Health Care Restructuring and Privatization from Women's Perspective in Newfoundland and Labrador*

by

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Summary

Since the early 1990s, extensive reform and restructuring of Newfoundland and Labrador's health care system have taken place. As elsewhere, the cornerstones of Newfoundland and Labrador's reform initiative was the regionalization of health care delivery and management and the formal adoption of a population health approach. Here, as in other provinces, privatization, or the transfer of some financial responsibilities from the state to the private sector, individuals and families, has been a key but poorly monitored aspect of the reform and restructuring. Another hidden aspect has been the individualization of responsibility for one's own health, which in some cases has meant a transfer of care giving work onto individuals and families, which has the potential to land on the shoulders of women. Oddly, given that gender is a recognized determinant of health within a population health approach, insufficient attention has been paid to the potential for differential effects of reform and restructuring on the women, men, and children of this province; nor has enough attention been paid to addressing questions of access and equity.

This document scans the health-related privatization initiatives that have taken place in Newfoundland and Labrador since 1990. We have attempted to document shifts in the health services available in Newfoundland and Labrador in terms of *who pays* for those services, *who provides* them, and, by extension, *who is able to freely avail* of particular services. Our major focus is on ways privatization has affected the cost of services for different groups of women, the demands on women who provide care (both paid and unpaid) and which groups of women appear to be particularly at risk in terms of their capacity to access health services. Due to time constraints, the analysis relies on secondary research and interviews with key informants. The information provided is as current as possible, but because policies are changing very rapidly, some information may be out of date. Finally, much more research is required to address the issues related to rural, aboriginal and disabled women.

The Scan begins with a discussion of the wider context behind restructuring and reform, followed by a description of the privatization of certain medical and non-medical services and their relationship to women's health. The third section looks at health care reform and its significance for health care workers; the fourth section at potential consequences of the shift from institutional to home-based care for women as care providers, care recipients, and unpaid care givers. The last section summarizes the findings from the scan and identifies relevant and pressing questions that could not be answered within the framework of the present study.

The Scan suggests that although health care reform and privatization have had dramatic effects on both men and women, some aspects of restructuring have affected women more than men, and differently than them and some groups of women appear to be more vulnerable to negative effects than others. While somewhat preliminary, the findings suggest that since women are more likely than men to be poor and elderly and, in their poverty, to have dependents to care for; since responsibility for unpaid caring work is more likely to fall on their shoulders than those of men; and since they make up a majority of health care workers who have, in most cases, lost employment, wages and job security as a consequence of privatization; women in general, and poor, rural, nonprofessional and elderly women in particular may have suffered disproportionately from the negative impacts of privatization.

Introduction

Since the early 1990s, Newfoundland and Labrador has experienced extensive reform and restructuring of the health care system. As in many other Canadian jurisdictions, the cornerstone of Newfoundland and Labrador's reform initiative was the regionalization of health care delivery and management, which has largely meant a transfer of direct responsibility for service provision and delivery from the state to the recently-established regional Community Health and Institutional Boards. Other equally significant aspects of reform and restructuring have included the adoption of a population health approach, which implies a shift towards prevention through a focus on health determinants, such as income, education, employment, and gender. A population health model has required a more holistic approach to policy development. For example, the recent movement of some social services, such as child welfare and youth corrections, from the Department of Human Resources and Employment to the Community Health Boards in the last two years has furthered the province's efforts at integrating health care and social services.[1] The provincial Government has also released a Strategic Social Plan (1996) to address social and economic issues in an integrated manner through an approach to social policy development, that considers the input of community groups.[2] The reform of primary care has also been on the agenda for health care reform, but little substantive change has taken place in this area. While the province remains the main provider of funding, the Department of Health and Community Services (before 1998, the Department of Health) is now mainly involved in policy development and financing the health care system.[3]

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[1]Community groups are speculating that more social services will come under the jurisdiction of the health Boards in the near future (ie: social housing).

[2]Government of Newfoundland and Labrador, *People, Partners, and Prosperity: A Strategic Social Plan for Newfoundland and Labrador*, 1998. The Strategic Social Plan stemmed from the recommendations of the Social Policy Advisory Committee (SPAC), contained in two reports: SPAC, *Volume I: What the People Said* (March 1997); and SPAC, Volume II: Investing in People and Communities, A Framework for Social Development (April 1997)

[3]I have used the Department of Health throughout the document in referring to the

One of the more hidden aspects of health care reform in Newfoundland and Labrador, as elsewhere, has been the transfer of some financial responsibilities from the state to the private sector, and individuals and families. Another hidden aspect has been the individualization of responsibility for one's own health, which in some cases has meant a transfer of care giving work onto individuals and families, which has the potential to land on the shoulders of women.

Since a population health approach implies a shift towards prevention through a focus on health determinants, and gender is a known health determinant, policy should be shaped by gender-informed, evidence-based decision making processes. In the course of changes to the health care system over the past decade in Newfoundland and Labrador, as elsewhere, it is becoming apparent that not enough attention has been paid to the potential for differential effects of reform and restructuring on the women, men, and children of this province; nor has enough attention been paid to addressing questions of access and equity. The gap that currently exists between the models of reform (many of which are promising in regard to meeting women's diverse health care needs) and what has actually occurred, especially in regard to women's health, has prompted the development of this report.

The research and writing of the report were informed by parallel projects done in other provinces, which were completed in 1999 as part of the National Health Reform Working Group. The Working Group encompassed representatives from the five federally-funded Centres of Excellence for Women's Health, which developed Regional Working Papers on Privatization in Health Reform From Women's Perspectives. Newfoundland and Labrador was not initially included in this national initiative. The intent of this report is to fill this gap by gathering information on the extent and nature of the privatization of health care in Newfoundland and Labrador, its impact on women, and to document efforts at monitoring the effects of reform on women as care recipients, care providers, and as unpaid caregivers, from around 1990 to the present. Whenever possible, the report highlights the unevenness of the effects of health care restructuring and reform on different groups of women. Due to time constraints, the analysis relies on secondary research and interviews with key informants. The information provided in the report is as current as possible, but because policies are changing very rapidly, some information may be out of date. Finally, much more research is required to address the issues related to rural, aboriginal and disabled women. The report is organized as follows:

- An overview of the context in which health care reform and restructuring in Newfoundland and Labrador has taken place and changes in the sector as a result of Government's reform initiatives [government policy, hospital amalgamations, community health boards, department of health, and public/private spending].

- An overview of the privatization of certain medical and non-medical services in Newfoundland and Labrador and how privatization is affecting or may affect women's

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Department of Health (pre 1998) and the Department of Health and Community Services (post 1998).

access to health services [de-listing of services, hospital user fees, drugs, rehabilitation, abortion, midwifery, contracting out, and health information and genetics industry].

- A scan of health reform and health care jobs in Newfoundland and Labrador, with an emphasis on women as paid care providers and changing working conditions [layoffs, casualization, workers' compensation issues, stress etc. Main focus: nurses].

- A look at the impact of the shift from institutional to home-based care on women as care providers, care recipients, and unpaid care givers within the context of restructuring [long term care, palliative care, home support, mental health, and targeted programs for women].

- An overview of the findings and identification of relevant and pressing questions that could not be answered within the framework of the present study.

The Context

As in other provinces, health care sector restructuring in Newfoundland and Labrador has occurred in a national context characterized by deep federal cutbacks to health care and social services funding, trade liberalization within the framework of the North American Free Trade Agreement (NAFTA), as well as a national policy objective to promote the export of Canada's health care goods, services, skill and expertise.[4] Ottawa's contribution to health care funding has fallen from 50 per cent of total public health expenditures to approximately 12 per cent in the past decade. Newfoundland and Labrador alone has lost hundreds of millions of dollars in federal transfer payments over the last five years.

Despite these massive cutbacks, the federal government has continued "to influence the legal and political framework in which the sector functions and evolves."[5] For example, the

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[4]Colleen Fuller, *Reformed or Rerouted?: Women and Change in the Health Care System*, (British Columbia Centre of Excellence for Women's Health, 1999) 3-8.

[5]Colleen Fuller, *Reformed or Rerouted*?, 4-5.

Canada Health Act of 1984 sets national guidelines and principles for universality in access to the health care system, but fiscal restraint and inadequate planning, in some instances, has meant that the restructuring initiatives of the provinces have not always successfully maintained the principles of universality and equity in access to health care services. In Newfoundland and Labrador this is especially evident in Government's lack of funding to community health initiatives, such as home support, which has come to the fore in three recently published reports.[6]

[6]Marika Morris, Jane Robinson, Janet Simpson et al. *The Changing Nature of Home Care and It Impact on Women's Vulnerability to Poverty*, prepared for the Canadian Research Institute for the Advancement of Women (CRIAW) 1999 ; Newfoundland and Labrador Employers' Council, *Home is Where the Care Is: Home Support Agencies Beyond 2000*, by William Shallow and Associates, March 2000; and the Institute for the Advancement of Public Policy, "Final Report: Review of the Home Support Program," submitted to the Department of Health and Community Services, Government of Newfoundland and Labrador, 7 June 1999.

The legal framework for the restructuring of Canada's health sector lies within the North American Free Trade Agreement (NAFTA). According to health care policy critic Colleen Fuller, it has yet to be determined whether or not Canada's publicly funded hospitals and community-based health facilities can be protected from "the full force of trade liberalization." Besides the legal framework, the federal government's commitment to the development of a health industry which can participate in global markets has also played a role in the restructuring. Economic policy initiatives such as this, in a sector of the economy that has been largely publicly-funded and delivered, have supported the development of public-private partnership ventures, business consolidations, and the entry of US-based companies into Canada under NAFTA, according to Fuller's research.[7] The Newfoundland and Labrador Government's ongoing efforts to diversify the province's weak economy have recently included the development of a health industry, based primarily on health information technology and, more recently, on genetic research. Such questions as who will share in the benefits of this research and innovation, and how the privacy of those involved will be protected remain, as of yet, unresolved.

Privatization, broadly-defined, lies at the centre of changes to the health care system, both nationally and provincially. For the purpose of this project, privatization is understood to encompass:

- the transfer of service provision from public and non-profit to private and for-profit organizations;
- the transfer of responsibility for service payment to individuals;
- the transfer of care work from institutions to private households and communities;
- the transfer of care work from paid to unpaid workers;
- the adoption of for-profit methods within health care service delivery; and

Privatization in the health care system can occur in the payment for health care services or the provision of health care services.

One of the objectives of this report is to document shifts in the health services available in Newfoundland and Labrador in terms of *who pays* for those services, *who provides* them, and, by extension, *who is able to freely avail* of particular services. For instance, the downsizing of acute care provision, through hospital bed closures, increases in out-patient treatment, de-institutionalization and an increase in community-based care has expanded the role of informal unpaid care providers, who are more likely to be women than men. It has also meant more out-of-pocket expenses for patients and their families, higher insurance premiums for those who qualify for health plans as paid employees, and higher co-payments for services that are not deemed "medically necessary" under existing legislation. This report argues that those particularly at risk of higher individual and family costs for health care caused by privatization, with little option

[7]Colleen Fuller, *Caring For Profit: How Corporations are Taking Over Canada's Health Care System* (Canadian Centre for Policy Alternatives, 1998).

other than to provide unpaid or poorly paid and supported services to family members and to manage without access to services, are the sick, the poor, the elderly and those who live in rural areas.

According to Colleen Fuller over the last ten years the private portion of health care spending has increased from around 22% to around 33% nationally.[8] While the Government of Newfoundland and Labrador has made few overt attempts to privatize health care, as it has maintained a commitment to supporting a publicly funded system (as opposed to Alberta for example), as in other provinces, there have been several instances where privatization has crept in, such as in genetic research, health information, the de-listing of some publicly insured medical services, privatization issues in the home support sector, as well as in the contracting-out of support services in institutions. Privatization has also occurred in the transfer of some health care services from institutions to the community. Like in other provinces, a key objective of health reform has been the movement of many non-acute care services out of the hospital sector and into more accessible community-based facilities. While the transfer of health services to community-based facilities (many of which have come under the jurisdiction of the Community Health Boards) does not necessarily lead to privatization, it is important to note that institutionally-based health care provision is publicly insured under the *Canada Health Act*, and that most services that are provided outside of institutions are generally only partially-insured or privately-insured. As Colleen Fuller has argued, "unless steps are taken to ensure these services are captured on the public health plan, privatization is the result" when they are shifted outside of institutions.[9]

This report considers that any analysis of these aspects of privatization and their impacts needs to be gender-informed. "A gender-based analysis is a process that allows for early identification and assessment of the differential impact on women and men of policies, programs, legislation, and community and industrial development. It is based on the view that policy cannot be separated from the social context of women's and men's lives and that social and economic issues are inextricably linked."[10] Although health care reform and privatization have had dramatic effects on both men and women, some aspects of restructuring have affected women more than

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[8]Colleen Fuller, *Caring For Profit*, 81-85.

[9]Colleen Fuller, *Reformed or Rerouted?*, 23.

[10]Barbara Neis and Brenda Grzetic, "From Fishplants to Nickel Smelter: Policy Implications, Policy Development and the Determinants of Women's Health in an Environment of Restructuring." Final Report produced for Health Promotions Branch, Health Canada, (Memorial University, St. John's: May 2000) 9.

men, and differently than them. Not all groups of women have been affected equally. While somewhat preliminary, the findings in this report suggest that privatization of health care services has had particularly negative impacts on women in Newfoundland and Labrador, and the possibility for further negative impacts is high. They suggest that since women are more likely than men to be poor and elderly and, in their poverty, to have dependents to care for; since responsibility for unpaid caring work is more likely to fall on their shoulders than those of men; and since they make up a majority of health care workers who have, in most cases, lost employment, wages and job security as a consequence of privatization; women in general, and poor, rural, nonprofessional and elderly women in particular may have suffered disproportionately from the negative impacts of privatization.

By themselves, health care reform, restructuring, and privatization have the potential to exacerbate women's vulnerability to poverty, and increase health risks to women as paid workers in the health care sector, as patients, and as unpaid care providers. Any transfer of costs from the public sector to individuals and families and non-governmental organizations without sustained funding can negatively impact women's health and well being, especially for those who have the least resources. However, in Newfoundland and Labrador, the potential negative health impacts of these changes for poorer, unemployed and underemployed women in rural areas in particular have been exacerbated by the concurrent health-related effects of environmental degradation, industrial restructuring, restructuring of post-secondary training and education and of the unemployment insurance program.[11]

Women's organizations and front-line health care workers, have long advocated a fully integrated, publicly funded system of health care delivery with a stronger focus on prevention and taking into account women's unpaid caring work in their homes and communities. The adoption of a population health model, and a shift from an approach that privileges acute care and illness to one that includes an emphasis on disease prevention and health promotion at the community level, as well as the reform of primary care (which has not yet been done in Newfoundland and Labrador) are reform initiatives that have the potential to benefit women. However, in the short term and in the absence of major social changes, if this change occurs at the expense of public support for universal access to a full spectrum of acute health care services, potential gains for women and men are likely to be jeopardized. Research and policies need to be gender-informed and women need to be fully incorporated into decision-making relating to all aspects of these reforms if they are not to be placed in jeopardy. We return to these themes in the Conclusion and discussion of areas requiring further research.

[11]Barbara Neis and Brenda Grzetic, "From Fishplants to Nickel Smelter."

Part I: Restructuring of the Health Care System

In Newfoundland and Labrador, the process of health care restructuring began in the early 1980s when the Progressive Conservative Government of Brian Peckford sponsored a *Royal Commission on Hospital and Nursing Home Costs*.[12] After several consultations with key stakeholders, the Royal Commission made 232 recommendations, most of which have since been adopted -- even though many of the recommendations took years to address and the province had not yet taken any serious measures to implement the changes. In its final report, the Commission argued that the *quantity* of care in institutions was too high and that there "are clinical efficiencies to be achieved in the longer term through a commitment to both sound planning and a rationalization of institutional services."[13] The Commission determined, for example, that there had been a 44 % increase in hospital staff between the 1970s and 1980s, salaries and wages had increased by about 180% between 1975 and 1983, and nursing home beds had increased from 1,065 in 1974 to 2,058 in 1983. Factors such as these were driving up the costs of health care, according to the Commission. The report also noted that there had been little change in the number of hospital beds between 1972 (3,045 beds) and 1982/83 (3,285 beds), when the Commission's mandate began. In fact, the Report suggested that if Government were to fully implement its recommendations, which included shorter hospital stays, more day surgery, an increase in chronic care facilities and decrease in acute care, a reduction of hospital beds per 1,000 population from 5.4 to less than 4, the transformation of cottage hospitals into clinics, the maximum use of part-time and casual nurses, the de-institutionalization of mental health patients and the physically disabled, reform would result in a substantial reduction of the overall health care budget.

[12]Government of Newfoundland and Labrador, *The Royal Commission on Hospital and Nursing Home Costs*, 15 February 1984.

[13]*Royal Commission on Hospital and Nursing Home Costs,* 6.

According to a 1994 report on health care reform published by the Department of Health, *Responding to Changing Health Needs*, Government did not begin its full-fledged restructuring process until 1990. "[I]t was during 1990, however, as a result of a bleak economic outlook, fuelled by a sustained national recession and coupled with decreased Federal Transfer Payments, that accelerated health care restructuring began in earnest."[14] Apparently, in response to an anticipated 14% shortfall in health care funding in 1990, Government established a Resource Committee to review the system. This was comprised of representatives from various bodies, including the Newfoundland and Labrador Medical Association, the Newfoundland and Labrador Hospital and Nursing Home Association, the Association of Registered Nurses of Newfoundland, Memorial University of Newfoundland Faculty of Medicine, and the Department of Health. While the Resource Committee did not produce any publicly accessible documents, the 1994 report explained that the Committee recommended: 1)resources should be moved away from certain sectors and into other areas; 2)all programs funded by the Department of Health should be subject to review; 3)quality of care should be a primary factor in the decision-making process; 4)duplication of services in the health system should be addressed.[15]

While participants in the Resource Committee, such as the ARNNL (Association of Registered Nurses of Newfoundland and Labrador), whose membership is dominated by women front-line workers, have advocated an increased role for nurses and other women workers in the decision-making process, six years later (in 2000) the ARNNL emphasized that their views had not been adequately represented in the process.[16] Even though women's organizations and health care professionals have supported the transformation of the health care system from a focus on acute care towards a focus on illness prevention, it appears that Government adopted these measures as part of a cost-cutting reform agenda instead of as part of a commitment to making the system more accessible and equitable.

A 1992 feature in the *Globe and Mail* on health care reform highlighted for the rest of Canada Newfoundland's efforts, which initially focussed on budget cutting and bed closures. As then Health Minister Chris Decker stated, "What we've done, the rest of Canada has got to do." According to the newspaper report:

> What Newfoundland did last year, as part of the severest budget in the province's history, was launch an unprecedented cost-cutting assault on its health-care system. When the smoke cleared, 450 of the province's 3,000 acute-care beds (15 per cent) had disappeared, and so had 850 jobs. Yet one year later the system

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[14]Government of Newfoundland and Labrador Department of Health, "Newfoundland's Department of Health Reform Initiatives, Responding to Changing Health Needs," (unpublished paper) 1994, 1.

[15]Department of Health, *"Responding to Changing Health Needs,"* 2.

[16]Personal Correspondence with Colleen Kelly, Nursing Consultant, ARNNL. Used with Permission.

seems to have survived.[17]

By 1994, the ratio of acute care beds per 1,000 population had been reduced to around 3.58. The ratio of acute care beds per 1,000 population does not reflect seasonal fluctuations in access to health care services. For example, in summer months the number of beds is reduced even further to accommodate shortages in staff due to summer vacations.

In furthering its reform and restructuring agenda, between 1993 and 1995 Government established Institutional Boards which consolidated the management and financing of hospitals and began the process of regionalization. Around the same time, the Department also established Community Health Boards, which were mandated to assume responsibility for a number of social services, long-term care, home support, and illness prevention and health promotion issues.

a) Regionalization:

[17] *Globe and Mail*, 27 April 1992.

As in other provinces, the corner stone of health care reform in Newfoundland and Labrador was the regionalization of service delivery and management. Within the regional framework, health care restructuring has also focussed on a population health model, an integrated approach to health care delivery, and a shift of non-acute care from institutions to community-based care.[18] Hospitals were targeted as a focal point for health care restructuring for reasons similar to those in other provinces, which Pat and Hugh Armstrong clearly explained in their report on privatization and health reform in Ontario.[19] According to Armstrong and Armstrong hospitals generally take up the largest percentage of the province's health budget, the services provided in hospitals are generally covered by the *Canada Health Act*, new technologies and drugs have created conditions for transformation in hospital care, and hospitals "appear to reformers to be quite similar to large, private sector corporations."[20]

Government began thinking about hospital restructuring in the early 1980s, when it started closing cottage hospitals in rural regions or transforming them into health clinics, focussing on chronic care. While many of these facilities were no longer viable and in desperate need of costly renovation and repair; the closures affected communities in terms of their sense of loss of control of their own infrastructure, and in terms of anticipation of future change. Thus, when Government proposed further restructuring in some communities only a few years after the loss of their cottage hospitals, they responded negatively.

During the 1980s, Government also gave the St. John's Hospital Council a mandate to plan for restructuring hospital facilities in the St. John's region. In 1989 the Hospital Council released a report to the province, outlining its plan for hospital amalgamation and restructuring, which the Council anticipated would cost $300 million. The Minister of Health did not adopt the recommendations in the report. Instead, he encouraged the Council to consider relocating the Janeway Children's Hospital to the Health Sciences Centre and to consider redeveloping the

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[18]Canadian Institute for Health Information (CIHI), *Health Care in Canada: A First Annual Report, 2000*, (Toronto: CIHI) 7.

[19]Pat Armstrong and Hugh Armstrong, *Women, Privatization and Health Care Reform: The Ontario Case*, prepared for the National Network on Environments and Women's Health, (December 1999) 2-3.

[20]Pat Armstrong and Hugh Armstrong, "Women, Privatization, and Health Care Reform," 3.

obstetrical and gynaecological facilities for the province. The Minister's recommendations served as the basis for future restructuring of hospitals in the St. John's region.

In 1992, as part of the hospital restructuring process, Minister of Health Chris Decker announced that Government intended to review the number of provincial hospital Boards operating under the *Hospitals Act.* Decker appointed Lucy Dobbin (past CEO of St. Clare's Mercy Hospital) to chair the Commission. Dr. Arthur May (future president of Memorial University) chaired the Advisory Committee, which conducted consultations in Newfoundland and Labrador as well as in Saskatchewan and New Brunswick. Dobbin's final report, *Report on the Reduction of Hospital Boards,* was released 3 March 1993. There were several independent hospital and nursing home boards throughout the province at that time. Dobbin recommended these be collapsed into six or seven regional boards. According to Dobbin's report, the reduction of the boards was considered in light of principles such as the "effective and efficient utilization of scarce human and fiscal resources;" "opportunities to take advantage of economies of scale that can be achieved by alternate board structures;" and, the "impact on quality of services provided."

In her report, Dobbin also stated that because of the challenge of geography (small population and vast territory), her intention was to keep primary care services as close to the people as feasible, ensure that secondary services were available in each region, and that tertiary care services were available only in St. John's.[21] Government adopted most of Dobbin's recommendations, which focussed on hospital closures (mainly in St. John's), amalgamations of budgets and administration, and the amalgamation of the Boards themselves. The first two Institutional Boards were set up in 1995.

Questions of access and equity were not addressed in any great detail in the report, nor was there any mention of the ways in which the regionalization process might have differential effects on men, women, and children from different parts of the province. For example, the issue of who pays for travel and transportation costs for patients and their families (discussed below), was not addressed in Dobbin's report. Further bed closures, staff reductions, and other reforms within individual hospitals would now be the responsibility of the Boards and not of the provincial Government. When the Institutional Board on the west coast of the island closed 22 beds in 1995, premier Clyde Wells said that Government had not given the Board that directive.[22]

The largest hospital restructuring project in the province took place in St. John's and is yet to be completed. Despite resistance from the individual hospital boards in St. John's, Dobbin recommended that the Janeway Child Health Centre and the Children's Rehabilitation Centre

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[21]Lucy C. Dobbin, *Report on the Reduction of Hospital Boards* presented to Hon. Dr. Hubert Kitchen, Minister of Health, Government of Newfoundland and Labrador (February 1993) 3.

[22]*Evening Telegram,* 2 August 1995.

should be merged and that one Board for all acute institutions should be established, amalgamating the Janeway, General Hospital, Grace, St. Clare's, Waterford, and Dr. Walter Templeman Hospital on Bell Island. Significantly, Dobbin mentioned that the Waterford Hospital had already started to de-institutionalize mental health patients and to move them into a community-based model of care.

On April 1, 1995, the Health Care Corporation of St. John's assumed responsibility for eight health care facilities in the St. John's region, three schools of nursing, Central Laundry facilities and the Regional Ambulance Service. Some key aspects of the restructuring in St. John's were the adoption of one budget for all institutions, the closure of the Salvation Army Grace Hospital, the closure of the Janeway (Pleasantville site) and the construction of a new children's hospital at the Health Sciences site. Hospital restructuring in the St. John's region was meant to cost $130 million, which was considerably less than the St. John's Hospital Council's 1989 figure of $300 million.

The labour and delivery component of the Women's Health Program was scheduled to be relocated to the Health Sciences Centre at the beginning of July 2000. In 1997 the Corporation noted that the process of moving the obstetrics and gynaecology service from the Grace to the Health Sciences, would take several months, "It sounds like we should be able to do it more quickly but realistically taking care of the sick -- sick mothers -- is going to take a period of time."[23] The Children's Hospital will also be moved to the Health Sciences Centre. This has been rationalized on the basis that children "will have access to the advanced one-of-a-kind medical technology and health care expertise currently based at the General Hospital. Children will no longer have to be transported to the General Hospital for certain procedures." According to Eileen Young, the Chairperson of the Corporation, the amalgamation of obstetrical services and pediatric services will be most effective "so new mothers will no longer be separated from sick newborns requiring medical attention."[24] Little publicly-accessible documentation exists on the potential positive and negative effects of these changes on women's health as care recipients and as paid workers.

Furthering the regionalization of service delivery and management, in 1993, the Department announced the establishment of Regional Community Health Boards, which were mandated to "provide a comprehensive range of community health services including health promotion, health protection, single point of entry for home care, home support services as well as entrance to personal care and nursing homes, continuing care, drug dependency, and mental health services."[25] In St. John's, for example, the Community Health Board came out of the merging of the St. John's Home Care Program, the St. John's Drug Dependency Services, and the

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[23]*Report of the Standing Committee of Public Accounts Respecting Paragraph 3.21 of the Report of the Auditor General for the Fiscal Year Ended 31 March 1997: Health Care Corporation of St. John's,* (St. John's: May 1999) 56. Hereafter this report is cited as *Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's.*

[24]Department of Health, *Newsrelease,* 4 September 1996.

[25]Department of Health and Community Services website, www.gov.nf.ca.

St. John's and District Health Unit. Within the next year, three other Community Health Boards were established in the province (Eastern, Central, and Western) as well as two Integrated Boards, which combined Community Health and Institutions on the Northern Peninsula and in Labrador.

Government's rationale for establishing the Community Health Boards was their commitment to emphasize "wellness over illness, empowering communities, and one-stop shopping."[26] The Minister also noted that the Boards' objective would be to promote "individual responsibility for one's own health."[27] As a result of the regionalization process, the Department's role changed to focus primarily on policy direction, funding, and monitoring.[28] Over the past five years the province has furthered the devolution of power and responsibility for certain social services and health care services.

On April 1, 1998 Child Welfare and Community Corrections, as well as Family and Rehabilitative Services, which were delivered by the Department of Human Resources and Employment, were integrated with the Department of Health, which was renamed the Department of Health and Community Services. According to the Newfoundland and Labrador Health Boards Association, by the year 2001 even more social services will be shifted to the Community Health Boards.[29] In 1998 the province drafted a new *Child, Youth and Family Services Act*, which "provides the framework for the development of prevention and early intervention strategies with services delivered by Health and Community Services and Integrated Boards, and community- based agencies. It will also expand services to youths aged 16 and 17."[30]

The recently named (April 5, 2000) Newfoundland and Labrador Health Boards Association (NLHBA) is the organization which represents the Boards in the province, providing group purchasing services, labour relations advice, and some research and monitoring of the situation.[31] The NLHBA has raised serious questions about the transferring of social services to

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[26]Department of Health, "Responding to Changing Health Needs," 3.

[27]Department of Health, *Newsrelease,* September 1993.

[28]Department of Health, *Newsrelease,* April 1993.

[29]Personal Communication with John Peddle, Executive Director of the Newfoundland and Labrador Health Care Boards Association. Used with permission.

[30] Department of Health, *Newsrelease,* 4 October, 1999.

[31]The NLHBA started off in the early 1960s as the Newfoundland Hospitals Association. In 1987 the Association changed its name to Newfoundland Hospital and Nursing Home Association, to be more reflective of its membership which now included nursing homes. In 1995 its mandate was broadened to include community-based health services and Community Health Boards were added to the membership. In accordance with these health care reforms the organization changed its name to the Newfoundland and Labrador Health Care Association. In 1998 its mandate changed again to integrate child welfare, family and rehabilitation, and community/youth corrections into the health system. The Community Health Boards became the

the Community Health Boards without proper planning and funding. One of the effects,

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Health and Community Services Boards and the Association became the Newfoundland and Labrador Health and Community Services Association. In 2000, the Association "reviewed the many attempts to match the name of the Association with the evolving mandate of the health system and voted for a final comprehensive change, choosing a name that is clear, distinctive, and flexible enough for future change." Newfoundland and Labrador Health Boards Association web page (www.nlhba.nf.ca).

according to the NLHBA has been the privatization of the delivery of some health and social services.[32]

In March 1998, the Department of Health added $2 million to the budget for the regional Community Health Boards. However, $300,000 of the total was allocated to a Vaccination budget for school children and the remaining $700,000 was allocated for protection, promotion, prevention and early intervention, mental health, addictions and continuing care.[33] It is difficult to analyse changes over time in funding to the Community Health Boards, because of the scope of the Boards' responsibility for administering non-acute care in the "community" as well as prevention and promotion. While overall funding for the Community Health Boards has increased from 3.14% in the early 1990s to around 15% in 2000/01, many new services, previously dealt with by other Government Departments, have come under the jurisdiction of the Boards.

b) The Changing Role of the Department of Health:

From a research point of view, the devolution of power and responsibility, as well as the scope of change (from around 30 individual boards to six or seven) has meant that tracking and monitoring the impacts of restructuring is extremely difficult. This is a prerequisite for doing a gender-informed analysis and in the absence of documentation it is difficult to monitor the differential effects of regionalization.

Over the past decade, the provincial Government has rationalized its movement towards further integrating services into the regional Health Boards in terms of providing better continuity of care and avoiding duplication. In 1993, Minister of Health, Hubert Kitchen stated: "the new board structure will provide the opportunity to enhance patient care services and will allow us to improve efficiencies in resource utilization. In general, this approach will provide a climate for more innovation and cost effective delivery of quality health care services."[34] In effect, however, as part of the restructuring process, the Department of Health has moved away from its past roles as a health service provider toward a focus on policy development. One of the most significant changes in terms of Government's role has been the movement of health services out of its area of responsibility and into the jurisdiction of the Boards. Prior to the implementation of reforms, the Department administered directly 18 to 19 cottage hospitals, which they closed or replaced with

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[32]Newfoundland and Labrador Health and Community Services Association, "Presentation to the Minister of Finance on Budget 2000," 1 March, 2000.

[33]Department of Health, *Newsrelease* 25 March 1998.

[34]Department of Health, *Newsrelease,* November 1993.

community health centres, as well as most of the major institutions. One of the most dramatic changes in terms of the impact on women as unpaid care providers, care recipients, and paid health care workers, has been that personal home support services, once administered directly by employees of the Department, have come under the

administration of the Community Health Boards. Outside of institutions, home support work is done primarily by non-unionized, low paid, untrained women workers.

The provincial Government has retained some degree of control over the Boards insofar as the Institutional and Community Health Services Boards are appointed and not elected in Newfoundland and Labrador. In provinces, such as Saskatchewan, where health board members are elected, the number of women directly involved in the decision making has increased substantially. [35]

For the first time ever, in May 1997, the Government held a Provincial Health Forum, chaired by Roger Grimes, who is presently the Minister of Health. It appears that the public forum was organized primarily to respond to the changes that restructuring had created for the newly-established Boards, for patients, and for front-line workers. While no publications came out of the forum, some of the issues addressed included: the need for a better integrated health system, doctor shortages in rural communities, emergency room doctor shortages, workload stress on front-line workers, waiting times for cardiac surgery, and other health services, the pace of reform, and the need for a more coordinated role for various health professionals, increased emphasis on prevention and public education, and more evidence-based decision making. The participants, who included a number of stakeholders, stated that "if government plans to make further changes in health service delivery, they should know with some certainty that improved service will be the outcome."[36]

In response to the problems raised at the public forum, the Department introduced the following measures: an improved compensation package for emergency room doctors ($5.3 million), implementation of Workload Measurement Systems for nurses, the establishment of Primary Service and Teaching Units in Twillingate and Port aux Basques, the formation of an Advisory Committee on health issues, as well as an injection of $20 million into the Institutional

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[35]Kay Willson and Jennifer Howard, *Missing Links: The Effects of Health Care Privatization on Women in Manitoba and Saskatchewan*, prepared for Prairie Women's Health Centre of Excellence (February 2000) 9-10.

[36]Department of Health, *Newsrelease*, 10 May 1997.

Boards.[37] This reactive, project-based, targeted-initiative rationale has characterized Government's planning and funding of the health care system since 1995. Reactive strategies such as these have a high potential to threaten sustainability, universality, and continuity of care for women and men.

[37]Department of Health, *Newsrelease*, 10 May 1997.

Front-line workers, reform-oriented community groups, and women's groups have all been supportive of the principles upon which the Department new approach to policy and program development lies with1) less focus on treatment and more on disease prevention and health promotion, 2) less focus on institutions and more on community; and 3)a primary health care approach, which supports the decentralization of decision-making.[38] However, these groups have been outspoken and critical of the results of reform and restructuring as it has occurred. The reform process has been characterized by a lack of consultation and a lack of planning, according to many groups of health care professionals and community groups. In that regard, one of the Department's most obvious shortcomings has been that it has not had the time or the resources to produce an annual report since 1995, which raises serious questions about accountability.

The provincial Medical Association (NLMA), the Newfoundland and Labrador Nurses' Union (NLNU), and the Association of Registered Nurses (ARNNL) have been particularly vocal about the reorganization of primary care. While doctors have been mainly concerned with maintaining their role as gatekeepers of primary care, nurses' groups have argued for an enhanced role in the health care system. Both groups have argued that such restructuring would require research and planning. For instance the NLMA argued that the cost-effectiveness of primary care provided by physicians and other providers should be studied thoroughly before any major changes are made to the system.[39] Nurses, however, have repeatedly and adamantly argued that they have not achieved the level of input into decision making they believed they should have had in the process.[40]

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[38]Sheila Tucker, "Increasing Efficiency in the Health Sector: A Case Study of the Newfoundland and Labrador Department of Health," unpublished paper (December 1996) 9.

[39]Newfoundland and Labrador Medical Association (NLMA), "Review of The Draft Model for a Redesigned Health Care System in Newfoundland and Labrador," 6 January 1996 (http://calloso.med.mun.ca/~nlma/nwslet/nlhca.htm)

[40]Personal Correspondence with John Vivian and Karen Carol, Newfoundland and Labrador Nurses' Union (NLNU), and Correspondence with ARNNL. Used with permission.

In 1995 the NLNU commissioned a study on primary care reform, "Community Health Centres: The Better Way to Health Reform, NLNU's Perspective." The study was conducted by Dr. Michael Rachlis (Professor of Medicine at McMaster University and a critic of health care reform) and Carol Kushner.[41] The report argued that if nurses, doctors, and allied health professionals and others worked as a team at the point of entry, patients "would get more services up front at a stage when they can, in fact, manage their medical condition.[42] Debbie Forward, president of the NLNU from 1996, stated that the NLNU supported the community health centre model, because it uses an expanded role for nurses as an entry point to the health care system. There is extensive documentation to support the fact that a nurse is a cost-efficient and qualified health care deliverer, Forward stated.[43] The NLNU also presented Government with a document titled, "Action Plan to Develop Community Health Centres in Newfoundland and Labrador" in 1996.[44]

The Danemark-Newfoundland primary care demonstration project on the southern shore of the Avalon Peninsula, used public community consultations to determine the health care needs of the local population. According to a representative from the ARNNL, some of the issues that women raised included increased stress levels due to the closure of the fish plant in the community, and "other lifestyle issues."[45] The project, which was co-sponsored by the World Health Organization, officially lasted for around two years, however, one of the region's community health nurses has continued to work within the project's framework and has begun to see profound change in the community after a number of years. Demonstration projects such as these are potentially useful if the funding continues and if they are used to inform policy in other regions.

c) Public/Private Sector Spending:

In Newfoundland and Labrador, just as in other provinces, the public and private sectors are both involved in the financing and delivery of health care. As is outlined in the *Canada Health Act*, public health, hospital services, services to status Indians and Inuit, and physician services are publically funded. Privately-funded health care expenditures usually encompass insurance premiums, out-of-pocket health care costs, drugs, dental service, vision care, and complementary medicines and therapies. The Canadian Institute of Health Information (CIHI) has recently projected that, on average, each Canadian will spend around $850 per year on health care in 1999. The CIHI has also noted that private spending on health care has outpaced public

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[41]*Evening Telegram*, 14 September 1995.

[42]*Evening Telegram*, 14 September 1995.

[43]*Evening Telegram*, 28 October 1996.

[44] Department of Health, *Newsrelease*, 1 May 1996.

[45]Personal Correspondence with ARNNL. Used with permission.

spending in the 1990s in Canada.[46] The CIHI's most recent figures indicate that 23% of health care spending in Newfoundland and Labrador would come from private sector sources in 1999. Compared with other jurisdictions, Newfoundland and Labrador's private spending percentage is relatively low. For example, Ontario's proportion was highest in Canada at 34%, followed by Alberta, PEI and New Brunswick at around 31%.[47] Significantly, the CIHI did not provide per capita breakdowns of the data or change over time figures in its Annual Report. Other CIHI figures indicate that per capita private health care spending (in current dollars) in Newfoundland and Labrador has increased from $381.53 in 1990 to a forecasted figure of $603.25 in 1999.[48]

Lower private expenditures may be more a consequence of relatively low incomes in the province than a reflection of the adequacy of public services. Poorer people tend to underutilize health care services relative to their actual health status.

[46]CIHI, *Annual Report 2000*, 19.

[47]CIHI, *Annual Report 2000*, 19.

[48]CIHI, *National Health Expenditure Trends (1975-1999) Report*, "Attachment 9" (http//.www.cihi.ca/medrls/nhexdec/attac9.htm).

In 1999, Newfoundland and Labrador spent (private and public) $2,037 per person on health care.[49] Relative to other provinces, Newfoundland and Labrador ranked fifth in terms of overall spending on health care in 1999. Generally speaking provinces with smaller populations and large geographical distribution spend more public monies on health care per capita than those with more populated areas. Newfoundland and Labrador and the Territories have the highest portion of GDP spent on health care.[50] Throughout the 1990s, Newfoundland and Labrador, however, had the lowest care per capita health care expenditures in the country, according to CIHI figures.[51]

Nationally, the highest percentage of public health care dollars is allocated to hospitals and the next highest percentage goes to pay the cost of prescription drugs. CIHI noted that retail drug sales now account for an extra six dollars out of every 100 dollars spent on health care, compared with the 1970s. In Newfoundland and Labrador the cost of health care has also been rising dramatically over the last ten years, with increased costs of new technology, new prescription drugs, new equipment, new medical specialists, and the integration of social services programmes into the health care Boards. Public funding has not kept pace with these changes, according to the NLHCBA.[52]

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[49]CIHI, *Annual Report 2000*, 16.

[50]Newfoundland and Labrador Health and Community Services Association, "Tax Cuts and Health Funding," Presentation to the Premier's Advisory Council on the Economy and Technology," (28 September 1999) 10. http//www.nlhba.ca

[51]CIHI, *National Health Expenditure Trends (1975-1999)*, " Attachment 5."

[52]NLHCSA, "Presentation to Minister of Finance on *Budget 2000*," 6.

The provinces and territories are responsible for administering the bulk of the public sector health care budget, a portion of which is financed through federal transfers of cash and tax points.[53] Newfoundland and Labrador is one out of seven provinces that receives equalization funding from Ottawa. The Federal government's eradication of Established Programs Funding and CAP (cost-sharing funding for health care and other social services transfers) in 1995, and its introduction of the CHST block funding scheme in 1996 has meant a dramatic reduction in Federal health care funding to this province, as in other provinces. Since the CHST has been introduced, it has been difficult to document where the federal dollars have been spent because the provinces and territories are free to allocate the CHST to health, education, and other social programmes according to their individual priorities. The National Union of Public and Government Employees (NUPGE) has also noted that, "because the point of entry into the health care system in Canada is increasingly community-based rather than institution-based," there is no guarantee that the provinces will put extra CHST/Social Union bonus money into the health care system.[54]

According to the NLHBA, Newfoundland and Labrador was hit particularly hard by the changes to Federal funding: "for Newfoundland and Labrador, the reduction in health transfers, at -12.8% between 1985 and 1995, has been greatest among all the provinces and territories, and is well below the national average of -8.7%.[55]" One of the factors that sets Newfoundland and Labrador apart from other provinces is that under the current system of tax point transfers (the federal government reduces its tax rate, allowing provincial governments to increase their tax rate without changing the "bottom line" that a tax payer pays[56]) The transfer of tax points, is, of course, less valuable to the poorer provinces with high unemployment and a less active economy. The federal Government's recent change of funding from needs based to per capita funding[57] scheme also hurts poorer provinces like Newfoundland and Labrador more than other more populated regions. It was within this context that the NLHBA lobbied against the Tobin Government's proposal to cut taxes, stating that the health care system would suffer as a consequence.

In 1996/97 the NLMA noted that the provincial government spent 26.8% of its budget on health care. "However, in comparing real per capita spending on health to other provinces, Newfoundland and Labrador ranks lowest."[58] "This has been manifest in reductions of acute beds,

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[53]CIHI, *Annual Report: 2000*, 18.

[54]National Union of Public and General Employees, "Backgrounder: Women in Health Care," prepared for the National Union's Advisory Committee on Women's Issues," May 2000.

[55]NLHCSA, "Tax Cuts and Health Funding," 10.

[56]CIHI, *Annual Report: 2000*,18.

[57]Government of Canada website: http://www.fin.gc.ca/budget00/bpe/bpch6_le.htm

[58]NLMA, "Pre-Budget Consultation Brief," 1997, 1, (http://calloso.med.mun.ca/~nlma/nwslet/bud97.htm)

closure and downgrading of some facilities, and elimination of government coverage (MCP) of some medical services." The NLMA also pointed out that the provincial health budget has been frozen for three years (1994-97). The Association also found that ninety-two percent of the public believe that smaller communities are having increased difficulty finding and keeping good physicians."[59]

[59]NLMA "Pre-Budget Consultation Brief," 1997, 2.

In the most recent provincial budget, *Budget 2000: for the Health of the People*, Government allocated 60% of the health care budget to hospitals and nursing homes, 15.6% to community health, 15.6% to MCP-Physician services, and 5.3% for medical and drug subsidies. The only item geared specifically to women's health was $2 million allocated to a Comprehensive Breast Health Centre at St. Clare's hospital.[60] Significantly, Newfoundland has the lowest level of mammograms in the country. Only 43% of women between 50 and 69 received mammograms in 1996/97 increasing to 48.2% in 1998/99 compared with the national average of 63.1% and 66.2% respectively.[61] In light of the CIHI figures, this targeted program for women appears to be reactive as opposed proactive.

It has yet to be determined whether the regionalization of health care has been cost-effective. However, evidence from a number of sources (ie: Auditor General's reports, CIHI data, NLHBA, and the Provincial Health Forum of 1997) has underlined the serious financial difficulties that the Institutional and Community Health Boards are facing. Since the restructuring, the regional Health Institutional Boards have faced significant financial difficulties. According to John Peddle, executive director of the Newfoundland and Labrador Health Care Association, the province's health care sector is supposed to go by yearly budgets, which has made long-term planning next to impossible. In 1995 when the Institutional Boards were asked to find $27 million "to help the province out of its $60 million deficit," the Boards were forced to cut.[62] In 1997, following the recommendations of the Public Health Forum, the provincial Government gave the Boards an additional $20 million. The next year (1998) the Boards' financial problems, which had resulted from "increased patient acuity; increased workload in emergency and outpatient services; aging population with multiple health and social needs; pay equity; new high cost drug therapies, such as chemotherapy and antibiotics; inflation on supply costs; new technology; and increased maintenance costs due to the aging of the equipment and facilities" continued to persist.[63] In

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[60]Government of Newfoundland and Labrador, *Budget 2000: For the Health of the People.* (www.gov.nf.ca)

[61]CIHI, *Health Indicators 2000* , in CIHI, *Annual Report 2000*, np.

[62]*Evening Telegram,* 8 April 1996.

[63]Department of Health, *Newsrelease*, 26 March 1998.

1998 the Department allocated an extra $10 million to the Boards.[64] Lack of information about government plans and the direction of reform and restructuring efforts have created a great deal of uncertainty throughout the institutional and community sectors.[65]

d) Barring Access: Gender, Rural-Urban Disparities and Restructuring:

[64]Department of Health, *Newsrelease,* 26 March 1998.

[65]Sheila Tucker, "Increasing Efficiency in the Health Sector," 13.

Despite restructuring, barriers to access to some health care services for women, men and children living in remote areas continues to be an issue, although the extent and nature of these impacts require more research. Because much existing research is not fully gender-informed it is difficult to access women's concerns about health care service changes and their impacts on women. A recent Community Needs Assessment done for the Grenfell Regional Health Services which has responsibility for Southeast Labrador, the Labrador Straits, and the St. Anthony, Flowers Cove and Roddicton areas found a relatively high level of overall satisfaction with regional health services. Satisfaction was highest with clinic and public health nursing services. It was lowest with allied health professional services, long term care and mental health services. Discontent with allied health professional services was related to the absence of such services within the region and limited availability of others. Mental health services were also considered to be inadequate. In all areas in the region the need for more home care and home support for the elderly was a major concern. Lengthy waiting lists, limits on the coverage available in the evenings and on weekends, and the cost of home care were issues. Some regions lacked basic facilities for long term care and where such facilities did exist, there were too few and staffing levels were insufficient. At 4.4 visits/person/year health service utilization in the region appeared to be below the Canadian average of 5.2/person/year. Unfortunately, interview findings on health care utilization and satisfaction are not fully broken down by gender in the report on the community needs assessment.[66]

Numerous communities have questioned the centralization of services and Boards have stressed their own inability, due to financial constraints, to deliver those services members of their communities need. Changes to the health care system have happened during a period in which many small communities have been losing their younger population to outmigration, their tax base, their provincial funding from the Department of Municipalities, and their sense of cohesion. As one NLNU representative stated, almost the day after the Government announced its regionalization scheme, trucks came into small communities to pick up medical equipment that was going to be relocated to the larger centre. These communities had fundraised for the equipment they were losing.[67]

At a community meeting recently held in Labrador West, residents and health care workers highlighted several problems relating to access to health care. Complaints voiced at a

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[66]B. Bavington, S. LeFort, L. Longerich, and A. Ryan, *Community Needs Assessment for Grenfell Regional Health Services*. Health Research Unit, Division of Community Medicine, Faculty of Medicine, Memorial University of Newfoundland 1999.

[67]Personal Correspondence, John Vivian and Karen Carol, NLNU. Used with permission.

public meeting related to cuts in available services, particularly in the areas of physiotherapy and occupational therapy; the movement of the site administrator at the Labrador City hospital to Goose Bay; a general downgrading of services, and a decline in visiting specialists. In short, residents of Labrador West argued that regional Boards in the northern regions of the province should get more funding because of their relative isolation and increased costs associated with remoteness.[68]

[68]*Western Star*, 4 October 1999.

To deal with the issue of physician shortage in rural areas and a shortage of other health care professionals, in 1998, Minister of Health, Joan Marie Alyward signed a Memorandum of Understanding with Division Surgeon 1 of the Canadian Air Force to bring air force physicians into the provincial health care system on an emergency basis. According to the Minister, "while the Air Force medical teams are not a permanent solution to the ongoing challenge of physician recruitment, they will provide relief for physicians and other health professionals and enhance health care in under-serviced areas of the province."[69] Practices such as these demonstrate the acuity of the situation as well as a lack of planning.

In terms of women's health, there are a number of issues involving uneven access to care, especially for those living in remote regions of the island. Regional nurses have worked effectively in northern areas where they can treat patients for the common cold, ankle sprains, urinary tract and vaginal infections, and conduct Pap smears. Many female patients feel more at ease having Pap smears with a female health care worker.[70] While a Nurse Practitioner Act was passed in 1998, nurses have argued that Nurse Practitioners have been underused in this province.

Access to sexual and reproductive health prevention and promotion in certain areas of the province is another serious equity issue. Teen pregnancy, sexually transmitted diseases and increasing risks of cancer in women because of lack of testing are expensive for the health and social services system in the long run, but the supports for these services have not been put into the regionalized system.[71]

The regionalization of medicine in this province has also meant increased reliance on long distance telephone services. Long distance phone lines to rural areas are constantly blocked from 6 pm on and, as a result, health care providers have had difficulties getting assistance. For instance, in December 1998, blocked telephone lines resulted in the deaths of two patients (one in Labrador and the other on the Bonavista Peninsula) because health care workers couldn't get through to the poison control centre in St. John's.[72]

Summary of Part I

[69]Department of Health, *Newsrelease,* 5 June 1998.

[70]*Evening Telegram,* 25 February 1997.

[71]Personal Correspondence, Peggy Matchim, Executive Director of Planned Parenthood, Newfoundland and Labrador. Used with permission.

[72]*Evening Telegram*, 9 December 1998.

The regionalization of the health care system in Newfoundland and Labrador and the formal adoption of a population health model with a related focus on prevention and health determinants have been the cornerstones of the reform and restructuring initiatives of the 1990s. These changes have taken place within a context of cut-backs, which have been partly a result of drastic cuts to federal transfers for health care. The effects of the hastily executed regionalization process in this process have been difficult to monitor. As the Health Boards Association recently stated, "the pace of change in the health system continues without clear directions, adequate funding for necessary infrastructure or assessment of the effects of restructuring.[73] Despite the formal shift to a population health approach, services related to health promotion appear to be particularly limited in many areas, as are services related to acute care. There is little evidence that restructuring was informed by a gender-based analysis, and there is little evidence that potential differential impacts of changes to the health care system on women and men are being monitored effectively, if at all. One of the consequences of poor planning and inadequate funding has been privatization, which can differentially affect women and men, as well as different groups of women.

[73]NLHCBA, "Presentation to the Minister of Finance on *Budget 2000,"* 5.

Part II: Privatizing Medical Services

Reducing public coverage of health services

As in other provinces, over the past decade, in Newfoundland and Labrador, public coverage for certain medical services has been privatized. In other words *who* pays for services, such as vison care, dental, prescription drugs, and physiotherapy, has in some cases shifted further from the state to individuals and households. Factors such as the regionalization of health care service provision, a shift from acute care in hospitals to care in the "community," more day surgery, and federal and provincial legislative and policy changes have changed somewhat the nature of health care costs (increased, for example, the transportation costs associated with accessing services), as well as who pays for them. They have meant that the financial burden for health care services is being shouldered increasingly by individuals, families and probably by the volunteer community/charity sector–although this report does not look at the latter. These changes are likely having a particularly dramatic effect on women, who are more likely to use the health care system than men, whose incomes are on average lower, and whose employment status is likely to be more precarious than that of men. The transfer of some costs to individuals and households through out-of-pocket payments, increased co-payments, and increased deductibles from private health care insurance has the potential to exacerbate women's vulnerability to poverty and relatedly, to illness in this province, particularly as care recipients and unpaid care providers.

a) Medical Care Plan and De-listing of Services:

Newfoundland and Labrador is no different from other jurisdictions insofar as over the course of the 1990s the provincial Government has de-listed some medical services that were once covered under the provincial Medical Care Plan (MCP). While services that fall under the *Canada Health Act* must be covered by public insurance plans, the province has control over coverage for other medical services listed in the Regulations of the *Medical Insurance Act,* such as prescription drugs, optometry, and some physician services. In other words, the province has some power to decide on what it deems as "medically necessary" but it is difficult to find out exactly how this is currently defined by Government. The NLMA has also pressured Government to delist some services that are supplied by physicians.

In 1988 the Department of Health began to reduce the amount of vision coverage under the provinces' medical plan, when it decided to provide one insured service per patient in a 24 month period instead of every 12 months. Responding to pressure from optometrists and others, in 1990 the government brought back 12 month coverage for persons under the age of 18 and those over the age of 64. Vision care is a service which has now been de-listed altogether. This restriction ignores the many eye problems that women experience with aging.[74]

[74]Pat Armstrong and Hugh Armstrong, *Women, Privatization and Health Care Reform*,

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The process of de-listing other services continued into 1991, when the NMLA announced its doctors would begin billing patients for services not covered by MCP, but for which patients had not generally been charged in the past, including:

- medical examinations for employment or a drivers' license;
- medical advice over the phone;
- absent-from-work forms and;
- the cost of dressing and bandages for casts and splints.

Joyce Hancock, the executive director of the Bay St. George Status of Women Council, criticised the decision, stating "many of the council's clients seek medical advice in the quickest way possible -- and that may mean picking up the phone and saying their child has a temperature of over a hundred. If they think in terms of cost that may stand in the way of their doing that, and that worries me." Hancock was also concerned that people "won't do things for their own health if it costs money," arguing as well that women working in stores and offices may be required to get a verification form from the doctor if they miss a day of work being sick. Hancock also noted that women may end up going to work sick and spending the money on their children, rather than paying for the verification. Rev. Christina Oosthuizen, also of the west coast of the island, asked "how is a person on social assistance looking for work going to pay $60 or $70 for a pre-employment medical. Such measures also have a high potential to hurt the working poor, as the minimum wage has not been indexed to inflation in Newfoundland and Labrador.[75] The minimum wage was increased to $5.50 an hour from $5.25 in 1999, but Newfoundland and Labrador's rate remains the lowest in the country. A study of minimum wages in Canada recently concluded that 64 per cent of all minimum wage earners in the country are women.[76]

In May 1995, Government announced that it was no longer going to insure medical exams required for seniors upon renewal of a driver's licence. This meant that the cost of a medical exam, which elderly drivers at 70 years were required to take every two years, and after 80 every year, would be shouldered by the individual driver. The cost of the exam was around $40 in 1995.[77]

Currently, The Newfoundland and Labrador Medical Care Commission, which came under

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[75] *The Georgian*, 17 December 1991.

[76]Michael Goldberg and David Green, *Raising the Floor: The Social and Economic Benefits of Minium Wages in Canada*, 1999, p.i.

[77]Department of Health, *Newsrelease*, May 1, 1995.

the jurisdiction of the Department of Health on 1 April 2000, has a Surgical-Dental Program, which covers a limited range of surgeries, a Dental-Health Plan, and a Medical Insurance Plan.

While other provinces have recently reduced dental health coverage for children or eliminated the program altogether, children up to and including the age of twelve, in Newfoundland and Labrador, are covered for the following services.[78]

- examinations at six month intervals
- cleanings at twelve month intervals
- fluoride applications at twelve month intervals
- x-rays
- fillings and extractions

Parents of children using the plan must, however, pay a variable amount directly to the dentist for each service provided. This fee differs from dentist to dentist. For example, phone calls to various dentist offices in St. John's revealed that a cleaning can involve a co-payment of anywhere between $4 and $12 and a filling can cost parents from $12 to $30 or $40. Those parents without private insurance pay the full amount. In Manitoba and Saskatchewan financial responsibility for children's dental care has shifted to families and private dental insurance programs over the past decade, while children of social assistance recipients still qualify.[79]

In Newfoundland and Labrador, Social Assistance recipients from 13 to 17 years of age also receive the same basic services as children under the DHP. Adult recipients of Social Assistance are eligible for emergency care and extractions only, or relief pain and infection services. Thus, if those over the age of 18 receiving Social Assistance prefer to have a cavity filled as opposed to waiting until their teeth need to be extracted, they must cover the cost privately. [80] Social Assistance premiums have been declining over the past ten years. For example, welfare benefits for single employable persons dropped by 43.1% between 1986 and 1996, and they dropped for single parents with only one child by around 8.6% between 1986 and 1996.[81] A co-

[78]Newfoundland Medical Care Plan website (http://www.gov.nf.ca/mcp/dental.htm)

[79]Kay Willson and Jennifer Howard, *Missing Links*, 24-25.

[80]Newfoundland Medical Care Plan website.

payment of $5.00 for each service is required for Social Assistance recipients, however, this is paid by the Department.

In December 1996, in reviewing the MCP's Annual Report, the House of Assembly noted savings of 2.4% in the province's DHP because some services were no longer covered.[82] While the legislature did not specify the source of the savings, it appears that surgical dental procedures in hospital, such as wisdom teeth removal were no longer covered even though the administration of general anaesthesia was covered if the procedure was done in hospital.

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[81]Canadian Council on Social Development, "Percentage Change in Welfare Benefits in Canada by Province/Territory Between 1986 and 1996," (http://www.ccsd.ca/facts.html)

[82]Department of Health, *Newsrelease*, 4 December 1996.

Under this province's *Medical Care Insurance Act*, the following services are currently insured for all persons in facilities approved by the Commission, such as hospitals: physician services, surgical-dental treatment, group immunizations, diagnostic and therapeutic x-ray and laboratory services.[83]

Services rendered by practitioners such as optometrists, chiropractors, podiatrists, osteopaths, denturists, psychologists, physiotherapists, audiologist, and paramedical personnel are not covered under the Act. More specifically, the following services are not currently covered under the Act: any advice given by a physician over the phone, the dispensation of drugs or medical appliances by a physician, the preparation of records, reports or certificates or letters, the time taken or expenses incurred in travelling to consult a beneficiary, ambulance service and other forms of transportation payments, acupuncture, examinations not necessitated by illness, plastic surgery for cosmetic purposes, testimony in court, visits to optometrists to see if new or replacement glasses are required, dentist, oral surgeon, or general practitioner's fee for routine dental extractions performed in hospital such as wisdom teeth removal (in the case of wisdom teeth, administration of general anaesthesia in hospital *is* covered), medical exams for drivers, reversal of sterilization procedures, in vitro fertilization, vaccination for travelling purposes and preparation of records.[84]

b) Coverage for Complementary Medicines and Alternative Therapies:

Complementary medicines and alternative therapies are not covered under the provincial health plan in this province, but they are being increasingly used for treatment and prevention by a number of women. According to a study by the Canadian Institute for Health Information, women are 50% more likely to use complementary medicines, such as acupuncture, naturopathy, massage, and homeopathy, than men. The same report indicated that Newfoundlanders and Labradorians are the lowest in the country in terms of use of complementary and alternative medicine, which includes chiropractic care.[85] Less than 4% use complementary therapies.

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[83]Consolidated Newfoundland Regulation 21/96, *Medical Care Insurance Insured Services Regulations under the Medical Care Insurance Act* (O.C.96-132) , Section 3.

[84]Consolidated Newfoundland Regulation 21/96, *Medical Care Insurance Insured Services Regulations under the Medical Care Insurance Act* (O.C.96-132) , Section 4. See also MCP website (http://www.gov.nf.ca/mcp/mcp.htm).

[85]CIHI, *Annual Report, 2000*, 38

Perhaps the fact that complementary medicines and alternative therapies are not publicly insured explains the low percentage of users in this province. This lack of coverage could be viewed as government not keeping up with the coverage of new and readily used services for those who cannot afford to pay. As certain medical services become more and more widely accepted and used for preventative purposes, only those with workplace health plans and adequate financial access can avail of these services with the remainder of the population forced to rely on more traditional curative therapies.

c) Drugs:

With respect to Canada's system of health insurance, medications received as part of institutional care are publicly insured and accessible to all patients, but not those that are prescribed in the community. Payers include governments, through pharmacare programs, hospitals, private insurers, including insurance companies, employers and unions, and patients paying out-of-pocket. There is no universal provincial drug plan in Newfoundland and Labrador, unlike in provinces such as Manitoba and Saskatchewan which have universal drug plans, where individuals pay a yearly deductible.[86] In Newfoundland and Labrador only some seniors and people on Social Assistance are provided with a drug card, which covers a number of prescription medications and few over-the-counter drugs.

Increases in the cost of prescription drugs and the use of expensive drug treatments for certain illnesses have meant that individuals have been carrying more and more of the financial costs of drugs. National policy changes over the past 10 years have contributed to these increases. According to Colleen Fuller, in 1993, on the eve of signing NAFTA, the Federal Government enacted Bill C-91, which granted twenty-year patent protection to expensive, brand-name drugs, most of "which were manufactured and distributed by the powerful U.S.-based pharmaceutical industry."[87] Bill C-91 has also meant a marked increase in the cost of prescription drugs over the past five or six years. For example, from 1987 to 1996 the cost of prescription drugs in Canada increased by 93%.[88]

In addition, more outpatient surgery and the deinstitutionalization of the mentally and physically disabled have meant that more and more people are having to pay for their drugs while being cared for at home. For example, the average length of stay in hospital dropped from 8.1 days in 1992-93 to 7.5 days in 1993-94.[89] This increase in cost for prescription medications can be especially prohibitive for women workers who are low income, part-time earners and not covered under private medical insurance policies.

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[86]Kay Willson and Jennifer Howard, *Missing Links*, 23.

[87]Colleen Fuller, *Caring For Profit*, 191.

[88]Colleen Fuller, *Caring For Profit*, 191.

[89]Government of Newfoundland and Labrador, Department of Health, *Annual Reports*, 1992-93, and 1993-94, pp.10-11.

Access to coverage for drugs for those who do not have private insurance or work-related health plans is minimal in Newfoundland and Labrador. The province offers a senior citizens' drug subsidy program for all residents over 65 years of age who are in receipt of the Guaranteed Income Supplement from the federal government and who are registered with Old Age Security. These are generally the poorest of poor seniors. Elderly women who do not qualify for the provincial drug subsidy would be hardest hit by this exclusionary policy.

People in receipt of Social Assistance are provided free coverage for prescription drugs. However, in 1996, Government capped coverage for dispensing fees at $3.50 for Social Assistance recipients.[90] The Minister noted that

> the rate of $3.50 is all government can afford to pay in light of the province's fiscal position. It was never government's intention to implement a co-pay for social services clients as is the case in most other provinces. If, however, some pharmacies choose not to dispense within the set rate then I acknowledge their decision to implement a co-pay and the market will establish the rate.[91]

Most recently, the Minister of Human Resources and Employment used the drug card as an incentive for getting people off Social Assistance and into the workforce. In May 2000 the Minister announced the extension of drug card benefits to singles and families without children, who move off welfare and into the workforce, stating that "for many clients, the loss of health benefits is a disincentive to taking employment."[92] Families with children already receive drug card benefits for six months when they move into the workforce. Individuals with serious illness or children in need of medication, who only have access to low wage jobs, may not be able to afford to work even under the new incentive plan.

***d)Physiotherapy**:*

Over the past ten years there has been an increase in the number of private physiotherapy clinics and a related increase in the amount of money that people are paying out-of-pocket or through private insurers for physiotherapy treatment outside of hospital and to avoid the long waiting lists for access. Questions of access to physiotherapy were raised in the early 1980s.

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[90]Department of Health, *Newsrelease*, July 16 1996

[91] Department of Health, *Newsrelease* 16 July 1996.

[92]Department of Health, *Newsrelease*, May 2000.

In a 1983 brief submitted to the *Royal Commission on Hospital and Nursing Home Costs*, the Newfoundland and Labrador Branch of the Canadian Physiotherapists' Association highlighted several issues that related to restructuring.[93] In the early 1980s, the majority of physiotherapists were employed in large centres or in hospitals. Community services were supplied by only two physiotherapists in 1983. The brief focussed on the fact that there had been a shortage of physios in institutions because of a hiring freeze and lack of staff relief during the summer. There had also been an increase in referrals to community and home care physiotherapy services due to "constraint measures in acute facilities, such as earlier discharge, and the decreased availability of beds, and from the integration of disabled children into the community and school system." The Association argued that access to physiotherapy in small communities was limited by the fact that the local physiotherapist (such as in Trepassey) was not funded to travel, and that while some patients were funded to travel (those with Veterans Affairs or on Social Assistance), others were not. The Association argued that the situation was not cost-effective because patients were referred to larger centres.[94] There is no evidence to suggest that the problems that the Association identified in 1983 have been alleviated.

The President of the Allied Health Care Professionals Association said that restructuring has not made a huge impact on her membership in terms of lay-offs or complaints because most of the job loss has been through attrition. Migration to the private sector has increased substantially over the last 10 years.[95] Private practice physiotherapists are often paid better ($65 an hour as opposed to $23) and have access to more possibilities for training and other benefits than those working in the public sector, according to the President of the Association. Physiotherapists working in private practice often deal with patients who have third party insurance coverage, as well as injured workers. The newly named, Workplace Health and Safety Compensation Commission's "get injured workers' back to work as quickly as possible" initiative has resulted in an increase in use of private clinics.

Access to physiotherapy because of shortages and an inability of many rural residents to pay for travel to a centre where those services are available, remains a huge concern for residents of rural communities. King noted that the Community Health Boards are still "experiencing a growing stage" and that many boards still have not hired physiotherapists.[96] Shortages of physiotherapists in some regions, such as on the west coast of the Island, may delay women's and

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[93]Newfoundland and Labrador Branch of the Canadian Physiotherapy Association, "Brief Presented to the Royal Commission on Hospital and Nursing Home Costs," (unpublished) October 1983.

[94]Newfoundland and Labrador Branch of the Canadian Physiotherapy Association, "Brief to the Royal Commission on Hospital and Nursing Home Costs."

[95]Correspondence with Sharon King, President of the Association of Allied Professionals. Used with permission.

[96]Personal Correspondence with Sharon King, Association of Allied Professional. Used with permission.

men's recovery from their workplace injuries. A recent report in a west coast newspaper discussed the cases of two women who were injured on the job. One woman was a worker at the Rufus Guinchard Health Centre in Port Saunders, and the other a home care worker at St. Barbe Manor. Both these women told reporters that they had year-long or more waits for rehabilitative treatment. The only option they had was to drive to Deer Lake or Corner Brook three times a week for treatment, which their doctors advised them not to do. Driving for long periods with a slipped disk can be more harmful to the injury.[97]

The Health Boards Association recently identified the expansion of privately-operated health services as a consequence of increases in "unfunded health needs, such as physiotherapy, laser eye clinics. Which are available only for those people who can afford to pay." The

[97] *Northern Pen* 18 October 1999.

Association recommended that government establish a financial plan for the health system with adequate long-term funding to ensure a continuum of health services in the system.[98]

e)Ambulance and Patient Travel:

The Health Care Corporation of St. John's has a tertiary care mandate for the entire province. According to the Department of Health, "The idea is to have major surgery done in St. John's with the patient being transferred as quickly as possible to the regional or secondary level and then back to the local community for home-based care."[99] Thus, patients from rural communities must travel to St. John's for all major surgeries, radiation treatments, and some other testing. Regionalization of services and the centralization of tertiary care in St. John's have raised serious issues of access and equity in terms of who pays for transportation and accommodation in St. John's, or in other larger centres of the island, for those from rural communities who must travel to receive care.

A recent community needs assessment for northern Newfoundland and southern Labrador found that roughly 20% of visits/person/year to health facilities involved travel to a facility in the region, province or outside of the province rather than to the local facility. This travel was to see specialists, for tests or treatments, and in 8% of cases to see a general practitioner.[100]

Local newspapers have reported on patients from rural communities who have suffered because of bed closures, and cutbacks on top of having a centralized system for tertiary care. For instance in 1999, one woman's 93 year old grandmother was put back into an ambulance for a five-hour drive after receiving a pacemaker in St. John's that afternoon. The ambulance had to turn around and come back because the woman was experiencing difficulty. The woman arrived in St. John's at 6 am that morning.[101]

Presently, the Department of Health administers the Emergency Air Ambulance Program

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[98]NLHCSA, "Presentation on *Budget 2000*," 10.

[99] *Evening Telegram*, 24 August 1996.

[100]Bavington et al.. *Community Needs Assessment for Grenfell Regional Health Services*, 21-23.

[101]*Evening Telegram*, 30 July 1999.

for the transportation of patients within the province and to hospitals outside the province if warranted. The Ground Emergency Ambulance Program assists in making ambulance services available to all residents. Users are required to pay co-payment charges in both cases. Residents who travel by commercial air to access medically necessary insured services, which are not available within their area of residence or within the province, may qualify for financial assistance under the Medical Transportation Program.[102]

[102]Health Canada (www.hc.gc.ca/medicare/nfld-e.htm)

The Medical Transportation Assistance Program, announced by the province in 1998, was targeted at individuals who had to travel by commercial air to access medically necessary insured services "within the province when an insured service is not available in the area of residence; and outside the province when an insured service is not available within the province."[103] Under the Medical Transportation Assistance program applicants pay a $500 deductible in any 12 month period from the date of initial travel. Once the deductible is paid the remaining balance of expenditures is shared at 50 per cent. When the program was announced, the Minister stated that "Government recognizes the increasing costs of transportation which people incur for medical reasons. In an attempt to lessen expenses in this area funding has been put in place to help provide more accessible quality health care at a lower cost to patients and their families."[104] The Department of Health did not address the issue of how low income patients were going to pay for air transport if they did not have the $500 deductible. The cost of plane tickets from Labrador or the Northern Peninsula often exceed $500. The cost incurred by a spouse or companion travelling with the patient is almost never covered. For example, in 1997 when the Department of Health had to send 50 people awaiting heart surgery to Halifax and Saint John to alleviate a growing waiting list, the Department would not help pay for a spouses' plane ticket.[105]

Ambulance services are covered when an in-patient of one hospital is conveyed to another hospital for special tests or treatment but remains an in-patient of the first hospital. Some coverage of transportation costs is available under the Ground Emergency Ambulance Program and the Emergency Air Ambulance Program.

[103]Department of Health, *Newsrelease,* 26 March 1998.

[104]Department of Health, *Newsrelease,* 26 March 1998.

[105]*Northern Pen,* 28 July 1997.

As in other provinces, it appears that Government is further privatizing the provinces' ambulance services, without evidence guaranteeing that private operators will adequately service remote areas.[106] In the most recent provincial budget Government announced $3.3 million for improved road ambulance services in the province and $6 million for the purchase of a King Air 350 air ambulance. In response to this allocation, the Community Ambulance Association has raised concerns over the fact that government has been steadily increasing its funding to private, for-profit ambulance companies as opposed to the community-based services which are run by volunteer labour. While private ambulance companies keep 80% of patient fees, many of the companies Government funded do not even have ambulances operating in the communities they are supposed to cover. [107] For example, NAPE has argued that the ambulance service in St. John's is inadequate. In 1999, there were only two ambulances to cover between 200,000 and 300,000 people on nights and weekends, which compared unfavourably with the ambulance coverage in the much smaller region of Conception Bay South, where there were two ambulances and drivers covering the region, seven days a week, 24 hours a day.[108]

Access to dialysis services has also been an ongoing problem for rural residents of the province. Presently, if dialysis is not available for patients in a remote region of the province, then the patient and his/her spouse who need the service 3 times a day would have to relocate to St. John's at their own expense.[109]

f) User Fees and Hospitals:

While under the *Canada Health Act*, institutional care in hospitals for medically necessary procedures must be publicly insured for all patients, in the 1970s and early 1980s, patients in Newfoundland hospitals paid a $5 per night user fee. This fee was eliminated in 1984, when the *Canada Health Act* came into effect, but the fee's elimination was met with opposition from the provincial department.[110] Since that time, patients have been required to pay user fees for a number of services they require in hospital, such as ambulance costs, some crutches, extra x-rays from the lab department, and photocopies of health records, according to the Health Care Corporation of St. John's.[111] While there has always been a cost for semi-private and private

[106]Pat Armstrong and Hugh Armstrong, "Women, Privatization, and Health Care Reform," 16.

[107]Personal Correspondence with Newfoundland and Labrador NDP Caucus. Used with permission.

[108]Newfoundland Association of Public Employee (NAPE) *Newsrelease*, 6 August 1999.

[109]*Northern Pen*, 8 Feb, 1999.

[110]*The Evening Telegram*, 7 January 1984.

[111]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) 37.

rooms, according to the Corporation, the insurance companies are no longer covering the entire cost.[112] Thus, the costs for private and semi-private rooms, based on rates set by the province, have been increasing for those who can afford to pay. In defence of questions about user fees in hospital, and access to quality of care for all recipients, CEO Sister Elizabeth Davis told the Auditor General that:

[112]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) 39.

> I think it is well recognized in Canada that 72 percent of the funding for health care is provided by government, 28 per cent is provided by the private sector, and that percentage is shifting. ...We can say, I think, without being contradicted, that basic medical care, basic hospital care, is provided to every citizen regardless of their ability to pay or not; there is no question about that...If I am richer, can I afford a private room? Yes. If I am poorer, can't I get a private room? Definitely not. We would argue that whether you are in a private room or not might help you personally, but it does not add to or take away from the basic hospital care that we provide.[113]

Some sense of the extent to which hospital user fees are prohibitive to many patients who require certain services can be garnered from the amount of money that patients owed the St. John's Health Corporation in 1997/98 due to unpaid patient fees. In 1997/98, for example, this amount was approximately $4.6 million. Early on in its mandate, the Corporation engaged five collection agencies to collect patient debts. The Corporation said that they rotate the claims between the collection agencies "in terms that if one company is unsuccessful in getting the money we turn it over to another collection agency"[114] The Corporation has also adopted a policy of asking for a deposit when patients are admitted to hospital. For example, "if you have insurance the deposit is $200, and if you don't have insurance, we want $300 from you in terms of, give us your credit card or something," according to a representative from the Corporation [115] What about low income patients who are not able to establish a credit rating with credit card companies? The actual extent to which hospitals continue to take deposits from patients is an area that requires further research.

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[113]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) 40.

[114]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) 37.

[115]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) 37.

Outpatient and day surgery have been on the rise over the past ten years. The percentage of day surgeries increased substantially between 1992/93 and 1994/95, from 41% to 57% of all surgeries.[116] Some operations such as those for cataracts and gallbladder can now be done using day surgery. Since services and drugs that are insured in hospital are not covered in the "community," the shift to outpatient care and day surgery entails transferring more of these costs from Government to patients and their families. Sister Davis highlighted the problems and challenges that this reorientation of health care to "community" has created for the Health Care Corporation:

[116]Government of Newfoundland and Labrador Department of Health, *Annual Report*, 1992/93, 1993/94, and 1994/95. There were no Annual Reports published after 1994/95, so the data is unavailable.

> The link with the community health board is a really important link because if people are going to be getting service in their own homes that has to be funded too. The first three years of our organization we transferred $1 million a year to the community health services, but it did not actually go into services that would reduce the stress on us.[117]

For example, many patients requiring IV treatment, which can be administered at home, must try to take it in hospital where this expensive medication is covered. In that regard, Davis stated that the Corporation is "trying to get around the *Canada Health Act* to provide that."[118]. While Davis recognized the problem, there is little evidence that patients are being consistently admitted to hospital so they can avoid having to pay these costs. The Health Boards Association noted, for example, that among the un-funded services that have been increasingly privatized in the recent past, have been "home support or private blood testing/cholesterol testing/blood sugar testing offered in the home." There is no charge for these services in hospital.[119] While not a simple relationship, shorter hospital stays has led to some privatization of costs. In some instances, shorter hospital stays may reduce the burden on unpaid care providers, however, much more study needs to be done in this area.

g) Midwifery: who will pay?

The transformation of midwifery into a public service is still underway in Newfoundland and Labrador, but the question of who will pay for the service when implemented remains open. In 1993, the Provincial Government established an Advisory Committee on Midwifery and

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[117]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) 48.

[118]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) 48.

[119]NLHCSA, "Presentation to the Minister on *Budget 2000*," 10.

recommended that an implementation committee should be appointed. The final report of the Advisory Committee was presented in May 1994. In February 1999, the Government appointed a multi-disciplinary Midwifery Implementation Committee. In Ontario, the implementation process began in 1989.[120] The Committee's main task is to provide advice to Government on the development of legislation related to midwifery and the implementation of midwifery services in Newfoundland and Labrador. The Committee is also responsible for recommending the scope and standards of midwifery practice, midwifery education and registration requirements, and eventually the establishment of a Board (College).[121]

[120]Pat Armstrong and Hugh Armstrong, *Women, Privatization, and Health Reform,* 37.

[121]Advisory Committee on Midwifery, *Final Report of Provincial Advisory Committee on Midwifery*, presented to the Department of Health, May 1994. For the most up-t-date information available on midwifery in the province see (http://www.ucs.mun.ca/`pherbert/)

In provinces where midwifery has been legislated, such as Manitoba, Ontario and Saskatchewan, the main issue is who will pay for the services. For example, according to Kay Willson and Jennifer Howard's research on Manitoba and Saskatchewan, while both provinces have midwifery legislation who pays differs. Saskatchewan has made no provision to pay for midwifery, except women under midwives' care would have hospitalization and diagnostic tests paid for. In Manitoba, Regional Health Boards are responsible for including midwifery as part of their health plans submitted to Manitoba Health for funding. It is thus difficult to track whether the services are consistently provided or not.[122]

According to Pat Armstrong and Hugh Armstrong, the use of midwives has been proven to be a cost effective measure of delivery, if publicly funded. "About 40% of midwifery deliveries take place at home, and women with midwives are much more likely than other women to leave hospital the same day they deliver, both because they have midwives to help at home and because they experience less intervention while in hospital."[123]

h) Abortions and Private Clinics:

In Newfoundland and Labrador abortions are publicly insured in hospitals. However, there has been a long history of problems with women being able to access timely abortions within their local areas. Several years ago, a private, non-profit Morgentaler clinic was established in St. John's. The issue of private clinics for certain procedures, such as abortions, is a complex one. Women's groups have supported the concept of private (non-profit) clinics for abortions because they have argued that the way in which abortions are done in hospital has not always met individual women's needs throughout this traumatic procedure, and because of inadequate access to the procedure in hospitals, lack of private and lack of other supports throughout this potentially traumatic process. Women's groups have also argued that abortions in all settings should be publicly insured.

In 1995 when Federal Health Minister Diane Marleau announced that if provincial governments did not pay patients' user fees for private medical clinics, they would receive reductions in transfer payments, Newfoundland and Labrador refused to comply. At the time, abortions were publicly insured when done at the Health Sciences Centre, which was the only hospital in Newfoundland and Labrador that did the procedure.[124]

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[122]Kay Wilson and Jennifer Howard, *Missing Links*,25.

[123]Pat Armstrong and Hugh Armstrong, *Women, Privatization and Health Reform*, 37.

[124]Abortions are still only available in St. John's. Personal correspondence with Peggy Matchim, Planned Parenthood. Used with permission.

When abortion was removed from the Criminal Code in a Supreme Court of Canada decision in the 1990s, it was added to the *Canada Health Act* as a medical procedure. The standard patient user fee for an abortion ranged from around $400 to $600, depending on the point in the gestation period. At this time the Morgentaler Clinic did about 400 abortions a year. The provincial Minister of Health held the position that the Government would only pay the physician's fees, which amounted to around $85 through Medicare at the Morgentaler clinic,

leaving women patients a bill of around $400 to pay themselves. That same year, the General Hospital, where there was no user fee, did about 400 to 450 abortions a year.

In response to the province's refusal to comply with the federal government's policy, Peggy Keats, manager of the Morgentaler Clinic stated: "we feel the province has an obligation to pay the fees...it's something they've been advocating for years, because private clinics are safer, more economical, cost effective, and less emotional for the patient."[125] Private (non-profit) abortion clinics emerged before abortions were legalized in hospital and their procedures and policies have been shaped more to women's specific needs. Keats argued that private clinics are better able to offer confidentiality to patients as well as additional counselling services such as family planning and testing related to HIV and other sexually transmitted diseases. Equally important, the waiting lists for abortions in private hospitals are 2 to 3 weeks as opposed to one week at the Morgentaler Clinic.[126]

In 1998, buckling under pressure from the Federal Government, which insisted that Newfoundland was not in compliance with the federal legislation, the province agreed to pay patients' facility fees at the Morgentaler abortion clinic. Government's decision did not involve increased expenditures because it had been losing between $8,000 and $11,000 a month in penalties back to the Federal Government. While this has eliminated financial barriers to free, accessible and safe abortions related to the actual service, it has not eliminated the barrier of high transportation costs for women outside of the St. John's area. To give some sense of the extent of this barrier, the airfare for a single day trip between Goose Bay and St. John's in July 2000 was $900. For someone travelling to the Morgentaler clinic from the Labrador coast, the cost would be even higher. There is no provision here for the airfare for someone to accompany the woman.

i) Workplace Health, Safety and Compensation Services:

In a recent Canadian Centre for Policy Alternatives publication, Colleen Fuller, highlighted the fact that "[e]xempt from the criteria of the Canada Health Act, provinces can require that workers' compensation insurance be administered on a nonprofit basis or can allocate the responsibility to private, for profit insurers that operate under provincial regulations. It operates parallel to public health plans." Over the past ten years, Fuller argues, "bending to pressure from powerful employer groups, some provinces began legislating reduced benefit levels, and other

[125] *Evening Telegram* , 3 September 1995.

[126] *Evening Telegram*, 22 January 1998.

entitlements in order to force employees to return to work more quickly."[127] There have been some significant changes in the Newfoundland and Labrador workers' compensation system in recent years that have entailed privatizing some services, reducing benefits, and transferring greater responsibility for recovery and re-employment to workers and their families.

In1984 a new wage loss system of workers compensation came into effect designed to provide a worker injured on the job with income replacement in line with his or her pre-injury earnings. This wage loss system was recommended in 1910. The Newfoundland and Labrador Workplace Health and Safety Compensation Commission (WHSCC), as it is now called, has made a significant number of complex changes to the way the system operates since 1984. Most of the changes have been driven by a will to reduce the Commission's unfunded liability.

[127]Colleen Fuller, *Caring For Profit*, 172.

By around 1990, the Commission was facing a financial crisis related to the wage replacement system and the 'broadening definition of injury and increasing knowledge about the causes of industrial disease which are compensable."[128] In 1990, the Board announced that it intended to undertake an organizational structure review in 1991 "in an effort to reduce unnecessary program expenditures."[129] Following the 1991 Statutory Review, the provincial government made legislative changes to the Act to reduce benefit replacement levels for injured workers, and levied a surcharge on employers. The Commission also directed some care to non-traditional medical therapy.[130] Other ways in which the Commission has gotten workers back to work quicker has been by queue jumping. For example, in the early 1990s the Medical Services branch of the Commission arranged for 797 injured workers to receive priority appointments with orthopaedic surgeons by paying a premium. According to the Commission, "the additional cost is offset because early consultation has the potential for workers to return to work sooner."[131] In some cases the Commission has also paid to open hospital beds.

[128]Workers' Compensation Commission, *Annual Report*, 1990, 3.

[129]Workers' Compensation Commission, *Annual Report*, 1990, 3.

[130]Workers' Compensation Commission *Annual Report*, 1991; see also, Government of Newfoundland and Labrador, *1991 Workers' Compensation Statutory Review*, 1991. For further discussion of coverage for alternative medicines and therapies under WCC, see Government of Newfoundland and Labrador, *Report of the 1996-97 Statutory Review Committee on the Workers' Compensation Act: Time to Refocus*, May 1997, 82-83.

[131] Workers' Compensation Commission, *Annual Report* 1990, 9.

Between 1990 and 1998 the Commission began to focus on promotion and prevention of workplace injuries. As stated by the Executive Director, "the objective of the commission is to get injured workers back to optimal medical recovery and back to work as quickly as possible -- the longer an injured worker is away from the workplace the less likely he or she will be able to return to work."[132] This shift took place within the context of swift budget cuts and additional reforms, including the integration of the claims and rehabilitation departments, and the adoption of a case management approach to claims management. The Commission also transformed the Miller Centre multidisciplinary assessment program for diagnosis and counselling from a residential to an out-patient system. In an effort to get workers back to work sooner, the Commission introduced ease back to work programmes. Prior to this, vocational rehabilitation was introduced when an injured worker achieved maximum medical recovery. Another dramatic change to the system was the implementation of "experience rating" in 1995.[133] Experience rating means that employers pay lower premiums if they have less reported injuries. This often leads employers to deal with injured workers outside of the system. These factors have contributed to a near-complete transformation of outpatient rehabilitation during the last ten years. The new focus on prevention has placed more of the responsibility onto injured workers.

Reduced benefit levels have forced workers to shoulder a larger proportion of the lost wages associated with removal from work–a potentially greater problem for lower income workers than higher income workers. Commission queue-jumping may have contributed to general delays in accessing important medical procedures for non-work related illnesses. By inadvertently encouraging employers to discourage workers from filing claims for work-related injuries with the Commission, experience rating may be placing particular pressure on workers vulnerable to layoff or demotion (many of whom are women) to resort to private health schemes or the public health care system for treatment and, in some cases, to do without rehabilitative supports they need and to which they should have access. See below, the discussion of issues confronting injured health care workers.

Privatizing Non-Medical Services: Contracting Out

While the Government of Newfoundland and Labrador has made few overt attempts to privatize health care, as it has maintained a commitment to supporting a publicly funded system, as in other provinces, there have been several instances where privatization has crept in. This trend is most notable in terms of the rate at which some non-medical services have been contracted out to private-for-profit firms. The privatization of non-medical services has been most dramatic in this province, in the outsourcing of dietary, laundry and housekeeping services in hospitals, as well as in the area of health information. Lab services have not been contracted out,

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[132]Workers' Compensation Commission, *Annual Report*, 1990, 4.

[133]For a criticism of experience rating, see Newfoundland and Labrador Federation of Labour, "Evaluations and Recommendations: A Review of Workers' Compensation," presented to the Workers' Compensation Review Committee, 27 May 1991, 24-25.

however, DNA testing and some HIV testing have been outsourced.[134] Any shift from public sector provision of health care services to the private sector has the potential to impact women as care providers, whose jobs are transformed from more secure, and possibly unionized positions in publicly-funded institutions to sometimes less secure jobs in the private service sector. Care recipients are also at risk in a climate of transferring services to the private-for-profit sector where there is inadequate legislation to protect the privacy of individuals in terms of the use of health information and in light of the food quality and cultural appropriateness issues associated with the standardized, centralized food production associated with multi-national food franchises.

a) Dietary, Laundry, and Housekeeping Services:

[134]Personal communication with John Vivian and Karen Carol, NLNU. Used with permission.

While hospitals receive the greater part of their revenue from provincial governments, according to health critic Colleen Fuller, "they increasingly act as conduits that funnel millions of public funds to the for-profit sector," which is found in out-sourcing and contracting-out arrangements. [135] Newfoundland and Labrador is no exception to a national trend in which in a climate of fiscal restraint for health care hospitals have been moving more towards their core mission thereby letting the private sector deal with other service provision.

In Newfoundland and Labrador there has been a direct link between cut backs to the health care system, Government's downloading of responsibility to the regional Institutional and Community Health Boards, and the contracting out of some services. In 1997, Elizabeth Marshall, the province's Auditor General, raised serious questions about the financial aspects of the St. John's Health Care Corporation's restructuring plan. According to Sister Elizabeth Davis, CEO of the St. John's Health Care Corporation, the Corporation had planned to finance its restructuring with no capital from Government. This was a first in Canada. In other provinces, such projects were usually funded with government money or through fundraising.[136] The Health Care Corporation of St. John's explained that it would finance the restructuring process through the yearly savings it would realize over the course of the process. For example, the restructuring process would result in operational savings of $20.52 million a year, with $13.2 million of the savings used to finance the $130 million in capital costs, while the remaining $7.32 million would be redirected back into health care programs. According to the Auditor General, the Corporation based its savings on the experience of a hospital in Vancouver. In that regard she said, "Although the circumstances were admittedly unusual, the Committee questioned whether the amalgamation was undertaken too hastily and with insufficient planning to enable those responsible to arrive at a realistic estimate of the cost of the project."[137] By 1997, the Corporation was running a deficit of $18.7 million.[138] Since then, the Corporation has been swift in its attempts to bring the budget in

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[135]Colleen Fuller, *Caring For Profit*, 229.

[136] *Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's.* (1999) 19

[137]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's.* (1999) 10-11.

[138]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's.* (1999) 7.

line. One of the ways in which it has cut costs is by contracting out dietary, laundry and housekeeping services.

As part of a cost-cutting agenda, many of the Health Care Boards in Newfoundland and Labrador have begun contracting out services such as laundry, housekeeping, and dietary. In 1996, for example, the St. John's Health Care Corporation announced the first of three phases of "expenditure reductions in dietary, housekeeping and laundry services." Since September 1996, Nova Services has been managing dietary and central laundry services, and Versa Services has been managing housekeeping for the Corporation. As part of the latter phases, in 1998, the St. John's Health Care Corporation purchased the H.H. Marshall Building in O'Leary's Industrial Park owned and operated by St. John's businessman Tom Hickman for $1.8 million. Davis said "the central kitchen, which will be in operation by late fall, will lead to lower costs." Since 1996, changes in the preparation and delivery of food for city area hospitals have resulted in $1.4 million in savings. Further savings of $1 million annually are projected when the central kitchen is up and running.[139] Food services in the hospital cafeteria have been contracted to major franchises such as Tim Hortons. In fact, patients staying in the hostel at the Health Sciences Centre in St. John's, for which they must pay a nightly rate, over the last few months have had few other options than to eat their breakfast, lunch, and supper at Tim Hortons, while other franchises complete their construction phase at the facility. Access to nutritious meals is jeopardized despite the determinants of health literature that reminds us of the importance of good nutrition to good health.

The contracting out and centralization of laundry and dietary services have meant significant job loss. In that regard, the Corporation's CEO said, "based on the expertise they have acquired in these areas over the years, the companies were able to implement more efficient ways of operating that would reduce the number of workers needed." In 1996, 143 full-time equivalent positions were supposed to be eliminated. The second and third phases would result in the loss of another 100 positions between 1997 and 1999, according to the Corporation.[140]

Instead of direct layoffs, however, the Corporation planned the job loss through attrition, a voluntary retirement program, as well as cutting hours of temporary workers. The housekeeping unit at St. Clare's was hit particularly hard when 51 employees lost 24.7 full-time equivalent positions. Davis told the Strategic Social Plan Advisory Committee that we are "putting a lot of people on unemployment or social assistance."[141]

When Versa took over cleaning services, the company timed cleaning workers at the Waterford Hospital with a stopwatch to see how long it took them to do their work. Apparently workers were doing 12 hours of work in 7 hours. Versa said that they were doing the "time studies" so that employees have an even workload and to compare work in St. John's with standards at their other hospitals nation wide.[142] Other Health Care Boards also began the process

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[139]*Evening Telegram*, 25 June 1998.

[140]*Evening Telegram*, 23 October 1996.

[141]*Evening Telegram*, 26 October 1996.

[142]*Evening Telegram*, 28 November 1998.

of contracting out those services.

Questions about food quality associated with centralized cooking facilities have been raised in various regions. For instance, in 1997 the Central East Health Board requested an independent review of the planning, preparation, and delivery of food to residents of Lakeside Homes in Gander after several resident complaints about quality. Following the results of the review, Government ordered the kitchen re-instated.

According to Pat Armstrong and Hugh Armstrong, in Ontario, "the contracting-out strategy has been adopted without supporting evidence to indicate that costs will be lower in the long run or that quality will be maintained."[143] Furthermore, research on the outsourcing of food services in Winnipeg, Manitoba has revealed that factors not taken into consideration included costs in terms of job loss for food preparation staff, costs to the local economy of not using local food suppliers, and the cost to the health of patients.[144] It appears that there has been little research on the effects of privatization of these services in Newfoundland and Labrador, let alone a gender-based analysis of the impact of contracting out. A majority of workers in this sector are women.

b) Biomedical Waste Management:

In 1997, the province gave a private-for-profit company a five-year, $3 million contract to provide biomedical waste, transportation, treatment and disposal services to health care facilities in the province. Since 1995 government has reduced the number of incinerators operating in health facilities in the province from 24 to eight. When Government announced the contract, it suggested that some of the funding would be redirected from funds currently used to operate the existing incinerators and the Department of Health would provide initial financial assistance in the first year of the contract up to $100,000. The company that secured the contract is a joint venture between SCC Environmental of St. John's and Mr. Shredding Waste Management of Moncton, New Brunswick. Immediately before the deal was struck the provincial Government stated that it "hopes its requests for proposals will result in a private sector company setting up a single incinerator site to take care of biomedical waste from every hospital in the province."[145]

***c) Financing of Hospital Construction and Privatization*:**

In a climate of fiscal restraint and budget cut backs to health care, both nationally and provincially, the task of restructuring without adequate funding has been incredibly difficult for the province. The money that Government extends to the regional health care Boards has not

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[143]Pat Armstrong and Hugh Armstrong, "Women, Privatization, and Health Care Reform," 15.

[144]Kay Willson and Jennifer Howard, *Missing Links*, 30.

[145]*Evening Telegram*, 7 September 1996.

been adequate to meet their infrastructure renovation needs. Over the past few years it has come up with creative ways of funding capital projects, which have often resulted in further privatization.

In 1998, the provincial Government took $25 million out of the Immigrant Investment Fund to finance hospital construction and renovation in various parts of the island. In reviewing this decision the Public Accounts Committee raised questions about this new funding practice.[146] The Immigrant Investment Fund is supposed to provide incentives for private companies to set up businesses in Newfoundland and Labrador, to create jobs, and bring capital into the economy. In the case of hospital construction, it appears that Government is handing the buildings over to private companies, who in turn are taking the risk, and then government will lease the buildings back from them.[147]

When Government could not finance the construction of a new hospital facility in Melville, it entered into a partnership in 1996 with Voisey's Bay Nickel Company, a subsidiary of INCO to build a hospital at Happy Valley-Goose Bay. Each partner would contribute 50 per cent funding for the project. President Stewart Gendron stated, "Voisey's Bay Nickel Company is a long term corporate citizen of Labrador...we have to ensure there are adequate health and medical facilities for our employees, something we are accustomed to doing in communities where we have operations such as Thompson, Manitoba, Sudbury, Ontario, and Soraoka, Indonesia."[148] Minister Lloyd Matthews stated, "this is clearly one example of how both the public and private sectors can benefit by pursuing new approaches and partnerships. INCO's contribution to health care in Labrador is greatly appreciated by government."[149] Government stated, "significant economic development potential also exists through this project. An estimated 139 jobs could be created through economic spin-offs, in addition to construction jobs."

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[146]Department of Health, *Newsrelease,* 26 March 1998.

[147]Government of Newfoundland and Labrador Public Accounts Committee, 7 February, 2000 (http://www.gov.nf.ca/house/pac/feb700.htm)

[148]Department of Health, *Newsrelease,* 22 November, 1996.

[149]Department of Health, *Newsrelease,* 22 November, 1999.

d)Health Information Systems:

One example of shifting non-medical health services to for-profit corporations in Newfoundland and Labrador has been the creation of a private a health information system known as SmartHealth. SmartHealth is a joint venture between EDS Canada Inc (51 percent) and the Royal Bank (49 percent). EDS is a global consortium, partly owned by Ross Perrot, with registered profits of around $18 billion last year. EDS has also been involved in welfare privatization in the U.S.[150]

[150]Bev Brown, "Stop Making `Decentralization to the Community,' A Code Phrase for Cutthroats and Cutbacks!" paper presented to the 10th Annual National Social Policy Conference" Montreal, June 1999.

While Manitoba, under the leadership of Progressive Conservative premier Gary Filmon, was the first province to enter into an agreement with SmartHealth, Newfoundland and Labrador is the first province, so far, to follow through on this partnership. The Manitoba deal fell through just before the 1999 provincial election.[151] The development of a private health information system in Newfoundland and Labrador has been key to the restructuring process. Government has proceeded without first adopting privacy legislation to protect individuals whose health information will soon be in the hands of private companies.

The Newfoundland and Labrador Centre for Health Information was established following the recommendations of the Health System Information Task Force in 1993 to "bring various existing health information systems together to establish an integrated and comprehensive information technology system for health and social services."[152] The Task Force recommended the development of a unique personal identifer (UPI), on the basis that "Quality information is not only important for improving the health of the population, it has become a commodity." The Task Force also recommended that the province adopt privacy standards, and that health informatics be identified as a priority strategy for the Provincial Economic Recovery Plan.[153] The health information industry has since become one of the province's targeted economic diversification schemes.[154] The Minister of Health supported the concept of the Centre because in his view it would be

> an essential step in health reform initiatives... the data collected will facilitate government's ability to make sound financial decisions based on proven health outcomes, ensure effective utilization of health services, and carry out sound financial and human resource planning. This is important in this province where we

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[151]Kay Wilson and Jennifer Howard, *Missing Links,* 31.

[152] Department of Health, *Newsrelease,* 8 October 1996.

[153]Department of Health, *Newsrelease,* 8 October 1996.

[154]See "Recommendations" in The Health Industry Sector Development Strategy Working Group and the Economic Recovery Commission, *Health Industry Sector Development Strategy* (March 1995), 67-71.

> are challenged by our vast geography and population, especially at a time when we are striving to enhance the quality of health services within our limited financial resources."[155]

In addition to health data, the new information system would incorporate statistics from the Department of Social Services in "recognition of the determinants of health such as income, employment, social support networks." According to Government, the Centre will work with local information technology companies, because in this case Government believed that "public/private partnering in this initiative is a positive step in enhancing local industry in the

[155] Department of Health, *Newsrelease,* 8 October 1996.

province and ensuring Newfoundland companies are key players in developing information system." [156]

According to the CEO of the St. John's Health Care Corporation, which is involved in the development of a unique identifer, "the biggest concern with that is confidentiality and privacy. That is why in this Province we are working with SmartHealth because SmartHealth was created by the Royal Bank and we know we trust a lot of our information to banks and they have the capacity to keep that confidential, they have those kinds of systems developed."[157]

NLCHI, along with its private sector partners: SmartHealth, ZeddComm, xwave solutions, and Jane Helleur and Associates (SmartHealth Consortium) have been working as a team since 1998 to develop a Unique Personal Identifier and a Client Registry. The Client Registry will create a "shadow number" for each person and will be used for communication among various information systems used in the health sector, particularly the Meditech system in hospitals and Client Referral Management System in Health offices.[158] According to Government, a UPI will enhance the capacity of the health system to critically evaluate its current use of resources through outcomes management and utilization reviews. The database linkages possible with UPI will enable service providers to evaluate the relationship between program costs, outputs, and outcomes, and to determine the most cost-effective use of resources in the system.[159] In May 2000 the province re-announced that the development of a Unique Personal Identifer registry was well underway as the first phase of eight in a provincial Health Information Network, which will be "comprehensive, integrated, person-centred...and will assist in the direct provision of health

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[156]Department of Health, *Newsrelease*, 8 October 1996.

[157]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999), 36.

[158]Department of Health, *Newsrelease*, May 2000.

[159]Department of Health, "Improving the Ability to Use Information in the Health System," August 20, 1999.

care services and research."[160]

In Manitoba, several community groups raised concerns about the privatization of the Health Information Network. These concerns included "the links of the Royal Bank and EDS to the private health insurance industry, as well as the application of the HIN to "eliminate waste" by monitoring -- and therefore limiting -- insured diagnostic procedures and prescription drugs covered by the provincial Pharmacare program." Other concerns raised were that private money is being spent on information technology that would be owned and marketed by private for-profit corporations."[161]

***e)Genetics Research for Profit**:*

Another recent development in Newfoundland and Labrador that raises issues regarding the involvement of for-profit companies in health care was the swift move on the part of government to support a genetics research industry. This province's unique history of settlement and migration coupled with its relatively small population base has meant that this Island, as with others like Iceland, has become a haven for genetic researchers in Universities and in the private sector. New technologies and scientific methods, which have rapidly created new possibilities for genetic researchers, have outpaced the development of privacy legislation to protect the individuals involved.

[160]Department of Health, *Newsrelease*, May 2000.

[161]Kay Wilson and Jennifer Howard, *Missing Links*, 31-32.

Recently, dermatologist, Dr. Wayne Gulliver, established Newfound Genomics -- a company founded by Lineage Biomedical of St. John's and Gemini Holdings of Cambridge, England – in St. John's. Through his previous research on psoriasis, Gulliver determined that the skin disease was often passed down from generation to generation and he saw an opportunity to conduct genetic research. In an interview with CBC radio in April 2000 Gulliver said that "he hopes other companies come here to research Newfoundland's genes...genetic research could also bring in pharmaceutical companies and research dollars to Memorial University."[162] He also noted that a genetics industry in Newfoundland and Labrador could create up to 500 jobs. With regard to sharing his profits with the provinces' population, Gulliver stated that Newfound Genomics would share one per cent of any profits with a non-profit organization for psoriasis suffers and that those individuals who give him their genetic information will retain their right to their DNA. Gulliver stated that "at a time when the government is struggling to find money for health care and education, genetic research is better left to private companies"[163] and that Newfound will "generate revenue by licensing the new therapies and pharmaceutical applications that come out of its research."[164] Gulliver has also been hoping that Government would put in some seed money for his company, but it is difficult to determine if this has in fact been the case.

In the past few months, the Department of Health has begun to consider the ethical and privacy issues involved in this new initiative. In a recent position paper on research, ethics and privacy presented to the Department, Dr. Verna Skanes, past Assistant Dean of Research and Graduate Studies (Medicine), emphasized that ethical and privacy protection mechanisms have not been put in place to deal with industry-sponsored clinical research. While University-based research is bound by the *Tri-Council Policy Statement for Research Involving Human Subjects,* the ethics review of research carried out by researchers who are not affiliated with academic

[162]Interview with Wayne Gulliver, CBC Radio, 21 April 2000. Transcript courtesy of Newfoundland and Labrador NDP Caucus.

[163]*Evening Telegram*, 22 April 2000.

[164]*Evening Telegram*, 22 April 2000.

medical centres, is generally carried out by for-profit review boards, which are not bound by the same guidelines.[165]

According to Skanes, most of the genetics research in this province has taken place in academic settings, and has focussed on *single-gene disorders* under the Tri Council Ethics policy. These types of diseases are relatively rare and have not interested private companies.[166] Skanes noted that new technologies developed as outcomes of the Human Genome Project have made possible the study of *complex genetics disorders,* such as rheumatoid arthritis and Type I diabetes, which are known to cluster in families. This is the type of disease that interests Gulliver, and the private sector more generally.

In her paper, Skanes argued that Newfoundland and Labrador lagged in terms of privacy legislation and that provinces such as Alberta, Saskatchewan, Manitoba and Ontario have Acts relating to the protection of health information. Skanes identified several issues relating to commercialization of genetics research. The profit motive, and industrial culture which requires "patenting, secrecy, nondisclosure of research results etc, are in contrast to the sharing of data, collaboration, publication etc." of most University-based research. She also raised the question of who will reap the benefits of such research? Often times marketing of the products that stem from this research is too early, such as in the case of breast and ovarian cancer tests. These tests are not publicly insured. Skanes also cautioned that the 'widespread commercialization of genetics and availability of a variety of genetic tests may ultimately affect our perception of normalcy, which will be more and more defined according to the needs of industry and insurance underwriters." [167]

Summary of Part II

Reductions in coverage for some publicly insured medical services through de-listing and de-regulation over the past ten years have changed somewhat *who pays* for medical services. Any increases in out-of-pocket payments, insurance premiums, and co-payments are likely hitting women of this province, particularly rural, lower income, unemployed, seasonal and part-time

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[165]Dr. Verna Skanes, "Issues Arising From Commercialization of Human Genetics Research: A Report and Some Recommendations for Discussion," presented to the Department of Health, February 2000.

[166]Dr. Verna Skanes, "Issues Arising From Commercialization," 3.

[167]Dr. Verna Skanes, "Issues Arising From Commercialization," 8.

workers, and elderly women particularly hard. Over the past decade or so while this health care privatization has been taking place, broad sectoral shifts in the nature of work have been eroding the protection working women have from the effects of privatization while increasing the proportion of women and men at risk of the hardship it can cause.

Recent research on employment and unemployment in Newfoundland and Labrador done by the Newfoundland and Labrador Federation of Labour (NLFL) has revealed some disturbing trends in the changing nature of work on the island.[168] One of the most pronounced of these changes has been the proliferation of relatively low-paying, temporary, part-time jobs, and the erosion of more secure, higher-paying, full-time employment. Recent aggregate Labour Force data from Statistics Canada, for example, show that between 1989 and 1998, the number of people employed in the goods-producing sector in Newfoundland and Labrador decreased by 11,300. Construction, utilities, trade, and the public service sectors also decreased over this period. At the same time, the number of people working in the accommodation, food, and service sectors increased dramatically. From 1997 to 1998 alone, jobs in the service sector increased by approximately 5,000, and there were 2,400 more people employed in food and accommodation jobs in 1998 than in 1997. Relative to employment in the declining sectors, employment in the expanding sectors tends to be non-unionized, low-paying, temporary (especially in jobs related to the tourism industry), and part-time. Statistics Canada figures show that workers in sectors such as service, food/accommodation, and retail, work an average of 27.5 hours per week, while workers in construction and manufacturing work an average of 40 and 38 hours per week, respectively.[169] The total number of part-time jobs in the province increased from 26,000 in 1989 to 31,900 in 1998 (the most ever), again as a result of sectoral shifts.

Women have been especially vulnerable to these trends. In every year from the period 1989 to 1998, the part-time employment rate for women over 25 was 3 to 4 times higher than that for men over 25. In 1998, for example, the part-time employment rate for women over 25 was 20.5 per cent; for men it was 5.8 per cent. Furthermore, the part-time employment rate for both men and women over 25 has been steadily increasing in recent years. For men, it has gone from 3.1per cent in 1989 to 5.8 percent in 1998, while for women it has gone from 17.8 per cent in 1989 to 20.5 per cent in 1998. The degree of seasonality has also increased in recent years in the fish and shellfish processing sector, a major employer of women in rural areas of Newfoundland

[168]Newfoundland and Labrador Federation of Labour (NLFL), "Brief Submitted to the Government of Newfoundland and Labrador Consultation on Labour Standards Legislation," April 2000 (researched and written by Rick Rennie and Ingrid Botting).

[169]NLFL, "Brief on Labour Standards Legislation."

and Labrador.[170] Part-time and seasonal workers have lower incomes, greater employment and income uncertainty and are less likely than full-time, year-round workers to have access to private health insurance and drug benefits. Since employment and income are health determinants, they may also be more vulnerable to ill-health. These workers are thus hit harder when publicly-insured services are de-listed.

[170]Barbara Neis and Brenda Grzetic, *From Fishplant to Nickel Smelter*.

Monica Townson's recent study on women and poverty in Canada revealed that women's poverty has been increasing in Canada over the last ten years. The report concluded that the poorest of the poor are disproportionately female.[171] Newfoundland and Labrador is no exception. Townson showed that the elimination of federal transfers associated with the shift from the Canada Assistance Plan (CAP) to the Canada Health and Social Transfer program (CHST) has meant that the provinces and territories have not made improvements to welfare systems. In fact total welfare income for a single employable person in Newfoundland and Labrador is now only 9% of the poverty level, according to Townson.[172] In 1997 the poverty rate in Newfoundland and Labrador was the highest in Canada for families (18.9%), unattached individuals (45.6%) and overall for all persons at (20.3%).[173] When measured in constant 1996 dollars, welfare benefits have been dropping over the last ten years in this province. For example, welfare benefits for single employable persons dropped by 43.1% between 1986 and 1996, and they dropped for single parents with only child by around 8.6% between 1986 and 1996.[174]

Single mothers and elderly women have the highest poverty rates in Newfoundland and Labrador, where poverty rates for all children under 18 have increased over the past decade, from 19.8% in 1989 to 22.8% in 1997 -- the highest rate of the Atlantic provinces.[175] In single mother families, the poverty rates among children under 18 was 72.3% in 1997, which was the highest in Atlantic Canada. This 1997 percentage of children in single-mother families living in poverty is considerably higher than it was in 1993, when 66.1% of such children were living in poverty. The Canadian average for single mother families living in poverty was 56%.

The poor and the elderly are also the most likely to suffer from ill health and hence to suffer from constraints on their access to health services. Researchers have shown that poverty and income equality are among the most reliable predictors of poor health. For instance, according to Dr. Ronald Coleman's recent study on gender and determinants of health in Atlantic Canada, poor women were 62% more likely to be hospitalized than non-poor women.[176] The likelihood of hospitalization for poor men and women between 40 and 64 was 57% and 92%

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[171]Monica Townson, "A Report Card on Women and Poverty," (Canadian Centre For Policy Alternatives: April 2000).

[172]Monica Townson, "A Report Card," 8.

[173]National Council of Welfare, *Poverty Profile 1997: A Report by the National Council of Welfare* (Autumn 1999) 23.

[174]Canadian Council on Social Development, "Percentage Change in Welfare Benefits in Canada by Province/Territory, Between 1986 and 1996," (http://www.ccsd.ca/facts.html)

[175]Dr. Ronald Coleman *Women's Health in Atlantic Canada: A Statistical Portrait*, prepared for the Maritime Centre of Excellence for Women's Health, Atlantic Region Policy Fora on Women's Health and Well-Being," (February 2000) 21.

[176]Dr. Ronald Coleman, "Women's Health in Atlantic Canada," 15.

respectively, much higher than that for their more affluent counterparts. According to Dr. Coleman "as hospitals are the single largest health care expenditure, strategic investments that alleviate poverty are likely to be highly cost effective in the long run."[177] Thus, increases in individual financial responsibility for medical services have probably hit women in Newfoundland and Labrador particularly hard.

The privatization of health information and genetics research represents a new direction in this province. There has been little evidence that these developments have been evaluated on the basis of their impacts on individuals and groups. In 1998 National Union of Public and Government Employees (NUPGE) warned, "Provinces are developing centralized electronic networks linking records of hospitals, physicians, pharmacies, laboratories, and other agencies in the health sector. Behind the scenes, corporations are

[177]Dr. Ronald Coleman, "Women's Health in Atlantic Canada," 15.

drumming up business with strategic plans for exploiting the valuable information contained in patient records. Pharmaceutical manufacturers, service providers and other private companies profit by using health information to design targeted marketing strategies and to influence policy decisions, which favour privatization and contracting out."[178]

Restructuring, reform and regionalization of health care delivery and service provision have also put the health care Boards under enormous financial pressure. In response to the pressure they have begun to contract out some non-medical services. This has the potential to negatively impact women as paid and unpaid care providers and support workers. We address these issues in the following section.

[178]National Union of Public and Government Employees (NUPGE), "Health Care Restructuring Update: A Province by Province Review." April 1998, 2.

Part III: Impact of Privatization on Women as Care Providers

In Newfoundland and Labrador women make up a large proportion of paid employees in the health care sector. Over the last decade 80% of health care workers have been women, compared with 20% of men.[179] In some occupations such as nursing and in the home support sector, women make up an even larger proportion of paid employees compared with men. Thus, cuts to jobs in the health care sector and the ways in which working conditions have changed over the course of the restructuring process have been particularly relevant to women's experiences as paid workers. While all women health care workers have been negatively affected over the course of rapid change, some women have been affected differently than others. In fact, most of the job loss has occurred in the lowest paid sectors of the health care system, which has increased these women's vulnerability to poverty.

a) Women's Employment in the Health Care System:

As elsewhere in Canada, Government cutbacks in health care and restructuring of the delivery of health care in Newfoundland and Labrador have, at various times, led to layoffs of women employed in health care occupations. While job loss in the health care system has directly affected women workers in some occupations more than others, the downsizing of support staff positions, middle management, and the transfer of some institutionally-based jobs to the private sector through out-sourcing, have created a ripple effect throughout the entire system. Furthermore, the loss of jobs has been felt unevenly in different regions of the province.

Table 1: Number of Women Employed (Full-Time and Part-Time) in Health Occupations, Newfoundland and Labrador, 1990 and 1999

	Full time	Full time	Part-time	Part-time
	1990	1999	1990	1999
health occupations: total	7500	10300	1100	1900
professional occupations in health, nurse supervisors and registered nurses	3800	5500	1000	1000
technical, assisting and related occupations	3700	4800	0	900

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

[179]These percentages are based on calculations from Statistics Canada, *Labour Force Historical Review*, CD-Rom, 1999.

Unlike in other provinces, Newfoundland and Labrador did not lose nursing jobs through restructuring. Between 1994 and 1999, the Northwest Territories, Nova Scotia and Ontario experienced the greatest declines in the number of registered nurses per capita employed in nursing, whereas the Yukon and Newfoundland experienced the greatest increases.[180] The Newfoundland and Labrador Nurses' Union (NLNU) acknowledges there was an increase in the number of nursing positions in the province and this is documented in Table I. Despite this trend, however, the NLNU and the Association of Registered Nurses of Newfoundland and Labrador (ARNNL) have repeatedly argued that there is a nursing shortage, and that at least 400 new nursing positions are needed in this province for appropriate health care delivery.[181] Acute shortages of health care professionals over the summer months in places like Corner Brook, where 63 acute care beds were closed in the summer of 2000 because of nursing shortages, are an indication of a shortage and can have devastating effects. The *Evening Telegram* recently reported:

> Corner Brook's daily newspaper, *The Western Star*, has been contacted with a parade of stories from irate patients, including eight people who waited for up to a month to have their heart condition diagnosed, a woman with lung cancer who lost her bed after receiving a pass to leave the hospital for Canada Day, and another woman who reported getting a cold after sleeping in the corridor."[182]

The St. John's Health Care Corporation is the largest industry in the Province, next to Government and "there are times of the year when the Health Care Corporation has more employees than government itself," according to the Corporation's CEO. Since 77% of its budget goes to salaries, most of the Corporation's "cost saving measures" have been geared

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[180]Canadian Institute for Health Information, "Canadian Institute for Health Information Reports Continued Drop in Registered Nurses per Capita in Aging Workforce," *Newsrelease*, 19 July 2000.

[181]NLHCSA, *Nursing Recruitment and Retention -- National Efforts, Information and Summary gathered at the 1999 National Labour Relations Conference* (Winnipeg, Manitoba, 22 September 1999) 8.

[182]*Evening Telegram*, 13 July 2000.

towards reducing staff. Cost savings have been achieved through the transformation of full-time permanent positions to part-time, temporary or casual ones.

The casualization of the nursing workforce in Newfoundland and Labrador happened rapidly. In 1992, 11.9% of the nursing workforce was casual. By 1998, 24.3%, or 1,300 of the NLNU's 4,500 members worked on a casual basis. As one NLNU representative remarked, "There was a generation of nurses waiting by the telephone."[183] The casualization of nursing has been a major issue for nurses throughout the 1990s. At the time, the president of the Union speculated that the number of casual nurses had increased by about 165 between 1997 and 1998 alone.[184] Of the 137 graduates of the 1997 nursing class who were working in the province in 1998, only one had a permanent position. As of 1998, casual nurses did not receive sick leave, vacation benefits, or compassionate leave, and they did not qualify for maternity benefits under the collective agreement, but received 14% of their salary in lieu of those benefits.

Prior to the 1999 nurses' strike, nurses had not received a pay increase since 1991. After the strike, when Government gave them a 7% increase. In effect, nurses' salaries have increased by only 7% over the past ten years, and that increase is not indexed to inflation. Since the nurses' strike (the first strike since 1979), the provincial Government has made a concerted effort to restore permanent nursing positions. In March 1999 Government announced that it would convert 75 casual nursing positions to permanent status (full-time and part-time) and create 125 new permanent positions.[185] In some communities there has been a lack of casual nurses. In the northern community of St. Anthony, for example, nurses recently complained that a lack of casuals has meant that nurses have been getting called back to work on their days off.[186]

This reversal of the casualization of nursing positions by Government came on the heels of massive protest and public support for the nurses. It does not indicate the involvement of these health care workers in decision-making related to their workplace needs. Other issues that emerged during the strike remain unresolved. For example, the NLNU noted that health care workers who are represented by the Newfoundland and Labrador Union of Public and Private Employees (NAPE) have better family leave provisions in their collective agreement than the NLNU, whose membership is female-dominated.[187]

The NLNU and the ARNNL have argued repeatedly that nurses were not adequately included in the decision-making processes that led to reform, and that when they were brought in

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[183]Personal Correspondence with John Vivian and Karen Caroll, NLNU. Used with permission.

[184]*Evening Telegram,* 10 June 1998.

[185]NLHCSA, *Nursing Recruitment,* 8.

[186]*Northern Pen,* 1 Dec 1999.

[187]Personal Correspondence with John Vivian and Karen Caroll, NLNU. Used with permission.

it was too late.[188] Nurses have argued for an increased role for R.N.s as entry points into the system and that more money needs to be shifted into the communities, especially for older people with complicated illnesses. These groups have also noted that as a result of shorter hospital stays and an enhanced role for community-based care without the support staff has been that patients who are sent home are ending up back in hospital, which is not cost effective. Nurses are also seeing more and more pressure being put on family members who are having to look after their relatives while they are in hospital because nurses' workloads are too high. Hence, even care within hospitals is being privatized.

[188]Personal Correspondence, NLNU and ARNNL. Used with permission.

Other health care sector workers, such as support staff, LPNs, and cleaning, laundry and dietary workers have experienced substantial job loss as a consequence of restructuring.[189] These women are the lowest paid in health care sector and the most vulnerable to poverty in an economy where there is high unemployment and an over-representation of non-unionized service-sector jobs.

The Health Care Corporation estimated that substantial staff reductions through restructuring would result in an estimated annual savings of about $14.5 million a year. In 1997, the Corporation told the Auditor General that they have no idea how many jobs would be lost "when the Grace closes and the Janeway is moved to the Health Sciences Centre in June 2000."[190] In 1997, Sister Elizabeth Davis also told the Auditor General that the Corporation had been in the process, since around 1996, of hiring temporary positions so that, "hopefully those will be the ones to go in 2000."[191] In July 2000, the NLNU stated that it was able to save almost all of the nursing positions, but the union also noted that LPNs and support staff "took the hit."[192]

Another way the Corporation has attempted to keep their budget in line has been through integrating and streamlining the administrative and support departments. The Corporation also out-sourced housekeeping, central laundry, and food services. There is little evidence of job loss in the other regional Institutional Boards, however, the loss of even one or two positions in smaller centres of the island can have devastating effects on the staff, community, and on the quality of care.[193] Many of those initially laid off in the St .John's region were in managerial

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[189]Personal Correspondence with Carol Furlong, NAPE. Used with permission.

[190]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) 23.

[191]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) 20.

[192]Personal Correspondence with John Vivian and Karen Carol, NLNU. Used with permission.

[193]Personal Correspondence with John Vivian and Karen Caroll, NLNU, Used with

positions, with highly transferable skills. However, those women working in dietary, laundry and housekeeping services would not have had access to comparable employment in the private sector once they were laid off. As Health Care Corporation chairperson Eileen Young stated,

permission.

> A lot of the people, 40 per cent of our managers, are not in the system. They are not working in our system any more. These people were able to go forward and get other jobs in other positions. However, we also had to let go some of the lowest paid and the lowest educated people who are in our food service and laundry area. Everybody in the board has a heart to realize that these people will not find a job in today's environment in Newfoundland.[194]

b)Working Conditions for Women in the Health Sector:

In a population health model, which has recently been adopted as policy by the province, income and working environments are important determinants of health. The restructuring process in this province has had serious ramifications for women workers in the health care sector, in terms of increased workload, stress, and other health risks. The NLNU stated it was in support of reform and restructuring of the health care system, "but not what we got...What we got was a system that was gutted."[195]

Over the past decade nurses and other hospital workers have reiterated the negative effects of so-called reform on their workers, such as high levels of stress, increased workloads, rapid change with little input from front-line workers, understaffing, and workplace health and safety issues.[196] Even though the NLNU's membership had not received a wage increase since 1991, the 1999 nurses' strike was about more than higher wages. Nurses went on strike because they believed that more nursing positions were required in hospitals, long-term care facilities, and in the community, their workloads were increasing at an alarming rate, as were workplace injuries, and that quality of patient care was at risk.[197] Government's lack of commitment to

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[194]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) Report, 20.

[195]Personal Correspondence with John Vivian and Karen Caroll, NLNU. Used with permission.

[196]Personal Correspondence with Colleen Kelly, ARNNL. Used with permission.

[197]*The Georgian*, 9 February 1999

contributing to the nurses' pension plan on a consistent basis, and other short-sighted health care policies encompassed other factors in the strike.[198]

[198]*The Evening Telegram*, 2 July 1993.

Front-line health care workers have noted that the most traumatic restructuring initiative in the province occurred in St. John's, where the Health Care Corporation changed the model of health care delivery, flattened hierarchies, and brought in program-based management. The St. John's Health Care Corporation moved away from a function-based, site-oriented approach to care delivery to a program-based approach in order to cut costs and stream-line operations. Sister Elizabeth Davis rationalized the adoption of a program-based approach on the grounds that, "across the country, as well as in the United States, there is a recognized management direction today called Integrated Delivery Services. It is modern thinking that says you should integrate health care services. That is the new management thinking, and that is all we are doing here."[199] One consequence of this approach is that the six departments of physiotherapy in St. John's hospitals in 1995 have been eliminated. The physiotherapists are now integrated into the medicine program, or the cardiac program. The other Regional Institutional Boards have not adopted a program-based approach.

The impact of the shift to program-based management on women workers and women care recipients does not appear to have been examined – though some of those studies (if they exist) may not be readily accessible. However, women's health services appear to have provided a model for this kind of approach. Sister Davis stated, "I can honestly say some programs were, from the beginning easier: women's health for example. Because St. Clare's had transferred obstetrics in the early 1990s, women's health was already pretty much functioning as a program.."[200] Front-line workers indicate that program-based management is based on a business model, which does not necessarily work effectively in the health care system because patients get lost and staff nurses lose their leadership at the unit level. From their perspective, these reforms have destroyed women's workplace culture and professional identities.

The issue of reclassification of jobs has been ongoing since the restructuring began. The nature of work has changed for many health-related professions and the current classification system does not properly reflect the complexity of the work they perform.[201] The Association of Allied Professionals is currently reviewing the classifications of physiotherapists, pharmacists, and dieticians. Government reclassified the management positions first and stalled the reclassification of other professions,[202] which tend to be dominated by women. Government has recently committed to reclassifying nurses.

In a survey conducted by the Union province wide, they found that 91% of those surveyed agreed the role of nurses should involve more emphasis on educating patients and members of the community on illness prevention and health care promotion. Nurses recognize the growing

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[199]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) 33.

[200]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) 31.

[201]Department of Health, *Newsrelease,* May 1, 2000.

[202] NAPE, *Newsrelease,* 22 July 1998.

importance of primary care and support the move toward community-based illness prevention and health promotion.[203] However, front-line workers have observed that Government is only paying lip-service to the shift to community-based care. Over the past ten years nurses have

[203]*Evening Telegram*, 18 January 1998.

experienced powerlessness, no input, lack of clinical support, and fewer opportunities for continuing education. Community health nurses have few opportunities to enhance their skills through continuing education, even though their roles have changed.[204] The ARNNL has also noted that the scope of practice issues and regulation in continuing care is a major issue that requires urgent resolution because patients' safety has been jeopardized.

The NLNU recently denounced any attempt to privatize medicare speaking out against Alberta's Bill 11. It asked the federal government to commit to funding increases, stop Alberta's decision, expand medicare to include home care and community care, impose a moratorium on public-private partnerships in health care, and declare that health care and social services be excluded from all trade agreements.[205]

***c) Occupational Health and Safety*:**

Occupational health and safety issues have been a major concern for nurses over the past decade. Policy and legislation changes to workers' compensation over the past decade (discussed above) have also had negative impacts on injured health care workers, and on women workers in other sectors of the economy. In 1998, the NLNU argued that "health care cutbacks in areas such as the number of hospital beds and the reduction in nursing positions have resulted in unsafe conditions for patients and nurses."[206] A study released at the NLNU's 1996 convention revealed that 85 percent of nurses experience some kind of abuse at work. A report on the convention indicated a direct link between restructuring and the abuse of nurses by patients: "Nurses feel that they're seeing more abuse because the cutbacks mean patients have to wait longer to receive care.[207]

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[204]Personal Correspondence with Colleen Kelly, ARNNL. Used with permission.

[205]*Northern Pen*, March 13 2000

[206]*Evening Telegram*, 18 January 1998.

[207]*Express*, 30 October 1996.

Only two years into its mandate the Health Care Corporation of St. John's began acknowledging the increasing levels of stress on workers by introducing an occupational health system to assist those workers. As the Corporation's CEO explained, "80 per cent of our workers in the clinical side are women who have families and therefore they are caring for children at home and they are also caring for elderly parents at home. So they are often caught in situations that make life very difficult. There are lots of stresses in our system and that is why we have introduced the support throughout the occupational health system that we have brought in."[208] Sister Elizabeth Davis also stated that the Health Care Corporation's employee assistance plan has been increasing because nurses are stressed.[209] However, two years later, the Health Care Corp proposed a "new sick-leave policy for nurses that would require nurses to waive their rights of patient-doctor confidentiality in order to avail of sick-leave benefits." In response to the policy change, John Vivian, executive director of the NLNU, said that the union is asking the corporation to redirect its energies to addressing the underlying causes of sick leave, rather than adding more stress to an already overstressed work environment."[210]

Policy and legislative changes to the workers' compensation system have also had a particularly dramatic effect on women workers in the health care sector. The NLNU stated that legislated cut-backs in benefits to injured workers have been devastating to its membership. For example, nurses, like other injured workers, are now only entitled to 80% of their pre-injury salaries. Any privatization of costs for injured workers has meant an unmanageable financial burden for many women in the health care field because of relatively low wages. The NLNU mentioned that some injured workers have had to declare personal bankruptcy because of difficulties in making ends meet while on compensation.[211] Another issue related to workers' compensation is that injured R.Ns are no longer retrained to the Baccalaureate level or beyond. Their skills are considered transferable by the Workplace Health Safety and Compensation Commission, but in reality these injured nurses are finding it difficult to get comparable work.

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[208]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) 50.

[209]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999) 58.

[210]*Evening Telegram*, 19 August 1999.

[211]Personal Correspondence with NLNU. Used with permission.

Summary of Part III

As Kay Willson and Jennifer Howard have noted, "nationally, health care is one of the most highly unionized sectors for women in the paid labour force. In 1993, 53.2% of women working in health care belonged to unions. Unionized positions often mean higher wages, benefits, and job security. The loss of unionized public sector jobs for women in health care jeopardize's women's income, economic status, and conditions of work in this sector. These are all regarded as important determinants of health."[212] As elsewhere, women represent the largest group of workers in the health care sector in Newfoundland and Labrador. The climate of fiscal restraint in which the restructuring of the health care sector has taken place has meant that there has been a substantial amount of job loss in the sector. Job loss has had a differential impact on different groups of women workers. Support workers, LPNs, and dietary, laundry and housekeeping have felt the effects more than any other group in terms of income status. Working conditions have deteriorated for all health care workers, who have experienced casualization, high stress levels, de-professionalization, and greater risks of workplace injuries. Changes to workers' compensation policies and legislation have meant decreased benefits for all workers and the privatization of costs and responsibility for workplace injuries. These shifts have created a climate of despair and stress in the health care sector.

[212]Kay Willson and Jennifer Howard, *Missing Links*, 50.

Part IV: Shifting from Long-term Institutional to Home and Community-Based Care

In the 1990s in Newfoundland and Labrador, as elsewhere, the shift away from institutional care in hospital to care in the community has opened the door for privatization (broadly defined) on a number of fronts. While medical services, and pharmaceuticals are publicly insured under the *Canada Health Act* for patients in hospital, once a patient moves into the community these services are no longer fully covered. Long-term care in the community can be accessed through home support services, personal care homes, which are mainly privately-run, nursing homes, and other caregiving services in the home. Thus, hospital bed closures, shorter hospital stays, increases in out-patient surgery have meant that more and more families are having to confront the issue of financing their short- and long-term care at home, or in long-term care institutions. The cost for such care has been increasing over the past ten years. In addition, this shift to community-based care, while supported in principle by women's organizations, has in actual fact been built on the assumption of women's traditional roles as unpaid care providers. All too frequently the burden of this shift to community has fallen onto women; we do not, however, know the extent to which this has occurred in the absence of provincially-based research on women's unpaid work. Long-term care also represents an aspect of health care delivery that is open to privatization. As elsewhere, access to privatized services in the home, such as personal nurses, home support, and home-making (in locations of the province where these services exist) are limited to those who can afford to pay in this province. Other essential services such as transportation services for the physically disabled and elderly have been privatized.

Institutional Long-Term Care

As elsewhere, in Newfoundland and Labrador there has been a shift in thinking in terms of how the chronically ill are cared for. Throughout the restructuring process, the demands on long-term care institutions have increased due to cut backs to acute care provision in hospitals. As more expensive acute care beds have been closed, new personal home care and nursing home beds have been opened. Beds in smaller hospitals in certain smaller communities were converted into long-term care beds as these hospitals became health centres. Unlike in other provinces, such as Manitoba, where clients are assessed on a sliding scale, home care and long-term care are not insured services in Newfoundland and Labrador. There has been a steady increase in user fees for long-term care for those who can afford to pay the full amount, and a decrease in the subsidy for those who require government assistance.

According to the Department of Health, 2,920 men and women receive institutional long-term care services in 19 nursing homes and 18 community health centres in the province.[213] No gender breakdown of these clients was available but given sex differences in life expectancy and potential gender differences in the capacity and willingness of female spouses to care for their ailing husbands suggest that a majority are probably women. In Newfoundland and Labrador,

[213]Department of Health, *Newsrelease*, 15 February 2000.

institutional long-term care, primarily for persons 65 and older and persons with debilitating diseases, is administered in community health centres and nursing homes. These long-term care institutions are now primarily administered by Regional Health Boards. However, seven nursing homes continue to operate under independent boards.

According to the Department of Health, a universal rate for long-term care was first established in 1984 at $1,400 per month, or approximately 70 per cent of the full cost at that time. The 1984 rate increased to $1,510 per month in 1986. Following a policy review in 1996, Health Minister Lloyd Matthews implemented a new rate structure for residents of long-term care institutions, the first adjustment since 1986. The 1996 rate for long-term care was set at $2,800 a month.[214] The Department rationalized its steep increase because of increasing pressures on the system related to an aging population, and a climate of fiscal restraint:

> currently there are 58,000 seniors in the province, but in the next 15 years there will be some 88,000 seniors.... those who have some ability to pay for nursing home care either through pensionable income, RRPs and RRIFs as well as savings, should be required to make a contribution. Otherwise the ability of government to offer a long term care program in the future is seriously threatened.[215]

Generally speaking, therefore, in 2000, if you have $5,000 or more at the time of the financial assessment, you pay $2,800 per month for residential long-term care.[216] If you have less than $5,000, all your income goes towards paying the monthly rate, but you are able to keep a personal allowance of $125 per month.

The rate for personal allowance for residents in facilities such as nursing homes, personal care homes, and residential settings such as Emmanuel House increased in 1999. In 1989 such residents were allowed to keep $110 per month for clothing and other personal effects. This rate was not increased until March 1999, when the Minister of Health proudly announced a $15 per month increase in honour of the Year of Older Persons.[217]

The 1996 rate structure often impoverished the spouses of those individuals in institutional long-term care who remain at home. Until May 2000, only a client's private income could be

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[214]Department of Health, *Newsrelease,* 19 July 1996.

[215]Department of Health, *Newsrelease,* July 19 1996.

[216]Personal Communication with St. John's Nursing Home Board.

[217]Department of Health, *Newsrelease,* 22 March 1999.

transferred to the spouse remaining at home, which meant that old age security, guaranteed income supplements etc. were clawed back. Although we have not been able to access gender disaggregated data on long-term care recipients and their spouses, thus we do not know the differential effects.

In response to pressure from various community groups, Government reversed this policy in March 2000, allowing the spouse at home to keep some or all of the client's total private and federal maintenance income. The Department's rationale for improving conditions for spouses living at home, was that "In the past there have been isolated incidences where our policy resulted in spouses at home having to avail of social assistance as a result of losing the ability to use their husband or wife's income after they enter a nursing home.[218]

a) Palliative Care:

Recipients of palliative care have also experienced negative effects from the restructuring process. According to a recent report on Palliative Care in Canada, the Department of Health in Newfoundland and Labrador is currently conducting a provincial survey of palliative care, followed by the development of a Provincial Framework for Palliative Care Services.[219] Thus only limited data on palliative care are currently available.

On April 1, 1998 the mandate of the four Health and Community Services Boards and two Integrated Boards was broadened and they began to receive global funding for palliative care in the community from the Department. The Health Care Corporation of St. John's has the most extensive palliative care program in the province, with an eight-bed, in-patient unit. According to the St. John's Health Care Corporation, palliative care is not covered for doctors by MCP, therefore, the only hospital in the province which offers a palliative care unit -- St. Clare's Mercy Hospital -- pays physicians a subsidy for working with patients in the eight bed unit. In 1997/98 the Health Care Corp allocated $50,000 a year for the subsidy, but stated that they were trying to reduce that expenditure.[220]

Other Boards have limited access to palliative care resources, and in many cases patients

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[218]Department of Health, *Newsrelease,* Feb 2000.

[219]Standing Senate Committee on Social Affairs, Science, and Technology, *Final Report: Quality End-of-Life Care: The Right of Every Canadian*, June 2000.

[220]*Report of the Standing Committee of Public Accounts on the Health Care Corporation of St. John's* (1999)50.

requiring palliative care outside of their homes have to go to long-term care facilities where they pay. The Newfoundland and Labrador Cancer Treatment and Research Foundation has a palliative care service, which conducts outpatient pain and symptom management clinics.

In June 2000, a Senate Sub-Committee released a report on Palliative Care in Canada, which argued that the state of palliative care in Canada was a disgrace.[221] According to the National Union of Public and General Employees (NUPGE), the report concluded that "[a]ccess to, and the successful delivery of, quality end-of-life care, where it exists, was described as the "luck of the draw" rather than basic entitlement." While the report did not include a gender analysis, many of the issues raised about the quality and access to palliative care were relevant to women in Newfoundland and Labrador.

The Committee raised several issues relating to privatization, including the fact that while in hospital some of the palliative care services are paid for, in long-term care facilities, residents are required to pay varying amounts. The Committee's national survey also found that selected aspects of home-based palliative care may be paid by provincial health plans as part of a home care program, but these plans do not always include the cost of drugs and equipment such as pain pumps, oxygen, commodes etc. Some patients are thus forced to seek admission to hospital (if this is possible). The survey also found that some plans pay for only a limited number of hours of professional and home support services. Consequently, people may need to use private insurance, personal savings, or contributions from social agencies and service clubs to cover costs. The Senate Committee recommended that the "federal government immediately implement income security and job protection for family members who care for the dying."[222]

Home Care

Home care is a health care issue of particular relevance to women, because women are more likely to rely on home care services than men, women make up the vast majority of home care workers, and women are also expected to provide more and more unpaid care to relatives.

a)The Policy Context:

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[221]Standing Senate Committee on Social Affairs, Science and Technology, *Final Report: Quality End-of-Life Care*.

[222]Standing Senate Committee on Social Affairs, Science and Technology, *Final Report Quality End-of-Life Care.*

In Canada public home care expenditures have increased by 104% from 1990-91 to 1997-98. Newfoundland's public spending on home care increased from 2.2% of total public health spending in 1990-1991, to 5.1% in 1997-98.[223] Since 1984, the budget for home support alone has increased from $1 million to $30 million in this province.

[223]Health Canada, "Public Home Care Expenditures in Canada, 1975-76 to 1997-98,"(www.hc-sc.gc.ca/datapcb/datahesa/E_home.htm)

The provincial government's involvement in the home support sector has changed over the past few decades. Home support started in the early 1970s in St. John's under the St. John's Home Care Program. Initially, services were contracted out to private providers (for-profit and non-profit) and were available to seniors only. Since that time the home support program has become province-wide and it has been extended to physically disabled persons under the age of 65. In 1996, the Department of Health assumed responsibility for the Provincial Home Support Program. Currently, the home support program has three components including: 1) the Continuing Care Division which administers the assessment for those over 64 for long-term care including home care and institutional placement; 2) Family and Rehabilitative Services which administers the assessment for those 18 to 64 with disabilities (as well as those under 18); 3)Child Welfare Division, for children in care or on protection case loads.[224]

The Department of Health has transferred the management of home support services to the Regional Health and Community Services Boards. In effect the province has increasingly divested itself from direct involvement in the administration and regulation of the home support sector. For example, while government once granted operating licences (under a provincial Licencing Board) to home support agencies, it has since abolished the Board and delegated the task of licencing to the Regional Health Boards.[225]

Throughout the restructuring process the Department has not provided clearly defined standards for the sector, nor has it allocated appropriate resources to the regional Boards to monitor the quality of care.[226] Some rural regions lack the number of case managers they need. In such instances, the home support sector is highly unregulated. In addition, in 1998, Government passed " An Act Respecting Home Support Services Provided to Persons In Self-Managed Care" or the *Self -managed Home Support Services Act*. This short Act declares that the person "to whom home support services are being provided is considered to be the employer of the person who provides the home support services." The Bill's objective is to make it clear that Government takes no responsibility for workplace issues (other than existing labour standards legislation) for home care workers in self-managed care.

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[224]Institute for the Advancement of Public Policy, *A Review of the Home Support Program.*

[225]William Shallow and Associates, *Home is Where the Care Is*, 39.

[226]William Shallow and Associates, *Home is Where the Care Is*, 38.

There have been three major studies done on home care in this province in the past two years. First, in January 1999, Health and Community Services commissioned the Institute for the Advancement of Public Policy to conduct a review of the Home Support Program to determine "the extent to which the program components are consistent in philosophy, orientation, and benefits extended to clients."[227] Even though the Institute's report did not include a gender analysis, its findings are particularly relevant to understanding the impact of privatization on women. It determined that pressure on the home support program is increasing substantially for a number of reasons including the fact that Government policies have increasingly promoted care in the "community" and the home, that the population is aging, and outmigration and rural to urban migration have meant that fewer informal, unpaid caregivers are available in the community.[228] Second, the Canadian Research Institute for the Advancement of Women (CRIAW), recently published a gender analysis of home care issues comparing the St. John's region of Newfoundland to Winnipeg, Manitoba. The CRIAW study linked home care directly to women's vulnerability to poverty as care recipients, care providers, and as paid workers. The third study was conducted by the Employers' Council of Newfoundland and Labrador and it focussed on issues related to home support agencies. In Newfoundland and Labrador, home care is done through agencies or the self-managed model. All three reports determined that the home support sector is currently in a state of crisis. The only study that used a gender analysis was the CRIAW study, even though the other studies alluded to the particular relevance of home support issues to women's health, and economic status.

Access to aggregate data on the number of home care providers and recipients in Newfoundland and Labrador is lacking. According to William Shallow and Associates, the firm that conducted the Employers' Council study: "Requests made in the process of this study to the Department of Health and Community Services Boards throughout the province have produced limited and in some cases no utilization data. The data provided are insufficient for a province wide measurement; within the available data, inconsistencies exist."[229] The researchers also noted that the Centre for Health Information does not presently collect data on home support and aggregate information is not consistently collected by all the Regional Boards. This presents a major obstacle to monitoring the situation, let alone to conducting a gender analysis.

b) Women as Recipients of Care and as Unpaid Care Providers:

While we could not do a gender breakdown of women and men as users of home support services with available data, the CRIAW study found that women outnumbered men by a substantial margin in their need for home support services. For example, the CRIAW study found

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[227]Institute for the Advancement of Public Policy, *A Review of the Home Support Program*, 1.

[228]Institute for the Advancement of Public Policy, *A Review of the Home Support Program*, 35.

[229]William Shallow and Associates, *Home is Where the Care Is*, 74.

that in St. John's 416 elderly women used home care in 1998 compared with 160 men. These researchers found a more even gender distribution in home support services to the physically disabled.

The demand for home support services is expected to increase exponentially over the next decade or so. For example, the CRIAW study determined that in the St. John's region in 1996 there were 17,075 men and women over the age of 65. If the proportion of women is the same as it is province-wide (57% of the population over age 65) then the gender breakdown of seniors in the St. John's region would be 9,733 women and 7,342 men. In 1998, only 1.2% (or 203) of these seniors qualified for subsidized care.[230] The number of seniors receiving subsidized care dropped from 800 in 1994 to 203 in 1998.[231]

As the use of home support services increases as a result of government policy and as a result of individual client preference (in many cases), more and more of the costs of home support are being shouldered by individuals. In Newfoundland and Labrador, there is no universal funding for home support services. Private clients can pay for their home support personally or through private insurance. For those who cannot afford the cost of home support, clients can apply for government subsidies. Subsidized clients are given the choice of using care provided by agencies (both not-for-profit and for-profit) or they can hire their own home support under the self-managed care model and become employers themselves. In general seniors over the age of 65 living in urban centres use agencies and recipients under 65 (with physical disabilities) and those living in rural areas generally use self-managed care. As noted above the number of those qualifying for a subsidy has decreased over the last five years.

[230]Marika Morris et al, *The Changing Nature of Home Care*, 15.

[231]Marika Morris et al. *The Changing Nature of Home Care*, 50.

Since the shift from CAP to CHST, the Newfoundland Government has tightened its limit on the number of hours a recipient can qualify for care. Before the shift to CHST, certain individuals qualified for 24 hour care.[232] In 1996, when Health Minister Lloyd Matthews announced an end to funding for 24 hour home care, he stated that "It is not reasonable to provide 24 hour at home care to individuals who require the high level of care provided in a nursing home...the home support was never intended to replace family care or nursing home care yet in many cases that is how the program has evolved."[233]

Since 1996 the ceiling for funding for seniors requiring home care has been $2,268 per month. Depending on their income, seniors might be required to pay from 10% to 90% of this amount. This funding equivalent to about nine hours per day of home support, which does not include professional nursing care, physiotherapy, social work, or occupational therapy, which are covered under the HCSBs in rural and urban areas. Long waiting lists mean that recipients who have insurance usually use it for these services.[234] In the St. John's region, their contribution averages around 12%. If their income and assets are above the criteria then they have to turn to private care at $10 an hour for home support and $15 an hour for LPN.

[232]Marika Morris et al *The Changing Nature of Home Care,* 31.

[233]Department of Health, *Newsrelease,* 15 January 1996.

[234]Marika Morris et al. *The Changing Nature of Home Care,* 15.

Government's rationale for the ceiling of $2,268 is to "allow approximately 8-10 hours of complementary care per day which would accommodate the working hours of families." This ceiling presupposes family support.[235] With regard to family support, CRIAW cited a Department of Health representative who stated that "we don't measure it here but we estimate that informal family support amounts to 80 per cent of care. This is a national statistic." [236] In addition, in this province, the financial assessment tool includes an inquiry into the extent of family support "that can be anticipated to enhance the senior's ability to remain in his or her home." [237] This has major ramifications for women, whose services are taken for granted by the system and who are the likely providers of these services. In addition many prospective clients have to wait for up to six months for their funding, during which time they have to pay for their own care. [238]

A recent review of home support in the province criticized financial assessment criteria, arguing that it is difficult for almost all individuals (except those on social assistance) to access government-funded home support because "eligibility is based on levels of income that are below the national poverty line....Those applicants who are just above the income limit, or have fixed assets such as their home but few liquid assets, feel this most acutely."[239] The reviewers also found the guidelines for assessment were inflexible and did not take into account factors such as variations in the cost of living in different parts of the province, and the seasonal nature of the economy and fluctuations in income levels. For instance, the review found evidence of families who have been forced to separate in order to qualify for home support services. Low income working people who are supporting a disabled person or a senior family member often do not qualify for home support services, though they have willingly accepted responsibility for the care of their family member.[240]

The CRIAW study found that some seniors were left without enough money for food and that several workers and agency staff said they regularly took food to their clients at their own expense.[241] It also concluded that "as family members, women are expected to supplement home care services for no pay at great expense to their health and economic well-being. Many unpaid

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[235]Institute for the Advancement of Public Policy, "A Review of the Home Support Program," 36.

[236]Marika Morris et al. *The Changing Nature of Home Care*, 26.

[237]Institute for the Advancement of Public Policy, *A Review of the Home Support Program*, 22.

[238]William Shallow and Associates, *Home is Where the Care Is*, 44.

[239]Institute for the Advancement of Public Policy, *A Review of the Home Support Program*, 39.

[240]Institute for the Advancement of Public Policy, *A Review of the Home Support Program*, 47.

[241]Marika Morris et al, *The Changing Nature of Home Care*, 28.

care providers have to take time off work. As a consequence they lose benefits, seniority, incur out-of-pocket expenses, become more prone to injury and stress, and lack of respite.

***c)Home Care Workers*:**

In 1997, there were more than 3,500 home care workers in the province working for individuals, agencies, or voluntary non-profit organizations. Over 95% of home support workers in this province are women. [242] According to the Newfoundland and Labrador Federation of Labour many home care workers are former employees of health care institutions, laid off as a consequence of restructuring of the health care system.[243] The CRIAW study argued that "the move from institutional care to home care is transforming an overworked and underpaid, mainly female labour force into an even more underpaid and isolated female labour force," as it found that home care is vulnerable to de-professionalization and that nurses and LPNs were being paid less than half the wages they would have received in institutions.[244]

Home care workers are not adequately protected under labour standards legislation in the province. For instance, the Federation of Labour, has found that it is not unusual for a home care worker to report for work only to be sent home without pay because a family member has made other plans. Many home care workers work one-hour shifts, with eight shifts per day, stretching from 8:30 am to 10:30 pm.. Many work for 12 days and then get two days off. Some work up to 50 hours per week. At least half of home care workers have other home care work, and some hold down three jobs.[245] Home care workers do not have adequate sick leave benefits, nor do they have access to injury prevention programs and little access to equipment while on the job. In terms of enforcing labour standards legislation, the Department of Environment and Labour operates on a "complaints driven" basis, and home support workers rarely lodge complaints. They quit instead.[246]

The CRIAW study also found that workers in St. John's and Winnipeg often mentioned the many out-of-pocket expenses they incurred in their work. This included professional licences and fees ($95 per year for an LPN in St. John's); updating first-aid and CPR courses, immunizations including hepatitis A and B ($100), gas expenses and buying food for poor clients. Workers also have to pay for their letter of conduct, and if they transport their clients in their

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[242]Statistics Canada, *Labour Force Historical Review* CD-Rom, 1999.

[243]Newfoundland and Labrador Federation of Labour, "Submission by the NFL to the Social Policy Committee of Newfoundland and Labrador on Home Care Workers," 4 March 1997.

[244]Marika Morris et al. *The Changing Nature of Home Care*, 17.

[245]Marika Morris et al, *The Changing Nature of Home Care*, 44.

[246]William Shallow and Associates, *Home is Where the Care Is*, 48.

own vehicles, they must pay for special insurance coverage themselves.[247] Recipients sympathized with the financial situation of home support workers.[248]

Home support workers are poorly paid, earning in general barely above the minimum wage. According to the Employers' Council Report, the average wage for home support workers in Newfoundland and Labrador was $6.00 – sharing with New Brunswick the status of being the lowest in Canada (See Table II). In fact, health care workers working in institutions earn double

[247]William Shallow and Associates, *Home is Where the Care Is*, 57.

[248]Marika Morris et al, *The Changing Nature of Home Care*, 46.

for similar work and experience. As one home support worker stated in 1999: "I've been a home support worker since 1988. My son who works in a fast food outlet, and my daughter, who works in a clothing store in the Mall, bring home more money than I do."[249]

Table II: National Profile of Remuneration to Home Support Workers:

Province/territory	Salary range	Average salary	Benefits	Self-managed care	Data year
B.C.	$13-16	$14-15	comparable to public sector	competitive but varied	2000
Alberta	$10.65-$13.09 (union) less in contracted	n/a	comparable to public sector	non-union, 70% of public sector	2000
Saskatchewan	n/a	n/a	n/a	n/a	n/a
Manitoba	HSW$11.16,HCA$13.59	n/a	n/a	competitive	2000
Ontario	$9.50-15	n/a	n/a	minimum $9.50	2000
Quebec	HSW $12-13.16	n/a	28% benefits	n/a	1995
New Brunswick	$5.50-$7.50	n/a	minimal	similar	2000
Nova Scotia	$7-9	n/a	n/a	not applicable	2000
PEI	$13	$13	part of public service	not applicable	2000
Newfoundland and Labrador	$5.50-$7.50	$6	varied but minimal	similar but no WCC	2000
Yukon Territories	$17.55-20.16	n/a	8% vacation	Not applicable	1995
Northwest Territories	HSW local $7.50-12, Boards $15.39-17.94	$10	None Public Sector Benefits	n/a	1995
Canada	$5.50-20.16		Varies, greatest when part of public sector	usually competitive to public sector or	

[249]William Shallow and Associates, *Home is Where the Care is*, 56.

				agency services	

Source: William Shallow and Associates, *Home is Where the Care Is*, 69.

Home care workers employed by agencies require 120 hours of training within the first six months of becoming employed but recent studies have determined that this is not always enforced. There are currently no guidelines or monitoring for training self-managed care home support workers.[250] Changes to Federal Human Resources and Development policy for retraining, which emphasizes EI eligibility has also been prohibitive to most of the women who work as home support workers. Twelve week training programs are sponsored by the Department of Education (provincial) at private and public training institutions, but the cost is $2,000, which is prohibitive given the low wages home support workers receive.[251]

Few home support workers are unionized in Newfoundland and Labrador. In the mid-1990s home support workers who worked with Olsten/Kimberly Quality Care were represented by the United Food and Commercial Workers Union local 1252. The UFCW also unionized workers at Comcare, which employed 300 workers in the St. John's Mount Pearl region.[252] In 1996, the Comcare (for profit) workers and the Southern Shore Home Support Agency (not-for-profit) workers went on strike for better working conditions. As one worker on the Southern Shore stated, "We went on strike because we wanted better working conditions. We were doing work we shouldn't have been doing, like shovelling, washing walls, and painting. If you hurt yourself, they'd say it wasn't in your job description, and it wouldn't be covered by compensation." [253] Most of the agencies that were established in Newfoundland in the 1970s and 1980s have since closed down.

The unionization of home care workers in self-managed care is a complex issue. Community organizations have opposed the unionization of home care workers because they believed that their individuals needs would not be met as a consequence, they have also raised the issue of continuity of care due to factors such as seniority rights. With self-managed care, the client is allocated a level of funding by the Government, then becomes the employer and hires a

[250]Marika Morris et al,*The Changing Nature of Home Care*, 47.

[251]William Shallow and Associates, *Home is Where the Care Is*, 48.

[252]*Evening Telegram*, 8 June 1995.

[253]Marika Morris et al, *The Changing Nature of Home Care*, 16

home care worker to do the tasks he/she deems necessary. According to CARP, self-managed care is more widespread in Newfoundland than anywhere else. For people with disabilities approximately 80% of services are provided through self-managed care, and 20% through agencies in this province. For seniors there is a 75-25 split." [254] The fact that Government has failed to support the self-managed care model effectively, has meant a lack of regulation, which in turn has placed an enormous amount of stress on clients and workers.

Home care workers in self-managed care are also ineligible for workers' compensation coverage, unless their employers purchase insurance out-of-pocket. There are no provincial regulations that state employers must provide workers' compensation benefits. Individual recipients of home support care are thus personally liable in the event of a workplace injury.

[254]Canadian Association of Retired Persons (CARP), *Putting a Face on Home Care: CARP's Report on Home Care in Canada*, 1999, 49-50.

Apparently in 1997, the provincial budget committed $1 million to extend coverage to home care workers in self-managed care but "this has yet to be implemented."[255]

Drastic change to the home support sector in this province is needed. The CRIAW study's recommendations for change were particularly aimed at improving economic and social conditions for women within the sector. These recommendations included that provincial governments: eliminate all fees for service; establish provincial professional associations for home care workers; eliminate gender bias in assessment process; require public and private agencies receiving government funds to be transparent and accountable to the public; and invest in respite care.

Other Issues Relating to Care in the "Community"

a) Mental Health:

At a national level, a majority of depression sufferers are women, diagnoses of depression increased by 38 per cent between 1993 and 1998, and the cost of prescription drugs for depression nearly doubled over the same period.[256] According to Moyra Buchan, Executive Director of the Newfoundland and Labrador Branch of the Canadian Mental Health Association, within the de-institutionalization of mental health patients began in the 1960s. While mental health advocates supported this shift to the "community," they did so under the assumption that proper supports would be available. In Newfoundland and Labrador individuals with serious mental illness still have to travel to St. John's to the Waterford Hospital.

The major issues in the mental health system in the province parallel problems in other aspects of health care reform, including regional disparities, distance from services, lack of community supports, outmigration of younger people, aging population, difficulties in recruiting and retaining mental health professionals in rural areas, centralization of specialized services, and a crisis orientation rather than one of prevention and intervention, according to Buchan.[257] Another issue may be the offloading of drug costs onto individuals and families through deinstitutionalization and greater reliance on outpatient treatment

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[255]Institute for the Advancement of Public Policy, *A Review of the Home Support Program*, 54.

[256]Susan McDaniel, "Untangling Love and Domination: Challenges of Home Care for the Elderly in a Reconstructing Canada," *Journal of Canadian Studies* 34(2), 200.

[257]Personal Correspondence with Moyra Buchan.

Since early intervention and prevention is particularly important for those experiencing mental health issues, any cuts to community groups and other organizations that provide emotional support as an adjunct to counselling and psychotherapy may have devastating affects on those men and women who need the support. According to Buchan, Government is still spending too much on institutions. When those budgets are cut money needs to go into the community and that is not being done. The restructuring process has also meant a lack of coordination of services, which can be difficult for those experiencing mental health issues.

Since the establishment of regional Community Health Boards in 1994 there has been a small increase in the number of community-based mental health counsellors and mental health programs in rural areas. In the private sector, there is a growing number of fee-for-service practitioners. While private health insurance programs and employee assistance programs often assist with part-payment of fees, many people who need services do not have access to these programs. In addition, people living with mental illness do not currently qualify for Home Support. They may qualify if they have an additional health related illness or disability but not based on their mental illness.[258]

In 1994, the Working Group on Women's Health's *Profile of Women's Health in Newfoundland and Labrador* found that many women had limited access to mental health services. Barriers to access included limited programs and personnel, distance, responsibilities as care givers, inappropriateness of existing services and the over-medicalization of women's health.[259] Mental issues are particularly significant for aboriginal women in the province. These were highlighted in a 1997 report generated by the Tongamiut Inuit Annait Ad Hoc Committee on Mining in Labrador. Generated as part of the Environmental Assessment Review Process for the Voisey's Bay nickel mine, the report recommended the "study of the mental health of women and families due to the effects of long-distance commuting fathers," and examining "the impact on women's physical and mental health of the stresses of teenage and unwanted pregnancies, increased abortion rates, single parenthood."[260]

b) Women's Health and Women's Organizations within a Population Health Framework:

Over the past ten years, the policy shift towards prevention, intervention and promotion, which has not been adequately funded by provincial or Federal Governments, has placed an extra burden on private non-profit organizations. In addition, the Federal government's policy change related to core versus project funding for women's community organizations has had disastrous

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[258]William Shallow and Associates, *Home is Where the Care Is*, 53.

[259]Working Group on Women's Health, *A Profile of Women's Health in Newfoundland and Labrador,* (St. John's: Department of Health, 1994) 47.

[260]Tongamiut Inuit Annait Ad Hoc Committee on Women and Mining in Labrador, *52% of the Population Deserves a Closer Look: A Proposal for Guidelines Regarding the Environmental and Socio-economic Impacts on Women from the Mining Development at Voisey's Bay*, 1997 (http://www.innu.ca).

consequences for the capacity of such organizations to provide ongoing, sustained input into health care at the grass roots level.

Newfoundland and Labrador has faired relatively poorly in terms of indicators for

women's health. Newfoundland and Labrador has the highest hysterectomy and c-section rates in the country -- 25% of all births are Cesarian, and the life expectancy for women is the lowest in the country, with the exception of the territories. While the Health Canada and the Department of Health have developed some programs targeted at women's health, these remain minimal. At the provincial level, they focus on issues such as smoking cessation, child welfare, cervical and breast cancer screening, and violence prevention initiatives. While all of these programmes have been welcomed by the women's communities, it remains an open question whether the funding will be sustained and whether the programmes will continue. In addition, targeted programmes do not address the overall need for research and analysis, which is gender informed and considers all aspects of women's health status as paid employees, unpaid care providers, and as care recipients. Project-based funded as opposed to core or operational support arguably threatens sustainability, universality, and equity in access to the health care system.

Planned Parenthood, a health centre which serves all parts of the province but is based in St. John's has seen its role change in the context of health care reform and restructuring. The St. John's branch of Planned Parenthood, established in the 1970s, has been able to survive because of federal Government funding and community support, while other branches in the province struggled to stay afloat and eventually closed. In 1981, the Federal Government stopped funding Planned Parenthood, which then had to rely completely on community support to stay in operation. The organization was saved by one private donor who had a considerable amount of money to donate for the purchase of a facility. In 1998, the provincial Department of Health began to provide $30,000 per year for the organization. This small injection meant the organization was able to implement a toll-free telephone number to extend its information services across the province. Presently this organization which promotes sexual and reproductive health issues assists more than 13,000 people annually

According to Peggy Matchim, the Executive Director, there is considerable stress on the organization's resources because government has done little in the way of developing a sexual and reproductive health program in the province. The situation is particularly poor for young women living in rural communities and gay and lesbian women. Lack of educational programming, lack of intervention, and lack of resources to Community Health Boards have meant that access to birth control is limited for many young women in the province. Some of these women find their way to Planned Parenthood in St. John's, but there is a need for more resources in rural communities. In addition, since the Department of Education started its Lifestyle's Course curriculum for high school students, Matchim stated the organization is receiving a number of calls from teachers to come in and give workshops to their classes. Since the Government has not put the resources into educating teachers on sexual and reproductive health issues, the role of Planned Parenthood has increased exponentially without adequate public funding support.

Matchim also noted that physicians are often reluctant to test female patients for chlamydia when they do routine Pap smears because some STD testing is not covered under MCP. Female doctors generally do the test for reasons of best practice. The Planned Parenthood's resources therefore are being increasingly allocated to doing free testing for STDs.

In November 1999, Government announced the allocation of $300,000 to continue the Cervical Cancer Screening Initiative in the Western Region for this year and next year.." This is a demonstration project, "to develop the model for an organized provincial screening program for cervical cancer."[261] The Minister stated that "this important women's health issue must be addressed systematically because organized programs have been shown to be effective. Hit and miss screening does not achieve optimal screening coverage and appears to have reached the limit of its effectiveness. We also know that women who are diagnosed with the disease are often those who have not been screened....With the high rates of cancer of the cervix in this province, combined with low rates of screening, this project will have a significant effect on improving women's health."[262] The Minister's words allude to the fact that this injection may have been crisis management.

The Women's Health Network of Newfoundland and Labrador has benefited from special programs such as the Centres of Excellence in Women's Health that have provided some funding for research and action related to women's health. However, when the Network recently approached the Federal Population Health Program for funding for its annual forum, which is on women's self care and cultural diversity. Health Canada responded to the request curtly, stating "no we do not fund community groups any more."[263] Health Canada only funds larger organizations to develop proposals for funding for the Department which focus on long-range and policy issues. When the Women's Health Network retorted that "most policy change initiates with the grassroots and how can we make suggestions for change without getting women in the same room," the Health Canada Population representative replied that "I know what it is like – even when our department goes out of town for meetings we have to stay at the cheapest motel." According to the Women's Health Network, the Federal Government needs to take some leadership and demonstrate some respect for the non-profit sector. "We need more than research to make long term change."

In 1992 Newfoundland did not have a breast screening policy, and women were faced with long waiting lists for diagnostic breast screening. The province stated that it was waiting for

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[261]Department of Health, *Newsrelease*, 1 November, 1999.

[262]Department of Health, *Newsrelease*, 1 November, 1999.

[263]Personal Correspondence with Donna Malone, Coordinator of the Women's Health Network of Newfoundland and Labrador. Used with permission.

the results of a National Survey before deciding how to proceed. After a three year pilot project, Government allocated $2 million in the 2000/01 budget for a Breast Screening Centre in St. John's.[264] The Centre has a provincial mandate and will coordinate provincial diagnostic activities and be the administrative hub for the breast health program for the whole province, according to the Department. The expenses for women travelling to St. John's for this service are not covered.

Another recent prevention and promotion initiative was the announcement of the launch of the Healthy Newfoundland and Labrador website, which is a website of consumer health information around the province. The local resources posted on the website for women include two breastfeeding support groups, the Women's Care Centre (which closed down recently), Planned Parenthood, the Urban Aboriginal Women's Group, and the Women's Health Network. All of these resources are St. John's-based with the exception of one of the breastfeeding support groups. In addition, groups such as the Urban Aboriginal Women's Groups, which runs out of the Native Friendship Centre in St. John's, has not been able to secure Government funding for any of its projects. Because of lack of financial support the group has only managed to coordinate a tutoring program for children based entirely on volunteer labour. The website exemplifies the ways in which Government has dealt with the issue of prevention and the promotion of population health model with the least amount of resources. In addition, many women around the province do not have access to the internet.

[264] *Women's Wellness: Report on the Development and Implementation of the Breast Screening Program* prepared for Newfoundland and Labrador prepared for the Department of Health and Community Services, Government of Newfoundland and Labrador, September 1998.

As a result of a joint federal/provincial National Child Benefit initiative Newfoundland and Labrador was allocated $10.5 million per year in 1998. The province has used the money to to improve and expand licensed child care, provide additional family resource project sites, develop a coordinated regional youth service network, to provide initiatives under the Social Assistance Program to assist families in making the transition to work, and introduce income support measures that address disincentives to employment.[265] In 1998, Government funded eight National Child Benefit and Family Resource Centres across the province as part of this joint federal/provincial venture. There is no guarantee that these centres will remain open.

Other private, non-profit organizations like the Women's Centres have been hurt by cuts in core funding from the Federal government, which now offers project money only. The small amount of money allocated to Women's Centres through the provincial Government is $30,000 per year. These Centres often provide vital services for women in the community, such as lay counselling, referrals, and early intervention.

While the federal and Newfoundland and Labrador Governments have not integrated a gender analysis into their health care restructuring processes, they have initiated several programs targeted at women over the past few years. These programs are often announced and re-announced, and they have focussed primarily on reproductive illnesses, child welfare, and violence prevention. Targeted programs, they are too often project-based and difficult to sustain, under-funded and to restricted in scope to ensure that women's health is promoted rather than jeopardized by policy initiatives.

[265] Department of Health, *Newsrelease,* 26 March 1998.

Part V: Conclusion and Areas Requiring Further Research

Conclusion

Restructuring and reform of the health care system in Newfoundland and Labrador over the past ten years have led to privatization on a number of fronts. Although the provincial Government has maintained its commitment to supporting a publicly funded health care system, privatization has crept in through the back door in terms of *who* pays for certain medical services, in terms of *who* provides those services, and in terms of *who is able to freely access* services. These shifts, which have meant that individuals and families are increasingly becoming responsible for their own health care and health care costs have occurred in a national context of trade liberalization, cuts and changes to federal transfer payments for health care, and new policy and legislative changes which favour global markets and corporations. The shifts have also occurred in a provincial context of a weakened economy, the regionalization of medical service provision and delivery, as well as a decreased role for the state in the delivery of health care services.

Within this context, health care reform and restructuring have affected men and women differently. Poor women including the working poor and single mothers, women in rural areas and women who are ill or disabled, of which there are many in the province, appear to been particularly likely to experience the negative effects of these changes.

For poor and marginally employed women in Newfoundland and Labrador, reduced social assistance benefits as well as other changes over the past decade have affected women's access to income and employment, thus jeopardizing their health and, in the current context, their free access to appropriate health care. Since the 1990s, rural Newfoundland and Labrador has been experiencing industrial and economic restructuring prompted in part by the collapse of the groundfish stocks and related policy initiatives. In resource-dependent regions of the province employment has been declining within the fisheries, forestry, and the public sector and shifting towards tourism, small business, and more generally the private service sector, as well as the offshore oil and other energy sectors."[266] One recent study found that, as with health system restructuring, the potential negative health impacts of industrial and other types of restructuring for women and men were not being monitored and policy initiatives were not subject to a gender analysis. It found that within fisheries, women's lack of access to adequate retraining programs combined with cuts to social programs, such as EI, less certain work and fewer jobs in the fish processing sector, where they were traditionally concentrated, and some new occupational health hazards have put women's health at risk.[267] Health care restructuring has also meant job loss in health care related jobs, where women make up around 80% of paid workers.

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[266]Barbara Neis and Brenda Grzetic, *From Fish Plants to Nickel Smelter*.

[267]Barbara Neis and Brenda Grzetic, *From Fish Plants to Nickel Smelter*, 2-3.

Cutbacks to the Unemployment Insurance programme in 1996 have had particularly devastating effects in the rural areas of the province where work is highly seasonal. The shift from a weeks-based system to an hours-based system has made it increasingly difficult for women to qualify for benefits in Newfoundland and Labrador as elsewhere. Not only have part-time, temporary, low paying jobs become more and more the norm for women over the past decade -- in Newfoundland and Labrador women make up 70% of the part-time workforce -- women are finding it increasingly difficult to access EI benefits. We do not have data for the province, but at a national level, in 1999 just 30% of unemployed women received EI, compared with 70% of unemployed women in the late 1980s.[268] Women have been negatively affected by these changes as part-time workers and as re-entrants to the labour force.[269]

However, problems are not confined to rural areas. The changing nature of service sector work has intensified women's representation among the working poor in urban areas as well. A study conducted by the Newfoundland and Labrador Federation of Labour on the changing nature of work in this province demonstrated that over the last ten years, jobs in the service sector have increased, most of which are part-time and most of which are done by women.[270] Newfoundland and Labrador has the second lowest minimum wage in the country at $5.50 an hour and the highest rate of minimum wage earners nationally. Around 10% of wage earners work for the minimum wage in this province. Unfortunately, there are no gender disaggregated data available on minimum wage earners. Most of these new service sector jobs are non-unionized and they do not offer health plans to employees, who work with little job security and no benefits. Cuts to public sector jobs have had similar effects.

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[268]"Summary of Workshop Proceedings, Presentation by Lana Payne" in Barbara Neis and Brenda Grzetic, *From Fish Plants to Nickel Smelter*, 34.

[269]Martha MacDonald, "Restructuring, Gender and Social Security Reform in Canada," *Journal of Canadian Studies* 34(2),73.

[270]Newfoundland and Labrador Federation of Labour, "Brief Presented to the Government of Newfoundland and Labrador's Public Consultation on Jobs and Growth," 1999.

Women are also particularly vulnerable to health risks involved in their increasing workloads as unpaid, informal care givers, and as paid health care workers. Current "population health" thinking has also increased the burden of responsibility on individuals for their own health problems and prevention. Despite Government's commitment to considering determinants of health as a measure of intervention, there has not been enough information gathered to determine if appropriate resources have been made available for a large percentage of the population to prevent illness. In fact, front-line workers and others have repeatedly noted that the supports have not followed the shift to community-based services. We are probably only beginning to see the effects of the downloading of responsibility to women who dominate the paid workforce in health care sector, not to mention the effects on female patients and on women as unpaid caregivers. In a brief presented to the Minister of Finance regarding the 2000/01 provincial budget, the Newfoundland and Labrador Health and Community Services Association (recently renamed the Newfoundland and Labrador Health Boards Association), argued that Government had underfunded the programmes and services which came under the social services sector of the Health and Community Services Boards. For instance, even though the mandate of the Boards has been substantially broadened, Government has not provided additional funding for infrastructure and the Boards are unable to meet the needs and demands of the populations that have recently come under their jurisdiction.[271]

Because of women's relatively high vulnerability to poverty in this province, exacerbated by the wider climate of industrial and economic restructuring, any transfer of costs to individuals for health care hits women particularly hard. Job loss in the health sector, poor working conditions, and the de-stabilization of the health care work force have also had devastating effects on women's economic status, health, and well-being. The transfer of care work from institutions to the community has privatized the responsibility of caring for the infirm, and elderly to women who are carrying an increasing burden of this responsibility on their shoulders to the detriment of their health and economic status.

Provincial demographic trends in Newfoundland and Labrador indicate that the province's population (540,000 in 2000) has been declining steeply since 1993, due partly to low birth rate, but mainly to outmigration. According to a study done by the Newfoundland and Labrador branch of the Canadian Mental Health Association, interprovincial net migration rose from -711 in 1990/91 to -9,285 in 1996/97.[272] More recent Statistics Canada figures show that between 1995 and 2000, 28,000 people have left the province.[273] The depopulation of rural communities and the relative impoverishment of those who stay may have serious ramifications for women's mental health as well as increasing the burden on them associated with performing unpaid domestic work

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[271]NLHCSA, "Presentation to the Minister of Finance on *Budget 2000*," 7-8.

[272]Susan Williams, *What's Happening With Youth? The Impact of Economic Change on Young People in Newfoundland and Labrador*, prepared for Health Canada Health Promotion and Programs Branch Atlantic Region, by the Canadian Mental Health Association, Newfoundland and Labrador Division, November 1998, 10-11.

[273]*Evening Telegram*, 9 July 2000.

and providing informal care for family members. In 1996/97, two thirds of outmigrants were in the 15-29 age group highlighting the ways outmigration is contributed to the isolation of older populations in rural communities. Since women tend to live longer than men, the relative aging of the population of rural and urban communities is a serious issue. Women tend to be there for men as men age, but the issue of who will care for these elderly women with children moved from the province has not been adequately addressed.

Changes to federal transfer payments, such as the elimination of CAP in 1995, have made it increasingly difficult for communities to fill the gap. Before its elimination, CAP funding provided money "not only for social assistance, but also for up to 6,000 agencies providing a range of services, including homes for the aged, transition houses, alcohol and drug addiction programmes, and programmes for foster children, sexual and physical abuse survivors."[274] In this province, as elsewhere, since 1995 there has been a shift to project-based, targeted initiatives, as opposed to core or operational support, which arguably threatens sustainability, universality, and continuity of care. Project funding comes with no guarantees that projects will continue. The implications of such policy shifts for women's and men's health and well-being and equity in access to adequate health care services are a serious concern within the current policy framework Lack of support to women's grass roots organizations, which have played an important role in intervention and protection of women's mental and physical health, has also had devastating effects. The implications of such policy shifts for women's and men's health and well-being and access to adequate health care services are a serious concern.

The gendered approach to human poverty, recently adopted by the United Nations, "makes it possible to look within the household [and communities] at the ways in which resources such as food, education, health services, as well as productive assets are distributed among family members."[275] This is also an effective approach for understanding women's increasing share of the health care burden within the context of shifts to community-based care and privatization.

Relevant and Pressing Questions for Further Research

1. We need a clearer sense of how health care reform/privatization processes in Newfoundland and Labrador have compared to those in other provinces–for example, how similar or different they have been from the decentralization processes that have occurred in provinces like N.S. and B.C. [276].

2. We also need to know more about governance structures within the province's health care system, including their gender dynamics.

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[274]Barbara Neis, "Presentation to 'Some Cuts Don't Heal:' Public Forum on Medicare and CHST Funding Changes to UI Funding, CLC and Coalition for Equality," 23 October 1995.

[275]Monica Townson, "Report Card," 6.

[276]Jim Bickerton, "Reforming Health Care Governance: The Case of Nova Scotia," *Journal of Canadian Studies*, 34,2 (1999) 159-190.

3. This report has said nothing about the potential impacts of privatization on the charitable and volunteer sectors in the province. A gender-based analysis of these impacts is needed.

4. Due to time constraints, we have said little about the provincial Strategic Social Plan and Social Audit process and their potential role in mitigating the impacts of privatization.

5. Given the history of feminist support for a shift to more accountable health care institutions with a greater focus on preventive care, we need to understand more clearly why in Newfoundland and Labrador, as elsewhere, reform and restructuring along these lines appear to have placed women at risk. One part of the answer might lie in the fact that in order to succeed, a shift towards a population health approach with decentralized and more democratic-decision making requires that any savings associated with better coordination and integration of health and social services must be plowed back into primary care services. If they are not, if there is no budgetary stability and "if savings get stripped from health care budgets and put towards deficit-debt reduction or towards higher drug costs and physician pay schedules, then reform will have been nothing more than an elaborate cover for downloading the burden of budget cuts into regions and communities",[277] particularly onto particular groups such as those identified in this report.

6. More research is required on the differential impacts of health care privatization on aboriginal women, disabled women, gay and lesbian women, and rural and urban women in the province.

7. We need to access and analyse more fully gender disaggregated data on health service utilization, home care work, minimum wage recipients, satisfaction with health care services, responsibility for unpaid caring work, etc.

8. The impacts of changes in WHSCC programs on injured women and men workers' access to compensation and rehabilitative services needs more research. Differences between unionized and nonunionized workers and seasonal/part-time versus full-time workers also need research.

9. The impacts of privatization on health care workers, particularly LPNs and laundry, dietary and housekeeping staff, allied health professionals require more research.

10. More research is needed on impacts of increased transportation costs borne by health service users on freedom of access to services, as well as research on the consequences of these costs and other health care costs for the capacity of households to meet other financial obligations.

11. More research is needed on the gender dimensions of out-migration and their relationship to the fit between health service/caring needs and existing services. Relatedly, we need to study ways escalating needs for care created by an aging population, a process accelerated by outmigration in

[277] Jim Bickerton, "Reforming Health Care," 182.

rural Newfoundland, are interacting with the hierarchical character of caring institutions and the commodification and individualization of care to affect the fit between health needs, health institutions, the provision of care and the health of care-givers.[278]

12. We need to know more about who actually receives paid and unpaid home care in Newfoundland and Labrador and how these recipients compare with those who receive long-term care. We need to do a gender breakdown of who provides that care and document ways providing that care might be affecting their health and well-being. We also need to know more about how those who need home care but do not have access to it are managing and the consequences of this for their health.

[278]Susan McDaniel, "Untangling Love,"192.

13. We need more research on the ways the CHST, health care privatization, as well as restructuring in other areas of social policy such as EI changes and changes in postsecondary education, might be interacting to affect the health of women and men and their access to health services. For example, existing research has linked the CHST to cuts to public childcare support in Canada, and to the erosion of national standards in social assistance benefits.[279] As childcare has become less accessible, worse quality and more expensive[280], how has this interacted with women's involvement in paid labour and the restructuring of the health care system to affect women?

14. Research is needed on the ways in which restructuring and reform in health services may be interacting with industrial restructuring and environmental degradation to impact the health of women, men and children in rural and urban areas.

[279]Katherine Scott, *Women and the CHST: A Profile of Women Receiving Social Assistance in 1994*, (Ottawa: Status of Women Canada, 1998).

[280]Susan Prentice, "Less, Worse and More Expensive: Childcare in an Era of Deficit Reduction," *Journal of Canadian Studies* 34, 2 (1999) 137-158; Gillian Doherty, Martha Friendly and Mab Oloman, *Women's Support, Women's Work: Child Care in an Era of Deficit Reduction, Devolution Downsizing and Deregulation* (Ottawa: Status of Women Canada, 1998).

Appendix

Institutional Health Boards

Health Care Corporation of St. John's/St. John's Nursing Home Board
Avalon Health Care Institutions Board
Peninsulas Health Care Corporation
Central East Health Care Institutions Board
Central West Heath Care Corporation
Western Health Care Corporation

Integrated Boards:

Grenfell Regional Health Services Board
Health Labrador Corporation

Health and Community Services Boards:

Health and Community Services St. John's
Health and Community Services Eastern
Health and Community Services Central
Health and Community Services Western