INTRODUCTION

Mr. Chairman. Senators. Thank you for the opportunity to contribute to your study on the health care system in Canada.

My name is Pat Armstrong and I am here on behalf of the National Coordinating Group on Health Care Reform and Women, a collaborative group that brings together the five federally-funded Centres of Excellence for Women's Health, the Canadian Women's Health Network and Health Canada's Women's Health Bureau. Our mandate is to coordinate research on health care reform across the Centres, to identify gaps in the research and take steps to fill those gaps, and to translate this research into policies and practices.

We begin with the assumption that health care reform is a women's issue because women provide more than 80% of the paid and unpaid health care. They also account for the majority of care recipients and of those who take others for care. This is especially the case among the elderly. And although women make many of the daily decisions related to health care, they are only a minority of the policy and management decision makers. We are, then, interested in what consequences reforms have for women as providers and patients, and their impact on women's participation in the decision-making process. But we are equally aware that there are significant differences among women related to their physical, social, economic, cultural/racial locations and their age and sexual orientation. These, too, must be considered in assessing the consequences of reforms. Which women are affected, in what ways, by which reforms are central questions for our group.

The complexity of the task quickly became obvious as we realized we were each talking about different reforms, depending on where we lived and what kind of work we did, and that there was no comprehensive overview of reforms in each region, problems I am sure you have come to appreciate in your own investigations.

In order to carry out our mandate, we decided to commission a series of papers that would provide a picture of reforms and of what we know about the impact on women, in order to set the stage for policy and research in the future. We submitted some of these commissioned papers to your Committee last year and plan to publish the entire set as a book in this summer. I would like to highlight our major conclusions here.

First, our research indicates that privatization is the primary strategy in health care reform, and this was the case even before Alberta and now Ontario made this strategy a public issue. 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 or even a market commodity. Privatization in the health care system can occur in the payment for health care services or the provision of health care services. The multiple forms of privatization often confuse the pubic debate and we found it useful to short out its various strands.
The privatization of health care includes:

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

health service providers;

- privatizing the delivery of health care services by shifting care from public institutions to community-based organizations and private households;
- privatizing care work from public sector health care workers to unpaid caregivers; and
- privatizing management practices within the health system, by adopting the management strategies of private sector businesses, by applying market rules to health service delivery and by treating health care as a market good.

All provinces have moved to shift health care costs to individuals, to shift care delivery to for-profit concerns, to shift managerial practices to for-profit approaches, to shift care responsibility to households and care work to unpaid caregivers.

Second, although there are similarities among provinces, there are also significant differences. The process is uneven across the country. Indeed, some provinces have reversed privatization in some areas while others explicitly rejected certain forms of privatization. In Ontario, for example, midwifery has become a public service and Manitoba has reverted to public home care services after experimenting with some for-profit delivery.

Third, reform is happening so quickly, and with so little public information on the changes, that it is difficult to draw a full picture of health care reforms. Clearly, more research on health care privatization is needed. We need to know more about both its many forms and its consequences for individuals, for groups and for the system as a whole.

Fourth, outside the Centres of Excellence for Women's Health, there is very little research examining the impact of reforms on women. There is even less research that considers differences among women in terms of the impact of reforms.

Fifth, the research that does take women into account suggests many health care reforms are having a negative impact on women. Those doing paid health care work are facing increasing workloads and increasing stress. More women are being "conscripted" into unpaid health care work, without training and with few supports. Those sent home quicker and sicker are finding it more difficult to get care, and important questions need to be asked about the quality of care they are receiving not only at home but also in institutions.

A Quebec study, for example, found that women often

> had to give their spouses more complex types of nursing care, such as changing dressings, irrigating wounds and administering and monitoring medications, hygiene and diet: 75% of these women were themselves receiving services from health care professionals every week...The main problem that these women reported were as follows: the lack of any choice about the way they handled the situation, having their own health become more fragile because of the burden they were carrying as caregivers; feeling insecure because they had to provide such complex care; the lack of planning surrounding the patient's discharge from hospital and the home care to be provided subsequently; and the transfer of costs from the health care system to the people receiving care[1]

The research on differences among women, although even harder to find, suggests that those who have traditionally been most vulnerable are facing deteriorating conditions for care. User fees, for example, can mean elderly women who are more likely than men to be poor cannot get their prescriptions filled.

Sixth, these reports clearly demonstrate the need for research on the impact of health care reforms that is gender-sensitive and woman-specific; research that begins with the recognition that women and men connect to the health care system in different ways and that there are also important differences among women.

Finally, the research demonstrates that there are real choices in how health care is reformed. Women need appropriate evidence and means to fully participate in making those choices. However, it is also clear that context matters. The trade agreements we have been hearing so much about lately are critical in establishing the conditions for health care, as are many other international transactions. We should not be undertaking reforms without assessing how these reforms will be transformed into practice under existing international and national conditions, and without assessing the impact on women not only as providers and patients but also as decision-makers.

In short, privatization in all its forms characterizes much of health care reform. Yet such a fundamental change in health care is being implemented without effective investigation into the consequences, especially the differential consequences

What the research from the five Centres of Excellence indicates is that women want and need services that respond to their needs, needs which vary depending on their physical, social and economic locations as well as on their personal histories. They want quality care, but quality that is defined in gender-sensitive and location-sensitive ways. They want recognition of the impact of caregiving on their lives, and they want strategies to address their concerns as caregivers. Privatization strategies serve to reduce their choices and access to quality care that recognizes their individual needs. Our research indicates privatization in all its forms is a problem, rather than a solution, for most women.

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1. Ducharme et al. quoted in Jocelyne Bernier and Marlène Dallaire, The Price of Health Care Reform for Women. The Case of Quebec. Quebec Le Centre d'excellence pour la santé des femmes.