

**MISSING LINKS:
The Effects of Health Care
Privatization on Women in
Manitoba and Saskatchewan**

Kay Willson and Jennifer Howard



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Executive Summary

During the past decade, the governments of Manitoba and Saskatchewan, like those in other provinces, have introduced major changes to the health care system. This process of health care reform and restructuring has been driven, in part, by federal and provincial policies to limit the role of the state and control public expenditures on health care. Health care reform has also taken place within the context of a public discourse on the determinants of health, which recognizes that health is influenced by social, economic, and environmental conditions, not simply by the delivery of health care services.

Several of the reforms in the health care system can be understood as a renegotiation of the boundaries between public and private responsibility for health. The privatization of health care refers to several different policy directions which limit the role of the public sector and define health care as a private responsibility. The privatization of health care includes:

- P privatizing the costs of health care by shifting the burden of payment to individuals
- P privatizing the delivery of health services by expanding opportunities for private, for-profit health service providers

- P privatizing the delivery of health care services by shifting care from public institutions to community-based organizations and private households
- P privatizing carework from public sector health care workers to unpaid caregivers
- P privatizing management practices within the health system, by adopting the management strategies of private sector businesses.

Historically, prairie women's organizations played an important role in the development of a publicly-funded, publicly-administered health care system in Canada. Women, to a greater extent than men, utilize the health care system to access services for themselves and other family members. Women are the majority of workers in several health care occupations, and women provide most of the unpaid, informal health care within the home. Women earn less than men, are more likely to live in poverty, and are less likely to have private health insurance.

Privatization in the health care system can be expected to have significant impacts on women as users of health services, as health care workers, as informal caregivers, and as citizens engaged in public debates over the future of the health system. Women in varying circumstances, with access to different resources, will

be affected by these changes in different ways. The purpose of this paper is to provide an overview of some of the forms of health care privatization which have taken place in Manitoba and Saskatchewan in recent years, and to begin to identify some of the impacts of those changes on various groups of women.

The vast majority of health services and programs in Manitoba and Saskatchewan are provided as publicly-insured services, without additional fees charged to patients. However, many people pay privately for prescription drugs, dental care, optometric services, complementary medicines, treatments by non-physicians, long-term care, and some home care services. Since 1990, public expenditures as a proportion of total health spending have declined and private health expenditures have risen substantially. There have been significant changes to provincial prescription drug plans and the provincial public health insurance plans have de-listed or excluded several important health services. The shift from institutional to community-based care has also resulted in a transfer of costs to the individual, as services, provided at public expense to hospitalized patients, are no longer covered for outpatients. Private health insurance programs have expanded to fill the gaps in public coverage, but private insurance is not accessible to all.

In addition to the costs of health services, the delivery of health services has been privatized in a number of ways, although the patterns vary somewhat in the two provinces. Examples of privatization include the elimination of the publicly delivered school-based dental programs, the contracting out of food and cleaning services in hospitals to private, for-profit companies, the use of private, for-profit medical laboratories, the expansion of private personal care homes, the privatization of home care services, and the expansion of private health clinics. These forms of privatization have, at times, been encouraged by government policy and, at times, been subjected to government regulation.

Health care in Manitoba and Saskatchewan has also been privatized in the sense that carework has been transferred from institutions to private households. Home care services have increased and now include a greater proportion of acute care patients. The number of institutional beds in both hospitals and nursing homes has declined. The average length of hospital stays has also been reduced.

There have been very few studies of the impacts of these changes on women, despite the fact that women are the majority of those who provide bedside care, either as paid health care workers, or unpaid informal caregivers. Among the studies surveyed, several important impacts on female health care workers were identified: loss of secure, well-paid, public sector jobs, increased workloads, stress, physical and emotional strain, financial losses, social isolation, loss of control, and working conditions which make it difficult to provide quality care.

The reorganization of health services and the transfer of health care costs to the individual may have affected women's access to services and the quality of care they receive, yet very little is known about the impacts of privatization on women as users of health services.

The shift from institutional to community and home care has created new demands on informal caregivers. The studies which centralize the experiences of caregivers point to the need to develop policies which will promote the well-being of care providers and enable them to deliver a high quality of care.

The impact of health care reform on women has not received the attention it deserves from the research community, although some women have been voicing their concerns about the adverse effects these changes have had on their lives and their health. This situation points to the need for a more thorough assessment of the impacts of health care privatization and other aspects of health care reform on women.

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PART

1 INTRODUCTION

A. PRAIRIE WOMEN AND THE CHANGING HEALTH SYSTEM

Prairie women's organizations played an important role in the historical development of a publicly-funded, publicly-administered health care system in Canada. Saskatchewan is known as the "birthplace of Medicare." Former Saskatchewan Premier Tommy Douglas is often credited as one of the "fathers of Medicare." Though less well-known, prairie women like Violet McNaughton, Sophia Dixon, Louise Lucas, and Beatrice Trew could well be identified as "mothers of Medicare." Years before the "birth" of Medicare, organizations of rural women persistently campaigned for a publicly-funded, locally-controlled system which would ensure that medical assistance be available to all. They raised public awareness and built alliances which encouraged prairie farm organizations, the Canadian Commonwealth Federation (CCF), and eventually the Saskatchewan New Democratic Party (NDP) government to develop a publicly-funded, universal health insurance program which allocates health care services on the basis of need rather than the ability to pay.

Recognizing the effects of poverty and inequality on the well-being of people and communities, many also campaigned for a radical redistribution of wealth and a greater voice in decision-making.¹

In 1947, the CCF introduced a public program of universal hospitalization insurance for residents of Saskatchewan. Manitoba brought in its first universal hospital insurance on July 1, 1958, with the support of the federal government. In 1962, the Saskatchewan NDP introduced *The Medical Care Insurance Act*, providing universal public health insurance for physicians' services. In 1969, Manitoba joined the federal government and other provinces in adopting Medicare.

Throughout Canada, access to publicly-funded physicians' services, hospital services, and some other health care services is now widely accepted as a basic human right. The extent and specific nature of public responsibility for

¹Georgina Taylor, "Mothers of Medicare," Women's History Month Presentation, Saskatoon, October 1998.

health services, however, remains contested terrain. Not all components of a comprehensive health system are covered by universal public health insurance. When Medicare was introduced in Canada, public insurance for physicians' services was seen as an initial, but incomplete, system of publicly-funded health benefits. According to Prime Minister Lester B. Pearson:

The scope of benefits should be, broadly speaking, all the services provided by physicians, both general practitioners and specialists. A complete health plan would include dental treatment, prescribed drugs, and other important services, and there is nothing in the approach we propose to prevent these being included, from the start or later. If this were the general wish. We regard comprehensive physicians' services as the initial minimum.²

It is important to distinguish between funding for health services, delivery of health services, and policies and programs which promote health. In Canada, many health services, while publicly-financed, are delivered through a mixture of public and non-profit institutions, private practices and community agencies. Increasingly, factors other than health services, such as income, social status, education, physical environments, and healthy child development, are being recognized as important determinants of health. This concept, called "population health," has expanded the traditional definition of health to include much more than hospitals and physicians' services. Declaring a commitment to population health promotion, governments have identified the need to address the broad social, economic, and environmental determinants of health.

²Lester Pearson at the, First Ministers' Conference in Ottawa, 1965. Cited in Fiona Chin-Yee, *Shifting the Goal Posts and Changing the Rules: The Privatization of the Canadian Health Care System*, M.A. thesis, Acadia University, 1997, p. 19.

During the past decade, the governments of Manitoba and Saskatchewan, like those in other provinces, have introduced major changes to the health care system. This process of health care reform and restructuring has been driven, in part, by federal and provincial policies to limit the role of the state and to control public expenditures on health care and social programs. Health care reform has also been influenced by a growing awareness that population health is determined by social, economic, and environmental conditions, not simply by the delivery of health care services. Within this context, government's role in health care and health promotion is being redefined. While expressing support for Canada's public system of Medicare, governments have also encouraged individuals and non-governmental sectors of society to take more responsibility for health. As a review of recent health reforms will show, the boundaries between public and private responsibility for health are changing.

This paper emerged out of a national effort to understand the effects of recent health reforms on women. Representatives of the five federally-funded Centres of Excellence for Women's Health³ formed the National Coordinating Group on Health Care Reform and Women. As a way to understand this complex subject, the Coordinating Group chose to focus on health care privatization. This paper is not based on original research. Each Centre of Excellence carried out a scan of privatization initiatives in its region, and conducted a literature search for regional research on health care privatization. In particular, we searched for materials which described the impact of privatization

³The British Columbia Centre of Excellence on Women's Health; the Prairie Women's Health Centre of Excellence; National Networks on Environments and Women's Health; Centre d'Excellence pour la Santé des Femmes—Consortium Université de Montréal; and the Maritime Centre of Excellence on Women's Health.

on women as patients, health care workers and unpaid caregivers. In examining current literature on health care reform in Saskatchewan and Manitoba, we quickly found that there was very little research on the impact of privatization and even less on the particular impact on women. Thus, the paper raises as many questions as it answers.

This paper provides a scan of some of the ways that health care is being privatized in Manitoba and Saskatchewan, and reports on the few pieces of research that demonstrate how women are affected by these changes. The greater contribution this paper makes, however, is to begin to lay out an agenda that will firmly place women in the picture when it comes to health policy research and that will allow the decisions that spring from that research to serve more fully the needs of women and men.

B. A DEFINITION OF HEALTH CARE PRIVATIZATION

The privatization of health care refers to several different policy directions which limit the role of the public sector and define health care as a private responsibility. The privatization of health care includes:

- P privatizing the costs of health care by shifting the burden of payment from the state to individuals;
- P privatizing the delivery of health services by expanding opportunities for private for-profit health service providers;
- P privatizing the delivery of health care services by shifting care from public institutions to community-based organizations and private households;
- P privatizing caregiving work from public sector health care workers to unpaid caregivers; and

- P privatizing management practices within the health system, by adopting the management strategies of private sector businesses.

Privatization in the health care system can occur in the payment for health care services or the provision of health care services. In determining whether or not privatization is occurring, we examined services for a shift in terms of who pays for the service or who provides the service. We defined services and providers broadly—for example, we included informal caregivers as providers and the provision of medical supplies as a service.

C. HEALTH REFORM IN MANITOBA AND SASKATCHEWAN

While it is clear that some forms of privatization are occurring in the context of health reform in both provinces, the scale and character of privatization initiatives are mitigated by different recent political histories.

From 1988 to 1999, Manitoba was governed by the Progressive Conservative Party, led by Gary Filmon. On September 21, 1999, the NDP was elected to a majority government and Gary Doer became Premier. David Chomiak, the former Opposition health critic, is the current Minister of Health. Diane McGifford serves as the Minister Responsible for the Status of Women, a critic portfolio she held while in Opposition. Health care was a major, and perhaps deciding, issue in this election.

In the early 1990s, the Manitoba Minister of Health committed to achieving the goals of health reform without introducing user fees or compromising on “the fundamental concept of

Medicare.”⁴ There is no reference to privatization in any of the health reform documents authored by Manitoba Health. However, health policy changes in Manitoba in the 1990s included several large-scale attempts at turning over parts of the public health care system to private for-profit corporations. The provincial Conservative government was not ideologically opposed to privatization, as can be seen by attempts to privatize parts of the Home Care Program, contract-out food services at Winnipeg hospitals and enter into a contract with Electronic Data Systems (EDS) and the Royal Bank of Canada to construct a Provincial Health Information Network.

During the 1980s, the Progressive Conservative government in Saskatchewan, led by Premier Grant Devine, took several steps toward redefining the health care system in the province, including the appointment of a Commission on Directions in Health Care. The commission issued its report in 1990, but the following year the Conservatives were defeated in the provincial election. The major health care privatization initiatives of the Devine government were the elimination of the publicly-funded, publicly-delivered school dental program, reduced coverage for prescription drugs, and other cutbacks in public funding for health and social programs, which led to widespread public protests in 1987.

Since coming to power in 1991, the NDP government, led by Premier Roy Romanow, has introduced several major changes to the health care system. The NDP health reform agenda was introduced in 1992 by then Minister of Health Louise Simard. The current Minister of Health is Pat Atkinson, a Saskatoon Member of the Legislative Assembly (MLA) who served as

Opposition health critic during the Devine era. The current Associate Minister of Health is Judy Junor, former president of the Saskatchewan Union of Nurses. Joanne Crofford serves as the Minister Responsible for the Status of Women. After the provincial election in September 1999, the NDP lacked a majority and reached an agreement with the Liberals to form a coalition government.

The Saskatchewan NDP government presents its position as one which defends Medicare in the face of federal cutbacks in transfer payments to the provinces. The government has expressed explicit opposition to the privatization of health care, particularly to a two-tiered system in which some services would be accessible only to those who could afford them. The government has presented its health reforms as strategies designed to improve the health system and to fulfill Tommy Douglas’s vision of a “second phase of medicare.” Opposition to privatization is evident in several provincial policies. There are no premiums charged for coverage by the provincial health insurance plan. The Medicare legislation includes an explicit prohibition on extra-billing by physicians. There are no private surgical clinics in the province. In 1996, the government introduced *The Health Facilities Licensing Act* which placed restrictions on the expansion of private health facilities, requiring them to secure a license from the province, and prohibiting them from charging patients extra fees. On the other hand, private expenditures for health care in Saskatchewan have risen, hospitals have been closed, care has been shifted from institutions to private households, long-term care in private personal care homes has increased, and some health sector services have been contracted out.

In both provinces there is evidence of privatization creeping into the health care system. While there has been a great deal of public disapproval

⁴Manitoba Health, *Quality Health for Manitobans: The Action Plan*, Winnipeg: Queen’s Printer, 1992, p. v.

towards user fees and extra-billing, health care costs are being transferred to the individual as a result of some health reforms, especially the shift from institutional to “community”⁵ care. While not overtly identified as a privatization initiative, this trend has shifted responsibility for health services out of the public sector and onto the shoulders of families and individuals, who have, in turn, utilized private health services to meet some of their needs.

Starting in the early 1990s, both Manitoba and Saskatchewan embarked on programs of major health policy changes in response to escalating provincial health expenditures and decreasing federal contributions for health care and social services. In Manitoba, this ongoing process is known as “health reform” in Saskatchewan, the government has shifted from a discussion of “health reform” to “health renewal.” Although these processes occurred under ideologically different provincial governments, they had very similar goals and components:

- P a shift to population health frameworks with an emphasis on the determinants of health, disease prevention and health promotion, from an emphasis on provision of health services and treatment of disease;
- P a shift to regional governance of health services from centralized control by provincial governments; and
- P a shift from institutional care to “community” and home-based care.

These various health policy changes were made to meet the goals of effectiveness and efficiency—achieving better health outcomes for individuals at the lowest possible fiscal cost to the province.

Health reform in Manitoba and Saskatchewan occurred at a time when provinces were receiving less federal funding for health care and social services. In Manitoba from 1987/88 to 1998/99, provincial government spending decreased by \$1.1 billion.⁶ In the same time period, federal transfer payments for health, education and income assistance programs were also radically changed. In the 1994 federal budget, the federal government introduced the Canadian Health and Social Transfer (CHST)—block funding for social programs that replaced existing funding schemes such as the Established Program Financing (EPF) and the Canada Assistance Plan (CAP). This change in social program funding has been called “the worst social policy initiative in more than a generation”⁷ because it abolished national standards and severely cut funding to the provinces for social programs. It is estimated that this change will remove \$1.1 billion from social program spending in Manitoba by 2002.⁸ In Saskatchewan, federal cutbacks for health, education and social programs were \$114 million in one year alone, 1996-97. Federal transfers for health were reduced by \$47 million, but the Saskatchewan government chose to fully cover that shortfall with new provincial funding.⁹ Saskatchewan has continued to maintain funding for health care,

⁵The term “community” is used throughout health reform documents in Manitoba and Saskatchewan, usually in the context of shifting the responsibility for caring for sick people from institutions to home and neighbourhood-based options. Using the term “community” to describe who has responsibility for this caring work is misleading, since it is often women, in low-paid and unpaid positions, who carry the load.

⁶Errol Black and Jim Silver, *A Flawed Economic Experiment: the New Political Economy of Manitoba*, Winnipeg: Canadian Centre for Policy Alternatives, June 1999, p. 4.

⁷National Council of Welfare, *The 1995 Budget and Block Funding*, Ottawa: National Council of Welfare, 1995.

⁸Black and Silver, p. 13.

⁹*Saskatchewan Budget Address*, Minister of Finance, 1996.

but it has also made a commitment to deliver balanced budgets over the past six years. Controlling public expenditures for health has been a priority and shifting to population health was seen as an opportunity to cut health care costs.

In 1992, the Saskatchewan NDP government, under Romanow's leadership, embarked on a process of health reform outlined in *A Saskatchewan Vision for Health: A Framework for Change*. The problems with the health system, according to the government, were an overemphasis on treatment of disease with inadequate resources devoted to health promotion, an overemphasis on institutional care, a lack of doctors in rural areas, fragmented service delivery governed by too many separate boards, and escalating health costs in a time of fiscal crisis. Noting that 60% of the provincial health budget was allocated to hospitals and long-term care institutions, the government embarked on a strategy of "streamlining institutional delivery systems." The government's aim was to decrease reliance on the health care system and to "encourage and enable people to take more responsibility for their own health."¹⁰ They suggested that the fee-for-service payment system was contributing to an overutilization of health care services. They identified several "issues that have not been adequately addressed, such as family violence, poverty, unintended teenage pregnancies, drug and alcohol abuse, and a lack of sensitivity to cultural differences."¹¹ The implication was that by freeing up health resources from institutional care, these other health needs could be addressed. They claimed that health reform would seek to "eliminate inequities in the health system by responding to the needs of women, families, the elderly, persons with low incomes, and others with special health needs" and that health reform would "make the health system more effective and efficient."¹²

¹⁰Saskatchewan Health, *A Saskatchewan Vision for Health: A Framework for Change*, 1992, p. 10.

¹¹*Ibid.*, p. 9.

¹²*Ibid.*, p. 11.

In 1992, Manitoba Health published *Quality Health for Manitobans: The Action Plan*, a document that set out the goals and philosophy of health reform—a strategy that would come to define health policy, planning and delivery in Manitoba in the 1990s. This document set out a series of goals for health reform, reached as a result of public consultations:

- P to improve general health status for all Manitobans;
- P to reduce inequalities in health status;
- P to establish public policy which promotes health;
- P to foster behaviour which promotes health;
- P to foster environments which promote health;
- P to provide appropriate, effective and efficient health services;
- P to develop mechanisms to assess and monitor quality of care, utilization and cost-effectiveness;
- P to foster responsiveness and flexibility in the health care delivery system;
- P to promote reasonable public expectations of health care; and
- P to promote delivery of alternative and less expensive services.¹³

One of the primary motivating factors for health reform in Manitoba was the rising cost of health services and the uncertain relation of these costs to health outcomes for Manitobans. To address these concerns, *The Action Plan* sets out a series of actions:

- P develop and strengthen appropriate community-oriented alternative services;
- P develop a new role for community health centres;
- P restructure the hospital system;

¹³Manitoba Health, *Quality Health for Manitobans: The Action Plan*, 1992, p. 2.

- P enhance public education/patient empowerment;
- P implement health human resource plans and resource allocation plans;
- P reform systemic cost drivers;
- P implement technology assessment and management;
- P develop provincial health information strategy; and
- P evaluate the restructured system.¹⁴

1. POPULATION HEALTH

At the time health reform and renewal were being introduced, health policy-makers in both provinces had realized that the provision of health services did not necessarily, in and of itself, result in a healthier population. Determinants such as income, education, environmental conditions, working conditions and social support networks had a great impact on an individual's capacity to make healthy choices. This led to an adoption of a population health philosophy in both provinces that essentially stated that the way to enhance the health of citizens was not only by opening hospitals and installing new technology like MRI machines. Ensuring that people had access to education, strong networks of family and friends, work that was safe and provided a decent income were also key ingredients in creating a healthier population.

In 1994, the Saskatchewan Provincial Health Council issued its report, *Population Health Goals for Saskatchewan: A Framework for Improved Health for All*. Defining health as "a dynamic process involving the harmony of physical, mental, emotional, social and spiritual well-being," the council set forth the following health goals for the province:

- P to change our thinking about health and to consider the broad determinants of health;
- P to provide equal opportunity for achieving health for all Saskatchewan people and communities;
- P to foster healthy social environments for individuals, families and communities;
- P to preserve and promote clean, safe physical environments which support health;
- P to place more emphasis on health promotion and illness avoidance; and
- P to improve health and create a healthier society through the cooperation and shared responsibility of all members of society.¹⁵

Manitoba and Saskatchewan health reform documents encourage the adoption of a population health philosophy that recognizes several determinants of health: income and social status, education, employment and working conditions, personal health practices and coping skills, biology and genetic endowment, child development, social support networks, physical environment and health services.¹⁶ Recently Health Canada has added gender, culture and social environments to its list of the determinants of health. While these additions have not been thoroughly incorporated into Saskatchewan and Manitoba Health documents, there are some indications that gender has occasionally been recognized as a determinant of health. In 1992, Saskatchewan Health recognized that "the state of people's health is influenced by age, income, education, gender, race and geography."¹⁷ In 1999, Manitoba Health announced the formation of a Women's

¹⁴*Ibid.*, p. 19.

¹⁵Saskatchewan Provincial Health Council, *Population Health Goals for Saskatchewan*, 1994.

¹⁶Manitoba Health, *A Planning Framework to Promote, Preserve and Protect the Health of Manitobans*, Winnipeg: Queen's Printer, 1996, p. 4, and Saskatchewan Health, *A Population Health Promotion Framework for Saskatchewan Health Districts*, 1999, pp. 11-12.

¹⁷Saskatchewan Health, *Annual Report, 1991-92*, p. iii.

Health Unit within the department. In 1999, Saskatchewan Health's *Population Health Promotion Model: A Resource Binder* was revised to include a section on gender as a health determinant.¹⁸

Strategies to promote population health include a focus on "wellness" rather than illness and a recognition that action to promote health could include setting health goals, changing individual behaviours, taking community action, changing public policies, and building supportive environments, as well as improving health care services. Provincial governments promised a commitment to "healthy public policy" which would ensure that "every major action and policy of government will be evaluated in terms of its implications for...health."¹⁹

In describing proposed changes in Manitoba, *A Planning Framework* set out the following required shifts in the health care system:

- P from a focus on health services to a focus on broad determinants of health;
- P from inequity of health to equity of health;
- P from the responsibility of Manitoba Health to an intersectoral approach;
- P from illness care to health system;
- P from reliance on government to partnership with the community;
- P from short-term action to investment in prevention and promotion; and
- P from service provider-driven to a focus on health outcomes and research-based evidence.²⁰

¹⁸Saskatchewan Health, *Population Health Promotion Model: A Resource Binder*, 1999 revisions.

¹⁹Manitoba Health, *Quality Health for Manitobans: The Action Plan*, 1992, p. 10.

²⁰Manitoba Health, *A Planning Framework to Promote, Preserve and Protect the Health of Manitobans*, Winnipeg: Queen's Printer, 1996, p. 7.

2. REGIONAL GOVERNANCE

In both Saskatchewan and Manitoba, one of the major health reform initiatives to transform the provincial health care system has been the integration of health services under the jurisdiction of newly-created regional governance bodies, known as health districts in Saskatchewan and Regional Health Authorities (RHAs) in Manitoba. While these regional governance structures have similar responsibilities in both provinces, they differ most prominently by the size of region they serve, the method of selection of board members and structural differences between rural and urban regions.

In 1993, Saskatchewan passed *The Health Districts Act* which laid out the authority and responsibilities of the new districts. By the end of that year, the southern portion of the province was divided into 30 health districts and governing boards were established. In 1995, most Saskatchewan Health community-based programs were transferred to the health districts and the first elections for district health boards were held. In 1996, two health districts were established in northern Saskatchewan and the regional restructuring phase of health reform was nearly complete.²¹ Saskatchewan Health continues to play a role in defining the overall framework for health care in the province, but many decisions about health services are now made at the health district level. Health services, except for the Athabasca Basin, are now planned and delivered by the districts, each governed by a district health board of elected and appointed members.

In 1996, the Manitoba government introduced *The Regional Health Authorities and Consequential Amendments Act* creating ten RHAs

²¹Saskatchewan Health, *Annual Report, 1996-97*, p. 45.

outside of Brandon and Winnipeg. One year later, the government introduced legislation to create the Brandon Regional Health Authority, as well as two health authorities in the city of Winnipeg. The Winnipeg Hospital Authority (WHA) has authority over hospitals and the Winnipeg Long Term and Community Care Authority (WCA) has responsibility for community health clinics and other community-based care, including responsibility for home care and mental health. The recently-elected NDP government has merged the two Winnipeg health authorities as a way to cut costs and minimize bureaucracy. These authorities are governed by government-appointed boards. There is no provision for gender equality in board appointments, nor are health care providers eligible to serve on boards. Women are under-represented on these governance structures.

Critics of regionalization in Manitoba expressed concerns that RHAs would allow Manitoba Health and the Minister of Health to relinquish accountability for health planning decisions, while retaining control over funding. There also was concern regarding the appointed, as opposed to elected, nature of the RHA boards. An evaluation of the regionalization process has not been conducted yet.

In both provinces, regional health bodies are given some flexibility in determining the particular combination of services to be delivered within the region. The rationale for this flexibility is the potential for regional boards to be more responsive to local health needs. District health boards receive funding from Saskatchewan Health largely on a population-needs-based formula. The district health boards allocate funding to health service providers and facilities within the district. A district health board can, for example, decide to expand the range of home care services offered within the district, decide to hire an advanced clinical practice

nurse to provide primary health care in rural areas, or establish a community development team to work with local groups addressing issues which affect the determinants of health. It is also within their jurisdiction to directly provide or contract-out some services to for-profit companies, e.g., meal services, laundry and cleaning for health care facilities.

In Saskatchewan, district health boards, with elected and appointed members, oversee the health services in their region. According to Saskatchewan Health, women are well-represented on district health boards. "Currently there are 188 women (or 51%) out of 367 board members. Appointments are chosen based on a number of factors. They include a commitment to serve the needs of the district, demographic and geographic representation, awareness of district concerns and issues, record of volunteer activities and community participation, and relevant knowledge and experience. Balanced gender representation is an important demographic criteria."²²

Both Saskatchewan health districts and Manitoba RHAs are responsible for service delivery, ongoing assessment of health needs and regional health planning and evaluation to ensure that health services meet provincial guidelines and standards. Provincial departments of health retain authority over funding allocations, legislation and policy, and maintaining standards of service.²³ Regional health bodies are also responsible for ensuring that all residents have access to a provincially-mandated set of core services, however, there is a large scope of decision-making for regional governance struc-

²²Sherry Miller, Saskatchewan Health, personal communication, November 1999.

²³Manitoba Health, *A Planning Framework to Promote, Preserve and Protect the Health of Manitobans*, Winnipeg: Queen's Printer, 1996, p. 5.

tures on the determination of the appropriate method and site and the allocation of staff resources to deliver the insured services.

3. THE SHIFT TO "COMMUNITY" AND HOME-BASED CARE

The costs of hospitalization account for a major portion of provincial health budgets. As governments of all political stripes have focused on reducing deficits, the reduction in hospital services has been seen as an important strategy for controlling public expenditures. In Manitoba and Saskatchewan, shifting care out of institutions into the "community" was also a key component of health reform, as outlined in provincial government documents detailing health reform strategies.

In *A Planning Framework*, Manitoba Health describes the need for a shift "from reliance on government to partnership with the community." *Population Health Goals for Saskatchewan: A Framework for Improved Health for All* envisioned the improvement of health and the creation of a healthier society through "the cooperation and shared responsibility of all members of society."²⁴

Quality Health for Manitobans: The Action Plan, includes the following as goals of health reform: "to promote reasonable public expectations of health care...[and] to promote delivery of alternative and less expensive services."²⁵ Among the strategies required to achieve these goals are [to] "develop and strengthen appropriate community-oriented alternative services...restructure the hospital system...[and] reform systemic cost drivers."²⁶

²⁴*Ibid.*, p. 7.

²⁵Manitoba Health, *Quality Health for Manitobans: The Action Plan*, Winnipeg: Queen's Printer, 1992, p. 2.

²⁶*Ibid.*, p. 19.

In both provinces this shift to "community" care and responsibility resulted in bed closures and funding decreases for hospitals. In Manitoba, the share of provincial health expenditures allocated for hospitals decreased from 44% of the health budget in 1977 to 41% in 1987 to 35% in 1996.²⁷ Between 1992 and 1998, 1,317 acute care hospital beds were closed in Manitoba, reducing the ratio of acute care beds from 4.8:1,000 persons to 3.6:1000 persons.²⁸ As part of its plan to fulfill its election promise to "end hallway medicine" (a reference to the overcrowding of Winnipeg emergency rooms that led to the use of hospital hallways to house patients), the newly elected NDP government in Manitoba recently announced a plan to open 138 acute care beds in the province.²⁹

During the 1980s, the Saskatchewan Progressive Conservative government pursued an active program of hospital and nursing home construction. While the number of institutional beds increased, operating budgets were tightened, staffing levels were cut, and concerns were raised that the quality of care provided in institutions was being undermined. Under the NDP health reforms, 50 hospitals throughout Saskatchewan were closed or converted into community health centres. Between 1991/92 and 1994/95, 1,200 hospital beds were removed from the health system in the province. Between 1991/92 and 1996/97, funding for hospitals in Saskatchewan was reduced by \$44 million, or from 37% to 35% of the total health budget.³⁰ Part of the rationale for reducing hospital beds

²⁷Canadian Institute for Health Information (CIHI), "Manitoba Health Expenditures," <http://www.cihi.ca/facts/manhe.html>

²⁸Manitoba Health, *Annual Report 1992/93* and *Annual Report 1997/98*, Manitoba Health, 1993, 1998.

²⁹Manitoba Health News Release, "Five point plan announced to end hallway medicine," November 22, 1999.

³⁰Saskatchewan Health, *Annual Report, 1996-97*, p. 30.

was the argument that dollars saved could be redirected to more appropriate home and community-based care.

In the 1992 document, *Quality Health for Manitobans—The Action Plan*, Manitoba Health outlines its goal to “shift more of our services from high cost institutional settings to lower cost and more appropriate prevention, support and home care services to help people avoid illness and delay or reduce their need for institutional care.”³¹

A 1995 paper produced by the Manitoba Centre for Health Policy and Evaluation (MCHPE) and published in the *Canadian Medical Association Journal* found that medical and surgical patients in four treatment categories (prostatectomy, hysterectomy, heart attack and bronchitis/asthma) were consistently being discharged from hospital more quickly.³² A subsequent paper published by the MCHPE reported that between 1992 and 1998, almost one-quarter of acute care beds in Winnipeg were closed. This study concludes that there were no negative impacts on patients’ access to hospitals, quality of care provided in hospital or the overall health status of Winnipeggers. However, the study does not examine the issue of who provided care to patients who were discharged early or underwent surgery as outpatients. The study did not assess the impact of early discharge and bed closures on health care workers.³³

³¹Manitoba Health, *Quality Health for Manitobans—The Action Plan*, Winnipeg: Manitoba Queen’s Printer, 1992, p. 16.

³²Lesley Graff Harrison, Noralou P. Roos, and Marni Brownell, summary by R.J. Currie, “Discharging Patients Earlier From Hospital: Does it adversely affect quality of care?” Winnipeg: Manitoba Centre for Health Policy and Evaluation, 1995, <http://www.umanitoba.ca/centres/mchpe/readmit.htm>

³³Marni D. Brownell, Noralou Roos, and Charles Burchill, *Monitoring the Winnipeg Hospital System 1990/91-1996/97*, Winnipeg: Centre for Health Policy and Evaluation, 1999.

Health reforms such as the shift to “community” care have been founded upon certain assumptions about the caregiving responsibilities of families, and particularly women. These assumptions and the values they reflect need to be examined more closely. As support for institutional care has declined, public resources for home care may be increasingly focused on medical procedures and nursing care. The provision of social, emotional and practical support for independent living, while recognized as important determinants of health, continues to be defined as a private responsibility.

D. WOMEN AND HEALTH REFORM

Women, to a greater extent than men, utilize the health care system to access services for themselves and other family members. Women are the majority of workers in several health care occupations, such as nursing, home care, and food and laundry services. Women provide most of the unpaid, informal health care within the home. Women earn less than men, are more likely to live in poverty, and are less likely to have private health insurance.

Privatization in the health care system can be expected to have significant impact on women as users of health services, as health care workers, as informal caregivers, and as citizens engaged in public debates over the future of the health system. Women in varying circumstances, with access to different resources, will be affected by these changes in different ways. The experiences and realities of women are often missing in current health policy research. The question of differential impact of health policy changes on women’s lives is rarely asked, and almost never answered. The diverse impacts of these changes on women’s daily lives do not make their way into the mainstream discourses of health research, planning and decision-making.

It appears that neither Manitoba nor Saskatchewan governments have used gender analysis tools in the health reform policy process.

Changes to health policy have not been examined for the ways they will affect men and women differently due to gender roles. Both provincial departments of health consider women's health as a priority area; however, women's health initiatives tend to be defined as a fairly narrow range of programs including such things as reproductive health, breast cancer screening, domestic violence programs, and services for persons with eating disorders.

While the Saskatchewan Women's Secretariat has promoted the use of gender analysis in public policy development, there is little evidence of gender analysis in the framework documents which laid the foundation for health reform. In response to our inquiry for documents pertaining to the impact of privatization and health reform on women, we received the following reply from a former Deputy Minister of Health:

I am not aware of any significant public documents on the questions you are raising. I doubt there has been any substantive research done on the questions, either. While there is a basis for your inquiry into the impacts on women, [at] the time the decisions were taken by the government, the impacts by gender were not a key component of the analysis...therefore one now can't readily obtain the information you need.³⁴

³⁴Duane Adams, personal communication, 1999. Used with permission.

The recently-established Women's Health Unit within Manitoba Health may provide a responsibility centre for gender analysis. However, analysing health reform through a gender lens has been largely left up to non-government organizations such as the Manitoba-based Women and Health Reform Working Group, a coalition of provincial women's organizations. In its gender analysis of Manitoba health reforms, it identified the scarcity of female appointments to RHA boards, lack of gender-sensitive planning, and the absence of information regarding the health reform process as key concerns.³⁵ As well, the Working Group recognized that the shift to early discharge and community care means that women will take on more of the burden for providing care at the same time they are also losing jobs due to health cuts.³⁶

The Working found that the Manitoba Core Services Agreement provided limited access to reproductive health services, such as birth control information, abortion and delivery in a woman's home community, and was lacking in woman-centred health promotion strategies.³⁷ It recommended that the regionalization legislation establish women's health advisory committees for each RHA. The Working Group also

WHAT IS GENDER ANALYSIS?

"...a process that assesses the differential impact of proposed and/or existing policies, programs and legislation on women and men. It compares how and why women and men are affected by policy issues. It makes it possible for policy to be undertaken with an appreciation of gender differences, of the nature of relationships between women and men, and their different social realities, life expectations and economic circumstances. It is a tool for understanding social processes and for responding with informed and equitable solutions."

Adapted from Status of Women Canada, 1998.

³⁵Women and Health Reform Working Group, *Health Reform: Making It Work for Women*, Winnipeg: Women's Health Clinic, 1997, p. 7.

³⁶*Ibid.*, p. 4.

³⁷*Ibid.*, p. 8.

recommended that “gender analysis and gender-sensitive planning be incorporated into all policies and activities undertaken with respect to the health reform at the regional and provincial level, especially the Community Health Needs Assessment.”³⁸ These recommendations were not accepted by Manitoba Health.

Community Health Needs Assessments (CHNAs) are carried out by regional health bodies in Manitoba and Saskatchewan. These assessments form the basis for regional health plans which are submitted to the appropriate provincial department of health for funding. In 1999, the Prairie Women’s Health Centre of Excellence published a report titled *Invisible Women* that examined health assessment and planning documents in Manitoba and Saskatchewan for evidence of gender-based analysis. The study also included the results of key informant interviews with regional health representatives. Some of the key findings of this study include:

- P Among the eight Manitoba RHAs and 17 Saskatchewan health districts participating in the study, there was little evidence of gender analysis or gender-sensitive strategies, as indicated by review of needs assessment and health planning documents, and interviews with representatives of the participating health bodies. For example, only 25% of the participating regional health bodies included any data about gender in their needs assessments.
- P Regional health bodies have not recognized the additional burden on women of providing informal care to family members and friends. Rather, they have potentially added to this burden by emphasizing women’s presumed role as the gatekeepers of family health. Women’s health did not appear to be valued in its own right.

- P Gender analysis did not appear to be valued by the provincial governments which fund the regional health bodies. For example, although Manitoba Health has set women’s health as one of its four priority areas, RHAs appear to have been given no background information about women’s health, nor any guidance about how to specifically assess the health of the women in their communities.
- P Neither province requires that health data be disaggregated by sex, although Manitoba does require that the sex of survey respondents be recorded. (Manitoba RHAs therefore can report the percentage of male and female respondents, but they have not reported if and how the responses of men and women differed.) While gender analysis is much more than simply looking at health data for men and women both separately and together, the lack of availability of sex-disaggregated data makes gender analysis impossible. Regional health bodies are also limited, since they did not have additional funds to order sex-disaggregated data from other sources (such as Statistics Canada) for their areas, nor did either province undertake to provide this to them.
- P The documents reviewed do not demonstrate an appreciation for the differing health needs of diverse groups of women, including Aboriginal women, women from ethnic and visible minorities, lesbian women and women with disabilities.
- P While both provinces officially promote a determinants of health approach, there is little evidence of this in the health plans reviewed for this project. Manitoba health plans contained, on average, reference to 2.4 health determinants, while Saskatchewan plans included an average of only 1.5 of the determinants used in our framework. Health plans tend to emphasize financial reporting and funding requests.³⁹

³⁸*Ibid.*, p. iii.

³⁹Tammy Horne, Lissa Donner and Wilfreda E. Thurston, *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress*, Winnipeg: Prairie Women’s Health Centre of Excellence, 1999, pp. 56-57.

Changes to the health care system introduced in Manitoba and Saskatchewan in the 1990s were not planned by taking a gendered approach, and their impact has not been evaluated. Both provinces were very clear at the outset of health reform in stating their desire to protect the fundamental nature of the public, universal health care system fought for by Prairie women. In Manitoba and Saskatchewan, public spending on health has been restricted; provincial control over health care services has decreased by shifting responsibility to regional governance structures; and the transfer of patient care out of institutions and into the “community” has been

promoted. These policy trends may have contributed to an expanding privatization of health care services. Some of these privatization initiatives have been overt attempts to shift control of parts of the health care system to for-profit, private corporations. Most health care privatization in Manitoba and Saskatchewan has been much less obvious, involving a shift of more responsibility for providing and paying for health care services from the state to individuals. These types of privatization and their impact on women have been missing links in most of the debate about current and future health care policy.

PART 2 PRIVATIZATION OF HEALTH CARE IN MANITOBA AND SASKATCHEWAN, 1987-1999

Privatization in the health care system can occur in the payment for health care services or in the provision of health care services. In determining whether or not privatization is occurring, we examined services for a shift in terms of who pays for the service or who provides the service. We defined services and providers broadly, for example we included informal caregivers as providers and the provision of medical supplies as a service. **Table 1** illustrates this definition of privatization, although health services rarely fit neatly into either the private or public category.

When discussing “public” versus “private” health services, it is important to distinguish between the *funding* of health services and the *delivery* of health services. As the National Forum on Health notes, “Privatization of financing is not the same as privatization of delivery.”¹ Many health services are provided by private institutions or individuals, but covered by public insurance plans. For example, most doctors in Manitoba and Saskatchewan operate their offices as private businesses, but many of the services a patient receives at the doctor’s office are paid for by the province.

As in the rest of Canada, most health care services in Manitoba and Saskatchewan are provided by a mixture of public and private institutions, organizations and health care professionals. There are a few examples of health care services that are provided entirely by the private sector and paid for entirely by individuals or private health insurance. In some instances, the responsibility for payment is shared by the individual and the state. This process is often referred to as “co-payment.”

	Private	Public
Payment	P Individuals P Private insurance plans	P State P Public insurance plans
Provision of Services	P For-profit, private providers and institutions P Not-for-profit, community providers and institutions P Unpaid caregivers P Private sector management style and structure	P Not-for-profit, publicly-managed providers and publicly-owned institutions

¹National Forum on Health, *The Public and Private Financing of Canada’s Health System*, Ottawa: National Forum on Health, 1995, p. 2.

Both Manitoba and Saskatchewan have a list of core, publicly-funded health services. There are no deductibles or premiums applied to these services and they are offered universally. When services are no longer publicly-funded and payment becomes the responsibility of the individual, this process is known as “de-listing.”

Private health care expenditures are generally associated with services that are not considered “medically necessary” under provincial health plans.² The definition of “medically necessary” differs from province to province. In Manitoba and Saskatchewan, examples of services that are not considered medically necessary include private duty nursing and cosmetic surgery, which are paid for directly by the consumer or through a third-party insurance plan. Examples of other services that are partially covered under provincial health plans or are covered only for specific groups of people, such as seniors or social assistance recipients, include chiropractic care, pharmaceuticals, dental care and chiropody services. Examples of medically necessary services include most primary health care.

In terms of delivery, public and private distinctions are less clear. As **Table 2** shows, many health services are delivered privately—that is, they are delivered by non-governmental organizations. However, this definition obscures the regulatory role government plays in service delivery. As the Forum discussion paper points out, “Most of Canada’s health system is regulated by and accountable to government (mainly provincial/territorial), even though governments deliver relatively few services directly, and in fact, seem committed to getting out of direct service delivery where feasible.”³

²Canadian Healthcare Association, *Canada’s Health System under Challenge: Comprehensiveness and Core Insured Benefits in the Canadian Health System*, Ottawa: Canadian Healthcare Association, 1996, p. 8.

³National Forum on Health, 1995, p. 3.

A. CUTBACKS IN PUBLIC FUNDING FOR HEALTH AND SOCIAL PROGRAMS

During the late 1980s, the Saskatchewan Progressive Conservative government pursued a pro-privatization agenda, advocating cutbacks in public sector jobs, greater reliance on the market, contracting out government services, and the sale of Crown corporations. This is similar to the legislative and policy agenda forwarded by the Manitoba Progressive Conservative government in the 1990s.

In 1987, the Saskatchewan government announced a series of cutbacks in health and social programs. The Saskatchewan Public Health Association sponsored a research study to examine the effects of provincial cutbacks on a wide array of health and social services that have an impact on health. Brown⁴ provided an overview of the cutbacks which effectively transferred costs to non-profit agencies, community groups, families and individuals. She noted the pressures placed on non-governmental organizations caused by rising demands for services and declining government funding. She described an increased reliance on community fund-raising and the promotion of volunteerism in the provision of community services. She noted increases in user fees for persons in special care homes or receiving home care services. She argued that reductions in health care services, earlier discharge from hospitals, and declining community services for seniors were indirectly encouraging the growth of private sector nurses and caregivers hired by those families who could afford to pay for private care.

⁴Brown, Carol, *Profile of Reductions in Health Care in Saskatchewan*, 1987.

TABLE 2: FINANCING AND DELIVERY OF HEALTH SERVICES IN SASKATCHEWAN AND MANITOBA		
Service Type	Financing	Delivery
Hospital services	<i>100% public for medically necessary services</i> (no user charges permitted) <i>Private payment for upgraded accommodation or non-medically necessary services provided in hospital</i> (these extra charges are covered by some private insurance plans)	<i>Public</i> In Manitoba, some hospital services, such as abortions, are provided in private clinics
Physician services	<i>100% public for medically necessary services</i> (no extra-billing permitted) <i>Private payment for non-medically necessary services</i> In Manitoba, legislation was recently introduced to remove “tray fees”—a practice of extra-billing applied to certain medical procedures, such as cataract removal, in private facilities. However, abortions performed in private clinics are still uninsured.	<i>Private</i> Physicians are independent and self-regulating
Dental/optometry care	<i>Mostly private</i> (insurance or out-of-pocket) Some provincial coverage for specific groups, e.g., children, social assistance recipients and other low income. Both Manitoba and Saskatchewan have reduced publicly-funded dental programs for children.	<i>Private and self-regulating</i>
Prescription drugs	<i>Mixed public/private</i> Coverage varies Drugs dispensed in hospitals are covered in hospital budgets. Balance is funded by combination of private insurance plans and out-of-pocket. Both Manitoba and Saskatchewan have public drug insurance plans—drugs are subsidized after a certain deductible limit has been reached.	<i>Private</i> Delivery includes prescription by physicians and dispensing by pharmacist or hospital
Non-prescription drugs	<i>Mostly private</i> (out-of-pocket)	<i>Private</i> Over the counter
Mental health services	<i>Mixed private/public</i> In Manitoba, psychiatrist and psychologist fees are covered when referred by a physician. They may also be covered by some private insurance plans. Fees for counsellors and social workers in private practice are generally not covered by Manitoba Health.	<i>Mixed public/private</i> Some community mental health services are operated by non-profit organizations. In Saskatchewan, mental health services are available to all residents through a network of over 60 mental health clinics, administered through the health districts.
Services of other professionals	<i>Mixed public/private</i> (insurance or out-of-pocket) In Manitoba, payment for midwifery services will be the responsibility of the state. In Saskatchewan, payment for midwifery services is the responsibility of the individual.	<i>Mixed public/private</i> (e.g., psychologists, physiotherapists, chiropractors, midwives, private duty nurses, traditional Aboriginal healers)
Complementary medicines	<i>Private</i>	<i>Private</i> (e.g., naturopaths, homeopaths, practitioners of oriental medicine, traditional Aboriginal healers)
Long-term care (residential)	<i>Mixed public/private</i> Public portion covers insured health care services; private portion covers room and board	<i>Mixed public/private</i>
Home care	<i>Partial public coverage provided</i>	<i>Mixed public/private</i> Informal caregivers play an important role
Ambulance services	<i>Partial public coverage</i> in some provinces; special programs for residents of remote areas	<i>Mixed public/private operators</i>
Public health programs	<i>Public</i>	<i>Public</i>
Services to status Indians and Inuit	<i>Public</i>	<i>Mixed public/private</i> Federal government employees deliver some services directly
Adapted from a national chart in <i>The Public and Private Financing of Canada's Health System</i> by the National Forum on Health, 1995.		

Brown reported cuts to groups engaged in advocacy for persons with disabilities, persons on social assistance, and women. She concluded that funding cuts were increasing inequities in health and that natives, youth, children, the elderly, the disabled, psychiatric patients, the mentally handicapped and victims of abuse are the losers.⁵

For both Manitoba and Saskatchewan, the level of provincial debt, the development of the Canada Health and Social Transfer (CHST), the reduction in federal transfer payments and provincial governments' pursuit of balanced budgets have limited government spending on social programs. Representatives of agencies providing services to women have raised concerns about the erosion of public support for women's services in recent years, but there has been no systematic survey of changes in women's services to examine the impact on women's health. Several organizations have raised concerns over unemployment, the lack of pay equity legislation, the inadequacy of social assistance payments and the continuing barriers to health caused by poverty. This topic cannot be dealt with adequately in this paper, but is mentioned here, to draw attention to the fact that the erosion of public spending for a wide array of social programs in health, education, housing, employment, social assistance, etc. are part of a broader pattern of privatization which is based upon reducing the role of the welfare state.

B. PRIVATIZING THE COSTS OF HEALTH CARE

Saskatchewan and Manitoba's health system is funded through a combination of general tax revenues and federal transfer payments. There are no health care premiums assessed to resi-

dents of Saskatchewan or Manitoba. In addition, some health services are funded by private health insurance, out-of-pocket payments, worker's compensation and public auto insurance. Our health system also relies on fund-raising, volunteers, and unpaid informal care arrangements. In 1995, the National Forum on Health reported that approximately 72% of the total health expenditures in Canada were publicly-funded.⁶ In Saskatchewan and Manitoba in 1995, that figure was slightly higher than the national average at 74.8% and 74.5% respectively.⁷

Table 3 and **Table 4** compare public and private sector health expenditures from 1990 to 1998. Data on private financing of health care in Saskatchewan and Manitoba indicate a steady and dramatic increase since 1990. Between 1990 and 1996, private health care expenditures increased by 43% in Saskatchewan and 33% in Manitoba. In contrast, between 1990 and 1996, public financing of the health system increased by only 3.2% in Saskatchewan and 7% in Manitoba. Moreover, total public health spending in current dollars actually decreased three times during that time period in Saskatchewan and once in Manitoba.

Shifting responsibility for the costs of health care to individuals has not been done by bold initiatives. A form of "creeping privatization" has occurred as more and more health care costs have gradually been moved into the private sphere as a result of the increasing levels of co-payment or deductibles; de-listing of services; narrowing the definition of "medically necessary" service; and shifting acute and chronic care out of institutions, into the community.

⁵Brown, 1987.

⁶National Forum on Health, 1995, p. 3.

⁷Canadian Institute for Health Information (CIHI), *National Health Expenditure Trends 1975-1998*, Ottawa: CIHI, 1999, p. 99.

TABLE 3: COMPARISON OF PUBLIC AND PRIVATE HEALTH EXPENDITURES IN MANITOBA 1990-1998						
Year	Public Health Expenditures (\$000)	Share of Health Expenditures	Change from Previous Year	Private Health Expenditures (\$ '000,000)	Share of Health Expenditures	Change from Previous Year
1990	1999.3	79.9%	11.0%	533.2	20.1%	---
1991	2059.0	78.3%	3.5%	569.9	21.7%	6.8%
1992	2106.5	78.0%	2.3%	594.8	22.0%	4.4%
1993	2078.1	76.0%	(1.3%)	656.2	24.0%	10.3%
1994	2097.2	75.3%	0.9%	688.3	24.7%	4.9%
1995	2138.3	74.5%	2.0%	732.8	25.5%	6.5%
1996	2149.8	73.1%	0.5%	791.7	26.9%	8.0%
1997f	2223.3	73.0%	3.4%	822.3	27.0%	3.9%
1998f	2327.5	73.3%	4.7%	849.7	26.7%	3.3%

f = Forecasted numbers
 Source: Canadian Institute for Health Information, *National Health Expenditure Trends 1975-1998*, Canadian Institutes for Health Information, 1999, p. 91, 97.

TABLE 4: COMPARISON OF PUBLIC AND PRIVATE HEALTH EXPENDITURES IN SASKATCHEWAN 1990-1998						
Year	Public Health Expenditures (\$000)	Share of Health Expenditures	Change from Previous Year	Private Health Expenditures (\$ '000,000)	Share of Health Expenditures	Change from Previous Year
1990	1810.8	79.7%	9.7%	460.1	20.3%	8.6%
1991	1844.4	79.0%	1.9%	490.8	21.0%	6.7%
1992	1831.3	77.9%	(0.7)%	518.7	22.1%	5.7%
1993	1732.3	75.3%	(5.4)%	568.3	24.7%	9.6%
1994	1813.8	75.2%	4.7%	599.5	24.8%	5.5%
1995	1811.8	74.8%	(0.1)%	610.0	25.2%	1.7%
1996	1868.8	74.0%	3.1%	656.9	26.0%	7.7%
1997f	1946.5	74.1%	4.2%	681.0	25.9%	3.7%
1998f	2035.7	74.1%	4.6%	709.9	25.9%	4.2%

f = Forecasted numbers
 Source: Canadian Institute for Health Information, *National Health Expenditure Trends 1975-1998*, Canadian Institutes for Health Information, 1999, p. 91, 97, 99.

1. INCREASES IN DRUG PLAN DEDUCTIBLES AND CO-PAYMENTS

The cost of prescription drugs is one of the fastest growing health care costs. While the cost of prescription drugs remains a public responsibility for some, the prescription drug costs of many Saskatchewan and Manitoba residents have been defined as a private financial responsibility. Both Saskatchewan and Manitoba have provincial public drug insurance plans that partially cover the costs of prescription drugs for some populations. A series of changes to these plans has resulted in a shift of the responsibility for payment for drugs to individuals and private health insurance plans. At the same time as

Manitoba and Saskatchewan were increasing deductibles and co-payments of provincial drug insurance plans, federal legislation was passed that allowed pharmaceutical companies to retain patents on drugs for twenty years, delaying the introduction of cheaper, generic drugs. This legislation has led to higher drug costs. Between 1987 and 1996, the cost of prescription drugs in Canada rose 93%.⁸

The Manitoba Pharmacare Program was changed from a universal deductible format to an income-based drug insurance program. In

⁸Frances Russell, "Profit drives up health costs," *Winnipeg Free Press*; December 8, 1999, p. A12.

1994, the Pharmacare deductible was \$129.00 for families with at least one member over 65 years of age and \$227.60 if the family had no members over 65 years of age.⁹ In 1996, the policy changed so that deductibles are currently based on 2% of adjusted income, if income is less than \$15,000 and 3% of adjusted income if income is more than \$15,000, with a minimum deductible of \$100. An individual with an adjusted income of \$20,000 would have an annual Pharmacare deductible of \$450. In order to be eligible for Pharmacare coverage, the drugs must be on the provincial formulary and not covered by any other provincial, federal or private insurance program. New drugs and those considered experimental may not always be eligible for coverage. These are often the highest-priced drugs. In 1997-98, the Manitoba Pharmacare Program processed 5,493,647 prescriptions and provided benefits totaling approximately \$60 million to 55,657 families.¹⁰

The Saskatchewan Prescription Drug Plan began in 1975 as a fixed co-payment scheme. Persons paid a set fee per prescription and the provincial government paid for additional drug costs. In 1987, the Progressive Conservative government introduced changes to the Saskatchewan Prescription Drug Plan which shifted more responsibility for payment to patients and their families. The policy change introduced annual deductibles of \$125 per family, \$75 per senior family, and \$50 per single senior. Persons were required to pay 20% of the drug costs which exceeded the deductible.

In Saskatchewan in 1991, the level of co-payment was increased and residents of special care homes were made subject to deductibles. Prior

to that time, they had paid \$3.95 per prescription. The most recent changes to the plan were made in 1993. At that time, semi-annual deductibles were set at \$850, and the rate of co-payment was increased to 35%. According to the former Deputy Minister of Health, one of the "biggest impacts on the individual (no breakdown by gender of which I am currently aware) had to do with changes in the qualifying rules of the drug plan."¹¹

In both provinces, there are special programs which provide coverage for people with certain medical conditions, palliative care patients, people with special support circumstances, emergency situations, and persons receiving income supplements.

According to Saskatchewan Health, in 1996-97, the province paid an average 97.7% of prescription drug costs for over 43,584 families who were not subject to a deductible. For those who were subject to a deductible and co-payment, the province provided, on average, 8.4% of total prescription costs.¹²

2. DE-LISTING OR REDUCING PUBLIC COVERAGE OF HEALTH SERVICES

a. Elimination of children's dental health programs

Payment for the majority of dental care in Manitoba and Saskatchewan is the responsibility of individuals and may be covered by private insurance. People receiving social assistance and Aboriginal people who are status Indians

⁹Manitoba Health, Annual Report 1993-94, Manitoba Health, 1994.

¹⁰Manitoba Health, *Annual Report 1997-1998* www.gov.mb.ca/health/ann/199798/4abcdefg.html

¹¹Duane Adams, personal communication, 1999. Used with permission.

¹²Saskatchewan Health, *Drug Plan and Extended Benefits Branch Annual Statistical Report, 1996-1997*, Saskatchewan Health, 1997.

receive insured dental care benefits. Manitoba and Saskatchewan independently introduced coverage for dental care for children as part of the publicly-insured health plans. School-based dental health programs that featured strong prevention and education components were popular features of the children's dental health programs.

In 1987, the Progressive Conservative government in Saskatchewan announced the elimination of the school-based dental program which had begun in 1974, despite studies which indicated its effectiveness. Five hundred seventy school-based dental clinics were closed. In one of the clearest examples of privatization of health services in recent Saskatchewan history, the government eliminated a publicly-funded, publicly-delivered service which provided basic dental care to children throughout the province. These services were delivered by public sector workers, most of whom were women employed as dental therapists and dental assistants. Under the new system, dentists in private practice became the main providers of dental services for children. Provincial coverage for children's dental services was discontinued for young people 14 to 17 years old.

In 1993, the Manitoba government excluded basic coverage of dental care for children from publicly-insured benefits. In 1996/97, the Weekly School Fluoride Rinse Program was discontinued and the responsibility for dental prevention and promotion programs was transferred to the RHAs as part of the Core Services mandate.¹³ According to government Opposition critics, the cancellation of the school dental program, which offered fluoride treatment and screening for cavities, saved \$3 million and

resulted in the lay-offs of 50 dental health practitioners, mostly women.¹⁴ In 1993-94, 22,500 children were participating in the weekly fluoride rinse program.¹⁵

Over time, financial responsibility for children's dental care has shifted to families and private dental insurance programs. Provincial governments continue to provide coverage for children on social assistance and in other low income families. A universal, publicly-funded, publicly-delivered children's dental program has been replaced by privatized service delivery and a mixture of public and private payment.

b. Midwifery: who will pay?

For many years, women's advocacy organizations in Manitoba and Saskatchewan have lobbied for the legalization of midwifery and the public provision of women-centered midwifery services. Both provinces have recently begun the processes of legalization, however, the way these services will be paid for is different in each province.

In 1994, the Saskatchewan Minister of Health established a Midwifery Advisory Committee. In 1996, the committee issued a report recommending that the province legalize midwifery, allow home births, and provide public funding for midwifery care. A Midwifery Implementation Committee was established to advise on the process of integrating midwifery services into the provincial health system. In May 1999, the Saskatchewan legislature passed *The Midwifery Act*, legalizing midwifery and establishing provincial licensing and regulation of the profession.

¹³Manitoba Health, *Annual Report 1997-98* www.gov.mb.ca/health/ann/199798/4abcdefg.html

¹⁴Shauna Martin, NDP Caucus Health Researcher, personal communication, March 1999. Used with permission.

¹⁵Manitoba Health, *Annual Report 1993-94*, Manitoba Health, 1994.

However, the Saskatchewan government has made no commitment to provide public funding for midwives' services, although women under a midwife's care would have their hospitalization and diagnostic tests covered. Without public funding, women choosing a midwife would be required to pay privately for those services. According to the Midwives Association of Saskatchewan, "[w]ithout government money, midwifery in the province is in danger of becoming non-existent....When the regulation of midwifery comes into practice, midwives will have to pay for malpractice insurance, association fees, and clinical costs, all of which will force them to raise fees to about \$2,000 per birth....Increased midwifery fees and no public funding will mean a two-tiered system where only the elite will be able to choose the care of a midwife."¹⁶

In 1997, the Manitoba government introduced and unanimously passed legislation legalizing midwifery in Manitoba. Proclamation of this legislation has been delayed pending the creation of an administrative and educational infrastructure for midwives. The legislation provided for midwifery to become an autonomous profession, governed by the College of Midwives in Manitoba. Practicing, licensed midwives are expected to be in place this year. On several occasions, the Minister of Health has stated that midwifery will be an insured service in Manitoba.¹⁷ However, RHAs are responsible for including midwifery services as part of their health plans submitted to Manitoba Health for funding. The availability of midwifery services in Manitoba will rely on the RHAs' belief about the need for these services. Given that research has demonstrated that RHAs have not successfully included gender analysis in their health planning processes in the past, women's health services, such as midwifery, may not be a visi-

ble need to the RHA Boards and administrators, and, therefore, a woman's access to midwifery in Manitoba may be limited by her geographic location.

c. De-listing eye exams in Manitoba

In April 1996, regular eye examinations for people between 18 and 64 years of age were taken off the Manitoba health insured services list. Exceptions are made for people with medical conditions that require exams by optometrists. Current fees for eye exams range from \$45 to \$90 and are often offered at locations that also sell eyeglasses and contact lenses. Manitoba Health saved \$3 million by eliminating its responsibility to pay for 45% of eye exams.¹⁸

d. Complementary therapies

Complementary therapies, such as acupuncture, naturopathy, massage, homeopathy and herbalist consultation, are not currently covered in Manitoba or Saskatchewan. These practitioners charge their clients fees for their services.

Chiropractic care is subsidized by Manitoba Health. Manitobans are allowed twelve visits per year to a chiropractor for adjustments only and are assessed a fee for each visit. The number of visits allowed have been cut in recent years. Treatment resulting from motor vehicle accidents is covered by Manitoba Public Insurance Corporation (public auto insurance).¹⁹ In Saskatchewan, the province provides coverage for chiropractic services, but chiropractors may charge patients additional fees. Full coverage is provided to persons eligible for supplemental health benefits.²⁰

¹⁶Jillian MacPherson, "Midwifery threatened by lack of government support," *Saskatoon Star Phoenix*, October 26, 1999.

¹⁷Health Canada, *Provincial Health System Reform in Canada - Manitoba Version 3*, Health Canada: 1997, p. 41.

¹⁸*Ibid.*, p. 29.

¹⁹Manitoba Health Web Site - Insured Benefits www.gov.mb.ca/health/ib/oipb.html

²⁰Health Canada, "Health System Reform in Saskatchewan," *Health Reform Database: Overview by Province, 1998-99*, p. 27.

3. HEALTH CARE SERVICES TRANSFERRED TO PRIVATE, FOR-PROFIT COMPANIES

When most people think of health care privatization, they conjure up the image of for-profit health businesses charging patients for their services. In some provinces, private surgical clinics have been allowed to bill governments for publicly-insured health services while charging patients additional facility fees. Access to these services therefore is not available to all on the basis of need, but is restricted to those who can afford to pay. In 1996, the Saskatchewan government introduced legislation specifically designed to prevent the development of this kind of two-tiered health system. Under *The Health Facilities Licensing Act*, all private health facilities are required to obtain a license from the provincial government and are prohibited from charging additional fees for services covered by Medicare. There are no private, for-profit health clinics operating in Saskatchewan.²¹

In 1997, there were approximately 13 private clinics offering surgical procedures in Manitoba. These clinics offered procedures such as endoscopy, abortion, eye surgery, plastic surgery and oral surgery. Physicians at these clinics received a fee-for-service from Manitoba Health for the procedure, and charged an additional “tray fee” to the patient. Health Canada viewed this as a violation of the *Canada Health Act* and penalized Manitoba \$49,000 per month for allowing the practice of extra billing.²²

In 1998, the Manitoba government introduced an amendment to *The Health Services Act*. This legislation, as well as the Surgical Facilities

Regulations, which came into effect January 1, 1999, will end the practice of facility or tray fees charged for some surgical procedures.²³

This legislation has been compared to Alberta’s Bill 11. Opposition government critics expressed concerns that the legislation provides a framework for negotiating with private for-profit companies to provide medical and surgical services, thereby opening the door for more private health care financed by public funds.

This legislation will not end the practice of charging a fee for abortions provided at the Morgentaler Clinic in Winnipeg. Although abortions are included in the provinces Core Services Agreement (a list of services that must be provided without cost to users), the provincial government has consistently refused to cover the costs of abortions performed outside of hospitals. Dr. Morgentaler launched a legal challenge to the province’s refusal to pay for abortions and on March 2, 1993, won his case. On July 27, 1993, the Manitoba government passed an amendment to *The Health Services Act* to counteract the court’s decision. This amendment excludes payment for non-hospital abortions.²⁴

In Manitoba, abortions are performed up to 14 weeks gestation in two hospitals in Brandon and Winnipeg. Waiting times at hospitals can be as long as six weeks, while wait times at the Morgentaler Clinic are usually less than a week. Abortions cost between \$500 and \$550 at the Morgentaler Clinic. This is not an extra-billing, as Manitoba Health does not cover the costs of abortions performed at Morgentaler at all.²⁵

²¹*Ibid.*, p. 26.

²²Health Canada, *Provincial Health System Reform in Canada - Manitoba Version 3*, Health Canada: 1997, p. 28.

²³Manitoba Health News Release, “Manitoba Health to pay facility fees for all medically insured services,” December 30, 1998.

²⁴Canadian Abortion Rights Action League (CARAL) www.caral.ca/situation1.html#situation1.html#mb

²⁵*Ibid.*

An often-cited criticism of private, for-profit medical care is that it creates a two-tier system of services. Patients who are able to pay extra costs are able to avoid wait times and may receive better care than patients who are unable or unwilling to pay privately for health care. A 1998 study by the Manitoba Centre for Health Policy and Evaluation (MCHPE) examined the case of cataract removal surgery in Manitoba. Researchers compared waiting times between private clinics offering the surgery to public hospitals. The researchers found that 40% of private clinic patients lived in the two lowest income neighbourhoods in Winnipeg, but this is not necessarily an indicator of personal income. In all cases the physicians' fees were paid by Manitoba Health, but private clinics charged patients an additional fee of between \$1,000 and \$1,200.

Proponents of for-profit health care argue that private clinics will decrease waiting times. The MCHPE study researchers found that some wait times may be increased because of the introduction of for-profit health care. Median waiting times for cataract removal surgery at private clinics were four weeks, while in public facilities wait times ranged from 10.9 to 17.9 weeks. Eighty-five to ninety percent of cataract removal procedures were performed in public facilities. The longest wait times were encountered by public facility patients of physicians who practiced in private, as well as public facilities. Researchers concluded that "if surgeons are allowed to operate in both [the private and public] sectors, there is an incentive for them to encourage long waits in the public sector, [and it is] more likely the patient will seek private care."²⁶

²⁶K.C. DeCoster Carrière, Sandra Peterson, Randy Walld, Leonard MacWilliam; summary by RJ Currie, *Surgical Waiting Times in Manitoba*, Winnipeg:: Centre for Health Policy and Evaluation, 1998, p. 54.

C. PRIVATIZING THE DELIVERY OF HEALTH CARE SERVICES

Privatization of the delivery of health services in Manitoba and Saskatchewan has occurred in a piecemeal fashion by shifting control of components of the health care system to for-profit, private corporations. In Manitoba, there have been three main attempts at this: the creation of the Urban Shared Services Corporation (USSC) and the development of a centralized food production facility, managed by a private corporation, to supply the major Winnipeg hospitals and long-term care facilities; the SmartHealth initiative by Royal Bank and later Electronic Data Systems (EDS) to administer an electronic health and drug information network; and the transfer of a significant portion of home care clients to the private, U.S.-based corporation, Olsten Health Services. In each one of these attempts to privatize components of the health care system, the provincial government publicly stated that the initiative would deliver services more effectively and reduce expenditures in the health care system. However, none of these large-scale privatization initiatives has yet achieved this goal. The privatization of parts of the home care system was abandoned after it was found that none of the private corporations who bid on the contract could deliver the volume of services at or below the current expenditure level provided to the public system. The SmartHealth initiative was ended in 1998 after costing an estimated \$34 million without achieving the main goals of the project. The USSC Food Services operation is currently undergoing a special audit to determine if it will be able to provide services to the partner facilities within the forecasted cost.

Other forms of service delivery privatization have not been as obvious. Regionalized governance of the health care system in Manitoba and

Saskatchewan and the lack of provincial legislation strengthening public delivery and provision of services, such as legislation introduced in British Columbia,²⁷ has allowed some regional health bodies to contract-out non-medical services, such as food preparation and cleaning services, to for-profit suppliers. These services are the less visible parts of health care facilities, although providing nutritious, appetizing food and a clean physical environment are key ingredients in the recovery and long-term health of patients. Administrators and the public may view the privatization of these non-medical services as less threatening to a universal and high-quality health care system than the privatization of medical services. In fact, a press release announcing the formation of a non-profit corporation to allow Winnipeg hospital and long-term care facilities to share certain non-medical services described these services as “areas behind the scenes, not in direct contact with patients and their families.”²⁸

1. SHIFT OF CONTROL TO FOR-PROFIT CORPORATIONS

a. Non-medical services

There have been some instances of health care organizations in Saskatchewan contracting out services to private companies. Gardner (1998) reports that the Swift Current Health District contracted with the U.S. multinational, Sodexo-Marriott Services Inc., to provide cleaning, kitchen, and maintenance services. The company, which describes itself as “the largest provider of out-sourced food and facilities

management in North America,” has cut laundry service, maintenance and dietary staff complements. In addition to staff cutbacks, both employees and residents report a noticeable decline in the quality of food services in the district. Previously homemade dishes have been replaced with prepackaged or frozen meals. According to Gardner, “with these changes comes the ‘de-skilling’ of dietary staff, and quality and nutrition go right down the drain.”²⁹ Local residents also note that the multinational company has quickly moved to cut off local suppliers, which in turn, has a detrimental effect on the local economy.

A number of health districts in Saskatchewan have considered contracting out food and house-keeping services to private, for-profit corporations. However, members of the Canadian Union of Public Employees (CUPE) have mobilized opposition to these forms of health care privatization. In the Assiniboine Valley, Battlefords, and Prince Albert Health Districts, CUPE campaigns contributed to health board decisions not to contract-out. The company seeking the contract, in all three cases, was Versa Foods (Aramark). Marriott Corporation has contracts to provide food services to health facilities in East Central Health District.

In Manitoba, the move to privatize certain hospital service sectors came under the guise of the Urban Shared Services Corporation (USSC),³⁰ which was formed in 1994 as a non-profit corporation by nine Winnipeg hospitals to pursue consolidation of laundry and food services, biomedical waste disposal and contracting, and

²⁷Section 3.3 of the British Columbia *Health Authorities Act* (Provincial Standards) states that “The minister must ensure that...health services in British Columbia continue to be provided on a predominantly not for profit basis.”

²⁸Manitoba Government News Release, November 24, 1994.

²⁹Gardner, 1998, p. 13.

³⁰The USSC includes Seven Oaks General Hospital, the Health Sciences Centre, Grace General Hospital, Deer Lodge Centre, Concordia General Hospital, Victoria General Hospital, Riverview Centre, St. Boniface General Hospital and Misericordia Care Centre.

purchasing and warehousing of materials. The goals of the USSC were “to determine the potential for improving efficiency, reducing duplication and increasing buying power.”³¹

In 1997, the USSC signed the Shared Food Service’s Patient Food Service Agreement with NewCourt Capital Inc., a Toronto-based capital finance firm. Other parties to this agreement include the Winnipeg Hospital Authority (now amalgamated with the Winnipeg Long-Term and Community Care Authority as the Winnipeg Regional Health Authority). The USSC then announced the construction of a central food preparation facility to serve Winnipeg hospitals, including two long-term care facilities. USSC contracted with Versa Foods, Inc., which has since become Aramark Ltd., to manage the facility.³² In the contract, NewCourt Capital is to provide long-term financing for the construction of the food preparation and distribution facility. Each hospital agrees to use and pay for this facility for twenty years.³³

Centralized hospital food preparation was supposed to result in cost savings of \$5.9 million because hospital cafeterias would not be refurbished, the new facility would have lower operating costs, and losses from non-patient food services would be reduced.³⁴ However, costs in terms of job loss for food preparation staff and costs to the local economy of not using local food suppliers were not taken into consideration. In addition, the cost to the health of patients, resulting from a perceived lowered quality and taste of food, was not recognized in making the decision to go forward with the agreement.

The 34,000 square foot USSC Regional Food Distribution Facility is the largest in North America. The facility began operations in August 1998. According to the USSC, its centralized system will result in the loss of 252 full-time equivalent positions.³⁵ Concerns have been raised with regards to the quality of food prepared using rethermalization techniques (freezing and re-heating prepared food) and the capacity of a centralized food service to respond to specific cultural and dietary requirements. Initial media reports concerning patients’ assessment of the meals are not favourable. This is especially true at long-term care facilities, such as Deer Lodge Centre.

During the 1999 Manitoba election, discontinuing the use of rethermalized food at long-term care facilities was a key NDP promise. The nature of the 20-year agreement, however, means that participating hospitals would have to continue to pay \$50,000 per month for the centralized food services, even if the program was discontinued.³⁶ On December 6, 1999, the provincial government announced it had taken over control of the contract that had existed between USSC and NewCourt Capital. The extension of the central food distribution system to Health Sciences Centre and St. Boniface General Hospital was put on hold. The government moved quickly to take over the contract when it became known that a banking giant, CIT of New York, had announced that it was taking over NewCourt Capital. By taking NewCourt out of the arrangement, the provincial government has ensured that approval for changes to the food distribution system will not be required from a financial institution in another country.³⁷

³¹ Philippe Cyrenne, *Analysing Shared Service Contracts: The Case of Food Services for Winnipeg Hospitals*, Canadian Centre for Policy Alternatives: June 1999, p. 1.

³² Health Canada, *Provincial Health System Reform in Canada - Manitoba Version 3*, Health Canada: 1997, p. 3.

³³ Cyrenne, 1999, p. 1.

³⁴ *Ibid.*, p. 4.

³⁵ *Ibid.*, p. 3.

³⁶ Doug Nairne, “NDP stuck with Tory leftovers”, *Winnipeg Free Press*: December 3, 1999, p. A4.

³⁷ Manitoba Government News Release, “Government takes over USSC contract,” December 6, 1999.

The costs of the USSC food distribution plan continue to increase. On December 3, 1999, the *Winnipeg Free Press* reported that many of the costs of the new facility had been underestimated and that the facility would be too small to realize its goal of delivering food to all of the participating hospitals. The new food system also required more staff than originally forecasted. The provincial auditor has ordered a special audit of the centralized food preparation and delivery system in 2000.³⁸ The existence of a centralized facility has been built into the future construction of health care facilities. There are new personal care homes currently under construction without kitchens. While the benefits in terms of cost savings may never materialize, the legacy of the USSC Shared Food Services Agreement will be with Manitoba citizens for many years.

Another example of shifting non-medical health services in Manitoba to for-profit corporations is the privatization of a health information system known as SmartHealth. SmartHealth was launched in 1993 as a wholly-owned subsidiary of the Royal Bank of Canada to investigate the application of technology to monitor use of the health care system in order to reform parts of the system and decrease public health care expenditures. To test its system, SmartHealth offered a free assessment of Manitoba's health care system at a cost of \$1 million to the Royal Bank. In December 1994, SmartHealth was awarded a contract to develop the Health Information Network. In 1996, the Manitoba government created the Health Information Services of Manitoba Corporation to partner with SmartHealth. Loan guarantees and additional financing worth \$166 million was provided to fund the partnership.³⁹ Since that time, the

Royal Bank has sold 51% of the shares in SmartHealth to Electronic Data Systems Corporation (EDS), a Texas-based multinational corporation that has been involved in welfare privatization in the U.S.⁴⁰

When fully implemented, the Health Information Network (HIN) was supposed to link authorized health care providers throughout the province to enable access to patient information such as immunization history, laboratory and x-ray test results, and current medications. During 1997/98, the HIN piloted the medication component of the system, the Drug Programs Information Network (DPIN), in five hospitals.⁴¹ A key component of this system was the "Smart Card," a plastic card with a magnetic stripe encoding patients' health information and history. The introduction of this form of information technology raised many concerns regarding privacy and security of health data.

When the contract was announced, the Manitoba Medical Association (MMA) and other organizations and individuals raised concerns about the security and privacy of personal health information contained in databases. As a result, the Manitoba government introduced *The Personal Health Information Act* in 1998. This legislation established a process to ensure the security of personal health information by setting limits on its collection, use, disclosure and destruction. The provincial Ombudsman is responsible for enforcing the act.⁴² Opposition critics had suggested that a Privacy Commissioner be established to deal with privacy concerns. For many organizations and individuals concerned about privacy and security, the legislation did not fully address these issues.

³⁸Dan Lett, "Food fiasco costs millions," *Winnipeg Free Press*: December 3, 1999, pp. A1, A4.

³⁹Dan Lett, "Health card quietly killed," *Winnipeg Free Press*: December 11, 1999, pp. A1, A4.

⁴⁰Jim Silver, "Privatization by Stealth: The Growth of Private, For-Profit Health Care in Manitoba", *Quarterly Review Vol. 1, No. 1*; Canadian Centre for Policy Alternatives: 1999, pp. 1-3.

⁴¹Manitoba Health, *Annual Report 1997-1998*.

⁴²Health Canada, *Provincial Health System Reform in Canada - Manitoba Version 3*, Health Canada: 1997, p. 30.

Other concerns raised with the privatization of the Health Information Network, include the links of the Royal Bank and EDS to the private health insurance industry, as well as the application of the HIN to “eliminate waste” by monitoring—and therefore limiting—insured diagnostic procedures and prescription drugs covered by the provincial Pharmacare program.⁴³ Critics argued that if EDS and the Royal Bank have interests in the private health insurance industry, as well as access to the personal health data of Manitobans, a potential conflict-of-interest may exist where the data contained in the HIN is used to justify moving medical costs from the state to the individual, thus creating a greater need for private insurance. Concerns were also expressed regarding the ownership of the technology given that public money would be used to develop technology that would be owned and marketed by private, for-profit corporations.

The SmartHealth program was projected to save \$700 million over ten years.⁴⁴ Throughout the HIN construction process, several critics of the plan voiced their concerns that SmartHealth was making minimal progress towards its goals and costs were well over budget. However, SmartHealth had advocates within government and continued to receive government funding. On December 11, 1999, the *Winnipeg Free Press* reported that the former Progressive Conservative government had discontinued the initiative in late 1998 by offering a settlement worth \$17 million. Reasons for ending the SmartHealth contract included the corporation’s billing to the province for work that had not been approved in the original contract, as well as concerns about the corporation’s efforts to secure similar contracts in Ontario and Newfoundland. In addition,

the provincial government may have been anxious to settle with SmartHealth in order to avoid a public court battle in the months prior to an election campaign. It is estimated that SmartHealth will cost the Manitoba government \$34 million, without achieving its main goals.⁴⁵

b. Privatization of medical services

Most of the privatization of health care services in Manitoba and Saskatchewan has not occurred in bold transfers to for-profit corporations. Privatization has occurred in a less obvious way by moving the delivery of medical services outside of traditionally defined hospitals. In a letter to provincial and territorial Ministers of Health dated January 6, 1995, then federal Minister of Health Diane Marleau reported on a legal opinion regarding the interpretation of the definition of hospital as contained in the *Canada Health Act* to be “any facility which provides acute, rehabilitative or chronic care...[which was] clearly intended to ensure that Canadian residents receive all medically necessary care without financial or other barriers and regardless of venue.”⁴⁶ However, the cost and provision of medical procedures deemed to be taking place outside of “hospitals” often are shifted to individuals.

In Manitoba, physiotherapy and occupational therapy are considered insured services when they are provided on a physician’s referral in a hospital facility.⁴⁷ However, these services are not insured when provided in private clinics. Therapy services are provided by Community

⁴³Silver, 1999.

⁴⁴Fuller, 1998, p. 221.

⁴⁵Dan Lett, “Health card quietly killed,” *Winnipeg Free Press*, December 11, 1999, pp. A1, A4.

⁴⁶Colleen Fuller, *Privatization in British Columbia (Draft Report)*, BC Centre of Excellence for Women’s Health: March 1999, p. 6.

⁴⁷Health Canada, *Provincial Health System Reform in Canada - Manitoba Version 3*, Health Canada: 1997, p. 29.

Therapy Services, Inc. (a private, non-profit corporation under contract to Manitoba Health and some rural RHAs) to personal care home residents and urban and some rural home care clients, without user fees.⁴⁸

According to the Association of Physiotherapists of Manitoba (the regulatory body for physiotherapists in Manitoba), the number of private physiotherapy clinics has increased in recent years. Many of the clients who use private physiotherapy clinics have their fees covered by private insurance, the Manitoba Workers' Compensation Board or the Manitoba Public Insurance Corporation (the public auto insurance corporation). Fees at private clinics are typically \$35 to \$40 per visit but are not regulated. One of the most common reasons for using private physiotherapy is the reduction in waiting times as compared to physiotherapy provided in hospital. Patients can wait up to eight months for treatment in a hospital or other insured facility. There is anecdotal evidence that some hospitals directly refer patients who have some type of private insurance or other coverage to private physiotherapy practitioners.⁴⁹ No data was found regarding quality of care comparisons between public and private, for-profit facilities.

Medical laboratories have been another site of privatization in Manitoba and Saskatchewan. According to the Saskatchewan Commission on Directions in Health Care, "[i]n recent years, private laboratory services have proliferated in the province, particularly in the large urban centers, and the costs and utilization associated with them have risen dramatically."⁵⁰

In 1990, a study of laboratory services by the Saskatchewan Department of Health found that private laboratories were charging higher fees than public laboratories for the same services.⁵¹ In 1993, the Minister of Health announced that the provincial government would stop providing funding to private laboratories on a fee-for-service basis. At the time, the government expected that public sector labs would assume responsibility for most processing, although private companies might continue to operate in a supportive role. However, under health reform, the Saskatchewan government transferred responsibility for laboratory services to the district health boards. The district boards were given the option of using a public laboratory system or entering into a partnership with a private laboratory. The Regina Health District contracted with the private health services company, MDS, to provide laboratory services, but has recently reduced that contract to equipment and collection services. MDS has a partnership arrangement with local doctors to provide laboratory services within the Saskatoon Health District. MDS used to have contracts to provide private laboratory services in Prince Albert and East Central Health Districts, but after studying their options, these districts decided to operate their own public laboratory services.⁵²

Medical laboratories in Manitoba are structured under private, for-profit and public, non-profit service delivery models. There are 22 private for-profit laboratories in Manitoba that perform 27% of the test volume in Manitoba. Routine laboratory services, performed in private physicians' offices, are usually performed by laboratory assistants and consist of a short list of stan-

⁴⁸Manitoba Health, *Annual Report 1997-98*.

⁴⁹Brenda McKechnie, Association of Physiotherapists of Manitoba, personal communication, March 1999. Used with permission.

⁵⁰Saskatchewan Commission on Directions in Health Care, *Future Directions for Health Care in Saskatchewan*, Regina: Government of Saskatchewan, 1990, p. 146.

⁵¹Beth Smillie, "A Deal in the Making," *Briarpatch* Vol. 23, No. 3, April 1994, p. 20.

⁵²Canadian Union of Public Employees (CUPE), *Protecting Public Health Care*, CUPE Saskatchewan Policy Paper, March 1999, p. 8.

standard tests—there are 769 such private physicians' laboratories in Manitoba that perform 3% of the test volume in the province. There are 70 public laboratories in Manitoba which are block funded by Manitoba Health. These include several large public sector laboratories in the City of Winnipeg and the Laboratory Imaging Service units in rural and northern Manitoba. These public sector laboratories perform 27% of the test volume in Manitoba. There are eight public sector laboratories located in Winnipeg hospitals that perform 43% of tests in Manitoba by volume. These laboratories are funded through their respective global hospital budgets.⁵³

As a result of the regional governance models under health reform, responsibility for rural diagnostic services were moved to the RHAs in 1997. Manitoba Health remains active in a consulting capacity to the RHAs regarding laboratory and imaging services. The Cadham Provincial Laboratory has served Manitobans as their public health laboratory since 1897. It has the sole responsibility for several province-wide public health surveillance and diagnostic services. It is also the central reference laboratory for the province.⁵⁴

D. SHIFTING FROM INSTITUTIONAL TO HOME AND COMMUNITY-BASED CARE

In terms of health care privatization, there is perhaps no better example of shifting the cost and delivery of health care services to the individual than the trend of shifting care from institutional settings to home and community-based settings. Shifting care into the home is recog-

nized as a health reform strategy in Manitoba and Saskatchewan designed to reduce health care expenditures. This shift in caring responsibility is built on women's traditional gender roles as caregivers. Often the women engaged in this caring work are unpaid, informal caregivers acting in their capacity as spouses, family members and friends. Paid caregivers are also overwhelmingly women.

Shifting care out of institutions transfers the costs of health care to the individual, in terms of prescription drugs and medical supplies. This shift of caring responsibility also opens the door to private, for-profit provision of home health care services and private ownership and operation of long-term care facilities. Provision of care is privatized as more of the caring work becomes invisible, transferred to women in the home.

The costs of hospitalization account for a major portion of provincial health budgets. As governments of all political stripes have focused on reducing deficits, the reduction in hospital services has been seen as an important strategy for controlling public expenditures. Between 1991/92 and 1994/95, 1,200 hospital beds were removed from the health system in Saskatchewan. Over 50 hospitals throughout the province have been closed or converted into community health centers. Part of the rationale for reducing hospital beds was the argument that dollars saved could be redirected to more appropriate home and community-based care. Between 1992 and 1998, 1,317 acute care hospital beds were closed in Manitoba, reducing the ratio of acute care beds from 4.8:1,000 persons to 3.6:1,000 persons.⁵⁵

⁵³National Union of Public Government Employees (NUPGE) Web Site, *Medical Laboratory Workers Survey*.

⁵⁴Manitoba Health, *Annual Report 1997-1998*.

⁵⁵Manitoba Health, *Annual Report 1992/93* and *Annual Report 1997/98*, Manitoba Health: 1993, 1998.

1. HOME CARE

Both Manitoba and Saskatchewan offer some form of publicly-funded home care program. In Manitoba, home care is an insured service, while in Saskatchewan, home care is delivered by health districts which receive provincial funding and charge user fees. Increases in the use of home care services and an increase in the acuity of home care needs has occurred in both provinces as the result of moving care out of institutions into the home and the “community” as a means of reducing health care costs. Health policy-makers in both provinces recognize that it is cheaper to provide long-term care in the home or in “community” settings, such as personal care homes, rather than in acute care beds in hospitals. It is also more cost-effective to discharge surgical patients soon after surgery and have follow-up treatment occur in the home, as well as to perform surgery on an outpatient basis. Care and treatment outside of institutional settings may cost the health care system less because of savings in terms of labour and facility costs, but it is also true that savings are realized because individuals bear a greater responsibility for health care costs when that care is not delivered as part of a hospital stay.

A key principle of health reform in Saskatchewan is to provide health services in the community wherever possible. The provincial government and district health boards have encouraged this shift to community care by more than doubling spending on home-based services since 1991, to \$67 million. At the same time, spending on acute care has dropped 14 per cent, to \$585 million. Today, patients are staying in hospital one day less than they did in 1991. One in four home care clients now receives home treatment which might otherwise have been provided in hospital, up from one in 10 in 1991.⁵⁶

Both public, non-profit and private, for-profit home care providers are in place in Manitoba and Saskatchewan. A shift in health care costs to the individual has taken place as drugs and supplies covered while a patient is in the hospital become the responsibility of individuals when that patient is moved into the home. Both provinces have introduced some programs to help off-set these costs. In Manitoba, for-profit enterprises have taken advantage of this shift by commercially providing medical supplies and equipment to private individuals. The most significant, and invisible, impact of an increased use and acuity of home care services in Manitoba and Saskatchewan has been felt by unpaid caregivers in the home, who are usually women.

a. Home care in Manitoba

Manitoba was the first province to introduce a comprehensive system of continuing care in 1974. The public system provides medical, rehabilitation and support services at home to any person who is assessed as requiring these services. The system also includes an appeals process for individuals who believe they have not been fairly assessed.⁵⁷ The Home Care Program is part of a continuum of services that include respite services, day programs and personal care homes.

Previously operated under the Office of Continuing Care within Manitoba Health, RHAs took control of the Home Care Program in 1997 and 1998. In Winnipeg, the Home Care Program was operated by the Winnipeg Long Term and Community Care Authority (WCA), which has recently been amalgamated with the Winnipeg Hospital Authority into the newly formed Winnipeg Regional Health Authority.

⁵⁶Health Services Utilization and Research Commission (HSURC), *Hospital and Home Care Study*, Summary Report No. 10, Saskatoon: HSURC, 1998, p. 1.

⁵⁷Evelyn Shapiro, *The Cost of Privatization: A Case Study of Home Care in Manitoba*, Canadian Centre for Policy Alternatives, 1997, p. 1.

The Manitoba Home Care Program's objectives are:

- P to provide effective, reliable and responsive community, health care services to Manitobans to support independent living and provide care in the community;
- P to develop appropriate care options to institutionalization that are acceptable to the consumer/family for persons who can be appropriately maintained in the community; and
- P to facilitate in collaboration with consumer/family admission to appropriate institutional care when living in the community is not a viable alternative.⁵⁸

In Manitoba, the provision of home care services is mostly provided by the public system, without additional user fees. This system includes case coordinators, managers, nurses, home care attendants and homemakers. There are also a number of private, for-profit companies that provide home care services, such as nursing, companionship, meal preparation, personal care and cleaning. These services are paid for by the consumer and may be covered by private insurance. No data was found on the share of home care services provided by the public system as compared to the private system in Manitoba.

In Winnipeg, 75% of home care consumers receive long-term services, the remainder receive services over a short period of time, usually for post-surgical or medical care after an early discharge from hospital. Elders comprise about 75% to 80% of home care recipients; about 20% of service users are adult post-surgi-

cal patients and people with disabilities; and about 5% of service users are children with severe disabilities. More women use home care services than men. Old age, poor health, disability, poverty and gender are determinants of home care use.⁵⁹

A Self-Managed Home Care Program was recently established in Manitoba. In 1997 there were 102 home care clients participating in this program. Self-managed care allows eligible clients to take responsibility for directly managing their own non-professional health services, such as personal attendant care, previously provided by the Home Care Program.⁶⁰ Disability rights advocates have expressed support for the program's capacity to increase independence and autonomy of people with disabilities. Union activists have expressed concern that this trend may lead to increased use of private services.

The following policy and population trends point to an expected increase in the need for home-based care in Manitoba:

- P the growth in the number of older Manitobans;
- P independent living initiatives for people with disabilities;
- P reduction in length of medical and surgical hospital stays; and
- P reduction in the ratio of personal care home beds to Manitobans over 75 years of age.⁶¹

b. Home care in Saskatchewan

Saskatchewan introduced a program of home care services in 1978 and by 1984 home care programs were delivered in home care districts

⁵⁸Manitoba Advisory Committee to the Continuing Care Program, *Home Care Reform: Challenge and Opportunity*, Manitoba Health: 1996, p. 3.

⁵⁹Shapiro, 1997, pp. 5-6.

⁶⁰Manitoba Health, *Annual Report 1997-98*.

⁶¹Shapiro, 1997, p. 7.

throughout the province. In 1990, the Saskatchewan Commission on Directions in Health Care, which had been appointed by Premier Devine, strongly recommended an expanded and comprehensive system of home care. While the benefits to patients were clearly part of the rationale for expanding home care services, the cost savings of keeping people out of health care institutions was also an important consideration. The Commission stated: “[t]he support services provided by home care offer an attractive alternative to costly institutionalization for residents requiring assistance to live independently.”⁶²

The Commission recommended that:

- P the home care program in each division should provide a full range of health care and other supportive living services to all residents, including the elderly, the young disabled, the mentally handicapped, the mentally ill and those with head injuries, who require these services to remain independent and at home for as long as possible;
- P the home care program in each division should include nursing, home support, and rehabilitation services delivered through a combination of staff and volunteers recruited by the home care program as well as other community-based programs and agencies;
- P user fees for home care services, based on the principle of accessibility, should be established on a province-wide basis to ensure equity for clients and division councils;
- P there should be no charges for nursing and rehabilitative services;
- P there should be charges for certain home support services such as home maintenance and meals on wheels; and

- P to provide a sense of security to caregivers and dependent people living at home, personal emergency response systems—electronic devices which connect their wearers with the nearest hospital or other designated emergency monitoring centre—should be introduced as part of the home care program within each division.⁶³

The Commission acknowledged that an increased reliance on home health care required community-based support services and the active participation of family caregivers. While acknowledging the financial, social and emotional consequences often faced by family caregivers, the Commission endorsed the provision of respite services, counseling and education services as a way to “assist and encourage families and friends to assume the role of caregiver in the home.”⁶⁴

In 1994, home care services were integrated with other health services under the jurisdiction of newly-formed district health boards. In Saskatchewan, all health districts provide acute, palliative and supportive home care services to residents. Services may include assessment and coordination of care, nursing, homemaking, meals, friendly visits, transportation, physical therapy, occupational therapy, social work, telephone surveillance, and home maintenance.

Home care services in Saskatchewan have expanded and now include services formerly provided in institutions, such as intravenous therapy and palliative nursing, as well as affiliated professional services, such as occupation or physical therapy. This shift reflects the trend to provide health care services in the home, which were once provided in institutions. Some have

⁶²Saskatchewan Commission on Directions in Health Care, 1990, p. 64.

⁶³*Ibid.*, pp. 65-66.

⁶⁴*Ibid.*, p. 67.

suggested that resources have shifted to support a more “medicalized” model of home care, and away from meal services, homemaking and personal care services.

In 1997/98, the Saskatchewan government spent \$67.8 million on home care, which represented 4.2% of the total provincial health budget. There are no fees for health district home care services provided by nurses, case managers, occupational therapists, physical therapists or social workers. Fees are charged for homemaking, meals and home maintenance services. According to Health Canada, “co-payment by the client is required based on income and the number of services required. Clients are charged \$5.45 per unit of service for the first 10 chargeable units of service received in a month. Charges for additional units are adjusted in accordance with clients’ income levels. Effective September 1, 1997, the maximum charge per month ranges between \$54.50 and \$331.00. Clients receiving social assistance and seniors receiving the provincial income supplement to Old Age Security pension, are charged at the minimum.”⁶⁵

c. Increases in home care in Manitoba and Saskatchewan

Saskatchewan Health notes that between 1991/92 and 1994/95, the amount of home care services have increased by 38%. In addition, the type of care provided in the home has changed, with more resources going to acute and palliative care. Between 1991/92 and 1994/95 palliative care services at home have increased by 130%, serving 39% more palliative care clients at home. More acute care is being performed in the home as hospital stays are reduced. Between

1991/92 and 1994/95 hospital stays have been reduced by a total of 375,000 patient days; day surgery has increased from 44% to 53% of all surgeries; and acute care services provided in the home (such as intravenous therapy and palliative care) have increased 83%.⁶⁶

In order to support the shift from institutional to “community” care, Saskatchewan Health districts have changed their health care expenditures. Eighty-two percent of district budgets in 1996/97 went to institutional services, such as hospitals and nursing homes, compared to 89% in 1991/92. The difference has been redirected to home and community services.⁶⁷

According to Manitoba Health’s 1997/98 Annual Report, there were 30,257 persons registered with the Home Care program in 1997/98, representing an 11% increase over 1996/97. Between 1995/96 and 1996/97 home care clients increased by 15%.⁶⁸ While the number of home care clients is increasing, there is also a continuing trend toward the provision of more acute care in the home. Since 1996/97 the provision of nursing services in the home increased by 15% and the provision of personal services, such as assistance with bathing, has increased by 22%. In 1997/98, home care expenditures totaled \$123,942,100 or about \$4,000 per client.⁶⁹

As **Table 5** and **Table 6** indicate, the use of home care services has increased in the time period when reforms to the health care system are taking place in both Manitoba and Saskatchewan.

⁶⁵Health Canada, “Health System Reform in Saskatchewan,” *Health Reform Database: Overview by Province*, 1998/99, p. 20.

⁶⁶Saskatchewan Health, *Health Renewal is Working: Progress Report*, 1996, pp. 3-5.

⁶⁷*Ibid.*, pp. 3-5.

⁶⁸Health Canada, *Provincial Health System Reform in Canada - Manitoba Version 3*, Health Canada: 1997, p. 23.

⁶⁹Manitoba Health, *Annual Report 1997/98*; Manitoba Health www.gov.mb.ca/health/ann/3a-m5.html

TABLE 5: SASKATCHEWAN HOME CARE CLIENTS AND AMOUNTS OF HOME CARE SERVICE, 1994-97		
Year	Number of Clients	Units of Service
1994-95	23512	1913438
1995-96	25704	2117464
1996-97	27410	2243037

Source: Canadian Home Care Association, *Portrait of Canada: An Overview of Public Home Care Programs*, (draft) February 1998.

TABLE 6: MANITOBA HOME CARE CLIENTS 1992-98	
Year	Number of Clients
1992/93	24460
1993/94	25121
1994/95	Not available
1996/97	29783
1997/98	30257

Source: Manitoba Health, *Annual Report: 1992-1998*.

d. Privatization of home care: shifting the provision of care to for-profit providers and unpaid caregivers

For the most part, health reforms in Saskatchewan have not directly transferred publicly-delivered health services to for-profit or non-profit service providers. However, by shifting more responsibility for caregiving to families, they may have indirectly created a market for private health care and home support services. For instance, the yellow pages of the Saskatoon phone book list businesses or agencies which provide home nursing, personal care, and homemaking services. According to the Health Services Utili-

zation and Research Commission,⁷⁰ there is very little use of private home care in the province, but it is not completely clear what is meant by that term.. Does it include private nursing services, non-profit services for seniors, and/or privately-run personal care homes?

The expansion of privately-delivered home care services may be an unintended consequence of policies designed to keep people out of institutions, while failing to provide sufficient public home care services to meet their needs. The former Deputy Minister of Health recalled that “[d]uring this reform period, where there was a shift in the burden of paying for or delivering certain health or family support services, there was no instance I can remember where the intention was to move the service to a for-profit centre. Or for that matter, I don’t recall moving public services to non-government, non-profit agencies (although there may have been a small example of this.) If either of these forms of service centres acquired new business as a result of the health reform, it would have occurred as a consequence of shifting the burden of payment or family support back to the family unit...who then consequently might have used a third party to help them (and accordingly paid privately).”⁷¹

According to the Canadian Home Care Association, user fees for chargeable home care services in Saskatchewan total approximately \$6 million per year.⁷² According to a recent CUPE policy paper, “the shift from institutional to community care has resulted in more health services being paid for and delivered privately.”⁷³

⁷⁰Health Services Utilization and Research Commission, *Hospital and Home Care Study*, Summary Report No. 10, 1998.

⁷¹Adams, 1999, personal communication. Used with permission.

⁷²Canadian Home Care Association, 1998, p. 2.

⁷³Canadian Union of Public Employees, 1999, p. 2.

It is difficult to track the changes in home care service delivery and actual patterns of private expenditures on home care, as they vary across health districts, and there does not appear to be a provincial data base which gathers this information for the whole province. Some sources indicate that user fees for home care services have declined, while others suggest that personal support and homemaking services are subject to more charges and are less available than in the past. Each health district determines the range of home care services offered within that district. Some districts have shifted home care resources to acute care and nursing while cutting back on homemaking and personal support services which help people maintain their health and independence. There is also variation within health districts, with rural residents having access to fewer home care support services than their urban counterparts.

Most formal home care services are delivered by health districts. In addition to the services provided by paid home care workers, health districts organize programs of community volunteers to provide various services including meal delivery, friendly visits, transportation, and home maintenance. In 1990, approximately 18,000 volunteers provided 126,000 hours of home care services.⁷⁴

In April 1996, the Manitoba government announced its intention to privatize 25% of personal care services provided by the Manitoba Home Care Program. Estimates of cost savings from this initiative ranged as high as \$10 million. This move resulted in a five-week strike by home care workers belonging to the Manitoba Government Employees Union (MGEU). The contract that ended the strike assured employees

that there would be no lay-offs for the duration of the contract; that the private contract would be confined to 20% of personal services out; and that the privatization initiative would be evaluated in two years.

In March 1997, the Manitoba government announced that Olsten Health Services, a corporation in the United States (U.S.), would provide nursing, home attendant and home support services to all new long-term care clients in certain areas of Winnipeg. This amounted to 10% of the workforce, as opposed to the government's goal of privatizing 25% of these services. Some analysts of the government plan concluded that this reduction in the amount of services to be contracted out had occurred because there were no private bids that could provide the volume of service that had initially been slated for privatization.⁷⁵

In December 1997, the government announced that the contract with Olsten would not be renewed. This announcement coincided with the result of a Canadian Centre for Policy Alternatives paper that reported FBI investigations of Olsten Corporation for improper Medicare billing in the U.S.. The paper also described Olsten as "a U.S. based multinational corporation... [that is] largely non-unionized...[and] has been charged by the State of Washington for allegedly failing to carry out physicians' instructions."⁷⁶

Several concerns were expressed by critics of the government about the province's plan to privatize elements of the home care system. Although the plan to privatize home care was not

⁷⁴Saskatchewan Commission on Directions in Health Care, 1990, p. 64.

⁷⁵Shapiro, 1997, pp. 1-13.

⁷⁶Jim Silver, *The Cost of Privatization: Olsten Corporation and the Crisis in American For-Profit Home Care*, Canadian Centre for Policy Alternatives: 1997.

ultimately successful in Manitoba, these concerns can provide a framework for analyzing other privatization initiatives:

- P privatization would result in lower wages for care-providers, failing to attract and retain qualified service deliverers;
- P privatization would lead to loss of control over standards, planning and administration, leaving the system open to over-billing;
- P clients would be pressured to purchase additional costly and un-prescribed health systems by private care providers; and
- P a private home care system would not include an appeals process.⁷⁷

Health reforms have been founded upon certain assumptions about the caregiving responsibilities of families. These assumptions and the values they reflect need to be examined more closely. As public support for “personal” care has declined, public resources for home care may be increasingly focused on medical procedures and nursing care. The provision of social, emotional and practical support for independent living, while recognized as important determinants of health, continue to be defined as a private responsibility. The following quote from the former Saskatchewan Deputy Minister of Health reveals how the issues related to home care are currently being framed.

The rapid expansion and use of Home Care services may be seen as a transfer of services to private care. I never saw it this way although I recognized that the family was picking up a larger private responsibility for “personal” not “nursing” care....There has not (been) so much a ‘transfer of health care delivery from institutions to private households’ as there has been a systematic attempt in the health system to assess the conditions of pa-

tients more carefully and place them in the setting most appropriate to their needs. Frequently this is seen, however, as keeping people less time in hospitals, or not admitting them to nursing homes.⁷⁸

While publicly-funded, publicly-provided home care services have clearly increased, it is important to remember that most home health care is provided by informal caregivers within the family. To support unpaid caregivers, Saskatchewan Health reports that respite beds have increased 44% and respite days in nursing homes have increased 54% between 1991/92 and 1996/97.⁷⁹

In 1995, the Seniors Education Centre at the University of Regina conducted in-depth community consultations with caregivers and service providers. The resulting video and discussion guide portray the experiences and insights of several informal caregivers and present the following information:

- P every day in Saskatchewan more than 80,000 informal caregivers provide assistance and support to chronically ill, disabled or elderly adult family members. Some fulfill this role while also maintaining full-time jobs, while raising children of their own, or while growing more elderly and in need of care themselves;
- P three out of four caregivers are women, between 50 and 65 years of age;
- P as many as 10% of female caregivers are over the age of 75;
- P almost half of all seniors age 65 to 74 live with some form of disability; and

⁷⁷Silver, 1997, p. 2.

⁷⁸Adams, 1999, personal communication. Used with permission.

⁷⁹Saskatchewan Health, *Health Renewal is Working: Progress Report*, 1996, pp. 3-5.

P the actual cost to the health care system of maintaining a person in a long-term care facility is approximately \$3,000 per month. Clients and their families typically pay about one third of that cost. Thus, by keeping family members at home, informal caregivers save the health care system more than \$2,000 per month or \$24,000 per year.⁸⁰

e. Privatizing home care: transfer of costs to individuals

One result of early discharge from hospital of surgical and medical patients has been the transfer of costs for medical supplies to the individual. While in hospital, costs for prescriptions drugs, as well as medical supplies and equipment, are insured. In the home setting, individuals bear these costs. While Manitoba and Saskatchewan have created some programs to help cover these costs, more and more responsibility for paying for the materials of health care fall to individuals.

The Manitoba Home Care Equipment Program covers part of the costs and maintenance of some equipment and supplies, such as wheelchairs. The program loans medical equipment and supplies for use in the home on a referral by a medical practitioner. While the number of individuals using the program has increased over the years, the number of services provided has decreased. In 1987/88, the Home Care Equipment Program provided 35,213 services to 15,487 individuals.⁸¹ By 1997 the program was providing 28,952 services to 23,310 individuals. In 1996/97 responsibility for this program was transferred to the Materials Distribution Agency

of Government Services, with the exception of the wheelchair program, which is run by the non-profit Society for Manitobans with Disabilities.⁸²

According to Saskatchewan Health, "Financial barriers to increased use of home care are being removed. Certain palliative supplies and drugs are available to clients without charge. As well, home care clients receive IV drugs and supplies, and certain home care nursing supplies, such as medical dressings, without charge. Health districts may even reduce or waive client fees in cases of financial hardship."⁸³ In addition to user fees for home care services delivered by the health district, "patients receiving home care are charged for some drugs and supplies provided at no cost to patients in hospitals."⁸⁴ Some of these supplies may be covered by the health district and some equipment is available on loan, as well some districts provide funding for medical alert systems.

In Manitoba, the transfer of costs for medical supplies and equipment to the individual is also contributing to the privatization of the provision of these supplies, as for-profit businesses take advantage of newly-created markets. A few years ago, a for-profit medical supply store (Stevens Medical Supply Store) opened in the Health Sciences Centre in Winnipeg so that patients and their caregivers could purchase these supplies after being discharged from the hospital.

In 1997, the Manitoba government signed a two-year contract with Rimer-Alco North America (operating as RANA-Medical) to provide home oxygen services under the Manitoba

⁸⁰ *Living for Others: the life stories of older women in Saskatchewan*, Seniors Education Centre, University of Regina, 1995, excerpts from the video and from the discussion guide, p. 1.

⁸¹ Manitoba Health, *Annual Report 1988-89*.

⁸² Manitoba Health, *Annual Report 1997-1998*.

⁸³ Saskatchewan Health, *Annual Report, 1997-98*, p. 20.

⁸⁴ Health Services Utilization and Research Commission, 1998, p. 9.

Home Oxygen Therapy Program.⁸⁵ This contract is worth about \$1.4 million and affects 800 clients. RANA-Medical will supply oxygen, as well as follow-up monitoring by respiratory therapists. The Manitoba Association of Registered Respiratory Therapists (MAART) expressed concern that it had not been involved in the process leading to the decision to privatize oxygen services. The government cited cost savings as the reason for privatization, although three earlier government-commissioned reports concluded that private supply of home oxygen services would be more expensive than the current publicly-provided services.⁸⁶

2. LONG-TERM CARE

Part of the shift to less expensive care settings included moving long-term care patients out of acute care beds into a variety of facilities and settings, such as nursing homes and personal care homes. Both Saskatchewan and Manitoba experienced a significant loss of acute care beds as a result of health reform measures. One of the arguments for closing these beds was that many of the patients in acute care beds could be adequately served in long-term care facilities. In Manitoba, 436 new personal care home beds were opened between 1992 and 1998, at the same time as more than 1,200 acute care beds were closed.⁸⁷ In Saskatchewan, the number of people living in special care homes has decreased as many seniors with lower care needs now reside in privately-operated personal care homes or private family homes. As a result, more long-term care has been privatized. In Manitoba, costs of long-term care continue to be transferred to the individual, even when that care is received in a hospital setting.

In Saskatchewan, “special care homes” are publicly-funded nursing homes which provide higher levels of care, while “personal care homes” are primarily privately-owned facilities which charge residents fees. In the early 1990s, the Health Services Utilization and Research Commission (HSURC) conducted a study of long-term care in the province. Citing data which showed that the numbers of long-term care beds per thousand residents over age 75 was higher in Saskatchewan than in several other jurisdictions, HSURC argued that the province was faced with “an excessive and costly dependence on institutional care.”⁸⁸ The fact that all these beds were occupied was interpreted as an indicator that long-term care providers had a financial incentive to keep the beds filled rather than a measure of the “true level of need for institutional care.”⁸⁹ HSURC also found that long-term care providers were not given incentives to admit patients with high levels of care requirements. As a result, often those persons with greatest need had to wait longer for access to long-term care facilities. The study also found that people requiring long-term care were being kept in more expensive acute care hospitals.⁹⁰

Reasoning that institutional care can have negative effects on patients’ physical and mental abilities, as well as their sense of independence, HSURC concluded that “Saskatchewan’s long-term care sector needs a major overhaul” and recommended restructuring “to better serve clients’ needs and recognize clients’ capacities for independent living.” Specifically, it recommended a reduction in the number of institutional long-term care beds and a need to focus institutional care on higher need patients. It also recommended that persons with light care needs

⁸⁵ Manitoba Health, *Annual Report 1997-1998*.

⁸⁶ “Praznik stands behind oxygen pact,” *Winnipeg Free Press*, March 22, 1997.

⁸⁷ Manitoba Health, *Annual Reports: 1992-1998*.

⁸⁸ Health Services Utilization and Research Commission, *Long-Term Care in Saskatchewan: Final Report*, Saskatoon: 1994, p. 1.

⁸⁹ *Ibid.*, p. 1.

⁹⁰ *Ibid.*

be encouraged to remain independent in their own homes by expanding home care, respite services, adult day care and other community-based support services.⁹¹

In 1992, the Saskatchewan NDP government stopped direct funding to long-term care facilities for persons requiring light (Level 1 and Level 2) care. This was part of a larger trend toward encouraging people to live at home or outside government-funded long-term care institutions. In 1976, there were 1,702 Level 1 beds in government-funded nursing homes, but by 1996, this number had dropped to 16. Between 1985 and 1994, 94% of the Level 1 beds and 69% of the Level 2 beds were removed from the health system.⁹²

Some of those who promoted deinstitutionalization argued that families were “dumping” their elderly relatives in long-term care facilities which were not appropriate for those with light care needs. This value-laden terminology defines light care as a family responsibility and is used to justify the withdrawal of public funding for this type of service. While deinstitutionalization may indeed have benefits, the decision to stop public funding may have been driven by the desire to reduce expenditures, as much as it was based on evidence of the health benefits.

Many of the people requiring light levels of care have remained in their own homes or moved into personal care homes. By January 1999, there were 256 personal care homes in Saskatchewan with a total of 2,087 beds, only six of these personal care homes in the province were operated by non-profit corporations.⁹³ Between 1996 and 1999, the number of personal care home beds in the province rose 28%. According to CUPE Saskatchewan, this rise in personal

care homes “represents a shift in funding and responsibility from the public to individuals to pay for private care.”⁹⁴

In 1996, the Saskatchewan government changed the regulations governing personal care homes. Under the new regulations, personal care homes were allowed to operate up to 40 beds, rather than the existing ten-bed limit. By 1999, there were 40 personal care homes with more than ten beds. Health care unions, operators of smaller personal care homes, and members of the Liberal opposition all criticized the government for opening the doors to larger, private, for-profit facilities and transferring responsibility for light level long-term care to the private sector.⁹⁵ According to CUPE, “since 1996, the number of personal care home beds has increased by 28%....[this] represents a shift in funding and responsibility from the public to individuals to pay for private care....Personal care homes are creating low-wage ghettos. Because there is no government funding to personal care homes, private operators are paying low wages in order to keep resident fees somewhat affordable and still make a profit.”⁹⁶

Saskatchewan continues to have the highest proportion of persons over 75 living in special care (e.g., nursing) homes, though under health reform their numbers have declined. Between 1992 and 1998, the number of Saskatchewan people living in special care homes dropped by more than 10%, from 10,141 residents to 9,111 residents.⁹⁷ Between 1991/92 and 1996/97, Saskatchewan’s nursing home bed ratio dropped from 158 beds per 1,000 people over 75 years of age to 143 beds per 1,000 people over 75 years of age, getting closer to the national average of 129 per 1,000 people over 75 years of age.⁹⁸

⁹¹*Ibid.*, p. 1.

⁹²Canadian College of Health Service Executives. *Health Reform Update 1996-97*, 1997, p. 49.

⁹³Canadian Union of Public Employees (CUPE), 1999, p. 3.

⁹⁴*Ibid.*, p. 3.

⁹⁵Murray Mandryk, “New rules said to make care less personal,” *Regina Leader Post*, May 14, 1996.

⁹⁶Canadian Union of Public Employees, 1999, p. 3.

⁹⁷Saskatchewan Health, *Annual Report, 1997-98*, p. 21.

⁹⁸Saskatchewan Health, *Health Renewal is Working: Progress Report*, 1996, pp. 3-5.

In Manitoba, long-term institutional care is mostly provided in personal care homes. In 1998 there were 120 personal care homes in Manitoba licensed for a total of 9,105 beds. Sixteen percent of Manitoba's personal care homes are privately owned and operated. Eighty-three percent are operated by non-profit bodies including religious or charitable groups, and service organizations. Only one personal care home in Manitoba is owned and operated by the provincial government.

In Manitoba, the costs of long-term institutional care are covered by the individual receiving care, as well as the provincial government. All residents of licensed personal care homes in Manitoba are assessed a daily residential charge. A sliding scale of rates based on income is established by the provincial government and reassessed each year. Effective August 1, 1997, a new rate structure for personal care home residents was put into place. The minimum rate was increased to \$24.80 per day and the maximum was increased to \$57.90 per day.⁹⁹ The maximum has since increased to \$58.40 per day. An amendment to the Manitoba Hospital Services Insurance and Administration Regulation passed on October 16, 1998 allows these per diem charges to be applied to persons in hospital awaiting beds in personal care homes. A 1999 study by the Manitoba Centre for Health Policy and Evaluation found that the average time an individual spends in hospital waiting for a personal care home bed was 108 days.¹⁰⁰ If a personal care home bed has become available and an individual refuses to accept it, hospitals are able to charge the full per diem cost for a hospital bed.¹⁰¹

3. MENTAL HEALTH SERVICES

In Manitoba, mental health services have gone through extensive changes in the health reform process. One of the most substantial changes has been moving clients from institutions into community-based care settings, that include group homes and supported independent living sites. Non-profit, non-government agencies, such as the Canadian Mental Health Association and the Salvation Army have been partners in many of these initiatives, receiving funding to provide services. The Brandon Mental Health Centre, one of the province's largest mental health institutions, was formally closed on March 31, 1998.¹⁰² Other mental health institutions continue to operate in Manitoba.

The delivery of services by faith-based agencies, such as the Salvation Army, raises concerns for some clients, especially gay and lesbian clients. If faith-based agencies support a traditional and patriarchal family model, women who are lesbian, survivors of childhood sexual abuse and/or family violence, may be less likely to receive the services they need.

In July 1997, Manitoba Health announced that long-term psychiatric patients receiving care in a psychiatric facility would be charged income-based per diem rates. A long-term stay was defined as being of a duration longer than 180 days. These fees are not applied to patients who are admitted involuntarily.¹⁰³ Anti-poverty activists raised concerns that these fees would be unmanageable for a population that relies on a fixed low income and may result in patients leaving facilities before their treatment was complete because they could no longer afford per diem rates.

⁹⁹Manitoba Health, *Annual Report 1997-1998*.

¹⁰⁰Manitoba Centre for Health Policy and Evaluation, "Bed Closures in Winnipeg: Problem or Progress?"

<www.umanitoba.ca/centres/mchpe/bedclz3.htm>

¹⁰¹*Manitoba Gazette*, Vol. 127, No. 42, p. 1394.

¹⁰²Manitoba Health, *Annual Report 1997-98*.

¹⁰³Health Canada, *Provincial Health System Reform in Canada - Manitoba Version 3*, Health Canada: 1997, p. 27.

PART 3 IMPACTS OF PRIVATIZATION ON WOMEN

In 1987, women’s organizations in Saskatchewan protested against the Progressive Conservative government’s substantial cutbacks in health and social services. Writing in a journal published by the Saskatchewan Action Committee on the Status of Women, Susan Dusel argued that reductions in state support for health care services would have particularly adverse effects on women—as health care providers, as health service users, and as unpaid family caregivers.

When the health care system is cutback women get hit with a triple whammy. First, women tend to be the health care workers who are losing their jobs or are being run off their feet because of understaffing. Second, women and their children tend to be the heaviest users of the health care system. Finally, women have to pick up the slack when the state no longer funds health care services.¹

Have the health care reforms of the nineties delivered a triple whammy to women? To what degree has the public health care system been cut back? In what ways has health care been

privatized? How have these changes affected female health care workers, service users, and unpaid caregivers? Within these broad categories, which women have benefited from health reforms, and which have been harmed?

In attempting to answer these questions, we searched government documents on health reform, as well as the health and social science literature. We found very little evidence that health reform policies in either province have been subject to any kind of gender analysis. The various forms of health care privatization and their impact on women have received little attention from health system planners or researchers. Yet women comprise the majority of those employed in health care, those receiving care, and those providing unpaid care in the home.

Given the lack of research in this area, we cannot provide a clear answer to the question, “How have the various forms of health care privatization affected women in Saskatchewan and Manitoba?” What we attempt to do here is present evidence which shows how some forms of privatization have affected or may be affecting various groups of women. This tentative evidence points to the need for further investigation of the impact of health reform on women.

¹Susan Dusel, “Government puts the brakes on women’s movement,” *Network of Saskatchewan Women*, Vol. 4, No. 7, 1987, p. 4.

A. WOMEN'S EMPLOYMENT IN THE HEALTH CARE SYSTEM

In Manitoba and Saskatchewan, as in the rest of the Canada, over 80% of those employed in health care occupations are women.² **Table 7** and **Table 8** illustrate that the number of women employed full time in health occupations increased in both provinces, between 1990 and 1998. The number of women employed part time in health occupations declined in Saskatchewan, but increased in Manitoba during the same time period. What these figures do not reveal are patterns of female employment within specific health occupations, or the annual fluctuations within the decade. Neither do they capture any information on the nature of wage levels or working conditions within these occupations. Yet income and working environments are known to be important determinants of health.

B. JOB LOSSES FOR WOMEN IN THE HEALTH SECTOR

Government cutbacks in health care or changes in the delivery of health services have, at various times, led to layoffs of women employed in health care occupations.

When the Conservative government in Saskatchewan eliminated the school-based dental program in 1987, over 400 dental workers lost their jobs.³ The overwhelming majority of these workers were women. Under the program, dental services had been delivered by a largely female profession of dental therapists, working independently, in schools throughout the province, including many in rural communities. Dental therapists were unionized public sector

²Statistics Canada, *Labour Force Historical Review*, 1999.

³Elizabeth Smillie, "Dental Plan in Decay," *Network of Saskatchewan Women*, Vol. 4, No. 10, 1987-88, p. 6.

	Full Time		Part Time	
	1990	1998	1990	1998
Health occupations	12900	16500	7500	6000
Professional occupations in health, nurse supervisors and registered nurses	5500	7600	3800	2700
Technical, assisting and related occupations	7400	8800	3700	3300

Source: Statistics Canada, *Labour Force Historical Review*, 1999.

	Full Time		Part Time	
	1990	1998	1990	1998
Health occupations	15300	17800	8100	9000
Professional occupations in health, nurse supervisors and registered nurses	6900	8300	3700	4000
Technical, assisting and related occupations	8400	9500	4400	5000

Source: Statistics Canada, *Labour Force Historical Review*, 1999.

workers represented by the Saskatchewan Government Employees Union. When dental services were privatized, these jobs were eliminated and dental therapists were left to seek employment with dentists in private practice, most of whom were located in urban centres. According to Opposition critics, the cancellation of the

school dental program in Manitoba resulted in job loss for approximately 50 dental health practitioners, mostly women.⁴

Hospital closures and health care restructuring have led to layoffs among health care workers. According to the Canadian Union of Public Employees in Saskatchewan, “The failure to implement a provincial labour adjustment strategy at the beginning of health reform led to thousands of health care workers being laid off without retraining opportunities.”⁵

Expenditures on nursing and other health care staff represent a large portion of hospital budgets. Therefore when hospitals receive a funding cut as part of the health reform shift to “community care,” savings are often made at the expense of nursing staff. The Manitoba Nurses’ Union estimates that more than 1,000 nurses were removed from the health care system since 1992.⁶ The Manitoba NDP reported that approximately 500 other health care workers were laid off during the Progressive Conservative administration.⁷ The Saskatchewan Union of Nurses reports that “as institutions slash costs, nursing labour is the first target. Saskatchewan nurses have lost the equivalent of 579.5 full time positions since 1990, nearly a 10% decline.”⁸ In 1999, in response to nurses’ demands and public concern over nursing shortages, the governments of both Manitoba and Saskatchewan have made commitments to provide funding and improve conditions of work in order to recruit and retain more nurses.

When the Saskatchewan government decided to stop funding Level 1 and 2 light nursing care for residents of long-term care facilities, the gap in services was partially filled by private, for-profit personal care homes. In some cases, unionized workers who were laid off from long-term care facilities were offered jobs in the privatized personal care homes, at lower rates of pay.⁹

The consolidation and privatization of food and other services within the health system has also been associated with job losses. An analysis of the Urban Shared Services Corporation (USSC) centralized food system, which was developed to provide food to nine Winnipeg hospitals, projected the loss of between 252 and 357 jobs.¹⁰ Unions in both provinces have opposed the contracting out of laundry, meal and cleaning services to private, for-profit corporations.

Nationally, health care is one of the most highly unionized sectors for women in the paid labour force. In 1993, 53.2% of women working in health care belonged to unions.¹¹ Unionized positions often mean higher wages, benefits, and job security. The loss of unionized public sector jobs for women in health care occupations could have an impact on women’s income, economic status and conditions of work, all of which are regarded as important determinants of health. Data comparing wages, benefits and job satisfaction between public sector and private sector health care workers was not found.

⁴Shauna Martin, NDP Caucus Health Researcher, personal communication, March 1999. Used with permission.

⁵Canadian Union of Public Employees, *Protecting Public Health Care*, CUPE Saskatchewan Policy Paper, March 1999, p. 2.

⁶Manitoba Nurses Union, 1996, p. 9.

⁷Manitoba NDP News Release, “Filmon’s layoffs coming back to haunt him,” February 9, 1998.

⁸Saskatchewan Union of Nurses, “Health reform offering constraints and opportunities,” *Spectrum*, January 1998, p. 4.

⁹Canadian Union of Public Employees, *Protecting Public Health Care*, CUPE Saskatchewan Policy Paper, March 1999, p. 3.

¹⁰Philippe Cyrenne, *Analysing Shared Service Contracts: the Case of Food Services for Winnipeg Hospitals*, Canadian Centre for Policy Alternatives, June 1999; Canadian Union of Public Employees, *Cooking Up a Storm: Part II*, 1998, p.6.

¹¹Canadian Labour Congress, *Women’s Work: A Report*, Ottawa: Canadian Labour Congress, 1997, p. 13.

Data concerning the representation of visible minority women, Aboriginal women and women with disabilities in the health care paid employment sector is noticeably lacking. However, shrinking employment opportunities or the transfer of jobs to the private sector could make it more difficult for these women to gain access to full-time, well-paid employment. According to a study of privatization commissioned by the Canadian Union of Public Employees, “[n]ot only are women as a group losing work that’s full time and well-paid, immigrant, visible minority and Aboriginal women just getting a foot in the door are now fighting to keep the door from slamming shut altogether.”¹² Health care job loss is also of particular concern to women living in rural and northern areas, as public sector jobs are often the best paid jobs for women in these communities.

C. WORKING CONDITIONS FOR WOMEN IN THE HEALTH SECTOR

Nurses and other hospital workers in Saskatchewan and Manitoba have repeatedly raised concerns over workloads, understaffing, and stressful working conditions within the health sector. When the Saskatchewan Union of Nurses (SUN) called a provincial strike in April 1999, it was the latest in a series of actions designed to call attention to conditions of work in the health system. Within hours, the NDP government passed legislation ordering the nurses back to work. However, Saskatchewan nurses defied the back-to-work legislation and refused to return to work until receiving a commitment that salary and workload issues, among others, would be addressed.

¹²Canadian Union of Public Employees, www.cupe.ca/doc/990114%2D7.html

According to one SUN representative, “In the last five years, Saskatchewan nurses have experienced enormous cumulative stress. RNs and RPNs have watched administrators and nurse managers toy with “mission statements” and “governance models” while nurses struggle to provide safe care with diminishing resources amidst the confusion and chaos of closures, amalgamations, and conversions. There was no orderly plan for restructuring.”¹³

Nurses’ expressed concerns have included inadequate levels of pay, job losses, understaffing, increased nursing workloads, increased levels of stress, and “the steady erosion of “caring” as an essential service in health delivery.”¹⁴ According to Glenda Doerksen, vice president of the Manitoba Nurses Union, “Health Reform has not been a positive thing for front line direct care providers. Even though we were the largest group affected by the changes, we were allowed no input into the process....Nurses feel devalued, frustrated and exhausted. There is no longer any time for the caring part of nursing or for patient teaching.”¹⁵

In 1998, the Manitoba Nurses Union published *Health Care in Manitoba: A Report from the Front Lines*. This report contains first-hand accounts by nurses, patients and the public of the impact of cuts to the health care system. More than 5,000 nurses, representing over 50% of the Manitoba Nurses Union’s membership, took part in the Nurses Survey on Health Care. Eighty percent of nurses responding to the survey reported that their workload had increased since September 1995. Nearly half reported that they suffered from three or more symptoms of “burn-out.” The report also cited evidence that the

¹³Larry LeMoal, “Nursing: In sickness or in health?” *Spectrum*, January 1998, p. 1.

¹⁴LeMoal, 1998, p. 2.

¹⁵Glenda Doerksen, “Providing Care” in *Health Reform and Women: Opportunities for Change, 1999 Provincial Forum*, Winnipeg: Women’s Health Clinic, March 1999, p. 52.

number of registered nurses leaving the province has exceeded the numbers of new registrants, including new Manitoba graduates.¹⁶

As management practices in the health system emphasize cost-effectiveness, some have argued that the health care workforce is being de-skilled, with less-trained and lower-paid workers taking over tasks and reducing the number of nurses. According to the Saskatchewan Union of Nurses, “[s]ince 1993, ‘licensed providers’ including RNs, RPNs and LPNs have lost 279.5 positions, while the number of health providers in the aide category have increased by 153.5. (Within the aide category there has been a shift from nurses’ aides to more special care aides and home care aides.) Registered nurses, as a percentage of these six health providers, have declined to 45.3 from 46.7 percent.”¹⁷ On the other hand, some health policy analysts predict that as health reform evolves, nurses will take on increasingly important roles in the health care system (e.g., as advanced clinical practitioners in community health centres and other community-based services.)

In Manitoba, part of the health reform strategy was to commission a report on nursing staffing from Connie Curran, an American-based health care consultant. The report recommended several changes designed to lower expenditures on nursing staff by introducing private sector management practices. One example of this is the de-skilling of nursing providers, where tasks performed by a higher skill level nurse are transferred to lower skill level, and hence, lower paid, staff. This strategy resulted in the lay-offs of many licensed practical nurses (LPNs) in the Manitoba health care system, whose tasks were transferred to health care aides.

¹⁶Manitoba Nurses’ Union, *Health Care in Manitoba: A Report from the Front Lines*; Winnipeg: Manitoba Nurses’ Union, 1998, p. 4.

¹⁷Saskatchewan Union of Nurses, “How rationalization of health services is effecting nursing in Saskatchewan,” *Spec-trum*, January 1998, p. 7.

In 1996, the Manitoba Nurses Union produced an analysis of 2,000 Workload Staffing Reports filed in 1995/96. A Workload Staffing Report (WSR) is filed when a nurse believes that “the workload/staffing situation is such that adverse effects regarding patient/resident well-being may occur.”¹⁸ Documentation of WSRs increased by 34% between 1993 and 1996. The WSRs most frequently cite inadequate care and monitoring of patients, inadequate time to provide psychological and emotional support to patients and families, and inadequate time for patient teaching as results of nursing workload and staffing problems.¹⁹ According to the report, some of the contributing factors to this increase include: provincial funding cuts, bed closures, nursing lay-offs, as well as the de-skilling, “intensification” and “casualization” of nursing labour.

Intensification, or speeding up, of nursing care is a management practice which cuts costs by increasing nursing workloads and reducing nursing staff levels. Intensification occurs as nurses are required to perform a target number of tasks, such as delivery of medications or monitoring vital signs, within a certain time frame. Bed closures and shorter hospital stays can contribute to intensification, since there is a greater number of admissions and discharges to manage, and the patients in hospitals are those who require higher levels of care. Nurses report that one of the results of intensification of their tasks is a loss of time for patient teaching and providing emotional support for patients and their families.²⁰ Patient teaching is especially critical when patients are being sent home more quickly after surgery. The provision of emotional support to patients and their families is important as social support is a known determinant of health.

¹⁸Manitoba Nurses’ Union, *Documenting Nursing Workload: Workload and Staffing Report 1995/96*, Manitoba Nurses’ Union: 1996, p. 1.

¹⁹*Ibid*, p. 15.

²⁰*Ibid*, p. 12.

Casualization of nurses is also occurring in Manitoba. Casualization means that there are more nurses hired on a casual basis, and fewer full time, permanent nursing positions. Casual nurses provide services to different wards on an intermittent basis, thereby affecting the continuity of care provided to patients. **Table 9** illustrates the shifts in employment classifications for nurses in Manitoba during the time period that health reform was introduced.

	1992	1993	1994	1995	1996
Full Time	39.7%	38.2%	37.2%	36.5%	34.7%
Part Time	43.0%	43.8%	43.1%	45.1%	46.4%
Casual	17.3%	18.0%	19.7%	18.4%	18.9%

Manitoba Nurses' Union, *Documenting Nursing Workload: Workload and Staffing Report, 1995/96*, p. 11.

How do private, for-profit employers and private sector management practices affect working conditions in the health sector? Are women particularly vulnerable to employer expectations that they do more with less? Health sector unions have raised concerns about health care privatization, public sector job losses, deteriorating working conditions and lower wages. Some argue that health management practices which emphasize cost-cutting are changing the pace and organization of work. Some of these changes also pose a threat to health workers' health and safety. Hospital food services, for example, may come to resemble a fast-paced assembly line, thus increasing the potential for job stress or occupational injuries, such as repetitive strain disorders.²¹ According to CUPE Saskatchewan, "[f]or several years, the health care

²¹Canadian Union of Public Employees, 1998, p. 6.

sector has had the highest rate of WCB injury rates in the province. Health care workers are working short-staffed and under incredible stress because of staffing cuts and non-replacement of workers on sick leave."²²

The shift from institutional to home care moves the locus of care work to the private household. How does this form of privatization affect health care workers? What occupational hazards are associated with care given in private households? Increased acuity of home care, the use of new medical technologies in the home, and the lack of readily available institutional supports have all been identified by home care staff as factors affecting their work and the quality of care they are able to provide. A research project funded by the Prairie Women's Health Centre of Excellence is currently conducting a study of changes in home care services in one regional health district in Saskatchewan. The study is designed to examine how changes in the labour process affect home care workers in three different occupational groups.²³

There are many unexplored questions regarding the experiences of women in a variety of health occupations. What are the levels of pay, job security, hours of work, and conditions of work? Have part time and casual positions increased? What differences exist between private, for-profit, and non-profit health care agencies? How do recent changes in the health system affect the health of health care providers?

One Canadian study of private home care services found significant gender and age differences between the staff compositions of for-profit and non-profit agencies. Non-profit agen-

²²Canadian Union of Public Employees, 1999, p. 6.

²³Allison Williams, *Women's Formal (Paid) Home Care Work in Transition: The Impact of Reform on Labour Process Change in Saskatoon*. (Research in progress).

cies were more likely to employ older staff, especially women, while for-profit agencies employed a larger proportion of younger men and part time younger females. “The prevalence of younger part-time females in profit-making organizations may or may not imply more flexibility in terms of job-sharing opportunities and less possibility of “burn-out,” which could have favourable implications for clients. Employment of older staff in the non-profit agencies could mean that clients are served by people with greater experience.”²⁴ Further study into these differences, including examination of types of work, levels of training and conditions of employment, would be of interest.

D. IMPACT ON INFORMAL CAREGIVERS

Women perform most of the unpaid caregiving work in Manitoba and Saskatchewan. In 1996, 188,475 Manitoba and Saskatchewan women reported performing some hours of unpaid care to seniors. Over thirty thousand women in the two provinces reported spending ten or more hours per week on elder care.²⁵ Wives, daughters, and mothers provide the bulk of care to family members who are ill or disabled.

Under health reform, women’s caregiving roles within the family have been taken for granted and the private household has been defined as the preferred locus of care for those with “light” care needs. Home care policies in both

provinces are based on the assumption that care within the home is largely a family responsibility. According to the Canadian Home Care Association, “The purpose of home care is to help people who need acute, palliative and supportive care to remain independent at home. It is intended to supplement, but not replace, support provided by the family and the community.”²⁶ When government health reforms emphasize “partnerships with the community,” women are often the “partners” expected to provide more care at home. Often they do so without sufficient support services, such as respite and home care services, or supportive policies, such as leave from paid employment.²⁷

Health reform in both provinces was designed to reduce health care delivery in institutional settings while offering home care and community-based services as an alternative. This shift, partly driven by the desire to reduce expenditures, also was intended to improve care receivers’ quality of life and to encourage independent living as long as possible. Reduced reliance on institutional care can have significant benefits, but reduced access to institutional care also can create tremendous pressure on families to provide much of the care that would otherwise have been provided by the health system. According to one Saskatchewan caregiver, “with health reform it’s getting tougher and tougher to get people into [nursing] homes or hospitals or so on. There’s a lot of pressure to keep them in their homes longer.”²⁸

²⁴Daphne Nahmiash and Myrna Reis, *An Exploratory Study of Private Home Care Services in Canada*, Ottawa: Health Services Promotion Branch, Health Canada, 1992, p. 36.

²⁵Statistics Canada, “Population 15 Years and Over in Private Households by Census Family Status, Presence of Children, Labour Force Activity and Sex, Showing Hours of Unpaid Care to Seniors, for Canada, Provinces and Territories,” 1996 Census, www.statcan.ca/english/census96/mar17/house/table11/t11p46a.htm

²⁶Canadian Home Care Association, in collaboration with l’Association des CLSC et des CHSLD du Québec, *Portrait of Canada: An Overview of Public Home Care Programs* (draft), February 1998, p. 1.

²⁷Women and Health Reform Working Group, *Health Reform: Making it Work for Women*, Winnipeg: Women’s Health Clinic, 1997, p. 8.

²⁸*Living for Others: The Life Stories of Older Women in Saskatchewan*, Video and Discussion Guide, Seniors Education Centre, University of Regina, 1995.

While some of the architects of health reform acknowledge the possible impact on informal caregivers, they have made very little effort to monitor the impact. As people are kept out of hospitals and long-term care facilities, women's carework in the home may intensify, but policy-makers remain largely unaware of the consequences of their decisions on women's lives. According to the former Saskatchewan Deputy Minister of Health, the reduced institutionalization of the elderly combined with the sometimes inadequate level of home care support could be expected to have "a major impact on women, but its nature, volume and effects have never been measured in Saskatchewan."²⁹ In a recent study of regional health planning in Manitoba and Saskatchewan, only one of twenty-three regional health plans included recognition that informal caregivers are more likely to be women than men.³⁰

In 1997, the International Centre for Unpaid Work organized three public forums on unpaid work in Saskatchewan (in LaRonge, Saskatoon, and Swift Current). One of the issues which emerged at these forums was the impact of health reform on the unpaid work of family caregivers. Participants in the forums felt that "health reform is shifting large amounts of labour to unpaid workers without properly supporting or protecting them, and this is putting unpaid workers' health and economic well-being at risk."³¹ Participants in the forums expressed a desire for, "more recognition that the majority of health care is done by family members at home, mostly women...[and that] the

health system is taking advantage of them by shifting care from paid workers without taking responsibility for understanding and protecting the conditions under which the unpaid caregivers work."³²

Research on family caregivers has shown that caregiving can have significant negative effects on the caregiver's physical, emotional, financial and social well-being. Older caregivers have reported increased stress, high blood pressure, fatigue, exhaustion, and a greater susceptibility to physical illness.³³ Caregivers are twice as likely to suffer from depression as non-caregivers.³⁴ While caregiving can be personally satisfying, it can also lead to feelings of anger, guilt, resentment, frustration, grief, depression, loneliness, and fear.³⁵ In one Saskatchewan study, nearly half the caregivers reported that their health had deteriorated since they had begun caregiving. These caregivers reported increased depression, exhaustion, stress headaches, and back pain since assuming duties as informal caregivers.³⁶ While many informal caregivers choose to provide care and find the experience rewarding, lack of access to institutional care or adequate support services has left some family members feeling trapped in roles as "involuntary" caregivers.³⁷ According to some observers, "[health] reform will work only if caregivers are connected to a network of services which are accessible, flexible, affordable and responsive."³⁸

²⁹Duane Adams, personal communication, 1999. Used with permission.

³⁰Tammy Horne, Lissa Donner and Wilfreda Thurston, *Invisible Women: Gender and Health Planning in Manitoba and Saskatchewan and Models for Progress*, Winnipeg: Prairie Women's Health Centre of Excellence, 1999, p. 39.

³¹Carol Lees, *Forums on Unpaid Work*, Saskatoon: International Centre on Unpaid Work, 1997, p. 8.

³²Lees, 1997, p. 9.

³³National Advisory Council on Aging, cited in *Living for Others Discussion Guide*, p. 3.

³⁴Cited in *Living for Others Discussion Guide*, p. 3.

³⁵*Living for Others Discussion Guide*, p. 3.

³⁶Bonnie Blakley and JoAnn Jaffe, *Coping as a Rural Caregiver: The Impact of Health Care Reforms on Rural Women Informal Caregivers*, unpublished manuscript, 1999.

³⁷Comments made by participants at *Winners and Losers: A Forum on Home Care*, sponsored by the Saskatchewan Health Coalition, Saskatoon, March 6-7, 1998.

³⁸*Living for Others Discussion Guide*, 1995, p. 5.

The International Centre on Unpaid Work reported that caregivers in Saskatchewan were adversely affected by the rising expectations of the health care system and the lack of adequate protection and support.

Home based caregivers are providing ever increasing amounts of care, at ever higher levels, without adequate support services, without payment, pensions, labour standards, insurance protection or workers' compensation. Unpaid workers describe heavy work loads and excessive hours of work, insecurity, isolation, exhaustion and feelings of helplessness. Pushing unpaid workers beyond their ability to cope leads to stress and depression, increases their risk of mental or physical breakdown, and reduces the quality of patient care.³⁹

Informal caregivers often face additional costs and financial burdens related to caregiving. These include payment of user fees for home care services, the cost of home adaptations, the purchase of equipment and supplies, fees for respite care, transportation to medical appointments, and direct medical expenses. These costs pose a financial barrier to women with limited financial resources. Older women on fixed incomes, and women living in poverty do not have the financial resources to access a range of support services which would reduce their burden of care.

For caregivers who can afford them, support services are available in some locations. For others, the cost of such services or their distance reduces their accessibility. Support services are crucial to maintaining the well-being of the caregiver, but only if they are affordable and accessible. Some caregivers report that fees charged for home care services, adult day care and respite services restrict access to those fam-

ilies with the ability to pay. Thus the privatization of responsibility for caregiving has different consequences for those who can purchase support services, and those who cannot.

"Money, of course buys anything you need, if you have it. So if you have lots of money then it's a moot point, because you can buy any service that you want to buy. If you don't have money, you're at the mercy of whatever system you can find, negotiate and make work for you."⁴⁰

When caregivers voice their concerns over the costs of accessing support services, they are sometimes met with an unresponsive system. One caregiver reported that when she spoke with a social worker about the costs of home care, she was told, "If you can't afford home care for your husband, you could get a separation, or quit your job and go on welfare."⁴¹ When residents in one health region repeatedly expressed a desire for additional home care services in heavy housework and yard work, the official response was a communications campaign to inform residents that such tasks were a private responsibility.⁴²

In addition to direct costs, many caregivers experience reductions in income as they adjust their employment in order to fulfill their caregiving responsibilities. According to the National Advisory Council on Aging, loss of income due to reduced or lost employment, foregone wages or opportunities for advancement and reduced pensions resulting from caregiving responsibilities, have negative implications for the economic well-being of caregivers.⁴³ A study of rural informal caregivers in Saskatchewan found that several women retired from paid employment because of the demands

³⁹Lees, 1997, p. 9.

⁴⁰*Living for Others* video, 1995.

⁴¹Lees, 1997, p. 3.

⁴²Horne, Donner and Thurston, 1999, p. 39.

⁴³Cited in *Living for Others Discussion Guide*, p. 3.

of caregiving; and several reduced their hours of paid work in order to have time for their caregiving responsibilities.⁴⁴

A recent study by the Health Services Utilization and Research Commission (HSURC)⁴⁵ sought to determine whether the substitution of home care for hospital care was truly a more cost-effective means of reaching the same health outcomes, whether such home care represented an additional cost to the health system, and whether any apparent public cost savings were masking a transfer of costs to patients and family caregivers. This study of acute home care as a substitute for longer hospital stays is one part of a larger study which will also examine home care as a preventive service designed to reduce demand for institutional care, and home care as a substitute for long-term residential care. It is important to note that this study deals with home care following an episode of acute care, not long-term care of the chronically ill or disabled.

The HSURC study used a Burden Interview administered to informal family caregivers two weeks after a patient's acute care episode. While the interview schedule covers some of the potential impact, it has its limitations. For example, the only question related to the financial burdens imposed on caregivers reads as follows: "Do you feel that you don't have enough money to care for your relative, in addition to the rest of your expenses?" Likewise, the impact of combining caregiving, other family responsibilities and paid employment are collapsed into one item which reads: "Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?"

⁴⁴Blakley and Jaffe, 1999, pp. 117-118.

⁴⁵Health Services Utilization and Research Commission (HSURC), *Hospital and Home Care Study*, Summary Report No. 10, Saskatoon: HSURC, 1998.

The HSURC study also used one-page logs for patients and caregivers to record their out-of-pocket expenditures and the time spent in caregiving. The time spent "keeping people company" was excluded from the calculations. While social support is widely recognized as a determinant of health, and friendly visits are listed as one of the services included in a comprehensive home health care program, the time spent providing this service has apparently no value.

The value of caregivers' time was calculated at a replacement cost of \$15 per hour based on the estimated costs of hiring someone from a private home support service agency. Caregivers in this study, which only focused on episodes of post-acute care, donated an average of 1.5 hrs of caregiving services per day over the 30-day logging period. The average value of unpaid caregivers' time was estimated to be \$564 per 30-day period, with very little difference between situations where patients received post-acute care in the hospital, received post-acute home care services, or were discharged with no post-acute care. The average out-of-pocket expenses for caregivers and patients was \$94 over the 30-day logging period. The average costs to patients and caregivers, including estimated values for the caregivers's time and out-of-pocket expenses, were higher for patients who received post-acute care in the hospital compared with those who did not. Similarly, the costs to patients and caregivers were somewhat higher for those who received home care services, than for those who did not.

While the HSURC study of home care costs included efforts to measure caregivers' burden and costs, including the value of caregivers' time and out-of-pocket expenditures, the data were not presented in ways which allowed for any gender analysis. Beyond noting that 61% of the caregivers who completed interviews were

female, there was no further discussion or analysis of gender differences in hours of care or measures of caregivers' burden. Income information gathered was based on household, rather than personal income so it is impossible to measure any changes in women's individual incomes, or their increased economic dependence on others, stemming from their assumption of caregiving responsibilities. The caregivers' burden interview results have been reduced to numerical scores used for comparing the level of burden between different groups of caregivers. They provide no adequate description of the conditions which reduce or exacerbate the burdens of caregiving.

The study found that self-reported levels of caregivers' burden were higher among caregivers who were between 45 to 59 years of age, living with small children, in poorer health, caring for a parent, or caring for a person with lower physical or mental health scores. Caregivers' burden scores and levels of satisfaction with services were very similar regardless of whether or not the patient received post-acute care in the hospital, and whether or not they received post-acute home care services. Given the similarity in physical health outcomes, as well as measures of patient and caregivers' costs and satisfaction with services, HSURC concluded that it makes sense to opt for the less expensive alternatives to hospital-based post-acute care.

The time demands of caregiving and a lack of family and community supports can reduce opportunities for caregivers to engage in social activities. In a study based on interviews with rural informal caregivers in Saskatchewan, the majority of respondents were dissatisfied with their level of social activities and attributed their lack of social participation to the time and energy required to provide care.⁴⁶

Those who provide care to family members, whose first language is not English, face greater risk of isolation. In cross-cultural situations, service providers may not be able to communicate with the clients or be aware of diverse cultural needs. Thus, caregivers are more reluctant to leave the care recipient in someone else's care. As one caregiver pointed out, "even if you get some care, extra care, nobody could look after her because of the language barriers."⁴⁷

Many caregivers experience a sense of accomplishment and personal growth through their role in a caregiving relationship. Some report that their lives are enriched by supportive individuals they have met within the health care system, church, and community. However, some describe caregiving situations which undermine their own health and well-being, and go beyond reasonable expectations of family care. A single mother with a chronically ill child described her caregiving situation in rural Saskatchewan:

I do daily the work of three shifts of nurses in a hospital setting: I administer 10 hours of peritoneal dialysis six day per week. I prepare charts which are reviewed by doctors. I dispense medications around the clock. I change surgical dressings. I oversee daily vomiting sessions. I attend all bathroom visits because of immobility due to renal osteoporosis. I hand feed one meal per day because of renal anorexia. I order medical supplies. I do daily the work of a hospital orderly: I lift a 46-pound child countless times. I lift her wheelchair as well as one very heavy bucket of dialysis effluent daily. I transport and lift 60 boxes per month of dialysis fluid. I have the physiotherapy exercises to oversee daily for strengthening leg muscles. I have the responsibility of a doctor, with my patient's life literally in my hands on a daily basis; one wrong

⁴⁶Blakley and Jaffe, 1999, p. 115.

⁴⁷*Living for Others* video, 1995.

gesture on my part with the dialysis tubing and she runs the risk of fatal infection. All these responsibilities are well over and above the task of responsible motherhood and I firmly believe they must be paid for....[I] am currently expected by the medical and social institutions to be "on duty" 24 hours per day with no days off, no vacations and no benefits.⁴⁸

This caregiver described a number of consequences of the health system's expectation that she perform the duties of a skilled health care provider 24 hours per day: social isolation, loss of paid employment, poverty, dependence on social assistance, physical and emotional strain. She has argued that the current expectations that she provide these services free of charge is a violation of her human rights, and she has asked that she be paid by the health district for the health care services she provides. Calculating the time during which she is performing the duties of a health care provider as 312 hours per month at an estimated value of \$20 per hour, she argues that the health district should be paying her \$6,240 per month for the specialized health care services she provides to her child. Her claim has drawn the attention of feminist academics and human rights activists at the University of Regina and the University of Saskatchewan who have assisted her in presenting her claim to members of the provincial government.

While informal caregiving is often assumed to take place within the home, family caregivers also report that they provide necessary care to family and friends within institutions. The level of informal caregiving within health care institutions has not been monitored, although anecdotal evidence suggests that family members take over tasks which paid health care providers do not have time to perform. A woman in Mani-

toba reported that she needed to provide daily care for a family member while he was hospitalized. "I spent every day for three months with my husband in hospital because I did not feel he would get good care if I left even for one day. When he was too sick or sedated to answer for himself, who knows what would have happened to him."⁴⁹

A recent study of rural women informal caregivers was funded by the Prairie Women's Health Centre of Excellence. The study explored the impact of health reforms on caregivers in a rural health district in Saskatchewan, and examined the ways in which the impact was further magnified by the lack of formal and informal supports in the region. The study revealed that caregivers were leaving paid employment or adjusting their paid work to accommodate their caregiving responsibilities, that caregivers were reducing their participation in social activities as a result of caregiving, that a majority of those interviewed reported that their health had worsened, and that rural communities faced particular challenges which health service providers needed to take into account.⁵⁰ Other research on women's caregiving is currently underway. Karen Grant, Barb Payne and David Gregory have received funding from the Social Sciences and Humanities Research Council (SSHRC) for a three-year project entitled, "Women's Caring Work in the Context of Manitoba Health Reform." Interviews will include paid and unpaid female caregivers and are designed to solicit information about health reform and the labour process, as well as the health and well-being of women engaged in unpaid caregiving.⁵¹

⁴⁸Lees, 1997, p. 4.

⁴⁹Manitoba Nurses' Union, 1998, www.nursesunion.mb.ca/report/graphs15.htm

⁵⁰Blakley and Jaffe, 1999.

⁵¹Karen Grant, personal communication, March 1999. Used with permission.

The Prairie Women's Health Centre of Excellence is currently funding two other research projects which look at the health of informal caregivers. One study, based on interviews with caregivers in Saskatchewan, looks at the effects of health reform, deinstitutionalization, and caregiving on the health of informal caregivers who provide long-term care for persons who are chronically or terminally ill, disabled or elderly. The other research project, using data from the Manitoba Study of Health and Aging, focuses on the relationship between gender, employment status, home care service use, and the health of caregivers.

The Prairie Women's Health Centre of Excellence has also awarded a developmental grant to the Peepeekisis First Nation in Saskatchewan. The project will examine the issues facing on-reserve women who care for multi-generational families. The combination of caring for more than two generations of family, living in a rural community with little or no support services to ease the burden, often compounded by employment outside the home, presents significant stressors which have the potential to affect the overall health and well-being of on-reserve women.

E. IMPACT ON WOMEN AS CARE RECEIVERS

We found very little research in Manitoba or Saskatchewan which focused on women's experiences of health reform as patients or users of health services. A recent study of community health needs assessments and health plans revealed that many regional health bodies in Manitoba and Saskatchewan did not disaggregate data by sex and were thus limited in their ability to identify the health needs of women in their regions.⁵²

⁵²Horne, Donner and Thurston, 1999, p. 33.

During the 1990s, the proportion of health care expenditures paid by individuals or private health insurance has increased. Many women may face financial barriers to accessing health services which are not fully covered by Medicare. Women, because of their lower incomes, their greater risk of poverty, and their lack of access to employment-based health insurance coverage, may be disproportionately affected by the privatization of health care costs. Many single mothers, women with disabilities, Aboriginal women and senior women live well below the poverty line. User fees for health care services would be especially damaging to low income women who have high health care needs.

Under the pressure to contain public expenditures on health, governments have shifted some of the responsibility for payment to individual users of services. Private expenditures for some health services have increased, though targeted public programs provide coverage to some low income people. Combined public/private payment schemes apply to prescription drugs, dental, eye care services and other supplemental health services. While programs of targeted financial coverage of health expenses reduce financial barriers and provide access for some, they are not without problems. A participatory action research project on poverty and health in Saskatoon revealed that some low income persons felt they were subjected to second-class treatment because their health cards identified them as social assistance recipients. On the other hand, low income residents who did not qualify for drug coverage or supplemental health coverage, felt that their access was restricted by their inability to pay.⁵³ In addition, targeted programs, in contrast to universal programs, run the risk of losing support from mem-

⁵³Personal Aspects of Poverty Group, *Poverty, People, Participation*, Saskatoon, 1995, p. 32.

bers of the public who are not eligible for benefits. Private, for-profit health service providers can be hired to provide home or in-hospital care for patients who will pay the fees. As the number of nurses have decreased in hospitals, some families are opting for this high-priced alternative to supplement care. Costs for these services can amount to \$100 per day.⁵⁴ Women may find themselves in a variety of situations where their access to some health services is mediated by their income and their access to public or private health coverage.

We found little research related to health care privatization and women's access to reproductive health services. In both Manitoba and Saskatchewan, the recent passage of midwifery legislation could expand the range of choices in prenatal, birthing, and postpartum care. However, in Saskatchewan, there has been no commitment to include midwifery services under the public health insurance program. Without public financing of midwives' services, this kind of care may be inaccessible to those unable to pay. A recent study of women's experiences of midwifery care found that midwifery clients valued the time midwives spent with them, the personalized care and support, and the holistic, unobtrusive, low-tech style of care provided. Participants in the study recommended that midwifery services be publicly-funded in order to be accessible to all women regardless of economic status.⁵⁵

Women in Manitoba seeking abortions are faced with the options of four to six week wait times or paying up to \$550 at the Morgentaler Clinic.

The refusal of the Manitoba government to cover abortions provided in a private clinic, despite introducing a legislative framework to cover other surgical procedures in private clinics, is an example of a differential impact of privatization on women as care recipients.

In Manitoba, there have consistently been waiting lists for personal care home beds. At the same time as more than 1,200 acute care beds were being closed in Manitoba, 436 new personal care home beds were created with the intention of moving people from more expensive acute care to less expensive personal care homes. All residents of licensed personal care homes are assessed a daily residential charge. A sliding scale of rates based on income is established by Government and the charge is reassessed effective August 1st each year. Effective August 1, 1997, the minimum rate was increased to \$24.80 per day and the maximum was increased to \$57.90 per day.⁵⁶ The maximum has since increased to \$58.40 per day. An amendment to the Manitoba Hospital Services Insurance and Administration Regulation passed on October 16, 1998 allows these per diem charges to be applied to persons in hospital awaiting beds in personal care homes. If a personal care home bed has become available and an individual refuses to accept it, hospitals are able to charge the full per diem cost for a hospital bed.⁵⁷ According to Manitoba Health Annual Reports from 1989 to 1997, home care clients in Manitoba have increased by 23% over that eight-year period.⁵⁸ Women make up a greater proportion of home care recipients.

⁵⁴Manitoba NDP News Release, "Two-tier health system evident in Westman," March 17, 1998.

⁵⁵Meaghan Moon, Lorna Breitzkreuz, Cathy Ellis and Cindy Hanson, *Midwifery Care: Women's Experiences, Hopes and Reflections*, unpublished manuscript, 1999.

⁵⁶Manitoba Health, *Annual Report 1997-1998*, www.gov.mb.ca/health/ann/199798/4abcdefg.html#Personal_Care_Home_Program

⁵⁷*Manitoba Gazette*, Vol. 127, No. 42, p. 394.

⁵⁸Manitoba Health, *Annual Reports 1989/90 to 1996/97*, Manitoba Health, 1990-1997.

In Saskatchewan, many older women who, in the past, would have received care in publicly-funded Level 1 and Level 2 long-term care facilities, are now living at home or in private personal care homes. The policy shift from institutional care toward more home and community care could be having a number of benefits for senior women who are able to maintain their independence and live at home. Home care may offer them some of the support needed to remain in familiar surroundings, close to family and friends, with access to health services provided at or near home. However, this major shift in care options for senior women should be monitored to ensure that residents of personal care homes have access to high quality care, and that women living independently receive the necessary supports to remain healthy at home. Reduced access to institutional care could mean reduced access to health services, unless an adequate system of community-based support services has been developed.

The policy of reducing hospitalization through outpatient surgery and earlier discharge has increased the number of home care patients receiving post-acute care. Some health care providers have raised concerns that shifting post-acute care to delivery within private households is changing the nature of home care toward a more medicalized model. According to the Manitoba Nurses' Union Survey, 79% of nurses in Manitoba reported that patient teaching is neglected.⁵⁹ The lack of appropriate patient education can lead to additional problems when patients are discharged soon after surgical procedures, as patients may not know how to care for wounds.

The overwhelming majority of elder care in Canada is provided by family members in the home. Many people express preferences for this type of care yet some older women may not be well-served by a privatized pattern of care.

⁵⁹Manitoba Nurses' Union, p. 13.

Women receiving care at home may experience social isolation, increased dependence on family members, feelings of being a burden, inadequate or unskilled care, neglect or abuse.

Family care of older women occurs within a cultural context which marginalizes older women and places a high value on individuals who are independent and self-reliant. Does the high value placed on independence and the expectation of family care create barriers to senior women seeking support and care from other sources? What happens to senior women who need more care than home care services and their family members are able or willing to provide? The needs of dependent aging women may be given lower priority than competing caregivers' obligations to jobs, spouses, and children. In Canadian society, older women are often culturally devalued and portrayed as a burden to their families and society at large, thus diminishing their sense of entitlement. The expectation that care is a private family responsibility may make them reluctant to make demands on public services:

These cultural assumptions and material realities work to sustain the existing pattern of care, keeping the major portion of responsibility outside the public realm and outside the concerns of men. However,...sustaining this pattern comes at a high cost to women; it introduces contradictions and strains into their lives that stifle and suppress their pursuit of need-meeting behaviour and opportunities for self-enhancement....Recognizing the ways in which the existing pattern of care constrains women and works to their detriment over the life course, the challenge for the future is to render thinkable other societal responses to old people's needs that do not operate at the expense of women....For women to identify their needs and wishes and translate them into action, not only would they require an array of available supportive services, but also a breaking down of these ideological barriers to using them....Reduction of these ideological constraints must be accompanied by the de-

velopment of alternative public responses to women's concerns that enhance their independence and security over the life course. Working toward such changes in the conceptualization of social policies and practices can contribute to freeing women to express their needs and pursue solutions to them without the spectre of guilt and shame to which they are presently subject.⁶⁰

The Maritime Centre of Excellence for Women's Health also has called for a gender analysis of home care policies in order to determine whether they place women at a disadvantage. The Centre argues that it is important to determine whether, "assessments of needs and resource allocations in care situations carry systemic biases by implicitly accepting women's role as unpaid informal caregivers and overestimating the ability of elderly women to care for themselves?"⁶¹

The rhetoric of health reform certainly promised that home and community-based health services would be enhanced, but more detailed monitoring of the changes in services would be required to assess how well those promises have been kept. A study of home care services should monitor whether resources have been diverted from the health maintenance and home support services which were seen as central to home care in the past. Because services are delivered on a regional basis, and may vary across regions, it is difficult to determine whether the support services needed by older women who wish to remain in their own homes have become more or less accessible.

⁶⁰Jane Aronson, "Women's Perspectives on Informal Care of the Elderly: Public Ideology and Personal Experience of Giving and Receiving Care" in *Health and Canadian Society: Sociological Perspectives*, edited by David Coburn, Carl D'Arcy and George Torrance, Toronto: University of Toronto Press, 1998, pp. 412-413.

⁶¹Maritime Centre of Excellence for Women's Health, *Home Care and Policy: Bringing Gender into Focus*, Discussion Series Paper No. 1, March, 1998, p. 5.

A research project funded by the Prairie Women's Health Centre of Excellence is currently examining the health practices of senior women living in the community.⁶² By interviewing women and working closely with those who provide housing and support services to seniors, this study will examine the effects of current policies and assumptions about public obligations and private responsibilities for the health of older women living in the community.

Another research project funded by the Prairie Women's Health Centre of Excellence examined the problem of social isolation and loneliness among senior women in Manitoba.⁶³ Using personal interview and administrative data from the 1996 Aging in Manitoba Study, the researchers found that older women were more likely than men to be widowed and more likely to live alone. Fifty percent of the women, and 39% of the men reported the highest levels of loneliness. This raises concerns regarding the adequacy of community-based supports for older women living in their own homes. Social isolation and loneliness may be exacerbated by lack of income, lack of transportation, and poor health.

The Saskatchewan Health Services Utilization and Research Commission has received funding to conduct an investigation of the benefits of providing non-medical home care to seniors. Although the study does not focus on women, hopefully the analysis of the data will shed light on the effectiveness of home care services in promoting health, independence and amount of medical treatment required.

⁶²Katherine Ash, *Health Practices of Community Living Senior Women* (Research in progress).

⁶³Madelyn Hall and Betty Havens, *The Effect of Social Isolation and Loneliness on the Health of Older Women*, unpublished manuscript, 1999.

F. SUMMARY OF IMPACT ON WOMEN

It is clear that the privatization of health care services affects women in their many roles and on a variety of levels. While there has been very little research on the impact, we know from the existing literature that women comprise the majority of health care workers, health care recipients, and unpaid caregivers. Therefore, any changes to health care policy and practice will affect women disproportionately. The fundamentals of gender analysis tell us that because of women's lower social status, the effects of policies and practices may be experienced differently, and in some cases, more acutely by women than men.

Privatization of health care has resulted in the loss of good jobs for women who comprise the majority of health care workers. In some cases, this has meant a direct loss of well-paying, unionized jobs as parts of the health care system are transferred to private corporate control. For nurses in both Manitoba and Saskatchewan, the adoption of private sector management strategies in order to save money on hospital expenditures has led to reports of a serious decline in working conditions.

The transfer of care for patients from institutions to the "community" is a form of privatizing the provision of health care services that affects women as care providers and care recipients. To some degree, the health reform policy of deinstitutionalization is founded on the assumption that women will continue in their traditional gender roles as caregivers. This assumption is not articulated in health reform documents, but it would be impossible to provide care in the community unless women were willing to do this work. In many cases, it may be preferable for people to receive care in their homes, but those who provide the care must receive adequate support so that they are not penalized financially for their efforts. It is also critical that the health of unpaid caregivers is protected. Serving in a traditional caregiving role may mean that women requiring care themselves are reluctant to ask for what they need. Who cares for the caregivers?

The privatization of health care costs and the privatization of health care delivery may affect women who use health care services in a variety of ways. However, the lack of gender analysis in research on health reform makes it difficult to know which women are benefiting and which are being harmed. Differences of culture, socioeconomic status, income, occupation, region, and age are just some of the factors which need to be taken into account, along with gender, in assessing the impact of health reform policies on women using the health care system.

PART

4 CONCLUSION

In Saskatchewan and Manitoba, health care privatization has taken several forms. In some cases, the privatization of health care is quite visible and overt. In other cases, the erosion of public responsibility for health care is less obvious. This report provides an overview of some of the forms of health care privatization which have emerged in recent years, and raises questions about the impact of those changes on women. Figuring out what is happening in the health care system is not an easy task. The health system is complex, multilayered, and constantly changing. The rhetoric of health reform, at times, seems to mask or contradict the reality.

In Manitoba and Saskatchewan, reforms to the health care system have occurred in an environment of decreasing federal and provincial public spending on social programs. Over the last decade, provincial governments have tried to make the health care system more effective at improving health status, and more efficient at spending resources to accomplish that goal. In an attempt to spend less public money on health services, provincial governments in Manitoba and Saskatchewan have allowed a creeping privatization in various parts of the health care system. Health reform policy strategies, such as regional governance and the transfer of care from institutions to the home and “community,” have re-

sulted in a shift of responsibility for the costs of health care to the individual, as well as the provision of these services to for-profit companies and unpaid caregivers. While privatization was not an explicit goal of health reform in Manitoba and Saskatchewan, it appears to have been one of the results.

Most health services and programs in Manitoba and Saskatchewan are provided as publicly-insured services, without additional fees charged to patients. However, many people pay privately for prescription drugs, dental care, optometric services, complementary medicines, treatments by non-physicians, long-term care, and some home care services. Since 1990, public expenditures as a proportion of total health spending have declined and private health expenditures have risen substantially. There have been changes to provincial prescription drug plans and provincial public health insurance plans have de-listed or excluded some important health services. The shift from institutional to community-based care also has resulted in a transfer of costs to the individual, as supplies and services, provided at public expense to hospitalized patients, are no longer covered for outpatients. Private health insurance programs have expanded to fill the gaps in public coverage, but private insurance is not accessible to all.

In addition to the costs of health services, the delivery of health services has been privatized in a number of ways, although the patterns vary somewhat in the two provinces. Examples of privatization include the elimination of the school-based dental program, the contracting out of food and cleaning services in hospitals to private, for-profit companies, the use of private, for-profit medical laboratories, the expansion of private personal care homes, and the privatization of home care services. In the cases of abortion and physiotherapy, private options exist in part due to long wait times for public services. While some government policies and regional health decisions have opened the doors to further privatization in the health sector, other policies have attempted to place limits on the privatization of health care. The debate over the scope of public responsibility for health care continues.

There have been three major attempts at privatization involving for-profit companies in Manitoba: Home Care (Olsten Corporation); the Manitoba Health Information Network (EDS, Inc. and SmartHealth, a subsidiary of the Royal Bank of Canada); and the Urban Shared Services Corporation Food Services (Aramark). In each case, the government cited cost-effectiveness as a primary motivator for securing private services. In each case, opponents of privatization were able to demonstrate that cost savings were negligible. In the case of home care, the Minister of Health eventually concluded that the public system was a more cost-effective alternative than private sector care. The Manitoba government ended its deal with SmartHealth in 1998, without having achieved the major goals of the health information project. In each of these attempts to shift control of large sectors of the health care system to private, for-profit corporations, American companies became involved in the deal by purchasing interests in the participating for-profit corporations.

Health care in Manitoba and Saskatchewan also has been privatized in the sense that care work has been transferred from institutions to private households. In Saskatchewan, many small rural hospitals were closed or converted to community health centres and public funding for light levels of institutional care was eliminated. Home care services have increased and the number of institutional beds in both hospitals and nursing homes has declined. Privatization has crept into many areas of the health care system, especially as more care has shifted out of institutions and into the home and community.

A. IMPACT ON WOMEN: MISSING LINKS

Women, to a greater extent than men, utilize the health care system to access services for themselves and other family members. Women are the majority of workers in several health care occupations, and women provide most of the unpaid, informal health care within the home. Women earn less than men, are more likely to live in poverty, and are less likely to have private health insurance. Privatization in the health care system can be expected to have significant impact on women as users of health services, as health care workers, and as informal caregivers.

Health care policies and programs in Manitoba and Saskatchewan are rarely informed by a gender analysis. There have been very few studies which focus on the impact of health care privatization on women. Nevertheless, several important impacts on female health care workers were identified including job losses, increased workloads, and stressful working conditions. Such impact poses threats to the physical and emotional health of women working in the health care system and make it difficult for them to provide high quality care.

The privatization of health care expenditures, in all likelihood, has created financial barriers which affect women's access to services, yet very little is known about the impact of privatization on women as users of health services. According to health care workers, efforts to control health expenditures have created staff shortages which have affected the quality of care, patient safety and patient education. The health system's assumption that family members are available and able to provide care also may leave some women vulnerable to inadequate or inappropriate levels of care, particularly as more complex caregiving tasks are being transferred to the home.

The shift from institutional to community and home care has created new demands on informal caregivers. The studies of caregivers identify impacts which include feelings of isolation, unrelenting demands on their time, lack of choices, loss of employment income, reduced social participation, and declining health. These studies point to the need to develop policies which will promote the well-being of care providers and increase their participation in the decisions which affect them.

B. WOMEN IN ACTION: RESPONDING TO HEALTH REFORM

Some women have been voicing their concerns about health reform and some have been organizing to develop health policies more responsive to women's health needs. In 1996, the Women's Health Clinic in Winnipeg published an article entitled, "Health Care Reform and Regionalization: Can Women's Voices Be Heard?" in which women were urged to seek opportunities arising from regional restructuring to advocate for services which would address

women's needs.¹ The Women and Health Reform Working Group (WHRWG) was formed in Manitoba in January 1996. Organizational members of the group have included the Manitoba Women's Institute, the Manitoba Women's Advisory Council, the U.N. Platform for Action Committee, the Provincial Council of Women, the Women's Health Clinic and the Prairie Women's Health Centre of Excellence. The group has organized outreach workshops in Dauphin and Thompson to discuss regionalization and health reform with women. The group continues to meet monthly, providing a forum for women's health researchers, advocates and policy-makers to meet and share information.² The group has met with Manitoba Health and staff of the Winnipeg Hospital Authority and the Winnipeg Community and Long-term Care Authority to discuss women's experiences with the health care system, in areas such as mental health, home care and health planning. In March 1999, the group organized a conference on Women and Health Reform that attracted over one hundred participants.³

Nurses unions in both provinces have taken action to bring nurses' perspectives on health reform to the attention of the public and policy-makers. In the spring of 1999, the Saskatchewan Union of Nurses went on strike demanding a collective agreement which would address their concerns over wages, workloads, working conditions, and staffing practices. Within hours, the government of Saskatchewan introduced legislation to force the nurses back to work. The nurses, however, refused to comply and continued the strike until some of their concerns over wages and working conditions were addressed.

¹Women's Health Clinic, *Womanly Times*, Spring 1996.

²Women and Health Reform Working Group, *Health Reform: Making it Work for Women*, Winnipeg: Women's Health Clinic, 1997, pp. i-iv.

³*Health Reform and Women: Opportunities for Change*. Proceedings of the 1999 Provincial Forum, Winnipeg, March 1999.

Women employed in the health care system often address their work-related issues through participation in labour unions and professional organizations. Health care workers in the Canadian Union of Public Employees (CUPE) are participating as part of a national campaign to oppose privatization of public services. CUPE Saskatchewan has developed a policy paper on privatization of health care which was brought before their annual convention in 1999. CUPE Saskatchewan adopted an action plan for 1999/2000 which included plans to lobby the government for expanded home care coverage under the provincial health insurance plan, prescription drug coverage for home care patients, increased public funding to address staffing levels in health care, and public funding for light levels of care in nursing homes. The plan also urged the adoption of community clinic models of care with salaried physicians rather than fee for service.

Public sector unions, such as CUPE, the National Union of Public Government Employees, and the Manitoba Government Employees Union have been vocal opponents of privatization because their members stand to lose well-paid jobs. In Saskatchewan, CUPE was successful in several of their efforts to oppose privatization through contracting out food, housekeeping and laboratory services.⁴

A group of caregivers in Saskatchewan worked with the Seniors' Education Centre at the University of Regina to produce a video entitled, *Living for Others*. The video documents many of the problems experienced by informal caregivers and has been used to stimulate further public discussion of caregivers' issues and concerns. The *Discussion Guide* which accompanies the video recommends that caregivers' par-

ticipate in decision-making regarding care and the new directions in health reform which effect their lives. Other recommendations include enhanced community programs, support groups, respite services, more flexible adult daycare programs, and emergency support for caregivers. Through the video and the *Discussion Guide* caregiving is presented as a valuable and important activity which must be a shared responsibility of men and women, families, communities and government. The video challenges the assumption that caregiving is solely women's work and argues that families, communities, government, churches and the private sector must share responsibility for caregiving. Caregivers also identified the need for public policies to offset the financial cost of caregiving.⁵ Some of these concerns are being addressed through reduced home care fees, more respite beds and additional day programs to provide more relief to family caregivers, better access to information, rehabilitation services and mental health counselling services.⁶

While the video *Living for Others* is the result of a collective effort to bring the voices of caregivers into the discussions of health reform, individual action also has been an avenue used by women to influence health policies. In Saskatchewan, an individual woman providing care to her disabled daughter has been seeking recognition that current health policies are based on unfair expectations and demands on family members. Maureen Stefaniuk has written to government representatives a number of times, outlining her individual circumstances as a single mother providing skilled care to her disabled daughter. Stefaniuk has argued that, as a result of the government's expectations of caregiving, she cannot work outside the home for pay and

⁴Canadian Union of Public Employees, 1999, pp. 7-8.

⁵*Living for Others Discussion Guide*, 1995.

⁶*Ibid.*

has been forced to rely on social assistance. Stefaniuk has argued further that current health care policies constitute a violation of her human rights. In response to her detailed description of the complex, stressful and health-threatening work she is expected to perform, she received a letter from former Health Minister Eric Cline, in which he reiterated the government's commitment to family-based care and rejected her request for financial compensation by saying, "Saskatchewan Health does not pay people in these circumstances for caring for family members." Her case has received attention from two feminist human rights advocates in Saskatoon, who met with the NDP Health, Social Policy and Justice Caucus Committee. A letter regarding this case is offered opposite.

The response from the government to the meeting, this letter, and subsequent phone calls was a letter to Ms. Stefaniuk five months later. It offered no action or promises.⁷

C. FUTURE DIRECTIONS FOR RESEARCH ON WOMEN AND HEALTH REFORM

Women are disproportionately affected by changes in health policy because women comprise the majority of paid workers, care recipients and unpaid workers in the health care system. Without gender sensitive research, the effects of changes in health care policy cannot be adequately measured. Researchers have given little attention to the impact of health care privatization or health care reform on women. Policies which increase private responsibility for health care expenditures, encourage private health service delivery, and shift care to the private household are not gender neutral. A thorough assessment of the impact of health care privatization on women is needed.

⁷Ailsa Watkinson and Glenis Joyce, personal communication, 1999. Used with permission.

TO: Suzanne Murray, Chair of Health, Social Policy and Justice Caucus Committee, MLA for Regina Qu'Appelle Valley; Violet Stanger, MLA for Lloydminster; Hon. Judy Junor, Associate Minister of Health; Hon. Harry Van Mulligen, Minister of Social Services

FROM: Ailsa Watkinson, Faculty of Social Work at University of Regina; Glenis Joyce, Women's Studies in Extension at University of Saskatchewan

DATE: December 17, 1998

Thank you for giving us the time to share the details of the day to day life of Maureen Stefaniuk and her daughter Ilara. In our discussion we stressed that the situation faced by Maureen needs to be seen in the context of women's lives, the valuing of women's work, the downloading of health care on families, primarily women, and our human rights obligations.

Women like Maureen bear the brunt of health reforms in that caring is passed onto them. The burden is especially onerous as Maureen is a single parent and Ilara is disabled.

We requested that Maureen and others in similar situations be compensated through a wage for the extraordinary work they do. Your initial response was to focus first on improving Maureen's immediate situation. It is our understanding that you will contact Maureen and, through the efforts of ministerial assistants in health and social services, work out a more effective way to support her and her daughter.

We understand that our request that Maureen and others in her situation be compensated through a wage, is one your committee has heard before. We also understand that it is something you are giving thought to, since we did talk about the fact that Maureen's work (and the work of others) saves the government money.

We appreciated your interest and frankness. We urge you to take timely action to lessen the burden the family and others are experiencing when faced with the daunting and exhausting task of providing health care for family members. We would be pleased to work with you on this issue in any way we can. Best wishes in 1999 to all of you.

Given the lack of systematic research on the impact of health reform on women's lives, it is important that the Centres of Excellence and other health research organizations support further work in this area. There are a number of unanswered questions about privatization, its various aspects, and their effects on women in diverse social locations. While analyzing sex-disaggregated data is part of the solution, it is important to know which data to gather, and to place it within a conceptual framework which actually captures the social conditions which play a major role in determining women's health. Research studies must be designed to let us hear women's voices describing their experiences, naming the barriers they encounter, and defining the solutions which will meet their needs. We also need qualitative and quantitative studies which enable us to define the broad patterns of women's experiences so that policies can address the needs of those groups of women whose health is most at risk.

It is important that studies of the impact of health reform on women pay attention to the broad social context and the major policy directions influencing government and institutional decisions. When the social environmental context is included in studies of caregivers, it is sometimes limited to the immediate household environment and the presence or absence of alternative caregivers. What is left out of the picture are the social, economic and health care systems which structure the circumstances and conditions within which caregivers find themselves. Without identifying the features of these systems, it will be impossible to develop social policies which can transform those systems to create more appropriate, health-supporting environments for caregiving. Links need to be made between the problems encountered by individual women, and the broader political economic forces shaping those experiences. We need to make the links between biography and history, personal troubles and public issues, the isolation

and economic dependency of an informal caregiver and a society which privatizes, devalues, and assigns caregiving work to women.

It is also, as Aronson⁸ points out, important to locate studies of women and health reform within a cultural or ideological landscape which defines the scope of public and private responsibility for health and care and often equates caregiving with 'women's work' or a 'labour of love.' Only by clearly articulating those underlying cultural assumptions can we examine their consequences and consider alternatives.

Part of the research on women and health care privatization must involve asking women to describe their experiences and the conditions which affect their health and well-being. Women's perceptions of the health system must be a part of the knowledge used to inform health policies. Women's voices are needed to describe the conditions in their homes and workplaces, to identify the barriers to their health and well-being, to shape health policies which address their concerns, and to design a health system more responsive to their needs. At the same time, it is important to recognize that women's voices have often been discounted, that richly detailed descriptions of experiences with the health system have been dismissed as "merely anecdotal" and that policy-makers ask for "hard" evidence to inform their decisions. Research on women and health reform therefore must draw upon a variety of methodologies and recognize the value of diverse voices in the process of knowledge generation.

In the process of developing this paper, several research questions emerged, which we were not able to pursue given time constraints. They are offered here as a first step toward the construction of a gender sensitive research agenda on health reform.

⁸Jane Aronson, 1998.

1. Public/Private Responsibility for Health

- a. To what extent are governments reducing, or increasing, the role of the state in health care, health promotion, health protection, and social and economic programs which contribute to population health? How does this affect different groups of women?
- b. What state programs have the greatest impact on the determinants of women's health and what is happening to these programs?
- c. In what ways do official policy statements and government budgets reflect a declining state role and a shift to more individual responsibility for health, or vice versa?
- d. Does the ideology of individual or family responsibility for health place any particular groups of women at a disadvantage or discourage them from seeking help from public service-providers?
- e. What is the effect of elected versus appointed models of governance on women's participation in decision-making? On decisions which encourage or limit privatization?

2. Privatization of Health Care Costs

- a. What health care services are covered by public health insurance and how has this changed over time?
- b. What are the gender patterns of utilization of these services?
- c. What health care services are not covered or only partially covered by public health insurance?
- d. What are the gender and income group patterns of utilization of these services?

- e. Are there any gender and income group differences in the utilization of services or therapies which are not covered by public health insurance?
- f. Are there particular services which are not accessible to women because they are not covered by public health insurance? Which services? Which groups of women have limited access?
- g. What are the gender patterns of private health insurance coverage? How has this changed over time? Which groups of women are least likely to have private health insurance coverage?
- h. How have user fees or charges for health services changed over time? How do they affect various groups of women and men?
- i. To what degree have the costs of medical supplies shifted to the individual as a result of early discharge from hospitals?
- j. How have women participated, or not participated, in decision-making regarding the privatization of health care costs?

3. Public Provision/Private Provision

- a. What health services are provided through private practice or private, for-profit organizations?
- b. What health services are provided through public service?
- c. What health services are provided through publicly-funded, non-governmental organizations?
- d. What health services are provided by unpaid community volunteers?

- e. What health services are provided by unpaid family members or informal caregivers?
- f. What is the gender division of labour in each of the above categories and how have patterns of employment and unemployment changed over time?
- g. Among health care workers, how are various groups of women affected by health system restructuring in terms of employment opportunities and quality of work life?
- h. What is the impact of health reform on women of colour and immigrant women working in the health system?
- i. What are the levels of pay and benefits, conditions of work, levels of unionization for women working in each of the above categories?
- j. To what extent does the health system reinforce traditional gender ideology with expectations of informal caregiving, and at what costs to women?

4. Institutional Care/Home and Community Care

- a. What are the trends in delivery of health services in institutional versus home and community settings?
- b. How has deinstitutionalization affected women who work as formal and informal caregivers?
- c. What are the pros and cons of the shift to less institutional care? Who benefits? Who loses?
- d. What work and health care costs are off-loaded to private households by the reductions in institutional care?

- e. How are male and female care receivers affected by the shift to home and community care in terms of access to services, quality of care, and continuity of care?
- f. How are women participating, or not participating, in the decisions regarding the scope and nature of publicly-funded, publicly-provided home care services?
- g. Do women's organizations have policy positions or recommendations regarding health care reform?
- h. How have health reforms addressed women's health needs or affected access to women-centred care, particularly in northern and rural areas?

5. Public Sector Cost Control Strategies Which Mirror Private Sector Management Practices

- a. To what extent are health sector employers reducing budgets by reducing staff or reallocating tasks to lower paid health care workers?
- b. To what extent are health sector employers increasing workloads and intensifying labour?
- c. To what extent are health sector employers shifting to casual and part time workers to meet flexible demands for labour?
- d. What is happening to the quality of care in the push for cost-effectiveness?
- e. What is happening to holistic, individualized treatment in a climate of standardized procedures?
- f. Are health care providers under pressure to minimize time spent with patients?

- g. Are the things which women want from the health care system incorporated into health planners' measures of desired outcomes?
- h. To what extent are health sector employers contracting out services to private companies?
- i. How does the reorganization of health care work affect the health of women health care workers' income, job security, stress, control over work, social status, safety, and ability to deliver quality care?
- j. How do private companies in the health sector compare with public services in terms of quality of care, cost-effectiveness, conditions of work, and access to services?

D. POLICY IS ABOUT MAKING CHOICES

Earlier this century, women on the Prairies organized campaigns for public policies which would address their needs for access to health care services. Women were involved in the political and social movements which led to public funding for hospitals, public medical insurance for physician's services, public programs of support for other health care needs, and the recognition that health care is a public responsibility and a basic human right.

Today, women, as citizens, as care providers, and as users of health services, are seeking ways to make the health system more responsive to their needs and concerns. Health policies must be analysed for differential impact among women, and between women and men. Women must be involved in the processes of policy evaluation and policy development. Women need the opportunity to participate democratically in decision-making which will set the course for health care in the coming years.

There are choices to be made: choices regarding public funding for health care services; choices regarding public levels of responsibility for home care, elder care, patient care, midwifery, and prescription drugs; choices between public services and private providers; choices regarding the valuation and recognition of caregiving work as a social responsibility. Just as it was important for women earlier this century to communicate the conditions of their daily lives, their health concerns and their visions to citizen organizations, political parties, and policy-makers, so too are women's voices needed today in the current debates over health care and health reform.

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