Executive Summary

In order to evaluate the impact of health care reform on women, data must be both collected and publicly available. This study of British Columbia's health reform process reveals that information about the impact of health care reform on women is inadequate, non-existent or not easily accessible by the public. As the majority of both health consumers and workers, women have a lot at stake in the process of health care reform. That process includes reduced federal government funding, the shift in emphasis from hospital-based to community-based care, changes in the job picture, privatization, outsourcing, amalgamations, etc. This paper places BC's health system reform in a national context and points out the large information gaps concerning issues (for example, with regard to access) affecting women users and workers in the system. Even when data is gathered, it is not always available to the public, particularly data gathered by private companies which are increasingly key players in the reformed health care system.

II

Introduction

This paper has been prepared for the BC Centre of Excellence in Women's Health as part of a cross-Canada review of available materials on the impact of health care reform on women who receive and provide care. It includes:

- An overview of the context within which health reform in British Columbia is taking place
- An overview of the changes in the sector as a result of BC's health reform initiative
- A scan of existing material detailing how these changes are affecting women
- A look at the potential and existing privatization outcomes of health care reform and how this is affecting or may affect women's access to health services
- Some suggestions about what kind of information is needed to ensure that women are able to help shape the new system that will result from the BC government's efforts to redesign the province's health care system

The National Context

Health care reform is creating new opportunities for private, for-profit providers of health services across Canada. British Columbia's provincial government has maintained a commitment to health care funding which has helped mitigate some of the factors that lead to privatization. But restructuring in the sector, combined with regionalization as a central focus of health care reform, is resulting in a transfer of many outpatient services – an area of the health system vulnerable to privatization – to profit-oriented entities. This development is creating many of the pre-conditions that have led to decreased access for certain population groups, chief among them women, in other jurisdictions.

Since the mid- to late-1980s, there has been a public policy shift at the federal level, which still exerts a substantial influence over what does or doesn't happen in the health sector.

To understand this more thoroughly, it is necessary to develop an overview of the broader context in which health care reform is unfolding. Since the mid- to late-1980s, there has been a public policy shift at the federal level, which still exerts a substantial influence over what does or doesn't happen in the health sector. In addition, many of the levers provincial governments have used in the past to achieve their public policy objectives have been eroded or even removed by severe cuts in federal transfers for health and by the legal requirements of international and internal trade agreements. These funding and policy changes have been complemented by changes in many provinces in which governments, fearing voter reactions to uncontrolled public spending, have undertaken massive reforms in health care funding and delivery designed to shift more and more responsibility to individuals. But even provinces that have attempted to implement reforms without shifting the costs for health care to individuals are confronting major difficulties, including BC.

At the federal level, the establishment of a flourishing health industry is a central policy objective for the services sector, and provides the overall framework in which health care restructuring is occurring in all provinces and territories. While many Canadians are concerned that privatization may be a consequence of health care reform (and of debt/deficit reduction), it is more accurate to describe privatization as a policy

objective in and of itself, and health care restructuring as one method intended to assist in achieving that goal.

Privatization is a more complex issue than many Canadians had thought, and nowhere is this more true than in the health sector. The role of federal and provincial governments in Canada's health care system is deeply rooted in history and in the jurisdictional arrangements embedded in our constitution. The passage of the Medical Care Insurance Act in the House of Commons in 1966 came after extensive negotiations between Ottawa and the provinces to ensure that federal funding for health care would not be attached to "criteria", but rather to "principles". This subtle nod to the provinces was amended when the Canada Health Act was enacted in 1984 after public pressure brought an end to the practice of extra billing among physicians. The 1984 Act enhanced the role of the federal government in establishing and maintaining national standards, and in financially assisting the provinces in meeting national criteria.[1]

Federal legislation governing health care established a tax-supported insurance model as the mechanism through which medical and acute care services would be funded. This differed from many European countries and the United Kingdom, which had set in place a tax-supported system that directly funded health care provision in the public sector. The 1966 legislation led provinces to combine insurance for medical care with existing public insurance programs covering acute care, substantially reducing the role of the private insurance industry in providing coverage. Provinces were required to establish and publicly administer non-profit health insurance plans for medically necessary physician and acute care services. But, in keeping with the Royal Commission's report on which it was based, the 1966 legislation, and the Canada Health Act 18 years later, maintained the status quo of private physician and health care service delivery. Physicians are self-regulated, fee-for-service entrepreneurs, while most provinces legislatively define acute care hospitals as non-profit institutions. In British Columbia, hospitals are incorporated under the Societies Act, and are operated by a board of management with representation from both the government and the appropriate regional health authority.[2]

The establishment of regional and community levels of governance in BC's health sector faces challenges within this overall public payer/private provider split. But there are other serious challenges, as well.

The establishment of regional and community levels of governance in BC's health sector faces challenges within this overall public payer/private provider split. But there are other serious challenges, as well. Although Ottawa's contribution to health care

funding has fallen precipitously from 50 per cent of total public health expenditures to approximately 12 per cent,[3] it continues to influence the legal and political framework in which the sector functions and evolves. This includes restructuring currently underway in all provinces under the general mantle of health care reform.

Health care reform was initiated in British Columbia on the heels of substantial reductions in federal transfer payments for health. Between 1986/87 and 1995/96, successive and unilateral cuts by the federal government amounted to a cumulative $30 billion. (Some estimates put this figure at $40 billion.) The introduction of the Canada Health & Social Transfer in the 1995 federal budget promised further cash reductions estimated at up to $40 billion by 2002/03, even with the $12.5 billion "floor" established at 1998 levels on the recommendations of the National Forum on Health. Following the 1999 federal budget, Ottawa will restore $11.5 billion to transfers for health over three years, but even with this extra cash provinces will continue to face mounting difficulties in financing health care services without a stronger federal role.

These dramatic reductions in federal cash transfers provide the economic framework within which health care reform has progressed in Canada. But the legal, political and institutional framework governing health care in the country has undergone equally dramatic changes during the last decade which influence the directions chosen by provinces embarked on health care restructuring.

The legal framework for Canada's health sector lies, to a significant extent, within the North American Free Trade Agreement. Although NAFTA's procurement chapter does not apply to provincial jurisdiction, it is being enforced through the inter-provincial Agreement on Internal Trade (AIT). NAFTA requires that foreign and domestic companies bidding on contracts with public bodies be accorded "national treatment" – that is, companies based in the US or Mexico must be given Canadian status. The AIT, on the other hand, prohibits provincial, municipal and regional governments from discriminating against Canadian companies located in another province. At the same time, the way NAFTA defines "company" makes no distinction between for-profit and non-profit institutions or providers in the health care and social services areas. The agreement requires public bodies to abandon policies that discriminate between these types of entities.

This legal context may undergo further changes in the future that will negatively affect the ability of provinces to protect non-profit providers. NAFTA requires that health and social services can only be protected from the full force of the agreement if they meet a "public purpose" test. During the NAFTA negotiations among Canada, the US and Mexico negotiators chose to leave the definitions of health care, social service and public purpose to future discussions. If these discussions resume, the conclusions reached will establish precedents about the definition of "public services" that can be used in other multilateral trade agreements to which Canada is a signatory.

The outcome of future trade talks will determine whether or not Canada's publicly funded hospitals and community-based health facilities can be protected from the full force of trade liberalization rules.

This is of great significance to Canada, which has argued that the level of public funding determines whether or not a service meets the "public purpose" test contemplated in NAFTA. The United States argues that only services in which governments have a complete monopoly, exclusive of both for-profit and non-profit, publicly funded providers, can be said to serve a public purpose. The outcome of future trade talks will determine whether or not Canada's publicly funded hospitals and community-based health facilities can be protected from the full force of trade liberalization rules. In addition, a legal opinion obtained in 1995 by the Canadian Health Coalition warned that, should Canada's definition prevail, decreases in public funding will undermine even Ottawa's position on what constitutes a public purpose.

The legal and financial framework set in place at the federal level has been accompanied by an over-riding political commitment to the development of a domestic health industry able to participate effectively in global markets. Since 1986, the federal government has identified health care goods and services as areas of high export potential. The challenge faced in the health sector, according to Industry Canada, was how to turn Canada's excellent reputation for high quality and affordable health services and products, and the world-renowned expertise and skill of those who work in the sector, into a profitable global commodity.

Industry Canada officials have concluded that to succeed in the global marketplace (worth an estimated US$3 trillion annually), the domestic industry must be strengthened. However, the ministry identified a number of obstacles that it said must be overcome. First, the industry is fragmented, and composed of too many small- and medium-sized companies, leading the federal government to support consolidation

through a strategy of mergers and acquisitions. Second, because the sector has been dominated by publicly-funded and non-profit providers, private entrepreneurs have been unable to acquire experience in delivering health care services to a public that expected those services to be both affordable and of high quality. This has led to policies that encourage public private partnerships, contracting out and for-profit joint ventures between hospitals and private businesses. Third, small, locally-based companies that predominate in the domestic industry lack valuable global experience, as well as the capital necessary to fund consolidation – a step that is necessary if companies are going to survive in the global market. Thus, Ottawa is supporting the entry into Canada of global, mainly US-based, corporations with access to large pools of capital and experience in the global marketplace. This entry is facilitated by NAFTA.

The export-orientation of the federal government has necessarily influenced domestic policies, including those developed at the provincial level. The Ontario government's Health Industries Advisory Committee, for example, urged the province in 1994 to implement steps to "ensure that…the domestic market supports the development of globally competitive companies," observing that "while notable exceptions exist, in most cases domestic success precedes success abroad."[4] The British Columbia government has given support to companies such as InterHealth Canada Ltd., a for-profit corporation that pursues international contracts for Canadian health sector firms in key markets around the world. In 1995, the BC government also contributed $10 million to a venture capital firm managed by Toronto-based multinational MDS Inc. (which put in $5 million, with another $5 million from the Royal Bank) to provide start-up funds to health companies in the province.

This is the federal framework in which health care reform continues to unfold across Canada, and within which privatization has become a central theme. British Columbia has attempted to minimize the participation of large corporations in health care by maintaining funding levels for acute care and physician services. Nonetheless, the strategies it has adopted for health care reform have led to increased fragmentation of provincial authority and, coupled with the legal requirements of current and future trade agreements, the province's ability to enforce its current policy goals in this regard are problematic.

IV

The BC Process

British Columbia was one of the first provinces in Canada to initiate major reforms in the health care system during the 1990s. Many of these reforms followed the recommendations of the Royal Commission on Health Care and Costs whose 1991 report, Closer to Home, said many of the problems experienced in the system could be attributed to structural, administrative and funding practices. Many of these practices, the Report concluded, were responsible for growing disparities in population health, and inequities in access to health services. The lack of an overall plan for health services delivery throughout the province, and misplaced priorities in health spending, also pointed to a system in need of an overhaul. The Report of the Royal Commission asserted that the current health system could and should be changed to produce better health results for the same or lower overall costs.[5]

In response, the Ministry initiated an extensive consultation and review process and outlined five inter-related themes to deliver more health care services outside the acute care sector and in a more efficient manner. These themes were: better health; greater public participation and responsibility; bringing health closer to home; respecting the caregiver; and effective management of the health system. The Ministry's report, New Directions for a Healthy British Columbia, was released in March 1993, sparking a vigorous reform effort in the sector.

The first phase of health care reform took place from 1993 to 1996, and involved the establishment of 102 Regional Health Boards (RHBs) and Community Health Councils (CHCs) throughout the province. An important focus during this phase was the movement of non-acute care services out of hospitals and into the community, a reduction in the hospital workforce by up to 10 per cent, and reduced utilization rates in the hospital sector (to 850 beds per 1000 population). To minimize the impact of resulting hospital layoffs, the province initiated discussions with the three main health care unions leading to an agreement on labour adjustment and retraining covering some 60,000 members. The agreement contained some of the most progressive job security language for health care workers in North America and has since been incorporated

into the collective agreements covering most members of the BC Nurses' Union (BCNU), the Hospital Employees' Union (HEU) and the Health Sciences Association (HSA).[6]

In mid-1996, the Minister of Health placed health care reform on hold pending a review by a Regionalization Assessment Team, made up of four Members of the Legislative Assembly. Another round of meetings and consultations took place, and in November of that year the second phase of health care reform was initiated. "New Directions" became "Better Teamwork, Better Care", and the framework for governance was modified somewhat. Instead of 102 boards and councils, transfer of authority for the delivery of health care began on April 1, 1997 to 11 RHBs in major urban centres, 34 CHCs in rural and geographically isolated areas, and seven newly established Community Health Services Societies.

IV

Health Reform and Governance

Regional Health Boards in British Columbia are responsible for the direct management and delivery of health care services, while Community Health Councils have responsibility for acute care and continuing care residential services at the community level. Community Health Services Societies have responsibility for public health, mental health and some continuing care at the community level. These new roles have been redirected from the Ministry of Health and from some municipal governments. The 52 regional and community health structures have replaced 700 boards that governed hospital societies and other health facilities throughout the province. Residential care facilities and agencies run by religious organizations (such as Catholic hospitals) operate under affiliation agreements or service contracts with boards or councils.

On the surface, it would appear that the devolution of authority to boards and councils would enable women to ensure that their collective and common gender interests are being met.

For women, the establishment of regional and community governance structures opened up opportunities for participation in key areas of decision-making in BC's health sector that had not existed before. In 1995, 53 per cent of the members appointed to RHBs and CHCs were women, compared to 25 per cent who were elected as Members of the Legislative Assembly, and 24 per cent of mayors and local government representatives who were women.[7] On the surface, it would appear that the devolution of authority to boards and councils would enable women to ensure that their collective and common gender interests are being met. It may be too early to judge whether this is or will be the case. However, without information about how women are affected generally and specifically by health care reform, it is questionable as to whether or not women can prepare themselves to play the advocacy role they might wish to in policy development, planning and budget allocations that affect their gender both directly and indirectly.

The 1996 Report of the Provincial Health Officer said the Ministry of Health must give a high priority to developing better information about the outcomes, effectiveness, and costs of health services. The Report also cited the need to develop better data to track income equality/ inequality and its impact on health. Nowhere in either the 1995 or 1996

Reports, however, is information about the impact of health care reform on female utilization and on women as paid and unpaid caregivers acknowledged to be lacking, or indeed to be required at all.[8] This is surprising since, according to a senior policy analyst at the Women's Health Bureau of the Ministry of Health "nobody does any gendered breakdowns" of data pertaining to "hospital and medical services" in BC.[9]

In 1994, health reform in a number of provinces – most notably, Alberta – was leading to the establishment of private, physician-run clinics that charged what were referred to as "facility fees" to patients. The fee was applied to non-physician services provided at the clinics, but not reimbursed by the province in which the clinic was located. In January 1995, then-federal Minister of Health, Diane Marleau, announced a new framework for private clinics that prohibited facility fees for medically necessary health care services under the Canada Health Act. Marleau pointed out that when clinics received public funds for medically necessary services and then charged a facility fee for "unnecessary" services, "people who can afford the fees are being directly subsidized by all other Canadians."

While Marleau's primary concern focused on the imposition of user fees in private clinics, she also expressed alarm at developments on the health reform front in a number of provinces. In a letter to provincial and territorial health ministers, Marleau wrote that advances in medical care had made it possible to deliver a wide range of procedures on an outpatient basis or outside of full-service hospitals. In a legal interpretation of the Canada Health Act obtained by the Ministry, Marleau said, the definition of "hospital" as set out in the Act "includes any facility which provides acute, rehabilitative or chronic care." The accessibility criteria of the Act, Marleau told her provincial and territorial counterparts, "was clearly intended to ensure that Canadian residents receive all medically necessary care without financial or other barriers and regardless of venue [emphasis added]."[10]

It is interesting to note that Marleau, in the same letter, reminded provincial health ministers that the "principles of the Canada Health Act are supple enough to accommodate the evolution of medical science and of health care delivery. This evolution must not lead, however, to a two-tier system of health care." The push for entrenched definitions of "medical necessity" in the Act could turn the legislation into an anachronism in a very short time, given the rapid

changes occurring in medical science and technology.

It is unfortunate that no province has moved to incorporate Health Canada's interpretation of the accessibility criteria of the Act, and that the federal government has chosen to back away from enforcing the policy. In 1996, British Columbia became the first and only province to incorporate the principles of the Canada Health Act in legislation banning the imposition of user charges for hospital and physician services. However, the province did not adopt Marleau's policy that the definition of a "hospital" included any facility that delivered medically necessary acute, rehabilitative or chronic care services.[11]

Public concerns about maintaining or even increasing access to health services across the population have been addressed in the government's commitment to assuring that adequate funding is available.

That same year, the province enacted the Community Care Facilities Act, establishing a branch responsible for the development and implementation of legislation, policy, and program standards for licensed child day care facilities and child and adult residential care facilities. These facilities were defined as those providing "care, supervision, social or educational training or physical or mental rehabilitative therapy, with or without charge." A community care facility might also provide food and lodging, and services to pregnant women – again, with or without charge.[12]

The legislation enacted by the province during the last five years has defined many of the terms within which health care reform is taking place. But a preoccupation with the structures that would be required to manage a reformed system (including those governing governance) is reflected in most of the language contained in the new legislation. Public concerns about maintaining or even increasing access to health services across the population have been addressed in the government's commitment to assuring that adequate funding is available. The positive role such a commitment plays in the health care system cannot be underestimated. In addition, the BC government has attempted to ensure that legislation provides them with the tools needed to protect the non-profit nature of health care delivery. But it is unknown how the various pieces of legislation will fare as more and more authority is transferred to regional health boards, or what will happen if a new provincial government with a different policy agenda is installed.

A revolution will be required, beginning at the level of information gathering, to develop an accurate picture of how health care reform leads to an increase in the number of for-profit providers, and how such developments impact on women at home and in the workforce. Without such

information, policies that adequately protect access to vital services by women regardless of where they live, their ability to pay or their health status will be insufficient and implemented haphazardly, if at all. The circumstances of paid and unpaid caregivers will remain unknown by the vast majority of the public, including those responsible for developing and implementing standards and policies in the health sector.

Women are affected disproportionately by restructuring that results in reduced access to health care services. But even among women, the effects of reduced access are felt unevenly.

Women are affected disproportionately by restructuring that results in reduced access to health care services. But even among women, the effects of reduced access are felt unevenly. Women of colour, Aboriginal women, women from ethnic minority groups, elderly women, lesbians, low-income women and women with mental and physical disabilities experience a multiple of impacts from actions that limit their ability to use the health system when they need to. This is because sexism combines with race discrimination, and stereotypes about specific groups, that further undermines the efforts of these citizens to achieve good or better health and increase their independence and autonomy. Information that reflects this diversity among the female population and the differences in how women are affected by health care reform and privatization is urgently required.

Women are entitled to information about their own conditions in order that they can better defend and exercise their rights and responsibilities as primary users and providers of health services in British Columbia. Such information needs to be collected and maintained in the public sector (within the context of privacy legislation), and protected from commercial exploitation and use by profit-making entities.

V

Health Reform and Health Care Jobs in British Columbia

Like other jurisdictions in Canada, the health care workforce in British Columbia is overwhelmingly female.

Health care reform in BC was kicked off with the 1992 closure of Shaughnessy Hospital, located in an upper middle-class neighbourhood of Vancouver, with 350-acute care beds and 1700 staff. Although opposition to the closure was fierce among the hospital's staff and their unions, as well as a number of patient groups, physicians, and others, the province worked diligently to ensure service levels would not be eroded. Despite fears throughout BC that the Shaughnessy closure would soon be followed by others, this has not happened. The majority of both staff and beds were relocated to other facilities within the region, and the provincial government fulfilled a commitment to establish a facility that would target its services at women. The old Shaughnessy site now houses the British Columbia's Women's Hospital and Health Centre and BC's Children's Hospital, as well as the BC Centre of Excellence for Women's Health.

The closure of Shaughnessy Hospital was the beginning of BC's effort to implement radical reforms to the health care system. The goals of the government were to reduce utilization rates throughout the province, transfer authority for the health care system to local levels of governance, and develop a more integrated approach to health care delivery. Downsizing in the hospital sector promised to be controversial, however, and steps were taken by the government to minimize the impact of bed and staff reductions on nurses, paramedical health professionals and health services and support staff.

Like other jurisdictions in Canada, the health care workforce in British Columbia is overwhelmingly female. Women make up between 85 per cent and 87 per cent of those employed in the hospital sector and in the delivery of health-related social and community services. Not surprisingly, therefore, the announcement by the Ministry of Health that services would be devolving to the community sent shock waves through the highly-unionized hospital workforce. The hospital sector had provided women with opportunities for mobility, career advancement, education and secure incomes: job characteristics that were and are

rare for most female workers. In addition, wage and benefit comparisons between the acute care sector and the largely unorganized community or social services sector were not promising. Unions which already had been concentrating some of their organizing efforts in the community had found that publicly funded, non-profit entities with small budgets and staffing levels of three, seven or ten people were difficult to organize and expensive to service. Those who worked in the community sector, however, were among those most in need of the benefits of a collective agreement.

An important part of the health reform process was the redistribution of union jurisdiction in the hospital, community and social services sectors and the establishment of multi-union bargaining associations in each area. The Health Sector Labour Relations Regulations established new bargaining units in the summer of 1995, sparking a lengthy review process among unions, employers and the Labour Relations Board to determine which employees belonged in which unions. In mid-1997, the Regulations were scrapped and replaced with Bill 28, which modified the structures created by the "old" Regulation. This process is on-going, but bargaining associations were established in Bill 28 for paramedical professionals in both the hospital and community sectors, health services/support staff in the facilities sector, health services/support staff in the community sector and nurses (both RNs and RPNs) in both the hospital and community sectors.

Under the health labour accord, the reduction in hospital staff was projected at up to 10 per cent, while utilization rates were to be reduced to 850 beds per 1000 population.[13]

A. The Health Labour Accords

As Shaughnessy wound down its operations, the government initiated talks with the BC Nurses' Union, the Hospital Employees' Union and the BC Health Sciences Association to reach an "accord" on job security and retraining. An agreement was concluded in 1993, establishing the Health Labour Adjustment Agency (HLAA) and provisions for province-wide seniority that allowed "bumping" from one facility to another. Although the accord did not initially ensure that as employees moved into the community, the job security provisions would go with them, it was an innovative approach to addressing the fears among hospital workers that "closer to home" would bring an abrupt end to their employment.

Under the health labour accord, the reduction in hospital staff was projected at up to 10 per cent, while utilization rates were to be reduced to 850 beds per 1000 population.[13] Among some employee groups, particularly in highly specialized areas, the prospects for alternative employment appeared slim. In part,

this was because the community-based facilities envisioned for the future would be oriented towards more general levels of care. The HLAA, which registers and matches available positions to qualified health care workers whose jobs have been slated for elimination, has worked closely with employers and unions to ensure that as many layoffs as possible are "voluntary" (for example, through early retirement incentives or retraining). But among some groups, for example medical laboratory technologists, the increasing use of robotics technology in the health sector and the amalgamation of hospital labs were combining with the province's downsizing efforts to severely reduce job opportunities. The HLAA has had less success in relocating these employees to other jobs in the sector.

Many outpatient rehab departments have seen a sharp increase in the use of private companies by the Workers Compensation Board (WCB) and the Insurance Corporation of BC (ICBC).

One clause in the health accord designed to protect unionized jobs prevented hospitals from closing outpatient diagnostic and rehabilitation services if such a closure resulted in a shift of funding for those same services to private providers within the same region. While an important tool in the unions' collective agreements, this did not stop the outflow of outpatient rehab and diagnostic services from the hospital sector. Many outpatient rehab departments have seen a sharp increase in the use of private companies by the Workers Compensation Board (WCB) and the Insurance Corporation of BC (ICBC).

In 1998, the Health Sciences Association and the Hospital Employees' Union negotiated what was referred to as a "side accord" agreement to address this problem. The accord established a joint union/Ministry of Health committee to advise the government on ways to enhance the role of public providers in two areas: laboratory services and breast cancer screening; and rehabilitation services and programs for clients of the WCB and ICBC. The committee would meet four times annually.

There are almost 3000 laboratory technologists registered with the Canadian Society of Laboratory Technologists, 2,333 physical therapists registered with the College of Physical Therapists of BC, and about 880 Occupational Therapists. The gender breakdown for lab techs and their primary place of employment are not known. However, in physiotherapy women make up 1,928 of the total, while among OTs, women number 827. Among PTs, 785 are employed in private practice, while a majority of the remainder work in hospitals, long term care, community health and other publicly funded programs.[14] Thus, the side accord promised to affect up to 4000

people employed in non-profit, publicly funded facilities, approximately 85 per cent of whom would be female employees.[15]

The agreement won support from ICBC, which agreed to explore partnerships with HSA and HEU, regional health boards and community health councils to provide a variety of rehab services to their clients. Similarly, the WCB expressed interest in partnering with hospitals to look at ways these facilities could better meet the needs of injured workers requiring rehabilitation services, including, where necessary, skills upgrading among caregivers.

Reception to the accord on "Strengthening BC's Public Health Care Services" among BC's two largest private lab companies was not as enthusiastic. Accusing the government and the unions of negotiating behind their backs, MDS Inc. and BC BioMedical, said the accord would lead to the expropriation of "community labs". This was not the case, but nonetheless, a province-wide petition campaign was launched by the companies, netting some 65,000 signatures amidst charges that the value of MDS shares on the Toronto Stock Exchange had fallen precipitously because of the "lab accord".

The accord between the government and the two unions established a basis for discussion of a new bloc funding system with the following elements:

- The "funding envelope" for all laboratory services would be transferred to regional health authorities to allocate within their geographic areas;
- Health authorities would be able to determine the appropriate number and location of outpatient and inpatient laboratory facilities, including collection stations;
- Health authorities could be expected to rationalize the provision of laboratory services and capture the savings potential from technological change.

As a condition of the new funding, health authorities would be required to plan and manage diagnostic services in a manner consistent with Section 3 of the Health Authorities Act.[16] For clarification, the accord stated "specifically, this means giving preference to the provision of services through the public sector and ensuring optimal utilization of existing and future public investment in laboratory services." This provision would also apply to any future changes to breast cancer screening.[17]

Side accords were also negotiated with other health care unions as a way of mitigating the impact of the government's "zero-zero-two" per cent wage guidelines over three years. But while the other negotiated accords provided a range of benefits to union members, the HSA/HEU/ government accord was the only one that fully addressed the issue of privatization in an important area of the health care sector. At the time of writing, the government had reassured the two unions that the accord would receive the necessary Cabinet approval, but there were growing doubts that regional health boards would be designated the funding envelope for laboratory services, or that the Ministry of Health would agree to licensing practices that favour hospitals over private labs.[18]

B. Wage Parity

Wage parity is a central issue for unions representing support workers in hospitals and the community. In the so-called "facilities sector" (covering non-nursing and non-professional hospital staff, including activity workers, care aides, Licensed Practical Nurses, nursing assistants, cooks and food service supervisors), unions won pay equity adjustments worth $64.1 million in wage increases, applied in 1998, 1999 and 2000.[19] The agreement covering these workers has been recognized as the "target agreement" – that is, those employed in the community sector will have achieved parity when their wages, benefits and working conditions match those that exist in the facilities sector collective agreement.

There are approximately 15,000 community social services workers in BC who work in approximately 5500 community facilities offering community living, family and children's services, services to women, and child care. According to the unions representing these workers (BC Government & Services Employees' Union, Canadian Union of Public Employees, HEU and HSA) community social services workers earn up to $8 an hour less than hospital workers who do the same or similar work. But union demands for parity for community social services workers by 2003 are proving to be illusive. In 1998, a general wage increase of 30 cents an hour was won for all community caregivers, while extended and dental benefits were established that match those in the facilities sector. But the government's offer of $12 million to address the wage gap will not move community caregivers up the income ladder as quickly as these workers would like.

In 1997, unions won an extension of employment security provisions to

members working in the community, provisions that were further improved upon during bargaining in 1998. Community caregivers now receive a 12-month period of job security following a notice of layoff. During this period, caregivers can register with the Health Labour Adjustment Agency to obtain alternate employment and receive their full wages and benefits.

Unionized women employed in non-profit, community-based and unionized health care are seeing major improvements in working conditions and have developed a long-term agenda for establishing parity with hospital employees.

Home support workers waged a strong campaign during the 1998 round of bargaining to win improvements for a large pool of casual workers. The new agreement sets out clear parameters for regular job postings that will enable casual employees to convert their hours into regular positions. Health employers must demonstrate that changes in scheduling are needed to meet operational requirements, and they must take into consideration "the personal circumstances of caregivers". Home support workers in jobs whose primary focus is client/resident care received wage increases to between $14.50 and $16.00 an hour. Where client/resident care is not the focus of the job, a caregiver will receive between $12.50 and $13.50 an hour. Home support workers will also be folded into the unions' community agreement in future.[20]

Despite the mammoth changes in the structure of health care bargaining begun in 1993, and the continuing tension over issues of wage and benefits parity, unionized health care workers in both the hospital and growing community sector have fared better than their counterparts in other provinces. Unionized women employed in non-profit, community-based and unionized health care are seeing major improvements in working conditions and have developed a long-term agenda for establishing parity with hospital employees. However, the wage gaps between organized and unorganized workers are not being adequately addressed. Unorganized workers face huge challenges – first, to obtain representation and, secondly, to convince employers in the community to accept the principle of parity. The number of providers operating on a for-profit basis is increasing in BC, and these will have greater resources to withstand pressures to increase wages above the minimum set in employment standards legislation.

C. Nursing: The Burden of Care

The nursing profession is undergoing tremendous change as health reform measures are being implemented in both the acute care and community sectors. There are approximately 31,000 Registered Nurses employed

in general, rehabilitation, extended and long term care facilities, mental health centres, home care and community health agencies in BC. Another 150 RNs are employed in private business. This compares with more than 5200 Licensed Practical Nurses, of which almost 3800 work in a hospital setting. The balance of LPNs are employed in home and community care, private business and physician offices. Only 1,095 RNs are males, while among LPNs only 381 are males. Within the health care workforce, the nursing profession is the most female-dominated area, and offers among the widest opportunities for career mobility.[21]

Workload issues topped the agenda during nurses' bargaining in 1998. This is not surprising, since early discharge policies in hospitals and the increase in outpatient surgeries mean higher levels of acuity and higher workloads for nurses. In a recent poll conducted for the BC Nurses' Union, more than 80 per cent of members reported that their patients/clients/residents were more seriously ill than they were five years ago. The results were particularly marked among nurses in acute care and the community. Despite rising acuity levels, however, almost one-third of nurses surveyed reported a decline in the number of RNs delivering direct care. According to the BCNU, these factors represent changes in the health care system that have affected nurses the most throughout the 1990s.[22]

Many health care employers have attempted to cut costs by replacing higher skilled Registered Nurses with lower-paid personnel with less training and experience. This is a controversial strategy for a number of reasons. First, many people feel Licensed Practical Nurses are capable of performing many of the duties traditionally carried out by RNs, while many employers have identified the transfer of duties to lower-paid staff as an acceptable way to save money. Some of the exchanges between LPNs and RNs on this issue have been tense, since for both groups jobs are at stake. Second, because acuity levels are rising, the demands on nursing staff with higher skill levels to provide direct care also increase. Inadequate staffing levels in some areas are exacerbating the problem.

Some of the statistics support the BCNU's position on inadequate staffing levels in the nursing profession. In 1994/95, BC had the lowest number of staffed hospital beds per 1000 population in short term care units in comparison to other provinces – 2.1 beds per 1000 population in BC, compared to the Canadian average of 2.8. BC patients also

stayed for the shortest period of time in hospitals without long term care units – 4.9 days compared to the Canadian average of 6.6 days. Overall hospital utilization in the province declined in 1997 to 645 beds per 1000 population, a 40 per cent decline from 1991.[23] In a study by the Advisory Committee on Clinical Resource Management in January 1997, researchers concluded that, although many patients may not require acute care services, most require some form of care and attention, and that at present many forms of alternate care are simply not available in BC.[24]

Early discharge and delayed entry into hospital places increased demands on nurses employed in the community sector, including those working in home care.

Early discharge and delayed entry into hospital places increased demands on nurses employed in the community sector, including those working in home care. The BCNU charges that the number of community nurses is inadequate for the increased burden of care required in the home. If the number of home care nurses is inadequate it is likely that the care received by patients discharged early from hospital is inadequate as well – and that the burden of care is falling on those mainly female "informal" caregivers in the home.

The BCNU survey also indicated that a growing number of younger nurses are choosing to leave the profession, often because of high stress levels and heavy workloads leading to "burnout". These work-loads are reflected in an increased rate of injury, with some 30 per cent of hospital nurses and 24 per cent of nurses in long term care reporting that they had suffered a workplace injury during the previous six months. The BCNU survey also indicated that as many as half the number of members polled would leave nursing for another profession "if they had the opportunity". This was particularly true among younger nurses.

The promise of more federal cash transfers delivered in the 1999 federal budget, and a threatened strike by the BCNU, led the Minister of Health to announce an increase in nursing staff of 10,000 in early 1999. This promises to alleviate some of the workload problems experienced by Registered Nurses, although it is too soon to know where those RN positions will be concentrated.

Two initiatives in 1995 dealt with the roles of unpaid caregivers in British Columbia. According to the BC Ministry of Health, unpaid care-givers provide the majority of care at home and in the community. A committee established by the health minister looked at ways of strength-ening support for informal care – identified as a priority in the New Directions strategy. The report, submitted to both the health and

human resources ministries, stressed the need for respite services for informal caregivers. In another initiative, Nanaimo was selected to participate in a national demonstration project to improve services for caregivers. The pilot project is to focus on finding better ways to use community services to meet the needs of informal caregivers who require respite services.

However, support services for informal caregivers, the majority of whom are women and, among these, many are elderly, remain sorely lacking. The focus on respite care, as opposed to home support and nursing services, suggests the continuation of policies that will place increasing burdens on women providing care to spouses, children or other family members in need. Studies documenting the impact of health reform, early discharge policies and evidence-based practices on women in unpaid caregiving roles are primarily anecdotal. Much further study is needed in this area to ascertain the gaps in the health care system and to provide services that are required by patients who choose to remain outside an institutional setting.

VII

Health Care Reform and Privatization

Regionalization is at the core of BC's health reform strategy, and involves a devolution of budgeting, planning and decision-making authority from the provincial to the community or regional level. Regionalization also has transferred some planning and governance functions from hospitals to regional health authorities.[25] At the same time, a key objective of health reform is the movement of many non-acute care services out of the hospital sector and into more accessible community-based facilities.

Like other provinces, the government vowed to locate a growing number of services in the community. But, unlike many other provinces, British Columbia had not developed a network of publicly funded community-based health centres during the 1970s and 1980s to deliver non-acute care services. Thus, the plan to transfer services to the as-yet few community health centres caused consternation among many caregivers and the public alike.[26]

The transfer of services outside of the hospital sector does not necessarily lead to privatization. But unless steps are taken to ensure these services are captured on the public health plan, privatization is the result. This is, in fact, happening in BC as outpatient services move out from under the insured umbrella of the acute care sector into a non-insured, partially-insured or privately-insured arena often referred to as the "community". Since the question of whether a hospital service is fully covered under public health plans appears to depend on the location of delivery, this movement may impede access by patients seeking outpatient hospital services. This is especially true for some outpatient rehabilitation services provided by individuals or companies that derive a growing portion of their revenues from user fees, as well as from private and workers' compensation insurers.

Privatization also results from the removal – or delisting – of services from the Medical Services Plan. British Columbia has de-listed some services and prescription drugs, and increased deductibles in some areas. In 1998, for example, the deductible for Pharmacare, excluding

seniors and other eligible enrolees, was increased from $600 a year to $800. A year earlier, user fees for physiotherapy and other supplementary health services delivered in a private clinic increased from $7.50 per visit to $10.00.

Services that have been de-listed are very few, but this may change in future. The agreement between the provincial government, the Medical Services Commission (MSC) and the BC Medical Association (BCMA) includes an undertaking to develop Protocols and Practice Guidelines for physicians, hospitals and other billing institutions in order to "contain utilization". The agreement defines insured benefits as "medically required services which fall within defined, approved Protocols and Practice Guidelines, and those medically required services where no Protocols or Practice Guidelines exist". Under the agreement, the MSC is required to give "priority attention" to proposals developed by the BCMA and, should the government fail to carry out the recommended cost saving measures, it must add the amount "which would otherwise have been saved" to the total allocated to physician services.[27]

Thus, it appears the government will have powerful incentives to implement future de-listing that may be recommended by the BCMA, a vocal proponent of increased private sector funding for health care services.

Private insurers are expanding the scope of services offered on their health plans, both as a consequence of de-listing, and in response to new commercial products and services marketed by health companies.

Private insurers are expanding the scope of services offered on their health plans, both as a consequence of de-listing, and in response to new commercial products and services marketed by health companies. Insurers also are benefiting from the movement of outpatient services from the acute care sector to the community. In addition, many individual providers in private practice are being encouraged to "opt out" of the Medical Services Plan which, in the view of some caregivers, maintains inadequate reimbursement schemes.

All of these activities threaten to impose financial barriers to patients who require services, and technically and legally summarize the nature of "privatization" in the health sector.

Barring Access

Barriers that impede access to health services insured by private companies are numerous. In addition to the economic barriers imposed by premiums charged by the private insurance industry, insurers maintain exclusions or higher premiums based on the age, gender, health status and the employment history of subscribers. Women above the age of 14 years access health services – both on their own be-

halves, as well as on behalf of children or elderly parents – far more frequently than men. Data for 1996-97 indicates that females in British Columbia accessed medical services on average 1.5 times more frequently than males. Female access to medical services was higher in 35 categories out of 46, and significantly higher in specific speciality areas such as obstetrics and gynaecology (which would be expected), massage and physical therapy, naturopathy, osteopathy, pathology, radiology, geriatric medicine and general practice medicine. Furthermore, as women age, their use of medical services increases even more sharply relative to men.[28]

Changes that result in the privatization of insured health services will inevitably have a greater impact on female patients.

Thus, changes that result in the privatization of insured health services will inevitably have a greater impact on female patients. The lack, or inadequacy, of public health insurance coverage for long term and home care services also affects women disproportionately. One study in the United States indicated that on average females pay 68 per cent more in out-of-pocket expenditures for health care than males.[29] This occurs for two reasons: first, more of the services women use are not covered by either private or public health plans and, second, more women are likely to be excluded by eligibility criteria on private plans because of pre-existing conditions (including pregnancy).

While similar studies have not been undertaken by the province of British Columbia, existing data indicate that some of the same conditions or preconditions may exist here. According to a report of the Physiotherapy Association of British Columbia, 58 per cent of physiotherapy users were female in 1998, and overall a growing number of people who visit a physical therapist do so in the private sector. According to a PABC survey, the use of private clinics has increased from 69 per cent of all those who used physio services in 1994, to 93 per cent who visited a physio in the past year. Of those who had visited a physical therapist during the year, 57 per cent said they would visit less often if they had to pay for the entire visit. Currently, patients pay a $10 user fee to visit a physical therapist in a private clinic.[30]

A health policy researcher with the Centre for Health Services & Policy Research (CHSPR) at the University of British Columbia has noted that as the number of physical therapists practising in private clinics or employed by private companies increases, the manner in which practitioners identify their interests changes also. Put simply, the commitment to providing care among some physios in private practice may overlap more substan-

tially with the economic well-being of the practitioner, and thus compromise her objective approach to the needs of the client or patient.

VIII

Hospital Reform

The reform of governance structures and management of health care services has impacted dramatically on the workforce and the public in British Columbia, but restructuring in the hospital sector has been at least as striking. Following the pattern established across North America, hospitals in British Columbia began reassessing the way in which they delivered care in the early 1990s. At the same time, the consulting industry was developing a relationship with the hospital sector, selling re-engineering schemes that promised to incorporate an industrial model of health care delivery.

In 1993, Chilliwack General Hospital became the first facility in British Columbia to implement a new and radical approach to patient care, a move that was closely watched by other hospitals in the province. The approach chosen by the hospital was Patient-Focused Care, a model developed in the US by Booz-Allen and Hamilton, a consulting company. PFC was introduced to Canada by American Practices Management (APM), Inc. in Winnipeg. The program resulted in the elimination of 403 positions at St. Boniface General Hospital and Winnipeg Health Sciences Centre, a fact that rang alarm bells among the staff at Chilliwack's hospital.

PFC advocates claim that the program will reduce operating costs by five to 10 per cent, operating space by 15 to 20 per cent, and staff by 10 per cent while providing care that is focused on patients rather than providers. The PFC approach uses "multi-skilled health practitioners", some of whom have had as little as 11 days training, to perform nursing tasks. The BCNU, HSA and HEU contracted the Trade Union Research Bureau to survey members at the Chilliwack facility to ascertain how the new health delivery program was affecting both employees and the quality of care. The survey found that 75 per cent of employees felt the system compromised patient safety, 89 per cent reported increased stress and workload, and only 20 per cent said their work had become more interesting due to multi-skilling.

The BCNU accused the hospital of compromising the quality of care and of "replacing highly skilled workers with unlicensed, unregulated

and underpaid workers." All three unions waged an intense campaign against PFC, leading to the appointment of a hospital-union-community team by the Ministry of Health to investigate the unions' charges. The committee was unable to reach a consensus on whether the "evidence" pointed to a compromise of quality care, and the investigation creaked to a halt without resolving the issues. The job security issues were resolved in the health labour accord, but employees continued to express frustration and unhappiness with the changes in their work and the standards of care they were able to deliver at Chilliwack General Hospital.

BC hospitals are moving quickly to embrace health care delivery management systems that promise to achieve what are referred to in the United States as "patient-centred outcomes measures".

These re-engineering efforts were occurring across the country, and in 1994 the Canadian Council on Health Services Accreditation introduced its new "Standards for Acute Care Organizations", which required hospitals to implement a "client-centred approach" to receive its stamp of approval. Consequently, hospitals in BC who wished to become accredited with the Council began adopting a variety of programs to meet the new criteria. Most of the data available on the impact of such programs is resident with the organizations that represent employers, employees and physicians, but very little, if any, is publicly available through the Ministry of Health.

A. Outcome Measurement

BC hospitals are moving quickly to embrace health care delivery management systems that promise to achieve what are referred to in the United States as "patient-centred outcomes measures". Outcome measurements are used to determine appropriate clinical practices, and have been heavily utilized by the insurance industry to evaluate the validity of claims for medical, hospital and other health services. Paul Ellwood, the architect of President Bill Clinton's "managed competition" health reform proposals during the 1990s, has defined outcomes management as "a technology of patient experience designed to help patients, payers, and providers make rational medical care-related choices based on better insight into the effect of these choices on the patient's life." Further, he states that this technology "consists of a…national database containing information and analysis on clinical, financial, and health outcomes that estimates as best we can the relation between medical interventions and health outcomes, as well as the relation between health outcomes and money." [31]

Outcome measurements change the day-to-day routines in clinical settings to facilitate use of health status measures. Such measurements are

heavily dependent on the use of information technology to provide clinical practices guidelines based on “best outcomes” or “best practices”, and data drawn from patient medical records. In theory, outcomes assessments begin with measuring patient status and developing treatment plans, monitoring patient progress, evaluating clinical effectiveness, and concluding with outcomes information being fed back to improve the structure and process of health care services. In reality, as Pat Armstrong has argued,[32] the combination of outcome measures and programs that change the delivery of health services are more cost-centred than patient-focused, and are being used to enable health care managers to deny care – and limit the ability of caregivers to deliver care.

While such strategies seek to establish appropriate models to determine the clinical effectiveness of care delivered in BC hospitals, there appears to be no acknowledged need to measure whether new programs and practices designed to facilitate outcome measurements will lead to reductions in service and autonomy for frontline caregivers. This would be an important step, given the experiences in US jurisdictions, where more than 1000 pieces of state legislation were introduced in 1996 alone to protect patients, most of them female, from guidelines that produced a litany of horrifying practices, including “drive-through mastectomies”.[33]

B. Outsourcing

Health care reform is affecting the way hospitals deliver care, and the relationship between the acute care and corporate sectors. Many companies have supplied hospitals with a range of products for many decades, and in the past hospitals often have worked to ensure that supply contracts are awarded to local companies. In the current environment, corporations have stepped up their attempts to negotiate “outsourcing” agreements with hospitals, and hospitals are being urged to narrow their “core missions” to areas of clinical care. A growing list of non-clinical services – such as laundry, maintenance, food services and health records management – are being contracted out to multinational corporations, despite studies that suggest the long-term savings from “outsourced” services are illusory.

The terms outsourcing and contracting out are used interchangeably with “partnership” and “alliance”, and cover a variety of arrangements. Selective outsourcing is used to farm out specific jobs, for example food preparation or maintenance. Facilities management (a service captured in

NAFTA) occurs when a team is hired to oversee all operations at a hospital. Transitional outsourcing brings in an "outsourcer" for a few years, after which the operations are returned in-house when the hospital has learned how to run them. And finally, full-service outsourcing turns over an entire operation, such as information systems, to outside companies. Contracting out services often displaces hospital employees, reducing the facility's labour costs while providing new opportunities for big corporations.

Outsourcing or contracting out, which companies say will assist the integration of health care delivery, are themselves an important element in the integration of Canada's non-profit hospital and for-profit corporate sectors.

Outsourcing or contracting out, which companies say will assist the integration of health care delivery, are themselves an important element in the integration of Canada's non-profit hospital and for-profit corporate sectors. Outsourcing represents a strategic and tactical alignment of interests in the health sector between publicly funded hospitals and the corporate sector. In Ontario, long-standing partnerships and outsourcing relationships between acute care facilities and corporations (many of them US-based) have evolved into more formal "joint venture" arrangements in for-profit entities that provide "alternative sources of revenue" to cash-strapped hospitals.

Hospitals are targets of corporate sales strategies, and many believe that outsourcing will lead to substantial savings. But comparisons of costs in the United States, where corporate outsourcing contracts escalated by up to 46 per cent from 1995 to 1996, and Canada, where most hospitals continue to supply their own needs, cast doubt on these assumptions. Studies between the two countries show that higher costs among American hospitals relate primarily to the use of more expensive non-patient care services. Hospital support services in the US (e.g., laundry and linen departments, dietary, housekeeping, equipment maintenance and plant operations) cost 24 per cent more per day than they do in comparable Canadian acute care facilities. Overall, hospitals in Canada were 41.6 per cent less expensive per discharge in 1995, with a 47.9 per cent longer average length of stay.[34]

Philadelphia-based Marriott International, which merged with France-based Sodexho last year, has been courting Canadian hospitals for a number of years. It is one of the largest "outsourcing" corporations in the hospital sector in North America. Contracts with Marriott at Peace Arch and Delta hospitals in BC were recently terminated because, in each case, the company was unable to produce the cost savings that were predicted. At the Peace Arch facility, management staff turnover was

exceedingly high with about six different managers hired over the two-year contract. After 10 years of managing St. Paul's Hospital's laundry services, Marriott left behind numerous outstanding employee grievances and a dismal record on quality of service. Marriott also managed housekeeping services at St. Paul's until the contract was terminated because the hospital was dissatisfied with the high costs and poor quality of service.

Marriott continues to manage the cafeteria at BC's Children's Hospital, where reported cost overruns in 1994 totalled $500,000. Complaints from patients, staff and visitors about the deterioration in the quality of the food served since Marriott took over the management of the cafeteria, in addition to cost overruns, led the hospital to review how food services were being managed. It agreed to support food service workers in developing an alternative approach to managing the cafeteria and other food services at the hospital.

As several hospitals in BC have discovered, outsourcing and other strategies to funnel tax dollars to corporations do not necessarily result in lower overall expenditures. However, many BC hospitals continue to adopt strategies used in other provinces to shift so-called non-core – and by implication, non-essential – functions out from under their umbrellas. The move to quality or outcomes measurements is leading some hospitals – such as St. Paul's and Vancouver Health Sciences – to develop information systems that will gather, organize and submit data on quality – and increasingly, they are outsourcing those systems to meet the demand.[35]

Outsourcing companies achieve their cost-savings almost entirely by reducing the cost of labour: maintaining low wages and benefits and fighting attempts to unionize. An assessment of "product costs" by The Toronto Hospital (TTH) found that, because hospitals are labour-intensive organizations, most of the savings that would accrue from outsourcing "will be derived from this category". TTH decided in 1993 that "the support services functions of the hospital could be carried out at less cost" by private companies. Hospitals, said TTH, "simply cannot compete with the economies of scale enjoyed by business."[36] BC hospitals have been vulnerable to the same temptations, and contracting out has increased in the province's acute care facilities, despite the fact that contracting out services often occurs in violation of collective agreement provisions. This is one reason why health care unions in BC – and across the country – have mounted

vigorous campaigns to oppose contracting out of so-called “non-core” services.

C. Amalgamations

Hospitals are also amalgamating their services, and this promises to be a more acceptable way to both save money and maintain services in the non-profit sector. It also will avoid the transfer of services to lower-paid workers in the corporate sector. These amalgamations are occurring in laboratory, food and laundry services in the Lower Mainland. In other areas, hospitals are adopting more industrial and private sector models of efficiency, methods that many analysts say are inappropriate in a health care setting. For example, some urban and suburban hospitals are establishing areas of medical speciality, both to improve efficiencies and to secure their funding base. Recently residents of Mission, BC voiced concerns that their local facility may no longer offer maternity care seven days a week if the hospital in Abbotsford, some 30 minutes away, becomes the “maternity hospital” for the Fraser Valley health region. Mission Memorial Hospital provides services to several smaller communities that may be inaccessible to Abbotsford, critics charge, if a ferry across the Fraser River stops running. While it may be more efficient and less costly to establish a hospital specializing in maternity care for the whole Fraser Valley, residents are worried that not all deliveries can be planned to coincide with visits of the Abbotsford obstetrician to their community.[37]

The movement of service delivery from a non-profit environment to a for-profit and more commercialized setting is as significant to women as the actual privatization of funding for health care.

The movement of service delivery from a non-profit environment to a for-profit and more commercialized setting is as significant to women as the actual privatization of funding for health care. The problems associated with maintaining adequate public funds for health service are compounded when the delivery of those services shifts to institutions primarily concerned with meeting the expectations of investors and shareholders. In this context, the provision of service relative to income received becomes paramount – that is, companies must ensure that the cost of providing services remains well below the level of revenue income. This is accomplished by reducing the number and/or quality of services, and by minimizing the cost of labour.

If patterns established elsewhere in Canada and in North America hold true, community-based non-profit providers in British Columbia will have an increasingly difficult time in a competitive health services market. Non-profit facilities dependent on public funding are often unable to establish the economies of scale in

which large global corporations are able to function, and are unable or sometimes unwilling to achieve the “efficiencies” of industrial model providers. Added to this is pressure from the health care workforce to achieve parity with their acute care counterparts, and similar demands from community social services workers involved in health-related fields such as the provision of home care.

Much more information is required to determine the impact of hospital reform and the adoption of evi-denced-based practices, utilization protocols and outcomes measure-ments on patients and health care providers. While some information is available, it is widely scattered, anecdotal, very subjective and not easily accessible. The impact of contracting out or outsourcing also requires more serious, in-depth study as the information that does exist often is unavailable due to company demands for confidentiality.

IX

Summary: The Information Gap

Information about how health reform is affecting women is minimal, and much of what does exist is kept in holdings outside of the Ministry of Health, or outside of public view altogether. The Centre for Health Services and Policy Research (CHSPR) at the University of British Columbia publishes a province-wide and regional breakdown of the health care workforce by place of employment, gender and age. Gender statistics are not available beyond 1992/93. Some information can be obtained from the Medical Services Commission which provides a breakdown of utilization and fee-for-service statistics that includes gender-based data; however this information is not easily accessed by the public. Information about programs and services offered to women by the Ministry of Health is available on-line, but most of this lacks statistical detail and can be described as promotional.

Unions representing health care workers probably have the most detailed and up-to-date information about their members' wages, benefits and working conditions in the province. Unions also track the rate of privatization in the health sector, but once members shift their place of employment to locations outside the unions' jurisdictions, the data ceases to be collected. Most professional associations lack the necessary funds to establish a sophisticated source of information, but some of what is available is useful.

Private companies operating in the health sector maintain data that enables them to plan their investments. Much of this information is extremely useful, but currently disclosure laws at both the provincial and federal levels place such information beyond the reach even of shareholders.

For policy makers and women to obtain an accurate picture of how reform efforts are affecting or could affect the primary users and providers of health services, information is key. There currently is no database in the province devoted exclusively to information about how women interact with the health system – either public or private. The Ministry of Health, while promoting public private partnerships, does not track

information about the use of private health services, although some of this data is available at the Workers' Compensation Board and the Insurance Corporation of BC because both are publicly regulated institutions. But there is no data available, for example, about the amount of out-of-pocket expenditures incurred by women who seek services in the uninsured health services sector.

If women hope to exert influence on the direction of health system reform – whether that influence is exerted at a governance, provider or patient level – we will need not only information, but guaranteed access to the data.

The United States, by comparison, has logged a broad array of data on women and the health care system. Many of these databases should be examined to determine how the collection and storage of information about women as paid and unpaid providers, and as users of health services, in British Columbia might be organized. This is an urgent matter, since change continues at a rapid pace in the province, and there are few areas in which it is possible to establish a base line prior to the introduction of health care reform.

If women hope to exert influence on the direction of health system reform – whether that influence is exerted at a governance, provider or patient level – we will need not only information, but guaranteed access to the data. Health care reform is leading to increased privatization of health-related information, both at the provincial and federal levels. One example is the Canadian Institute of Health Information (CIHI), a consortium funded by large corporations such as IBM, Hewlett-Packard, SmartHealth, SHL Systemhouse (a subsidiary of MCI), and several hospitals. The head of CIHI is Michael Decter, Canadian vice-president of American Practices Management, Inc. CIHI collects data on health services and expenditures (including utilization statistics broken down by gender, age and location), and financial, statistical and clinical data, information which is provided to its members. Annual membership fees are between $1000-$5000 annually, costs which are prohibitive for most of the population. The information now stored with CIHI used to be available free from Statistics Canada, Health Canada and the Hospital Medical Records Institute.

In British Columbia it is important that such data be protected from commercial use while being made available to the public free of charge. Currently, provincial and federal discussions concerning patient medical records are focusing on how to protect privacy while enabling private companies to gather, manage and distribute such information – for a fee.

Finally, companies that deliver health services, or which insure BC residents, should be required to submit utilization and cost information to a

public data bank at no cost, since many will be operating on a fee-for-service basis paid entirely or subsidized by public expenditures.

Endnotes

[1]Colleen Fuller, *Caring for Profit: How Corporations Are Taking Over Canada's Health Care System* (Vancouver: New Star Books and the Canadian Centre for Policy Alternatives, 1998).

[2]*Hospital Act* of British Columbia, [RSBC 1996] CHAPTER 200 [Updated to October 31, 1997].

[3]The 1999 federal budget provided $11.5 billion more to federal transfers to the provinces for health over a three-year period, bringing Ottawa's contribution up to an estimated 15 per cent of public health expenditures. However, this is a one-time injection of cash, and will not boost the federal government's funding contribution on a permanent basis.

[4]"Healthy and Wealthy: A Growth Prescription for Ontario's Health Industries," report of the Ontario Health Industries Advisory Committee to Honourable Ruth Grier, Ontario Minister of Health, March 1994.

[5]*Strategic Plan for Health Information Management in British Columbia*, Health Information Management Co-ordinating Council, April 1996.

[6]"Health System Reform in British Columbia," Health Canada, 1997. This document is part of an ongoing review of heath reform in Canada begun in Spring 1995 and conducted by Health Canada's regional offices, with the co-operation of provincial and territorial Ministries of Health.

[7]*Executive Summary*, BC Provincial Health Officer's Annual Report, 1996.

[8]*Executive Summary,* BC Provincial Health Officer's Annual Report, 1995.

[9]Phone interview with Tracee Schmidt, Senior Policy Analyst, Women's Health Bureau, British Columbia Ministry of Health, March 1999. Ms. Schmidt also expressed interest in the project of the BC Centre of Excellence for Women's Health on the impact of health reform and privatization on women.

[10]"RE: *Canada Health Act*," Letter from Diane Marleau, Minister of Health, to provincial and territorial Minister of Health, dated January 6, 1995.

[11]*Medicare Protection Act,* [RSBC 1996] CHAPTER 286 [Updated to October 31, 1997].

[12]*Community Care Facility Act*, [RSBC 1996] CHAPTER 60, [Updated to October 31, 1997].

[13]Utilization rates in BC hospitals have fallen to approximately 645 beds per 1000 population, while the reduction of hospital staff has been minimal. These falling utilization rates are not unique to British Columbia. See "Hospital utilization, 1996/97," a national study conducted by the Canadian Institute for Health Information, February 24, 1999.

[14]Rollcall Update '97, "Introduction", Tables 3 and 4; "Physical Therapists", Tables 2 and 4; "Occupational Therapists", Table 2. Published by the Centre for Health Services & Policy Research. URL: www.chspr.ubc.ca.

[15]This number was arrived at by calculating approximately 2200 lab technologists employed in hospital laboratories (based on HSA membership figures), plus 925 physical therapists and virtually all 880 occupational therapists employed in public or publicly funded institutions.

[16]Section 3 of the Health Authorities Act (Provincial standards) states that:

(1) The minister may, by regulation, establish Provincial standards for the provision of health services.

(2) The minister may, by regulation, specify a health service, or the level or extent of health service, that must be provided in a region or community.

(3) The minister must ensure under subsections (1) and (2) that health services in British Columbia continue to be provided on a predominantly not-for-profit basis.

(4) The minister must not act under subsection (1) or (2) in a manner that does not satisfy the criteria described in section 7 of the Canada Health Act (Canada) respecting public administration, comprehensiveness, universality, portability and accessibility.

(5) Any grant to a board or council by the government must be made on condition that the board or council complies with all applicable regulations made under subsections (1) and (2).

[17]"HSA lab campaign pays off with 'accord' on lab, breast cancer screening and rehab services," *News Bulletin*, Health Sciences Association of BC, September 24, 1998.

[18]Currently the Medical Services Commission is responsible for licensing both private and hospital laboratory collection sites. Hospitals

have experienced problems obtaining licenses from MSC, which has expressed a preference for licensing private labs. In 1996/97, $54.7 million was paid in lab fees to hospitals for outpatient services, compared to $117.4 million paid to private companies in BC. From 1992/93 to 1996/97, billings for outpatient lab services grew by 4 per cent in the hospital sector, and by 22 per cent in the private sector. Up to 80 per cent of private sector outpatient lab services are used to provide a relatively short list of routine services. Furthermore, fee for service billings ignore whether a test is performed in a highly automated environment or not. See "Province of BC Fact Sheet: Laboratory Services in BC", October 16, 1998, BC Ministry of Health.

[19]BCGEU Bargaining Update #12, Facilities Sub-Sector, September 21, 1998.

[20]"HEU community members urged to vote no in contract ratification; Absence of firm future parity pledge from government the problem", Hospital Employees' Union Bulletin, September 17, 1998.

[21]Rollcall Update '97: Introduction, Table 3; Licensed Practical Nurses in British Columbia, Tables 2 and 4; Registered Nurses in British Columbia, Tables 2 and 5. Centre for Health Services and Policy Research, URL: www.chspr.ubc.ca/hhru/rollcall/1997.

[22]"Working too hard", The British Columbia Nurses' Union Magazine, September 1998.

[23]Statistics Canada, "Hospital Downsizing" in Health Reports Vol. 8, No. 4 (catalogue 82-003), Spring 1997.

[24]News Release, B.C. Ministry of Health: "Better Utilization Management of Hospital Beds Recommended", March 11, 1997.

[25]*Regionalization,* Canadian Medical Association Journal 1996; 154: 572A-572B, 1996, Canadian Medical Association.

[26]Community health centres are characteristically those facilities that provide a broad range of integrated services, rather than community facilities that focus on specific and segregated areas of care.

[27]Article 6, "Utilization and Cost Saving Measures," Renewed Working Agreement Between the Government of the Province of British Columbia, the Medical Services Commission and the British Columbia Medical Association, dated May 3, 1996.

[28]"Fee-for-service Payment Statistics, 1996/97", MSP Information Resource Manual, prepared by Information and Analysis Branch.

[29]"Reproductive Freedom News," Contemporary Women's Issues Database, December 12, 1998, Copyright 1998 Center for Reproductive Law and Policy (CRLP).

[30]"1998 Market Research," Highlights of a Poll by MarkTrend Research, Physical Therapists Association of British Columbia at URL: www.physiobc.ca.

[31]"Quality of Care and the Outcomes Measurements Movement", American College of Emergency Physicians. Undated, (copyright, 1996-1999. Dallas, Texas).

[32]See, for example, Wasting Away: The Undermining of Canadian Health Care, by Pat Armstrong and Hugh Armstrong, Oxford University Press (Don mills, Ontario), 1996.

[33]Merline, John, "The backlash against managed care", Vol. 79, Consumers' Research Magazine, November 11, 1996. "Drive-through" mastectomies refers to breast removal surgery done on an outpatient basis – an "evidenced-based practice" enforced by cost-conscious US insurers utilizing outcome measurements.

[34]"How do Canadian hospitals do it? A Comparison of Utilization and Costs in the United States and Canada," by Jim Weil, Vol. 73, Hospital Topics, January 1, 1995.

[35]"Measuring Value in Healthcare: The Quality Factor," Compensation & Benefits Review, September 18, 1997; "Outsourcing," by Tyler L. Chin, Health Data Management, August 19, 1997.

[36]James H. Stenhouse, Alan R. Hudson and Michael J. O'Keefe, "Private-Public Partnerships: The Toronto Hospital Experience", in *Strategic Alliances in Health Care: A Casebook in Management Innovation*, edited by Peggy Leatt, Louise Lemieux, Charles and Catherine Aird (Ottawa: Canadian College of Health Care Administration, 1996).

[37]These comments are drawn from my own notes taken during a meeting in Mission, BC, organized by the Council of Canadians, March 9, 1999, on regionalization and health care reform in the Fraser Valley.