



## backgrounder

# Women in Health Care

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## **The need for a Gender Analysis**

Why focus on women in health care when it is everyone's issue? Women's health care activists are often asked this question. But there are very good reasons for considering gender effects when discussing health care.

### *Women use the health care system*

Women tend to make more use of the health care system. This is primarily because women make up more than half of the total population, live longer and more often in poorer economic situations than men. Some quick facts help illustrate this point:

- Women comprise a larger proportion of the seniors population than men (57% for 65 years and older, 60% of those 75-84 years old and 70% of those 85 and older).
- Statistics Canada indicates that 18.2% of all women live in poverty. The figures for senior women jump to 24% for 65 years and older and for single senior women as high as 49%. By comparison only 12% of senior men live in poverty and 33% of single senior men.
- In 1999, nearly 19,000 women were diagnosed with breast cancer and about 5,000 died from the disease. Current waiting lists are so long for radiation therapy (up to four months in some provinces) that many experts worry that they might see physicians performing more total mastectomies rather than risk the wait.
- Nearly twice as many women as men suffer from depression.
- More than two thirds (67%) of people receiving home care are women.
- Senior women are more likely than men to: suffer a serious injury (7% to 4%); be hospitalized for a longer period of time (23 days/visit to 17 days/visit); and suffer chronic pain.
- Senior women are far more likely to live in an institution (retirement residences, nursing homes, and hospitals) than men.

But women make up a small proportion of those professionals in health care with decision-making authority. The gender gap in research, medicine and hospital administration is quite pronounced. Furthermore, the number of women in government, not to mention ministries of health, is quite small. Knowledge about women's health needs is most often researched, described, decided upon and implemented by men. This has resulted in very large and disturbing gaps in the provision of health care.

### *Women work in health care*

There is also a pronounced gender divide when it comes to who works in the health care system. In Canada, 80% of health care workers are women.

Furthermore, the overwhelming majority of home care workers are women who earn significantly less than their counterparts working in hospitals and clinics. The past decade of funding cuts to these services has disproportionately affected these women workers. With the privatization of housekeeping and even management services, it has primarily been women who are overworked or squeezed out of unionized, well-paid and protected work.

### *Women pick up the pieces*

The recent period of downsizing has depended on the unpaid work of women to avert a national health catastrophe. In what amounts to a return to the past, the double burden of home and job faced by most women has intensified as home now more often includes caring for a family member in need. Furthermore, as the cost of care is being shifted to individuals and their families, financial pressure on women is increasing. As the baby boomer generation ages this trend is likely to intensify in the future.

Recent statistics indicate that more than 1.6 million women provide assistance to a relative, friend or acquaintance that has a long-term health problem. Women employed full-time average seven lost work days each year to attend to personal or family responsibilities whereas men lose less than one day. Two-thirds of these caregivers work outside the home, 20% report health impacts and 40% incur expenses.

Funding for community care is piecemeal and uneven and comes from a variety of private, public, non-profit and charitable sources. Whether people will receive the care they need will often depend on where they live.

### **Women in Health Care – A Long History**

Women have always been the “glue” that holds together a community's health care system. The effect of current restructuring of health care and the impact this has on women's health and occupations must be considered within the backdrop of a historical legacy of exclusion and limited access to decision-making power.

The current world view on health care developed quite recently in Western societies. In North America, women, in both the Aboriginal and European communities, played the dominant role in the provision of health care right up until the late 19<sup>th</sup> century. Primarily as mid-wives, healers and caregivers, women held a respected and highly utilized role in any village or urban setting. Skills and technical knowledge tended to be passed down from one generation of women to the next through apprenticing with a family member or an elder. In New France newly developing hospitals and treatment clinics were staffed and operated by French nursing orders.

During the mid 18<sup>th</sup> century hospitals were increasingly used to segregate new immigrants, mainly from England and Ireland, with highly contagious diseases (such as cholera, typhoid and smallpox) from the rest of the population. Thus women's traditional community-based health care methods were increasingly shifted to the institutional setting. Given that those hospitalized were often poor and dying the support provided by these institutions tended to be only the bare minimum of care. Poor sanitary conditions and improper healing practices often placed both the sick and the practitioner at risk. Staff tended to be mainly poor women and evidence suggests that the death rate for these young women was very high.

During the late 1700s there was another trend rising in the provision of health care. The central actors in this trend were the barber surgeons (literally the barber who also acted as a surgeon) which came to prominence within military service. These barber surgeons were mainly English men from a respected family and holding military rank, whose primary clientele were the rich and powerful. As medical schools were established the significant political influence these individuals held came to be even further instituted in society. While competition between these school trained allopathic professionals and the lay practitioners continued there was an increasing shift to the institutional model.

Supporting this trend to the professionalization of medicine was the rise of the western scientific paradigm. Much of the research in this field at the time was overtly hostile to the lay practitioner and even outright misogynistic. Women practitioners had little influence over the sweeping changes this new science brought to health care provision. A widespread campaign to publicly discredit mid-wives and herbalists was embarked upon by the new scientific practitioners.

But women were also actively excluded from joining this new form of medical practice. While some women were permitted to enroll in medical schools, by 1883 most universities had banned women's inclusion. The academic doors started to open up by the early 1900s but societal wide discrimination against women in any type of scientific profession kept the number of women graduating as doctors quite small. Those who did manage to earn their degrees faced a hostile medical establishment in the male dominated professional associations, faculties and research departments. This often resulted in factually erroneous beliefs about women's bodies being accepted as scientific truths – even until quite recently.

At the same time there was a growing need for trained hospital workers who could work in the technologically advanced workplaces. In 1910, a highly influential report was released, the Flexner Report on Medical Education in the United States and Canada, which shaped the form of health care training in both countries. It stressed the need for: standardized entrance requirements; rigorous adherence to scientific principles; and hospitals as training sites.

Accompanying the trends already mentioned, by 1920 a hospital system that would be recognized by most contemporary Canadians was firmly in place. An essential aspect of this system was the dominant role played by women as nurses, cleaners, kitchen and laundry staff, all subservient to doctors and subject to divisions and rankings within their own occupational groups.

Women played a highly significant role in the development of the public health movements in the early 20<sup>th</sup> century. Working as public health nurses in rural and urban areas they often provided immigrant and impoverished communities with information on hygiene, birth control and disease prevention. In fact, it is quite likely that improved public awareness of these issues has done more to improve health outcomes for Canadians than has the institutional medical establishment. But, the wealthy professional practitioner still exerts a disproportionate amount of authority in the public policy debates around health care.

### **The Development of Canada's System**

The first coordinated system of health care delivery started in 1832 with the government of Upper Canada. As was previously mentioned, the primary role of this system was to isolate individuals who, by way of illness or mental dysfunction, were seen as "threats" to the health of the community. During this time we saw the enactment of a Sanitary Commission and Boards of Health to oversee sanitation and quarantine measures. Similarly, legislation like the Food and Drug Act, Narcotics Control Act and the founding of clinics and hospitals was seen.

Much of today's health care disputes can be traced back to this era with the establishment of Canada as a nation under the British North America Act of 1867. Largely a reflection of the geographic barriers presented within the new nation, partly a lack of foresight, the public health care system was decentralized. As such the provision of these services has been a responsibility of the provinces since Confederation. In turn the provinces have vigorously defended their rights, often with the support of insurance companies and private health care providers.

Still it was apparent to all that the system was a chaotic jumble of services greatly varying in the degree of accessibility to Canadians. The 1937 Royal Commission on Dominion-Provincial Relations emphasized the potential problems that would be experienced if some provinces, outside the private health insurance system, implemented taxes on employers to cover health care. In a manner quite familiar to contemporary observers the Royal Commission thought that different taxation rates would influence the attraction and retention of businesses between provinces. As a result, when popular demand for a public health care system grew after the second world war, policy makers were

committed to balancing provincial control with uniformity across Canada. This is the origin of a federally collected tax for health care.

Unable to broker a consensus over the plan the federal government ultimately used its spending power to bring the provinces into a national plan. In the best “let’s make a deal” manner the federal government offered to pay half, 50%, of hospitals’, and later physicians’, costs in exchange for a commitment to a set of five basic principles. With the enactment in 1984 of the Canada Health Act the process was basically completed and the five principles made explicit.

### *The Five Principles of the Canada Health Act*

#### Portability

- Citizens can receive health care services in all provinces;
- Can receive services anywhere within a province;
- If specialized treatments are not available in home province can access them in another province.

#### Public Administration

- Enables government to distribute services efficiently;
- Private insurance is forbidden;
- No opting out of paying taxes for the public system.

#### Universality

- Everyone is covered;
- Cheaper to administer than a bureaucratic means testing two-tier system.

#### Accessibility

- Health services provided under uniform terms and conditions;
- Two-tier system explicitly forbidden as is user fees and other means of providing differential treatment;
- Access to health care based on need rather than ability to pay.

#### Comprehensiveness

- All medically necessary services provided by doctors and hospitals.

Basically the Canadian Medicare system provides for public financing of private health care provision. Almost all bills, hospitals and doctors, are submitted to the province for payment. Hospitals are controlled by the provinces, who set standards of care and allocate budgets. The daily operation of hospitals was left to local boards and administrators.

While this was a system with flaws it still was a relatively successful means of delivering health care services to the population. Indeed an overwhelming majority of Canadians are quite proud of the system.

### **The growth of public sector unions and women's equality**

As we have seen, women have predominantly been the providers of health care services. While doctors are still predominantly men, physicians actually provide a relatively small proportion of health care services. Statistics gathered in 1991 indicate that nearly 80% of those paid to work in health care were women. In what is perhaps an even more telling figure, 13% of all women employed worked in this sector.

An explicit gender bias that has continued into the present is the belief that many of the nurturing/caring tasks performed by women arise out of intrinsic feminine qualities. This has been reflected in the gender gap in wages.

But health care, as the entire public sector, also saw the rise of large trade union movements. The majority of members in these unions were often women. While not free of the sexist attitudes of the broader society, they did provide an effective means for women to address gender inequality in wages, benefits and political access. Through collective bargaining the wages of women in the public sector have dramatically increased over the past 30 years.

Through their unions women have embarked upon national campaigns for pay equity, maternity benefits, and opposing domestic violence. It has also supported the growing presence of women in government. And, as public sector unions comprise the largest proportion of the unionized workforce the awareness of women's issues has improved dramatically within the labour movement.

This is primarily where health care restructuring has had the greatest detrimental effect on women as workers. A disproportionate number of women have seen their jobs either transferred to the private sector, and outside the trade union movement, or eliminated entirely. Home care and other community-based services have expanded to meet the growing need, but again these workers are primarily unorganized and, these jobs are a low-wage alternative to the better paid unionized institutional positions.

### **The Canada Health and Social Transfer and the Social Union**

The first funding cuts to health care were implemented by the Mulroney Tories under the old funding regime, the Canada Assistance Plan (CAP). The Tories, over a number of budgets, reduced transfers to the provinces for health care by approximately \$41 billion. Funding was further cut another \$7 billion per year by

the Chrétien government. But probably the most dramatic change came in the 1995 budget with the replacement of the former funding mechanism by the Canada Health and Social Transfer (CHST), a federal block funding arrangement.

The debate about Canada's Social Union refers to the distribution of powers, responsibilities and resources between the federal and provincial governments. Following the establishment of the CHST the provinces met with the purpose of hammering out a new arrangement between themselves and Ottawa.

The provinces' motivations for the Social Union talks are quite easy to see. While the five principles of the *Canada Health Act* were retained in the CHST, and two new standards were added (no user fees or extra billing) only the federal government can judge whether a province is complying with these national standards. Dramatically reduced funding made it far more difficult for provincial governments to deliver programs as they were in the past. The provinces were irritated that the federal government was giving them so much less, while binding them to national standards and retaining the exclusive right to police the system.

At the beginning of the Social Union debate, the provinces wanted the federal government to be barred from introducing new national programs without provincial approval. They wanted an end to the right of the federal government to decide whether provincial spending, on health care especially, was living up to national requirements. The provincial governments also wanted an assurance that federal transfers would not be cut unilaterally.

When the talks appeared to be going nowhere, the federal government simply purchased the Social Union agreement to the tune of \$3.5 million per province in the form of a trust fund for health care.

On February 4<sup>th</sup>, 1999, the agreement was reached without any public consultation and without approval by Parliament, or any of the provincial legislatures. The Social Union framework is still unclear on a number of issues. The agreement stipulates that it will promote equality of opportunity for all Canadians, however there is no mention on how this will be achieved. The five principles of Medicare are mentioned but the new principles under the CHST, namely no user fees and no extra billing are not referred to. The deal also talks about "monitoring outcomes of social programs and reporting to constituencies on the performance of these programs", but is very vague as to what that means.

The \$3.5 million trust fund that was referred to earlier in the report is a one-time supplement to the CHST. In effect, it was a bonus for signing the Social Union framework. This money will be put into a trust fund for the provinces to draw on over three years, although if they choose they can take all the money in year one.

However, under the CHST, the federal government can no longer ensure that the provinces will actually spend these funds on health care. Consequently, the provincial Premiers stated, by way of letters, that they would spend the money exclusively on health care.

Community-based services such as home care are not included in the *Canada Health Act*. Hence, the CHST money and the \$3.5 million trust fund are not going towards these types of services. This is unfortunate because the point of entry into the health care system in Canada is increasingly community-based rather than institution-based.

In every province, there has been a decentralization or regionalization of health care services. If governments wish to put the health care system back on its feet, they need to look at a new foundation for the proposed system, and where they want to go with it, rather than come up with band-aid solutions tailored for the old structure.

## **Trends in the Health Care System to Watch Out For**

### *Patient-focused Care*

Patient-focused care is based on management initiatives such as total quality management and quality circles. The template for patient-focused care is based on the Japanese auto industry where these management-driven programs were initiated. Given that metal and steel and the human body and mind have little in common, it is not surprising that the outcomes of patient-focused care are not what was expected. According to a California Nurses Association study patient-focused care contributes to a decrease in the quality of patient care, it lowers worker morale, and increases staff turnover.

Along with major consulting firms, for-profit health care companies are selling the patient-focused care model, or other models along the same lines, to hospital managers who are being told that their bottom line will improve once the new model is implemented.

Consulting firms are taking advantage of the state of chaos that has been created in the health care sector by posing as saviours of the system. It is thus important that the labour movement keep track of corporations, as well as individuals, who are travelling across the country in hopes of selling management-driven models to governments and health care managers.

## *Public-Private Partnerships*

In Canada's health care sector, as in other sectors that were formerly under exclusive government responsibility, public-private partnerships are henceforth part of the landscape. Public-private partnerships are a stepping-stone to the full privatization of the health care sector, and hospital managers and governments are buying into it. For example, two years ago the Government of Ontario made it easier to establish public-private partnerships in laboratories, by way of pilot projects. Two-thirds of the money, which is from public funding, is going into an envelope for these pilot projects and one-third of the money is coming from the private sector. As a result, MDS a privately-operated company, now manages most labs in Ontario's publicly-funded hospitals.

The Canadian Council for Public-Private Partnerships has adopted the following definition to help clarify what is meant by this concept. A public-private partnership is defined as "a cooperative venture between the public and private sectors, built on the expertise of each partner, that best meets clearly defined public needs through the appropriate allocation of resources, risks and rewards." According to a New Brunswick government publication, the essence of a public-private partnership arrangement is the sharing of risks. Central to any successful public-private partnership initiative is the identification of risk associated with each component of the project and the allocation of that risk factor to either the public sector, the private sector or perhaps a sharing by both. The desired balance to ensure best value (for money) is based on an allocation of risk factors to the participants who are best able to manage those risks and thus minimize costs while improving performance.

Minimizing costs while improving performance has become an all too familiar mantra for public sector workers. What this means is low wages, a generally non-unionized workforce, lower standards, decreasing quality of care and access.