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Health Care in Rural Communities: Exploring the Development of Informal and Voluntary Care

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SEDAP Research Paper No. 79

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HEALTH CARE IN RURAL COMMUNITIES: EXPLORING THE DEVELOPMENT OF INFORMAL AND VOLUNTARY CARE

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Abstract

Nation-state restructuring has resulted in significant political, economic and social change in rural communities. One manifestation of this transformation has been the changing nature of local governance, characterised by the re-working of central-local relations and public-private responsibilities, such that local informal and voluntary sectors now play an active and direct role in the organisation and delivery of health care services. This paper investigates the relationship between the changing nature of local governance and the provision of health care services, and places it within the context of rural communities and population aging in Canada. In particular, it considers the ascendancy of informal and voluntary sectors with respect to homecare in rural Ontario, and features an analysis of data from the National Population Health Survey and the National Survey of Giving, Volunteering and Participating, representing user (demand) and provider (supply) perspectives respectively. The results provide a cross-section of informal and voluntary home care in the late 1990s, which indicates that informal and voluntary sectors are major players in the local organisation and delivery of health care services in rural communities. This suggests that the current state of health care provision in rural communities of Ontario is affected very much by the changing nature of local governance associated with restructuring. The 'snap-shot' of health care in rural communities presented in this paper highlights the need to examine further the relationship between governance and health care services at the local level. It also points to the need for more detailed data sets that integrate health, informal and voluntary care data at meaningful geographical and administrative scales to reflect clearly rural communities in Canada.

INTRODUCTION

In the past three decades, Western capitalist societies have experienced significant political, economic and social changes. The development process has been characterised in part by national policies promoting public institutional restructuring (Pinch, 1997). Within this context of reform, governments have sought to re-scale the responsibilities of the state, communities and individuals with respect to the provision of public (welfare) services (Tickell, 2001). Although experiences vary considerably within and between nation-states, the attendant re-working of central-local relations and public-private responsibilities has at once facilitated the changing nature of local governance and the organisation and delivery of health care services (Pinch, 1989; Jessop, 2000; Stoker, 2000). These transformations have important outcomes for local communities, which are inherently sensitive to political-economic changes, especially in rural areas that face the challenge of reconciling the uneven development of public services and downloading of responsibilities associated with restructuring (Kearns and Joseph, 1997; Goodwin, 1998; Liu *et al*., 2001).

Health care in rural communities provides an excellent example of the dynamic and complex relationship among restructuring, governance and public services. Key academic and public policy debates surrounding this state-society relationship recognise the active and direct role of local institutions and regulatory networks in mediating the impacts of nation-state restructuring processes in general and health care reforms in particular (Goodwin and Painter, 1996; Burke *et al*., 2000; CHSRF, 2001). This is indicative of the changing nature of local governance in rural areas, which is characterised by the ascendancy of community-based, informal and voluntary sectors in the local development process (Reimer, 1997; Crampton *et* al., 2001; Hall and Banting,

2001; Little, 2001). This transformation has significant implications for the organisation and delivery of health care services in rural communities, which already face considerable economic and demographic challenges (Bryant and Joseph, 2001). Indeed, rural communities have among the highest relative proportions of elderly population (Moore *et al*., 1997; 2000), and it is at this level where the growing pressure to provide care through informal and voluntary means associated with restructuring is most acute. Ironically, it is also here where the capacity to cope may be most problematic.

This paper investigates the relationship between the changing nature of local governance and the organisation and delivery of health care services, and places it within the context of rural communities in Canada. In particular, it considers the ascendancy of informal and voluntary sectors in the provision of health care in rural communities, and features an exploratory analysis of informal and voluntary home care in Ontario using the National Population Health Survey (NPHS) and the National Survey of Giving, Volunteering and Participating (NSGVP). The results from these Statistics Canada surveys represent user (demand) and provider (supply) perspectives respectively, and provide a cross-section of informal and voluntary home care in the late 1990s. This 'snap-shot' is used to illustrate the current state of health care in rural communities as it relates to the changing nature of local governance.

The remainder of the paper is organised into five major parts beginning with a description of the conceptual approach. Section Three considers the current debates and literature, and presents a descriptive framework for exploring the development of community-based, informal and voluntary care in rural communities. Following a discussion of the data and methodology (Section Four), the results of the cross-sectional

exploratory analysis of informal and voluntary care are summarised with respect to national trends, inter-regional variations, and geographical patterns in Ontario in Section Five. The empirical results and their implications for understanding the link between health care and voluntarism in rural communities are discussed in Section Six. The paper concludes with insights into the changing nature of local governance and health care in rural Canada and advances suggestions regarding further research on the development of informal and voluntary care.

CONCEPTUAL APPROACH

The conceptual and theoretical foundations of this research occur at the intersection of four broad bodies of literature: (1) political-economy of public services; (2) local governance; (3) health care services; and (4) rural community development. Each perspective provides a specific framework or lens for understanding the local manifestation of health care issues and the dynamics of local governance in rural communities.

The first body of literature emphasises the irrevocable link between political and economic practices in the development process (Armstrong *et al*., 2001). It recognises that changes in local public institutions and services, such as health care, are directly attributable to the macro-level re-orientation of the state and economy following the crisis of capitalist production since the 1970s (Aronson and Neysmith, 1997; Pinch, 1989; Coburn, 2001). This perspective provides a framework for understanding the scope and nature of change in rural communities as a process greatly influenced by broader political and economic forces.

The second body of literature is characterised by a shift in academic discourse on state-society relations away from the concept of 'government', which is concerned with the formal institutions and structures of the state, towards broader considerations of 'governance', which recognise the wide range of state and non-state institutions involved in the local development process (Jessop, 1995; Goodwin, 1998). 'Local governance' focuses on how the development process of the local state involves partnerships and networks across boundaries within the public sector, and between the public sector and private or voluntary sectors (Goodwin and Painter, 1996; Reimer, 1997; Stoker, 2000; Edwards *et al*., 2001). This perspective provides the basis for understanding the roles and responsibilities of local institutions with respect to the organisation and delivery of health care services.

The third body of literature engages in critical analyses of place, structure and agency with respect to the nature and extent of health care service issues in numerous regions and at various levels (Kearns and Gesler, 1998; Rosenberg, 1998). This stems from recent critiques of the biomedical model driving conventional geographical research on health care issues, which have led to an increased focus on the relationship among health, health care services, and place (Kearns, 1993; Moon, 1995; Mohan, 1998). This literature also emphasises connections between analyses of health care service issues, such as uneven development and spatial inequalities, and public policy (e.g., Moon, 1990; Rosenberg and James, 1994; Kearns and Joseph, 1997; Hanlon and Rosenberg, 1998; James, 1999; Cloutier-Fisher and Joseph, 2000; Hanlon, 2001). Health care services research and policy informs our understanding of health care issues in rural communities, and the political and institutional framework within which they occur.

Rural community development is the final component of the conceptual approach. This body of literature conceptualises 'rural community' as a local social system constructed of multiple communities of place and communities of interest (Bryden, 1994; Kearns, 1998). Communities are places in which apparently unified geographical and administrative (institutional) boundaries, such as health care units, surround the presence of activities and structures that bind together shared local interests and needs (Wilkinson, 1986; Moon, 1990; Selman, 1996). It is at this level where the extension of national restructuring processes, such as health care reforms, to the individual occurs and the changing nature of governance and health care service issues are played out (Wistow, 1995; Kearns and Joseph, 1997). This perspective forms the basis for understanding rural communities as the pre-eminent place in which and from which people experience a restructuring society (Joseph and Knight, 1999).

The integration of concepts and findings from political-economy, local governance, health care services and rural community development provides an important backdrop for the cross-sectional exploration of survey data that constitutes the descriptive and analytical core of the paper. It is within the broad political-economic framework that rural communities experience and respond to the dynamic issues of changing governance and health care services. This conceptual approach informs our understanding of community-based, informal and voluntary care; however, consideration must first be given to the broader political, economic and institutional context within which it occurs.

EXPLORING INFORMAL AND VOLUNTARY CARE IN RURAL COMMUNITIES

Rural communities in Canada are experiencing complex and inter-related political, economic and social changes. Since the 1950s, rural Canada has moved from a position of national centrality to one of marginality, facilitated primarily by the expansion of the broad area under urban influence (the 'urban field), and the de-coupling of communities from their service centre roles (Beesley and Bowles, 1993; Troughton, 1995; Bryant *et al*., 2000). Various functional shifts and subsequent transformations of livelihoods have occurred as a result of the demographic transition and socio-economic transformations associated with these urbanising and industrialising trends (Dahms, 1998; Fuller and Nichol, 1998). Of particular concern are the relatively high proportions of elderly within rural populations as compared to those in urban areas (Moore *et al*., 1997; 2000). In addition, with only approximately 16 per cent of the total population in Canada currently considered 'rural' (of which only 19 per cent live on farms), many rural areas have experienced significant de-population and economic stagnation (Bourne and Rose, 2001). At the same time, provincial level policies emphasising the re-organisation of public services in response to changing population needs and cost efficiency imperatives have left many rural communities, especially those in more remote areas, unable to prevent the severe decline in essential services such as health care, brought about by declining populations and decreasing economic viability (Halseth, 1999; Bryant and Joseph, 2001; Lui *et al*., 2001).

As a result of these broad-scale dimensions of change, the organisation and delivery of health care services in rural communities, already characterised by uneven development and spatial inequalities, are shifting away from institutional (hospital-based)

care towards community-based, informal and voluntary care (Gesler *et al*., 1992; Joseph and Martin-Matthews, 1993; Halseth and Williams, 1999; James, 1999). This shift is symptomatic of the changing nature of local governance and health care services in rural areas as local communities respond to the impacts of public institutional restructuring (Cowen, 1999; Cloutier-Fisher and Joseph, 2000). The key elements of this relationship are captured in a descriptive model for exploring the development of informal and voluntary care (Figure 1). This figure provides a framework for conceptualising the various forces of change affecting local governance and the organisation and delivery of health care services, and in turn the development of community-based care. The three themes of public institutional restructuring, changing nature of local governance and community-based care are essential to the model, and are explored in this section respectively to provide a broad understanding of informal and voluntary care in rural communities.

Public Institutional Restructuring

Public institutional restructuring involves a wide range of political, economic and social processes aimed at re-scaling responsibilities of the state with respect to public (welfare) services (Pinch, 1989; Tickell, 2001). This has been facilitated primarily through the re-working of central-local relationships and public-private responsibilities (Moran, 1999; Burke *et al*., 2000), which amount to a "changing of the rules" under which people experience society (Joseph and Knight, 1999, p. 1). Restructuring processes include (de)centralisation, privatisation and devolution, which involve the spatial re-organisation of public services according to cost efficiency or accessibility criteria, the introduction of private ownership and market allocation mechanisms to

services previously provided and owned by the state, and the transfer of public service activities to the private and voluntary sectors respectively (Pinch, 1997). Yet, what all of these processes represent, and what underscores public institutional restructuring in general, is the changing role of the state as a producer of goods and services and as a regulator of private spheres of production and consumption (Joseph and Knight, 1999).

The scaling-back (or 'hollowing-out') of state responsibilities for public (welfare) services has resulted in the re-regulation of the roles and responsibilities of the state, communities and individuals (Jessop, 1994; Moran, 1999; Joseph *et al*., 2001). Re-regulation is articulated through the re-engineering of the social infrastructure of local communities, placing increasing pressure on local informal and voluntary sectors to replace public (welfare) services previously provided by the state (Rekart, 1993; Lewis and Moran, 1998; Moran, 1999). This is indicative of the shift from institutional (hospital-based) care to community-based care in rural areas, which face growing pressure to provide care through local informal and voluntary means associated with public institutional restructuring in general and health care reforms in particular (Kearns and Joseph, 1997; Marshall, 1999).

Changing Nature of Local Governance

Accompanying the political, economic and social changes associated with public institutional restructuring has been a significant transformation in the development processes of the local state (Lewis and Moran, 1998). The shift towards community-based, informal and voluntary care is representative of the changing nature of local governance in rural communities, and is indicative of the blurring of the boundaries among the state, community and individuals. Local governance is characterised in part

by the increasing importance and inter-dependence of state and non-state institutions within the local development process (Goodwin and Painter, 1996; Edwards *et al*., 2001; Little, 2001). Within 'restructured societies', the local development process involves relationships among a wide range of organisations and actors drawn from and also beyond the formal institutions of the state including private agencies (for-profit and non-profit), voluntary organisations and 'informal' households and individuals (Reiner, 1998; Jenson and Phillips, 2000; Stoker, 2000).

With the shift away from the hierarchical co-ordination of the state towards the development of partnerships and networks among non-state institutions and actors, voluntary and informal sectors now play an active and direct role in the local development process (Wolch, 1990; Reimer, 1997; Lewis and Moran, 1998; Hall and Banting, 2000; Crampton *et al*., 2001). This is the result of a displacement of (central, public) power, whereby state functions, such as the provision of health care, are transferred both vertically (downloaded to local communities and individual households) and horizontally (shifted across to the private, voluntary and informal sectors) (Barnett, 2000). As a result, voluntary and informal partnerships and networks have developed to replace the public (welfare) services once provided by the state (Rekart, 1993; Crampton *et* al., 2001; Edwards *et al*., 2001). This has affected at once the nature of local governance and the organisation and delivery of health care services in rural communities, and has led to the development of community-based, informal and voluntary care (Goodwin, 1998; Cowen, 1999; Marshall, 1999; Cloutier-Fisher and Joseph, 2000).

Community-Based Health Care Services

The development of community-based, informal and voluntary care stems directly from the re-working and re-regulation of the relationships, roles and responsibilities of the state, community and individuals with respect to public (welfare) services in general and health care services in particular. At the same time, provincial-level hospital restructuring and long-term care reform policies emphasise a shift away from institutional (hospital-based) care towards increased reliance on community voluntary organisations and individual households (Halseth and Williams, 1999; James, 1999; Cloutier-Fisher and Joseph, 2000; Hanlon, 2001). Community-based care, therefore, can be seen as a local manifestation of restructuring processes promoting health care services reform and changes in local governance that emphasise the ascendancy of informal and voluntary sectors in the local development process (Reading, 1994; Wistow, 1995).

'Community-based' care encompasses a wide range of health care services provided 'in the community' instead of the health care institution (hospital) (Means and Smith, 1994; Cowen, 1999). The potential ensemble of services provided through community-based care includes: acute care; assistance with activities of daily living such as mobility, nutrition and personal care; meal preparation and delivery; shopping for groceries and necessities; light and heavy housework; physical, occupational and speech therapy; nursing care and caregiver relief (respite) (KFLA CCAC, 2000). It primarily involves publicly- and privately-funded programs specifically designed to provide care and supportive services in the place of residence (i.e., 'home care') (Health Canada, 1998; Coyte, 2000). This type of care is co-ordinated formally through local public, private (for-profit) and voluntary (non-profit) organisations (Hall and Banting, 2000;

Jenson and Phillips, 2000). It also involves informal care provided by individuals, usually family members or friends of those in need, who are from outside of the public, private or voluntary frameworks of care (Cloutier-Fisher and Joseph, 2000; Coyte, 2000). The diverse range of people who benefit from (need) community-based care includes those with chronic conditions and/ or disabilities that limit their functioning, those who are acutely ill and require intensive nursing care, those who need palliative care, and informal caregivers who need relief (KFLA CCAC, 2000).

The remainder of this paper focuses on publicly-funded, community-based, informal and voluntary home care. This is an important, if not vital, component of health care services in rural communities who face the challenge of reconciling the downloading of responsibilities for health care services under conditions of increasing demographic pressure and declining economic viability (Halseth and Williams, 1999; Bryant and Joseph, 2001). Indeed, the changes in central-local relations and public-private responsibilities associated with public institutional restructuring, and articulated through public policy (e.g., Ontario HSRC, 2000), are predicated on the assumption that state provision of health care services can be replaced effectively by informal and voluntary sectors at the local level (Coyte, 2000; Crampton *et al*., 2001). A cross-section of informal and voluntary home care in Ontario illustrates that the issues surrounding the shift towards community-based, informal and voluntary care discussed above (and represented schematically in Figure 1) are becoming increasingly important for our understanding of health care in rural communities.

METHODOLOGY AND DATA

The analytical approach employed in this research features an exploratory analysis of informal and voluntary home care in Ontario using Statistics Canada data from the 1998-1999 National Population Health Survey (NPHS) and the 1997 National Survey of Giving, Volunteering and Participating (NSGVP). The survey data was extracted from the NPHS and NSGVP Public Use Microdata Files (PUMFs) and analysed using SPSS® software. Results from the analysis of NPHS and NSGVP survey data reflect the utilisation (demand) and provision (supply) of informal and voluntary home care respectively, and their integration provides a cross-section (or 'snap-shot') of the organisation and delivery of health care in Ontario in the late 1990s.

The Statistics Canada NPHS 1998-1999 PUMF provides insights into the demand for and utilisation of home care services. The 1998-1999 NPHS cycle is employed because it provides the most current, comprehensive information on public health (n=49,046). According to Statistics Canada (1998-1999b), representative households from all provinces were randomly selected and from each sample household one individual was randomly chosen to complete the public health questionnaire. Exceptions to the NPHS sample include residents of the Yukon, Northwest, and Nunavut territories, and people living on Indian Reserves, on Canadian Forces Bases or in remote areas in Ontario and Quebec.

The Statistics Canada NSGVP 1997 PUMF provides insights into the supply and provision of home care services. The 1997 NSGVP is the most comprehensive survey focussing on voluntarism in Canada (n=18,301). According to Statistics Canada (1997b), similar to the NPHS, each sample household was randomly selected, and from each household one individual was randomly chosen to complete the giving, volunteering and

participating questionnaire. Exceptions to the NSGVP sample include residents of the Yukon, Northwest, and Nunavut territories, and people living on Indian Reserves, full-time members of the Canadian Armed Forces, or inmates of institutions.

With respect to information on informal and voluntary home care, the NPHS and NSGVP data can be aggregated to represent four sub-national regions: *Western Canada* (British Columbia, Alberta, Saskatchewan, and Manitoba); *Ontario*; *Quebec*; and *Atlantic Canada* (New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland). It would be preferable to analyse each province separately; however, aggregation at regional levels in Western and Atlantic Canada is necessary in order to maintain consistency across all tables and figures. The NPHS does provide stable data for sub-provincial levels in Ontario, and this is used to compare the utilisation of home care between the Toronto census metropolitan area (CMA), and the 'urban' and 'rural' sub-regions of Ontario. According to Statistics Canada (1998-1999b), urban Ontario includes those continuously built-up areas having a population concentration of 1,000 or more and a population density of 400 or more per km^2 based on the previous (1996) census. To be considered continuous, the built-up area must not have a discontinuity exceeding two km. Rural Ontario includes those enumeration areas outside the Toronto CMA that are not designated as urban Ontario.

The analytical approach to this research, subsequently, focuses on three levels: (1) national trends of the utilisation and provision of informal and voluntary home care in Canada; (2) inter-regional trends of utilisation and provision of informal and voluntary home care; and (3) sub-provincial trends of utilisation of informal and voluntary home care in Ontario. The integration of results from the analysis of NPHS and NSGVP data at

national and regional levels with results from the analysis of NPHS data at the sub-provincial level provides an empirical basis for understanding the current (circa 1997, 1998, 1999) state of informal and voluntary home care in Ontario.

HOME CARE SERVICES AND VOLUNTARISM IN ONTARIO: RESULTS FROM THE NPHS AND NSGVP

The results of the exploratory analysis of informal and voluntary home care data are summarised in two parts. First, the results concerning key national trends and inter-regional variations in the utilisation and provision of home care are highlighted. This sets the empirical context for the specific focus on the geographical patterns of utilisation and provision of home care within metropolitan (Toronto), urban and rural Ontario.

National Trends and Inter-Regional Variations

In Canada, 2.7 per cent of the total population use some type of formal home care service. Figure 2 shows that, regionally, Ontario has the most use of home care services per capita (3.1%), while Quebec has the least (2.2%). The types of home care services received in Canada according to the proportion of total services used include: nursing (28%); housework (27%); personal care (21%); other health care (such as physical or occupational therapy) (9%); meal preparation or delivery (9%); shopping for groceries or other necessities (3%); and respite for informal and voluntary caregivers (3%) (Statistics Canada, 1998-1999a).

The use of home care differs between gender, age and income. Table 1 reveals that women, those over 65 years of age and those with an annual household income (AHI) below $40,000 receive more home care than men, those under 65 and those with an AHI above $40,000. While this general trend is replicated regionally, it is clear that

Ontario has the largest proportion of women and men, of those over and under 65, and of those with an AHI below and above $40,000 receiving home care.

It is also important to consider the different demands (or needs) for home care. Major types of help needed include: acute medical or post-surgical care; rehabilitative care; palliative care; habilitative care; supportive care (for those with on-going physical and personal needs related to a chronic health condition); and others such as mental health needs (KFLA CCAC, 2000). The level and type of need for home care are examined using the NPHS variable 'derived need for help in a series of tasks'. As indicated in Figure 2, approximately 11 per cent of the total population requires some form of help with tasks relating to home care (11.1%). The highest need for help, regionally, is in Atlantic Canada where 13.3 per cent of the population needs help, as compared to Quebec which has the lowest proportion of its population needing help (10.3%). The proportion of the population that needs help in Ontario mirrors the national average at approximately 11 per cent. The types of help needed for home care related tasks include according to the proportion of total help required: heavy household chores (44%); housework (19%); shopping (16%); meal preparation (10%); personal care (6%); and moving about inside the home (5%) (Statistics Canada, 1998-1999a).

The need for home care related tasks also varies between gender, age and income. Women, those over 65 years of age and those with an AHI below $40,000 receive more home care than men, those under 65 and those with an AHI above $40,000 (see Table 2). While this general trend is similar to that of home care received, and is reproduced regionally, it is clear that Atlantic Canada has the largest proportion of women and men,

of those over and under 65, and of those with an AHI below $40,000 that need help. Ontario has the largest proportion of those with an AHI above $40,000 that need help.

In terms of voluntarism, approximately 31 per cent of the total population in Canada is involved in some type of voluntary activity. Figure 3, shows that, regionally, Western Canada has the most volunteers per capita (37.3%), as compared to Quebec, which has the least (22.1%). The proportion of population in Ontario that volunteers is just above the national average at 32 per cent. 'Volunteers' are those individuals age 15 and over, who willingly perform a service without pay, through a group or organisation, and who volunteered at least once in the 12 months preceding the NSGVP (Statistics Canada, 1997b). Voluntary activities in Canada are co-ordinated through various organisations focussing on a wide range of interests including: arts and culture; education and youth development; employment and economic interests; environment and wildlife; foreign and international development; health; law and justice; multi-domain (e.g., Red Cross and YM/YWCA); religion; social services; society and public benefit; and sports and recreation (Hall *et al*., 1998). Several of the activities co-ordinated through health and social services organisations are related directly to the utilisation of home care services discussed above. Home care related voluntary activities include providing care and support; preparing, delivering and serving food; driving; and maintenance (Statistics Canada, 1997b).

Excluded from the NSGVP definition of 'volunteer' are those people who give their time as individuals, unconnected to formal group structures or activities. As indicated in Figure 3, in Canada, approximately 73 per cent of the total population volunteers 'informally' (73.1%). Similar to the inter-regional variations in formal

volunteering, Western Canada has the most informal volunteers per capita (77.3%), Quebec has the least (67.2%) and Ontario is just above the national average (73.2%). Informal volunteers are involved in various types of activities including housework; yard work and maintenance; shopping and driving; support for the sick and elderly; support for recovery from short-term illness; visiting the elderly; baby-sitting; assistance with correspondence; teaching and coaching; business and farm work (Statistics Canada, 1997b). The first five types of informal activities listed above also relate directly to the use of home care services.

With respect to gender, age and income, Table 3 reveals that women, those under 65 years of age, and those with an AHI above $40,000 volunteer (formally) more than men, those over 65, and those with an AHI below $40,000. Parallel differences in gender, age and income exist with respect to informal volunteering (see Table 4). The general trend of formal and informal volunteering is mirrored in every region except Quebec, which has a marginally higher proportion of men volunteering formally than women. It is also evident that Quebec has the least amount of volunteering (formal and informal) per capita across all gender, age and income categories. Western Canada has the largest proportion of women, men, and those under 65 volunteering (formal and informal) per capita. Ontario has the highest percentage of those over 65 volunteering (formal and informal). With respect to income, the parallel trends of formal and informal volunteering, however, diverge. Western Canada has the highest percentage of those with an AHI below $40,000 formally volunteering, while Atlantic Canada has the highest percentage of those who informally volunteer. Conversely, Atlantic Canada has the

highest percentage of those with an AHI above $40,000 who formally volunteer, while Western Canada has the highest percentage of those who informally volunteer.

The NPHS and NSGVP results summarised above indicate the importance of home care and voluntarism within Canada, and that Ontario is the region closet to the national average (see Figure 1, Figure 2, Table 1, Table 2, Table 3, and Table 4). In order to shed light on the sub-provincial relationship between health care and voluntarism, the remainder of this section considers the geographical patterns of utilisation and provision of home care within Ontario.

Geographical Patterns within Ontario

In Ontario, approximately three per cent of the total population receives some type of formal home care service (3.1%), and approximately 11 per cent of the total population requires some form of help with tasks relating to home care. While these percentages mirror the national averages, as shown in Figure 4, there is variation within the province. With respect to the use of home care, Rural Ontario has the largest proportion per capita (3.8%), followed by Urban Ontario (3.5%), and Toronto (CMA) (2.4%). With respect to need for help, Urban Ontario has the largest proportion per capita (13%), followed by Rural Ontario (12.5%) and Toronto (CMA) (8.8%).

Similar to the national trends, in Ontario, women, those over 65, and those with an AHI below $40,000 receive more home care and have a greater need for help than men, those under 65, and those with an AHI above $40,000. With the available NPHS data, the need for help within Ontario can be broken down further to show that demand for home care services is not consistent throughout the province. Table 5 reveals that more women in Urban Ontario need help than in Rural Ontario; that more of those under

and over 65 need help in Urban Ontario than in Rural Ontario; and that more of those with an AHI below $40,000 need help in Rural Ontario, but more of those with an AHI above $40,000 need help in Urban Ontario. Across all gender, age and income categories, Toronto (CMA) has the lowest proportion of the population that need help.

The major types of services used by the population receiving home care in Ontario are nursing care, other types of health care, housework, and personal care. Figure 5 shows that the population receiving home care uses nursing care the most (35%) and personal care the least (12%). All six types of help required with home care related tasks nationally are needed in Ontario. Figure 6 shows that the population requiring home care needs help with heavy chores the most (43%) and with moving about inside the home the least (5%). Figure 7 indicates that the general pattern of need for help is consistent within Ontario; however, there is a disparity between the types of home care services received and the types of help required. This suggests that there are a number of types of help needed that are not being met through formal home care service provision.

Indeed, a key consideration when exploring the utilisation and provision of home care services is: how many individuals are receiving informal care? This question can be resolved, in part, by using the percentage of respondents in the NPHS who identify a need for help with home care related tasks who also receive formal home care services (Yantzi and Rosenberg, 2001). Figure 8 shows that in Ontario, only approximately 20 per cent of the total population that requires help, received formal home care services. It can be inferred that that individuals who identify a need for help but do not receive formal home care services rely on the informal sector to provide the assistance or care that is required, or that they do not receive any care at all. Within the province, Rural

Ontario has the smallest proportion of population who need help and do not receive formal home care (75%), followed by Toronto (CMA) (80.5%) and Urban Ontario (81.2%). This suggests that with respect to the utilisation of home care services in Ontario, both the informal and formal sectors are important components, and, in turn, this raises questions regarding the scope of (formal and informal) volunteering.

Voluntarism in Ontario also replicates the national trends, with 32 per cent of the total provincial population involved in voluntary activities and approximately 73 per cent involved in informal volunteering (73.2%). Due to the sample limitations of the NSGVP, comparisons between metropolitan (Toronto), urban and rural Ontario are not available. Similar to the national level, however, in Ontario, women, those under 65, and those with an AHI above $40,000 volunteer (formally and informally) more than men, those over 65, and those with an AHI below $40,000 (see Figure 9).

The scope of the voluntary sector in Ontario can be explored using the proportion of the population involved in different types of home care related formal and informal voluntary activities. There is a wide range of formal voluntary activities in Ontario, including according to proportion of provincial population involved: organising activities (16.1%); canvassing, campaigning and fundraising (13.9%); membership of a board or committee (12%); teaching and coaching (9%); consulting, executive and administrative assistance (9%); educate, influence and lobby public (8.7%); collecting, serving and delivering food (6.9%); provide care or support (6.9%); driving for an organisation (5%); maintaining, building and repairing facilities (3.8%); environmental and wildlife protection (3.7%); provide health care for seniors in hospitals (2.2%); working with self-help groups (2%); and first-aid, fire-fighting, and search and rescue (1.4%). This range is

shown in Figure 10, which indicates that approximately four to seven per cent of the provincial population are involved in some type of formal volunteering relating directly to the provision of home care in Ontario, namely, collecting, serving and delivering food; providing care and support; driving; and maintenance.

There is also a wide range of informal voluntary activities in Ontario, including according to the proportion of the provincial population involved: unpaid baby-sitting (41.4%); shopping and driving for necessities (40.4%), correspondence and writing letters (35.8%); yard work and maintenance (33.3%); housework (32.5%); visiting the elderly (31.8%); supporting the sick and elderly (27.3%); supporting recovery from short-term illness (24.7%); unpaid teaching and coaching (14.5%); and business and farm work (12%). The breadth of informal activities is shown in Figure 11, which indicates that approximately 25 to 40 per cent of the provincial population are involved in some type of informal volunteering relating directly or indirectly to the provision of home care in Ontario, namely, shopping and driving; yard work and maintenance; housework; supporting the sick and elderly; and supporting recovery from short-term illness.

Although comparisons can not be made between metropolitan (Toronto), urban and rural Ontario, the results from the NSGVP do suggest that formal and informal voluntary activities are important components of the provision of home care services in the province. These results complement the suggestion from NPHS results that formal and informal sectors are both important components of health care in Ontario.

DISCUSSION: LINKING HEALTH CARE AND VOLUNTARISM IN RURAL COMMUNITIES

The exploratory analysis of NPHS and NSGVP data provides remarkable insights into the utilisation and provision of informal and voluntary home care in Canada and Ontario as it appears in the late 1990s. The cross-section (or 'snap-shot') illustrates the key trends and variations in the use and type of formal and informal home care, and in the extent and type of formal and informal voluntary activity. Overall, the empirical evidence suggests that the current state of community-based, informal and voluntary care in Canada, Ontario, and when comparing metropolitan, urban and rural Ontario reflects the changing nature of local governance associated with public institutional restructuring.

While there is much variation in the utilisation of home care and provision of home care related voluntary activities between regions and within Ontario, there are no discernible geographical patterns. This result is indicative of the idiosyncratic nature of provincial home care policies that stems, in part, from the lack of national regulatory standards concerning home care. At the same time, it is symptomatic of the inter-dependent nature of health care and voluntarism policy decision-making, which leads to diverse and disparate experiences within and between provincial jurisdictions. The NPHS and NSGVP results, however, do demonstrate that informal and voluntary sectors are major components of the local organisation and delivery of home care in Ontario.

Specifically, the NPHS results indicate that both the formal and informal sectors are important features of home care services in Canada and Ontario. Various types of formal and informal home care services, including nursing, housework, personal care and meal preparation, are used for managing acute illness and supporting individuals with long-term, complex care needs. The exploration of NPHS data is even more significant

given the evidence that less than one-quarter of the national and provincial population who require help with home care related tasks receive formal home care services (i.e., three-quarters of the population who need help rely on the informal sector to provide care, find other ways to cope or forego any type of help at all).

The NSGVP results indicate that formal and informal voluntary sectors are important components of health care in Canada and Ontario. More importantly, the analysis reveals that various types of (formal and informal) voluntary activities, including housework, maintenance, support for the sick, elderly and short-term recovery, preparing and delivering food, and shopping and driving, are related directly to the organisation and delivery of formal and informal home care. The results of this analysis accentuate the suggestion that the development of community-based, informal and voluntary care in Canada and Ontario reflects the changing nature of local governance associated with public institutional restructuring. This is a thesis, however, that warrants more sophisticated analysis, and it is here where the focus on rural communities as the pre-eminent places in which and from which people experience restructuring outcomes becomes important.

Several important reasons underscore the emphasis on rural Canada that permeates this research. First and foremost, as Moore *et al.* (1997; 2000) have demonstrated, rural communities have among the highest relative proportions of the elderly population, making the demand for home care in rural Canada an acute and immediate issue. Second, the same demographic trends that have led to higher proportions of seniors living in rural areas have also left the potential pool of (formal and informal) volunteers, and the associated capacity for voluntarism, relatively small in

comparison to that of urban areas. Third, low population densities, which define rural areas, make the delivery of formal home care services even more challenging than in urban areas (i.e., it is difficult to develop economies of scale). Fourth, rural areas generally have smaller tax bases and even less potential to generate new revenues than urban areas (see Rosenberg and Moore, 1990). This raises the question: how will rural administrators pay for restructured health and social services if higher levels of government fail to transfer adequate resources? Finally, there remains a perception that rural communities have a stronger sense of voluntarism than urban communities. Yet, traditional 'rural values' are being challenged as more people from urban places retire to rural communities (see Halseth and Rosenberg, 1995a,b; Halseth, 1998). What this increasingly complex cultural relationship means for voluntarism and the delivery of health care services among a population that no longer knows each other needs to be considered.

The results demonstrate also the considerable empirical and conceptual limitations of the NPHS and NSGVP. The surveys are indicative of the general paucity of accessible and appropriate quantitative (or qualitative) data regarding the development of informal and voluntary care at the local level (whether rural or urban) (Hall, 2001; Thériault and Salhani, 2001). Notwithstanding their respective sample sizes, neither survey provides appropriate respondent criteria to meet Statistics Canada data release requirements for analyses at the local (community) level (Statistics Canada, 1997b; 1998-1999b). Indeed, the NSGVP is considered to only scratch the surface of voluntarism at the national level (Hall *et al*., 2000).

At the same time, the NPHS and NSGVP are indicative of prevailing survey research designs that neglect to conceptualise the link between health care and voluntarism. This is an important concern given the current restructuring and reform policy environment, which assumes that informal and voluntary sectors can and will play an increasingly important and effective role in the provision of health care services (e.g., Ontario HSRC, 2000). Despite a comprehensive range of questions respectively, neither survey is designed to understand current health care regimes that are increasingly dependent upon voluntarism. These limitations resonate with concern for the 'informational vacuum' within which governments, health policy analysts and service providers (not to mention social science researchers) operate with respect to health care in rural communities (Coyte, 2000; Pong, 2000).

CONCLUSION

Current discourse and debates surrounding the political-economy of public services, local governance, health care services and rural community development inform the exploration of community-based, informal and voluntary care in rural Canada. The integration of the concepts and findings from the literature provides a framework for understanding the development of community-based, informal and voluntary care with respect to the broad political-economic and (public) institutional context within which rural communities experience the dynamic and complex issues of changing governance and health care services.

The dynamic relationship between the changing nature of local governance and health care is played out through the local organisation of health care services. This is explored with respect to rural communities in Canada, which are experiencing significant

political, economic and social changes associated with the development process in contemporary Western capitalist societies (Pinch, 1997). Public institutional restructuring, including attendant re-working of central-local relations and public-private responsibilities and subsequent re-regulation of the roles of the state, community and individuals, has facilitated the ascendancy of community-based, informal and voluntary sectors in the local development process (Wolch, 1990; Rekart, 1993; Goodwin, 1998; Marshall, 1999; Moran, 1999; Stoker, 2000). As a result, rural communities and their informal and voluntary sectors are emerging as major players in the local organisation and delivery of health care services (Halseth and Williams, 1999; Cloutier-Fisher and Joseph, 2000; Jenson and Phillips, 2000).

The exploratory analysis of Statistics Canada data described in this paper provides enough evidence to suggest that there is a geographical expression to health care and voluntarism, and that the relationship between the changing nature of governance and health care services in rural communities should be pursued further at the local level. At the same time, the conceptual and empirical limitations of the NPHS and NSGVP reinforce the need for more detailed information that integrates health care and voluntarism data at meaningful geographical and administrative scales that reflect rural communities. These conclusions build on the limited literature surrounding restructuring, governance and health care in rural communities, and engage directly the need to consider in greater depth the changing nature of local governance and the ascendancy of local informal and voluntary sectors with respect to health care issues (Crampton *et al.*, 2001; Hanlon, 2001). It is here where the conceptual framework for exploring the development of community-based, informal and voluntary care may prove useful.

Although theoretical links between the changing nature of local governance and health care services are being developed in academic and public policy discourse (e.g., Coyte, 2000; CHSRF, 2001; Jenson, 2001), there is still a need to think about how to explore the scope of this relationship empirically. Indeed, if public institutional restructuring processes in general, and health care reforms in particular, continue to depend on the ascendancy of community-based, informal and voluntary sectors, why not begin to collect appropriate information at this level? Regardless of the methods and data employed, future research will require more attention to the rural context, addressing recent calls in the literature to shed light on the 'curious neglect' of governance and health care services issues in rural communities (Kearns and Joseph, 1997; Goodwin, 1998).

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FIGURE 1 **Framework for Exploring Community-Based, Informal and Voluntary Care**

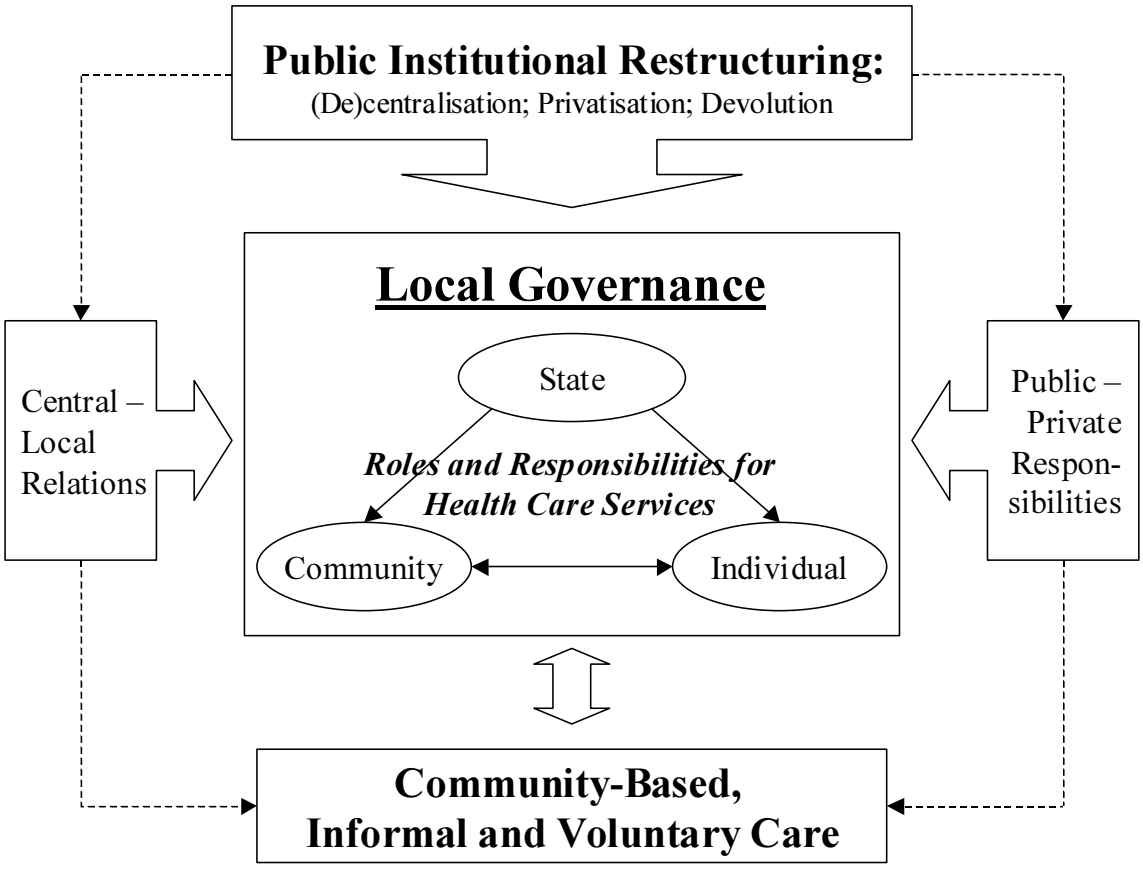
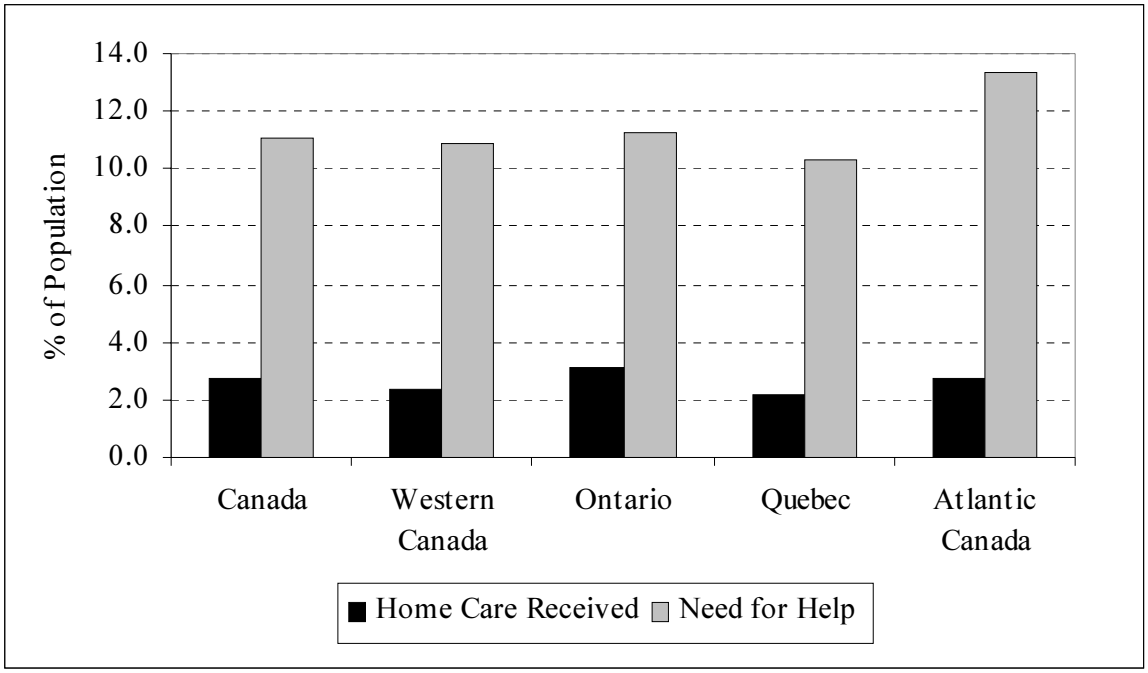
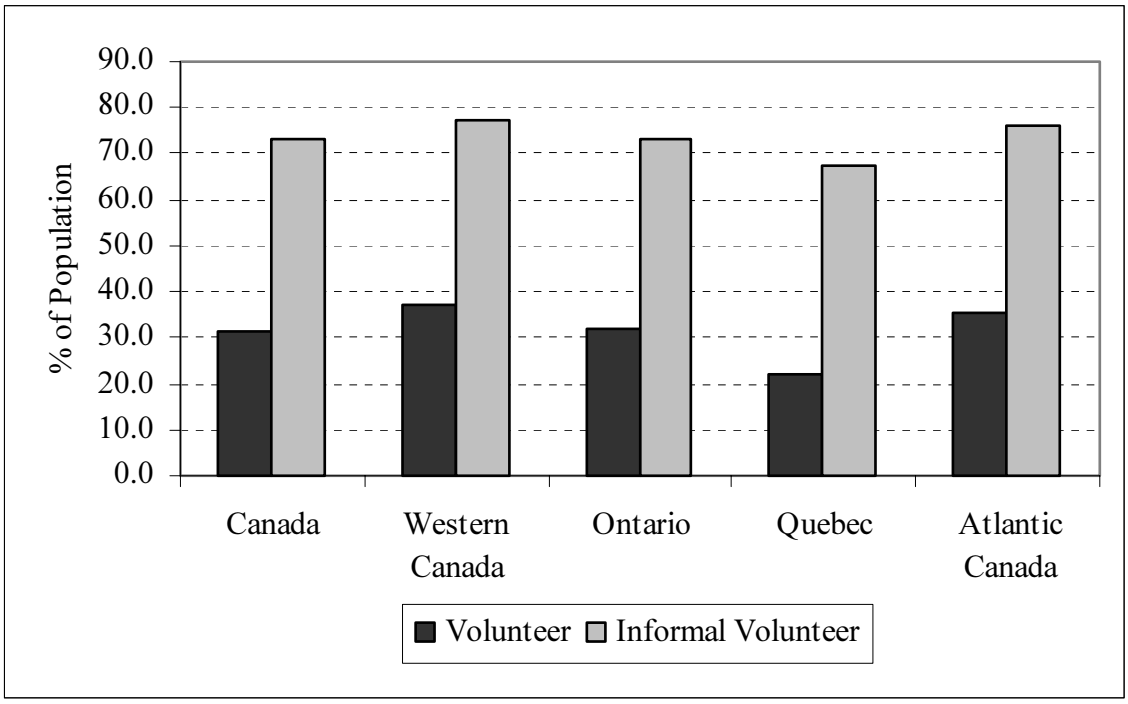


FIGURE 2 **Home Care Received and Need for Help in Canada**



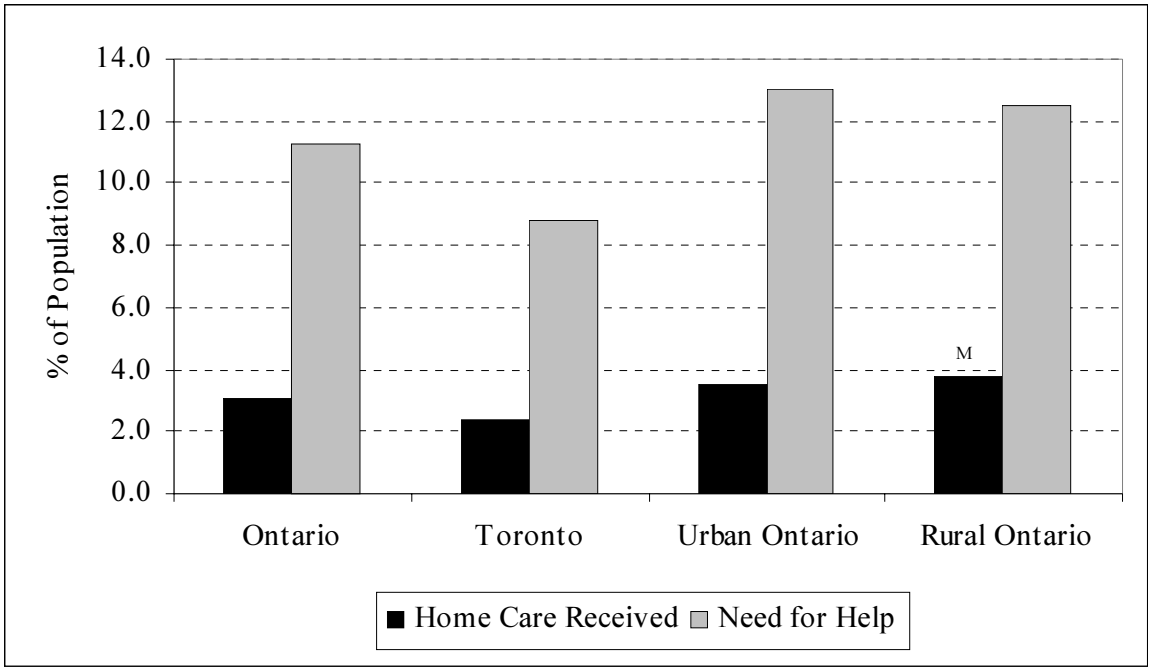
(Statistics Canada, 1998-1999a)

FIGURE 3 Volunteers and Informal Volunteers in Canada



(Statistics Canada, 1997a)

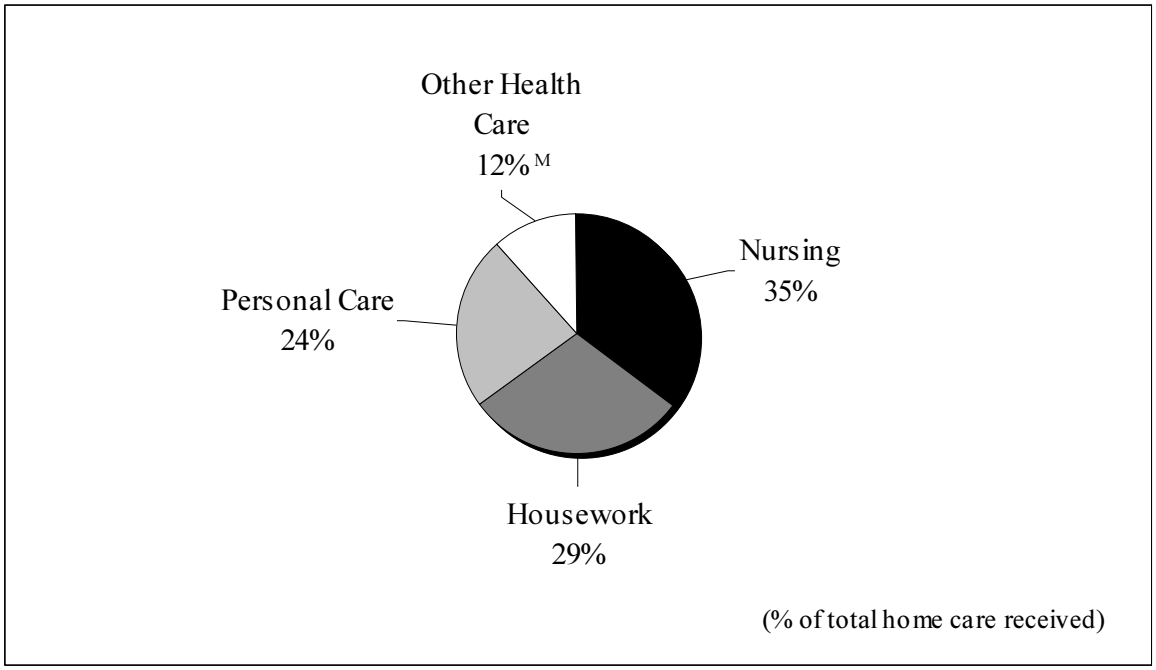
FIGURE 4 Home Care Received and Need for Help in Ontario



[M] According to Statistics Canada (1998-1999b), the coefficient of variation for this estimate is between 16.6% and 33.3%: it has a high sampling variability.

(Statistics Canada, 1998-1999a)

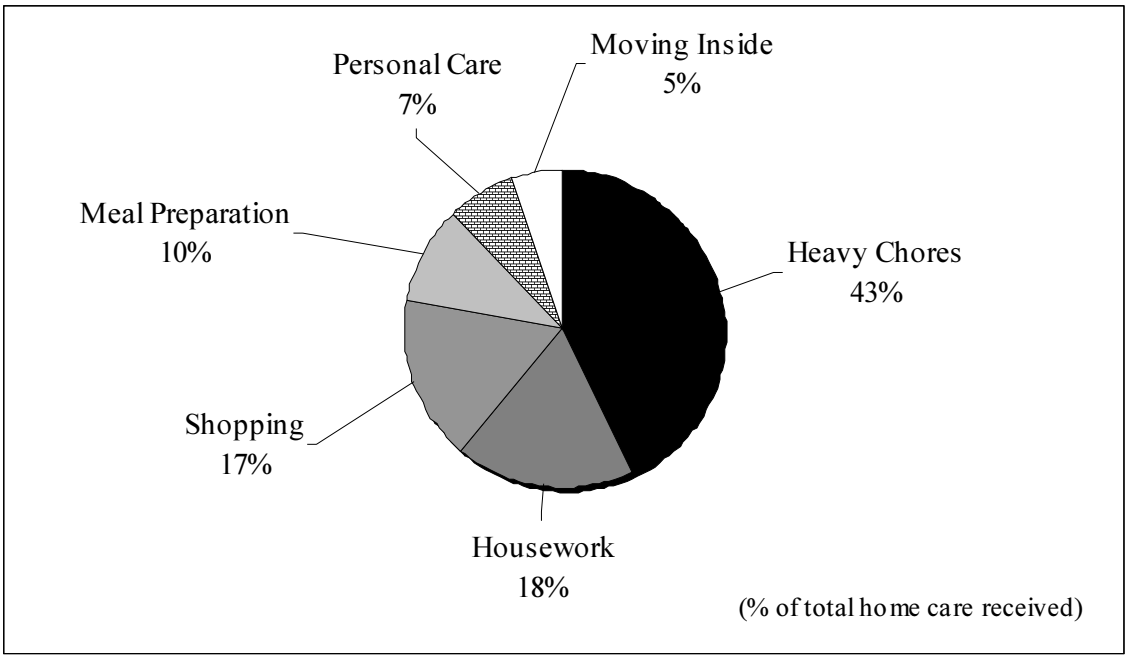
FIGURE 5 Types of Home Care Received in Ontario



[M] According to Statistics Canada (1998-1999b), the coefficient of variation for this estimate is between 16.6% and 33.3%: it has a high sampling variability.

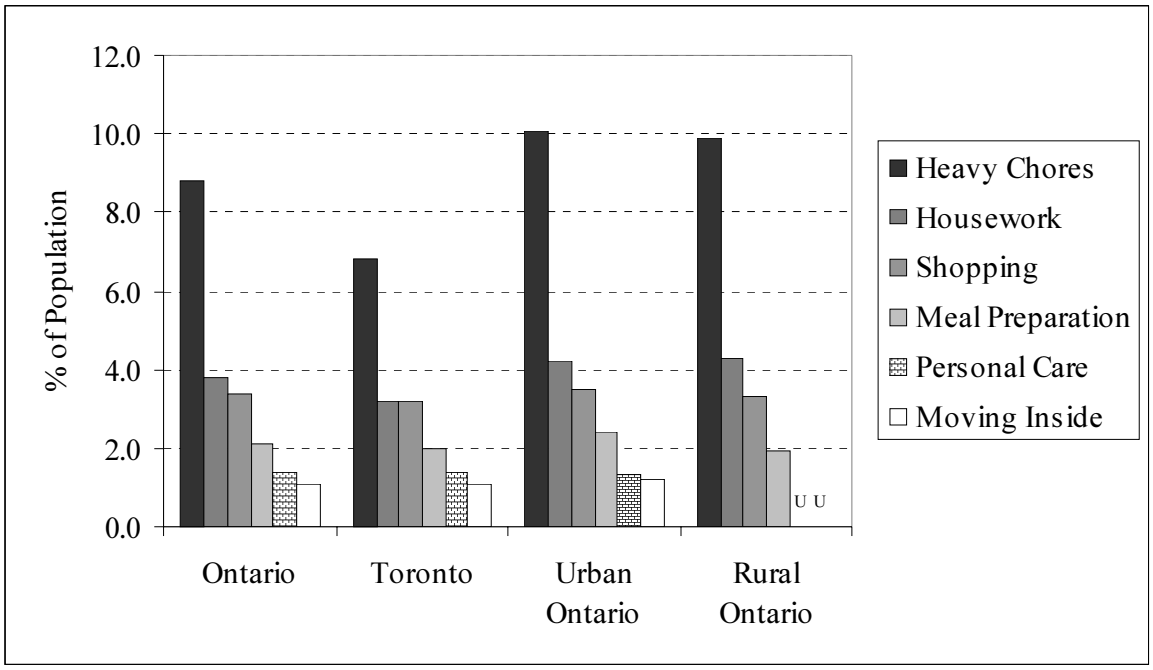
(Statistics Canada, 1998-1999a)

FIGURE 6 Types of Need for Help in Ontario



(Statistics Canada, 1998-1999a)

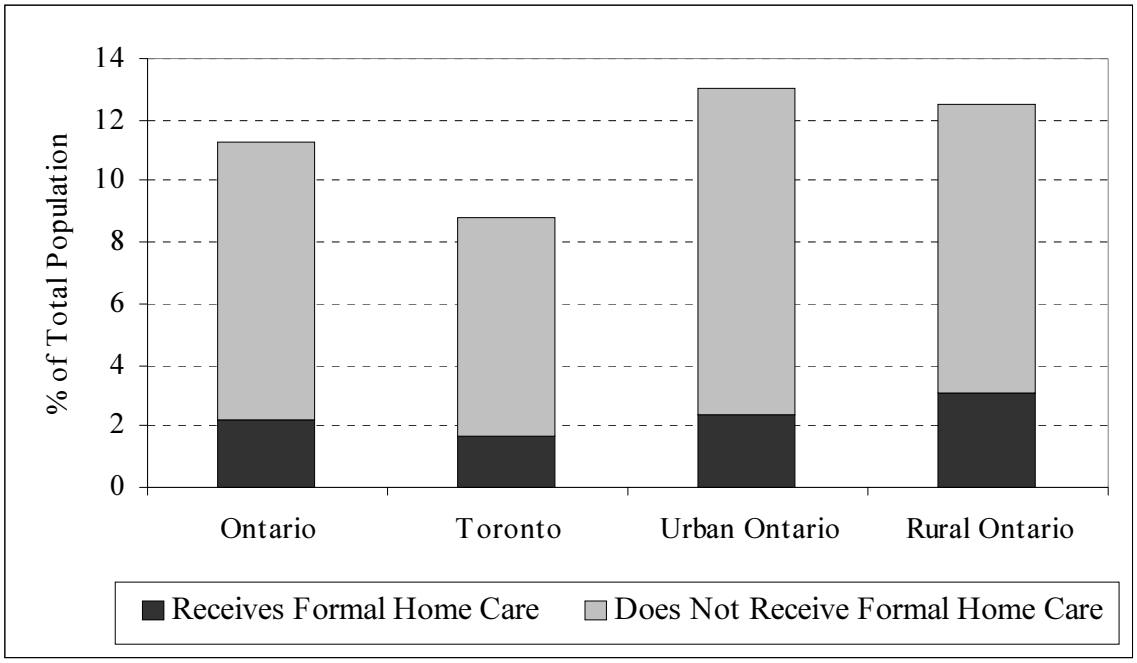
FIGURE 7 **Types of Need for Help in Ontario, Toronto, Urban Ontario and Rural Ontario**



[U] According to Statistics Canada (1998-1999b), the coefficient of variation for this estimate is greater than 33.3%: it unacceptable for release.

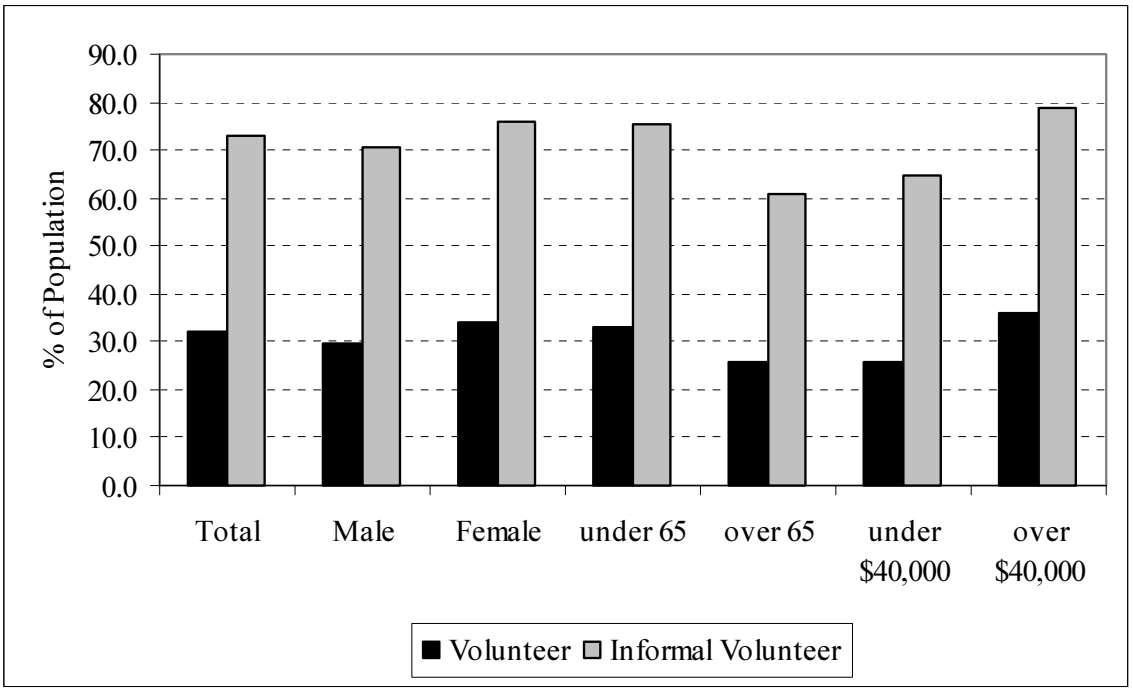
(Statistics Canada, 1998-1999a)

FIGURE 8 **Receipt of Home Care within Population that 'Needs Help' in Ontario**



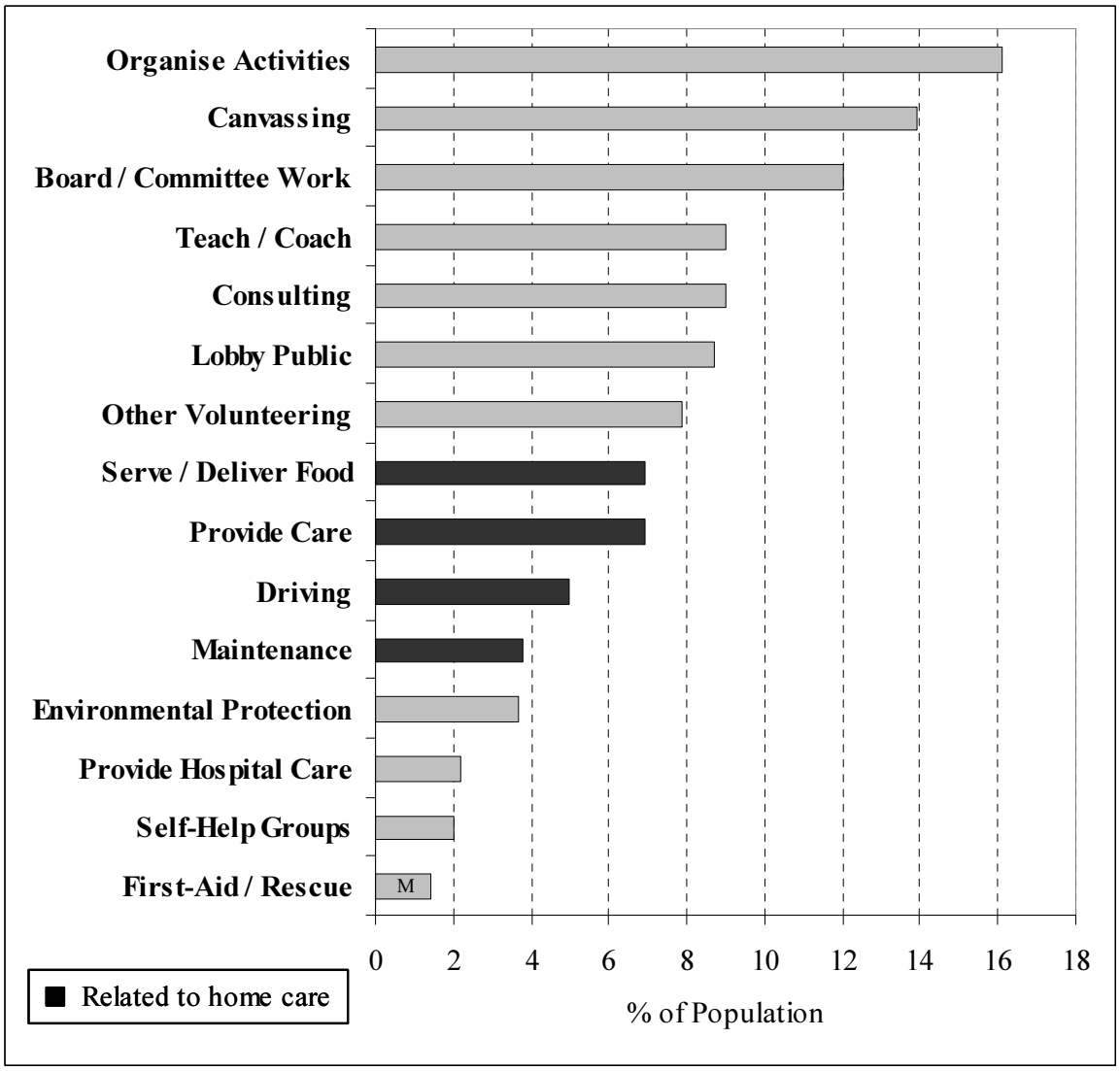
(Statistics Canada, 1998-1999a)

FIGURE 9 Volunteers and Informal Volunteers in Ontario



(Statistics Canada, 1997a)

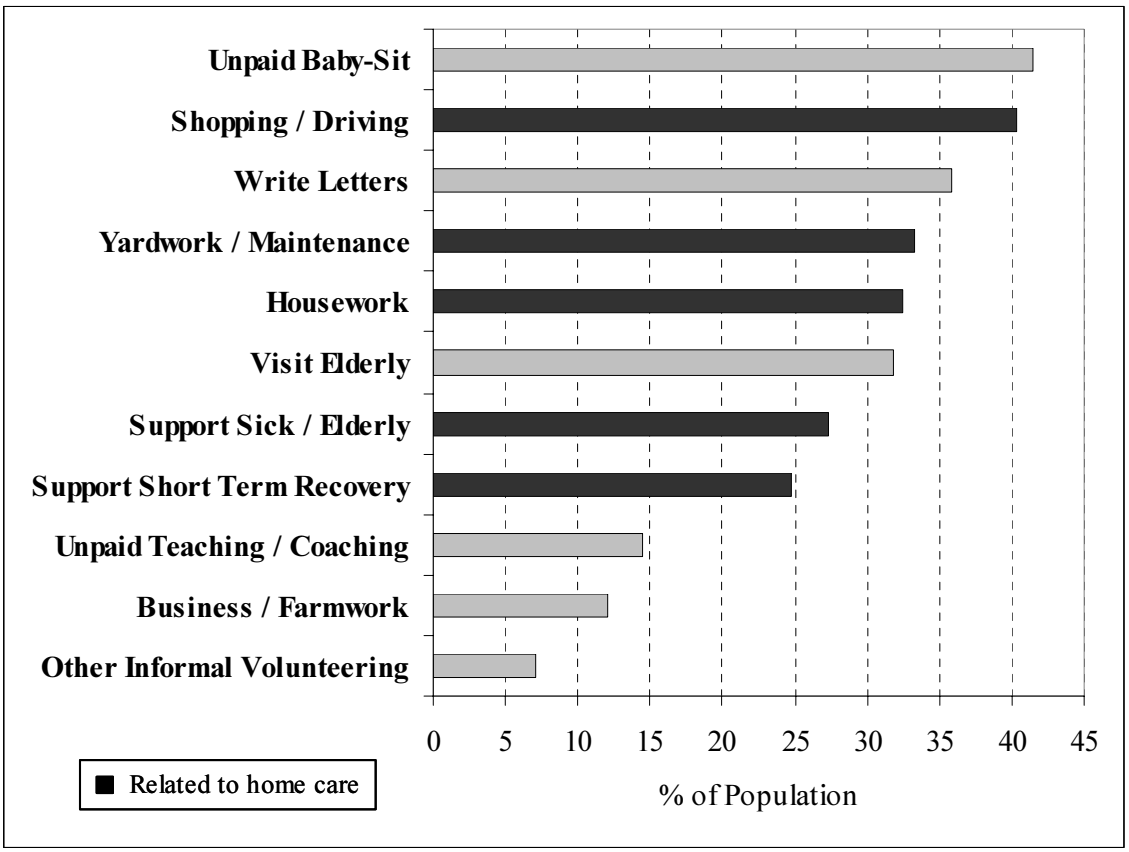
FIGURE 10 Types of Volunteering in Ontario



[M] According to Statistics Canada (1997b), the coefficient of variation for this estimate is between 16.6% and 33.3%: it has a high sampling variability.

(Statistics Canada, 1997a)

FIGURE 11 Types of Informal Volunteering in Ontario



(Statistics Canada, 1997a)

TABLE 1 Home Care Received in Canada by Gender, Age and Income

	Canada	Western Canada	Ontario	Quebec	Atlantic Canada
% of Total Population	2.7	2.4	3.1	2.2	2.7
% of Male Population	1.8	1.5	2.1	1.7[M]	1.9
% of Female Population	3.5	3.4	4.0	2.7	3.4
% of Population under 65	1.0	0.9	1.2	0.8[M]	1.0
% of Population over 65	11.5	10.7	13.1	9.9	11.6
% of Population with Annual Household Income below $40,000	4.8	4.3	6.6	3.5	4.0
% of Population with Annual Household Income above $40,000	1.0	1.0	1.1	[U]	1.1

[M] According to Statistics Canada (1998-1999b), the coefficient of variation for this estimate is between 16.6% and 33.3%: it has a high sampling variability.

[U] According to Statistics Canada (1998-1999b), the coefficient of variation for this estimate is greater than 33.3%: it unacceptable for release.

(Statistics Canada, 1998-1999a)

TABLE 2 Need for Help with Home Care Related Tasks in Canada by Gender, Age and Income

	Canada	Western Canada	Ontario	Quebec	Atlantic Canada
% of Total Population	11.1	10.9	11.3	10.3	13.3
% of Male Population	7.9	7.3	7.7	8.0	10.9
% of Female Population	14.1	14.4	14.7	12.5	15.6
% of Population under 65	6.8	6.9	7.0	5.8	8.3
% of Population over 65	37.5	35.2	37.4	38.5	43.0
% of Population with Annual Household Income below $40,000	17.4	16.7	18.8	15.9	19.1
% of Population with Annual Household Income above $40,000	6.5	6.7	7.0	5.3	6.3

(Statistics Canada, 1998-1999a)

TABLE 3 Volunteering in Canada by Gender, Age and Income

	Canada	Western Canada	Ontario	Quebec	Atlantic Canada
% of Total Population	31.4	37.3	32.0	22.1	35.7
% of Male Population	29.4	33.8	29.7	22.5	32.2
% of Female Population	33.3	40.8	34.2	21.7	39.1
% of Population under 65	32.9	39.4	33.1	23.3	38.0
% of Population over 65	22.8	25.5	25.6	15.2	22.7
% of Population with Annual Household Income below $40,000	25.3	30.0	25.9	18.6	29.7
% of Population with Annual Household Income above $40,000	37.1	43.8	36.2	26.8	45.0

(Statistics Canada, 1997a)

TABLE 4 Informal Volunteering in Canada by Gender, Age and Income

	Canada	Western Canada	Ontario	Quebec	Atlantic Canada
% of Total Population	73.1	77.3	73.2	67.2	76.0
% of Male Population	70.9	74.9	70.3	66.2	73.8
% of Female Population	75.3	79.7	75.9	68.2	78.2
% of Population under 65	75.8	80.5	75.3	68.9	79.5
% of Population over 65	57.8	59.2	60.8	52.1	56.3
% of Population with Annual Household Income below $40,000	67.5	71.1	64.8	64.7	73.2
% of Population with Annual Household Income above $40,000	73.5	82.8	78.9	70.7	80.5

(Statistics Canada, 1997a)

TABLE 5 Need for Help in Ontario by Gender, Age and Income

	Ontario	Toronto (CMA)	Urban Ontario	Rural Ontario
% of Total Population	11.3	8.8	13.0	12.5
% of Male Population	7.7	6.1	8.6	9.7
% of Female Population	14.7	11.5	17.0	15.2
% of Population under 65	7.0	5.2	8.3	7.9
% of Population over 65	37.4	34.9	38.9	38.2
% of Population with Annual Household Income below $40,000	18.8	13.8	21.7	22.3
% of Population with Annual Household Income above $40,000	7.0	6.4	7.5	7.1

(Statistics Canada, 1998-1999a)

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