THE DIFFERENTIAL IMPACT OF HEALTH CARE PRIVATIZATION ON WOMEN IN ALBERTA

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THE DIFFERENTIAL IMPACT OF HEALTH CARE PRIVATIZATION ON WOMEN IN ALBERTA

Executive Summary

BACKGROUND

The Prairie Women's Health Centre of Excellence is a member of the National Coordinating Group on Health Care Reform and Women. The Coordinating group is comprised of representatives from the five Centres of Excellence for Women's Health, the Canadian Women's Health Network, and the Women's Health Bureau of Health Canada. It has developed a framework for investigating the impacts of health reforms on women to guide researchers' efforts to monitor the effects of health reforms on women—as patients and service recipients, as paid and unpaid health care providers, and as participants in health policy discussions.

As part of this national project, the Centres conducted provincial and regional scans of policies and research related to privatization in health reform and its impacts on women. The Prairie Centre conducted the Manitoba and Saskatchewan scans in 1999. The recent commissioning of this report by the Prairie Centre, and a similar examination of Newfoundland under the auspices of the National Network on Environments and Women's Health, completes the coverage of provincial jurisdictions in the scans.

The National Coordinating Group hopes to foster collaboration and encourage other health researchers and women's health organizations to take up the challenge of monitoring the impacts of health reforms on women and women's responses to health reforms.

OVERVIEW

The purpose of this paper is to explore the extent to which health care privatization is taking place in Alberta and to determine the impact of health care privatization on women. To do this, we used a gendered lens to examine a number of key pro-

vincial health policy documents. The review was conducted between February and April 2000. It was beyond the scope of this project to directly examine the impacts of health care privatization; no new data were collected. While this report is not intended to provide a complete review of all policy related to health care privatization, it provides an overview of policies and initiatives that exemplify of the Alberta government's policy platform.

This report traces the development of health policy initiatives from 1989 to the present, demonstrating that there has been consistent support for increasing the role of the private market in Alberta's health care system. Privatization takes several forms - shifting service delivery out of public institutions such as hospitals to private clinics, shifting costs of services from government to individuals, shifting caregiving work from public sector health workers to unpaid caregivers and adopting the management strategies of private sector business.

There has been a perception among many people in Alberta that health care restructuring was initiated and continues without having an overall plan in place. While there may have been a lack of clarity regarding specific strategies for change in the health system, there has been a consistent commitment to increasing the involvement of the private sector in health care financing (e.g., out of pocket costs) and delivery (e.g., services delivered through for-profit clinics, work for family caregivers, particularly women). This commitment has not wavered, despite the equally consistent expression of public concern regarding the potential negative impact of health care privatization.

The shift to more privatization in health has been accompanied by resistance to acknowledging the detrimental impacts of privatization, particularly on women. Women are providing more services at home, in the not-for-profit organizations, and with less support. Women working in services in Alberta know that, as elsewhere, the gendered impacts of restructuring are not evenly distributed among women, and that young women, immigrant women, women of colour and working class women have been hardest hit. Restructuring has been linked to the intensification and feminization of poverty for young and elderly women in particular.

The government's commitment to privatization of the health system has also been accompanied by a trend toward increasingly limited and controlled public participation in the planning processes. Legislative and public opposition to the current privatization policy agenda has done little to alter the course or the pace of change. Given the government's apparent lack of responsiveness to public input, it is not surprising that there appears to be a great deal of skepticism among Albertans regarding their ability to influence the policy process. This was illustrated again recently during public discourse around Bill 11, which permits increased private sector involvement in the health system. As well, Albertans must now deal with 17 regional health authorities when it comes to organizing around health policies that affect them at the local level, rather than being able to deal with a central provincial structure.

PART 1 INTRODUCTION

The purpose of this paper is to explore the extent to which health care privatization is taking place in Alberta, and to determine the impact of health care privatization on women. The review was conducted between February and April 2000. It was beyond the scope of this project to directly examine the impacts of health care privatization in Alberta; no new data were collected. While this report is not intended to provide a complete review of all policy related to health care privatization, it provides an overview of policies and initiatives that exemplify of the Alberta government's policy platform.

Gender is a culturally determined symbol-system used to understand and organize human behaviours (Mackie, 1991). Gender-based analysis (GBA) assesses the implications of culturally-defined roles for policy implementation and evaluation. Gender-based analysis of health and social policy raises issues that are otherwise obscured in analyses that are purported to be gender-neutral, issues that have major implications for the goal of equity in policies and programs. The impetus for gender-based analyses originated in the women's movement and feminist theory as a response to women's low status in society, and the social problems experienced by women and their children. Recent theoretical advances have recognized the diversity among women, and the need to consider interlocking systems of oppression (e.g., racism, ablism, homophobia, classism). Gender-based analysis, therefore, is about understanding how privilege is maintained, as well as how disadvantage is created. Though a complete gender-based analysis includes examining the impact of policies on men as well as women, the primary focus for this report is women.

For the purposes of this paper, we have adopted a broad conceptualization of privatization which includes:

- privatizing the costs of health care by shifting the burden of payment to individuals;
- privatizing the delivery of health care services by shifting care from public institutions to community-based organizations and private households;
- privatizing carework from public sector health care workers to unpaid caregivers; and
- privatizing management practices within the health system by adopting the management strategies of private sector businesses (Willson and Howard, 2000).

This definition moves beyond a limited one which focuses on movement into private business ownership and purports to be gender-neutral, but ignores important realities of women's and men's lives.

Horne, Donner and Thurston (1999) reviewed tools for applying gender-based analysis within the health sector, developed a framework and applied it to policy documents in Manitoba and Saskatchewan. They recommended that both processes and policy or program content be assessed for gender sensitivity. The following are key issues in each category:

Processes

1. representation of women in policy decision making and in leadership roles within the health sector (e.g., employees, board members);
2. inclusion of men as well as women in redressing inequities and promoting women's health and equality;
3. availability of training in women's health and gender issues (in both practice and research) for both decision makers and staff;
4. use of inclusive public participation processes that take differential barriers to participation into account (e.g., child care, language, disability);
5. links to women's organizations and other sources of expertise in gender analysis, as well as other equity seeking organizations (e.g., Aboriginal);
6. inclusion of women in research, both as participants and as decision makers;

Content

1. recognition of the differential impact of social context on health (i.e., social and economic factors);
2. assessing whether the focus on women's health is inclusive (e.g., reproduction, role as mothers, conditions specific to women);
3. gender sensitivity in all programs, not just those specifically for women;
4. the focus of outcomes, equality rather than sameness of activities or treatment and inclusiveness of indicators of success (i.e., an equity approach);
5. equitable distribution of resources, access and quality of services;
6. dis-aggregation of data by sex and other demographics; and
7. the impacts of health policies on family members through unpaid care-giving and out-of-pocket expenses.

We will use this framework to guide our analysis of provincial policies and explore the socio-political context within Alberta and how it has defined the current discussion of health care reform in Alberta. In Part 2, we will conduct a detailed gendered analysis of the privatization of health care in Alberta. We will conclude the paper with a discussion of the implications of the analysis in Part 3.

GENDER-BASED ANALYSIS IN ALBERTA

In this section, we review evidence concerning the current level of gender-based health policy analysis supported by the Alberta Government. While our focus is health reform, some relevant reports look at more general public policy. We will then highlight some of the other sources of gender-based analysis in the province (Alberta has a large number of local women-focussed groups, many of which are explicitly feminist, and other groups with specific interests, such as lesbian rights, interests of women of colour, immigrant women, professional women).

Linda Trimble (1997) examined the Alberta Legislative debates between 1972 and 1994 to determine whether a critical mass of women made a difference in having women's concerns

addressed within the parliamentary system. Trimble's systematic analysis of the Alberta *Hansard* index demonstrated that "under certain circumstances, female legislators can make a difference" (p. 151). In particular, she noted the impact of female MLAs raising issues and educating colleagues from all parties:

> Before 1986, six governing-party women had little effect, while Opposition men (and one Tory backbencher) occasionally raised gender-equality issues. The 1986 election brought four Opposition women to the legislature, and these women had a significant impact on the tone and direction of debate. They introduced feminist analysis of a wide range of issues, analysis which was adopted by their male colleagues in the Opposition ranks (Trimble, 1997, pp. 151-152).

Between 1986 and 1993, female MLAs cooperated across party lines to bring women's issues to the table. Since 1993, however, this level of cross-party cooperation has all but disappeared. Although the ruling Conservative caucus included several women, these women publicly supported their party's economic and social policy agendas (Trimble, 1997). The government position was that deficit reduction measures were gender neutral "despite evidence to the contrary" (p. 151), and consistently resisted taking gender into account as part of policy formulation. Having several women in caucus was not sufficient to make gender-based analysis a reality, but we have no way of knowing if or how they moderated the decisions and the potential impacts on women and children. We do know that the environment became more anti-feminist in the last decade. Although the current provincial government has had a number of high-profile female ministers over the last seven years (1993 to 2000), including the former Minister of Health (Hon. Shirley McClellan) and the Minister without Portfolio who co-chaired the Health Planning Secretariat (Hon. Dianne Mirosh), these women have tended not to take a feminist perspective, and in some cases, have been overtly anti-feminist.

A major barrier to incorporating gender-based analysis into the discourse on health privatization in Alberta, therefore, is the provincial government's history of anti-feminism and the pejorative labelling of women's organizations and others critical of government policy as "special interest groups," or more recently, as "left-wing nuts." Dacks, Green and Trimble (1995) note that some members of Caucus have been publicly aligned with the Alberta Federation of Women United for Families, a group that supports traditional patriarchal family roles for men and women, and is opposed to any policy that questions those traditions (e.g., child care programs, pay and employment equity). Dacks *et al.*(1995) also cite several examples from *Hansard* and MLA quotes from the *Edmonton Journal* that suggest negative attitudes toward women who do not stay at home or live in nuclear families (e.g., that kindergarten has become a substitute for day care; that a mother was to blame for the rape of her six-year-old daughter by a babysitter; that most women want to go back home and promote the family unit; that women seeking child support maintenance enforcement are "vindictive leech moms").

Dacks *et al.* (1995) note statements from the 1993 Premier's Council on Alberta Families that suggest that it is most desirable for families to be supported by one income, and that some families become two-income households by choice rather than by economic necessity, as though the latter is the only value of employment. These authors interpret the Premier's Council's vision (and its connection to government policy) as follows:

> Such a family should be supported by a single wage earned by the father and the unpaid labour of the mother in the home and community. This vision is at the heart of the so-called Alberta Advantage, for it helps government exploit the unpaid labour of women in order to reduce the public sector and shrink government spending. The government can then attract business and investment to Alberta by passing along the "saving" to corporations via incentives and tax reductions (Dacks *et al*., 1995, p. 280-281).

Despite government rhetoric about the importance of single-income families and full-time parenthood (motherhood), Teghtsoonian (1997) points out that support for such policies is limited to economically privileged heterosexual nuclear families. She notes that such encouragement is not provided to lesbian or gay families, or to families on low incomes or receiving social assistance (where there is an expectation that mothers should be in paid employment rather than caring for children full time). This disrespect for women's concerns and the anti-feminist, pro-family agenda is a barrier to incorporating gender-based analysis into health planning in general and privatization in particular.

Further evidence of the government's lack of interest in hearing about gender analysis is the dismantling of the Alberta Advisory Council on Women's Issues (AACWI). The Council, in existence from 1986-96, was intended to be arm's length from government and to identify issues of concern to women. AACWI's main roles were to conduct research, to make recommendations to government, and to consult with and provide feedback to the public. The Council commissioned 13 research reports and discussion papers, but of the 86 recommendations put forward by the government, only seven were accepted (AACWI, 1996a). In the last two years of its mandate, it became increasingly clear that the Council work was not well-received by the government (e.g., specifically discussed and applied gender-based analysis to determine the differential impact of the government's economic policies—the so-called "Alberta Advantage"—on women and men (Kerr, 1995). In her discussion of health care, she noted that women are more likely to be disadvantaged by funding cuts through the loss of well-paying jobs in the health sector as well as by increased expectations for unpaid care-giving as services shift to commu-nity settings. She also cited a number of govern-ment recommendations that would raise home care and long-term care user charges, income-dependent rather than universal coverage of se-niors health benefits, and increased health care premiums. Dacks, Green and Trimble (1995) not-ed that a number of MLAs began questioning fund-ing to AACWI shortly after the 1993 election. In 1996, the provincial government announced its in-tention to invoke the sunset clause that would see the Council eliminated nine months before the end of its mandate (Alberta Advisory Council on Wo-men's Issues, 1996b).

Academics, women's health organizations, regional health authorities, unions, and others have also conducted gender-based analyses despite the government's lack of interest. Dacks *et al.* (1995) pointed out that Alberta's deficit reduction initiatives—cutting health, education and social services—have hurt women most. Women benefit from the welfare state both as service recipients and as employees, and public sector em-ployment has contributed to many women's economic independence. Dacks *et al*. cite public sector union statistics indicating that more wo-men than men suffered job losses in 1993 and 1994, as more of the employees were female. They note that job losses by women in the public sector have two effects: women are forced to look for work in the private sector (usually for lower pay, security and

benefits); and they com-pensate for loss of public services by providing unpaid labour to take up the slack (e.g., more care-giving as hospitals admit fewer patients and release patients sooner).

A qualitative study for the Edmonton Women's Health Network (EWHN) of the impact of health reform on women in the Capital Region found that women had five major concerns:

- money is not allocated to appropriate areas of the health care system (including health promotion and home care);
- financial barriers interfere with women's ability to care for themselves and their families (in particular for services such as physiotherapy and midwifery);
- minority Canadians have difficulty accessing the health care system (e.g., because of language and cultural barriers);
- women sense a lack of trust, understanding and support from health professionals (e.g., regarding choice of treatment and caregiving responsibilities); and
- health care reform has had a negative impact on women's ability to care for themselves and their families (e.g., early discharge, stress on health professionals) (Bubel and Spitzer, 1996).

The concerns expressed by these women include provision of services and working conditions for women in the system.

In 1997, Thurston, Scott and Crow examined the published literature and held three focus groups with women who represented women's organizations in rural and urban Alberta to discuss two policy initiatives, health reform and funding for women's organizations. The authors concluded that while substantial work had been done by policy-makers on gender-based analysis of social issues, such analysis was "inconsistent and often weak unless the document is specifically about women, and the implications of the analysis cannot often be found in the policy recommendations that follow" (p. 11). The predominant focus of policy documents that do demonstrate a gender-based analysis is on the health needs of women and men identified by epidemiologic research rather than on the role of gender in the production of these health needs, or the access to and utilization of services.

Thurston, Crow and Scott(1998) surveyed nine of the 17 Regional Health Authorities in Alberta to determine how women's health was treated in administrative policies and programs once regionalization occurred. Overall, urban centres had more comprehensive approaches, and a specific focus on women's health was more evident than in the rural areas. For example, the Calgary Regional Health Authority produced a feminist model recognizing women's lived experiences of health, the influence of roles, economic resources, societal attitudes, culture, gender and social support on women's health. Calgary also made women's health one of its top priority areas (Thurston *et. al.* 1998). Only one rural region had a program labelled "women's health," and health services for rural women appeared to be limited to reproductive health and breast cancer issues. However, one re-gion did have a policy for deal-ing with sexual assaults that involved collaboration between the hospital emergency department, police and the local sexual assault centre. One needs assessment survey asked female respon-dents about programs that would interest them. In sum, despite the hostility of government to wo-men's issues, some Regional Health Authorities have paid some attention to women's health. This brief overview of Alberta health regions showed, however, that woman-centred programming was narrowly (and medically) defined in most.

In 1993, the Edmonton Business and Professional Women's Club hosted a talk by health economist Richard Plain who concluded that women lose most when health care services are cut back (Hadley, 1993). Thurston *et al.* (1998) noted that it is through such women's organizations that women have participated in the public policy process. Cutbacks to organizations that serve disadvantaged women have coincided with cutbacks in health services. These cutbacks have re-sulted in a shift in roles of women's organizations away from advocacy and lobbying so that direct ser-vice demands can be addressed. Thurston *et al*. (1998) state that "with inadequate resources to devote to public policy development, women's organizations and thus women, have become disconnected from the policy process" (p. 17). Thus, mechanisms for parti-cipation in policy development are being eroded at the same time that women are being required to assume increased burdens both as formal and informal caregivers. Despite this, women have organized and been effective on many fronts, most often at the local level (e.g., providing and sustaining services to abused women, affecting municipal policies and Regional Health Authority programs).

THE EVOLUTION OF ALBERTA HEALTH AND SOCIAL POLICY IN THE CANADIAN CONTEXT

The purpose of this section is to describe selected aspects of Alberta's history of health policy development. It is beyond the scope of this paper to fully explore the socio-political context; however, an overview is important to understanding Alberta's health system reform. Since provisions of the *British North American Act* give provinces principal power over the organization of health and social services, the Canadian health system is actually comprised of several sub-systems. Not surprisingly, the history of commitment to universal health care policies has ebbed and flowed with provincial political and economic tides. Although Alberta has been ruled by various conservatively-oriented political parties for over 75 years, we have seen variations in health policy there as well.

In Alberta, Ralph Klein's Progressive Conservative Party has been in power since 1992, and it was preceded by two Conservative governments (1971-1985 and 1985-1992) under different leaders (see Appendix A; Marsh, 2000). Alberta is one of the wealthiest provinces in Canada, has no provincial sales tax and one of the lowest rates of personal income tax. Alberta's wealth is largely dependent on the oil and gas industry, and although economic diversification has occurred, this industry continues to hold enormous political influence. As we will show, the energy sector is strongly in favour of a market-oriented economy, small government, and is a male-dominated employment sector. The energy sector and its Al-berta political supporters have a history of anti-federalist sentiment, support globalization and have the resources to influence policy that few civic society organizations could imagine.

The political influence of the energy sector, not surprisingly, extends beyond Alberta. The Energy Council of Canada (2000a) says:

> The energy sector is an important part of Canada's economy in terms of investment, trade, income generation, and employment. The energy sector employs more than 280,000 Canadians and accounts for 6.8 per cent of GDP and 16 per cent of total investment in Canada. However, there are marked regional differences in energy production and consumption.

As in health, control of the energy sector is shared between federal and provincial governments. The National Energy Policy enacted by the federal Liberals in the 1970s infuriated the Alberta Conser-

vatives and became a popular, as well as governmental, example of how federal government intervention was bad for Albertans. Not surprisingly, the energy sector was strongly in favour of the Canada-US Free Trade Agreement and North American Free Trade Agreement (Cameron and Gonäs, 1999). Removal of government control and restrictions is viewed by the energy sector as good all round:

> It is increasingly held that deregulation and the introduction of competition can result in lower prices for consumers, stimulate technological innovation, **allow the size of government to be reduced, enhance efficiency, and improve the quality of service** [emphasis added] (Energy Council of Canada, 2000b).

The overlap in the discourse of health reform—reduced government, efficiency and quality—is not accidental. It represents strongly held beliefs in the value of a "market-oriented" world. While "Canada's federal energy policy underwent a major reform during the mid-1980s, the result of which was a more market-oriented energy sector" (Energy Council of Canada, 2000b), "other government agencies" are under scrutiny:

> Canadian experience on energy regulation reflects a broad, growing, and persistent worldwide trend toward the deregulation of monopoly industries and government agencies. It is increasingly held that deregulation and the introduction of competition can result in lower prices for consumers, stimulate technological innovation, allow the size of government to be reduced, enhance efficiency, and improve the quality of service (Energy Council of Canada, 2000b).

Thus, Alberta has a particular policy history supported by a private sector with a clear agenda, and international influence. This sector is domi-nated by males at all levels, which is to say that insider influence by women on corporate culture and beliefs has been minimal.

The market-oriented approach to health care is historical in Alberta. When the economic depression of the 1930s forced Canadians to re-evaluate the social organization of the country, the Social Credit Party of Alberta advanced an entrepreneurial-philanthropic approach to social programs (Crichton, Hsu, and Tsang, 1990). The approach was based on individual enterprise and responsibility and was associated with the proliferation of voluntary social service agencies and charity hospitals. Municipal assistance programs frequently supported the philanthropic enterprises and in some instances, where the economic base for charity did not exist, smaller municipalities became the social assistance authority. We continue to see individual enterprise and responsibility in today's discourse.

In Alberta, the lack of ideological support for social welfare programs meant that as the economy improved during the 1950s and 1960s, support for an entrepreneurial system began to re-emerge as a dominant theme. Medical care prepayment schemes and fee-for-service options regained viability in more economically prosperous times. The *Medical Care Insurance Act* was passed in Canada in 1966 despite opposition from the governments of Alberta and Quebec. These provinces expressed the concern that the Act would interfere with provincial priorities (Wilson, 1995). The Act promised 50/50 federal-provincial cost-sharing of hospital and physician services if provincial plans met four health care principles (comprehensiveness, universality, pubic administration and portability). The 1984 *Canada Health Act* added a fifth principle—accessibility—thus prohibiting extra-billing and user fees. Enforcement of the *Canada Health Act* took the form of financial penalties levied on those provinces that failed to comply with the Act. Since 1984, the federal government has continued to cut back the block transfers to the provinces. Bills C-69 (1990) and C-70 (1991) effectively froze transfer payments for five years. In 1995, the

Canada Health and Social Transfer Act (Bill C-76), combined federal-provincial health and social transfers into one block payment (Wilson, 1995). This Act continued the trend toward reduced levels of federal expenditures on health care while giving the provinces even greater flexibility in implementing health and social programs. The Alberta Government's response to Bill C-76 has been to implement a series of policy initiatives that reflect a return to an emphasis on individual enterprise and individual and private responsibility. Specific Alberta policy initiatives will be explored in Part 3 of this report.

Since the 1930s, Canadians have seen their health systems shift from idiosyncratic programs based on private financing, administration and delivery to a system unified by principles of comprehensiveness, universality, public administration, portability and accessibility. The health system in each province and territory developed distinctive features, but there was a sense, however inaccurate, that there was a Canadian system. During the 1980s and 1990s, the unifying nature of the health system was eroded by changes in financial and administrative mecha-nisms. Rapid health reform, rationalization, re-engineering became the norm. In 1994, Alberta chose a regionalized management system in which 17 regional health authorities replaced numerous hospital, public health and other boards and committees. As was the intent, these authorities are strongly influenced by local socio-political contexts; therefore, a more disparate management and delivery systems is evident in Alberta. At the same time, the government department of health was reduced in size.

While financial considerations have been identified as the main impetus for regionalization initiatives in Alberta, these financial imperatives have also been couched in discourse around local control, de-institutionalization and community—giving people control over health and health care decisions, recognizing the public as a partner in the health care system, and putting the "consumer"[1] at the centre of decision-making (Alberta Health Planning Secretariat, 1993; Alberta Health, 1991; Premier's Commission on Future Health Care for Albertans, 1989). This discourse is, of course, familiar to proponents of a more humane health care system, and of a system more involved in the promotion of health and well-being. What is absent in government discourse, and openly resisted, is an analysis of the gendered impact of such reforms.

Alberta has a strong history in disease prevention, health promotion, and population health. For example, the Federal/Provincial/Territorial Advisory Committee on Population Health that was chaired by Cecilia Lorde, Assistant Deputy Minister of Health for Alberta, produced an influential population health report in 1994 (Federal/Provincial/ Territorial Advisory Com-mittee on Population Health, 1994). There is, however, a danger of making the economic goals of health reform those of prevention and health promotion. As Noseworthy (1999) points out, disease prevention programs could be framed as a reason to reduce health care spending. Unfortunately, Alberta's expertise at the program level in delivering a cross-section of health promotion programs has not included attention to gender as a determinant of health. In a review of health promotion projects, none were identified that included this determinant (Thurston, Wilson, Felix, MacKean, Wright, 1999).[2]

In the face of a provincial budget surplus, the Alberta Government has begun to discuss reinvesting in health care. For example, discussions have in-

[1]During the 1990s, the term "consumer" has been increasingly used in the literature to refer to people who access health services. The term embodies the market model of health care and the notion that health care and the social relations of health care are commodities (i.e., products rather than services).

[2]This included a substantial but not complete sample of Alberta program reports.

cluded the possibility of increasing front-line nursing staff in both hospital and community settings and introducing legislation that would expand opportunities for private, for-profit health care facilities. Discussions of increasing the role for private facilities have, however, been limited to exploring for-profit options and have neglected the role of the private, not-for profit sector. The not-for profit sector (e.g., community health centres) has historically played a role in the provision of health services in Alberta but under strict public regulations that limit profits.

Public control of the financial arrangements related to health care is discussed by Donaldson and Gerard (1993). These authors suggest that by controlling health care finances, governments are permitted more direction of the health care system "in the pursuit of societal objectives" (Donaldson and Gerard, 1993, p. 53). Discussions relating to health care reform and privatization initiatives in Alberta have included debate about the relative weight that specific policy initiatives give to objectives such as efficiency and equity. In economics, maximizing the efficiency of the system or program means maximizing social benefits with scarce resources (Mooney and Sal-mond, 1994). It relates to whether a program is worth doing (allocative efficiency) and the best ways of producing worthwhile programs (operational efficiency). Equity refers to both financial equity and equity of opportunity to access services.

Although there is currently a budget surplus in Alberta, there are not infinite dollars available to finance the health care system. In a climate of limited resources, the interaction between equity and efficiency implies a trade-off. That is, if there are scarce resources, financial equity and equity of access may be ensured if efficiencies are compromised. In Alberta, health reform has made a number of trade-offs; for example, provision of services in remote and in rural areas may compromise the objective of finding the "best ways" to produce worthwhile programs (i.e., operational efficiency). Legislation that is currently being introduced by the provincial government (Bill 11) is purported to increase efficiencies in the system (i.e., decrease waiting lists). While there are questions about whether such efficiencies would be found through this legislation, there are also concerns that potential increases in efficiency would be at the expense of both financial equity and equity of access. Bill 11 would allow private surgical facilities to operate using both public and private financing; therefore, in such institutions, the provincial government would be permitted less control over the objectives that guide service provision. By giving up control, the government might not be able to ensure a balance between equity and efficiency.

Private health providers bring many factors from the market sector into play in the health system. Taft and Steward (2000) point out that for-profit companies have added costs such as taxes, marketing, payments to investors, and duplication of expensive equipment among competing providers. Conflicts of interest arise when private providers are also in decision-making positions within the public health care system. Several examples of this have been noted within one of the largest Alberta Regional Health Authorities—in Calgary.[3] Private

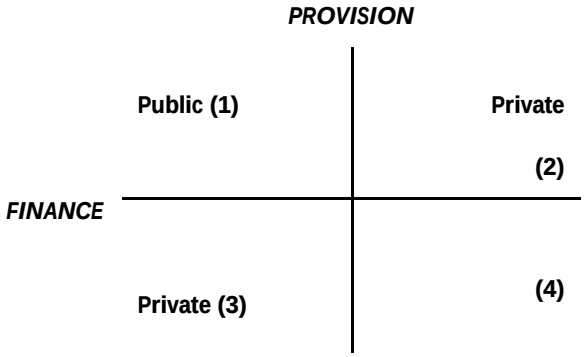
[3]Dr. Chen Fong was head of radiology at Foothills Hospital in Calgary at the same time as he was medical director for Western Canada MRI, and is now head of radiology at the Calgary Regional Health Authority (CRHA). When an MRI unit was taken out of operation during a move between hospitals, the CRHA referred urgent MRI cases to Western Canada MRI. Dr. Kabir Javraj, an owner of Surgical Centres Inc., was hired by the CRHA as their chief medical officer six weeks after his company was awarded an acute-care services contract. In 1998, opthamologist Dr. Peter Huang and otolaryngologist Dr. Ian Huang, owners of Enterprise Universal Inc., purchased the Holy Cross Hospital facility (which had been closed by the CRHA) for $4.5 million. At the time, Peter Huang was head of opthamology for the CRHA and had a contract to perform all of Foothills Hospital's cataract surgery in his private clinic. After Enterprise Universal Inc. purchased the Holy Cross Hospital, it was awarded a contract to perform eye, nose and throat, and foot operations at the Holy Cross site.

interests also conflict with public goals, such as a provincial breast screening program. Private radiologists fear loss of a profitable population of clients if the Alberta Cancer Board is permitted to institute such a program. These radiologists may believe strongly in the benefits of a systema-tic screening program, follow-up, and research, but their business models demand that they be able to screen any woman who requests screen-ing, regardless of practice guidelines, and that they maintain control of the case through records.

The private provision of health services in Alberta has existed for a number of years. Therefore, the argument that there is no room for private enterprise within the Alberta health care system will persuade few Albertans. Physicians and physiotherapists, for example, may be salaried employees within the public health system, private practitioners who work under contract to Regional Health Authorities, or who directly bill Alberta Health and Wellness for the services that they provide. In each of these situations, the provider may be working privately, but her or his services have been financed publicly. This single-payer system is a tax-based public insurance system that pays for health services that are mainly supplied by the private sector (Fuller, 1998). As discussed below, it is the expansion of private financing mechanisms (e.g., an individual paying directly for uninsured or enhanced health care services or paying for private insurance policies in addition to the public premiums) that threatens to undermine the principle of accessibility.

Donaldson and Gerard (1993) present an economic model of the public-private mix in the financing and organization of health care that can be used as a starting point in assessing privatization initiatives. This model illustrates four possible scenarios for financing and providing health care (Figure 1). That is, public financing with either public provision (1) or private provision (2) and private financing with either public provision (3) or private provision (4). Currently, the health system in Alberta is dominated by scenarios (1) and (2). There are instances, however, where enhanced services have been offered by either public (3) or private providers (4) (e.g., the provision of a higher quality lens for eye surgery). The latter two scenarios have the potential to compromise financial equity and equity of opportunity to access services, and reflect the emergence of a second tier of health care in which those who can pay will receive a higher quality service or more rapid access to service than those who are unable to pay (Donaldson and Schiell, 2000).

PUBLIC/PRIVATE MIX IN HEALTH CARE FINANCING AND PROVISION



(1) Public finance & public provision
(2) Public finance & private provision
(3) Private finance & public provision
(4) Private finance & private provision

Source: Donaldson, C. and Gerard, K. (1993). *Economics of Health Care Financing: The Visible Hand.* London, UK: MacMillan. p. 53.

Part of the discourse around efficiency involves implying that public employees as greedy, inefficient, and even lazy. Jerome-Forget and Forget (1998) and McArthur, Ramsay and Walker (1996) state that health care wages have been rising faster than the industrial average. Jerome-Forget and Forget also suggest that hospital workers are less productive (from 1969 to 1989) than those from other sectors based on the number of patients treated per hour of work. They also cite a U.S. study (*cf.*

Ashby and Altman, 1992) that found productivity increases to be small despite increased labour cost inputs for similar levels of case complexity over time, with little added bene-fit to patient well-being. McArthur *et al*. (1996) compare many of the unionized jobs in hospitals (excluding nurses, technicians and lab assistants) with those of unionized hotel workers as evidence that public sector health care workers are overpaid relative to their private sector counterparts. People who work in hospitals, however, are at greater risk of exposure to germs, sometimes need to provide non-clinical assistance to patients, such as helping them to use phones or call for a nurse (Armstrong and Armstrong, 1996), and serve a population that is generally much more stressed than in the hotel industry.

When it comes to professionals, what is absent from the analyses of labour costs is the context of historically low pay and status of nurses prior to the 1970s (Armstrong and Armstrong, 1996) and the lengthy struggle for better pay and working conditions. This raises the question of whether the above-average wage gains of hospital workers (many of whom are nurses) was simply a "catch up" from being undervalued and underpaid in earlier times. As noted by Renouf (1995), health care wages in Alberta did rise faster than both average incomes and inflation during the 1980s; however, these increases addressed prior pay inequities:

> These gains did not come without struggle, exemplified by province-wide strikes of unionized nurses in 1980, 1982, and 1988. Health care unions fought to increase pay levels which, in real terms, had been very low for their predominantly female membership. Compensation increases in the 1980's were neither unjustified nor the product of a lax and free-spending provincial government. Primarily, they reflected pressures to address long-standing pay inequities (p. 229).

The government actively opposed the wage adjustments that occurred (Renouf, 1995).

PUBLIC PARTICIPATION

The government's commitment to privatization of the health system has also been accompanied by a trend toward increasingly limited and controlled public participation in the planning processes. Alberta Health has held various types of community consultations (e.g., the Rainbow Report in 1989, Partners in Health in 1991, Roundtables in 1993, the Health Summit in 1999). In addition, the Alberta Advisory Council on Women's Issues held a public consultation process in 1996 and the Provincial Health Council of Alberta held public consultations in 1997.

Although these avenues provided opportunities for input and feedback to decision makers, it is not clear how the data gathered was translated into policy decisions by Alberta Health and the health regions. While the early consultations associated with the Rainbow and Partners in Health Reports (see Part 2 of this paper) appeared to be open and responsive to the concerns of the public, more recent consultations have appeared much less responsive. For example, an *Edmonton Journal* columnist who covered the 1993 Roundtables reported that one of the co-chairs was to summarize the discussions from both the public and invitation-only consultations, but there was no information on how he would decide on the main themes or handle conflicting views, suggesting that not all perspectives were given equal respect:

> In the roundtables you had to listen carefully to pick out the whiners and special interests. The voice of Alberta was a lot like crude oil. Before it could be used, it had to be purified (Lisac, 1995, p. 156).

In contrast, the Provincial Health Council consultations reported diverse feedback about the health care system, both positive and negative. For example, public meetings and focus groups reflected concerns that health reform has focussed too much on cost control rather than quality; that there has been little citizen involvement in the

decision-making of their Regional Health Authorities; and that providers are not always sensitive to patient needs. They also supported an emphasis on prevention and encouraged more attention to this area. In addition to these face-to-face meetings with members of the general public, the Council also visited health authorities, interviewed former board members about their experiences with health reform to date, and conducted a province-wide survey of Albertans. From these various types of consultation, the Council concluded that:

> ...cost containment through government expenditure has largely been achieved, although there has been an increase in cost to individuals, employers and communities (Provincial Health Council of Alberta, 1997a, p. 17).

On a more positive note, the Council also found more recognition of the linkages among lifestyle choices, social and economic policy, and better health. The Council emphasized integration of health and other sectors was needed to move health reform forward, as well as better use of provider skills and health facilities, and better prevention programs. This example illustrates how public and other forms of consultation by a government body can be used to provide both positive and critical feedback on policy and make constructive suggestions for change. In 1997, the Council was examining ways to further expand its process for consulting with Albertans, particularly Aboriginal people. The Council was eliminated in 1998.

Shortly before its demise, the Alberta Advisory Council on Women's Issues (AACWI) carried out a public consultation process with women across Alberta. This consisted primarily of focus groups of women from diverse backgrounds, as well as opportunities for written or telephone submissions. In their discussions of their attempts to communicate with the government, most who participated felt their efforts had minimal results in terms of effecting change. When discussing barriers to effecting change and having impact, women identified lack of awareness of women's issues (including on the part government); fear of consequences in their communities for speaking out; a belief that the government does not listen, especially to women; as well as more practical barriers like lack of time, money, knowledge and comfort with speaking up (Alberta Advisory Council on Women's Issues, 1996b).

Though a minority of women favoured discontinuing AACWI, many believed its closure "would weaken the government's ability to create legislation, regulation and policy that were sensitive to women's needs and concerns." (Alberta Advisory Council on Women's Issues, 1996b, p. 28). Most either supported continuing AACWI or developing a replacement structure that would still provide opportunities for women to work with government. Of all the options that were put forward, the government chose to follow through with its intent to close AACWI. While women's organizations have struggled to provide services where government cutbacks created gaps, their ability to engage in consultation at the provincial and local levels has been restricted. In addition, given the anti-feminist stance of the current government, there is little trust that women will even be listened to, let alone heard.

Health care was the most frequently raised major concern in the AACWI consultations. Specific concerns relevant to the present discussion of privatization included:

- impact of cuts on quality and availability of medical treatment;
- concern about increased use of users fees and potential for limited access to adequate health care by poor women and their families;
- concern regarding government and community expectations that women will be long-term caregivers at home for family members;
- concern about skill levels and quality of training for home care staff and other out-of-hospital care providers; and

- future availability of abortions given recent discussions regarding de-insuring abortions from health care coverage (the government decided not to de-list abortions from health insurance coverage, and covers full costs of abortions performed in private clinics as well as hospitals). (Alberta Advisory Council on Women's Issues, 1996b)

The use of progressive discourse to mask regressive policy directions is evident in policy related to social policy initiatives in Alberta. For example, Kline (1997), in discussing the Action Plan for the decentralization of children's services to regions (prior to its implementation), describes how the government uses the discourse of community to promote private responsibility for children's needs (in the family and done primarily by women), rather than collective community responsibility. Kline (1997) notes that early intervention is presented as an individual issue of skills training for parents, and social issues such as "low income" and "family violence" are seen as family and community issues that are not the responsibility of government. Thus, there is no recognition of the relationship between social and economic inequalities and individual actions. Kline (1997)also points out that:

- groups designated to be represented on the Regional Health Authorities include categories such as parents, volunteer organizations, religious groups, elders and service clubs—with no mention of women or gender;
- the shift to more community involvement can be used not only to recognize skills of community members, but also to justify de-professionalizing of work (and fewer social workers, who are mostly women);
- the process of contracting-out may not actually facilitate meaningful involvement of community agencies as contracts may go to for-profit businesses or large chains, and grassroots agencies could be co-opted by government funding to provide services on the government's terms (e.g., restrictions on lobbying);
- the Action Plan talks about more power and control for First Nations communities, but in reality they will be constrained by government requirements and that the language of the plan actually "pathologizes" First Nations communities.

Kline (1997) does not view the formation of regional authorities as actually giving more power and control to local communities. She notes that such structures actually insulate the government of accountability, and also observes that in Manitoba and Ontario local decision-making structures were disbanded when they became critical of government policy and demanded change, including more funding and expanded services. This is a pattern that has been repeated in Alberta with the disbanding of the Alberta Advisory Council on Women's Issues, the Provincial Health Council and decreased funding for women's organizations. The AACWI consultation (1996b) contained several recommendations to ensure representation of women in government decision making. These included:

- gender analysis of legislation, policies and programs;
- improved communication through an annual consultative forum for women and women's groups;
- increased communication by MLAs with women and women's groups in their constituencies;
- political party support for women seeking and attaining office and more gender balance in government appointments;
- support (including funding) for independently conducted policy research addressing issues of concern to women; and
- inclusion in business plans and performance reports of differential impacts of legislation, policies, programs and other decisions on women and men, including sex-disaggregated data (AACWI, 1996b).

Strategies such as these must be set in place to ensure that policy is responsive to the needs of women.

Given the government's lack of responsiveness to public input, it is not surprising that there appears to be a great deal of skepticism among Albertans regarding their ability to influence the policy process. This is apparent in recent discussions around the introduction of Bill 11. The provincial government has not held any open debates about the legislation, but it did (briefly) propose to disperse "truth squads" to inform Albertans about the implications of the Bill. At the same time, fora sponsored by other organizations and groups (e.g., the CBC, Friends of Medicare) have been well-attended by participants vocal in their opposition.

PART 2 PRIVATIZATION OF HEALTH CARE IN ALBERTA

THE CURRENT VISION FOR THE HEALTH OF ALBERTANS

The provincial government's vision for the health of Albertans has evolved over the years and, in the course of this evolution, has facilitated the current shift toward policies that emphasize greater private responsibility for health care. While the language of privatization has become more explicit, the gendered implications of this shift remain absent from the discussions of health care reform.

The following information, taken from the "Health 1999-2002 Business Plan" section of *Budget 99: The Right Balance: Fiscal and Business Plan Documents* (Alberta Treasury, 1999), presents some the Alberta Government's current communications about the health care system.

In the 1999-2002 business plan from Alberta Health (the name of the Ministry changed from "Alberta Health" to "Alberta Health and Wellness" in the Spring of 1999), the three major dimensions of emphasis were access to quality health care services, promoting and protecting the health of individuals, and the contribution to health of healthy social, economic and physical environments (Alberta Treasury, 1999). This same business plan also states three "system characteristics" of relevance to this discussion of privatization (p.2):

- Alberta will continue to be part of a publicly-administered health system that guarantees universal access to medically-necessary hospital and medical services without user fees or extra billing;
- the Alberta health system will continue to provide benefits in excess of the *Canada Health Act*; and
- incremental introduction of better approaches to health care will occur as evidence demonstrates their outcomes.

This plan opens the door for privatization through options for the provision of "benefits in excess" and "better approaches." The present 2000-2003 business plan, while emphasizing consistency to the principles of the *Canada Health Act*, is explicit about the private sector as a partner:

> The achievement of this vision requires individuals to take responsibility for their health in their communities, in collaboration not only with the Ministry and providers of health services, but with a wide variety of parties including other Ministries, other levels of government and the private sector (Alberta Treasury, 2000a, p. 3).

This statement, with its reference to individuals collaborating with the private sector (among others), did not appear in the previous plan of 1999/2002. The timing of adding a statement about collaboration that includes individuals

collaborating with the private sector—in the year that Bill 11 is being introduced—suggests the government's intention to allow expansion of the private sector, including the ability of private clinics to market non-insured services to Albertans. On the other hand, the statement could be read to mean that people should take a more active role in their insured health care treatment that is provided by physicians (who are publicly-funded private providers), or joining private physical activity programs. The statement—though more specific in mentioning the private sector than last year's plan—allows for many interpretations about both the role of the private sector and the nature of collaboration. Though policy documents such as departmental business plans usually are written in broad terms, further definition at the operational level is needed to define the intended roles for the private sector in Alberta's health care system.

THE PROVINCIAL PLATFORM: KEY POLICY INITIATIVES

The current emphasis on private responsibility for health care has been a consistent theme in the Alberta health system since the 1930s. For a brief period during the 1980s the force of this underlying ideology was diminished and policies that reflected the objective of equity were able to emerge (e.g., the legislation that enabled the creation of the Alberta Advisory Council on Women's Issues). In the late 1980s, there was again a shift back to a focus on individual responsibility for health. This emphasis has continued to develop in policy documents throughout the 1990s.

In this section, we use a gendered lens to examine a number of key policy documents that reflect this emphasis on private responsibility for health care. While documents that were generated during the early stages of health reform in Alberta do reflect an understanding of the need to clarify the roles of individuals, organizations and sectors in the health care system, this does not evolve into a understanding of the differential impact of such roles for men and women.

1. *The Rainbow Report*

In December 1987, the Premier of Alberta, Don Getty, signed an Order-in-Council establishing the Premier's Commission on Future Health Care for Albertans. The purpose of the Commission was to conduct an inquiry on the future health requirements for Albertans with respect to four general Terms of Reference (Premier's Commission on Future Health Care for Albertans, 1989, p. 12):

- to examine changes in future health requirements as they relate to population trends, advances in active treatment and preventative health measures, health training and technology, types and patterns of illness, public needs and expectations, organization funding structures, and such other factors that may be relevant;
- to examine roles, responsibilities and expectations of individual Albertans, volunteers, community agencies, the medical and related health care professions, private sector interests, and governments in planning, delivering and funding future health services and programs;
- to examine incentives and mechanisms to maintain quality and accessibility of health services; to encourage the most innovative, effective and economical use of health resources and to focus on the promotion of health and the prevention of disease; and
- to examine, comment on, and make recommendations on such other matters that the Commission may deem to be relevant.

This mandate clearly indicates a recognition of the need to maintain quality and accessibility of health services while clarifying the roles of the public and private sectors in health care delivery and funding, including the roles of individuals and community agencies.

Chaired by Lou Hyndman, the eight-member Commission was comprised of three women and five men, and had two years to complete its task. Throughout 1988, the Commission implemented

extensive methods to gather information relevant to its task, including town hall meetings, public hearings interviews, written submissions, and toll-free telephone submissions. By July 1989, 1,600 written and telephone submissions had been received. The data were qualitatively and quantitatively analyzed and additional information was gathered on a number of the major concerns and issues. In early 1989, a Newsletter Special Edition which summarized the findings from each of the town hall meetings and public hearings was circulated to the public for further feedback (Premier's Commission on Future Health Care for Albertans, 1989b). *The Rainbow Report: Our Vision for Health* contained 21 major recommendations which distilled down to the following six directions for change in the Alberta health care system:

1. "Healthy Albertans, living in a healthy Alberta" can be achieved if the government is prepared to be bold....We need legislation—including a strictly-enforced Alberta Code of Health and Environmental Ethics—that ensures that the health of individual Albertans is consciously and publicly in balance with economic development and other initiatives.

2. More individual responsibility for health—1% of the total Alberta Health budget needs to be allocated to targeted promotion and prevention programs.

3. Return the authority for decisions affecting the relevance of health services to people within the communities familiar with local needs and priorities. Health authorities, with responsibility for allocating funds and comprised of locally-elected trustees, should be established throughout the province.

4. Individual Albertans and/or their designates, should have the responsibility for disbursing and managing the funds required for their health and health care needs.

5. The Government of Alberta should provide matching grant funds for the establishment of a publicly-accessible Ethics Centre to assist Albertans facing complex issues which require deliberation and discussion (e.g., dying with dignity).

6. The vision of "Healthy Albertans, living in a healthy Alberta" needs an Advocate who would communicate with and to Albertans and the government about health and health care.

In the years since its publication, *The Rainbow Report* has been heralded as the foundation for many of the current reforms. In reality, few of the recommendations have been implemented as envisioned. Although the province has moved toward a regionalized health system (17 regions rather than the recommended 9), the Regional Health Authority boards remain appointed, not elected. The Provincial Health Ethics Network has been established. The vision, referred to in the sixth direction for change remained the vision for Alberta Health until this year when it was changed to "citizens of a healthy Alberta achieve optimal health and well-being" (Alberta Treasury, 2000a, p.3).

Despite the Commission's strong emphasis on the development of a health system based upon a common vision and values, there has not been explicit discussion of the values underlying the vision. The vision proposed in *The Rainbow Report* is one of understanding of the need to balance individual rights with the societal good and for the government to assist, support and protect individuals in achieving their individual health goals (Premier's Commission on Future Health Care for Albertans, 1989a). The central role of the government is reflected in the suggestion that the provincial government support individual responsibility for health by dedicating a percentage of the budget to health promotion and disease prevention initiatives.

The Commission highlighted the need for government to provide special support to some individuals or groups who may face barriers to accessing health care services (i.e., young people, women, the elderly, Aboriginal Albertans, and persons with disabilities). The report links the special support required by women to the multiple roles that women play (i.e., "homemakers, parents, breadwinners, career people, care givers" and "maintaining the primary role in decision-making about child health care matters" (Premier's Commission on Future Health Care for Albertans, 1989a, Vol. II, p. 52). Thus, while the final recommendations are couched in gender-neutral terms, the substance of the report reflects some level of understanding regarding differential access to health care services for women and men even though women's roles were primarily in the realm of caregiving. While an understanding of the unique needs of women was reflected in the discussion of access to services, the same level of understanding was not apparent in the section of the report that dealt with health care providers. The thrust of the report in this area was to emphasize the need for building positive relationships among health care providers and between health professionals and the individuals to whom they provide care. Strategies were advanced to reduce the barriers among providers and between providers and patients.

In the appendices to *The Rainbow Report*, the Commission took the opportunity to comment on the importance of volunteers in the health sector. While the report does identify that six of ten volunteers are women, having volunteers is seen as a strength of the system. There is no further analysis to examine the impact this level of voluntarism has on the lives of women, or the changes occurring in voluntarism and implications for the future. Dependence on unpaid labour that may not be available as more and more women enter the labour force could be seen as a weakness of the system.

2. *Partners in Health*

To assess the findings and recommendations of *The Rainbow Report*, the government of Alberta established a Cabinet Task Force. The Task Force, chaired by the Minister of Health, Nancy Betkowski [MacBeth][4] "was to ensure that any recommendations accepted and implemented would support the principles of universality and reasonable access, provide for the continued provision of basic health services, support health promotion, take into account environmental and economic factors, and not restrict access to health services because of an individual's inability to pay" (Alberta Health, 1991, p. 2). In 1991, the Task Force published its response to *The Rainbow Report*, entitled *Partners in Health: The Government of Alberta's Response to the Premier's Commission on Future Health Care for Albertans* (Alberta Health, 1991). The report explicitly stated that "*The Rainbow Report* [was] designed to encourage Albertans to become more fully involved in defining and setting directions for the health care system" (p. 3). In keeping with this commitment to citizen involvement, the Task Force solicited and analyzed submissions from individuals (200) and interest groups (179) from across the province. It is not clear from the report how the public input was solicited. In the list of organizations, there are very few that represent women's organizations—the Catholic Women's League of Canada and perhaps the Alberta Association of Homemaker Services are the only two such organizations. The Alberta Advisory Council on Women's Issues is conspicuously absent from the list. The Task Force supported, to varying degrees, 17 of the 21 specific recommendations arising from *The Rainbow Report*. In many instances, the Task Force supported recommendations in principle, but identified the need to

[4]Ms. MacBeth is currently the leader of the provincial Liberal Party.

collaborate with other sectors to develop appropriate strategies (e.g., education, justice, the environment).

The recommendations that were not supported by the Task Force were the suggestion that the government explore allowing all Albertans to manage the funds required for their health care needs, the creation of a provincial Health Advocate (this was felt to be the role of the Minister of Health), and the establishment of Regional Health Authorities. The government endorsed the need for coordination and cooperation on regional basis, but not through RHAs. At this point in time, the provincial government still espoused the need for a strong provincial role in the coordination of the health system. The public responses argued against RHAs on the grounds that they would create another level of bureaucracy, reduce local autonomy, and would have uncertain effects on accountability mechanisms. It is interesting to note that within three years, the provincial government had reversed its opposition to RHAs (see *The Regional Health Authority Act* below).

3. *Starting Points*

Following the *Rainbow Report* and the *Partners in Health* report, one of the first documents of the Klein government to outline health reform directions was *Starting Points: Recommendations for Creating a More Accountable and Affordable Health System* (Alberta Health Planning Secretariat, 1993). This report builds on the feedback the provincial government obtained through a Roundtable process consisting of public forums, written submissions from the public, visits to hospitals, consultations with health officials in other provinces, and a review of recent past reports on health system issues prepared for the Alberta Government. The report was prepared by MLAs Dianne Mirosh and Lyle Oberg, the respective Chair and Co-chair of the Public Roundtables on Health.

The report's first recommendation is that "the new system adopt a service-oriented attitude that places the needs of the consumer as the highest priority" (Alberta Health Planning Secretariat, 1993, p. 13). This recommendation addresses maximum access and choice (involving a range of providers and locations). One-stop shopping is recommended, where a person can access the range of providers and options when entering the system at any point. The report(Alberta Health Planning Secretariat, 1993) assumes not all these available services will be covered by Alberta Health Care:

> However, consumers will recognize that they will need to pay for services considered **non-essential** [emphasis in original] under a newly created definition of basic health services (p. 13).

The second recommendation in the report builds on the last point:

> It is recommended that a definition of **basic health services** [emphasis in original] be established. This definition will clarify health needs and health wants (p. 15).

This recommendation does not necessarily promote privatization, though the intent to "provide maximum value to the consumer" is consistent with a market perspective. The report uses the language of best practices to say that the result will be a definition of basic health services which ensures taxpayers only fund those services that meet established standards for quality health, and provide maximum value to the consumer (long-term benefit) and the taxpayer (cost-effectiveness).

The report does acknowledge that "cost-effective" does not always mean the lowest cost service, and that occasionally, a more expensive service may be required to achieve a better long - term result. The report also states that defining

basic health services will restrict the number of publicly funded services offered, and that the "consumer first" approach demands that consumers have access to an optimum number of nonessential services. It also states that:

> We must understand that the consumer's **right** to a maximum choice of nonessential services will include the consumer **responsibility** of paying for those services [emphasis in original] (Alberta Health Planning Secretariat, 1993, p. 15).

This statement reflects a free-market approach. Also, choice is made in a context of not only what is available, but how it is promoted or marketed. Thus "need" can be created—which is a fear expressed by critics of private clinics that are able to offer "enhanced" uninsured services. This raises the question of who is involved in discussions of what is essential and non-essential, and to what extent those involved understand women's health issues.

A subsequent recommendation is to establish a commission to define essential services. Later recommendations on accountability also mention payment, as well as individual responsibility for healthy lifestyles and use of the health care system and the need to educate consumers about the costs of health services and how to use them properly (e.g., through issuing receipts to consumers after they use the health system and/or through electronic "Smart Cards").

A number of other recommendations pertain to regionalization (e.g., board structure, integration of organizations and services, funding formulas, more focus on wellness, roles of province and region in capital construction). However, some recommendations are directly pertinent to the current discussion of private facilities working under contract to Regional Health Authorities. One states:

> It is recommended that non-profit associations and the private sector be given a greater opportunity to provide facilities. Health regions should be encouraged to work with non-profit associations and the private sector to establish joint venture or autonomous facilities. The provision of health services to the facilities would remain the responsibility of the region (Alberta Health Planning Secretariat, 1993, p. 21).

It is not clear from this statement whether the region is responsible for delivering the services directly, or merely paying for the service delivery. In the latter case, the delivery could be by government, non-profit, or private for-profit providers. The wording of the recommendation does not preclude any options.

Later recommendations in the section entitled "Paying for the Health System" are more explicit about the potential role of the private sector in direct service delivery. In addition to reiterating the need for "consumers paying for services deemed to be non-essential," this section also discusses using the private sector to help reduce unnecessary overhead costs. For example:

> The private sector must be allowed to provide services if the services meet or exceed health standards... Partnerships can be created between the private sector and local associations for wellness promotion, contract health services, and so on. These partnerships must be encouraged wherever possible to offset system costs (Alberta Health Planning Secretariat, 1993, p. 26-27).

There is also a recommendation that regions develop long-term partnerships with pharmaceutical firms to reduce drug costs.

The *Starting Points* report concludes with a number of challenges and questions which are not recommendations but are presented as points to consider. Some of these relate to the potential for various forms of privatization (e.g., health regions selling services to non-Albertans, contracting out food, laundry and maintenance services, partner-

ships between public and private sector x-ray/ diagnostic labs). This section also raises the issue of shorter hospital stays and more out-patient services, but does not acknowledge the likelihood of an increased role for informal caregivers (who are most often women). Although the five principles of the *Canada Health Act*—public administration, comprehensiveness, universality, portability and accessibility—appear in an appendix, there is no explicit reference to them in the report's recommendations, and no reference to the appendix in the body of the report.

4. *Health Goals for Alberta*

In late 1993, *Health Goals for Alberta: Progress Report* (Alberta Health, 1993) also mentions links to the private sector. In a discussion of maintaining quality and accessibility of the health care system, this document states:

> Partnerships between those who provide services, those who use health services and those who pay for health services, will be needed. Only in this way can we allocate our resources for the greatest benefits of all Albertans (p. 12).

Partnerships are also recognized as one of the six principles that are part of the vision "Healthy Albertans living in a healthy Alberta" (Alberta Health, 1993):

> Individual Albertans and people representing organizations from inside and outside the formal health system need to be involved in realizing our vision for health (p. 17).

These statements are not specific about who the potential partners are. The very general wording of the document could include many meanings of "partnership." If partnership is intended to involve patients and their families in more meaningful ways as they deal with the health system, it would not be inconsistent with woman-centred models of care (see Horne *et al*., 1999 for examples.) If partnership, however, means informal caregivers being expected to take on more responsibilities as health care staff are cut or to pay a greater share of their health care costs, then partnership would be more akin to cost shifting.

Later in the document, Goal 4 addresses health service delivery, and lays some early groundwork for the approach to health care reform that followed when health regions were developed. This goal addresses when and where services are provided, by whom, how they are integrated to improve accessibility, and cost-effectiveness. The report suggests the need for new ways of delivering services focussing on the individual consumer and the particular needs of each community, and suggests strategies to support people with health limitations to remain in their own homes, partnerships with groups outside the traditional health system and cost-effective service delivery.

5. *The Regional Health Authorities Act*

In 1993, despite earlier indications that Regional Health Authorities were not favoured by the government (Alberta Health, 1991), the concept re-emerged as a strategy to facilitate the coordination of responsive services. Based on the Provincial Roundtables on Health held in September and October 1993, the Health Planning Secretariat recommended that "a regional structure be created for local decision-making" (Alberta Health Planning Secretariat, 1993, p. 17).

The Health Planning Secretariat endorsed this concept because the members felt it would:

- encourage local accountability for providing affordable health services;
- recognize that health needs vary from region to region and give providers and consumers the freedom and flexibility to customize delivery to meet those needs;

- streamline the health system by eliminating nearly 200 boards;
- provide potential economies of scale;
- encourage institutional and professional co-operation within and between regions; and
- encourage innovation within and between regions.

The language used to describe the anticipated impacts of regionalization is clearly the language of efficiency (e.g., "accountability," "customize delivery," "streamline," "economies of scale"), with little emphasis on equity. While members the Secretariat endorsed regionalization for these reasons, it is unclear that mechanisms were set in place to ensure that these outcomes could be achieved. Regional Health Authorities were not, for example, supported by mechanisms to assist with accountability (i.e., a health information system). The lack of accountability was emphasized in the 1998-1999 Annual report of the Auditor General of Alberta in which he reiterated his recommendation from previous years that the Department of Health work with health authorities to improve the accountability system (Valentine, 1999). One proposed mechanism for customizing delivery was to mandate the creation of Community Health Councils in each RHA. However, their formation has been inconsistent across the province, and there are no specific guidelines for diversity of representation within the Community Health Council regulations (Government of Alberta, 1997). To this point, women have not had much success in customizing the health system to meet their needs. Increased numbers of female medical graduates have helped (e.g., women tend to choose female physicians) but of the leaders in medical education and medical research, only 20% are women even though medical classes are 50% female. In addition, these women tend to be in the lower ranks of academia (McKenna, Hanion-Dearman and Yassi, 1999).

It is interesting to note that between 1991 and 1993, the government had completely reversed its interpretation of some of the potential impacts of regionalization. In the *Partners in Health* report (Alberta Health, 1991) some of the reasons for rejecting the concept of regionalization included the uncertain impact on accountability, added bureaucracy, and the impression that improved coordination of health services was not necessarily linked to "boundary lines on a map" (p. 40).

The Regional Health Authorities Act (Government of Alberta, 1994) legislated the formation of 17 Regional Health Authorities and their links with two existing boards (the Mental Health Board and the Alberta Cancer Board). The 17 regions replaced over 200 separate boards of hospitals, health units and other health service institutions. Initially, RHA boards were appointed with the provision within the Act for having locally elected Boards, this has yet to happen. The Act legislates that the RHAs shall:

- promote and protect the health of the population in the health region and work towards the prevention of disease and injury;
- assess on an ongoing basis the health needs of the health region;
- determine priorities in the provision of health services in the health region and allocate health resources accordingly;
- ensure that reasonable access to quality health services is provided in and through the health region; and
- promote the provision of health services in a manner that is responsive to individuals and communities and supports the integration of services and facilities in the health region.

The interpretation of this legislation has varied from one Regional Health Authority to another and is easily influenced by the socio-political context within the region, such as differences in rates of eye surgeries (see Armstrong, 2000).

Five years after the implementation of regionalized health management in Alberta, the assump-

tions of its benefits have yet to be demonstrated. Donna Wilson (2000a) questions whether regionalization is "a successful format for managing health care planning and delivery of health services in Alberta" (p. 2) and highlights several features of regionalization that have added to the cost of managing the health system. Wilson conducted a basic cost-benefit analysis of health system performance. She notes that "there have been considerable redevelopment costs and redevelopment issues in changing Alberta's centralized health system into a regionalized model" and "it is of concern that the funds which were used to build and are now used to sustain a regionalized health system are not available for direct patient care" (p.2). Based upon the results of her study, Wilson (2000a) suggests that:

- regionalization has not improved health care planning and delivery;
- citizens feel more disenfranchised from health care than they did prior to regionalization;
- regionalization has not improved communication and coordination of care between and among regions (there is actually greater diversity in programming); and
- Regional Health Authority boards have become responsible for issues which are provincial government issues.

In sum, Wilson states that "a fragmented system, with considerable duplication and health care issues, has developed through regionalization" (Wilson, 2000a, p. 13). Wilson (2000a) concludes that until it is determined that regionalization is a successful format for managing health care planning and delivery of health services, "it would be unwise to expect Regional Health Authority boards to assume the responsibilities associated with contracting out major surgery to for-profit firms" (p. 14).

In 1997, rural women who participated in focus groups indicated that the creation of 17 RHAs and the development of funding barriers between regions had resulted in a competitive environment and in limitations in access to services for rural Albertans (Thurston, Scott and Crow, 1997). For example, participants stated that even though some rural people may live closer to the major centre of a neighbouring region, they were discouraged from accessing services outside of their own region and in some cases, were refused service. One participant "indicated her dismay that the Alberta health care system was reverting to a dysfunctional regionalized system that had existed in the province in the 1940's and 1950's" (p. 17). Related changes in long-term care services have meant that people who are elderly or disabled may be placed anywhere within a region depending upon where the long-term beds become available. "This situation potentially creates tremendous family upheaval and imposes increased stress upon family members who are encouraged to provide support to long-term care residents" (Thurston, Scott and Crow, 1997, pp. 17-18).

Wilson (2000a) discusses the implications for the regions of the population-based funding scheme that was introduced in the 1997/98 fiscal year. As a consequence of this funding program, regions may receive reduced funds because patients have received care in other regions (i.e., patients who are transferred to tertiary care institutions). The associated lack of funding permanence is especially problematic in rural regions where staff lay-offs are the most viable method for achieving short-term savings. As the majority of health care workers are women, the consequences of such lay-offs will have a greater impact on women either as paid or unpaid caregivers.

More recently, the Alberta Health 1999-2002 Business Plan (Alberta Treasury, 1999) describes the role of Regional Health Authorities as follows (p. 2):

- Regional Health Authorities will plan and deliver health services based on evidence of needs, with input from residents and community health councils and directions from the Minister of Health;
- services will be provided, when appropriate, **in homes and communities** [emphasis added], not just in hospitals;
- health services will be integrated with better linkages between hospital care, home care, community services, mental health services, long term facility-based services, rehabilitation services and public health;
- Regional Health Authorities will work with other organizations in their communities to address social, economic and environmental issues which affect health.

Of particular relevance to the current discussion is the statement that services will be provided in homes and communities and not just in hospitals. The emphasis in this statement is on where, but not how, services will be provided. There are underlying assumptions regarding who will provide care that will be explored below in the section on "Community-based care and Home Care."

6. *The Delegated Administration Act* and *The Government Organization Act*

The provincial government has favoured private delivery of government services since early in its first mandate. For example, *The Delegated Administration Act* (Bill 57) was introduced in the Fall of 1994 by House Leader Stockwell Day (Legislative Assembly of Alberta, 1994a). Bill 57 was designed to facilitate private delivery of government services by either for-profit or nonprofit organizations. Critics were concerned about diminishing legislative authority and accountability as well as potential for favouritism in the awarding of contracts (Harrison, 1995). Edmonton Journal columnist Mark Lisac (1995) wrote:

> The bill brought a distinctive red-market approach to restructuring of government. It was privatization, but not complete free-market privatization. It was privatization with continuing political control...The bill confused public and private business in many ways. One of the certainties seemed to be that cabinet ministers would not answer in the legislature for anything done by corporations to whom they had delegated responsibility, though the ministers would retain significant control over these corporations. And the province's auditor general would not have free access to review any of the agencies (p. 157).

The government eventually withdrew the Bill blaming the withdrawal on "a very public misinformation campaign" by the Liberals (Crockatt, 1994). The government re-introduced Bill 57 in the Spring of 1995, accompanied by a discussion paper distributed to a select number of groups in the province called "Delegated Administrative Organizations: A Third Option," to address "a number of inaccuracies" in part of the Bill (referenced in Harrison, 1995). Harrison (1995) also points out that though Bill 57 was withdrawn a second time, *The Government Organization Act* (Bill 41), which was subsequently introduced, was an onmibus bill that included creation of government departments, boards, committees, councils, inter-ministerial and intergovernmental relations, and ministerial authority, as well as several pages of amendments to various Acts (Legislative Assembly of Alberta, 1994b). The openness of some sections caused concern. For example, section 9(l) stated that "A minister may in writing delegate any power, duty or function conferred or imposed on him by this Act or any other Act or regulation to any person'. With regard to fees, Bill 41 not only authorizes the Minister or the Minister's department to charge fees "for any

service, material or program the performance of any function or the doing of any thing," but also allows fees to be charged "by any board, commission, council or other agency for which the Minister is responsible" (section 12(l)). Section 14(3) allows disposal of government property.

Bill 41 was passed in 1994. The open-endedness of the wording of section 9 in particular appears to make it possible for the government to accomplish many of the aims of the defeated *Delegated Administration Act* with even less public scrutiny. Does "any person"...or "other agency for which the Minister is responsible" include corporations—private as well as not-for- profit? According to one critic, Bill 41 "allowed ministers to create programs and services, change regulations, make loans, sell public property, or transfer programs and services to the private sector which could in turn set fees - all without legislative approval" (Harrison, 1995, p. 126). At the time, an unidentified government insider pointed out that the intent of Bill 57 could be accomplished through Bill 41 (Crockatt, 1994).

7. *A Better Way* (I)

Over the next three years (1994-97), a number of other government documents further illuminated the government's plans for the health system. For example, *A Better Way: Securing a Plan for Alberta's Future* (Alberta Health, 1994), cites principles and criteria that include individual and community responsibility, consumer focus, affordability and appropriateness of services (i.e., need- and evidence-based), and reduction of the cost of health care providers. The document is committed to public funding, but also states that "additional health services not based on significant need will be available, but will require a partial or full direct financial contribution from the consumer"(p. 5).

The themes of individual responsibility and accountability appear again under the section "Strategies for Achieving the Spending Targets." In addition to downsizing and rationalizing the system, the strategies advanced in this section also address shorter acute care stays and shifting various types of care (pre- and post-operative, long-term palliative) to "the community." As discussed elsewhere in this paper, shorter stays and shifts from the institutional settings to "the community" risk placing caregivers obligations on family members—predominately women—unless formal community-based services are in place and adequately funded before such shifts begin to occur. Though privatization of formal service delivery is not explicitly mentioned, the strategies do include rationalizing and restructuring of diagnostic services—many of which have been privatized (see Taft and Steward, 2000). Another strategy was altering Blue Cross co-payments for drugs, which led to co-payments from individuals increasing from 20% to 30%. Providers were asked to take a 5% rollback in wages. There were some elements of the strategy that had the potential to promote reforms in how providers work and are supported such as clinical practice guidelines (to reduce inappropriate services), alternative payment mechanisms and workforce re-adjustment. However, most of the focus was on overall restructuring with an emphasis on cutbacks. Later on in the document, as part of a discussion of the future health system, the issue of basic health services was again raised in terms of the need to define basic services and the conditions under which they will be publicly funded. The latter statement raises the question of whether the document views basic services as different than "medically-necessary" as the latter must be publicly funded.

Strategies for the second goal included improvements in home care and long-term care services. The new home care services would address complex or long-term health needs. However, the home care strategy also included the elimination of "non-essential home care services," which were not defined. Additional long-term care

services included several independent living options, as well as respite and education for family caregivers. Additional strategies covered a range of community-based mental health services, community rehabilitation to replace physical therapy and other fee-for-service rehabilitation services, and availability of medical equipment and supplies for home use. For the latter, there is no discussion of whether these will be free of charge nor about the complexity of medical procedures that people would be expected to perform at home with such equipment.

The third goal focussed on shifting an increasing proportion of health care costs to individuals by seeking "financial contributions regardless of age" (Alberta Health, 1994, p. 7) for universal health programs. Seniors would be required to pay health care premiums, where before they were exempt. Also, the income thresholds for premium assistance for other Albertans would be increased. The report also recommended health care premium costs rise by 20% (only Alberta and B.C. still have premiums). Other proposed increases in user charges included home care fees for "non-medical services," an increased proportion of room and board fees to be paid by long-term facility residents (though Alberta's rates are among the lowest in Canada—Alberta Health, 1997), changes to Blue Cross non-group benefits, and discontinued coverage for senior's optical and dental coverage by Alberta Health. There was an assumption that costs would be covered through an increased Alberta Senior's Benefit which handles senior's subsidies.

The fourth goal emphasized personal accountability and responsibility for health and the proposed strategies with health promotion initiatives, research and evaluation, information systems (including the "Smart Cards" that were never implemented), ethics, and information and training. The primary focus was education and skill development for individuals, particularly to encourage independence, healthy lifestyles, and appropriate use of the health care system. These are all important for helping people take actions to improve and maintain their own health. However, such an individual approach to promotion and prevention assumes health is the responsibility of individuals, rather than recognizing that individual behaviour and health status are embedded in a broader social context.

8. *A Better Way* (II)

Alberta Health (1995) released a follow-up document - *Better Way II: Blueprint for Building Alberta's Future 1995/96-1997/98*. This document was presented as a business plan, and also discussed the progress on the goals and strategies from the earlier document (e.g., regionalization, wage rollbacks, premium increases, reallocating $110 million to community-based services). The second document also mentions "de-insuring medically unnecessary services" as part of an onmibus agreement reached with the Alberta Medical Association, along with developing clinical practice guidelines, lab restructuring, and reduced spending on physician services.

The 1995 document was more attentive to diversity (i.e., age, urban/rural, Aboriginal and immigrant populations, disabled persons) than previous documents, but gender was not mentioned other than in reference to performance measures concerning in-patient hospital days and home care for new mothers. This is consistent with other Alberta Health documents we reviewed. There was also more mention of collaboration with other sectors to address social issues such as unemployment and underemployment, neighbourhood safety and substance abuse. The new document also added the "the impact of socioeconomic and environmental determinants of health will be considered" (Alberta Health, 1995, p. 7) to its principles and criteria. Many of the strategies under the four main goals were the same or similar to those of the 1994 document.

A notable addition under the first goal was to "ensure the development of a framework for

participation of not-for-profit provider organizations in the Regional Health Authority structure" (p. 11). At the time of regionalization, several such entities (e.g., community health centres, voluntary sector hospitals run by religious organizations) were already operating and had a long history of community service. In the first year of planning for regionalization (1994-95), the role of these organizations and their boards was uncertain. In the end, not-for-profit agencies retained their own community boards and entered into service agreements with the RHAs.

It is interesting to note that the Quebec regional privatization scan conducted for the National Coordinating Group on Health Care Reform and Women raised the distinction between shifting services to community organizations ("communautarisation") and the commercialization of services by for-profit businesses. Both are private, but one is non-profit and the other is for-profit. The scan noted that some authors encourage the social economy strategy to keep the for-profit sector from taking over formerly state-provided services, as well as encouraging the public sector to innovate. The Quebec paper also notes the potential negative result of institutionalization of community services and increasing control over these by government.[5]

In discussing characteristics of the health system in the future, *A Better Way II* states that "not-for-profit organizations, volunteers, volunteer organizations and private for-profit operators will continue to make significant contributions to the health system" (Alberta Health, 1995, p. 15). The document also mentions private alternative approaches to health services, dealing mostly with complementary therapies and counselling. Individuals would contribute to or cover the costs of such services.

What is the present state of some of the user charges discussed in the *Better Way* documents? In 1999, premium assistance for health insurance for non-seniors is such that single individuals with incomes over $7,560 per year and families (two or more people) with incomes over $12,620 per year pay full premiums. Full subsidy is only available for singles under $5,000 and families under $7,500 (Alberta Health, 1999a). Thus, only those on extremely low incomes qualify for any subsidy at all. Premiums are at a flat rate regardless of income once the relatively low subsidy thresholds have been exceeded. Thus, lower-income families pay the same premiums as higher-income families. As eligibility is based on the previous year's tax return, those who suddenly fall on "hard times" (e.g., loss of a job) must wait until the following year for assistance. Single seniors with incomes less than $20,825 and couples with incomes less than $32,650 are eligible for full or partial subsidy based on income. About 35% of seniors pay full premiums. The gender implications of government policy are that women are more likely to benefit from the subsidies than men. However, for the non-seniors in particular, the thresholds are low and more women than men will "fall between the cracks" by having too much income to qualify for subsidy, but not enough to be able to comfortably afford the full premium amount. High income earners, more likely to be men, will spend a lower proportion of their overall income on premiums than lower income earners who are above the threshold cut-offs.

Current home care policy states that assessment, case coordination, direct professional and personal care (e.g., meals, bathing assistance) services are provided free for nearly two-thirds of clients. For those assessed fees, homemaking is $5 per hour and meal services are $5 apiece (Alberta Health, 1999a). The gender implications are that unless there is adequate funding for trained staff to spend time in these community settings, the shift to the community will require more work by family caregivers, most of whom

[5]Jocelyne Bernier and Marlene Dallaire, *What Price Have Women Paid for Health Care Reform? The Situation in Quebec*, Montreal: Centre d'excellence pour la santé des femmes—Consortium Université de Montréal (CESAF), 2000.

are women. User charges for homemaking and meal services could be seen as financial barriers for some families, even though they are on a sliding scale based on income and number of dependents. This could lead to more work for informal caregivers who feel they must make trade-offs between the fees and other living expenses (e.g., seniors on fixed incomes who encounter rental or property tax increases or home repair expenses).

9. *Action on Health*

The government documents from 1993 and 1996 heavily focus on cost saving (often cost shifting even though this is not acknowledged as such). In 1997, the government began to focus on discussion of re-investment in *Action on Health: Access, Quality, Stability* (Alberta Health, 1997). In this document, it was argued that the cuts of 1993 to 1996 were necessary because "costs were spiralling out of control" (p. 13). The document went on to indicate that because the government had taken action on the deficit and debt repayment, it was now possible to address problem areas (e.g., waiting lists) and put in place a stable, predictable funding base for health. The assertion is questionable as total Alberta public sector health care expenditures per capita in 1999 dollars increased by just under $107 (from $1,738 to $1,845) between 1990 and 1993 (i.e., the four years preceding the start of major restructuring efforts), compared to a much larger average increase for Canada as a whole (almost $176 per capita).[6] As well, the rate of increases in per capita expenditures was much less from 1990-93 than in the previous four year period of 1986 through 1989—when per capita costs increased by $171 (from $1,489 to $1,660). Thus, the rate of public cost increases was declining prior to the major restructuring of the mid-1990's (Canadian Institute for Health Information, 1999).

The *Action on Health* document also reiterates a commitment to public sector control of the health care system and coverage of medically-necessary services without user fees, extra billing or other barriers. Waiting lists were a concern for both specialized province-wide services and services at the regional level. One of the commitments to address waiting lists was to hire front-line health care staff. In addition, it was acknowledged that "there's a lot of pressure on families when home care isn't available," and that long-term care in rural areas was not always available close to the homes of other family members. There was a commitment in the document to hiring staff in community as well as acute care settings, and implementing strategies (unspecified) to ensure seniors can get long-term care in locations close to their homes and families.

There was little specific mention of gender in this document, except for performance measures pertaining to female-specific diseases (i.e., breast cancer screening rates and cervical cancer deaths), low birth weight newborns, and the population funding formula which would account for age, gender and socioeconomic status. Health education for parents of young children was also mentioned, which is most likely to reach mothers.

The focus on re-investing funds in health care had the potential to benefit women, as they make up the majority of health care workers and informal caregivers. The question is: to what extent did the proposals of *Action on Health* actually happen?

According to Alberta Health's (1999a) web site section on health care providers, a additional $22 million was added in 1996-97 and $43 million in 1997-98 to hire more nurses and other front line staff—leading to a total increase of 1,401 full-time equivalent positions. According to the Canadian Institute for Health Information (CIHI, 1999), the number of registered nurses employed in nursing in Alberta rose from 20,751 in 1996 to 21,428 in 1997. There was an increase in both full-time and part-time positions, and in the number of nurses per 100,000 population (from 751 to 763). During any given year, women form ap-

[6] Per capita expenditures around rounded to the nearest whole dollar

proximately 97% of the registered nursing workforce in Alberta (AARN, 1997, 1996, 1995).

As well, total public sector health expenditure per capita in Alberta increased from $1,674 to $1,791 between 1996 and 1997 (CIHI, 1999). After percentage decreases of 6.5% and 5.8% in 1994 and 1995, there was a 3% increase in spending by the end of 1996, and a further 7% increase by the end of 1997. After being considerably below the national average (by $100 dollars are more) from 1994-96, 1997 expenditures brought Alberta close to the national average again. CIHI presented further projected public expenditure increases for 1998 and 1999 (to $1,982 for 1999), but actual numbers are not yet available.

Thus, there has been some re-investment in Alberta's health care system. Health care workers, however, have questioned whether it has been adequate. For example, the United Nurses of Alberta's contract bargaining of 1999 addressed not only wage and salary issues, but also workload, overtime requirements, weekend and shift work, and parity of facility and community-based nurses. Documents from the UNA suggested that managers had unrealistic expectations and did not recognize the stressful working conditions of nurses, particularly workloads which were seen as tied to ongoing inadequate staffing levels. Despite averting a potential strike and winning wage increases and some improvements in working conditions, the union's concerns about staffing and workload remain (UNA, 1999). This re-investment focus continues with the 2000/01 budget, particularly for the hiring of more nurses (Alberta Treasury, 2000b). It is too early to determine the extent to which this will benefit providers and users of the health care system.

The Provincial Health Council of Alberta[7] (1997a) also expressed concerns about strain on health care providers:

> Many individual service providers have been profoundly affected by job loss, fear of job loss and job change. Staff resignations and reassignments have, in some cases, led to frequent changes in personnel. This creates difficulties in maintaining standards of care. Staff are sometimes performing unfamiliar roles without the support that was available before restructuring. We have been told that many providers feel uncertain, devalued and highly stressed. Many of these feelings are brought on by frustration resulting from loss of control or any sense of participation in decision-making (p. 11).

The Council expressed concern that low morale and job satisfaction among providers in turn affects the availability and quality of care through absenteeism, long-term disability leaves, turnover, recruitment difficulties, and low levels of trust that can lead to resistance to change and lack of concern for patients and colleagues. The Council also acknowledged, however, that in some cases staff reductions have led staff to collaborate in new ways.

10. *The Health Statutes Amendment Act*

Bill 37 (*The Health Statutes Amendment Act*) of 1998 was the first attempt by the government to

[7]The Provincial Health Council was established by the Minister of Health in 1995 to monitor and report to the legislature the progress of health reform in Alberta. It was disbanded in 1998. There is a new Premier's Advisory Council on Health in the planning stages. It will be chaired by former Deputy Prime Minister Don Mazankowski (presently chair of the Institute of Health Economics) and will advise the premier and the government on health system sustainability (Alberta Health and Wellness, 2000b).

regulate the provision of surgical services provided outside of public hospitals. Much of the Bill addresses accreditation of facilities and qualifications of practitioners, as well as information required by the Minister to make decisions about the use of surgical facilities. The use of the term "non-hospital surgical facility" (defined as a "facility at which insured services, together with related facility services, are provided"), was open-ended enough that it was difficult to see how it would prevent the mixing of insured and uninsured services within a facility and thus, the charging of fees for services that might normally be covered.

A panel commissioned by Alberta Health to review Bill 37 concluded that the Bill and its amendment were complex pieces of legislation that could be easily "misconstrued." The panel members recommended that:

- a patient should be able to insure against the residential component cost of care where that cost may be legitimately charged in a hospital, auxiliary hospital, or nursing home;
- the distinction between hospital and non-hospital procedures should be based on the principle of required recovery time (i.e., the safe discharge of the patient within 12 hours of completion of the surgical procedure);
- specified surgical procedures that comply with the 12-hour safe discharge recommendation (cited in Appendix C of Alberta Health, 1999b) may be provided in an "approved hospital or a non-hospital surgical facility" and those that are not listed or do not comply must be provided in an approved hospital;
- a temporary measure be implemented to provide the Minister with the legislative power and the responsibility for the regulation of approved hospital facilities providing both uninsured or insured services within the Alberta Health care system; and
- the legislation be replaced with amendments to three separate acts (i.e., *The Alberta Health Care Insurance Act, The Hospitals Act* and *The Medical Profession Act* (Alberta Health, 1999b).

The government eventually withdrew this bill in the face of strong opposition (Taft and Steward, 2000).

11. Health Summit '99

The Provincial Health Council reports released in 1997 had expressed concern about the strains that had been created in the health system (Provincial Health Council of Alberta, 1997a, b). The reports indicated that, while some elements of the system had been reorganized, health reform had not taken place. Following the release of these reports, Halvar Jonson, the Minister of Health, announced Health Summit '99. The Summit was touted as an opportunity for Albertans to assist in the development of strategies on important directions for the future of Alberta's health system.

Two hundred participants were invited to Calgary on February 25-27, 1999 to debate four questions and to strategize the future of the health system. The participants included approximately 100 representatives of people working in the health system, as well as approximately 100 randomly selected members of the public. The four questions that were debated were:

- What is essential in Alberta's health system?
- What changes should be made in how health services are delivered and managed?
- What responsibility do individuals have for their own health?
- How much money is enough to sustain our publicly funded health system? (Alberta Health, 1999c, p. 4)

Prior to answering the first question, participants discussed the principles and values that they wanted to guide Alberta's health system. Several

of the principles strongly reaffirm the principles of the *Canada Health Act* with particular emphasis on public funding and administration and equality of access. The participants chose not to identify specific components of the system that are essential or non-essential. The general conclusion was that "priorities cannot be placed on essential components: all components are important to different people at different times" (Alberta Health, 1999c, p. 20). There was general agreement on the need to expand primary health care and prevention and promotion strategies. In the final report from the Summit, it is indicated that participants were also clear in their view that responsibility for health is more than an individual responsibility. It is a responsibility shared among "individuals, families, the health system, communities, different levels of government, and other sectors outside the health system" (Alberta Health, 1999c, p. 26). There was no consensus among the participants on the appropriate level of funding for Alberta's health system. "People need to come to a consensus on what an appropriate system is for the province before decisions can be made about how much funding is needed" (Alberta Health, 1999c, p. 30).

12. Health Information Systems: *The Health Information Act*

In 1997-98 the government of Alberta began to lay the groundwork for a new health information network called "alberta we//net." Part of this groundwork included the initiation of legislation that would balance protecting the privacy of health information and sharing information to improve health and the health system. *The Health Information and Protection Act* (Bill 30)was first introduced in the Spring of 1997. The Alberta Medical Association (AMA, 1998) issued a position statement summarizing a number of concerns with the proposed Act. While the AMA conceded that the use of health information could advance the public good, the Association had some concerns regarding the logistics of managing the information. The specific concerns included:

- violation of the patient-doctor relationship;
- failure to protect personal identifiable health information; and
- a profound operational and financial impacts for physicians.

In the face of strong public opposition which primarily centred around the lack of control that individuals would have over the release of personal health information, the government withdrew the Bill. After further revisions, the Bill was again introduced to the legislature in November 1999, this time as *The Health Information Act* (Bill 40) The change in the name of the legislation is of note. Although there is a stated commitment to the protection of personal privacy within the summary documents, the conditions under which information could be accessed without consent may be broadly interpreted. For example, the "custodian" may access information without an individual's consent to determine if someone is eligible to receive a health service (i.e., to see if they are registered for Alberta Health Care Insurance or other benefits, Alberta Health and Wellness, 1999). There was heated debate in the legislature about the openness of the proposed legislation. The Official Opposition proposed a number of amendments to the Bill which would increase the level of control over personal health information and ensure that the legislation cover private as well as public health care providers (Alberta *Hansard*, December 7, 1999). The government closed debate on this Bill and it was passed in the legislature on December 8.On December 8, a question posed in the legislature by the Liberal labour critic highlighted some of the concerns about this Bill:

> As contractors with health information custodians, will private hospitals have access to the government's health information database so they can screen patients and avoid the cash flow uncertainty that comes from treating high risk and high cost patients? (Alberta Hansard, December 8, 1999)

The potential for private funders and providers to

screen out people who are at higher risk would differentially impact people who earn low incomes (e.g., women, people who are disabled).

13. Bill 11: *The Health Care Protection Act*

With *The Health Information Act* in place, the Alberta Government proceeded to introduce Bill 11, *The Health Care Protection Act*. The introduction of this legislation has sparked substantial federal and provincial debate. We will analyse the Bill in the context of that discourse focussing on the background leading to the proposed Bill and its implications.

In late 1995, the federal government began to withhold transfer payments to penalize Alberta for allowing private clinics to charge facility fees to people receiving medically insured services. In 1996, while attempting to resolve this issue, the federal and Alberta provincial health ministers agreed to 12 principles (see Appendix B) outlining the Alberta approach to health care management (Alberta Health and Wellness, 2000a).[8] These principles had originally been drafted in Alberta through consultations between Alberta Health and the Alberta Medical Association. Seven of the principles specifically discuss issues related to private purchase and provision of health services, but it is principle 11 that is perceived to have put in place much of the groundwork for the introduction of Bill 11. This principle, as stated originally, recognized that "physicians can receive payment from both the publicly funded system and fully private systems" (Alberta Health and Wellness, 2000b). In the Federal/Provincial Working Agreement on the principles, it was stated that:

> The same physician can practice in both the public and private system if he/she is offering insured services which are fully paid for by the public system and non-insured services which are paid for privately. All medically necessary services are insured services. A service is non-insured when deemed to be not medically necessary in that it does not meet a Clinical Practice Guideline (CPG) which would include criteria of medical condition, appropriate timeframe, etc., or is otherwise determined to be not medically necessary through a medical decision.... (Quoted in Armstrong, 2000)

Armstrong (2000) raises the concern that a physician has some flexibility to decide on medical necessity for a particular patient, and that he/she could make more money by deciding the procedure is not medically-necessary. Women's history with the health system has been characterized by bad experiences, ranging from misogyny to paternalism. Only through concerted activism, including fighting for the right to become physicians, have women succeeded in making the health system more appropriate (Strong-Boag, 1994). Many women, however, do not fully trust male physicians (Webb and Opdahl, 1996); therefore, why would women as a population want the medical profession to decide what was medically-necessary?

Health economist Robert Evans of the University of British Columbia has pointed out that privatizing health services has the effect of redistributing income from the less to the more healthy and wealthy (Evans, 1997). Evans also points out that a shift to more private sources of payment will be regressive for those on low incomes, using the example that insurance premiums are not linked to income. This is an issue in Alberta even within the public system, as Alberta is one of only two provinces that charge Medicare premiums. These redistributive and regressive effects again

[8] After several attempts, we were able to obtain an original copy of these principles from Alberta Health and Wellness. It was indicated that it was just by chance that someone had kept a copy. We sincerely appreciate the cooperation of the staff person who shared this public information with us.

hit women hardest as a group, as women on average earn less then men. Also, Armstrong and Armstrong (1996) point out that women are more likely than men to be in part-time work, and that the recent gains in self-employment have been more pronounced for women. These types of work are less likely to have employer-paid premiums for either Medicare or private insurance. If the continuing development of private health care facilities in Alberta leads to de-insuring of more services or failure to insure new types of treatments, women will be particularly impacted. On April 4, 2000, in a publicly televised discussion of Bill 11 in the Alberta legislature, the Premier indicated that the intent of the Bill was to protect the public health system and to create an additional tool to deal with waiting lists. The ability of the Bill to adequately address either of these issues has been questioned (CUPE, 2000; Barer, Evans, Lewis, Rachlis, and Stoddart, 2000; Rachlis, 2000; Wilson, 2000b).

The title of the Bill is *The Health Care Protection Act*; however, the primary focus of the proposed legislation is on practices related to acute care (i.e., care provided in public hospitals and approved surgical facilities). A departure from this focus is found in Part 4 of the Bill where it addresses the formation of the Premier's Advisory Council on Health. This Council would consist of "persons appointed under the regulations"(Alberta Health and Wellness, 2000b, p. 14). The regulations have yet to be defined. The mandate of the Council would be "to provide advice to the Premier on the preservation and future enhancement of quality health services for Albertans and on the continuing sustainability of the publicly funded and publicly administered health system" (p. 14). It should be noted that this does not state that the Council will provide advice on the preservation and future enhancement of the public health system.

The preamble to the proposed legislation affirms the commitment of the Government of Alberta to a publicly funded and publicly administered health system and to the principles of the *Canada Health Act*. However, the section of the Bill that deals with the designation of surgical facilities includes a clause that would permit the Minister to consider "any other factors the Minister considers appropriate" (Alberta Health, 2000b, p. 9). These "other factors," left to ministerial discretion, could override concern for whether the provision of such services would have an "adverse impact on the publicly funded and publicly administered health system or impair the government's ability to comply with the *Canada Health Act*" (Alberta Health, 2000b, p. 9). In a legal opinion obtained by the Canadian Union of Public Employees (CUPE, 2000) the law firm of Arvay Finlay states that "the Bill's provisions violate *Canada Health Act* requirements dealing with universality, accessibility and comprehensiveness and may threaten the public administration requirement" (p. 1). In addition, it is stated in the Bill that "no decision made by the Minister in the exercise or purported exercise of power... under this Act may be questioned or reviewed in any court" (Alberta Health, 2000b, p. 11)**.** The level of ministerial control and the exemption of the Minister from legal questioning has also been raised as a concern in public discussions regarding this Bill.

The opening section of the Bill states that "no person shall operate a private hospital in Alberta" (Alberta Health, 2000b, p. 3) and that surgical services may only be provided in public hospitals or approved surgical facilities. "Approved surgical facilities" are distinguished from public and private hospitals by stipulating that the primary function of such facilities is to provide a limited range of surgical services. It is also stated that major surgical services can only be provided in public hospitals (p. 3). The distinction between what is major and what is not major surgery has not been clearly defined. Although Bill 11 gives the College of Physicians and Surgeons the authority to decide which procedures can be

safely provided in surgical facilities, some parameters for such decision are provided in the Bill. For example, "uninsured in-patient surgical" services may be provided in such facilities and are defined as services that require "a medically supervised post-operative period of care exceeding 12 hours" (p. 18).

By indicating that approved surgical facilities may provide uninsured surgeries that require overnight stays, there is an unclear distinction between major and "not major" surgery. Dr. Tom Noseworthy, former head of the Royal Alexandra Hospital in Edmonton and present Chair of Public Health Sciences at the University of Alberta, points out that minor procedures are now done primarily as day surgery and people are not admitted to hospital overnight unless their surgery is major (Pederson, 2000a). Noseworthy generally favours a role for private service delivery with public financing (as currently exists), and yet he raises concerns about extending private delivery to include surgical facilities with overnight stays, noting that such clinics would no longer be doing minor surgery.

There is also some question about whether the private health care facilities reduce waiting lists. Noseworthy (1999) pointed out in his address to the 1999 Health Summit that in Britain, waiting lists in the public National Health Service are longest for conditions that are the "bread and butter" of private hospitals. Noseworthy also spoke of his experience in the late 1980s working in intensive care units in Australia to link the issues of waiting lists to the ability of physicians to work in both the public and private systems:

> It seemed as if physicians attempted to finish rounds as early as possible in the morning, so that they could go to the private hospitals where they would spend the balance of the day and, or course, garner the majority of their income. The private system was very well capitalized. There was no question about the fact that physicians created different streams of patients and allowed those less able to pay to stack up in a public line, while they rapidly serviced those that had cash on the barrel head. The myth propagated is that a private parallel system helps the waiting lists in the public system. The truth suggests otherwise (p. 9).

Others have also noted that "waiting lists exist because too few resources have been directed toward quality control and resource management" (Davies, 1999, p. 1470).

Although Bill 11 states that it will allow neither direct billing for medically-necessary service nor "queue- jumping," private clinics will be able to bill for uninsured extra services. Thus, there still appear to be incentives for physicians practising in both public hospitals and private clinics to direct people to the private side. Unless doctors are prohibited from working in both systems (the key principles developed in 1995/96 encourage physicians to work in both systems), or conflict of interest guidelines are introduced to forbid physicians from referring patients to clinics in which the physician has a vested interest. A study of cataract surgery in Alberta (Armstrong, 2000) found that not only were private surgical contractors more costly to the provincial public health care plan, but also that patients were being offered enhanced uninsured services that in some cases also reduced their wait time for service. Waiting lists for publicly insured operations were longer for surgeons operating in both the public and private systems than for those operating in the public system alone. Also, the enhanced "soft" or "foldable" lens option was more expensive ($250 to $750 per eye) in Calgary where all publicly insured cataract surgeries are contracted out by the Regional Health Authority to private clinics, than in Edmonton ($250-$425 per eye) where only 20% are contracted out. In Lethbridge, where all cataract surgeries are done in the public system, the enhanced product is provided at no charge (and costs the health region

less than $100 per eye). While there are some limitations of this report, it raises issues that must be addressed, the potential for conflict of interest and the need for regulation of such conflicts.

Under Bill 11, approved surgical facilities will be able to provide insured surgical services under contract to a Regional Health Authority. Given the need to generate profits for shareholders, it is questionable whether such private facilities would be willing to share in the costs associated with negotiating, implementing and monitoring contracts with Regional Health Authorities (Wilson, 2000b). In fact, Bill 11 specifically states that the money for contracts will come out of the RHA budgets (Alberta Health and Wellness, 2000b, p. 7). Money that is required for such contracting services will not be available for direct service provision. It is equally unlikely that it will be a priority for such facilities to assume responsibility for linking patients to services provided through the public health system (i.e., home care, diagnostic and intensive care services). This implies that patients who require assistance during or following surgery will have to acquire such services themselves. These implications have obvious consequences for caregiving responsibilities of family members, primarily women.

Even within the public system, designating sites for different levels of acuity (i.e., major or minor) has proven complicated. For example, during the early stages of regionalization, the Capital Health Authority attempted to divide surgical care into high and low acuity settings; concentrating high acuity procedures in two hospitals and designating other hospitals (which had been downsized to "community health centres") for day surgery and low acuity in-patient surgery (Hamilton, Letourneau, Pekeles, Voaklander, and Johnston, 1997). The intent was to develop specializations for various sites in the hope of finding efficiencies to deal with funding cuts that accompanied regionalization. In studying the impact of this system on physicians, Hamilton *et al*.(1997) found a 3.5-fold increase in the number of surgeons working in more than one site after this restructuring compared to before. They note that most surgeons do both high and low acuity surgeries, thus were working in two sites on a regular basis, with increased reliance on surgical house staff (with whom they spend less time and are thus less familiar with the limits of their skills), interference with continuity of care, increased commuting time for both surgeons and medical residents, and less contact between surgeons and residents.

The Capital Health study focussed on providers rather than health outcomes, and has some limitations in terms of being retrospective and not having consistently comparable data from before to after regionalization. There was no change in inpatient mortality for surgical inpatients during the short timeframe of the study (1995-96). Capital Health has since abandoned this system of high and low acuity hospitals. We mention it here because some of the same problems could arise if surgeons are doing both high acuity surgeries in public hospitals and lower acuity surgeries in private clinics. As private clinics are not an integral part of the public system, there would likely be even more discontinuity when surgeons practice on multiple sites.

This Bill has also raised concerns about de-insurance of more services that could then be picked up as uninsured user-pay procedures, or further privatization of public services. An existing example of privatization of public services in Calgary is the transfer of the Grace Hospital (which focussed on women's health)[9] to the private sector. This previously public facility now houses the Health Resources Group (HRG),

[9]The Grace has since been relocated to the Foothills Hospital site and renamed the Grace Women's Health Centre.

a private clinic that is particularly interested in contracting with the Regional Health Authority for overnight stays (Taft and Steward, 2000).

A recent study of hospital utilization patterns in Alberta found that reductions in both hospital separation rates (i.e., cases admitted to hospital and average lengths of stay) led to a 40% decrease in Alberta's age-sex standardized hospital days rate between 1991-92 and 1996-97 (Saunders, Bay and Ahbhai, 1998). The results of the study also indicate that the reduction of the hospital days rate slowed down in 1996-97 because average lengths of stay increased even though the separation rate continued to decline. The researchers noted that average case-intensity increased over that time period, "suggesting that sicker, more resource-intensive patients were admitted to hospitals"(p. 15). The researchers also pointed out that hospital utilization was already on a downward trend in the five years prior to 1991-92 (a 26% drop in the standardized days rate) and that health reform and associated funding reductions accelerated the trend. There have been concerns raised about the impacts on women of short hospital stays and the shift from acute care institution to community care. There is no indication (and some doubt) that these concerns will be addressed in the shift toward private facilities (i.e., that private clinics would allow, at no charge, longer stays than public hospitals).

Concerns have also been raised about the implications of Bill 11 for the NAFTA. Rachlis (2000) states that under this agreement, "health care is protected only to the extent that it is considered a social service carried out for the public good" (p. 5). If the Bill is passed, health care may be treated as any other sector of the economy that is not "explicitly and exclusively reserved for public action" (Barer et al., 2000, p. 3). That is, health care in Canada may be open to global competition and, once it occurs, may be irreversible. It has been argued that private for-profit hospitals already exist in Canada (e.g., the Shouldice Clinic in Ontario) and therefore the NAFTA has already been tested and proven innocuous with respect to health care. These arguments do not acknowledge that the Shouldice Clinic and other small facilities existed before the *Medical Care Insurance Act* (1966) and were grandfathered into private hospital legislation. New, for-profit facilities have not been licensed in Ontario, for example, since 1973 (Rachlis, 2000).

For-profit institutions primarily operate on an incentive for profit rather than a concern for public benefits. In Canada, a motivation for profit is an accepted element in many sectors of the economy, but control of the profit motive has been a force behind much of the federal health care legislation since the early1960s. To ensure that profits are made and shareholders benefit, private for-profit facilities attempt to reduce costs where possible. Potential sources of cost savings include reduced labour costs and increased costs for the purchaser (i.e., individual citizens or Regional Health Authorities). Barer *et al*. (2000) suggest that reduced labour costs may be accrued by either reducing the numbers of staff or shifting services from union to non-union environments in which case there is no improvement in efficiency. In their critique of Bill 11, Barer *et al*. (2000) state that private payment shifts costs of care disproportionately to those with lower incomes. In Alberta, we know that the majority of people living on low incomes are women (CSWAC, 1999).

In the face of opposition to Bill 11, the Premier announced on February 10 that he was sending out "truth squads" to counter "the malicious misinformation being circulated about the government's private health care plans"(Johnsrude, 2000a). The government planned to hold Roundtables across Alberta to inform people of the intent of Bill 11. In this article, Premier Klein distinguished this approach from town hall

meetings "where people can get up and yell and shout and so on." This again underscores the Alberta Government's negativity toward those who oppose its views. Though the focus on the "truth squads" has been retracted, the government continues to refer to opponents as misinformed, as seen in a recent televised debate on the Bill.

In early April 2000, the government began discussing amendments to the Bill, including tightening procedures to prevent "queue-jumping" and addressing conflict of interest (Geddes, 2000). Shortly thereafter, the federal minister of health suggested more substantive amendments, including restrictions on insured and uninsured services being offered by the same providers and banning overnight stays (Pederson, 2000). On April 11, 2000 Premiers Ralph Klein's government announced that it would introduce a motion to block any further amendments and force a vote on second reading of the Bill as early as that night (Johnsrude, 2000b).

14. Community-based Care and Home Care

In 1997, Casebeer, Scott and Hannah explored strategies for shifting service delivery patterns towards increased community-based care in one Regional Health Authority in Alberta. At the time of the study, regionalization had been in place for two years and it was clear that the management team in the region was still some distance from defining what community-based care was to be. In some instances, key informants described the shift as a change in the location of service delivery without acknowledging that need for a change in the way services are provided. There was also a lack of agreement among the study participants regarding the role of volunteers in providing community-based care. Some saw it as an opportunity to "mobilize the community for voluntarism"(Casebeer, *et al*., in press) while others acknowledged that it could not be expected that such services would be provided on a voluntary basis. As already noted in *The Rainbow Report*, in 1989, 6 of 10 volunteers in Alberta were women. The suggestion that community-based care may be equated with increased reliance on voluntarism thus has direct implications for women.

The Provincial Health Council of Alberta (1997a) indicated that despite the government's indications that there had been more funding for community and home-based services, the Council had no details on how the funding was being used and whether (a) Albertans have undergone personal expense and effort to supplement services that support early discharge from hospital, or (b) demands to support early discharge have adversely affected other community services that help people with chronic conditions. The Council (1997a) concludes:

> The whole issue of the consequences of "off-loading" costs by removing them from publicly funded health services and making them the responsibility of individual Albertans or other areas of the community needs to be rigorously examined and weighed in the balance to properly assess the benefits of reform (p. 15).

Even though the Council recognized off-loading and its potential negative impacts, it did not acknowledge that women bear a disproportionate share of informal caregiving. In a section of the report entitled "Developing capacities in families and personal networks contributes to health reform" the Council cited the 1996 survey results that 40% of respondents who provide health care support to a family member found it to be a minor inconvenience and 16% found it a major disruption. The Council proposed that "additional education and training, or improved availability of respite care might assist Albertans in providing support without undue strain" (Provincial Health Council, 1997a, p. 23) Thus, the Council took

family caregiving as a given, rather than questioning it. As the Council was a ministerially-appointed body, it did not have a mandate to go beyond monitoring and reporting on reforms as defined and implemented by the government. Within that mandate, it did provide a more critical analysis than other bodies within government.

More recent studies have demonstrated that a substantial percentage of adult Albertans are providing health care support to a family member. A provincial survey, commissioned by Alberta Health and Wellness and conducted by the University of Alberta Population Research Laboratory, found that 44% of females and 32% of males provided such support in 1999 (Northcott and Northcott, 1999). Of those providing support, 44% said it was a minor inconvenience and 12% said it was a major disruption of their normal activities. Women were more likely than men to say that providing support was a major disruption. The survey did not assess amount or level of support provided, so we are unable to examine hours and types of work by gender which might explain gender differences in perceptions of inconvenience. Other researchers (Armstrong and Armstrong, 1996), however, have pointed out that in most cases women take on a greater proportion of caregiving tasks than men. In comparison with 1996 survey statistics using the same questions and methods (cited in Provincial Health Council of Alberta, 1997a), there is a slightly lower percentage of respondents saying provision of support is a major inconvenience (12% in 1999 compared to 16% in 1996). A slightly higher percentage viewed provision of support as a minor inconvenience (44% in 1999 versus 40% in 1999). Thus, we are not seeing substantial shifts in the public's perception of their involvement in providing health care support to family members, despite re-investments in health care from 1996-97 onward.

Noseworthy (1999) expressed similar concerns to the Health Summit '99 about how an increasing portion of the costs of providing community--based care falls to patients and their informal caregivers, but he did not acknowledge the gendered nature of caregiving. Noseworthy was a member of the National Forum on Health, which recommended a publicly-funded national home care program. (National Forum on Health, 1997).

By examining Alberta Health annual reports between 1996-1999, Wilson (2000a) illustrates that, despite a commitment to increasing support for home care and community health, the proportion of health system funds devoted to these areas has remained relatively constant (4.7% in 1996-97, 4.9% in 1997-98, 5. 1 % in 1998-99). At the same time, hospital downsizing resulted in the removal of approximately one half of all inpatient acute care beds across Alberta (i.e., from 12,000 beds to 6,260 beds in 1998/99) (Wilson, 2000a). Wilson notes that a consequence of hospital downsizing has been the "shift of caregiving and cost of care to the family" (Wilson, 2000a, p. 4). Morris *et al*. (1999) cite statistics from the Canadian Home Care Association noting that in the early days of health restructuring in Alberta, the government cut $749 million from acute care but added only $110 million to home care over three years.

There is also the issue of out-of-pocket costs. For example, Morris *et al*. (1999) expressed concern about home care recipients and their informal caregivers picking up costs (e.g., meals, drugs, medical devices) that would be covered if the recipient was in a hospital. The limited hours and services for which recipients are eligible also lead to them having to pay fees for services beyond that level. This may be reflected in the upward trend in private coverage in Alberta which, in other provinces.

Another area where provider strain is reported as high is among paid home care staff. For example, Morris *et al*. (1999) found low wages, irregular hours, inadequate training and high turnover among workers (mostly women). Workers observed that these conditions resulted in lack of continuity of care, staff shortages, waiting lists, health risks to both workers and recipients and impoverishment. Some home care workers reported working several jobs to make ends meet, and others were living below the poverty line. Morris *et al*.(1999) also discuss "deprofessionalization" of home care work, isolation of workers, lack of adequate training, exposure to violence or harassment, and the absence of professional associations or unions (which has had a negative impact on wages). They found some examples of home care workers, as well as family members, picking up out-of-pocket costs (e.g., equipment, meals, drugs) for low-income clients; costs that would be covered in hospital. Morris *et al*. (1999) point out that as there is more competition between for-profit and not-for-profit providers (e.g., VON) there is likely to be continued downward pressure on wages and that for-profit providers will not reinvestment money back into service provision.

Representatives of provincial health ministers have already indicated that they prefer to have transfer payments restored to use as they wish in their existing health care systems, rather than participating in expanded home care and community care, which they call "boutique programs" (Mackie and Sequin, 2000). Given the government's record of expecting women to put their families first and volunteer their unpaid labour as public services are cut back, it is unlikely that Alberta would use extra funds to design the type of home care program that would not rely to a large extent to the unpaid work or underpaid of women.

PART 3 CONCLUSIONS

The current Conservative government holds 64 of 83 seats in the provincial legislature, with the opposition Liberals and New Democrats holding 16 seats and one seat respectively. Through participation in public forums and town hall meetings focussed on health care restructuring, Albertans have added their voices to those of their elected officials; however, legislative and public opposition to the current privatization policy agenda has done little to alter the course or the pace of change. Despite the level of public discourse regarding the current legislation, there has been little public discussion of the gendered impacts of the move toward privatization.

We have demonstrated that there has been a long-standing commitment in Alberta to increasing the role of the private sector in health care. While we recognize that the private sector is currently and will continue to be an integral part of the health system, we advise caution. In this report, we conducted gender-based analysis of key health policy events that took place in Alberta between 1989 and 2000. This analysis highlights the serious implications that increased health care privatization will have for women (such as lower wages, less secure jobs, out-of-pocket costs, informal caregiving obligations). Before current legislation is passed, and before any further legislation is introduced, the implications for all citizens, most particularly for women, must be comprehensively and systematically examined using strategies for meaningful public participation in decision-making.

> If we are to preserve the environment on a sustainable basis, achieve gender equality, take into account the legitimate claims to identity of certain minorities within existing democratic states, and foster the development of cultural options beyond commodification, we require an activist democratic state. (Broadbent, 1999, p. 92)

Appendix A
Chronology of Alberta Premiers

Alexander Rutherford	Liberal	1905-1910
Arthur Sifton	Liberal	1910-1917
Charles Stewart	Liberal	1917-1921
Herbert Greenfield	United Farmers of Alberta	1921-1925
John Brownlee	United Farmers of Alberta	1925-1934
Richard Reid	United Farmers of Alberta	1934-1935
William Aberhart	Social Credit	1935-1943
Ernest Manning	Social Credit	1943-1968
Harry Strom	Social Credit	1968-1971
Peter Lougheed	Conservative	1971-1985
Don Getty	Conservative	1985-1992
Ralph Klein	Conservative	1992-

Source: Marsh, J. (Ed.) (2000), *Canadian Encyclopaedia—Year 2000 Edition.* Toronto, ON: McLellan and Stewart.

Appendix B
Public/Private Health Services: The Alberta Approach

KEY PRINCIPLES

- ensure reasonable access to a full range of appropriate, universal, insured health services, without charge at the point of service.
- Alberta retains the authority and responsibility to manage the publicly funded health care system in the province.
- recognize the demands from both the public and health professions for an approach to health services that is consistent with long term sustainability and quality.
- ensure a strong role for the private sector in health care, both within and outside the publicly funded system.
- public and private sector should work together to provide patient choice, quality of service, and effective outcomes as the first priority.
- Regional Health Authorities assess health needs in their regions and be funded to provide appropriate health services in accordance with the health needs assessment.
- consumers have the right to voluntarily purchase health services outside assessed need.
- maintain the restrictions on the role of private insurance, while introducing measures to expand the opportunities for the private sector to deliver services within the single-payer envelope.
- private clinics should have the option of becoming completely private (patient pays), or allowing them to enter into a variety of funding arrangements with the public sector to cover the full costs of insured services.
- there is a place for medical training in both public and private settings, however, care must be taken to ensure there is no deterioration in the world class training physicians currently have.
- recognize that physicians can receive payment from both the publicly funded system and fully private sources.
- province must at all times be able to demonstrate “reasonable access” to insured health services with no fee at point of service, or penalties would apply. An understanding is necessary on the mechanisms to determine and measure “reasonable access.”

Source: Communications Branch, Alberta Health and Wellness (2000).

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