Speaking Notes

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The views expressed here are those of the National Coordinating Group on Health Care Reform and Women, and do not necessarily represent the views of the Centres of Excellence for Women's Health Program or the Women's Health Bureau, Health Canada.

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Thank you for inviting me to appear before the Commission. I am here on behalf of the National Coordinating Group on Health Care Reform and Women, a group that crosses the Centres of Excellence for Women's Health. One of these Centres is here at York University, while others are located in Atlantic Canada, the Prairies and British Columbia. The mandate of our group is to coordinate research across the Centres, identify gaps and fill them, and to link research to policy and practices.

Today, I want to address two issues that have not received much attention in these hearings. The ***first*** is that **health care is a women's issue**; and the ***second***, that **there are different forms of privatization that have different consequences for women and for women from different groups**.

As you know, the government of Canada has a commitment to gender-based analysis[1] and Health Canada's Women's Health Strategy has as its first objective "to ensure that Health Canada's policies and programs are responsive to sex and gender difference and to women's health needs".[2] Canada recognizes both sex and gender as determinants of health.

Health reform is clearly a women's issue, given that

- ✍✍ women account for over 80 % of those providing paid care
- ✍✍ women account for a similar proportion of those providing direct personal care as unpaid providers
- ✍✍ women are the majority of patients, and account for up to three-quarters of the institutionalized elderly
- ✍✍ women are the majority of those taking children for care
- ✍✍ women have fewer financial resources than men to assist them in getting or giving care
- ✍✍ women are a minority of those making policy decisions about health and health care
- ✍✍ women are less likely than men to be the subjects in developing evidence

Existing conditions for caregiving mean that:

- ✍✍ women providing care often end up in poor health
- ✍✍ women are rewarded by caregiving, although inadequate resources limit these rewards while making it harder to care
- ✍✍ First Nations, Inuit and Métis women face persistent and pervasive obstacles in giving and

receiving care

- ✍✍ women from immigrant, refugee and visible minority communities may face racism in giving and receiving care, along with language and cultural barriers

- ✍✍ women giving and receiving care are often subject to violence and other risks, especially when the care is provided in isolated households

- ✍✍ women are facing deteriorating conditions for giving and receiving care, conditions that are often hidden by the fact that it is women who give and need care

Our group appeared before Senator Kirby's Committee, but we see no evidence of our concerns in the reports released thus far from that Committee. We trust this will not be the case with your Commission.

Having set out why health care reform is a women's issue, let me turn to forms of privatization and their impact on women. Our group has examined health care reforms through the lens of privatization, treating privatization in a social as well as economic sense. We have done so because we think it is the most useful way to understand reforms now underway.

More specifically, we have looked at five forms.

First, the **privatization of costs**. This of course refers to the 30% you have talked about as now paid by individuals or their insurance companies. Because women are the majority of the poor, of single parents and of those with low income, and because they not only have lower paid incomes than men but also are less likely than men to have supplementary health benefits through their work, women bear the greater burden of these costs. This is especially the case for immigrant women, Aboriginal women, women of colour and women with disabilities. And it is the case for most women under conditions where other social supports have been cut back or eliminated.

Second, the **privatization of delivery**. Within facilities, services have been contracted out to for-profit concerns or provided through public-private partnerships with such firms. This has been the case particularly with support services in facilities and homes. These services are often redefined as hotel services in direct contradiction to the determinants of health model, and to the way these mainly women providers see their own work. This kind of privatization not only means some money goes to profit rather than to care, but also that every effort is made to reduce the reliance on the mainly female labour force and to make those who remain in paid work do more for less. With this move to private for-profit delivery often comes increased insecurity, lower wages, heavier workloads and fewer benefits for the women who provide paid care.

Third, the **privatization of managerial approaches and market strategies to service delivery**. Like the shift to for-profit delivery, the adoption of managerial strategies developed for goods production is transforming the work for the women who provide the majority of care and is doing

so in ways that become evident in high injury and burnout rates.[3] The emphasis on measurement and management often fails to count the skills, effort and responsibility involved in the work, in part because such skills are associated with women's natural capacities and in part because much of care cannot easily be measured or counted, at least not by current approaches. As is the case in the private sector, more of the jobs are casual, part-time or short-term even though the hours and shifts may be long. Women are struggling to fill in for the deficits in care that result, but many are doing so at the risk of their own health.

Fourth, the **privatization of responsibility for care through the movement out of hospitals and other institutions into the community**. Hospitals have been redefined to include only the most acute, short-term interventions, and long-term care facilities now do what hospitals once did. The women who work in these facilities are often expected to take on this different work without additional training, supports or compensation. Those who work in the volunteer community organizations taking up some of the care work sent there are also facing more and more complex work, also without additional training, supports or compensation. And the care load increase too often means they must abandon or at least cut back on their efforts to advocate for women's health needs. Indeed, the strain can undermine the communities women have built.

Fifth, the **shift of care work to the household, and thus to women**. Women, more often than men, are expected to provide unpaid personal care, frequently and increasingly with little training or support. Women provide more demanding care, work longer hours and have more responsibility for care than men. Moreover, women with care needs receive fewer hours of paid home care than do men.

Our Group has taken up this final issue through a workshop that brought together policy makers, researchers and providers to consider gender and home care. This group developed a declaration on the right to care, setting out the principles for a more comprehensive public system that would be gender-sensitive in its approach to care. We would like to end our presentation by submitting this declaration, and the explanations of its principles, to you.

Thank you again for this opportunity and I would be pleased to address any questions arising from this presentation.

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1. Canada's commitment to implementing gender-based analysis is articulated in *Setting the Stage for the Next Century: The Federal Plan for Gender Equality* which was presented at the Fourth UN Conference on Women.

2.Health Canada, *Health Canada's Women's Health Strategy*. Ottawa: Health Canada, March 1999, Table of Contents.

3.Canadian Institute for Health Information, *Canada's Care Providers*. Ottawa: Canadian Institute for Health Research, 2002.

Further Sources

P. Armstrong, Carol Amaratunga, Jocelyne Bernier, Karen Grant, Ann Pederson, Kay Watson (eds.), *Exposing Privatization: Women and Health Care Reform in Canada*. Aurora: Garamond, 2002.

The Charlottetown Declaration on the Right to Care. Available at www.cewh-cesf.ca/healthreform

Marika Morris, "Gender-Sensitive Home and Community Care and Caregiving Research. A Synthesis Paper." Ottawa: CEWH, 2002. Available at www.cewh-cesf.ca/healthreform