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THE PRICE OF HEALTH CARE REFORM FOR WOMEN
The case of Quebec

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EXECUTIVE SUMMARY

This **preliminary document** is produced in connection with a Canada-wide project of the Centres of Excellence for Women's Health. It is aimed at ascertaining the scope and nature of privatization trends in the health care system in Quebec and its consequences for women with regard to the use of services, service delivery, and participation in decision making regarding the directions to be taken in the health and social services system.

This overview of the situation in Quebec focuses on the changes that have occurred in the health and social services network since the early 1990s. It is based on a review of the main Quebec government documents dealing with the direction, funding and organization of the health system, as well as on studies carried out on changes in the Quebec health system, from the perspective of public and private sector relations. It also looks at observations flowing from experiences in the field and research on the impact of these changes on women.

Some aspects of privatization

Analysis of the transformations in the health and social services system from a privatization perspective covers a variety of realities. The policy papers or analysis documents approach this issue from the perspective of one of the four major roles of the State: main insurer (*funding component*), service provider (*service delivery and organization component*), administrator or employer (*management and resource allocation component*), and guardian of the public interest (*regulatory component*).

With the reform in the early 1990s, the State greatly modified the organization of the public health and social services network, making major cuts in public funding. Various strategies have been implemented in connection with this withdrawal from the State. On the one hand, major reductions in funding for the public network have led the institutions to take various cost-cutting measures: closing of hospital beds as well as contracting out and user charges, not only for auxiliary services, but also for direct delivery of some services. This placed pressure on the network as a whole, since the institutions called on to take over responsibility do not yet have the resources to handle the shift over to them of demand from a population requiring more resource-intensive care. The vacuum left by these cuts have encouraged the appearance of new private players offering health and social services in a context of deregulation, while the performance indicators in the public network still focus more on production institution by institution, rather than on use of services or service co-ordination and continuity among various providers, be they public or private.

The shift toward more ambulatory care has also had the effect of transferring delivery of certain services to the private sector – that is, to family members, mainly women, who are called on to provide increasingly difficult and complex care as caregivers, without protection or adequate support; or to community organizations, who often have the impression that they serve as overflow channels to meet needs that the public network cannot absorb.

Moreover, the government has proceeded with active deinsurance measures, such as the limiting of service coverage or the excluding of certain population categories, thus opening the door to transfer of costs in the direction of various sources of private funding. In addition, a form of passive deinsurance is taking place with the trend toward more ambulatory care. Some costs, such as those for drugs or medical supplies, which used to be provided for free at hospital centres, are being transferred to patients and their families, even with a pharmacare plan which leaves room for private insurance companies. People with access to private insurance plans are being offered new insurance products, including coverage for convalescence, in return for an additional premium.

Consequences for women

There have been some studies of the impact of various aspects of health reform on women, mainly on caregivers and nurses, and different position papers on this question issued by community groups, nurses federation and feminist coalitions in Quebec. In order to gain an overview of the reform's impact on women, it is necessary to explore four major "areas of involvement for women": women as service users, women working in the public services network, women playing a caregiver role and women as citizens involved in community organizations or participating in decision-making structures.

As the main users of services, women are the persons most affected by the consequences of the reform, including deterioration in the quality of care, increased waiting times, deinsurance of certain services and transfer of costs, as well as a certain confusion caused by the mergers of institutions and the changes in their services. Moreover, the biomedical model has been dominant, but now there is even less room for comprehensive approaches that reflect women's reality.

Women working in the public health and social services network have been hard hit by the adverse effects of the reform. The aspects that have had the most impact on the working conditions of women employed in the public network are the closing of institutions, the mergers, the redefinition of duties, staff movements, and the huge number of staff departures.

Women serving as informal caregivers are feeling the effects on several levels: their living conditions, their health (stress, anxiety, physical and mental burnout), their personal and family lives (role conflicts being a source of multiple tensions). They also encounter obstacles where participation in various social activities is concerned. Ambulatory services provided by the hospital centres and C.L.S.C.s are now meant to complement those provided by family members.

Representatives of women's groups have become involved in decision-making structures created in the context of health system reform, but they experience culture shock because of the contrast between technocratic culture and community culture. On the other hand, the partnership into which community organizations are asked to enter seems to be not egalitarian and limited to the institutional programs defined by the State. The service component of the groups' activities ends up overshadowing the groups' work to educate the public, raise awareness, and mobilize people. While part of the community network was negatively affected by the shifting of demand toward them by an overloaded public network, other projects flowed from community organizations in social economy enterprises providing services in sectors with emerging needs connected with deinstitutionalization or the trend toward ambulatory care. Some authors, using the term "c*ommunautarisation*," draw a distinction between this transfer of services to community agencies and the marketing of services by private for-profit enterprises.

Some concerns conveyed by the women's movement have been reflected in the policies and programs implemented in the context of Quebec's health and social services system reform. However, the situation is difficult in terms of issues relating to health or women's living conditions, and these issues end up lost in the management of programs planned for "at risk clienteles". In Quebec, recommendations for policy advice and research projects should be developped in collaboration with existing women's networks already involved in the "*Feminist coalition for transforming of the health and social services system*"

1. INTRODUCTION

The health and social services system in Quebec has undergone major transformations since the early 1990s. This paper seeks to examine the consequences that these reforms have had for women's health, considering the differing roles that women and men play in our society. It also seeks to examine the various effects that these measures have had on the status and health of women from differing socio-economic environments.

Whatever efforts are made to avoid bias in analysing the consequences of policies and programs, such studies cannot disregard the reality of differences between the sexes. Some differences have already been well established in surveys of public health. More women than men report being in poor health or only fair health; women are making more use of health care services, even when services surrounding pregnancy and childbirth are excluded (Guyon, 1996). Three-quarters of the workers in the health and social services system and the vast majority of the workers in community health and social services agencies are women (Conseil du statut de la femme, 1996a). Moreover, the central element in recent health care reforms–the shift of many services from institutions out into the community–has significantly altered the relationships among the government, the public health care system, private health care providers, community organizations, and the "domestic" economy[1], in particular the informal care that is provided chiefly by women in family settings (Standing, 1999).

In Quebec, the Feminist Coalition for Transforming the Health Care System [Coalition féministe pour une transformation du système de santé], the Council on the Status of Women [Conseil du statut de la femme], and other coalitions of community organizations and labour unions have sounded the alarm concerning the specific effects that health care reform has had on women.[2]

The present overview of health care reform in Quebec and its particular effects on women is part of a Canada-wide project being conducted by the Centres of Excellence for Women's Health[3] to provide a picture of the situation in the various parts of the country. Because of the scope and complexity of the reform in Quebec, this report focuses on an issue that lies at the heart of the current debate on the future of Quebec's health care system: the changing relationship between the public and private sectors. Our discussion of the trend toward privatization in the health care system is based on a review of the main Quebec government documents concerning health care policy directions, funding, and organization. This discussion is also based on various studies of the long-term evolution of this system.

The privatization process has been analysed by various authors from various perspectives, including how services should be organized and delivered through the system, how it should be managed, how it should be funded, and how its activities should be governed and regulated so that they serve the public interest and meet socially acceptable quality standards.[4] In the first section of this report, we analyse the issues raised by the current reform from these four perspectives, attempting to address a number of questions. Are the changes being made in the organization of services promoting the transfer of services to the private sector? Does the private sector play only a marginal role in Quebec's health and social services system? Can the development of partnerships with the private health care industry improve access to and quality of health care services? Can the public health care system benefit from adopting management methods developed by private enterprise? What factors influence the relative proportions of public and private funding for health care services? How can government preserve the great achievements of our health care system while still containing costs?

The second section of this report deals with the special consequences that various aspects of the reform of Quebec's health and social services system have had for women, to the extent that these consequences have been identified to date. But in this regard, a caveat is in order. It is almost impossible to isolate a given government action and its impact from the social, political, and economic context in which it takes place. In Quebec, the context for the current health care reform includes a broader review of social policies and a new questioning of the role of the State--some would even say an attempt to dismantle it (Poirier et. al., 1998).

Moreover, it must be recognized that the health and social services system is only part of a larger set of determinants of public health, and to analyse the effects of this system, we must also consider other factors that affect women's and men's living conditions and health throughout every stage of their lives.[5] To provide an overview of the price that Quebec women have paid for health care reform, the second section of this report therefore examines four major ways that women are involved in the health care system:[6] as users of health care services, as workers in the health and social services system, as caregivers to family members, and as participants in various capacities in community organizations.

Any analysis of the consequences that health care reform has had for women must also consider how such consequences may vary with factors such as age, social and economic status, ethnic and cultural background, physical and mental health, and place of residence (urban or rural). This section therefore reviews findings from various studies of women's experience in the field and from research on the consequences that these sweeping changes have had for women.[7] It brings out the need for more comprehensive studies and analyses designed to properly reflect differences between women and men.

2. HISTORICAL OVERVIEW

Before analysing the recent reform in Quebec's health and social services system from the standpoint of privatization, we will briefly review the history of the system to provide some context for the direction that this reform has taken and the effects that it has had.

There is nothing new about private institutions' delivering health and social services in Quebec. Before 1960, the government had almost no role in funding or delivering such services, and the cost of health care was one of the main reasons that families went into debt. Hospital and social services were provided by private corporations, often associated with religious institutions,[8] and doctors worked in private practice. It was not until the advent of government hospitalization insurance in 1961 and government medical insurance in 1970 that the State began to finance most health care services, through the budgets that it allocated to public institutions and the public health-insurance system that it used to compensate medical service providers.

In the early 1970s, with the adoption of the *Act respecting health services and social services,* the Quebec government began to put a public system of health and social services in place. This law, inspired by the report of the Castonguay-Nepveu Commission (1966-1971), established the main administrative structures of Quebec's health and social services system. It created twelve regional health and social services councils, which were given an advisory role; hospital centres (CHs), whose administrative management was separated from their medical management; and local community service centres (CLSCs) to provide front-line health and social services at the local level. The organization of Quebec's health and social services system was thus characterized by the integration of front-line health and social services in the CLSCs and the creation of the Department of Social Affairs [Ministère des Affaires sociales], with broad authority to rationalize the system's operations and to ensure free, universal access to its services. Also, the door was opened to public participation in the running of regional agencies and institutions (Bergeron and Gagnon, 1994).

At that time, Quebec gave the mandate to deliver social services to two kinds of public agencies: local community service centres (CLSCs), which provided such services in community settings, and social services centres (CSCs), which provided them in institutional settings. But access to government-funded social services still remained more limited than access to government-funded health care services (Ouellet and Roy, 1994).

During the 1980s, various pressures on the health care system began to build up. Technological advances brought new treatments and new technologies that were increasingly expensive.[9] Demographic changes such as increased life expectancy resulted in new needs, including an increase in the incidence of chronic illness compared with acute health problems. At the same time, changing social values transformed Quebecers’ vision of sickness and health, with a new emphasis on deinstitutionalizing frail individuals and helping them live in their communities. The growing ethnic and cultural diversity of Quebec society due to immigration necessitated adjustments in how the services are delivered. The increased availability of information altered the relationship between health care professionals and some of their patients, who now demanded the right to participate in decisions about their treatment, or to seek alternative therapies.

All of these changes made managing the costs of the health care system more complex. In the mid-1980s, questions began to be raised about the proportion of public expenditures that should go to the health care system, especially because increases in health care costs were not necessarily accompanied by improvements in the public’s health[10], and because our health care system consumes a larger share of the national wealth than in other developed countries (Rheault, 1994; Contandriopoulos, 1991).

In 1985, the Quebec government established a commission of inquiry on health and social services, known as the Rochon Commission, and gave it the mandate to conduct an in-depth review of the orientations and organization of Quebec's health and social services system. In its 1988 report, the Rochon Commission concluded that efforts to democratize the health care system had failed, and that the system had become a hostage to various corporate interests. The Commission proposed strengthening public participation in decision-making processes at the regional level.

Following the Rochon Commission's report, the Quebec government began restructuring the province's health care system in the early 1990s. Various analysts see this reform as having pursued the same general policy directions as in the past, while attempting to resolve the tensions that had marked the development of Quebec's health care system over the preceding twenty years (Bergeron and Gagnon, 1994; Turgeon and Anctil, 1994).

Quebec Liberal Minister Marc-Yvan Côté initiated the first phase of the restructuring with the publication of a policy paper entitled *Une réforme axée sur le citoyen* [citizen-focussed reform] in 1990. This paper was followed in 1991 by the passage of Bill 120, which amended the *Act respecting health services and social services*, and by the publication of a document on the funding of health care services, *Un financement équitable à la mesure de nos moyens* [equitable funding that is within our means]. Paradoxically, it was not until 1992 that the policy objectives of improving population's health and welfare were made public, in a paper entitled *La politique de la santé et du bien-être* [health and welfare policy].

Quebec's health and social services reform of the 1990s was carried out against a backdrop of budget cuts, which had been the order of the day in the public system since the mid-1980s, regardless of which political parties were in power in Quebec or in Ottawa. Starting in the 1993-94 fiscal year, the cuts in the health and social services system became more severe, as the Quebec government launched a campaign to realign public spending and public administration in order to balance its budget. At the Department of Health and Social Services [Ministère de la Santé et des Services sociaux : MSSS], this campaign got under way with a document entitled *Défi Qualité-Performance* [the quality/performance challenge], which proposed some $750 million in budget cuts over three years. The election of a Parti Québécois government in 1994 did not lead to a change in policy, and talk of zero growth in government spending continued. In a context where it was not always easy to determine which changes reflected budget cuts and which ones reflected restructuring in the health and social services system, the new Minister, Jean Rochon (who had chaired the commission of inquiry into health and social services from 1985 to 1988), argued more strongly than his predecessors for some major reallocations of financial resources, designed to replace costly services provided in institutions with less costly services provided in the community.

Following the October 1995 referendum campaign and the arrival of Lucien Bouchard as Premier of Quebec, problems in public finances came to the forefront once again. After holding an economic summit in March 1996,[11] the Quebec government adopted a budget policy aimed at achieving a zero deficit in four years. All government spending and social programs were affected by these successive initiatives to restore public finances, including the health and social services system, which accounted for nearly one third of Quebec government spending.

The regional health and social services boards, established by the *Act respecting health services and social services* in 1991 to substitute the regional councils, were given the mandate to meet the budget targets set by the Department of Health and Social Services and to prepare the restructuring plans for the 1995-98 period. However, the major financial directions continued to be defined at the highest political levels; only administrative decisions were transferred to the regions. On the one hand, this regionalization policy, which the Quebec government was pursuing in a number of other areas as well, brought management of the health and social services system closer to the actual needs of Quebecers in the various administrative regions.[12] But on the other hand, even though the government retained substantial powers over policy development and deregulation, this decentralization helped to draw attention and opposition away from the government itself.

Thus these two trends, budget cuts and regionalization, have characterized the backdrop against which health and social services reform has taken place in Quebec in the 1990s. These same trends have been seen elsewhere in Canada. The similarities are clear, especially as regards the financial situation. The federal government, which had provided a large proportion of health care funding since the 1960s, began unilaterally reducing its transfer payments as early as 1982.[13] In its 1995 budget speech, the Liberal government in Ottawa announced a series of measures to cut public spending and reduce Canada's deficit. Many social programs were affected by these cutbacks, and particularly by a major reduction in federal transfer payments, which drastically reduced funding for health, education, and social services in every province of Canada.

Yet despite having substantially reduced its contribution to the health care budget, the federal government strongly reasserted its intention to make the provinces comply with the standards of the *Canada Health Act* of 1984, and specifically the requirements for health-insurance plans to be publicly administered and universal, to provide comprehensive coverage for all "medically necessary" services, to provide access to treatment at no additional charge, and to make benefits portable from one province to another.[14] But because the Act applies only to medical and hospital services, it has become increasingly restrictive with the advent of new kinds of services that are delivered outside of hospitals, new kinds of treatments delivered by other types of health care professionals, and new kinds of medications that cost more and more to buy.

Even now, most front-line medicine in Quebec is practised in private doctor's offices, though it is paid for by Quebec's public health-insurance plan, the Régie de l'assurance-maladie du Québec (RAMQ).[15] Many residential and long-term care centres (CHSLDs) are run by private organizations that receive public funding under agreements with the Quebec Department of Health and Social Services and operate under government rules. More and more social and health care service providers, such as psychologists, social workers, nutritionists, and physiotherapists, practice independently out of private offices, and their clients must pay for their services either directly or through private insurance plans. Thus Quebec actually has a mixed system of health and social services, in which the private sector co-exists with public institutions and receives government funding in proportions that vary according to the kinds of services provided.[16]

Various health care services, especially ones delivered outside of hospitals, can be offered commercially. This opportunity has attracted the interest of private businesses, which are submitting more and more proposals for partnerships with the public health and social services system. The major cutbacks taking place in public institutions only make the prospects for these proposals brighter. NAFTA has created still more opportunities; major US corporations are now trying to penetrate the Canadian health care market, particularly in the areas of home care and high-tech medicine (Métivier, 1999; Fuller, 1998).

3. ANALYSIS OF THE TRENDS TOWARD PRIVATIZATION

3.1. Reform in the Organization and Delivery of Services

The reform begun in 1990 has overturned traditional ways of delivering health care. The goal of these reforms has been to promote integration and complementarity of services and co-operation among institutions, with the underlying objective of improving the efficiency of the system as a whole. It has also contributed to a change in the relative proportions of health care services delivered by the public and private sectors.

- Changes in the Public Health Care System

The major thrust of the changes in the ways that services are delivered has been the shift toward ambulatory care, which has been accelerating since the mid-1990s. The previously mentioned document from the Department of Health and Social Services, *Défi Qualité-Performance*, summarizes the scope of these changes as follows: "[translation] *There is a growing emphasis on alternatives to institutionalizing patients. In hospitals, preference is given to less invasive surgical procedures, as well as to outpatient surgery and medicine and increased use of ambulatory care. Some general types of hospital services and treatments, and even some specialized ones, are increasingly being delivered in the home. The result is better patient recovery, as well as shorter hospital stays and even a decrease in the number of beds required. In non-hospital settings, the emphasis is on home care services; group homes; respite services; support from families, friends, neighbours, and community agencies; and so on*" (MSSS, 1994: 6).

This shift toward ambulatory care was effected very quickly, in response to the government's desire to achieve a zero deficit. The shift particularly altered the way that care was provided in hospital centres. While the average length of hospitals stays decreased from 8 days in 1993-94 to 6.8 days in 1997-98, and the proportion of day surgeries increased by nearly 20%, more than 5 000 beds were closed in hospitals throughout the province, and nine hospitals in the Montreal region were either shut down or converted into other types of institutions.[17] In addition, as budget constraints led to limitations on access to diagnostic services, specialized treatment equipment, and operating rooms, waiting lists grew so long that the Quebec government had to inject some $28 million in the summer of 1998 to try to shorten the wait for certain kinds of surgery.

Despite these additional resources, the total number of people in the Montreal region waiting for all types of surgery combined rose from 35,109 in September 1998 to 39,318 in September 1999, an increase of 12% (Bégin, 1999e). In the fall of 1999, the Department of Health and Social Services decided to start sending cancer patients to the United States so that they could receive treatment within a reasonable time, even though this cost more than providing them with the same treatment in Quebec.

This deterioration in the accessibility of services poses the risk of creating a two-tier health care system. In the supporting document for consultations on its 1998-2001 three-year plan, the Montréal-Centre regional health and social services board itself admits that: “[translation] *One of the factors that can contribute to the emergence of a two-tier system is excessively long waiting times for certain services, which can lead to the idea of creating a second system available to those who have the means to access it and thereby jump the queue. For the vast majority of people, a move toward a two-tier system would mean either waiting even longer to access health care services, or paying substantial fees*” (Régie régionale de Montréal-Centre, 1997: 12).

The changes in the way hospital services are delivered have had repercussions throughout the health and social services system, especially in the CLSCs, whose mission is “*to offer, at the primary level of care, basic health and social services of a preventive or curative nature and rehabilitation or reintegration services to the population of the territory* [that they serve]” (R.S.Q., c. S-4.2, s. 80).

The shift toward ambulatory care happened so fast, and under so much pressure to reduce public health care spending, that a critical first step was overlooked — not enough money was reinvested in CLSC home care services to let the growing number of people being discharged earlier from hospital obtain the home care services that they need. The share of public health care spending in Quebec that went to home care rose from 1.7% in 1990-91 to 2.4% in 1997-98, but the province still falls significantly below the Canadian average, which rose from 3.3% to 4% over the same period.[18] Illustrating this, J.-F. Bégin writes: "[translation] *This year[1997-98], the Montreal-Centre regional board is allocating $66 per capita for this type of service — an improvement over the $47 per capita spent in 1995, but still lower than the $70 that Ontario was already spending three years ago*" (Bégin, 1998c: A-6).

Even though total funding for CLSCs has risen significantly, from $686 million in 1993-94 to $870 million in 1997-98, this amount represents only 8% of the total budget for the public health care and social services system. Moreover, most of the increase did not occur until the last year of the 1995-96 to 1997-98 three-year plan. One consequence of making the CLSCs meet the rapidly increasing demand for post-hospitalization home care, without giving them enough extra funds to cope with it, is that they have had to neglect the preventive health care activities that are also part of their mandate, and part of the government's official health and welfare policy. For example, some CLSCs have withdrawn nurses from schools where they were delivering preventive programs and reassigned them to home care services. Health care workers used to make home visits to frail seniors, for the precise purpose of preventing their health from deteriorating. Such visits have now become increasingly rare, and even visits to provide disabled people with basic services such as personal hygiene have had to be more widely spaced. Some agencies even say that the original mandate of the CLSCs has been shelved and that the CLSCs have become "traffic cops" and health care providers, at the expense of their other role, as providers of social services (ROCQ 03, 1997:16).

One major goal of health care reform is to provide quick, easy access to front-line health and social services while limiting the use of the most expensive services, such as visits to emergency rooms and doctors' offices. This was the reason for introducing the Info-Santé CLSC services, through which the public can consult nurses by telephone 24 hours per day, 7 days per week. These services were extended to all CLSCs in 1995.[19] Women constitute the vast majority of users of these services — 89.4% — which is consistent with other data showing that women make more frequent use of health care services in general and are more closely involved in caring for dependent persons within their families. According to Hagan et al. (1998), most of the women using this telephone service are well educated and middle-aged, and they report themselves as being satisfied with the advice that they receive.[20]

Many CLSCs, especially in the major urban centres, do not have enough physicians to offer the full range of front-line health care services or to extend their service hours (for example, to stay open evenings and weekends).[21] The Department of Health and Social Services favours the creation of regional general medicine departments (DRMGs), under the auspices of the regional health and social services boards, to foster co-operation between CLSCs and doctors' private practices, where more than 80% of all front-line medical care is delivered, especially in urban areas.[22] Many experts believe that such initiatives will make very slow progress so long as the government does not give general practitioners financial incentives to participate in them. At present, these doctors can still make more money in their private practices than they can by providing services to CLSCs.[23] Moreover, the fee-for-service system does not encourage doctors to form group practices that take a "global" approach. In contrast, the CLSCs' services are based on an interdisciplinary approach involving several different kinds of health care and social-service professionals (nurses, nutritionists, psychologists, social workers, etc.) (Demers, 1994; Turgeon and Anctil, 1994).

The shift toward ambulatory care in physical health services was made after similar experiments in other parts of the health and social services system — the overall trend toward deinstitutionalization that began in the 1960s — but without the appropriate lessons' having been learned. Deinstitutionalization involved taking various categories of people who had been institutionalized (frail senior citizens, people with physical or intellectual disabilities, and many people who had been treated for severe mental illness), returning them to their families or the community, and trying to keep them there insofar as possible. However, when these patients were shifted out into the community, appropriate resources were not always shifted along with them, so that deinstitutionalization produced some significant failures, especially for mentally illed people. The Department of Health and Social Services 1997 plan for transforming mental health services recognized this fact and called for the proportions of resources allocated to institutional and community-based services to be reversed (as of the mid-1990s, the proportions were still 60% and 40% respectively).

Efforts to co-ordinate the work of institutions with that of the various organizations delivering services in the community are now organized through regional service organization plans (PROS), which were developed in the early 1990s. These plans require every institution and community agency to stop seeing itself as an isolated entity that provides certain services and to start seeing itself as a link in a chain, with specific responsibilities in a continuum of services. A 1997 study of deinstitutionalization and the regional service organization plans reported uneven results, varying according to the population concerned.[24] With the increasingly severe budget cutbacks of the second half of the 1990s, implementation of regional service organization plans has often been set aside. The responsibility for supporting people suffering from mental illness or various disabilities has generally fallen back on their families and on community and alternative resources. As a result, an especially heavy burden has been placed on women, who traditionally assume the responsibility of caring for the frail and dependent. Many people with severe, chronic mental illness have swollen the ranks of the homeless (chiefly in major urban centres), because they lacked adequate outside assistance when their families could no longer shoulder the burden of caring for them and providing them with psychological and social support.

As the trend toward supporting people in the home has grown, the severity of the health problems of people who still live in residential and long-term care centres has increased. In the space of a few years, the percentage of residents with cognitive deficits has increased by 10%, though it varies from one centre to the next, and the average age of residents is now 85 years. Most of these residents are women, because women have a longer life expectancy than men and spend more years of their life with some kind of disability.[25] In many of these centres, neither the staff nor the facilities were ready for this sudden change, and the additional resources needed to raise the level of services were not forthcoming. On the contrary, according to the Quebec Association of Local Community Service Centres and Residential and Long-term Care Centres [Association des CLSC et des CHSLD du Québec], financing for the 137 public residential centres in the province fell from $1.5 to $1.2 billion between 1995 and 1998, so that the average rate of response to residents' needs fell from 74.4% to 68.3% between 1991-92 and 1997-98; more than half of the residential centres fell below this provincial average.[26] According to the Quebec Council on the Status of Women [Conseil du statut de la femme] "[translation] *To continue providing certain support services to their residents, many institutions must improvise as best they can. Instead of permanent employees, they often have volunteers transport residents from their institutions to appointments, or organize leisure activities. Sometimes, they employ people under work-force re-entry programs; these employees are unlikely to stay for very long.*"(Conseil du statut de la femme, 1999).

Lastly, it should be noted that the public network has gone through a major restructuring, with some formerly separate institutions being grouped under one board of directors, and many other institutions being merged. In some outlying regions, many public institutions with very different mandates (hospital centres, CLSCs, and residential and long-term care centres) have been combined into single administrative units. In the larger urban centres, institutions have generally been merged with others in the same or similar categories — for example, residential facilities with other residential facilities, rehabilitation centres with social services centres, and hospital centres with other hospital centres.

This last type of merger has resulted in the creation of university hospital centres that offer highly specialized services and perform teaching and research functions as well. However, the initial assessments of these combinations and mergers indicate that they have not met expectations, neither in terms of economizing on resources nor in terms of providing continuity of service to the public.[27] In the view of David Levine, a well known administrator in the health care system, "[translation] *The mistake is that the mergers were carried out during a period of belt-tightening, because of financial constraints, without any funds being set aside to make the necessary investments in the transition*" (Bégin, 1999c).

These numerous organizational upheavals have also complicated implementation of the various protocols for referrals and follow-up among institutions, especially when patients are discharged from hospital early because of the shift toward ambulatory care. The quality and continuity of patient services have deteriorated. Communications between institutions are delayed, information on required treatment goes missing, home-support services fail to take over as soon as they should. Often it is the patients' relatives — mainly women — who have to make up for the shortcomings in the public system and sometimes even take charge of co-ordinating the services that patients need. Recently, some steps have been taken to try to solve these problems of integrated management and co-ordination of services. For example, an experimental program is now under way to provide integrated services to frail seniors and a single entry point for home-support services has been introduced. However, there are still many discontinuities, especially in medical services, and the growing number of private service providers in the system may only aggravate these problems.

- Private Health Care Providers

The changes in the network of public institutions have created opportunities for private health care services to begin operations or expand them into new areas. For-profit private corporations are setting themselves up in competition with public institutions in areas where the public system can no longer meet the demand, such as long-term residential facilities, convalescence and rehabilitation centres, private physiotherapy and radiology clinics, and medical clinics providing state-of-the-art diagnostic services.

Private firms specialized in home care and home-support products and services (such as nursing services, remote diagnostic and monitoring equipment, and technical aids) are growing rapidly. One example is the Medisys Health Group, which has 450 permanent staff and employs nearly 2,000 contract workers, mainly nurses. Another is the US multinational Olsten Corporation, whose executive director of health services recently spoke at a conference sponsored by the Quebec Hospital Association [Association des hôpitaux du Québec], on the subject of “a new model for introducing home health care services in Canada” (Poirier et al., 1998).

In another example of private-sector growth, the number of unlicensed private residences for seniors in Quebec rose by 500% from 1989 to 1996. A study by the Université de Sherbrooke’s geriatrics institute research centre showed that 32% of the managers of these institutions have no specialized training and 59% have no past experience in working with the elderly. The proportion of residents receiving inadequate care was found to be highest — over 20% — in licensed and unlicensed small residences (with 9 or fewer beds) and unlicensed medium-sized residences (with 10 to 39 beds) (Bravo et al., 1999). These residences are not closely supervised by the regional boards[28] and CLSCs, who, with their limited resources, must give priority to monitoring the care provided to seniors who are living alone.

Various private firms have also made proposals to take advantage of new developments in medical technology[29] or of facilities that are being underutilized because of public-funding cuts. For example, the Quebec Department for Development of the Greater Montreal Area [Ministère du Développement de la métropole] and the City of Montreal have established a health committee that includes the directors of the Montreal-Centre regional health and social services board, several Montreal hospitals, and a good number of private firms, such as Merck-Frosst, Hoechts-Marion-Roussel, Medisys, and Bell Canada. A report issued by this committee in August 1997 contains a number of proposals for moving in its recommended direction, including "[translation] *arranging technology transfers among university, hospital, government and industry research centres*", "*facilitating export of Quebec medical expertise — for example, through telemedicine*", and "*developing the market of foreign clients for Quebec medical services, where the system has excess capacity*" (quoted in Poirier et al., 1998: 83). This partnership with the health care industry is encouraged in the latest three-year plan of the Montreal-Centre regional health and social services board, which wants to strengthen this industry's position as one of the economic pillars of the Montreal region (RRSSSM-C, 1998: 105 ss.).

More recently, this strategy has received further impetus from the report of a task force commissioned by the former Quebec health minister Jean Rochon to examine the complementarity of the private sector in pursuing the fundamental objectives of the public health care system in Quebec. The Arpin Report, as it is known, proposes letting hospitals negotiate partnership agreements under which "affiliated" private clinics could provide some services that do not require hospitalization. Under these agreements, the clinics would be compensated by the Quebec health insurance plan, and compensation would include the costs of the specialized equipment that the clinics use. The wisdom of this approach is questionable, given that hospitals are currently being forced to curtail the use of their own equipment, for lack of funding. As Daniel Adam, one of the directors of the Québec Hospital Association, puts it: "[translation] *We already have the necessary infrastructure in the public system. Why not make better use of it before we go seeking help from the private sector?. . . There is no evidence that private clinics can really offer the proposed services at lower cost or more effectively*" (Bégin, J.F. 1999c).

The prevailing discourse gives more and more prominence to private-sector delivery of health care and social services in Quebec, with the risk of whittling down public institutions until they are left with responsibility only for the patients who require the most resources to care for. But many analysts say there is no proof that introducing a parallel, private system will ensure better cost controls or better access and greater equity for patients[30] (National Forum on Health, 1997; Armstrong, 1996; Arweiler et al., 1995; Rheault, 1994; Contandriopoulos, 1991, 1989; Soderstrom, 1987).

- Community Organizations

The reorganization of the public system has also affected the network of community organizations active in the health and social services field. Many of these groups were established in the 1970s to respond to emerging needs or to implement new practices in areas where the public network was not taking action. Examples of such organizations include women's health centres, shelters for battered women, alternative mental health facilities, drug-addiction treatment centres, and programs that work with the homeless. Some of these organizations have even inspired new initiatives in the public system — for example, community health clinics and health centres served as the original models for the government-run CLSCs.

After exerting much pressure, these community health and social services organizations gained some official recognition in the 1991 *Act respecting health services and social services*. Some of them received substantial funding increases and formed new partnerships with the public system. The budget for community organizations rose from $86 million in 1989-90 to $171 million in 1997-98.[31] But according to representatives of these groups, "[translation] *Not all community agencies have received funding increases. In fact, most new funding is being channelled to organizations that are useful to the government, in sectors that enable the government to achieve its own priorities. Thus, in the field of health and social services, the community agencies that receive the most funding are those that 'participate' in the shift to ambulatory care (for example, by providing assistance in the home or running support groups for psychiatric patients) or that accept government contracts (for example, to run half-way houses)*" (Greason, 1999).

According to the Montreal-Centre regional health and social services board, the number of people who made use of Montreal community agencies more than doubled from 1995 to 1997.[32] The Intersectoral Coalition of Montreal Community Organizations [Regroupement Intersectoriel des Organismes Communautaires de Montréal : RIOCM] notes that the increase in demand often exceeds the additional funding provided to cope with it. Also, the problems of the people who seek help from community agencies are becoming more and more complex. In these organizations, which consist mostly of women, staff working conditions are deteriorating, and volunteers are assuming more and more responsibilities for a population that is more and more distressed. As one woman who works in a centre for victims of sexual violence reports: "*We ask them to do follow-up, work that was not done by volunteers before. It requires co-ordination, training, supervision. . . . It takes a year to set up a team of volunteers. It's the only way we've come up with, because we can't do everything any more*" (RIOCM, 1998:139). Some agencies thus feel that they are becoming a catch basin for the overflow that the public system can no longer absorb.

Under these circumstances, relations between community organizations and government institutions have produced many tensions. According to the RIOCM (1998:83), "*[Such relations,] when they exist, are more often than not hierarchical, even if words like 'partnership', 'concerted action', and 'dialogue' are promoted.*" A number of community groups thus perceive official recognition as a two-edged sword: "[translation] *Today, more lip-service is being paid to the value of community-based agencies, but what the government mainly wants to do is offload its former obligations onto private organizations that will provide the services for free. This amounts to contracting out . . . In the current context, unfortunately, community agencies are being recognized not for the alternatives they provide, but for their ability to compensate for gaps in the public system*" (Doré, 1991: 4).

While some community organizations have thus been negatively affected by the offloading of demand from the overburdened public system, others have initiated "social economy enterprise" projects designed to achieve two goals at once. These projects are intended both to create jobs that will help people re-enter the work force, and to provide services to meet unmet needs that have recently emerged as the result of deinstitutionalization and the shift to ambulatory care. These projects have also introduced fees for services that the CLSCs can no longer provide.[33]

In their 1995 march against poverty, the Quebec women's movement demanded public investment not simply to produce government goods and services but rather to produce "social infrastructure" — goods and services that are socially useful. Social economy enterprises that provide home-support services are one way that this idea has been put into practice. But some authors say that these enterprises end up shifting women from well-paid jobs in the public sector to insecure jobs in the "social economy". Opinion in the women's movement therefore remains divided about "social economy" entreprises.

Some authors (Vaillancourt, 1997; Vaillancourt et al., 1993) use the term "*communautarisation*" ["communitization"] to make a distinction between the shifting of services to community organizations and the commercialization of services by for-profit businesses. These authors think that the social economy strategy should be encouraged, not only to keep the private, for-profit sector from taking over all of the services formerly provided by the State, but also to motivate the public sector to innovate. But other authors think that Quebec is now witnessing the "institutionalization of the community sector" (Dumais, 1999:182). The government is imposing more and more controls on this sector, through its new Secretariat for Community Action [Secrétariat à l'action communautaire]. Regional social economy committees are being established, and social economy enterprises that provide home services are being included in the transformation plans of certain regional health and social services boards. These developments have triggered debates in the community sector, regarding its role in the rationing of public services and the transferring of certain responsibilities to for-profit and non-profit private organizations.

In conclusion, the transfer of responsibilities for health and social services to private organizations is not simply the result of changes in service-delivery methods. It also reflects the ascendancy of an economic logic that emphasizes efficiency and performance in the management of the health and social services system.

3.2. Reform in Management of the Health and Social Service System

In response to budget cutbacks, various strategies have been applied to reduce the costs of services in public institutions. Efficiency has become the watchword in managing the health and social services system today. Some directors of public institutions hope to improve their management methods by adopting practices developed in the private sector. The influence of the US health care system, dominated by large private corporations focussed on competition and profit, is being felt. In an analysis of the Canadian situation, Chin-Yee (1997:59) writes: "*This corporate culture has infiltrated the publicly funded organizations so that they too are trying to restructure by cost containment and rationing.*" This corporate culture is also seen in the increased use of private consulting firms and is leading to closer and closer ties with various private businesses.

In the administration of health care institutions, management performance has often become a more important criterion than service quality and health outcomes. Beds are often eliminated for budgetary reasons. Budget and staffing cutbacks are making waiting lists for treatment longer, causing patients to turn to the private sector to obtain certain services more rapidly. Sometimes, public institutions redirect their own patients to private services. For example, to cope with the excess demand for post-hospital home nursing services, some CLSCs have encouraged patients with private insurance to obtain their care through private agencies.[34] Other CLSCs purchase services, at lower cost, from private agencies or social economy enterprises that offer their mainly female workers less advantageous working conditions than the public sector. In February 1999, when the crowding of Quebec hospital emergency rooms reached crisis proportions, the private nursing agencies said they were so overwhelmed that they had trouble in meeting requests from hospital centres and CLSCs to handle their overflow of patients requiring post-hospitalization home care (Desjardins, 1999:A-3).

Because nearly 80% of all public health care expenditures goes to pay wages and salaries for all categories of staff,[35] spending reductions in this sector have been achieved by slashing payrolls drastically. The measures used to achieve these payroll cutbacks have included increased use of on-call labour, a wide-scale early-retirement program, and mass transfers of staff in connection with restructuring of the network.

Women, who in 1991 accounted for 74.7% of all workers in the health and social services system, have been hit hard by these measures. With the shift toward ambulatory care, the number of patients in the acute treatment phase is increasing, placing growing pressure on a smaller, less experienced staff. The substantially heavier workload and other adjustment problems associated with these measures are realities that some managers in the public system openly acknowledge.[36]

Hospital support services have also been targeted in the effort to reduce costs. In a 1996 document, the Quebec Department of Health and Social Services wrote: "[translation] *The regional boards and the Department have agreed to channel as high as possible a proportion of financial investments into direct services to clients, thus containing and reducing the size of expenditures for support services. Some savings can be achieved in this area, especially as regards production costs and expenditures*" (MSSS, 1996: 24). A consultation paper prepared by the Montreal-Centre regional health and social services board targeted cleaning, laundry, facilities maintenance, and general administration as support services on which a 10% spending reduction could be achieved. This same regional board has announced plans to have a private management firm analyse its situation and make recommendations for improving its return on investment (Régie régionale de Montréal-Centre,1997:145).

Hospital officials seem to give little attention to monitoring and maintaining the quality of the nutrition and sanitary services that contribute to their patients' quality of life and help them to get better. Subcontracting to the private sector is being considered as a way of reducing the costs of producing services, as if this were a sector independent of public health care services. In one region, for instance, public health care institutions purchase laundry services from private and prison laundries, through a regional laundry service that acts as a broker. But studies have shown that buying from the private sector does not always guarantee lower costs. The Chair of Socio-Economic Studies at the Université du Québec à Montréal has compared 5 privatized food services with 23 comparably sized food services managed by public institutions. Its study showed that the cost of a meal served by a privatized food service was 10.5% higher than the cost of the same meal served by a government-run service (Poirier et al., 1998). The Quebec hospital association, in its January 1998 report, also stressed certain dangers of privatization, stating that "[translation] *a comparative analysis of health care systems indicates that the more developed the private sector, the harder it becomes to control costs and quality."* (AHQ,1998).

Directors of public institutions are also looking for ways to form partnerships with the private sector to increase their revenues. For example, some hospitals that no longer have sufficient budgets to run their equipment and their staff at full capacity have proposed obtaining additional private funding by offering specialized treatments to American clients who can afford to pay for it.[37] Other institutions have achieved notable revenue increases by charging for "ancillary" services (making residents in long-term facilities pay part of their housing costs, charging hospital patients extra for private rooms, charging for ambulance services, raising parking fees, and so on). According to the Quebec Department of Health and Social Services, "[translation] *The revenues generated from billable services totalled close to $1 billion in 1994-1995, or the equivalent of 7.5% of government spending in this sector"* (MSSS, 1996: 35).

The Arpin Report has proposed “[translation] *leveraging the available public funds by . . . [using various methods] to take advantage of private funding sources. [These methods include] optimizing fees revenues for certain services while still respecting the principles of accessibility and equity; supporting and encouraging voluntary funding [from private foundations]; and generating revenues from excess equipment capacity by laying the groundwork for new kinds of partnerships.”*[38] The Arpin Report does advise “[translation] *not to create conditions favourable to the sale of medical and hospital services to foreign residents.”* But it also suggests *“encouraging the purchase of accommodation in private residential facilities, through calls for tenders, when this is more economical”* (Groupe de travail sur la complémentarité, 1999: III-IV).

Questions also arise about resource-allocation methods. Various authors (Contandriopoulos, 1987, 1989, 1991; Rheault, 1995) have reported on the ways that methods of obtaining funding and paying for resources affect equal access to services, equity in health care treatment, efficiency, and control of public costs and total costs of health and social services.[39]

Some proposals have been made to stimulate “internal competition” among public institutions in order to contain cost increases for health and social services, even as the need to increase the complementarity and continuity of these services is being felt more and more. Based on the observation that funding and payment methods do not provide health care institutions or professionals with any incentive to assume responsibility for specific populations, some authors have proposed a 180-degree turn in resource-allocation methods. Jérôme-Forget and Forget (1998: 13) write: “[translation] *At present, our hospitals receive global budgets, and our doctors are paid on a fee-for-service basis. Instead, we propose a capitation payment method, in which doctors receive a budget based on the number of patients who are signed up with them, and the hospitals obtain their funding from the flat fees that doctors pay them for their services.”* This proposal is inspired by the experience with HMOs in the United States and with “GP fundholders” in the United Kingdom.[40] It raises some complex issues for the future of the public health and social services system. This proposal cannot make services more accessible as long as management of the system remains focussed on the production of services by categories of institutions, rather than on service-usage patterns and continuity among the various providers. Both the capitation model and the GP fundholders model of resource allocation need to be analysed in depth to determine their effects on public health, because they pose the risk of selecting clients who have higher incomes and better health, while screening out sicker clients with fewer resources, a majority of whom are women.

In reviewing methods of managing the health care system, we must ask a number of questions. How much should the public system systematically rely on the private sector? Can management methods developed by private enterprise actually benefit the health care system, where the relationship between users and providers is so radically different from that between consumers and suppliers in market transactions? Before we blindly transpose private-sector management methods into so sensitive a setting as health care, we must systematically evaluate their impact on accessibility and quality of health care services. Such caution does not mean that the health and social services system should not make any changes in the way it does things. For example, some initiatives have been taken recently to revitalize human-resources management in Quebec's health care system by encouraging interdisciplinary co-operation and the creation of service networks.[41] These initiatives are centered on responsibility for service quality and continuity, which are the heart of the mission of the public health and social services system.

3.3. Changes in Public and Private Funding of the Health Care System

In Canada, the public health care system is administered by the provinces. It insures "medically necessary" medical and hospital care[42] and is funded mainly through tax system (income tax, sales tax, contributions paid by employers and employees into the provincial health-insurance plan, and transfer payments from the federal government). Officially, this system does not involve any direct user fees for medical and hospital services, to which free, universal access is mandated by law. However, certain fees may be applied even in public institutions, such as additional charges for private rooms in hospitals, or for the accommodation component of stays in long-term care facilities. Also, “complementary” items such as laboratory tests, X-rays, prescription drugs, and services of professionals such as dentists, optometrists, and physiotherapists are not covered by the public plan if they are provided outside of hospital settings. These goods and services can, however, be covered by private insurance.[43] Canada’s health care system is thus funded from a combination of public and private sources. The recent shift in the relative proportions of public and private funding signals a trend toward the privatization of the health and social services system.

The Quebec government’s budget for health and social services has fallen from $13.17 billion in 1994-95 to $12.61 billion in 1997-98.[44] This means that public spending per person per year on these services fell from $1,692 to $1,608 over this period. This is lower than in any of the other provinces, and represents a significant deviation (-11.7%) from the Canadian mean, which was estimated at $1,821 per capita for 1997-98.[45] The proportion of public funding in the Quebec system fell from 81.5% in 1980 to 69.1% in 1998. Quebec can thus «boast» the sorry record of having gone from being the Canadian province with the highest percentage of public funding in 1980 to being one of the two provinces with the lowest percentages in 1998.[46] It should be pointed out that the federal contribution to the funding of total health care expenditures in Quebec also fell, from 42% in 1986 to 30.4% in 1997, thus coming approximately even with the proportion of funding from private sources (30.9%).

Since the mid-1980s, the percentage of private spending has risen continuously, though this growth did slow somewhat with the economic downturn of the early 1990s.[47] Private health care spending as a proportion of total health care spending has increased significantly, from 25% in 1989 to 30.9% in 1998.[48] The majority of private funding — 55% — comes from direct outlays by individuals, and only 35% from private insurance (Métivier, 1999).

The Quebec Health and Welfare Council [Conseil de la santé et du bien-être :CSBE] attributes this increase in private spending to four major factors: the growth in spending on items not covered by the public system, the delisting of services previously covered by the public system, the emergence of new kinds of services that are not well supported by the public system, and government-imposed increases in user contributions (CSBE, 1997). The Arpin Report, however, states that not all of the growth in private expenditures can be regarded as a substitution effect of the reduction in public funding.[49]

Indeed, the increase in private spending has come in areas not covered by the *Canada Health Act*, such as consultation of professionals other than medical doctors,[50] purchases of prescription drugs, and care at non-hospital institutions. For 1994, the proportion of private spending was especially high for services by professionals other than medical doctors (89.3%) and for prescription drugs (68.7%). There has also been a rise in direct outlays by individuals for services and expenses associated with participation in private insurance plans. This funding trend raises the fear that ability to pay may become a factor that limits access to certain essential services, particularly for women, who see health care professionals more than men do and whose average personal income is only 58% that of men.

Since the early 1990s, certain cost transfers have also been achieved through active "delisting" measures, such as limiting the services covered by Quebec's public health insurance plan or excluding certain categories of clients who were previously covered for dentists' or optometrists' services under this plan. With the delisting of therapeutic dental services for children beyond age 10 in 1992, the number of eligible children fell from 1.5 million to 1 million in a single year; with a single stroke, half a million children lost their benefits under the plan. The decrease in the total number of children's dental treatments paid for by the Quebec health insurance plan is even more striking. From 1981 to 1996, it fell from 9.6 million to 1.6 million, a drop of about 83%. The trend for optometry services has been similar. In 1992, people aged 18 to 40 stopped being covered for such services. In 1993, people aged 41 to 64 were excluded as well. The number of insured treatments fell by 57% from 1991 to 1996 (Poirier et al., 1998).

As the government has withdrawn from these areas, private insurance companies have taken over, offering supplementary coverage to people who qualify for group insurance plans. The result has been an increase in costs. A brochure from one of these companies, SSQ-Vie, states that since 1992, dental insurance premiums have risen by 10%. Private insurers also offer to defray the costs of using private services to bridge the gaps and avoid the waiting lists encountered in the public sector. SSQ-Vie also reports that total reimbursements for visits to private physiotherapy clinics rose from about $1 million in 1990 to over $4 million in 1996. The private insurance sector is growing rapidly. For example, in 1987, health insurance premiums represented only 13.6% of the total premiums collected by the Sun Life Assurance Company. By 1996, they represented 19.8% — a 45.6% increase over the figure one decade ago (Poirier et al., 1998).

The involvement of new payers such as private insurance companies increases administrative costs. The Quebec Health and Welfare Council [Conseil de la santé et du bien-être]estimates that in the United States, administration may account for as much as 25% of total costs, compared with 8 to 10% in a public system (CSBE, 1997).[51]

Another phenomenon has been a kind of passive delisting of health and social services. For example, the Quebec government's budget for 1999-2000 introduced a new refundable tax credit for persons age 70 and over who are no longer wholly self-sufficient but wish to continue living at home. This tax credit allows seniors to claim 23% of the eligible expenses they incur for the home-support services they need. The ceiling on eligible expenses is $12,000 per year. Any difference has to be made up entirely by the seniors themselves. Eligible expenses are for home-support services such as meal preparation, supervision and support, and assistance in daily activities, such as eating, dressing, and personal hygiene. These are the kinds of services that are normally provided for free by family and social assistants from the CLSCs. But in this case these services may be provided by private agencies, or by social economy enterprises, or by independent workers, typically women, who are paid with “service employment pay cheques” and act in a sense as subcontractors of the CLSCs. The Quebec Council for the Status of Women rightly criticizes these arrangements as representing a drift toward privatization of home services (CSF, 1999:104).

Another part of this passive delisting trend is that as more and more treatments are provided at home after patients are discharged from hospital, part of the costs of drugs and medical supplies that hospitals used to provide for free must now be borne by patients and their families. And because these “ambulatory” patients may have to visit their doctors frequently, they incur additional expenses for transportation and for people to accompany them. Those who are fortunate enough to have private medical insurance may be offered new kinds of coverage for the costs that they incur while convalescing at home. Thus people with private insurance have different access to treatment and services compared with people who depend solely on services that are provided free by the public system or that are covered by the Quebec health insurance plan. A substantial portion of the people who cannot afford private insurance are low-income women and women in casual employment.

- The Quebec Drug Insurance Plan

The Quebec government introduced a public drug insurance plan in 1997.[52] It did so with several objectives: to provide drug coverage for more than 1.2 million people not insured by private plans; to use various funding mechanisms (including premiums, deductibles, and co-insurance) so that the government itself would not have to make any outlays; and to preserve the private sector’s predominance in the insurance industry (St-Pierre, 1999:74). Another objective that we might cite would be the desire to maintain the advantages that drug companies enjoy in Quebec, such as ten-year patent protection for their new products. Also, the government yielded to pressure from these companies by not requiring drug insurance reimbursements to be limited to the cost of equivalent generic drugs.[53]

The Quebec Drug Insurance Plan, which is administered by Quebec's provincial health insurance board (the RAMQ) is available only to people who do not already have access to private group insurance either directly or through their spouse.[54] The public drug insurance plan is thus complementary to the coverage provided by private insurers. This is a far cry from how Quebec's provincial medical insurance works. Though the Quebec Drug Insurance Plan does represent an improvement for people who would otherwise have no drug insurance coverage, it still leaves a large part of all such coverage in the hands of private companies. It also includes deductibles and co-insurance requirements that make insured persons pay part of the costs themselves when they purchase their drugs. The plan has also put an end to full drug coverage for the poorest members of society, which again means mostly women. "[translation] *Whereas welfare recipients had previously received prescription drugs for free, the new plan saw this group now contribute an annual total of $90 million to the province's drug bill. Seniors, who had hitherto paid $42 million, saw their total contributions rise to $275 million . . . Meanwhile, the government's share of the burden plummeted from $922 million to its current level of about $551 million*" (St-Pierre, 1999:71).[55]

Between fiscal years 1997-98 and 1998-99, spending by the public drug insurance plan rose by $156 million, or 15% of the total cost of the plan, which exceeds $1 billion. This increase can be attributed to two causes: more people than expected have joined the plan, and the cost of prescription drugs has risen steadily. The plan's projected deficit for 1999 is $210 million. To deal with it, Quebec Health and Social Services Minister Pauline Marois is considering options that could raise the premiums, deductibles, or co-insurance paid by the insured, thus further reducing the most disadvantaged Quebecers' access to medication.[56]

As some analysts have pointed out, "[translation] *The funding mechanism for Quebec's public drug insurance plan is the least redistributive of Quebec's three major health-related public insurance plans, because unlike its public hospital and medical insurance plans, it is not financed through personal income tax"* (Reinharz et al., 1999:163). Thus, even though drugs play an ever-growing role in medical treatment, the law does not regard them as "medically necessary" services and hence excludes them from the basket of services that are fully covered by public funds, even when they are prescribed by doctors. In other words, medications are being treated simply as consumer goods that are marketed by major pharmaceutical companies.

Recently, Ms. Marois announced a public debate on health care funding issues: "[translation] *What is the extent of the services that the State should continue to fund? What level of taxation are we ready to accept to fund them? Should we finance health care from a separate public account, or from the general accounts?"* (Lévesque, 21/1/2000: A-10). At the same time, a survey revealed that Quebecers favour seeking solutions within the public system: "[translation] *84.9% believe that the government should make an effort to improve the services offered by the CLSCs; . . .89.3% think that more hospital beds should be opened"* (O'Neil, 24/1/2000: A-1). Although the pressures to make more room for the private sector are strong on the policy level.[57]

Women make a broad contribution to health and social services and are paying the price of reform by accepting poorer conditions for their paid work and doing more unpaid work both for their families and for charitable organizations. Hence women have a direct interest in this debate.

3. 4. Reform and Governance of the Health Care System

The future form of governance[58] of the health and social services system raises some fundamental questions about the evolving relationship between the public and private sector. How can the government maintain the great achievements of our health care system in a context of privatization and deregulation? Is it possible to continue to regulate this system centrally while disengaging from it financially? This latter question refers more specifically to the role of the federal government: "[translation] *For the federal government to oblige the provinces to abide by standards that it defines is starting to mean going beyond the federal power to spend money and creating a federal power to make the provinces spend money"* (Duperré, 1987, quoted by Maioni, 1999:69). Maioni also feels that the decentralization of the health care system is part of a broader debate about the role of the State in society and in the economy. Other authors believe that: "[translation] *a reform that combines central administrative regulation by the State with a withdrawal of the State from funding may prove to be only a temporary compromise, because the withdrawal of funding saps the very legitimacy of central government regulation"* (Bergeron and Gagnon, 1994:27).

The reform of Quebec's health and social services system has in fact been accompanied by a process of decentralization. The Quebec government has decided to give more power to the regional health and social services boards. It has given them a mandate to consult the population of the regions they serve on the way that services should be organized in these regions, and to develop co-operative efforts among the various players in the health and social services system. It is through these regional boards that health and social services institutions receive close to three-quarters of the public health care budget each year. Many reasons for pursuing decentralization have been cited: political reasons, such as ensuring more citizen control; economic arguments, presenting regionalization as a way to meet public needs more efficiently and effectively; and administrative reasons, such as better integration and co-ordination of services (Turgeon and Lemieux, 1999:181-182).

But in practice, the decentralization achieved by creating the regional boards has been primarily administrative. These boards are chiefly responsible for implementing decisions of the provincial Department of Health and Social Services and serving as its go-between with the various players in the health and social services system. This does not really represent a decentralization of power from the province to the regions, because the boards operate within tight parameters established by Quebec

Department of Health and Social Services. One indication that the real authority still rests with the Department was the abolition in 1996 of annual assemblies where representatives of the health care system, community organizations, and other stakeholders (municipalities, school boards, etc.) in each region used to receive a report on the regional board's activities. Abolishing these annual assemblies has reduced the accountability of the regional boards and removed one forum for public debate about the way the system is managed.

Health care reform has accentuated this trend toward reduced participation in the various settings where it might have taken place within the health and social services system. As Mireille Tremblay states: "[translation] *The way that health care services have evolved in recent years, with budget cuts, institutional mergers, and the shift toward ambulatory care, has put significant pressure on the kinds of deliberations and debates that can be held within the various parts of the system. At no time could these economic imperatives be questioned by the individual institutions or the regional boards; their job was to execute the Department's orders. Anyone who spoke up in opposition was quickly reminded of their obligations and the limits of the arena in which they could negotiate the collective contract"* (Tremblay, 1999:123).

The absence of any real room for decision-making may go a long way toward explaining why so few citizens vote in the elections to health care boards and why some members of boards of directors in different health institutions are so disillusioned. In the fall 1996 elections, scarcely 2.5% of the people eligible to vote bothered to do so. Citizens do not feel that they exercise any real power when they sit on a board of directors. For example, according to the chairman of the board of directors of the Saint-Laurent CLSC-CHSLD [local community service centre/residential and long-term care centre] in Montreal: "[translation] *Getting elected is one thing, but then there's the question of real power. The real power lies more with the regional boards, the Department, and the civil servants."* According to him, the volunteers who sit on boards are literally "stifled" by the laws, regulations, and directives coming down from higher levels of the health care system (quoted in Bégin, 1999b: A-6). As we shall see later in this report, this sense of disappointment has also been expressed by the representatives of women's groups who are involved in bodies such as the regional boards and who say how hard it is to get the health and social services bureaucracy to address women's concerns (see l'R des centres de femmes, 1997). This raises the question, what should the logical organizing principle be for the governance of the health care system?[59]

The original rationale offered for reforming the health and social services system was to "place citizens at the heart of the system", in their roles as users, payers, and decision-makers.[60] This might have implied a democratic approach to governance, whereby the public participated in defining needs and solutions for the health care system, as well as in administering it. But such an approach never really had a chance to become established, in the face of a technocratic logic that bases decision-making on a rationale planning process. "[Translation] *After having analysed the form that participation in public administration or in the administration of the health and social services sector now takes, many Quebec researchers have concluded that this kind of participation strengthens the technocracy while weakening democracy, political institutions, and the power of citizens*" (Tremblay, 1999:79).[61]

Some analysts believe that under the currently prevailing model of central regulation with administrative decentralization, the government's withdrawal from health care funding will inevitably result in a gradual transfer of health spending from the public to the private sector (Bélanger, 1994; Bergeron and Gagnon, 1994; Contandriopoulos, 1987). According to Raisa Deber, "*Governments are . . . in a conflict of interest situation. As guardians of the public interest, they should ensure that necessary goods are financed in the most economically efficient manner, which would often imply public financing. But as payers, they also have strong incentives to shift costs out of their budgets, even if overall costs to the economy would rise*" (Deber, 1999:64). Given the State's ongoing financial disengagement and the system's current dysfunctions, weakening the mechanisms for public consultations and public participation in decision-making encourages the assertion of an economic logic that focuses on efficiency and promotes deregulation to facilitate the "free play of supply and demand" within a framework of "internal competition", thus reinforcing the process of privatization.

The current rules for governing the health and social services system, for using its resources, for organizing it, and for ensuring the quality of its services give scant importance to analysing the differential effects of health care reform on women and men. The following examples will show why such an analysis is relevant.

When midwives were seeking recognition as a profession, they encountered a great deal of resistance from physicians, who wanted to maintain their control over the professional standards governing this area of practice, even though many women were expressing the desire to "demedicalize" their labour and delivery and have access to the services of midwives in a safe setting. After numerous experiments and assessments, midwives have still attained only limited recognition and are still supervised by the medical profession. In this case, instead of furthering the cause of high-quality patient care, professional logic was applied to defend corporate interests and to keep a particular area of practice as the sole preserve of one profession.

An analysis of the differences between men and women also seems to be lacking in the way the technocracy does its planning. One good example is the planning done to ensure a better distribution of medical staff in outlying regions and in high-priority settings such as emergency rooms, CLSCs and residential and long-term care facilities.[62] Though modifying the way that doctors are paid might be one way to achieve this goal, it will be only partially successful if planners fail to consider how the feminization of the medical profession is altering models of practice.

The narrow economic logic underlying current health care reform obscures the price that women are paying for them. This logic camouflages the transfer of responsibilities to women who take care of their family members without pay, and the setbacks for women who work in the health care sector, where they are in the majority and formerly enjoyed adequate working conditions.

4. THE CONSEQUENCES OF HEALTH CARE REFORM FOR WOMEN IN QUEBEC

The current reform of Quebec's health and social services system are being carried out with no real consideration for the differing roles played by men and women within the family. In Western countries over the past thirty years, the realities of family life have undergone significant changes. Fertility rates have fallen. Families have become more diverse and now include single-parent families, "blended" families, homosexual couples, and immigrant families with different cultural norms. Life expectancy has increased, and relations between the generations have changed. Emotional ties with family members remain a significant factor in individual well-being, and society still values the support that family members give each other. But the interactions among family members are increasingly subject to negotiation and no longer have the same meaning that they did in past generations. The family network is becoming smaller, and women — more and more of whom work outside the home — must cope with multiple tasks, sometimes having to take care of their children and their aging parents at the same time.[63] These changes affect families' ability and willingness to care for relatives who are sick or who can no longer take care of themselves. Meanwhile, the Quebec government is currently developing conflicting policies in this regard — instituting a $5 per day day-care system to help parents with pre-school-age children while at the same time thrusting back onto families much of the responsibility of caring for their aging members.

The reform is also having repercussions that may affect women in each of their roles as health care workers, health care users, family caregivers, and participants in community organizations. For example, because of budget cutbacks, the size of the work force in Quebec's public health and social services system has been reduced. In July 1997, 17,678 unionized workers and 1,051 managers took advantage of the government's early-retirement program. According to Quebec's Commission for Administering Public Sector Retirement and Insurance Plans (Commission administrative des régimes de retraite et d'assurance du secteur public : CARRA), these retirements represent a 10% decline in the size of the total work force (Bégin, 1998b). These staff reductions have consequences on the organization of responsibilities within the health care institutions, and hence for the women who work in the public system. They include growing workloads, increased stress, and the need to adapt to new service-delivery methods. All of this affects the quality of care and hence affects women as users of health care services. Women are also affected when they are increasingly called upon to compensate for the system's deficiencies by providing care in their own homes or by working in community organizations.

All of these effects are linked to the process of privatization described in the preceding sections of this report. The literature consulted reveals a certain consensus that the shift toward ambulatory care would not have the same effects on women if sufficient resources were made available in their communities to provide pre- and post-hospital care and if the drugs and equipment that patients needed in their homes after being discharged from hospital were provided systematically and free of charge (AFÉAS et al., 1998; Coalition féministe pour une transformation du système de santé et des services sociaux, 1998; RIOCM, 1998).

Some consequences of health care reform affect both women and men, while others are specific to or more pronounced among women. Other consequences differ according to women's living conditions and personal traits. For example, problems of accessibility of health and social services are more pronounced or even different in nature for women who live in remote regions, where doctors are scarce and costs of travel for treatment are higher. The deteriorating quality of health care has an especially strong impact on elderly and handicapped women who live at home or in residential centres. Ethnic and cultural diversity also must be considered in analysing the effects of health care reform in terms of accessibility and suitability of services and differing dynamics surrounding the care of family members.

Thus the experience of women as health care users, health care workers, family caregivers, and participants in community organizations highlights the need for systematic study and research on the issue of price of health and social services reform for women.

4.1. The Consequences of Reform for Women as Users of Health Services

Women are the primary users of Quebec's health care system. As Guyon (1996: 67) states, "[translation] *The Quebec health insurance plan's statistics on hospitalization and medical consultations reveal a greater general use of health care services among women aged 15 to 64."* It is therefore reasonable to assume that these women are more affected by the consequences of reform, including poorer service quality, longer waiting times, delisting of certain formerly insured services, and the downloading of costs, as well as a certain confusion caused by mergers among health care institutions and changes in their missions.

The deterioration in the quality of health care is especially apparent in hospital emergency rooms, according to the Quebec College of Physicians [Collège des médecins du Québec] itself: "[translation] *The staff exhaustion and long delays caused by chronic overcrowding in emergency rooms are affecting the quality of care . . . Too many patients spend too much time lying on stretchers in packed hallways while waiting for the overworked doctors and nurses to have the time to give them care or treatment, or simply to deal with them at all"* (Collège des médecins, 1999:1). The College even talks about the emergence of an "emergency-room syndrome" in which patients need treatment but refuse to go to hospital because of past experiences which were negative in emergency rooms.

The cuts in nursing staff are also affecting hospital patients' health. According to Valerie Shannon, Director of Nursing at the McGill University Health Centre, "[translation] *Studies confirm that the results of medical interventions are affected by the number of nurses and their skills. These two* *important variables are closely correlated with patient mortality. . . Other studies show that patients treated in short-staffed units experience more complications (such as bed sores and urinary infections) than comparable patients treated in 'adequately' staffed units"* (Shannon, 1999).

Though the biomedical model has always predominated, the workload of health care professionals today means that they have less time or interest in trying more global approaches that might be better suited to the realities of women's lives. For example, in units that serve mental patients and the elderly within the public system, the medicalization of problems is often the only treatment approach offered.[64] At the end of a recent symposium on inequalities in health care, the Canadian Association on Gerontology noted that "[translation] *Females and elderly patients have much less chance than young men of receiving proven treatments for cardiovascular diseases, because doctors diagnose and treat these diseases less often in these two segments of the population . . . Unfortunately, 84% of hypertensive patients, or 3.4 million people, fail to get their blood pressure stabilized, and older women (age 65 to 74) account for 36% of all women who suffer from hypertension"* (La Presse, 30/5/99).

The shortage of resources also affects the quality of care received by seniors living in institutions, the great majority of whom are women. According to the Association des CLSC et des CHSLD du Québec [Quebec Association of Local Community Service Centres (CLSC) and Residential and Long-Term Care Centres (CHSLD)], only two-thirds of the resident's needs are being met by services.[65] The Fédération des infirmières et infirmiers du Québec (FIIQ; Quebec nurses' federation) and the Ordre des infirmières et infirmiers du Québec (OIIQ; Quebec order of nurses) report that in some residential and long-term care centres, there is no nurse on duty at night or in the evening, which increases the use of physical and chemical restraints and the incidence of falls and bed sores among residents. As these two nursing organizations also state, "[translation] *Nurses are in a position to observe the increase in complications that could have been avoided and that cause patients to come back to emergency rooms, or even to be readmitted to hospital"* (FIIQ and OIIQ, 1998: 2). A wide-ranging survey of over 2,000 nurses in various institutions in the Quebec City area revealed that many nurses think that physical care is being given at the expenses of other needs (Bourbonnais et al., 1998).

In hospitals, the pressure to free up beds is so intense that hospital stays are being cut short.[66] There do not seem to be any strictly applied professional standards for determining when a patient is "cured": "[translation]: *Only a minimal, approximate assessment of the patient's physical condition is done when the decision is being made whether to discharge them. Sometimes all it seems to cover is whether the patient can get up and walk, even though the patient may still be dizzy or in a generally weakened state*" (AFÉAS et al., 1998: 23). A survey conducted for the Quebec City regional health and social services board found that "[translation] *Between 20% and 40% of respondents who had had inpatient surgery and 24% of respondents who had had outpatient surgery would have preferred to stay in hospital longer*" (Régie régionale de Québec, 1997: 29). The reduction in the length of hospital stays and early post-partum discharge from hospital[67] sometimes create hardships for new mothers, especially when they have little support at home. This is a source of increased anxiety, especially for young mothers and mothers living on modest incomes.

With the bed closures and staff shortages, the waiting lists to be seen and the waiting times for some required treatments are growing longer (Jérôme-Forget and Forget, 1998). To see a psychiatrist on an outpatient basis, patients can expect to wait several months (RIOCM, 1998). And one delay often leads to another. First one has to wait for an appointment with a general practitioner, then wait to be seen by the specialist to whom the GP refers you. After that, one may experience further delays while waiting for the tests and treatment that the specialist prescribes (Ramsay and Walker, 1998). In the breast-cancer prevention program, for example, screening examinations are provided for free in private X-ray clinics. But if further investigation proves necessary, a woman may wait about four months to get an ultrasound at a hospital, unless she wants to pay the fee to obtain this service in the private sector. She will then encounter further delays if she needs treatment, and then she could be referred to the United States.

Within Canada, Quebec seems to take the prize for longer waiting lists: "[translation] *In 1993, Quebec was the province where patients waited the least time to see a specialist — 2.9 weeks. As of 1997, Quebec patients were enduring waits of 5.4 weeks, or 2.5 weeks longer"* (Léger, 1998: A 5).[68] In many cases, the long delays increase patients' distress and anxiety and can even affect their health. *"In this regard there is no persuasive evidence that mortality rates in Canada are increasing significantly owing to a failure to provide medical services. If however, one regards the elimination of pain and suffering as the objective of medical care, then any additional pain suffered by patients because of delays is medical treatment denied"* (Ramsay and Walker, 1998: 5).

Another consequence of the longer waits is that more and more people are tempted to replace the public medical services that are not available to them with private services that they can access more rapidly outside of Canada (Ramsay and Walker, 1998). As the RIOCM, a coalition of Montreal community agencies relates, "[translation] *Examinations, health care, and social services that require long waits or are unavailable in the public system have become products that are promoted in the highly lucrative and growing health care market"* (RIOCM, 1998: 54). Access to abortion services in public institutions is limited and subject to long waits, which encourages women to go to private clinics where they must pay for these services themselves. What happens with the principles of free, universal, accessible health care that are supposed to be the foundation of the public system?

After discharge from hospital, continuity of care is not automatically ensured. The complaints commissioner of the Quebec Department of Health and Social Services reports a 15% increase in complaints in 1997-98 compared with the preceding year, and in particular an increase in complaints regarding accessibility and continuity of care. The commissioner also notes having received complaints concerning the operation of the health care system, citing problems such as ineffective, insufficient mechanisms for co-ordination between institutions; inconsistency in the criteria used to determine the scope of services to be provided by the public system; lack of information on procedures for accessing services; practices that violate the rules regarding consent to care; and problems in accessing rehabilitation services in outlying regions.[69]

Ground has also been lost in delivery of preventive programs. For example, some CLSCs now offer pre-natal courses and post-natal follow-up only to women who have a certain number of risk factors in their pregnancies (AFÉAS et al. 1998). However, some of the preventive programs that have received priority from the Department of Health and Social Services and various regional boards do deal with matters of concern to women, such as curbing domestic violence, reducing deaths from breast cancer, and improving infant health and welfare by working with mothers during pregnancy. This represents progress, but it remains fragile, because the resources allocated for these objectives are not always adequate, and the efforts at co-ordination with other sectors — particularly the community network — have had uneven success in the various regions of the province.

Another way that health care reform affects women as users of health care services is the downloading of costs from the public system to users, which takes various guises. With the shift toward ambulatory care and outpatient surgery, pre-operative and post-discharge nursing care must be provided in the home. The CLSCs are designated to provide this care, but their resources are clearly insufficient to meet the demand. "[translation] *In 1996-97, scarcely 8% of all patients who were hospitalized received help from a CLSC after they were discharged. Among seniors, only 53% of the clients assumed to require such services actually received them*" (Coalition féministe pour une transformation du système de santé et des services sociaux, 1998: 30). When a request for home care services is received at some CLSCs, they first check whether the person has private insurance that covers such services, and if they do, the CLSC directs them to a private agency (Coalition féministe, 1998)[70]. Some handicapped people who used to receive many home-support services for free must now defray the costs themselves.

Women users of health services assume an increasingly large share of the costs of drugs and supplies they need. The shortening of hospital stays has also shortened the time during which the hospital provides these supplies for free. As discussed earlier, the Quebec Prescription Drug Insurance Plan does not cover all prescribed drugs, nor all the costs of purchasing drugs. Co-insurance fees — specified percentage of the balance due after paying the deductible — put a major dent in the incomes of senior citizens and welfare recipients. The Quebec Ombudsman has intervened with the government on three separate occasions to demand a fairer system. Community agencies observe that the drug insurance plan destabilizes the poorest members of society "[translation] *first, by its impact on their budget, but also in some cases by its impact on their health, either by preventing them from purchasing a prescription drug or by forcing them to go without food or to delay paying their rent or their phone or electrical bills in order to purchase the drug*" (ROCQ 03, 1997: 20).

A study by researchers at McGill University outlined the following findings. The introduction of the Quebec Prescription Drug Insurance Plan caused use of medications to drop by an average of 9% among seniors and by an average of 14% among welfare recipients. The decline in use of essential drugs had negative effects on the health of the most vulnerable persons and increased their use of other health services (doctor's visits, emergency room visits, hospital admissions, and so on). Moreover, these negative effects were greater among welfare recipients than among seniors, and greatest among welfare recipients who suffered from serious, persistent mental illness. On the other hand, the decrease in the use of less essential drugs reduced the number of doctor's visits among seniors who took these kinds of drugs regularly (Tamblyn, 1999, quoted in MSSS, 1999b). However, "[translation] *the most recent changes in the drug insurance plan* [designed to restore free access to medication for people suffering from chronic mental illness] *have not been extended to seniors. One reason cited was that seniors have higher incomes than welfare recipients do. This is true if no* *distinction is made between men's income and women's. But looking at the situation more closely, the income of many older women who live alone place them below the poverty line* (Conseil du statut de la femme, 1999b:45).

The Coalition sur l'assurance-médicaments [coalition on drug insurance], whose members include several Quebec advocacy groups, has pointed out other problems associated with the drug insurance plan: "[translation]: *the inequalities that it creates among citizens who have similar income but have to contribute different amounts when purchasing prescription drugs; the obligation that it imposes on thousands of workers to cover their spouse and their children under their private plans, which drastically increases their premiums; the disparities between the public plan and private plans; and the lack of confidentiality, since claims for reimbursement must sometimes be submitted through people's employers"* (Guay, 1999: A-7).

As the preceding discussion has shown, women who use health care services are particularly affected by the trend toward privatization, not only because women make more use of health care services, but also because more women live in poverty. Such women often find it harder to secure services that are becoming less and less accessible, to mobilize support resources when they are discharged from hospital early, to get their needs met when they are old and live alone, and to assume the additional costs of drugs that are indispensable to their health.

4.2. The Consequences of Reform for Women as Health and Social Service Workers

Women represent three out of every four employees in the public health and social services sector. They have been hit hard by the reform that it has undergone. The changes that have had the greatest impact on women's working conditions in the public system are closures and mergers of institutions, redefinitions of jobs, large-scale transfers of personnel, and massive layoffs and early retirements.

The large number of staff transfers have required a great deal of flexibility and adaptability on the part of thousands of female health and social service workers. For example, a nurse who is transferred from a specialized unit in a hospital to a CLSC where she has to perform a much wider range of tasks may feel unqualified for her new job, especially if she did not receive any refresher training to prepare her. Transfers have also dismantled teams of workers with years of experience in their work place, sending them off to work in new environments with different organizational cultures, which can be a major source of stress. Temporary workers have suffered as well; when they see new full-time staff with secure union jobs transferred in from other institutions, it makes them feel less secure in their own jobs. These many sources of tension, combined with a heavier workload, pose a risk of exhaustion for workers in the system.

In all types of institutions, working conditions are harder. There is too much work, the pace is faster, the nature of jobs is being transformed, and the risk of errors is increasing (AFÉAS et al., 1998). In hospitals, there are fewer staff to take care of patients who are sicker and need more care. The Director of Nursing Services for the McGill University Health Centre reports: “[translation] *At the McGill University Health Centre, two separate, well respected methods of assessing workload, and an analysis of the trends over the past four years, have shown that in adult care institutions, the amount of care provided to medical patients has increased by 15% and the amount provided to surgical patients has increased by 17%. Our capacity to respond, which means having the nursing staff put in more hours, has not grown accordingly*” (Shannon, 1999).

In a survey of nurses (both male and female) in the Quebec City region, the workload for nursing staff was reported to have increased by 85%, and 74% of respondents said that they did not have enough time to do their jobs (Bourbonnais et al., 1998). In the same survey,41% of the respondent reported a high level of psychological distress whereas only 29 % had done so in a survey done the year before the shift to ambulatory care and the wave of budget cutbacks. This high reported level of psychological stress (which was even higher — 56% — among nurses with part time jobs) makes nurses a group at risk of developing health problems.[71]

In emergency rooms, working conditions have deteriorated so badly that at the Hôpital du Sacré-Coeur de Montréal, for example, the nurses have refused on more than one occasion to show up for work, because they deemed the working conditions at their jobs to be hazardous. And the Commission de la santé et de la sécurité du travail (the Quebec occupational health and safety commission) has found in their favour. Doctors too perceive an increase in their workload, in all areas of practice (Leclerc, 1998).

Heavier workloads are also very common for the CLSCs' workers who provide home care. The number of home visits that a CLSC nurse must make each day has increased by about 50%. The CLSCs' family and social assistants also must work faster, and their risk of work accidents is growing, especially when they work alone and have to move people with limited mobility from one place to another in their homes. "[translation] *The data for 1993-96 show that assistants suffer 48% of all work injuries, even though they constitute only 13% of the work force*" (Conseil du statut de la femme, 1999: 71). The number and kinds of clients for home care services are increasing continuously, so women who provide such services face increased risks of harassment and verbal aggression, and sometimes even of physical aggression.

The changes in professional practices and in the places where services are delivered, together with workforce reductions, also raise concerns about the professional roles that various groups of employees play and the ways their skills are used (Dussault, 1994). One concern is that poorer working conditions, decreased job security, and the growing proportion of casual and part-time jobs may lead to a loss of technical competence. "[Translation] *Because only casual positions are available, only 8% of the nursing graduates from 1998 and 17% from 1994 now occupy full-time* *positions in Quebec. The lack of opportunities has resulted in a loss of professional qualifications"* (Shannon,1999). Another concern is that cutting staff and redefining jobs will create role conflicts between, for example, registered nurses and nurses' aides. The traditional division of labour between these groups has been overturned by hospital restructuring and staff reductions. Some occupational groups look as if they will eventually disappear, with all the risks that this entails for the organization of work within the health care system. Members of all occupational groups worry about being replaced with "cheaper" workers.

As discussed earlier, private agencies and social economy enterprises providing home care services have proliferated, in part because of contracting-out by overwhelmed CLSCs. In 1994-1995, CLSCs in the Montréal-Centre health and social services region purchased over $8 million worth of services from private agencies, at an average hourly rate of $9.94, while the average hourly wage of CLSCs' family assistants was $16 to $18 (Corbin, 1996). The data from an initial assessment of social economy enterprises (prepared for the Quebec Department of Health and Social Services) indicate that close to 9 out of 10 of their employees are women and that 40% of them were receiving welfare benefits before being hired. Though there are some notable variations among these enterprises, the hourly wage of their employees who provide direct services ranges from $6.80 to $8.30, and close to half of these employees work only part-time (Bélanger, 1998, quoted in Conseil du statut de la femme, 1999: 78). A comparison with working conditions in the public system suggests that the government is reducing the costs of health care services by creating "second-tier" jobs for the women who constitute the vast majority of health care workers. Some analysts may claim that this is not really a direct replacement of decent jobs with jobs that are insecure and more poorly paid. But there is no denying that on the whole, the gains realized by women in this female-dominated sector of employment have been rendered more fragile by the reform of the health care system.

4.3. The Consequences of Reform for Women as Caregivers

The current reform has also required a new division of responsibilities between families and the State. As far as home support for elderly persons is concerned, families have now become the main, if not the only, source of help. A review of the Canadian, Quebec, and US literature on support for the aged (Garant and Bolduc, 1990) indicates that as of the early 1990s, 70% to 80% of personal care and services for the aged were provided by family members, whereas the combined contribution of community and government agencies was only 10%. More recent research has confirmed that families still provide 70% of nursing care and assistance for frail seniors who live at home and receive some services from the public health and social services system. For seniors who do not receive any help from the public system, this figure is even higher — 80% (Hébert et al., 1997).

With the shift to ambulatory care, however, there has been a paradigm shift as well. Home care is now being provided to people of all ages, including many seniors who are discharged early from hospital after surgery or medical treatment. These seniors do not always need long-term care, but their condition does mean that they need family members to be available, often at very short notice. The home has become an officially recognized site for providing health care, and women who help their family members are more and more becoming health care providers. These changes increase the pressure on families, and especially on women.

Women are being expected to provide increasingly complex kinds of care, but are not being adequately prepared for their heightened responsibilities. This is an additional source of stress, especially for older women. “[Translation] *Some women have only had to provide ‘simple’ forms of home care such as administering medication, providing light assistance with daily activities, and occasionally checking an incision, and these women generally have a positive perception of the shift to ambulatory care . . .But other women have had to give their spouses more complex types of nursing care, such as changing dressings, irrigating wounds, and administering and monitoring medication, hygiene, and diet; 75% of these women were themselves receiving services from health care professionals every week . . . The main problems that these women reported were as follows:*

the lack of any choice about the way they handled this 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 the services" (Ducharme, F. et al., 1998). Moreover, the kind of care that one family member provides to another under the shift to ambulatory care is very different from the kind of care provided by professionals who are subject to ongoing assessment and professional standards. The inextricable emotional component in any family relationship makes it more difficult for caregivers to have their own personal limitations recognized.

Women bear most of the responsibility for providing care and support to family members. A survey conducted for the Rochon Commission among a representative sample of people providing care to frail seniors, showed that 67% of these caregivers were women (Jutras and Veilleux, 1989). In a recent report on new trends in informal health care, prepared for Health Canada, [72] Nancy Guberman (1999: 25) writes: *"Research has documented that in most families it is not the family unit, be it extended or nuclear, but one family member who assumes the primary responsibility for care, and this member is usually a woman (Biegel & Blum, 1990; Finch & Groves, 1983; Guberman et al., 1991; Guberman & Maheu, 1997)."* A survey done by "Santé Quebec" has also shown that among female and male caregivers who live with the person to whom they are providing care, 80% of the females are the primary caregivers, while only 46% of the males fulfill that role (Lavoie, Lévesque and Jutras, 1995).

Thus the reform of the health care system has had very different effects for women and men, because of the contribution that women are expected to make to caring for family members. Various studies have confirmed that if the caregiver is a man, different use is made of formal and informal supports, reflecting the pressure exerted by the social roles that women are expected to play: "[translation] *Male primary caregivers receive more help from other family members than female primary* *caregivers do (Walker, 1991). When a man takes care of his wife because she cannot care for herself, he gets help from his daughters. This does not happen so often when a women is taking care of her husband (Roy et al. 1992). In the few cases where a son is caring for an elderly parent, his wife — the daughter-in-law — very often takes on major responsibilities for the parent's care. According to Matthews and Rosner (1998), a daughter who cannot or does not want to take care of an elderly parent feels guilty and has to offer some good excuses. For a son, not helping seems more normal"* (Vézina and Pelletier, 1998: 8). Family dynamics often contribute to a sense of guilt among female caregivers, even when the relative in question is being cared for in a residential facility. This sense of guilt plays a certain role in families' reluctance to make use of formal services; "[translation] *Men seem less reticent than women to ask for support . . .Men in general are more 'vulnerable' when placed in a caregiving situation, because they feel at a loss to handle tasks that they traditionally have not performed"* (Paquet, 1997:117).

The kinds of tasks and responsibilities that caregivers assume also vary with their sex. Female caregivers provide more personal and domestic care than males and spend more hours per week giving care. Men are more likely to provide transportation and do administrative chores. Male caregivers also experience less conflict between their caregiving tasks and their regular jobs (Guberman, 1999).

Despite the massive influx of women into the work force in the past few decades, the division of domestic labour has not changed significantly (though things are slowly changing). The increased responsibilities of caregiving thus make it even harder for women to reconcile the demands of home with those of their paid jobs. More than a third of female caregivers in Canada are employed, and one third of this latter group report that their caregiving responsibilities interfere with their work (Canadian Study in Health and Aging, 1994; Gottlieb et al., 1994; Guberman and Maheu, 1993). "[Translation] *Women who are in the work force are no less involved in caregiving; instead, they tend to combine paid work, housework, and caregiving by sacrificing their own free time. They sometimes even decide to work only part-time, or to quit their jobs. This fact does not negate the* *contribution made by other family members, but it does highlight the predominant role that women still play in caring for the family, as well as the still highly sexualized nature of the 'natural' caregiving role within families and the relatively little change that has taken place in the division of labour between men and women"* (Guberman and Maheu, 1997: 19). In this regard, a survey has revealed that 9% of caregivers, mostly women, have curtailed their hours of work, 5% have turned down professional responsibilities, and 6% have stopped working (Jutras and Veilleux, 1989). Though hard to quantify, this represents a major price being paid by women who take care of family members with acute or chronic health problems.

Taking care of someone who is incapacitated affects many aspects of caregivers' existence. They often experience difficulty in reconciling their responsibilities as caregivers with their personal lives: "[translation] *For the majority of caregivers, taking care of an elderly relative makes it hard to work a regular job and to take vacations; it also affects their physical and mental health. For many, caregiving upsets their daily routine and creates problems in planning social and recreational activities away from home, as well as in their intimate relationships. In some cases, having to care for a relative creates a financial burden and limits availability to spend time with other family members"* (Paquet, 1990: 107).

A number of studies have reported the impact of the caregiving role on women's living conditions and quality of life, as well as on their health (stress, anxiety, physical and emotional exhaustion)[73]; on their personal, family, and spousal relationships (where role conflicts create many tensions); and on their ability to engage in other social activities at their jobs, on their own time, or as volunteers in various organizations. When caregivers have to continue providing care for extended periods, the effects on their living conditions and their health are substantial (Gottlieb, 1998: 462).

The kinds of constraints faced by female caregivers relate to several factors. These include the nature of the incapacity of the person for whom they are caring; the length of time that this person requires care; the family's financial resources and ability to seek outside help; whether the family structure and atmosphere encourage other family members to help out (especially important for women in vulnerable situations, such as single mothers and women with spouses or other family members who are violent); the caregiver's ethnic and cultural background, which affect social roles and family dynamics; and her personal situation, including her other family responsibilities, her job, and where she lives, since living conditions in rural and urban areas are very different (Lauzon et al., 1998).

Some studies indicate that women are not refusing to help their relatives, and that some even find helping them a positive experience, especially in less complex situations (Ducharme et al., 1998; Brault, 1998). For someone to feel at ease in the role of caregiver, it is important that she has chosen this role of her own free will, without being pressured to do so by public institutions, and that she has real alternatives to the family's providing the care. It is also important to continue monitoring the caregiver's willingness to fill this role as the condition of the care recipient and his or her relationship with the caregiver change over time, because the physical and emotional burden involved can be difficult to assess initially.

Unfortunately, caregivers are not necessarily consulted with when decisions about the organization of health care services are being made, even if these women are identified as partners in certain policies regarding home care services. The public system often treats the family, and in particular the women in the family, as having the primary responsibility for providing care, with the system itself intervening only in a back-up role. Women caregivers are still not recognized as potential users of this system, because it is focussed chiefly on the person who is sick or incapacitated and requires home support. The policy statements issued when health and social service reform was first implemented scarcely mentioned the need to promote the health and welfare of the caregivers themselves, or these women's right to receive support for their own needs from the public system (Lavoie et al. 1998).

Despite these well known facts, an analysis of home-service policies and programs in Quebec reveals a lack of interest in the health of female caregivers. "[Translation] *Every component of the health and social services system has the objective of encouraging dependent persons to be cared for in their natural environment and of avoiding recourse to institutions as much as possible. At the same time, this system — in other words, the government of Quebec — has tended to redefine its role as one of providing secondary support or back-up for family and community resources. In this process, the government generally treats female caregivers as resources — important ones to be sure, but essentially instruments for achieving its objective of maintaining dependent persons in the community"* (Lavoie et al., 1998:81). The policy documents not only of the Department of Health and Social Services, but also of the regional health and social service boards and the CLSCs (with a few exceptions, in these last two cases) place very little emphasis on the situation of caregivers. These institutions' lack of understanding of this issue is apparent in the assessment tools that they use and in the way they regard caregivers as largely a means to an end. To the extent that they talk about the situation of caregivers at all, most policies and programs focus mainly on the need to support them so that they do not become exhausted.

The assessments that have been made of various caregiver-support programs to determine their most important elements and impacts have not always been conclusive (Gottlieb, 1998).[74] Combinations of various support strategies should therefore be tried, including community initiatives (such as self-help groups and support and respite services for caregivers), government initiatives (such as tax deductions for taking care of dependent persons at home), and private-sector initiatives (such as flexible work hours and family leave) (Guberman, 1999).

The contribution that women make to the care of people who are sick or incapacitated represents a major human, social, and economic cost. A study by the Quebec Department of Health and Social Services "[translation] *confirms the significant value of the work done by family members to support* *dependent seniors who live at home. This contribution represents more than half of the total costs of such support, averaging from $37 to $60 per day, depending on the value (public sector cost or private sector cost) imputed to them . . . The burden of this work affects caregivers' own health and interferes with their own functioning, so it also generates significant indirect social costs"* (Hébert et al., 1997: 260). In addition, costs of goods and services that used to be provided in public institutions under public health insurance are now being transferred to private households. Examples include the costs of drugs and medical supplies formerly provided free in hospitals, the increased costs of transportation to medical appointments, and the cost of supplementary private insurance to cover risks associated with post-hospital care in the home. Some organizations refer to this process as 'privatization of health services through the back door'.[75]

Some economic analyses of the restructuring of health and social services evaluate only the short-term improvements in the efficiency of public institutions, without analysing the cost-effectiveness of restructuring from the standpoint of the longer-term health of both the recipients and the providers of home care (MSSS, 1991, 1994, 1996; Angus et al., 1995). And yet, some perverse effects of this restructuring are emerging, and they could generate extra costs in the longer run — for example, the costs of providing health care to the caregivers themselves, or of reinstitutionalizing the sick and disabled because their home caregivers had suffered burnout. Another point is that analyses of the efficiency of public health care spending must be placed in the context of total health care costs, including the money that families have to spend privately because public services have been restructured. Such considerations cast doubt on a narrow vision of the efficiency of the health and social services system, one that looks only to reduce public spending and institutional budgets. Such an approach underestimates or ignores the economic impact of health care reform on families, and especially on women who care for family members.

However, more and more analyses are now taking a more penetrating look at the consequences of health care reform for caregivers. Some of these studies do indicate that people who receive care from their family network use fewer government and community services. But on the whole these studies indicate the need for a change in policies (Renaud et al., 1987; Leseman and Chaume, 1989; Roy, Vézina and Paradis, 1992; Paquet, 1994; Roy, Vézina and Cliche, 1998) and also point the way to some possible solutions. If the health care and social services system is regarded as a determinant of the public's health, then the effects of the transformations in this system on the health of women as caregivers must lead to significant steps to provide them with better support.

4.4. The Consequences of Reform for Women Involved in Community Organizations

Whether as workers, as activists, or as volunteers, women play a vibrant role in community health and social services organizations and constitute the majority of their membership. And increasingly, it is to such organizations that public institutions are sending people when they need support (AFÉAS et al. 1998; RIOCM, 1998; ROCQ 03, 1997; Parent, 1997). Under this new pressure, community groups tend to lose sight of their mission and alter their practices. "[translation] *The scope of the needs created or amplified by the shift to ambulatory care rapidly drives community groups into a vicious circle where providing services stops being a means of acting for and with the community and starts becoming an end in itself; what was supposed to be temporary becomes permanent*" (ROCQ 03, 1997: 14). The service-provider mentality infiltrates community organizations at the expense of their work of educating the public, increasing public awareness, and mobilizing public action. People get used to requesting services from community groups without seeing any need to get involved themselves. One woman representative of an advocacy group comments: *"In the beginning . . . the people in the groups were activists. Then we had members. Now, we have users of services."* (RIOCM, 1998:120).

According to a survey that the RIOCM (Regroupement Intersectoriel des Organismes Communautaires de Montréal; inter-sectoral coalition of Montreal community organizations) conducted among its member organizations, many groups have increased the services that they provide without creating any additional positions to provide them. The increased load borne by the teams that work for these organizations seems to be a generalized phenomenon. As one representative of a community agency that works with families reports: *“The workload is heavier, and because of that there is more pressure on the work team. We no longer succeed in managing all the priorities; everything is a priority now. Our work schedules expand in virtually unlimited fashion. We have to be versatile, we have to be able to do a bit of everything as well as assuming the uncertainty of our own financial situation”* (RIOCM, 1998:126).

Some people who run these agencies also fear that the overload will cause relations among their workers and the quality of their work to deteriorate. As one woman who works for a centre for victims of sexual violence puts it:*“In the past, we worked to prevent burnout in our work environment and to have a certain quality of life. But without realizing it, we have nibbled away at the time allocated for supervisory meetings, discussions and training”* (RIOCM, 1998: 128).

Volunteers in community organizations are seeing their workloads increase as well. Moreover, “[translation] *volunteers’ motivation is decreasing steadily, because the new demands are perverting the whole concept of volunteerism, which is based on making a gift of one’s own time of one’s own accord. Some of these demands are perceived as abusive — for example, volunteers are being asked to look after people who have just had serious operations, or to provide respite care overnight and on weekends”* (Coalition féministe, 1998: 30).

To our knowledge, there have been few systematic studies of the consequences of health care reform for community organizations and for the women involved in them. The public health and social services system often refers to these organizations as if they were simply extensions of itself, but without really understanding how reform is affecting the women who work for these groups, whether in paid jobs or as volunteers.

4.5. Participation of Quebec Women’s Organizations in Public Decision-making Bodies

In Quebec, the Quebec Council for the Status of Women [Conseil du statut de la femme] and women’s organizations in the various regions of the province are raising questions about the ways that women participate in the various decision-making and advisory bodies that were established to help implement health care reform. The representatives of these women’s groups would like to act as partners in the regionalization of the health care system. But they experience culture shock when their community orientation comes up against the culture of the regional decision-making and advisory bodies (l’R des centres de femmes du Québec, 1997). In these bodies, technocratic discourse predominates. Questions about women’s health and the impact of reform on their health and living conditions seem to excite little interest and are rarely the subject of discussion.

A study by the Conseil du statut de la femme has shown that from 1980 to 1995, these regional bodies neglected the entire issue of women’s living conditions (Conseil du statut de la femme, 1995). For each of Quebec’s sixteen health and social services regions, the report traces the history of the issue and compares the current situation with the situation before the regional health and social services boards were created. The indicators used to measure changes in this situation were as follows: the presence of someone specifically responsible for this issue at the regional board; this person’s employment status; their position and reporting relationship; and the amount of time spent on the issue. At the time the study was conducted, only one of the sixteen regional boards had an employee assigned to the issue of women’s living conditions full-time!

Some concerns raised by the women’s movement have been addressed in certain policies and programs that the Quebec government has implemented recently, such as the Department of Health and Social Services’ action plan on the status of women,[76] or the recent recognition of midwives as health care practitioners. But many women who have participated in decision-making bodies within the health and social services system have felt that they lost their bearings in an approach that emphasizes “clients”, “programs”, and management through a “continuum of services”.[77]

“[Translation] *When they began playing a direct role in managing services, activists suddenly found themselves dissecting people according to their problems and needs, turning them into the subjects of administrative measures and procedures categorized by sectors and programs”* (Couillard et al., 1997: 177). John Ralston Saul has expressed this problem as follows: “*A patient-centred approach to health care requires openness and cooperation on a non-interested basis among experts, citizens and governments. It requires transparency, public involvement, debate. Under a corporatist technocracy the disease-based approach is preferred because it is much more controllable”* (Saul, 1999:14).

The privatization of the funding and delivery of services augurs badly for women’s participation in any decisions about the health and social services system. Likewise, citizen involvement, which was supposed to facilitate reform by democratizing regional bodies and decision-making processes, has been frustrated by some of the effects of the reform itself. Women from community organizations are being overburdened. They are being called on to provide care and services in both their professional and their private lives, at the same time as they themselves are being hit by cuts in social programs and growing poverty.

5. CONCLUSION

To understand the consequences of health care reform that affect women specifically, one must recognize the social roles that condition women's experience in the family, in the work force, in the health care system itself, and in their public role, particularly in community organizations and decision-making bodies within the health and social services system. Women have always played a fundamental role in caring for people, both in their families and in health care institutions, but their contribution has not always been recognized. The government's talk about making families more responsible for caring for their members (so that the State can stop doing so) belies the reality that families already provide far more care to their sick and disabled members than the public system does. And despite the increasingly complex kinds of health care that must be provided in the home, women still play a major role in providing health care to their families. The development and professionalization of the public health and social services system may disguise this special contribution that women make to the well-being of our society. Moreover, for years the women's movement has been demanding that the various stages of life be "demedicalized" and that women have control over their own bodies. These demands have contributed to a change in values concerning health and the use of health care services. To reflect these facts, a comparative analysis of the two sexes is essential. This approach must be fully and genuinely integrated into any analysis of the consequences of health care reform and of the best ways of transforming the health and social services system.

As stressed earlier in this report, many studies have shown that investing more resources in the health and social services system has less impact on population's health than specific public health measures, at least in industrialized countries. But this does not mean that the current sweeping changes and budget cutbacks in this system have no effect on the health of the public in general, or of women in particular, because the health care system interacts with other determinants of health. Some effects of health care reform are direct. For example, when budgets for long-term residential facilities are cut back, but the need for their services keeps increasing, these services must be provided at home instead, even though insufficient resources are being reallocated for the purpose. When reform reduces access to public health services, waiting lines for heath care grow longer, which can increase stress and affect the health of the people who are waiting for care.

Other effects of health-system reform are less direct, occurring in combination with other health determinants. For example, reform is shifting the burden of providing increasingly complex forms of care to families, and mainly to the women in these families, without providing adequate support for this purpose. This new responsibility creates multiple tensions in women's immediate social surroundings. It also makes it harder for women who work outside the home to reconcile their domestic chores with the requirements of their jobs. In another example, the heavier workload and numerous structural upheavals in health and social services institutions have had significant effects on the health of workers in this environment, most of whom are women. The job cuts and increased use of casual labour both in public and in private health care organizations have been a significant step backward for their mainly female work force, with ripple effects on women in the work force as a whole.

Changes in the health care system interact with the other determinants of health in such a way that the reform affect women differently according to factors such as their age, their physical disabilities, their support network, their social and economic status, their ethnic and cultural background, and whether they live in a rural or an urban area. Older women are especially affected in their role as users of health care services and as caregivers. In rural areas where many young people have left, there is more pressure on women to provide support to the growing number of people who need it in their communities, so that some authors regard these women as having practically become "career caregivers".[78] Women who live on modest incomes — especially older women who live alone and women who are heads of single-parent families — must absorb downloaded costs that represent a greater burden for them than for women with higher incomes or access to private insurance. For women from various ethnic and cultural communities, differing values and family dynamics will affect the way they make use of services and their ability to adapt to rapid structural changes in the organizations that provide them. These are just some examples of the variety of situations that women experience, and they illustrate the need to pursue more systematic research to identify the many consequences of health-system reform on the living conditions and health of women from various backgrounds, and to propose remedies based on meaningful data.

The present analysis and the literature review on which it is based also show that the effects of health care system reform on women's health is related to the trend toward privatization, which is accentuating the current changes. This raises the question: are there any options for the future of the health and social services system besides privatization? Service delivery methods are now being changed so that services which used to be provided in institutional settings, at great expense for the State, are now being provided more cheaply in the community. Is replacing public services with unpaid labour by women in the family setting, or by private services that pay women low wages, the only way to achieve deinstitutionalization? Wouldn't it be better to provide significant support to families (in particular to women who agree to care for their relatives at home) and to develop some real alternative ways of caring for people in the community?

Another assumption of health care reform seems to be that the way to manage health and social services more effectively and efficiently is to foster "internal competition", contract work out, and place a heavier workload on a predominantly female work force. Perhaps, instead we should promote the development of integrated, inter-institutional service networks and build stronger multidisciplinary teams that improve services by drawing on the varied skills of these women, including both professional and non-professional staff.

Similarly, perhaps the best way to allocate resources so as to ensure equality and equity in accessing health care services is not to rely more heavily on private spending. Perhaps it is to go back to funding health care mainly through fiscal mechanisms — especially since increasing the proportion of private spending does not reduce the total cost of health care, while it does put more of a burden on women, who as a group still live on much lower incomes than men.

These are some of the issues surrounding equity between men and women in the context of the reform of the health and social services system. From the standpoint of women's concerns, privatizing health care funding and moving to a market model for accessing health care poses significant risks for the future of health care, as well as for women's rights. Many analysts and ethicists have already made the following points: health is not just a consumer good like any other; people who use health care services are not in the same position as consumers who have a variety of alternatives; the costs of health care services are determined largely by those who provide them, rather than by the individual choices of those who use them; a large part of the increase in health care costs, and particularly in the price of drugs, can be attributed to changing health technologies.

Health care reform cannot be analyzed solely from a narrow perspective that seeks to increase efficiency and reduce public spending in the short-term while ignoring negative effects that could increase health and social services costs in the longer run. In particular, a broader perspective that includes a specific analysis of differences between women and men can make a special contribution. It can provide a more nuanced understanding of the processes involved in organizing and funding health care services. This perspective will shed vital light on the options being considered for renewing health care practices and reorganizing health and social services. Any attempt to find solutions to the challenges faced by the health and social services system must recognize and seek to reduce the considerable price that women are being forced to pay for the recent sweeping changes in this system.

END NOTES

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1. We use this term to distinguish caregiving within the family or so-called "natural" caregiving from those given in the private sector (by for-profit corporations), in the public sector (by government institutions), in the volunteer sector (by

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non-profit organizations), or in the informal economy by (what is usually called “black-market labour”). It should be noted that the Quebec government has established rules to control black-market labour by requiring anyone who hires someone else to provide services in the home to register as an employer.

2. See in particular the list of demands of the Coalition féministe pour une transformation du système de santé et de services sociaux, in *Pour des services sociaux et de santé adaptés aux attentes des femmes*, Montreal, November 1998; and *Le virage ambulatoire: le prix caché pour les femmes*, Conseil du statut de la femme, Quebec City, 1999.

3. The Centres of Excellence for Women’s Health Program is financially supported by Health Canada and funds five such centres throughout the country.

4. See in particular: Conseil du statut de la femme, 1999; Métivier, 1999; Contandriopoulos et al. 1999; Poirier et al., 1998; Conseil de la santé et du bien-être du Québec, 1997; Armstrong and Armstrong, 1996; National Forum on Health, 1995, 1997; Gouvernement du Québec, MSSS, 1991; Janssen and Van der Made, 1990; Soderstrom, 1987; Vaillancourt et al. 1987, 1997; Stoddart and Labelle, 1983.

5. An analysis of data from across Canada by researchers in the Department of Economics at the Université du Québec à Montréal has established a relationship between cuts in health care expenditures and indicators such as infant mortality and life expectancy (Crémieux, Ouellette and Pilon, 1997).

6. The Coalition féministe pour une transformation du système de santé et des services sociaux [feminist coalition for transforming the health and social services system] uses the expression “univers d’implication”. It should be stressed, however, that these four categories are not mutually exclusive.

7. Some studies published on these subjects in 1998 include: Association féminine d'éducation et d'action sociale Canada et al., *Who will be responsible for providing care? The impact of the shift to ambulatory care and of social economy policies on Quebec women.* Ottawa: Status of Women Canada; Bourbonnais et al. *La transformation du réseau de la santé: mesure des caractéristiques du travail et de la santé des infirmières de l’agglomération de Québec,* Quebec City: DSP. The action plan on the status of women published by the Quebec Department of Health and Social Services in 1998 (*Plan d’action 1997-2000: santé, bien-être et conditions de vie des femme)* calls for certain studies to be conducted on the impact of changes in the system on women, in particular women who are health care workers or family-care providers. An annotated bibliography of the main documents consulted in this study will be published shortly.

8. Many private corporations still own the buildings in which public hospital centres are located and have a reserved seat on their boards of directors.

9. Previously, acquisitions of new equipment and technology were not under government control; the funding often came from private foundations.

10. See Mustard, J.F. and Frank, J (1991) *The Determinants of Health*, Toronto: Canadian Institute for Advanced Research, Publication No. 5*;* under the direction of Evans, R.G., Barer, M.L. and Marmor, T.R. (1994) *Why Are Some People Healthy and Others Not?* New York: Aldine De Gruyter; Wilkinson, R.G. (1996) *Unhealthy Societies: the Afflictions of Inequality.* London: Routledge; National Forum on Health (1996) *Advancing the Dialogue on Health and Health Care: A Consultation Document,* Ottawa; and more particularly, on women’s health and the status of women, Townson, M. (1999) *Health and Wealth: How Socio-Economic Factors Affect Our Well-Being.* Ottawa: Canadian Centre for Policy Alternatives.

11. This summit brought together government, business, union and community representatives to discuss government

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priorities, including ways to revitalize the economy and employment and to balance public finances.

12. There are currently 16 regional boards, and a health and social services council operates in the First Nations territories of northern Quebec and James Bay.

13. These reductions affected the Canada Assistance Plan (CAP), created in 1966 to share the costs of social assistance and certain social services funded by the provinces, and the Established Programs Financing (EPF) program, created in 1977 to share the costs of health and post-secondary education with the provinces. Both CAP and EPF were abolished by the federal budget of 1995, which replaced them with the Canada Health and Social Transfer (CHST).

14. For example, the federal government has recently threatened to reduce its transfers to Alberta in proportion to the amounts that private medical clinics in that province bill above what is covered by provincial health insurance.

15. Source: RAMQ [Quebec health insurance plan].

16. [Translation]: "The private sector accounts for exactly the same proportion of the health care system in Quebec as in France – 30% – which is higher than in most other countries in Europe." A.-P. Contandriopoulos, quoted by Bégin, 1999a: p.B-5.

17. Sources: MSSS statistical analysis service and Med-Echo.

18. Source: Health Policies and Systems Division, Health Canada.

19. The Quebec Department of Health and Social Services gave the regional boards responsibility and funding to establish these telephone services in 1994. These services let callers obtain immediate, general answers to questions about physical health.

20. The Centre of Excellence for Women's Health is currently conducting a study on how well these CLSC-based health information services are meeting the needs of immigrant women. It would also be worthwhile to examine ways of tailoring telephone-consultation services to the learning styles of less educated segments of the public.

21. See the position of the Collège des médecins du Québec.

22. Such co-operation should include sharing of "off-hours" duties between doctors in private clinics and doctors in CLSCs. Some observers have noted that one of the reasons hospital emergency rooms become so overcrowded during the year-end holidays is that private medical clinics and CLSCs are closed then.

23. "[Translation]: *The Fédération des CLSC* [now the Association des CLSC et CHSLD]...*is calling for financial incentives to attract more than 250 new general practitioners, whose services are essential if the CLSCs are to play their role properly*" (Gagnon, 1999, p. A-21).

24. Vaillancourt (1997) gives differing assessments of deinstitutionalization for the mentally ill and for the intellectually handicapped, though in the latter case, families also assume a significant portion of the burden of taking care of people who are often vulnerable and unable to care for themselves.

25. This trend will probably grow more pronounced in the coming years, even though the gap between men's and

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women's life expectancy is starting to close. According to Guyon (1996:34), "*Females born in Quebec in 1992-1993 can expect to spend 12.3 years, or 15% of their lives, with some form of disability, whereas their male counterparts, who will die younger, will spend 11% of their lives in this condition.*"

26. Source: Press release from the Association des CLSC et des CHSLD du Québec, 23/11/99, quoted in Bégin, 1999d:A-8.

27. Source: Turgeon and Sabourin (1996)

28. Source: Bravo, G. and al. (1999)

29. These proposals have come from the pharmaceutical industry, the biotechnology industry, the medical equipment industry, and the telecommunications industry (for "telemedicine" services). For more information on these health-related industries, see C. Métivier *La production de biens et services destinés au marché québécois de la santé face à la privatisation*, Groupe de recherche sur la reconversion industrielle, Université du Québec à Montréal, 1999.

30. For example, the US health care system, which is mostly private, is the most expensive of any developed country's and leaves more than 40 million people without any health coverage. Moreover, it employs a sometimes brutal form of rationing, in which private insurance companies try to cut their costs by disputing doctors' recommendations.

31. Source: MSSS statistical analysis service, 1998.

32. Figure disclosed by the Montréal-Centre regional health and social services board on October 20, 1997, cited in RIOCM, 1998: 43.

33. In social economy enterprises, clients who receive home-support services must pay fees, but the fees are adjusted to the client's ability to pay.

34. The number of nurses in private practice who are registered with the Ordre des infirmières et infirmiers du Québec also increased by 11% from 1996 to 1997. This number is still very small — it represents only 1% of all nurses registered with the Ordre — but this trend will probably accelerate with the shift toward ambulatory care.

35. This figure includes payments made to physicians, dentists, and optometrists through Quebec's provincial health insurance plan.

36. Marcel Villeneuve, general manager of the Montreal-Centre regional health and social services board, quoted by Bégin (1998b: A-25).

37. Some hospital centres, such as the Jewish General Hospital and the Montreal Heart Institute, have been active promoters of such projects.

38. Here is one example of such a partnership. The Hôpital Anna-Laberge in Châteauguay, Quebec, has lent an operating room that it does not use on weekends to an American company, which is using it to test a new instrument for treating excessive menstrual bleeding on a few patients. Even though the operating room is not being used on weekends, for lack of resources, and even though doctors from the hospital are participating in the research, such arrangements raise ethical questions, given how long the waiting lists are for other kinds of surgery.

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39. Contandriopoulos (1991) finds that the more a health care system is funded through budget allocations determined in advance, on the basis of the populations to be served (for example, by capitation), the more equitable it tends to be. In contrast, he finds, the more that resources are paid for after the fact, on the basis of the services provided (for example, when doctors are paid on a fee-for-service basis or when hospitals are funded according to Diagnosis-Related Groups, the more potential the system has to contain inequities. Contandriopoulos therefore believes that a health care system will have a greater chance of being equitable if it includes mechanisms for gathering, analyzing, and disseminating information on the health outcomes and effectiveness of the services that it provides.

40. Health Management Organizations (HMOs) in the United States were established by private corporations and insurance companies. Their clients sign up with them and, in exchange for a premium, are assured of receiving the services that the organization deems appropriate, based on the recommendations of health care professionals. There are many criticisms of the HMO model, in particular that it has a selection bias which tends to exclude people with chronic health problems, and that it tends to ration services for financial reasons. In the GP fundholders arrangements in the United Kingdom, GPs (general practitioners) receive public funds according to the number of patients they have, and they can negotiate service contracts for more specialized treatment with hospitals and other health care establishments.

41. Observers will want to closely monitor the progress of experiments such as the SIPA (integrated services for seniors) project and the capitation project in the Haut St-Laurent regional country municipality, which are currently under way and will be evaluated.

42. This includes, at a minimum, all insurable services provided by doctors and hospitals. In Quebec, most diagnostic services and services provided by hospital clinics and freestanding clinics are covered, as are doctor's services both inside and outside of hospitals. However, the Quebec Department of Health and Social Services and the RAMQ (Quebec health insurance plan) have identified a number of practices, such as *in vitro* fertilization and certain types of cosmetic surgery, that are classified as "not medically necessary" and therefore not covered by the provincial plan. Certain other services provided by other health care professionals also are not covered.

43. See Chapain and Vaillancourt, "Le financement des services de santé au Québec", in *Le système de santé québécois: un modèle en transformation* , 1999.

44. Source: MSSS SAS (statistical analysis service).The two major items included in these figures are the budgets for public health care institutions and for the Régie de l'assurance-maladie du Québec (RAMQ — Quebec health insurance plan), which pays for doctors' services and other, complementary services.

45. Source: MSSS, Canadian Institute for Health Information. Data cited in "État détaillé de la situation" in the Arpin Report, p.46.

46. Source: Canadian Institute for Health Information (CIHI) and MSSS statistical analysis service. Only in Ontario does public funding account for a lower proportion of total health care spending: 66.9%.

47. The growth rate for private spending fell from 9.5% per year for the period 1989 to 1991 to 5% per year for the period 1991 to 1998, while the growth rate for public spending dropped more radically, from 9.4% for the former period to 0.7% for the latter.

48. This figure comes from the Arpin Report and differs from the figure of 32.2% established by the CIHI for 1997. According to the Arpin Report, the figure of 30.9% for private spending as a proportion of total health care spending is based on more recent CIHI data and on adjustments made by the Quebec Department of Health and Social Services.

Another source of private funding is private foundations, which contribute in ways such as purchasing high-tech medical equipment for hospitals.

49. But here is how the Arpin Report explains the 5.9 percentage point increase in private spending: by **a gross increase of 12.5 percentage points, due solely to the effect of the slowdown in public health care spending starting in 1991**, from which 5 percentage points must be subtracted to account for changes in the price of services (due partly to the decline in employee wages) and a few more percentage points attributable to a slight slowdown in the actual use of private spending and the interaction of various factors (Arpin Report, p.17). This argument seems like cover-up!

50. As early as 1987, Contandriopoulos pointed out that "[translation] *The growth of the private sector and the growing importance of alternative medicine in the health and social services system is another indicator of the tension between efforts to cap public funding of this system and its inherent growth dynamic.*" (Contandriopoulos, 1997: 163).

51. Also worth mentioning is that in the discussions surrounding the introduction of the Quebec Prescription Drug Insurance Plan, the private insurers acknowledged that their administration costs were much higher than those of Quebec's provincial health insurance plan, the RAMQ.

52. This plan was made available somewhat earlier for senior citizens and welfare recipients, in summer 1996.

53. Recently, Dr Jean Cusson, chair of the Quebec government's Conseil consultatif de pharmacologie [pharmacology advisory board], denounced the extensive social and political pressure exerted by the drug companies to get their products included on the list of drugs covered by the provincial drug insurance plan. According to Dr Cusson, "[translation] *The weaker their case is scientifically, the more pressure they exert.*" See Hachey, 2000, p. A-6

54. Many complaints have arisen from the requirement to take out all the coverage available for spouses and dependants under private plans, which involves costly premiums.

55. Prior to the introduction of this plan, welfare recipients had access to free medication, while seniors paid only $2 per prescription, which is much less than the co-insurance costs and deductibles that they pay now. For more on the impact of the Quebec Prescription Drug Insurance Plan, see Tamblyn et al. 1999. We will return to this topic later in this report.

56. Public consultations on the Quebec drug-insurance plan are scheduled for early 2000, after which the amendments to the legislation will be introduced.

57. For example, the public positions taken by former health and social services minister Claude Castonguay, who has proposed creating a health care assistance fund and providing tax credits to help the private sector develop long-term residential facilities and to promote the development of "well organized, efficient private clinics" (La Presse, 22/10/99).

58. "Governance" means the methods by which political decisions are made and the rules under which the system operates, both financially and in terms of service delivery. Governance is distinguished from management, which involves decisions about the implementation and organization of services.

59. This question is raised by André-Pierre Contandriopoulos in "Transformer le système de santé", *Ruptures*, Vol.3, No.1, 1996, pp.10-17

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60. "[Translation] *Citizens as users should have access to quality services that meet their needs. Citizens as decision-makers should participate in and control the decisions that affect them, both individually and collectively. Citizens as taxpayers should participate in and control the costs of the services that they pay for through their taxes"* (Tremblay, 1999:113).

61. On this same subject, see Godbout, 1991; Lemieux, 1989; Léonard, 1985.

62. In a press conference on February 2, 2000, the Collège des médecins du Québec [Quebec college of physicians] criticized the flawed planning for medical staffing, as well as the pursuit of lucrative 9-to-5 medical practices in private clinics while high-priority needs elsewhere go unmet.

63. A research paper published by the Conference Board of Canada, *Caring About Caregiving: The Eldercare Responsibilities of Canadian Workers and the Impact on Employers*, 1999, refers to workers who are in this position as the "sandwich generation". Such workers are now estimated to represent 15% of the work force, compared with 9.5% just a few years ago. See E. Church, "Number of workers who care for elderly and children rising",*The Globe and Mail*, 11/11/99, p. B-12.

64. See "Médicalisation et contrôle social", Louise Bouchard and David Cohen, editors, in *Les cahiers scientifiques de l'ACFAS*, No. 84, 1995, and particularly the following articles: Maria De Koninck, "La gestion biomédicale du corps des femmes: un progrès?"; Hélène David, "L'insoutenable lourdeur de l'autonomie pour les personnes âgées"; and Paul Morin, "Ordres et normes: la psychiatrie obligatoire".

65. Association des CLSC et des CHSLD du Québec, press release, 23/11/99.

66. "[Translation] Whether it is cutting the number or length of hospital stays, what is striking is the highly quantitative objectives that are driving the shift toward ambulatory care," says the Conseil du statut de la femme (1999:34). The pressure on institutions to achieve better performance as measured against such benchmarks is very strong. The Bas-Saint-Laurent regional health and social services board received a letter of reprimand from the Minister when it failed to engage in such a measurement exercise. (Letter included in the 1995-1998 three-year plan for this regional board, C.S.F., 1999: 35).

67. As a result of the shift toward ambulatory care, the average length of a woman's hospital stay after a vaginal delivery without complications has fallen from 3.5 days in 1992-1993 to 2.5 days in 1996-1997. The average length of the stay after a delivery by caesarian section has fallen from 6 days to 4.8 days. Source: MSSS, *Bilan ponctuel sur les programmes de congé précoce en périnatalité au Québec*, cited in Conseil du statut de la femme, 1999:88. Another study on this subject has been conducted by L. Goulet and D. D'Amours of the Faculty of Nursing Sciences at the Université de Montréal.

68. However, a report sponsored by Health Canada, conducted by three research teams, and entitled *Waiting lists and waiting times for health care in Canada: more management! more money?* (Macdonald et al., 1998*)*, concludes that there are currently no reliable data on the effects of waiting lists and waiting times to obtain health care services in Canada. According to this report, the harmful effects of these delays on health and on recourse to private services have not been demonstrated either.

69. Source: Commissaire aux plaintes en santé et services sociaux. *Rapport sur l'application de la procédure d'examen des plaintes 1997-1998,* Montreal, MSSS, 1999, quoted in CSF, 1999, p. 30.

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70. As we shall see later, families, and especially women as primary caregivers, are regarded as resources in home-support services policies and programs.

71. Source: Conseil du statut de la femme, 1999:70.

72. Nancy Guberman (1999). *Caregivers and Caregiving: New Trends and Their Implications for Policy.* Final Report prepared for Health Canada. Photocopied document.

73. The data from the most recent survey by Santé Québec showed that 35% of women who were "natural caregivers" showed high levels of psychological stress.

74. According to Gottlieb (1998), p. 472: "[translation] *It is still too early to draw definite conclusions about what intervention methods work best for caregivers, because the research and pilot programs being conducted in this regard have not been evaluated for long enough for us to determine whether their results are reproducible or generalizable.*"

75. In Quebec, the Coalition Solidarité Santé, a health coalition that includes a total of 24 union organizations (CSN, FTQ, CEQ, FIIQ, etc.) and community organizations (Coalition des aînés, Fédération des femmes du Québec, consumers' federations, federations of community agencies, etc.) has developed a common position on this subject. This position is summarized in Regroupement intersectoriel des organismes communautaires de Montréal (1998), pp. 138 et ss.

76. MSSS, *Plan d'action 1997-2000: santé, bien-être et conditions de vie des femmes,* 1998. This plan proposes that differential analysis by sex be used in planning policies for the Quebec Department of Health and Social Services, and that an assessment be done of the impact of the health care system reform on caregivers and workers in this system, "most of whom are women".

77. The regional boards' transformation plans are generally based on "continuums of services" in physical health, mental health, services for seniors, services for the physically challenged, services for the intellectually challenged, and social adjustment services.

78. See Guberman, Nancy (1999).

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