

# The Politics of Women's Health Equity

## Through the Looking Glass

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*Following the health services reforms of the mid-1990s in Toronto, hospital-based women's health services were being practiced in ways that reversed, and at times, circumvented the advancement of many ideals of the women's health movement despite a public discourse which reinforced the movement's vision. Starting in the 1960s across Canada, the women's health movement had challenged the bio-medical model, criticized the health system's gender inequity, and proposed an alternate philosophy that articulated more empowerment of women as patients and providers and attention to the social determinants of health. By the early 1990s, the movement had been instrumental in creating new models of holistic service delivery and in expanding the number of women practicing medicine. In 2007, following the reforms, women's health was increasingly practiced as an obverse of the movement's philosophy. This reversal resulted in challenges to the health equity of women as health care workers and as patients. This article exposes the contradictions between the movement's philosophy, neoliberal policy direction and the resulting contradictions in women's health service delivery, funding and administration.*

*Suite aux réformes des services de santé dans les années 90 à Toronto, les*

*services de santé pour les femmes dans les hôpitaux ont quelquefois subi des bouleversements et les avancées de plusieurs idéaux issus du mouvement pour la santé des femmes ont été escamotées en dépit des discours publics qui en renforçaient la vision. Dans les années 60 à travers le Canada, le mouvement pour la santé des femmes a défié le modèle bio-médical, critiqué l'inégalité des sexes dans le système de santé et proposé une philosophie alternative qui donnait plus de pouvoir aux femmes comme patientes et portait davantage sur les déterminants sociaux de la santé. Au début des années '90, le mouvement a créé de nouveaux modèles de services holistiques et a augmenté le nombre de femmes dans les facultés de médecine. En 2007, suite aux réformes, la santé des femmes était perçue de plus en plus en opposition avec les philosophies féministes. Ce revirement a accentué les iniquités chez les patientes et les soignantes et cet article montre que les contradictions entre les philosophies du mouvement, et la direction des politiques néolibérales affectent les services de santé des femmes, leur financement et leur gestion.*

"I declare it's marked out just like a large chessboard!" Alice said at last. "There ought to be some men moving about somewhere—and so there are!" She

added in a tone of delight, and her heart began to beat quick with excitement as she went on. "It's a great huge game of chess that's being played—all over the world—if this is the world at all, you know. Oh, what fun it is! How I wish I was one of them! I wouldn't mind being a Pawn, if only I might join—though of course I should like to be a Queen, best."

—Louis Carroll, 1871  
(Chapter 2, para. 61)

The looking glass<sup>1</sup> is the mirror that Alice stepped through to gain entry to an imaginary world where everything was the backward reflection of the real world. It is an apt metaphor for the contradictions that surfaced following the health services reforms of the mid-1990s in Toronto, where hospital-based women's health services were being practiced in ways that reversed, and at times, circumvented the advancement of many ideals of the women's health movement despite a public discourse which reinforced the movement's vision. Funded programs were increasingly governed by neoliberal policy paradigms and by medical models of care. Funded health interventions premised on individual responsibility, lifestyle and behavioural modifications were

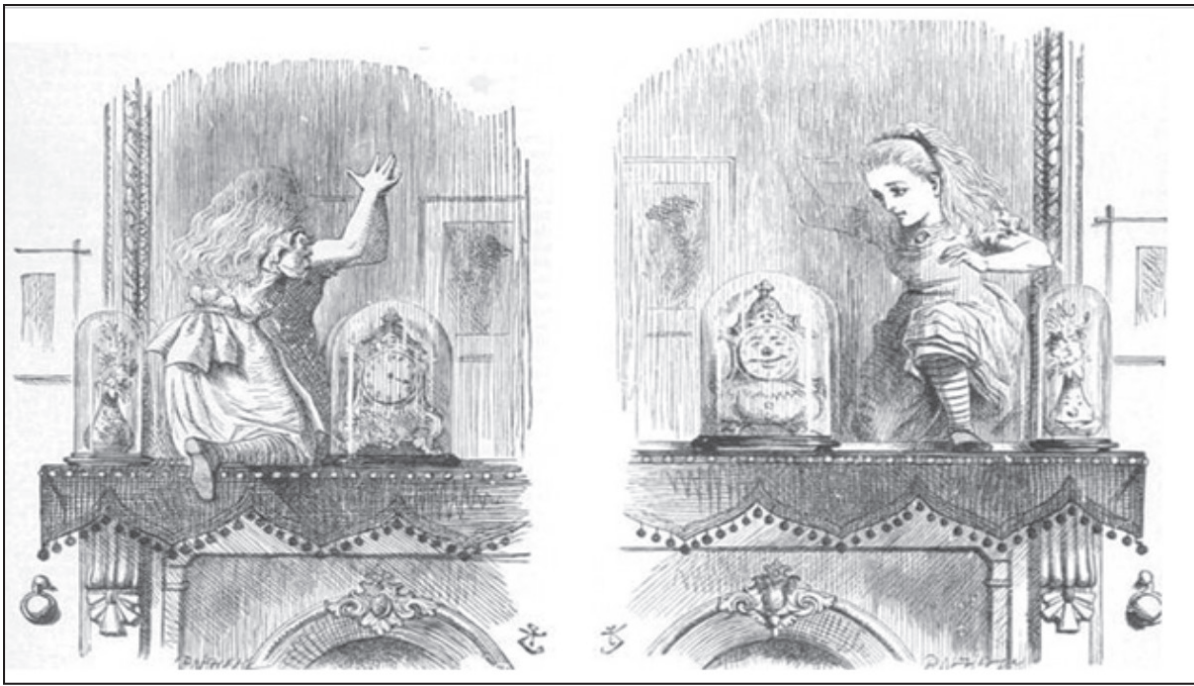


Illustration by: John Tenniel, 1871, "Through the Looking-Glass, and What Alice Found There"

privileged. Starting in the 1960s across Canada, the women's health movement had challenged the dominance of the bio-medical model. It criticized the health system's gender inequity and proposed an alternate philosophy that articulated more empowerment of women as patients and providers and increased attention on the social determinants of health. Proponents argued that macro level social, political, cultural, and economic circumstances that disenfranchised women, in combination with meso level health system barriers that resulted from how services were financed, delivered, and organized, contributed to health disparities for and amongst women. Amongst its accomplishments, by the early 1990s, the movement was instrumental in shifting some approaches to care, in creating new models of holistic service delivery and in expanding the number of women practicing medicine.

The picture changed following the period of neoliberal reform to health care that began in Ontario in the mid-1990s, which solidified the hegemony of the medical model. Following the reforms, targeted women's health programs increasingly adopted individualized and

lifestyle foci and catered to wellness for well-to-do women. Holistic programs that targeted under-served or under-privileged groups of women lost status over the course of the study period. Decisions to focus programmatic attention on wellness for well-heeled women created contradictions between practices and the philosophy: women's health was increasingly practiced as an obverse of the movement's philosophy. As a result, by 2007 many hospital-based women's health programs were a backward reflection of the movement's stated goals and previous achievements. This reversal resulted in challenges to the health equity of women as health care workers and as patients. This article focuses on the separation between the movement's philosophy and women's health service delivery, funding and administration in practice, the challenges of implementing an alternate model of work organization in a system predominated by funding centred on physicians' labour, the adoption of neo-liberal business ideals in the administration of health services, and how funding and accountability requirements limited the growth of the women's health philosophy.

This analysis is based upon data from a qualitative comparative case study of changes to the administration, delivery, and funding of urban women's health services in Toronto, Canada during the period from 1990 to 2007. After situating the study's theoretical approach and method in section two, section three identifies the major tenets of the women's health movement as it departed from the bio-medical model and outlines aspects of neoliberalism that have been adopted by health care policy makers. Section four discusses the neo-liberal politics of health reform, and the restructuring that occurred between 1990 and 2007. Section five explores the continuities and contradictions between philosophy and practice and compares programs across the areas of cardiovascular health, HIV/AIDS, mental health, and reproductive and sexual health using examples from the two hospital sites. The paper concludes by noting how the system has not adequately accommodated the women's health philosophy because there was little incentive coming from the highest policy levels to adopt the approach. With a belt-tightening climate and more limited autonomy, the first site

re-imagined its niche. One strategy involved filling gaps in service left by other publicly funded health care providers. In order to provide the team-oriented care consistent with the philosophy it provided services in the marketized health care arena.

### **Theoretical Framework and Method**

This article employs feminist political economy (Andrew, Armstrong et al., 2003; Armstrong, Armstrong and Coburn; Doyal and Pennell), to analyze shifts in how women's health was articulated, politicized, and practiced in Toronto over the two decades between 1990 and 2007. Women's health involves more than a biological construct to differentiate male and female body parts; it also involves women's gendered life experiences of their daily social, political, cultural and economic realities. Women's health is impacted by: biology and genetics as well as by power relations between men and women and among different women; by opposing lay and professional knowledge structures; and by intersecting social locations including class, ethnicity, sexual orientation and disability. Lesley Doyal argues that understanding gender is essential for understanding health, and that health equity is about women's and men's access to the health care resources needed to achieve their health potential. Reid points out that "[w]omen's health involves the interplay of social, individual and biological factors and is experienced within physical, emotional, intellectual, social and spiritual dimensions" (3). While biology is about the complexity of the body, gender places bodies in their social, political, economic and cultural contexts. Women's health is influenced by biology and by gender relations; a full account of women's health needs to take account of bodies, and of bodies' multiple and shifting contexts.

The study's research design and questions assumed the following: *all* health services are women's health services since women have

cardiovascular and mental health needs as much as they have reproductive and sexual health needs; and, while women have many things in common, different women have different gendered life experiences that depend on intersecting class, race /ethnicity, and sexual orientation, ability, geographic and other social locations. We recruited key informants from two secondary care sites, where we focused on publicly funded services in the identified study areas. Primary data were drawn from verbatim transcripts of key informant interviews with 16 managers, and from five focus groups held with managers from community-based providers of women's health services who regularly interacted with clients in need of hospital and community supports. Archival documents such as annual reports, budgets, and strategic planning documents, as well as Ontario and Toronto health system policy and planning documents were collected and thematically analyzed. Transcripts and archival document analyses were conducted separately and then collectively reviewed and discussed amongst team members to elicit key themes and tensions in the data. Thematic content related to the philosophies of women's health and to the provision of health care to women patients are reported in this article.

### **The Discursive Context for Women's Health Services**

#### *Women's Health Movement*

According to Madeline Boscoe and colleagues, the women's health movement in Canada was fostered out of the same spirit and energy for equality that drove the broader women's movement. Three issues dominated feminist critiques: the unequal system of health care delivery; the development and the analysis of the social determinants of health; and the need to increase women's participation in health care (Boscoe, Basen, Alleyne et al.). The critique of service delivery centred on the unequal power relations between (largely white)

male physicians and female patients that resulted in biased treatment options, and too few women trained as physicians. The epistemological foundations of the medical model were critiqued because of the overt bias that favoured biological and individual lifestyles and behaviours, but ignored the importance of the social determinants such as social policies, housing, education, and income inequality, and the central role of gender as a health determinant. Sue Sherwin argued that women were "no longer patient," demanding more patient autonomy in decision-making, better control over reproduction and a focus on the social impacts on health. Thus, central to the movement was the creation of a woman-centred model that acknowledged user control of delivery systems as an alternative to the hegemonic medical model; the creation of innovative services and centres; the creation of peer and self-support that recognized women as experts and included access to health promotion and education; de-professionalized health service jobs and medical knowledge; emphasis on the social context in programs; demands for equity in hiring; care continuity in terms of services and providers; and access to female health practitioners. The model was one of partnership, collaboration, and team-based knowledge. It returned power to patients and called for women's equality overall, and within the field of medicine. It was more accepting of the complimentary knowledges of naturopathic, osteopathic, and traditional Chinese medicines. It supported midwifery. It also identified the social and cultural components of health and was attuned to the impact of living and working conditions and class position.

The beliefs of the women's health movement stood in contrast to the hegemonic health discourse. In vogue in the post-Marc Lalonde's world of "public health," there was a focus on individual bodies constructed around a health more attuned to individual lifestyle choices and behaviours than to the public. In addition, allopath-

ic medicine focused on expensive technologies, pharmaceuticals, genetics and genomics, and acute care interventions. The women's health movement located health in social environments, and identified issues such as poverty and lack of power to be crucial to poor health, acquiring disease and experiencing disability. The movement's social approach to health was exactly the opposite of

choice are the discursive foundations of neoliberalism as practiced in health policy. This approach ushered individualized lifestyle "choices" and individual behaviours to the forefront of policy agendas not only in Ontario but also around the globe. More rabid forms of the focus on individualism have taken the form of blaming health care users with pejorative terms like "bed blockers." Less

formula, provinces received much less federal funding to cover the costs of insured physician and hospital services. Signaling the mounting pressures on hospitals in the late 1980s Women's College Hospital twice required bridge funding to cover two \$2 million deficits. This hospital was a unique institution dedicated to providing leading women's health services, research, and employment.

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neoliberal policy frameworks that dominated health care policy approaches in Canada in the late 1980s and beyond.

### *Neoliberalism*

The theory of neoliberalism supports free trade, strong private property rights, and markets free from state intervention except in areas like health care and other social services where the state's role is to create markets even if by state fiat. Many have argued that neoliberalization as a process involves the destruction of previously established institutional frameworks, of divisions of labour, of reproduction, of value systems, of interactions with the environment, of welfare provision and of the technologies we use (Harvey; Braedley & Luxton). The tying of conservative family values with neo-liberal theories about the state and economy, a variant referred to as neo-conservatism, introduced traditional family values into the economic theory and represented a backward social step for women's equality.

As David Harvey notes, the state's withdrawal from welfare provision has accompanied a diminished role in health care, education and in social services, with greater emphasis on personal responsibility and personal failing. Individual freedom and

obvious are the foci on anti-smoking and physical fitness campaigns in vogue post-Marc Lalonde. These campaigns started long before the advent of neoliberalism, but shared assumptions enabled them to grow in step with the policy popularity of neoliberalism. Concomitant with these changes, there was an increased emphasis on market-based managerial practices to govern hospitals, with a focus on measuring what could be counted and ignoring anything not collected for counting or that could not easily or possibly be counted. Reforms made to the state apparatus were portrayed as a rational project of good management, a way for governments to "steer and not row," and a way to ensure that the system was operating as efficiently and accountably as possible. Thus, during the period when neoliberalism was gaining traction in Canada, several changes were made to reform the overall system and the system of women's health in particular. The next section documents the history of women's health services reform.

### **The Politics of Women's Health Reform**

After 1986 as a result of changes to the Established Programs Financing, the federal health care transfer funding

Ontario's protracted recession began during the early 1990s. The massive restructuring of the manufacturing and finance sectors followed the signing of the Canada U.S. Free Trade Agreement (1987), cemented with the signing of the North American Free Trade Agreement (1994). The shift to neo-liberalism was swift and painful. Prior to 1990, rising hospital deficits had garnered policy-makers' attention. A Women's College Hospital Board proposal to merge with the Toronto Hospital, a geographically proximate but much larger hospital, was met with strident opposition from medical and other staffs, as well as from the newly formed advocacy group, "Friends of Women's College Hospital." The merger failed (Bryant). After the election of the New Democratic Party, the government of Bob Rae took small steps to stave off mounting provincial health care costs that resulted from a loss of federal funding with strategies that included closing hospital beds and implementing forced holidays known as "Rae Days." Many different initiatives, notably hospital bed closures and nurse lay-offs, were an effort to stave off pressures to commercialize health care; they led to considerable quality problems in the system. Though the impact of bed closures were felt across the province, it wasn't

until 1996 that Ontario's neoliberal health reforms began in earnest under the Mike Harris Conservative government's creation of the arms-length Health Services Restructuring Commission (HSRC). The HSRC was given a four-year mandate to restructure Ontario hospitals, and to make recommendations about reinvestments and restructuring for other parts of the health care system. With the release of each region's report, all hospitals in the province felt the sting of reforms, and many hospitals were closed or merged. The province went from having 119 Public Hospital Corporations operating at 144 sites to just 76 on 117 sites post-HSRC. This was more than a one-third reduction of Ontario's hospital corporations (Jordan and Stuart).

Many HSRC recommendations about Toronto made in July 1997 hailed initially from a 1995 Hospital Restructuring Committee Report (mtdhc), a document that attracted controversy as a result of the method and data used to support its claims (Feldberg and Miller; University of Toronto Faculty of Medicine). Amongst its recommendations, the report called for the closure of Women's College Hospital, the transfer of its women's health programs and the merger of its governance with Sunnybrook Health Sciences Centre. This set of recommendations was criticized by the University of Toronto's Faculty of Medicine because it de-emphasized women's health programs and jeopardized the "educational value of a distinct approach to women's health." With the release of the final HSRC Metro Toronto report in July 1997, it was recommended that the Orthopaedic and Arthritic Hospital and Women's College Hospital be amalgamated with Sunnybrook Health Science Centre into one corporation governing all services except the Sexual Assault Treatment Centre slated for transfer to the Western Division of the Toronto Hospital. Maternal-newborn and musculoskeletal services were targeted as new hospital priority programs (HSRC). The report was received unfavourably in the com-

munity: the commission received 650 submissions from hospitals, health agencies and organizations, labour union representatives, individuals and other groups, and an additional 15 letter-writing campaigns, which contained thousands of signatures opposing the HSRC report.

Women's College did not "go gently"; it rallied a formidable opposition to the proposed merger. It criticized the Commission's report methodology, including its overt emphasis on the use of indicators such as the number of procedures carried out at the hospital, to make the merger decision. It also criticized its apolitical claims to shepherd hospital restructuring as a primary means of ensuring the survival of publicly funded health care. The Hospital opposed the report with its own evidence that highlighted its accomplishments and its assets, and it used the philosophical tenets of the women's health movement to contrast its contributions to women's health with the system's neglect of gender (Bryant). A highly effective public relations and media campaign fuelled attempts to get the HSRC's directions nullified in court. This campaign was backed up with multiple proposals and demands to meet with the Metropolitan Toronto restructuring team (Sinclair, Rochon and Leatt). Despite these efforts, the amalgamation proceeded. Thus, through legal means and negotiation with the province's Health Services Restructuring Commission, the organization retained a quasi-independent governance structure,<sup>2</sup> as well as a legislated provincial government commitment to women's health (Bill 51) and to a sexual assault centre. Under the new arrangement, Women's College remained regulated under the *Public Hospitals Act*, but lost its inpatient hospital beds. As a result the hospital became an ambulatory care centre.

In the aftermath of the official period of restructuring, the organization of women's health research and practice evolved to encompass what appeared to be a much larger vision for women's health, one that would transcend the boundaries of a single

institution. The HSRC recommended the establishment of the Ontario Women's Health Council (OWHC) to advance leadership in women's health and to advise the minister on health issues affecting women. The Ministry of Health's Ontario Women's Health Bureau was folded into the OWHC to create a single provincial women's health entity. In 2003, in order to mainstream gender perspectives, the OWHC introduced "Women's Health Champions" into hospitals throughout the province. The "champions" were charged with being the communication liaison and women's health advocate in their own organizations, and with influencing mainstream medical and health system practices by integrating gender based approaches and philosophies into health services delivery. The notion was to expand understandings of women's health beyond a traditional focus on maternal health.

In 2005, the Minister also announced a new provincial women's health institute (WHI), mandated to promote women's health throughout Ontario and to address women's health issues. The Institute would be a separate entity from Women's College and its research institute, with its own Board of Governors. It would incorporate the role and mandate of the former OWHC. After being appointed its vision lead, Dr. Diana Majury of Carleton University consulted stakeholders about the potential role of the institute. Following consultations, the name was changed, and "Echo" was allotted an operating budget of \$7.6 million per year. The moniker was not initially intended to be an acronym, but following some controversy over the choice, the organization adopted the following one: "effecting change in women's health in Ontario." It was later changed to "improving women's health in Ontario." The new institute opened under the direction of Dr. Caroline Andrew of the University of Ottawa, committed to conducting, funding and partnering on women's health; providing policy input and advice to the Minister to improve women's

health status; to promoting accessible, effective and equitable care; and to educating women about health.

Meanwhile, despite the merger of Women's College, the Friends of Women's College maintained political pressure on the government to reverse it. In August 2005 the Honourable George Smitherman, the former Minister of Health and Long-Term Care, announced a newly

to the new women's college hospital emphasized the innovative and scientific role of the hospital. In conjunction with the hospital and its research arm, the renewal of a province-wide institute dedicated to women's health demonstrated that some elements of the discourse of the women's health movement continued to hold political currency. Thus, despite the major restructurings that resulted from the

decision-making and planning; programs adaptable to the context of women's lives; high quality of care that acknowledges patient choice and autonomy; innovative and creative approaches to women's health research; and the provision of quality academic, career and leadership opportunities for women and working together with the community (Bradshaw and Campbell). Like Sevenhuijsen's

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## An in-depth review of the practice of women's health, with examples taken from two secondary care institutions, reveals many contradictions between the discourse of the women's health movement and the practices, and thus reveals some of the ways in which neoliberalism had undermined the ideals of the women's health movement.

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independent Women's College. The Honourable Elinor Caplan reviewed the dissolution from Sunnybrook and on April 1, 2006, the New Women's College Hospital was launched. It was to create "a state-of-the-art academic ambulatory care hospital to meet the special needs of women and their families" (Strategic Plan). Women's College organized its services around women's cross-disciplinary health themes: primary care; surgical services; management of chronic disease; reproductive and sexual health; women and cancer; and women and violence. The establishment of the Women's College Research Institute emphasized research. Programs included an ambulatory surgical services day program including same-day breast and urological surgeries; expanded cancer care services particularly focused around rapid screening and diagnostics for under-served immigrant and marginalized women; an urgent care pilot project; and a task force to aid in the site's capital re-development (Strategic Plan).

In summary, institutionalized women's health was partially resilient to neoliberal restructuring pressures. An independent physical place was preserved for the one hospital dedicated to women's health, with its physical plant renewed by post-flood renovations. A research institute tied

neoliberalization of health care in Ontario, and the structural upheavals that accompanied the period of health reform, some continuity with the past continued. However, as the next section shows, an in-depth review of the practice of women's health, with examples taken from two secondary care institutions, reveals many contradictions between the discourse of the women's health movement and the practices, and thus reveals some of the ways in which neoliberalism had undermined the ideals of the women's health movement.

### **Practicing Politics: Women's Health Services in Toronto**

This section explores the continuities and contradictions between philosophy and practice that existed between the organizational philosophies of women's health at the two secondary sites.

#### *Philosophy and Service Delivery*

At site A the definition of women's health (1997) was simultaneously a source of organizational strength and of practical difficulty. The definition encompassed the following elements: empowerment of women; equality between patients as partners and equals; accessibility of the programs; advocacy for women; collaborative

notion of solidarity, which involves caring for women at individual and political levels, their definition was relational and situated women in their life context; envisioned equality of status between health providers and patients through empowering and engaging women in making health decisions; and tied to a need to differ "philosophically and structurally from other health organizations" (Bradshaw and Campbell).

One manager noted that the philosophy was one of collaboration and cooperation between large multidisciplinary, self-managed, practice teams. Only a few doctors were included in the teams alongside many allied and other health professionals. Other key informants also revealed what they perceived as a sense of division between the philosophy and practice of women's health, and admitted that there were still hierarchical aspects to the organization, and that often, when individuals attempted adherence to women's health values, they were not well-received by their colleagues (Clinical Manager 061707).

In some cases, the dominance of the medical model at the system level made it difficult to practice in a way that was consistent with the values of the women's health movement. In the case of mental health, for example, teams included counselors,

psychologists, nurses, social workers, art therapists, and sex therapists among others (Manager – 051806). Some noted that these programs were becoming increasingly difficult to fund, as they would receive short-term project funding but could not be sustained without heavy involvement of physicians because of the remuneration models at the Ministry level.

When asked about hospital management, some people in positions of authority noted the flexibility, the lack of hierarchy, the distributed control, and that individuals were empowered to react to patient's needs. Other managers contradicted this. In one instance, a manager noted how a more hierarchical approach had led to a shift in terms of patient focus.

[T]he difficulty is the administration here, the decisions are made right now at a very senior level and they don't involve front line staff in brainstorming or being part of committees and they don't use resources they have here ... because ... many of the administrators ... don't understand women's health. They're very, they're women who have been successful in life, have money ... [and] don't want to deal with tough issues like abortion, like sexual assault, like women who are poor and consequently stay above the fray and are making decisions that I don't think they understand the implications (Manager – 030906).

Since health reforms had resulted in many organizational challenges such as insecure funding for programs and little organizational autonomy, hospital A secured its position by achieving the neoliberal aims of government funders, while framing women's health as an exclusive commodity. It sought to shift the philosophical approach away from (biomedical) cure towards prevention and care, and to maintain its differentiated status among health care institutions. It did so by focusing on "unique" programs that attracted wealthier, educated and

philosophically supportive women as patients.

Some innovative preventative or rehabilitative programs were exclusionary because they charged out-of-pocket fees. The fees for these programs created potential barriers for those unable to pay, and, although there were provisions to assist people who were unable to pay, prior to and during the period of the study, the cardiac program had not yet enrolled anyone who required financial assistance. One interviewee noted that, "we waive the fee for anything [that requires private payment], but it's not who has traditionally been attracted to [the program]." This statement suggests that hospital programs treated women lacking resources differently. In addition, user fees represented a marketization of health care, and a clear example of neoliberalization.

In a country where most hospital services are publicly funded, many of the programs and services provided by the hospital were restructured to "focus on specific patients/clients with customized services." They provided services that were "unique in the eyes of the clients," "that provide[d] the organization with competitive advantage" and that ensured "customer loyalty"; they created services that were "difficult for the competitors to duplicate" (Bradshaw and Campbell). Seen in these terms, the hospital sought to position itself as *the* centre for women's health service delivery. But, senior management did not aim to reproduce the model at other organizations, nor did they seek to move the system to adopt a women's health framework. If anything, they adopted market language and sought to prove that they had something unique to sell amongst the competition for scarce resources with the "big boys down the street," a common turn of phrase that showed up repeatedly across multiple interviews. In choosing the marketization route, site A faced turning women into "objects of treatment and revenue production" by co-opting feminist ideals of empowerment and alternative modes of health delivery as Thomas and Zimmerman argued had

happened in the United States (361).

While payment likely prevented some women from accessing programs that charged out-of-pocket payments, accessibility may have been greatly enhanced for other women because doctor referrals were not a requirement for enrollment. Many programs were accessible to a woman who had met roadblocks in terms of the traditional medical referral structure, or for whom seemingly unconnected health complaints were taken more seriously under the care of a team who practiced with a holistic, multidisciplinary approach. This example highlights one of the many contradictions inherent in the provision of women's health.

In choosing to deliver preventative and wellness based programs, site A faced structural constraints that resulted from insufficient levels of public funding. Programs either operated on a tight budget with very long waiting times or charged users a fee. As an example of the latter approach, a women's heart health program was created as a primary prevention program focused on assessment and lifestyle interventions, and was modeled in part around a pre-existing osteoporosis program. A \$150 / six month fee was levied on patients to be admitted to the cardiovascular program in order to cover non-OHIP services. Another preventive care program for women aged from 40 to 70 years of age who had experienced early menopause, also charged fees for some services. Around the hospital, some staff argued that out-of-pocket payments for some programs were necessary because ambulatory care was "seen as less" due to the resource-intensive needs of acute care (Program Manager – 090807SB). With increased private payment for "extras," others highlighted how patient equity issues were an issue. The strategic direction revealed racial, cultural and class contradictions: access was decreased for some women and options were increased for others.

At site B, an urban community hospital, women's health was simi-

larly defined as at site A, but it was practiced differently. The hospital's organizational definition linked women's health to social and biological determinants, recognized the "validity" of women's life experiences, beliefs and experiences of health, and ensured women's opportunities to sustain and maintain her health "to her full potential" (Confidential Report). As a result, the hospital's philosophy linked the caring for women to women's empowerment, and acknowledged that women often take a lead role in negotiating health care for their families and friends. Parallel to the philosophy posited by site A this approach acknowledged support for interdisciplinary team approaches to health, but it differed by being more firmly grounded in bio-medical and managerial models that were linked to traditional approaches to medicine and to the use of quantitative health indicators and benchmarks for administration. Their definition addressed the need for social justice and equity of access to care, but did not directly acknowledge diversely situated women's needs, nor did it address the need to train and mentor women practitioners who represented the majority of the health care workforce. What the community hospital's definition did reflect was the province's organizational culture: it was focused on quantitative measurement; it aimed to understand sex-sensitive and sex-based indicators of care; and to provide care at or above benchmarks for women's health. How this type of benchmarking was applied and incorporated into everyday practices was not articulated in their plan.

In 2004, like other hospitals across the province that responded to the OWHCs call detailed above, the hospital nominated a "women's health champion." Rather than having individual managers demonstrate how they provided outstanding care that targeted women's and men's specific needs, the task of encouraging the entire hospital to address women's health was charged to a single person—already holding a large and

short-staffed portfolio—who headed a small committee without a budget. The mandate of the committee was to "...demonstrate that women's health as a concept is imbedded in operations and planning" (email exchange, Sept 13, 2005). The inability of this small team to significantly challenge the organizational culture, especially in the absence of a budget or clear direction from senior management, was not surprising. As a result of the failure to move the women's health agenda forward to encompass all areas of women's health, the community hospital retained a traditional approach to women's health by only offering outpatient programs in reproductive care such as postpartum adjustment; breastfeeding; family learning for birth preparation; and choice of practitioner for birthing – and a few select clinics in colonoscopy and osteoporosis. There was little evidence of the marketization of women's health, beyond advertisement of a status it held for encouraging breastfeeding.

How each organization's women's health philosophy was imbued in its practice thus depended upon a number of factors including how it replicated Ministry ideals, its institutional status, and the practice philosophies of individual physicians and staff. The women's health philosophy competed against managerial approaches, practice models, and funding formulas that favoured the provision of brief, biomedical, acute physician-led services.

#### *Work Organization*

The women's health philosophy espoused equality of treatment for women as health care providers. Despite advocating a model that was empowering to women, with collaborative decision making and a work environment conducive to women practitioners, site A sometimes failed to care for its practitioners in ways that were consistent with its values around collaborative decision making. Good working conditions were negatively affected by cost containment and staff shortages. One respondent noted that:

If you don't have the money you can't do it. We need retention things to deal with retention issues. I do procedures in the OR. It's incredibly short staffed. And the morale gets bad when you're short staffed because the people are doing more work. And you get this downward spiral, right? And only money will fix that (Clinical Manager – 061707).

The link between good working conditions and being able to provide good women's health services was clearly articulated by one interviewee: "[i]f you really do care about women's health you have to care about the health of your staff as much as you do about the health of the patients coming to you because you can't have one without the other" (Clinical Manager – 072307SB). Site A was founded on a commitment to train and mentor women clinicians, practitioners and managers; however, some respondents argued that organizational challenges including a failed merger, had shifted its foci:

...we were a beacon in terms of leadership for academics for women for a long time. We aren't anymore ... we used to be able to say ... half of our department chiefs are women or more, or more than half, and our leadership is women. We can't say that anymore (Clinical Manager – 061707).

Another interviewee lamented what had happened to nurses in terms of staffing shortages and the ability to attract highly skilled people to the profession:

We're pared down to the absolute minimum levels of nursing that we can do. We don't understand the cost that that takes in terms of job satisfaction, in terms of personal health, and the fact that these nurses are skilled, creative, caring people and if they're not able to do a job that is satisfying to them they'll do



something else. We've watched a huge exodus of highly competent, skilled, well-educated nurses to go to something else. We're trying hard to backfill but we're not backfilling is my overall impression. We're not attracting the same people to nursing that we did in the past. If we want to have skilled nurses we have to be prepared to pay for them and we have to be prepared to give them careers that are rewarding, you know, that they feel that they've made a difference. (Senior Clinical Manager – 072307SB)

Nurses were also targeted at site B: one of the ways in which the community hospital coped with constrained resources and their simultaneous need to ensure staff covered certain shifts, was to supply nurses with a pager on their time off, paying them for the hours that they covered the pager and requiring them to come into work if they were on call (Manager 061907TD). This strategy created many challenges in terms of employee work life balance (e.g. issues of child care and time with friends and family, the types of activities one can engage in while on call, the distance from home once can be etc.), and contributed to a challenging and tension filled workplace. At the same time, site B spearheaded initiatives to control and monitor activities in the hospital that prevented and better managed violence. For instance, managers tried to create an environment where workers felt safe, both inside the hospital and while traveling to vehicles. The hospital was also committed to wellness programming focused on “mind-body-spirit” connections—programs that included a 24-hour gym, acupuncture, spinning, pilates and yoga, singling, volleyball, poetry and photography classes. Whereas in the past there had been little access to food past certain hours, a 24-hour food cart was introduced to keep staff “nourished and healthy.” Site B also made attempts to create a stable work environment where staff members were not constantly being laid off and re-hired, while also offering flexibility

in returning to work following illness. Still, despite these programs, the pressures to operate in a cost constrained environment resulted in staff being asked to do more with less. This was often in direct contravention of maintaining a healthy work environment: directors, one level below hospital vice-presidents that retired or left were not replaced; nurses were asked to be on call on days off; and staffing intensity levels did not reflect service demands. Directors were “managing to a budget” and “must sign off on the budget” to meet new Ministerial accountability requirements (Manager – 061907TD).

### *Funding and Accountability*

Site A formally partnered with other hospitals and organizations, and senior managers stressed that competition was not part of their mandate (Manager 051806). But the repeated use of words such as “fight,” and “survive,” “competition” and “big boys down the street” peppered throughout the transcripts, suggests that the hospital's focus on survival may have negatively affected its abilities to collaborate, to retain providers, and to continue to develop innovative programming. Indeed, many innovative programs, including a popular pelvic pain program were lost. Site A was prevented from developing its holistic women's health vision by its status as an ambulatory hospital with no inpatient beds, and only day surgeries. The site's ambulatory status contributed to the loss of its Perinatology and Gynaecology programs after the Ontario Ministry of Health and Long Term Care commissioned a review (Kits), which concluded that retaining birthing services at the hospital would require “repatriation” of inpatient medical and surgical services in order to ensure patient safety and for the program to remain sustainable. The report advised against this restorative course of action and indicated that the program should be transferred to a former partner site. The cultural and philosophical loss of maternity care was difficult to calculate: it was the program that had historically

grounded the hospital. One interviewee described it as a program that had been “well-protected, well-loved and well-nurtured” (Manager – 051806).

Provincial funding mandates precluded innovative chronic health programs with a whole body, multi-disciplinary team approach from receiving more than short term episodic program funding. With only one or two doctors supervising the programs, they generated insufficient mainstream Ministry funding. Other services, such as a sexual assault centre were diluted, while important practical and philosophically important programs such as the maternal and newborn programs were shifted to the other hospital involved in the merger. In many cases, the clinical practitioners moved to work at other sites while the political turmoil raged—which placed the hospital in a situation to re-build its professional staff and its services. The site re-built its services by “filling gaps” around other hospitals' lack of services, or it engaged in turf wars to get some important women's health services back under the organizational rubric.

In the site B hospital, administrators took few fiscal chances, and managed the hospital conservatively. It was very favourably situated in comparison to other hospitals with respect to Ministry funding and accountability parameters, and for many years it had run a surplus budget. Key informants described the hospital as a “doc shop,” with physicians holding a lot of managerial power, and thus programs operated comfortably within the prescribed physician-led medical model. There were few alternative programs, and little discussion of team care. Because programs offered by site B retained a traditional approach to women's health, practices across the hospital changed little to accommodate the women's health philosophy that their own women's health committee had espoused. The appointment of a women's health champion without an assigned budget or management buy-in to re-orient programs so as to accommodate the philosophy meant

that it remained rhetoric and not real in practice terms. Given how women's health was discussed, compared with how it was practiced, it appears that the appointment of a champion was largely an accountability practice to meet the OWHC's request.

The women's health mandate was perceived by managers as an extra responsibility, but not associated with extra funding. When an informant

## Conclusions

At the site A hospital, the loss of many of its programs and people meant that it was in a position to have to re-imagine itself. The limits imposed by a funding system that remunerated acute medical care and favoured hospital services that were brief, biological, and episodic, not chronic and contextualized in the

extra that the Ministry did not fund them to provide. At that hospital, the philosophy remained at the level of a very contained rhetoric. Its forays into women's health were externally sponsored and lacked management support. Thus, women's health was practiced as it had always been practiced—as women's reproductive health—and little about the philosophy was inculcated into new ways of

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## The limits imposed by a funding system that remunerated acute medical care and favoured hospital services that were brief, biological, and episodic, not chronic and contextualized in the realities of people's lives, were key challenges to orienting the system to the women's health philosophy.

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was asked if the hospital should have more emphasis on women's health issues, the response was: "We're not asking 'Should we have the best men's health program in all of Toronto.' We're asking more general questions. It's a challenge because all of our resources are dedicated right now" (Manager – 082007TD). General questions referred to the general population—literally anyone who walked through the hospital's doors. There was a sense that managers were unable or unwilling to dedicate resources to attend to the needs of specific groups of people even though they had evidence of different needs. For instance, hospital surveys of their patients identified that women were less satisfied with care, but how managers used this information to better respond to women's needs in departments other than maternal and newborn care was unclear. In an email exchange, a key informant noted that, "apart from the provision of surgical services to women in the areas of gynecology and plastics, surgery is not directly responsible for women's health" (Sept 13, 2005). One interviewee noted, "...it's been a real struggle to try and put anything beyond reproductive health on the map as far as women's health is concerned" (Manager – 071106SA). Another noted that women's health was perceived as "soft" (Manager – 071106SB).

realities of people's lives, were key challenges to orienting the system to the women's health philosophy. It was challenged also by having its autonomy threatened with the forced merger. When it was returned to an autonomous position, it had many of its powers as a full hospital stripped away and it was relegated to be an outpatient hospital that provided specialized, self-funding care. The combined hegemony of the medical model and neoliberalism meant that women's health was increasingly being practiced in the gaps and the privatized spaces between other publicly funded programs. The work organization model espoused by the movement was not fully realized, and many decisions were made without consultation with front line staff. In terms of funding and accountability, because program innovation was frequently partnered with marketization of programs, the programs produced contradictory results: some women's access was increased, while for other women who were unable to afford the high end, specialized programming was diminished. Women's health was increasingly something that was considered as "extra"—and could be had by some for a price.

Site B never really adopted the women's health philosophy and managers perceived women's health as an

knowing or practicing health across all health care areas. Furthermore, tight budgets and conservative fiscal management that was in line with Ministry objectives meant that the hospital continued to be oriented to the work organization practice model favoured by physicians.

In *Through the Looking Glass*, Alice finds that life reflected through the mirror is not as it should be:

"I should see the garden far better," said Alice to herself, "if I could get to the top of that hill: and here's a path that leads straight to it—at least, no, it doesn't do that—" (after going a few yards along the path, and turning several sharp corners), "but I suppose it will at last. But how curiously it twists! It's more like a corkscrew than a path! Well, this turn goes to the hill, I suppose—no, it doesn't! This goes straight back to the house! Well then, I'll try it the other way." (Carroll, 1871, Chapter 2, para. 1)

In a similar way, when held up and examined, the philosophy clearly articulates the path to better services and better women's health overall. But, like the path that Alice encounters, when we examine the practice of women's health closely we find it has

mired us in strange twists and turns that obfuscate and sidetrack.

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<sup>1</sup>Through the Looking Glass and What Alice Found There (1871) was Louis Carroll's sequel to *Alice in Wonderland*.

<sup>2</sup>The Hospital's Board retained independence by signing of a management agreement with the merged Hospital Corporation to operate the Ambulatory Care Centre, though all of the assets of the Hospital were transferred to the new Corporation.

## References:

- Armstrong, P. "Gender Sensitive Research, Policy and Practice in Canada." Gender and Health Summit, Promoting Equality for Men and Women, 2003. Conf. paper.
- Armstrong, P., H. Armstrong and D. Coburn. "The Political Economy of Health and Care." *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada*. Eds. P. Armstrong, H. Armstrong and D. Coburn. Don Mills: Oxford University Press, 2001. vii-x. Print.
- Bourbonnais, R., C. Brisson, R. Malenfant, and V. Michel. "Health Care Restructuring, Work Environment, and Health of Nurses." *American Journal of Industrial Medicine* 47 (2005): 54-64. Print.
- Bourbonnais, R., and M. Mondor. "Job Strain and Sickness Absence Among Nurses in the Province of Quebec." *American Journal of Industrial Medicine* 39 (2001): 194-202. Print.
- Boscoe, M., G. Basen, G. Alleyne, B. Bourrier-Lacroix, and C. White. "The Women's Health Movement in Canada." *Canadian Woman Studies* 24.1 (2004): 7-13. Print.
- Bradshaw, J. and P. Campbell. *Maintaining Women's Health Values in the Context of Change*. Toronto: Women's College Hospital, 1997. Print.
- Braedley, Susan and Meg Luxton, eds. *Neoliberalism and Everyday Life*. Montreal: McGill-Queen's University Press, 2010. Print.
- Bryant, T. "A Critical Examination of the Hospital Restructuring Process in Ontario, Canada." *Health Policy* 64 (2003): 193-205. Print.
- Carroll, Lewis. *Through the Looking-Glass, and What Alice Found There*. 1871. [iPad version]. Web.
- Confidential Report. 2004.
- Doyal, L., and I. Pennell. *The Political Economy of Health*. London: Pluto, 1979. Print.
- Doyal, L. "Gender Equity in Health: Debates and Dilemmas." *Social Science and Medicine* 51.6 (2000): 931-939. Print.
- Feldberg, Georgina and Fiona Miller. "Who's Counting? The Faulty Calculations of the Metropolitan Toronto District Health Council's Hospital Restructuring Committee." *Centre for Health Studies*. York University, Toronto. Nov. 14, 1996. Conference paper.
- Havery, David. *A Brief History of Neoliberalism*. New York: Oxford University Press, 2007. Print.
- Health Services Restructuring Commission (HSRC). *Metropolitan Toronto Health Services Restructuring Report*. Toronto: HSRC, 1997. Print.
- Jordon, M. and N. Stuart. "Hospital Mergers: Why Some Fail and Others Succeed." *Healthcare Quarterly* (Winter 1999/2000): 41-46. Print.
- Karasek, R. and T. Theorell. *Healthy Work: Stress, Productivity and the Reconstruction of Working Life*. New York: Basic Books, 1990. Print.
- Kits, J. *Sunnybrook and Women's College Health Sciences Centre Perinatology and Gynaecology Program Review, Final Report*. Ottawa: The Ottawa Hospital, 2005. Print.
- Lalonde, Marc. *A New Perspective on the Health of Canadians: A Working Document*. Ottawa: Government of Canada, 1974.
- McDonough, P. "Job Insecurity and Health." *International Journal of Health Services* 30.3 (2000): 453-476. Print.
- Metro Toronto District Health Council (MTDHC). *Hospital Restructuring Project Final Report*. Toronto: MTDHC, 1995. Print.
- Osbourne, D. and T. Gaebler. *Reinventing Government*. Boston: Addison-Wesley, 1992. 427. Print.
- Public Hospitals Act. R.S.O. 1990*. Chapter p. 40. Web.
- Raphael, D. *Poverty and Policy in Canada*. Toronto: Canadian Scholars' Press, 2007. Print.
- Reid, C. *A Full Measure: Towards a Comprehensive Model for the Measurement of Women's Health*. Vancouver: BC Centre of Excellence for Women's Health, 2002. Print.
- Sevenhuijsen, S. *Citizenship and the Ethics of Care: Feminist Considerations on Justice, Morality and Politics*. London: Routledge, 1998. Print.
- Sherwin, S. *No Longer Patient: Feminist Ethics & Health Care*. Philadelphia: Temple University Press, 1992. Print.
- Sinclair, D., M. Rochon, and P. Leatt. *Riding the Third Rail: The Story of Ontario's Health Services Restructuring Commission, 1996-2000*. Montreal: Institute for Research on Public Policy, 2005. Print.

Stewart, D. E., A.M. Cheung, L. E. Ferris, I. Hyman, M.M. Cohen, and J. I Williams. *Ontario Women's Health Status Report*. Toronto: Ontario Women's Health Council, 2002. Print.

*Strategic Plan: Above All, We Care*. Toronto: Toronto East General Hospital, Confidential Report, 2006. Print.

*Sunnybrook and Women's College Health Sciences Centre Act*. Bill 51, 2nd Session, 36th Legislature, Royal Assent 26 June 1998. Ontario.

Thomas, J.E., and M.K. Zimmerman. "Feminism and Profit in American Hospitals: The Corporate Construction of Women's Health Centers." *Gender and Society* 21.3 (2007): 359–383. Print.

University of Toronto, Faculty of Medicine. *Med.E.Mail* 4.10 (6 Nov. 1995). Web. 28 Sept. 2007.

Woodward, C., H. Shannon, C. Cunningham, J. McIntosh, B. Lendrum, D. Rosenbloom and J. Brown. "The Impact of Re-Engineering and Other Cost Reduction Strategies on the Staff of a Large Teaching Hospital: A Longitudinal Study." *Medical Care*, 37.6 (1999): 556–569. Print.

Zboril-Benson, L. "Why Nurses Are Calling in Sick: The Impact of Health-Care Restructuring." *Canadian Journal of Nursing Research* 33.4 (2002): 89-107. Print.

## KAY R. EGINTON

### Icy Wind

No sound floats on an icy wind.

Incapable of sound

We walked the distance from school  
through the snow

One lone light visible

in the kitchen, through the trees

My mother peeling potatoes at the sink  
for the evening meal.

She cried sometimes, as we carved a way  
through the snow.

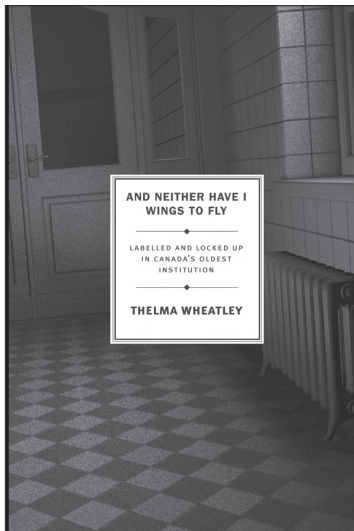
We were cold and alone  
my brother and I

My mother always alone, though always a neighbor  
someone nearby with a sly smile.

It was winter in many ways  
That shy mother alone in the afternoon

As we walked home.

*Kay R. Eginton has published four times with Canadian Woman Studies (2003, 2007, 2010, and 2011). She also has published with Lyrical Iowa and self-published one volume, Poems (Penfield Press, 1981). Kay lives in Iowa City, Iowa.*



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