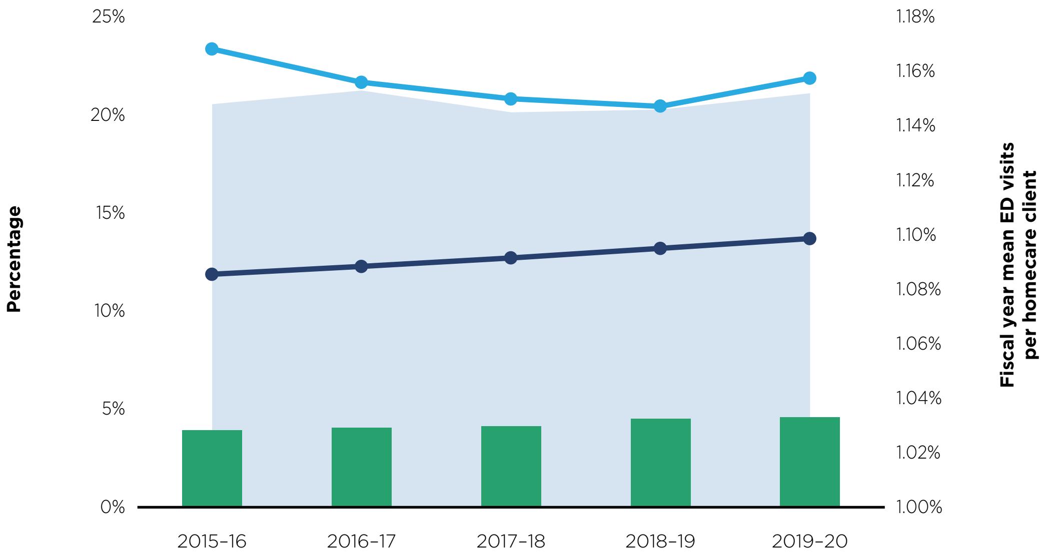
FIGURE 4. Annual percentage of assessments/placement from community compared with mean costs per homecare client per day per fiscal year



	2015–2016	2016–2017	2017–2018	2018–2019	2019–2020
🟩 Mean Fiscal Year Expenditures Per Day Per Homecare Client (AHS)	$15.44	$15.97	$16.37	$17.77	$17.83
● AHS All Patients Mean Hospital Fiscal Year, Length of Stay	7.70	7.88	7.92	7.85	7.90
● All Home Living Homecare Clients Mean Hospital Fiscal Year, Length of Stay	18.31	18.61	18.69	18.06	17.60
● Mean Acute Care Days in Acute Care for Homecare Clients in the Last 30 Days of Life	13.66	13.60	13.19	13.31	12.60
● Acute Care Inpatient Days Per Homecare Client (Not Including Those Assessed and Waiting for CCLO)	6.84	6.74	6.44	6.40	6.27
Total Unique Homecare Clients Who Died	8,656	9,025	9,277	9,462	9,989

AHS = Alberta Health Services; CCLO = continuing care living option. As the daily cost per homecare client increased, the average acute care length of stay in the last 30 days of life for homecare clients decreased from 13.8 (8,656 clients total) to 12.6 (9,989 clients total) days. The mean annual length of stay per hospital visit for homecare clients decreased from 18.69 to 17.60 days between 2017–18 and 2019–20, while the average acute care length of stay per hospital patient for all those served in Alberta remained relatively the same between 7.92 and 7.90 days.

FIGURE 5. ED visits per homecare client compared with the senior population, FPSCs, and percentage of homecare costs compared with global expenses



	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
🟦 ED Visits Per Client Per Year – Home Living Homecare Clients	1.148	1.153	1.145	1.146	1.152
🟩 Homecare Expenditures as a Per Cent of Overall Provincial Health Authority Healthcare Expenditures	3.94%	4.06%	4.13%	4.51%	4.59%
● % FPSC – Family Practice Sensitive Conditions (ED) – Home Living Homecare Clients	23.37%	21.67%	20.83%	20.44%	21.88%
● % Seniors in Population (Alberta)	11.88%	12.28%	12.71%	13.20%	13.70%

AHS = Alberta Health Services; CCLO = continuing care living option; ED = emergency department; FPSC = family practice sensitive condition.

As the percentage of overall expenditures in home care increased year over year, the mean emergency visits per homecare client remained relatively constant over the five years, with a slight decrease between years 2016–17 and 2018–19. Furthermore, the percentage of family practice sensitive condition (FPSC) also decreased from 23.37 to 20.44% in 2018–19 and then increased to 21.88%. Lastly, during these five years, the proportion of seniors in the province continued to grow yearly (11.9–13.7%), following a similar growth pattern specific to the proportion of homecare costs of overall global health authority costs.

Cost-effectiveness analysis

Using the same cost per client day and actual annual homecare client growth, we estimate that the total net new costs over the period amount to estimated additional costs above a yearly increase of $240.3 million, with $95.8 million accounting for the 2019–20 fiscal year. In Table 2, we report that the investments of $240.3 million resulted in a

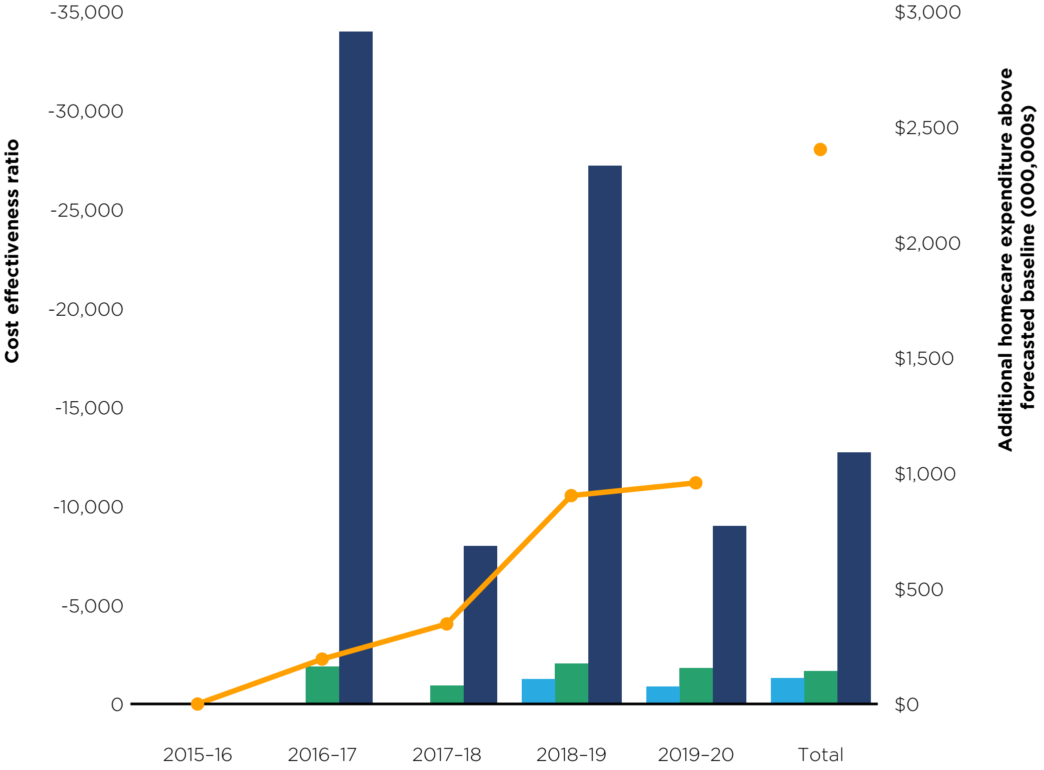
TABLE 2. Financial homecare system quality and performance measures

	2019–20 Differences (actual minus projected)	2019–20 CER	Total (all years) Differences (actual minus projected)	Total (all years) CER
Homecare costs differences (actual cost minus projected)	$95,817,858		$240,264,642	
Y1. Days averted CCLO clients waiting in hospital	52,992	870/1	144,882	1,317/1
Y2. Days averted acute care utilization	110,078	1,808/1	182,439	1,658/1
Y3. Days averted acute care days in last 30 days of life	10,655	8,993/1	18,891	12,719/1
Total results	173,725	552/1	346,212	694/1

CCLO = continuing care living option; CER = cost-effectiveness ratio.

346.2-thousand-unit reduction in the overall utilization of acute care services for the three groups of homecare clients combined. CER calculations using the total net new investments per type of acute care reduction are calculated at 1,317 for those waiting for CCLO, 12,719 for those in their last 30 days of life, and 658 for all homecare clients (excluding CCLO and the previous 30 days of life cohort). The total CER for all three main areas combined (Y1, Y2 and Y3) compared with the costs over the five years was 694 per unit gained.

FIGURE 6. CER by acute care reduction type per year and cumulative



Difference in utlization	2015–16	2016–17	2017–18	2018–19	2019–20	Total
Additional Investment in Homecare (Above Forecasted General Growth)	–	19,449,560	34,697,636	90,299,570	95,817,858	240,264,624
CER: Total Investment Difference in Homecare / CCLO Acute Care Days Difference From Baseline				-1,248	-870	-1,317
CER: Total Investment Difference in Homecare / Total Acute Care Days (No CCLO, No Palliative) From Baseline		-1,890	-930	-2,040	-1,808	-1,658
CER: Total Investment Difference in Homecare / Total Acute Care Days Last 30 Days of Life Difference From Baseline		-33,995	-7,986	-27,210	-8,993	-12,719

CCLO = continuing care living option; CER = cost-effectiveness ratio.

In Figure 6, acute care reductions specific to those waiting in hospitals for a CCLO do not decrease over baseline until 2018–19, at which point, based on the 2017–18 baseline, we observe a positive CER for each year and positive cumulative CER. We observed that the CER ratio for the last 30 days of life ranged from 33,995 per unit to 7,986 over the four years. Lastly, we observe that the CER per year for all homecare clients ranges from 930 in 2016–17 to 2,040 in 2018–19.

Interpretation, Findings, Generalizability and Current Knowledge

The study provides insights into the impact of increased homecare funding on health system utilization and costs, with implications for policy makers and health system leaders. The evolution of the federal transfer program targeting homecare investment growth combined with the provincial $200 million investment announcement enabled cost shifts for AHS in the following fiscal years. When applied to health system data, we show that the core cost-based indicators can portray compelling cost and utilization information. As a result, these new indicators could effectively guide policy makers and health system administrators in their decision making for future shifts and changes to the overall structures of the publicly funded health system.

Many health systems globally face similar challenges regarding the allocation of resources between acute care and home care. The trends observed in Alberta can provide valuable insights for other regions with comparable healthcare structures and funding mechanisms. The study's findings on the impact of increased homecare funding on acute care utilization can inform policy makers in other jurisdictions. By demonstrating the cost-effectiveness of investing in home care, the study supports the argument for reallocating resources to enhance homecare services.

This analysis of how funding affects outcomes in home care reveals that funding homecare programs can improve health system cost-effectiveness. For each year, the increased homecare costs above the projected 2015–16 annual homecare investments show a decrease in acute care utilization and acute costs for these clients. In this study, for Alberta, the reduction in homecare-specific acute costs equates to approximately 346.2 thousand acute care bed days over the study period. In addition, for 2019–20, we calculated the most impactful CER of 552 per unit gained. As such, we estimated a reduced utilization of 173.7 thousand bed days annually, equivalent to a 476-bed hospital at 100% occupancy. It is estimated that today (2024–25), a hospital this size would cost over $2.5 billion and 10 years to construct from planning to completion (AHS 2024b).

These trend observations and their potential impacts on Alberta's overall healthcare system are a critical component that should inform policy makers across Canada on further considering funding the system as the system requires a focus on efficiency. System sustainability is at risk in Canada. We understand that as a percentage of gross domestic product, Canada spent 12.3% on healthcare in 2021, which is significantly more than the OECD 9.7% average (including the US's 17.8% figure within), and Canada has almost half (2.6 per 1,000 population) the number of hospital spaces per population of the OECD average (4.3 per 1,000 population) yet has a higher-than-average length of stay at 8.2 days per hospital admission, with approximately one extra day more than the OECD average (Commonwealth Fund 2021). CIHI (2022) informs that, due to the lack of available homecare services, one in 10 admissions to CCLO are inappropriate and that these individuals could have been managed at home with homecare programming.

The newly identified homecare financial quality and performance indicators used in this study can be adapted and applied in other health systems. These indicators provide a framework for assessing the financial performance and quality of homecare services, which can be useful for health system leaders and policy makers worldwide. As mentioned, it is estimated that there are 2,000 people daily in hospitals across Canada waiting for homecare services. If we reduced this by half through investing in publicly funded homecare services nationwide, we could allow more people to receive care in their homes and free up scarce and expensive hospital capacity. This would come with the promise of reducing congestion and improving upon efficiencies for hospital-based care.

The ecological trends observed in this study, such as changes in health system utilization and costs, can serve as a reference for other regions. Understanding these trends can help health system leaders anticipate the potential impacts of similar funding changes in their own contexts. This trend observation aligns with similar models and research from other provinces such as Ontario (Kralj and Sweetman 2024) and countries such as Singapore (Low et al. 2015) and China (Yi et al. 2023) that conclude that with a focus on home care, a significant number of services could shift from expensive traditional in-patient facilities to the home without a reduction in quality or access. Based on international comparisons, and the current performance of the Canadian health system, there is a need for further application of cost-based indicators to achieve the promise of timely access and safe services.

Future Direction

The Canadian healthcare system is becoming increasingly unsustainable; we cannot build hospital-based services or residential long-term care (LTC) spaces quick enough to meet the needs of the aging and growing senior population. Policy makers need to do more than announce funding; there is a need to understand how scarce public funds are being spent under the promise of sustaining services for Canadians. We recommend that policy makers and healthcare executives implement these indicators to better understand the impacts of homecare investments on the overall health system structures and utilization of those served. Applying these indicators at provincial and national levels can assist health system policy makers to understand how their programs/systems/provinces are structured compared with others and where they are leading or are deficient in their approaches to sustaining the publicly funded health system. Furthermore, there is a need to view the results out of Alberta at a national level; when policy makers support constant homecare funding and expenditure growth, the most significant impacts on health system sustainability are in the latter years. There is a need to consider the development and protection of targeted multi-year (5+) strategic funding plans that are protected and could outlast government election cycles, allowing for less disruption based on political mandates. Lastly, as a consideration for the future, a publicly accessible dashboard that visualizes homecare expenditure data is an essential step toward knowledge translation. When citizens can easily access information on how governments allocate funds for homecare services and related outcomes, it fosters accountability for policy makers and health system operational leaders. As there are trade-offs with increased homecare funding, this transparency empowers citizens to become informed interest holders who can advocate for evidence-based decisions. Publicly funded home care costs a fraction of the cost to build and operate hospitals and LTC facilities. Public discourse is often focused on facility-based growth, such as hospitals and residential care; this results in election cycle campaigns focusing on announcements specific to these high-cost resources. Part of this is because little is known or shared with the public about strategic funding and expenditures tied to homecare programs.

Furthermore, there is a need to understand the impacts of increased public costs in homecare and the impacts on caregiver support and private healthcare expenditures, including private home care. CIHI is undertaking future work to develop home and community care spending data. The concept and definition of homecare and community care have been expanded to include home support and community-based services as part of ongoing quality improvement at CIHI (2025). Once this data is available and refined, we can better examine shifts in private expenditures.

Limitations

While the study provides valuable insights, it is essential to consider contextual factors such as demographic differences, healthcare policies, and economic conditions that may influence the generalizability of the findings. The challenge in this study as a population-based ecological trend assessment is that we cannot quantify and adjust for the complexity of the population served as homecare clients within the overall healthcare system. There is an endless number of factors that contribute to the way individuals interact with the publicly funded health system, such as changes to the demographic profiles (comorbidities), provider availability (providers per population, funding models affecting access) and practitioner policy/practice shifts, to name just a few. Due to this, there is a need to hold the assumption that as the healthcare system and the population continued to shift in a variety of ways and factors, beyond our ability to quantify these shifts, the overall increase in the funding per homecare client was significant enough that this changed the way individuals interacted with the system as witnessed in the identified trend analysis.

The CEA of this study provides insights into the impact of increased homecare funding on health system utilization and costs, with implications for policymakers and health system leaders. Limitations include the study's observational nature and potential contextual factors affecting generalizability. These trend observations and the CEAs used internal and external dispersed data sources with many indicators created for operational purposes and not scientifically validated or rigorously defined. The methods selected are intentional to support a discussion at the policy and health system operational leadership level on the quality and performance indicators through various visualizations portraying the conceptual impacts of homecare investments on system utilization shifts. The analysis is grounded in knowledge and conducted by measuring the differences between the annual fiscal reporting periods matched to annual AHS homecare client data.

Conclusion

The trend observations portray that adequate funding for home care is essential for ensuring high-quality patient care, improving health outcomes and maintaining cost efficiency. Generally, it is crucial to understand that investments in home care are not wasted even if outcomes do not dramatically shift as a substantial amount of care currently being delivered in higher levels of care could shift to patients' homes, freeing up needed resources (Bestsennyy et al. 2022). Canada's population is aging and growing (Statistics Canada 2022). By 2051, the number of seniors will have more than doubled to 1.4 million (Statistics Canada 2022). As such, for policy makers, measuring homecare investments and outcomes regarding population growth and demand is crucial to sustaining the publicly funded health system.

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Erratum

The journal, *Healthcare Policy*, publishes corrections when an error is made by the author, editor or staff which affects the interpretation of data or information presented but is not significant enough to impact the conclusions. Errata appears as a note on the corrected article and as a separate piece in *Healthcare Policy* 21.1.

In the article *Jajszczok, M., C.A. Eastwood, M. Lu, C. Cunningham and H. Quan. 2025. Impacts of Home Care Investments in Alberta: Ecological and Economic Trend Analysis. Healthcare Policy 20(3):58–77. doi:10.12927/hcpol.2025.27616* there was an error on page 59 in the sentence that originally read "In 2022, hospital care cost Canadians about $81 billion nationally, with the standard cost per hospital day in Canada at $7,803 (CIHI 2023a). Furthermore, the standard cost per hospital day per province and territory varies drastically based on local policy decisions, with Alberta having the highest cost among the provinces at $9,341 (CIHI 2023a)." The word "day" has been corrected to the word "stay" in both places.

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