

**Who Will Be Responsible for Providing Care?
The Impact of the Shift to Ambulatory Care and of
Social Economic Policies on Quebec Women**

(Translation)

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Status of Women Canada is committed to ensuring that all research produced through the Policy Research Fund adheres to high methodological, ethical and professional standards. The research must also make a unique, value-added contribution to current policy debates, and be useful to policy makers, researchers, women's organizations, communities and others interested in the policy process. Each paper is anonymously reviewed by specialists in the field, and comments are solicited on:

- the accuracy, completeness and timeliness of the information presented;
- the extent to which the analysis and recommendations are supported by the methodology used and the data collected;
- the original contribution that the report would make to existing work on this subject, and its usefulness to equality-seeking organizations, advocacy communities, government policy makers, researchers and other target audiences.

Status of Women Canada thanks those who contributed to this peer review process.

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PREFACE

Status of Women Canada's Policy Research Fund was instituted in 1996 to support independent, nationally relevant policy research on gender equality issues. In order to determine the structure and priorities of the Policy Research Fund, Status of Women Canada held consultations from March to May 1996 with a range of national, regional and local women's organizations, researchers and research organizations, community, social service and professional groups, other levels of government, and individuals interested in women's equality. Consultation participants indicated their support for the Fund to address both long-term emerging policy issues as well as urgent issues, and recommended that a small, non-governmental external committee would play a key role in identifying priorities, selecting research proposals for funding, and exercising quality control over the final research papers.

As an interim measure during the fiscal year 1996-1997, consultation participants agreed that short-term research projects addressing immediate needs should be undertaken while the external committee was being established to develop longer-term priorities. In this context, policy research on issues surrounding the Canada Health and Social Transfer (CHST) and access to justice were identified as priorities.

On June 21, 1996, a call for research proposals on the impact of the CHST on women was issued. The proposals were assessed by Status of Women Canada and external reviewers. The research projects selected for funding in this area focus on women receiving social assistance, economic security for families with children, women with disabilities, the availability and affordability of child care services, women and health care, and women's human rights.

The call for research proposals on access to justice was issued on July 18, 1996. Also assessed by Status of Women Canada and external reviewers, the selected policy research projects in this area include a study of abused immigrant women, lesbians, women and civil legal aid, family mediation, and the implications for victims of sexual harassment of the Supreme Court ruling in *Béliveau-St. Jacques*.

The objective of Status of Women Canada's Policy Research Fund is to enhance public debate on gender equality issues and contribute to the ability of individuals and organizations to participate more effectively in the policy development process. We believe that good policy is based on good policy research. We thank all the authors for their contribution to this objective.

A complete listing of the research projects funded by Status of Women Canada on issues surrounding the Canada Health and Social Transfer and access to justice is provided at the end of this report.

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TABLE OF CONTENTS

List of Abbreviations	vii
Glossary of Institutions and Programs	ix
Summary	xiii
Introduction	1
Chapter 1. Context of the Study	3
Chapter 2. Methodology	9
General Presentation.....	9
Data Collection	11
Data Analysis.....	14
Chapter 3. The Shift to Ambulatory Care and the Restructuring of Health and Social Services: Its Impact on Women	17
A Forgotten Reform.....	17
Patients, Caregivers and Their Relatives	21
Health and Social Service Workers	41
Reform in Progress: A First Critical Look at the Shift to Ambulatory Care.....	61
Chapter 4. Social Economy Policies and the Restructuring of Health and Social Services	71
The Social Economy: One Paradigm, Many Visions	72
The Heterogeneous and Consultative Nature of the Regional Committees	74
CRÉS Mandates and Activities	76
Project Selection: Profile and Debate	79
The Social Economy and the Shift to Ambulatory Care: Chance or Necessity?.....	83
Challenges Facing Women	85
Conclusion	93
General Conclusion	95
Recommendations	98
Appendix 1: Discussion Framework for Focus Groups with Caregivers	102
Appendix 2: Distribution of Focus Group Participants According to Region, AFÉAS Membership and Role in Caregiving	103
Appendix 3: Framework of Interviews with Health Care and Social Services Workers	104

Appendix 4: Distribution of Health and Social Services Workers Interviewed, According to Region, Position, Facility and Specific Experience Relevant to the Study	107
Appendix 5: Framework of Interviews with the CRÉS Members	112
Appendix 6: Framework of Interviews with Representatives of Provincial Associations	113
Bibliography	114
Endnotes	118

LIST OF ABBREVIATIONS

CEGEP	Collège d'enseignement general et professionnel
CLD	Centre local de développement [local development center]
CLÉ	Centre local d'emploi [local employment center]
CLSC	Centre local de services communautaires [local community service center]
CRCD	Conseil régional de concertation et de développement [regional consultation and development council]
COCÉS	Comité d'orientation et de concertation sur l'économie sociale [steering committee on social economy]
CRD	Conseil régional de développement [regional development council]
CRÉS	Comité régional d'économie sociale [regional committee on the social economy]
CSF	Conseil du statut de la femme [council on the status of women]
CSN	Confédération des syndicats nationaux [Confederation of national trade unions]
EXTRA	Programme Expérience de travail [work experience program]
FDCE	Fonds décentralisé de création d'emploi [decentralized job creation fund]
FIIQ	Fédération des infirmières et infirmiers [Quebec nurses federation]
MRC	Municipalité régionale de comté [regional county municipality]
MSR	Ministère de la sécurité du revenu [ministry of income security]
MSSS	Ministère de la santé et des services sociaux [ministry of health and social services]
MUHC	McGill University Health Centre
PAIE	Programme d'aide à l'intégration en emploi [job re-entry program]
RRSSS	Régie régionale de la santé et des services sociaux [regional health and social services board]
SDR	Secrétariat au développement des régions [regional development secretariat]
SQDM	Société québécoise de développement de la main-d'œuvre [Quebec society for labour force development]

GLOSSARY OF FACILITIES, AUTHORITIES, SERVICES AND PROGRAMS

1. HEALTH AND SOCIAL SERVICES

Centre local de services communautaires (CLSC)

These local community service centres were established in the early 1970s to provide front-line health and social services. They offer curative, preventive, rehabilitation and reintegration services on their premises as well as in the patient's environment (school, work, home, etc.). Their comprehensive and preventive approach distinguishes these centres from other health care facilities.

Chronic care hospital

Chronic care hospitals provide temporary or permanent stays to patients in need of physical or psychological care. The range of services provided by this type of facility includes shelter, assistance, support and supervision, as well as nursing, medical, psychosocial and rehabilitation services.

Hospital

The hospital's role is to ensure the delivery of diagnostic services and to provide general or specialized medical care (general or specialized hospitals) or psychiatric care (psychiatric hospital).

Ministère de la santé et des services sociaux (MSSS)

The ministry is responsible for developing health and social service policies and programs, and ensuring their implementation. The ministry is also in charge of distributing human, financial and material resources in the regions, planning tertiary services and accrediting both public and private facilities. It also negotiates collective agreements.

Nursing home or residence

These two types of facilities offer accommodation for people who are in need of physical or mental assistance. They now share that mandate with chronic care hospitals.

Régie régionale de la santé et des services sociaux (RRSSS)

Every administrative region in Quebec has its own regional health and social services board which oversees the planning, organization, implementation and evaluation of the health and social services for its territory. Each board defines its own regional health and social service priorities, taking into account the needs of the population as well as the objectives set out by the Ministère de la santé et des services sociaux. Each regional board allocates budgets to the various facilities located within its territory and provides grants to community organizations as well as to privately owned accredited establishments. In addition, the board implements measures to ensure the protection of public health as well as the management of human, material and financial resources.

Régime d'assurance-médicaments

This drug insurance plan, which came into effect in 1997, provides basic coverage to all members of the population for drug costs. The plan is compulsory and requires a financial contribution by its users. People benefiting from a private group insurance plan must, by law, direct their claims to their own insurance company.

Service Info-Santé

Info-Santé is a health information line available 24 hours a day, seven days a week, and is part of the CLSCs. Nurses provide information by telephone on first-aid treatment and available resources.

2. ECONOMIC FACILITIES, SERVICES AND PROGRAMS

Centre local de développement (CLD)

Local development centres are organizations financed by the government at the local level. Once fully implemented, these centres will integrate and manage the full range of support services for enterprises, including those related to the social economy. The CLDs mandate includes the elaboration of a local economic and employment action plan as well as a local strategy designed to stimulate business development. The jurisdiction of each CLD covers the same territory as that of the Municipalité régionale de comté (MRC) or its equivalent. In addition, the CLD acts as advisory committee for local employment centres (Centres locaux d'emploi or CLÉ).

Centre local d'emploi (CLÉ)

Similar to CLDs, these local employment centres are in the process of being set up. They are integrated public service employment centres, designed to reach all categories of individuals seeking employment as well as employers and businesses in search of employees.

Chantier de l'économie sociale

This social economy committee is responsible for examining possibilities for implementing social economy projects and serves as an incubator for such initiatives.

Comité régional sur l'économie sociale (CRÉS)

Regional committees on the social economy are mandated to develop the social economy in the administrative region within their jurisdiction. Originally, these committees were made up of regional representatives of various ministries, including the Ministère de la sécurité du revenu, four representatives of women's groups and one regional representative from the Conseil du statut de la femme. In 1997, the government expanded the initial membership of the CRÉS to include representatives from community groups as well as labour organizations and co-operatives. In the future, based on the *Politique de soutien au développement local et régional* (policy to support local and regional development), each CRÉS will be associated with the regional Conseil régional de développement (CRD). The CRÉS' mandate is to elaborate, as part of the region's strategic planning (in economic development), the section devoted to the social economy; ensure representation of social economy players on the board of directors of the CLDs; promote consultation between local and regional social economy

players to ensure cohesion and to maximize the impact of their interventions (Gouvernement du Québec, 1997) [translation].

Conseil régional de développement (CRD)

The role of the regional development council is to promote consultation on economic development among the various regional players. Its objective is to develop a strategy as well as regional development plans, and to sign a framework agreement with the government to this effect. The agreement serves to guide the actions of ministries and government authorities over a three- to five-year period based on the priorities of each region. The council can also reach sectoral agreements with ministries or government authorities: financial or prescriptive agreements for the adoption and adaptation of measures, programs or interventions based on that region's specificities. The new *Politique de soutien au développement local et régional* consolidates the role of CRDs and CRCDs which are increasingly becoming the government's regional representatives, in addition to advising the government on regional economic development issues.

Défi-Autonomie

A social economy pilot project for home care assistance.

Direct allowance

A direct allowance is allocated to patients to enable them to hire individuals to provide health care and assist in household tasks. This term also refers to caregivers' salaries.

Fonds décentralisé de création d'emploi (FDCE)

This decentralized job creation fund was under the Secrétariat au développement des régions and was intended, as its name indicates, to provide grants to enterprises for the creation of jobs. The fund was abolished in April 1997.

Ministère de la sécurité du revenu (MSR)

The ministry of income security no longer exists per se. In fact, in December 1997, it changed its name to become the ministry of employment and solidarity (Ministère de l'emploi et de la solidarité). This ministry manages measures and programs related to social assistance, and ensures a direct link between the problem of unemployment and professional training.

Municipalité régionale de comté (MRC)

Regional county municipalities are administrative and political structures that include members appointed by the municipalities of a given territory. As opposed to municipalities, MRCs have no power of taxation. However, their jurisdiction encompasses issues relating to the development of the territory and realty assets. Instead of an MRC, Quebec's three metropolitan regions have urban communities (CUO, CUM, CUQ). The *Politique de soutien au développement local et régional* determines the territory of each MRC or the corresponding territorial units as the levels in charge of the programming, management and the implementation of front-line services.

Programme d'aide à l'intégration en emploi (PAIE)

This job re-entry program is aimed at income security recipients having difficulty securing paid employment. The program assists individuals in re-entering the work force in order to gain experience.

Programme Expérience de travail (EXTRA)

This work experience program is designed to help income security recipients develop basic personal skills to increase their chances of securing or maintaining a paid position.

Secrétariat au développement des régions (SDR)

The regional development secretariat is a provincial ministry that co-ordinates the implementation of the government's regional development policy. To achieve this, the SDR works on harmonizing government action at the regional level and acts as an advisor to the government on policies, strategies and programs that may have an impact on the development of the regions. Each Quebec region has its own SDR office.

Société québécoise de développement de la main-d'œuvre (SQDM)

This Quebec society for labour force development had offices in 12 regions across Quebec. Each regional SQDM worked to create jobs throughout its territory and offered training programs to promote labour force development. The organization is currently being dismantled and its services will be integrated into new employment structures.

S U M M A R Y

Over the last few years, Canada's health and social services system has undergone profound change. Hospital stays have been shortened while home-based care and services have grown. Since 1996, Quebec's stated objective has been to introduce a new approach to delivering medical care while reducing hospital waiting lists and responding to new needs. It has also been to introduce a new series of budget cuts made necessary, in part, by the reduction in transfer payments from the federal government. As a result, we are witnessing a systematic shortening of hospital stays, an increase in day surgery and the widespread use of ambulatory services. In addition, there is the transfer of staff from hospitals to local community service centres (CLSCs), the conversion of general hospitals into long- and short-term health care facilities, the amalgamation of facilities (hospitals, CLSCs and nursing homes) and a reduction in staff size and hospital beds. Hospital and CLSC employees are facing heavier workloads, and it has become common for patients still under medical supervision to be cared for by relatives.

Concurrent with this reform, and following the Socio-Economic Summit of October 1996, the Quebec government began to support the social economy sector more actively, in a belief that social economy enterprises would develop new economic activity and create jobs while satisfying the demand for certain public services not currently being met.

This study is the result of research conducted from November 1996 to June 1997. It examines the impact on women of changes to health and social services, and the measures taken by the provincial government to support the social economy in this area. The restructuring of services has had a major impact on the workplace in the health and social services network and has led to a deterioration of working conditions, with a number of consequences for the lives and health of employees in this field, who tend to be mostly women. Furthermore, the transfer of aspects of care delivery from health facilities to patients' homes has resulted in greater responsibilities for relatives or close friends, the vast majority of whom are women. These volunteer caregivers must provide a growing and increasingly complex range of treatments. More and more, women are expected to assume a heavier burden, and this has repercussions financially, in terms of their health and general well-being (stress, anxiety, insecurity, exhaustion) and in their personal, family and professional lives. The restructuring of services and the transfer of care to the home has also had a direct impact on the quality of care: caregivers are overworked and patients' relatives are not always qualified, or capable, of delivering the necessary care.

Our study also focuses on a series of issues related to the activities of the regional committees which are responsible for funding projects on the social economy (CRÉS), and on the general effects of social economy government policies on women. These include the disengagement of the state and the transfer of public sector responsibilities to the private and community sectors, where jobs are less stable and lower paying; the threat to gains made by women in the work force; and the confinement of women to domestic-type work. The impact of social economy policies on women's groups is also addressed, given that they have been mobilized around social economy strategies and have found themselves at the core of a new political scene that places them in direct competition with other groups.

The results of this study are aimed primarily at policy makers in Quebec and Canada. This report emphasizes a few of the main problems arising from the current restructuring of services, both for service providers (workers and unpaid caregivers) and patients. Steps must be taken to correct these problems that threaten the accessibility and quality of services and affect the well-being of many women. The results of this study will also be of interest to women's groups and to those interested in women's issues, since many of these transformations have direct (e.g., greater professional and domestic workloads) and indirect (e.g., participation in the work force, value of women's work, participation in volunteer activities) repercussions on women's lives.

INTRODUCTION

I gave birth on a Sunday night, and was discharged 24 hours later, at 8 o'clock Tuesday morning.... At 5 that evening I was readmitted to the emergency because I was hemorrhaging. (Patient, Montreal)

After three days she was told she could go home.... She's all alone. She couldn't even dress or feed herself. I said: "Find her a convalescent home." The doctor thought that was frivolous. (Caregiver, Montreal)

We're being asked to look after very sick people but we don't have the training. It's not just a question of giving someone a bath, it's regulating their medication, making sure they're all right, checking their pressure. (Caregiver, Outaouais)

In the past, a nurse had five patients...two who were scheduled for surgery the next day, three for surgery that day and one who had had surgery two to three days earlier. Those on either end didn't require care while the ones in the middle did. These days, there's no one at the two ends. You're dealing with five patients who require major ongoing care. (Nurse, hospital, Saguenay-Lac-Saint-Jean)

When I first started (some 21 years ago), I'd have up to five people over 38 hours. Now, you can have 20 people in 35 hours. (Homemaker, CLSC, Quebec City)

I feel like I'm being rushed by the system and I'm really scared of rushing patients...that's one of my big fears...I don't want to rush anyone but we're rapped by the shift...and we're forced to rush. (Nurse, hospital, Bas-Saint-Laurent)

These first-hand accounts clearly illustrate some of the situations we encountered over the course of our research. Given what we already know about the impact of previous policies of de-institutionalization and home care, we are apprehensive about some effects of the accelerated shift to ambulatory care. We believe it has been useful to identify the impacts of this trend, from the very first stages of its implementation, on the public in general and on women in particular. The Association féminine d'éducation et d'action sociale (AFÉAS) and the researchers embarked on this study with the shared assumption that those on the front lines of caring for relatives, namely women, would be particularly affected by the shift to ambulatory care since it is explicitly based on the presence in the home of a "natural helper" (hereinafter referred to as caregiver¹) to assist the patient in recovery, a role previously assumed by the hospital system.

The AFÉAS², which in recent years has redoubled its efforts to win recognition for the invisible work performed by women, had already observed some of the effects of the shift

among its members who work as caregivers. These individuals had less time for the AFÉAS and other activities outside the home since they had to care for relatives returning home after shortened hospital stays — a responsibility which seemed to require constant availability. The extent of this reality and the impact it could have on women prompted the AFÉAS to conduct an inquiry into the situation.

For their part, researchers working on the welfare state, caregiving and gender relations were also taking a critical look at the orientations and procedures that appeared to underlie the restructuring of Quebec's health and social services network. In August 1996, a coalition of women's groups issued a warning to the public and to government of the potentially harmful effects of the shift to ambulatory care.

A number of questions arose from these various analyses as to the consequences for women of state orientations and actions in the area of health care organization. For instance, was it a given that women would be available to fill the void left by the health care system with regard to looking after sick or convalescing relatives? What did these new responsibilities entail? What would be the consequences on women's lives, health, participation in the work force, financial autonomy, volunteer commitments, studies, leisure time? And what would be the impact on women who, for various reasons, rely more heavily on health care than men? Would they be most affected by the changes brought about by the shift to ambulatory care? Is it important to document the quality of care that can be provided in the home as well as the way women cope with new caregiving responsibilities? How will social economy projects provide support to caregivers? Will they ultimately fill the void created by cutbacks in public services?

The partnership between the AFÉAS and the research team grew out of these shared concerns. Research began in December 1996 when measures related to the shift to ambulatory care and social economy were being implemented. We, therefore, attempted to identify phenomena as they were developing and evolving.

Given this context, the portrait we have drawn may be incomplete and, at times, impressionistic, but we believe it provides a first glimpse at a reality that is profoundly changing the lives of women in Canada. We hope to contribute to the analysis of the current restructuring of Canada's health care systems, to alert policy makers to the adverse effects of certain aspects of these reforms and to suggest areas for future research.

CHAPTER 1: CONTEXT OF THE STUDY

The social and political context in which this research was conducted is the product of several changes to health and social services in Canada. These changes are not the result of chance or spontaneity: they are the result of a long maturing process punctuated by a series of legislative, political and financial reforms. The effects of budget constraints in the area of health and social services are being felt in every province in Canada. There is a tendency to privatize certain services, sub-contract public services to the private sector, amalgamate facilities and to shift toward the community without the necessary injection of funds (Armstrong et al., 1994: 48). This has raised a number of questions throughout North America and the western world with regard to the impact of these changes on the quality of life of both patients and caregivers as well as on the value of care provided. Our objective is to better understand this reality. In order to do so, we chose to analyze the articulation of these reforms in a single Canadian province, Quebec. The fact that health and social services are a provincial responsibility is only part of the rationale for our choice. The mechanisms in place in Quebec, in the area of health and social services, also informed our choice, for they will, in our opinion, help to shed light on the major tendencies observed across Canada.

This study attempts to document and analyze the impact on women of the shift to ambulatory care and the social economy policies currently being implemented in Quebec. The abrogation of the Canada Assistance Plan and the Established Programs Funding in 1996 and their replacement, the Canada Health and Social Transfer, all acted as catalysts for these phenomena. These reforms, announced by Finance Minister Paul Martin in March 1996, reorganized federal transfers for health, post-secondary education and social services. The new single fund was then slashed by \$700 million (for Quebec)³ for the year following the announcement of the budget. In return, the provinces were given greater freedom in determining how the money would be spent and in developing compensation strategies to make up for lost revenue. The rules governing medicare were maintained, leading many to believe that health care systems would be less affected than social services. For Quebec, this announcement also represented an adjustment in the amount of funding received in relation to its shrinking population, compared to the rest of Canada: its portion of total transfers of 27.3 percent in 1996-97 will drop to 25.5 percent in 2002-03.

The provincial reforms following these announcements were intended to simplify and rationalize programs and services, and were justified as part of the Quebec government's efforts to achieve a balanced budget. As elsewhere, we are witnessing state restructuring and disengagement from health and social services. In the future, the Quebec government plans to *accompany* initiatives taken by civil society, rather than take them itself.

In this respect, it is important to recall the reorientation of Quebec's health and social services in the 1980s⁴ according to a new approach to service delivery. Emphasis was placed on health and social problems rather than on the existence and accessibility of services. Services were to be viewed in terms of their objectives: the effectiveness and efficiency of health and social services were on the agenda in terms of resources and the search for solutions.

In 1989, the government also began adopting a series of laws and policies transferring certain responsibilities for the development of the economy as well as health and social services to the regional level. This *regionalization*, went hand-in-hand with the provincial government's disengagement from direct intervention in these fields.⁵ The health and social services sectors were one of the first to come under regional management. The Côté reform announced in 1990 (Gouvernement du Québec, 1990) and implemented by Bill 120 in 1992, was structured around this new sharing of responsibilities between the administrative regions and the central government. It also responded to criticisms of the system's centralization, bureaucratization and inflexibility.

In the wake of this reform, the Quebec government undertook a new wave of budget cuts and restructured the mandate of health and social services facilities. This led to the amalgamation of nursing homes, residences and chronic care facilities into chronic care hospitals. The law also created regional health and social services boards — Régies régionales de la santé et des services sociaux (RRSSS)⁶ — which were to become major players in the system.

The ensuing wave of reforms to health and social services has been termed the “shift to ambulatory care.” It entails a profound reorganization of the system not only from a management perspective, but also in terms of the delivery of services. It aims to reduce the length of hospital stays, to increase day surgery and, as a result, to increase the volume of medical care and services delivered outside the hospital setting. These changes affect all health and social services facilities. They have led to a reduction or transfer of personnel from hospitals to CLSCs, a new relationship between CLSCs and hospitals in the area of post-hospitalization follow-up, and the specialization of hospitals in the delivery of certain health care services. The private sector, also affected by the restructuring of the health network, will be assigned greater responsibility and leadership. The responsibilities of health and social services workers in both the private and public facilities will grow, despite the fact that it is becoming increasingly common, and in some cases unavoidable, for relatives to assume caregiving responsibilities.

The shift to ambulatory care, therefore, entails a change in the philosophy of care and responds to certain administrative needs, such as reducing hospital waiting lists and meeting new collective needs (for example, ageing and the increase in chronic diseases). This shift is also, and above all, about implementing a series of budget cuts made necessary, in part, by the decrease in transfer payments from the federal government to the provinces and the resulting reduction in the provincial budget allocated to health and social services. The shift to ambulatory care is thus the outcome of changes to many aspects in the organization of care.

From another perspective, any understanding of the emergence of the social economy in Quebec, must take into account the 1995 Women's March against Poverty. In response to one of the demands made by the marchers — the establishment of social infrastructure that would recognize women's invisible work for their relatives and community — the Quebec government announced it would allocate significant funds over the following five years and set up a series of working groups with a mandate to analyse and then create a Chantier de

l'économie sociale.⁷ This conceptual, strategic and practical exercise was designed to help the government support the development of a mixed economy that would be capable of responding to the need for services, the shortage of jobs and state disinvestment. This was the government's response not only to the public budgetary crisis but also to the demands of social movements in a context where public health and social services were somewhat at the heart of a social, political and economic cohesion. The social economy would also be an answer to the limitations of the market economy and a response to ongoing high unemployment rates, responsible for huge government spending in the area of social security. From the government's point of view, the social economy would enable it to reduce its expenses in the area of employment and pursue a review of its entire role in the area of social security.

But the social economy represents something entirely different for other sectors of Quebec society which view it as an opportunity to democratize the economy. Social economy enterprises have a social purpose: to produce goods and services that respond to the needs of a community and whose objective is collective well-being rather than profit. The development of a social economy constitutes a strategy to strengthen the social forces that have long been at work within social movements and which will now focus on economic development. These forces regard the social economy as an answer to the need to create jobs for society's poorest and most marginalized sectors.⁸

Since the reorganization of the health and social services sector has led to new needs related to caring for patients sent home following shortened hospital stays, a relationship may be implicitly forged between the shift to ambulatory care and the development of the social economy. The social economy could meet these needs by creating community services.⁹

New services linked to the social economy, however, emerge in a number of different contexts and run the risk of lacking uniformity. Inequalities in the quality and accessibility of new goods and services may arise. We can also expect to see variations in the range of goods and services available from one community to the next in Quebec, since the establishment of local services linked to the social economy occurs in a context of budget cutbacks in health and social services (Conseil du statut de la femme, 1996a). This raises the concern that good jobs (in the public sector) will be replaced by lower-paying jobs, despite the assurances and negotiations that took place to ensure that the jobs created by the social economy would be longer lasting (three years) and pay above minimum wage.

The de-institutionalization of health and social services initiated in the 1970s reduced the public services available to individuals suffering chronic mental health problems or physical disabilities (Guberman et al., 1993: 15). Since the end of the 1980s, fewer and fewer services have been offered, and public health and social services are no longer able to meet needs. Emergency wards are severely overcrowded and must occasionally be closed and, despite the increase in resources devoted to home care, it is becoming difficult to offer patients as many services as could be expected in the past.

The major organizing principle behind the shift to ambulatory care is to *offer health care while maintaining individuals within their communities* (Conseil du statut de la femme,

1996b: 11). Community is defined here as the patient's family, not a hospital. This represents a major transformation occurring across Canada (Armstrong and Armstrong, 1996). Hospitals will no longer be the exclusive site for healing but rather a place for short-term stays for the delivery of specialized care and services.

Certain treatments once delivered in hospitals (for example dialysis, hemodialysis, antibiotic therapy, chemotherapy) will now be provided in out patient clinics and will no longer require hospital admission. Some treatments will even be administered by the patients themselves or by a relative or home care service. Pre- and post-operative services will also become ambulatory: patient stays in the recovery and operating rooms will be shortened, admissions will be processed by out-patient departments, and preparations (for example washing and shaving) will be performed by patients themselves. Post-operative follow-up will be conducted by patients or their relatives with instructions issued (possible complications and actions to take) and CLSCs will conduct telephone follow-up 24 hours after surgery (Conseil du statut de la femme, 1996b: 12).

Ambulatory services delivered by hospitals and CLSCs will be complementary to those dispensed or obtained by patients' relatives. Hospital-based ambulatory services will primarily take the form of patient admission and transfer to CLSCs for follow-up treatment. The hospital will, however, remain at the heart of the system as it will continue to be responsible for medical follow-up and will have to co-ordinate its actions with those of the CLSCs. For their part, CLSCs will become responsible for home support that cannot be assured by the patient or a relative (administering medication, nursing care and personal care).

Research has revealed that women continue to be the primary caregivers, despite recent changes in attitudes and attempts to achieve a more equitable division of responsibilities. These responsibilities are often misunderstood or go unrecognized. Their goal is the physical, mental and emotional well-being of others. This work involves seeing to patients' personal hygiene, housekeeping, maintaining and purchasing items such as clothes, maintaining a social network, communicating and mediating with social institutions (schools, social and health services) and managing emotional relations in the home (Therrien, 1987: 6). Of course, men also participate in these tasks, but to a much lesser extent since they are rarely responsible for managing these tasks.

Society expects women to take responsibility for caring for their relatives even when this represents unpaid informal work. Caregiving entails a whole series of activities in the home, within the community and in health care facilities. Essentially, this work is relational since it involves an exchange between two individuals, the caregiver and the patient, and demands responsibility and continuity on the part of the caregiver (Saillant, 1991, 1992).

It has often been noted that mental and physical health problems arise when these tasks and functions are not fulfilled. To this day, there is a tendency to criticize when this care is not provided and "these silent and unpaid female workers have rarely been given credit as important actors in the health system" (Therrien, 1987: 7) [translation].

For instance, it is generally a single member of the family who takes primary responsibility for supporting elderly relatives who have lost their autonomy. In 70 percent to 80 percent of cases, this caregiver is a woman. One half of women in Quebec between the ages of 35 and 64 can expect to take care of an aged relative (Garant and Bolduc, 1990: 33). Every North American study concurs on this point: to talk about care provided by the family or of “natural helper” is a euphemism for care provided by women (Brody, 1987, 1981, 1990; Horowitz and Dobrof, 1982; Stone et al., 1987).

The caregiver assists and cares for the person in need (medical services, physical caregiving, moral and psychological support, help in organizing day-to-day activities, monitoring). She also ensures mediation between the patient and public services (mobilizing resources in the health, social services, legal and financial realms, mediating to ensure social integration) and organizes as well as co-ordinates the work entailed in taking responsibility for a patient (co-ordinating various services and actors involved, co-ordinating the various demands in the patient’s life) (Guberman et al., 1993: 33).

Given the great extent to which women are now active in the work force, several studies have attempted to determine the relationship between taking responsibility for the care of a patient and participation in the work force. In 1993, 72 percent of Canadian women between the ages of 44 and 54 — a major potential pool of caregivers — held jobs (Armstrong and Armstrong, 1996). It is estimated that one third of women providing care to a dependent elderly relative are employed (Lesemann and Chaume, 1989; Stone et al., 1987). This number rises to 50 percent for women caring for a parent, thus excluding spouses (Stone et al., 1987).

A number of studies have revealed the negative consequences on the career development of women who are assuming home care responsibilities. Absenteeism, changed work schedules, missed promotions, reduced work productivity and partial or total withdrawal from the work force are some of the consequences (Guberman et al., 1993; Lang and Brody, 1983; McKinnon and Odynak, 1991; Matthews and Rosenthal, 1993; Neal et al., 1993; Scharlach et al., 1991).

More specifically, an Ontario study has shown that in Canada, eight times more women than men have lost one week of work due to *personal reasons* (Armstrong et al., 1994), and women were five times more likely to quit their jobs for this reason. According to the Conference Board of Canada (MacBride, 1990 cited by Armstrong and Armstrong, 1996) women are two times more likely to state that their chances for promotion are hindered by home care responsibilities. The proportion of caregivers in the work force who have quit their job to take on these responsibilities is estimated at 9 percent (Canadian Study of Health and Aging, 1994).

Working women who take on the responsibility of caring for a sick or dependent relative will probably be obliged to reorganize their jobs around their home care responsibilities, withdraw partially or totally from the work force for an extended period, or choose a job in line with their caregiving responsibilities (Guberman et al., 1993: 52-53). Consequently, following a shift to ambulatory care, women run the risk of reducing their access to paid

employment and increasing their informal workload within the family (Armstrong et al., 1994: 103). Women looking for work are often forced to put their search on hold or risk having their benefits cut. This occurs precisely at a time when they are most in need of an income. Furthermore, family and community members (women in the majority of cases, even though they are not usually explicitly called upon) put their own health at risk. Stress levels are very high since *women tend to feel morally obliged to provide care in these situations* (Saillant, 1991, 1992).

The restructuring of health and social services also has implications for another group of women, those working in public health services who face job loss or transfers and increased workloads (Armstrong et al., 1994: 48). The Rochon Commission recognized, as early as 1988, that women represent close to three quarters of the work force in the health and social services sector and they still assume the greatest responsibility in helping relations (Guberman et al., 1993: 27). The rate of feminization of this work force reached 75 percent in 1991 and represented 16.2 percent of the available female labour in Quebec (Conseil du statut de la femme, 1995a: 98).

CHAPTER 2: METHODOLOGY

General Presentation

In keeping with our objectives, we have opted for an exploratory study and a descriptive analysis. Given that the *combined* realities of the shift to ambulatory care and social economy policies were still relatively unknown to researchers, in part because they only began to be implemented in Quebec in 1996, we did not wish to prematurely judge their various dimensions and evolution. Our aim was to define the various manifestations and dimensions of these two realities as they were being played out in the social sphere, in order to better measure their possible effects, if only in the short term. As this study demonstrates, however, these combined realities were not easily grasped, possibly because they were difficult to define, often confounded with much wider realities (for example, the shift to ambulatory care with the restructuring of health services, the social economy with the community sector).

This exploration offers possible paths for further inquiry and working hypotheses rather than definitive results. It is important to acknowledge the reality of our research topic, or rather its context. The shift to ambulatory care and the implementation of social economy policies were initiated in 1996 and will surely continue for the next two or three years. Studying them now allows us to identify several measures and to anticipate others. This is a first foray into a sphere of society that is literally taking shape before our very eyes.

The methodological difficulties arising from this context require researchers to be open and flexible. The changes implicit in the shift to ambulatory care and the implementation of social economy policies have led to an unprecedented and profound disruption in the personal and professional lives of many people. As we were conducting our research, thousands of female workers were displaced, dismissed or de-skilled; families were forced to adapt to the increased responsibilities related to the *homeward shift* of health and social services; women's groups were mobilized by the Socio-Economic Summit in the fall of 1996 and struggled both for their survival and to prevent the derailment of their mission; negotiations took place between public sector unions and the government. Finally, the social economy policies so vaunted by the government took time to materialize: some regional committees on the social economy (CRÉS) did not make decisions regarding the allocation of funds until March 1997. As a result we were obliged to limit our research on social economy policies, and to focus greater attention on the shift to ambulatory care and the diverse processes that had already been implemented when we began our research in December 1996. As is usual, although more pronounced in this context of profound organizational change, conditions required us to adhere to reduced time frames; to interview people whose lives had been disrupted; to seize opportunities for very candid discussions in a context of organizational and political reconfiguration and great uncertainty; to listen to how individuals are coping with all these changes and new visions, even in the worst scenarios — in short to know how to adapt our planned research and activities to a rapidly mutating reality.

To ensure wide coverage, we conducted the exploratory inquiry in different regions of Quebec, collecting data from the metropolitan centres (Montreal, Quebec City), from medium-sized urban zones, (Hull, Gatineau and Aylmer in the Outaouais, Chicoutimi in the Saguenay-Lac-St-Jean region, Rimouski in the Bas-du-St-Laurent region) and also from rural zones. In addition to the fact that these cities are home to the five universities to which our researchers are affiliated, this approach enabled us to address the question of the regionalization of services, closely tied to the restructuring of health and social services, as well as the regional impact of restructuring. This approach also helped us to avoid imputing the realities of one of the large urban centres to the various regions. (Côté et al., 1995). Our objective was to reach a variety of milieu reflecting the diverse social, economic, demographic, cultural and organizational realities of women in Quebec. In this way, the experiences related are typical of the regions studied, which has permitted us to analyze them both individually and comparatively.

Our primary methods of data collection were semi-structured, individual interviews with open questions and focus groups based on themes. These techniques have the necessary advantage of flexibility given the context described above. To ensure that the research was conducted in a consistent manner across the five regions, we designed and tested standardized tools (interview framework). These tools permitted us to obtain comparable data from each region.

We were interested in meeting with the major categories of women affected by the shift to ambulatory care and the implementation of social economy policies. We will begin by examining the shift to ambulatory care.

The women most directly affected by the shift to ambulatory care are those caring for a relative or friend at home following a hospital intervention and those working in health and social services. The shift to ambulatory care has meant shorter hospital stays and greater involvement of patients' families and friends in health care. As we will show, women in this context are affected both as caregivers and as patients. One of the key elements of the shift to ambulatory care is 24-hour childbirth and, in this context, we met with both caregivers-turned-patients and patients-turned-caregivers. We organized focus groups in the fall of 1996, with the assistance of the AFÉAS, primarily among women members of the AFÉAS who had recently experienced the effects of the shift to ambulatory care.

In terms of women working in the areas of health and social services, we met with hospital and CLSC personnel: nurses, nursing assistants, homemakers, orderlies and social workers. These workers all deliver some form of assistance and care in the public service. Nurses and nursing assistants dispense nursing care; homemakers provide domestic help in the home; orderlies provide help and support in a hospital setting (such as personal care and food services); and social workers plan and deliver social services (such as placement and referral) to CLSC and hospital patients. The shift to ambulatory care is closely tied to the reorganization of health services and directly affects the workers in this sector — their job security, tasks (nature and quantity), responsibilities and futures. Individual interviews were conducted at the end of the fall of 1996 and winter of 1997, in the five regions identified and among different categories of workers. Some interviewees occupied positions in their

unions, some were program administrators or members of regional consultative bodies; others were workers who could provide accounts of their situations as well as those of others, given the depth of their knowledge about their group, institution or region. These people were recruited based on contacts established in various milieu targeted by our researchers in each region. In this sense, the people we met constitute a key group of informants across the province able to provide reasonably accurate accounts of the circumstances and effects of the shift to ambulatory care on women and, in this case, on female health care workers. All these women have been affected in some way by the shift.

To the extent that the shift to ambulatory care is occurring at the same time as Quebec's social economy project, we also observed certain aspects of the implementation of this project in the community and among community groups in Quebec. Our initial intention was to devote much greater coverage to the social economy project, but this initiative is actually occurring at a much slower rate than expected. In fact, projects funded and initiated by the provincial program were only just starting to be implemented by the time we began writing this report. For this reason, we limited our data collection to interviews with women on the CRÉS in the five regions who had observed at close range, in various capacities and at different times, the decision-making processes related to projects affecting women. We also solicited the views of women's groups and others directly engaged in debates on the social economy. Based on this approach, we were able to identify the intersection between the shift to ambulatory care and the government's social economy policies, and better understand how projects will fill the void created by the shift.

The major stages of our research are explained in detail in the following sections.

Data Collection

Focus Groups

We organized two focus groups in Montreal and one in each of the other regions. To promote and facilitate communication, we chose group meetings instead of individual encounters. Our main objective was to define the effects of the shift to ambulatory care on home care, on the women who provide home care and on the women receiving it in this period of service reorganization. This portion of the research directly involved the AFÉAS as we recruited participants from the ranks of its membership. Recruitment turned out to be more difficult than expected. In fact, despite the specific criteria we provided and the financial resources we made available to accommodate participation in our focus groups, we were obliged to recruit beyond the AFÉAS membership. In some instances, the criteria were an obstacle to recruitment (they appeared too focused, especially in less populated areas such as Rimouski and Chicoutimi). In others, AFÉAS members were not prepared to share their experiences with others and, in some instances, participants had claimed to meet our criteria but, once in the group interview situation, it became clear that this was not necessarily the case and that the selection criteria had been widened. In cases where the AFÉAS was unable to supply the names of its members, researchers turned to associations and networks they were familiar with through previous research or teaching.

The specific objectives of the group meetings were to document and analyze the impact of the shift to ambulatory care on women across Quebec. More precisely, the objectives were:

- to share different personal experiences related to the shift to ambulatory care and to the ensuing changes on home life, be it from the caregiver's or patient's perspective; and
- to determine collectively the impacts of this experience on daily life, the changes introduced, and the actions to be undertaken.

In elaborating selection criteria for our focus groups, it was important to first define the shift to ambulatory care. We adopted the definition proposed by the Conseil du statut de la femme (CSF) (1996b: 10):

In lieu of hospitalization, the shift to ambulatory care consists of offering health care while maintaining individuals within their communities. Maintaining individuals in their home environment has meant replacing hospital services with various options or shortening hospital stays [translation].

The following criteria were used to select participants for the focus groups.

- Women who are members of the AFÉAS.
- Women who have experienced, as caregiver or patient, a situation linked to the shift to ambulatory care (shortened or cancelled hospital stays as a result of services reorganized in the last three years).
- Women who have had this experience over the last six months.

There were advantages and disadvantages to prioritizing AFÉAS members. One major advantage, in the context of this exploratory research, was to have access to accounts from women who are particularly aware of women's issues. The major drawback was that the AFÉAS membership undoubtedly excludes certain groups of women who are marginalized and living in great poverty, and who are hard hit by the Quebec government's social and public health policies.

Our criteria also dictated that women had to be primarily affected by the shift to ambulatory care as caregivers, although this did not exclude their experiences as patients. In certain cases, as we will see, these situations coexisted. Finally, the experiences had to be recent, in order to better distinguish between home care situations and situations related to the shift to ambulatory care. A discussion outline was proposed to the participants, which appears in detail in Appendix 1. The following themes were addressed:

- the context in which the patient left the hospital and in which the decision was made as to who takes responsibility for the patient;
- support received from public and private services;
- the impacts of assuming responsibility for the patient on the personal and

- professional lives of caregivers, on their health and on the quality of the care provided; and
- the costs incurred by providing care and the survival strategies developed by caregivers as well as the solutions they propose.

Each of the six focus groups, made up of four to eight women, met for an average of three hours. In total, 32 people were interviewed. The distribution of participants in the focus groups according to region and their role in caregiving can be found in Appendix 2. All interviews were recorded on audio-cassette following written consent from the participants. Participants' contributions were generally very good, although this varied depending on the group's composition (number and characteristics of participants) and how the discussions unfolded (themes addressed and the overall scope of the discussion). In some cases, conversations were more serious, especially when the situations described evoked difficult personal experiences. In all the regions, the wealth of material collected is undeniable.

There is no question that this sample, with all the difficulties we have described, is not perfect. Ideally, we would not have grouped health care workers with the other participants, although we do not feel that their participation hampered the discussions. The participation of women who had been patients was also significant; in fact they were present in almost equal numbers to the caregivers. This is an important point, that has helped to characterize the shift to ambulatory care in relation to home care, from the perspective of women's status. In terms of home care, the research focused primarily on the situation of caregivers. As will be illustrated, in the present context, women are not only seriously affected in their role as caregivers, but also as patients.

Individual Interviews

Health and social services workers

Health and social services workers were interviewed individually. To promote open communication, we created a setting that was less threatening than a group interview involving workers from different categories, for example nurses and registered nursing assistants. We also wanted to obtain the most specific information possible from the various groups affected by the shift.

In each of the five regions, we selected 6 to 10 people who, by virtue of their position and the responsibilities or their particular experience, could present an overview of the situation in terms of the shift to ambulatory care for that category of workers and that region. A total of 38 people were interviewed. The distribution of these respondents according to region, position, facility and experience vis-à-vis our research objectives is presented in Appendix 4. We selected individuals, for example, affiliated with major labour federations representing a particular category of workers (principally FIIQ and CSN), occupying a middle-level management position (e.g., someone responsible for a CLSC home care program) or sitting on a regional or provincial roundtable (for example, the Table de concertation des travailleurs sociaux en milieu hospitalier) or the board of directors of a regional workers' association (for example, the association of homemakers). The respondents came from different departments in their respective facilities.

The distribution of the respondents according to region, position, type of facility and experience is widely varied (see Appendix 2). While our focus is on the conditions of female workers, a few men did participate in the study in the Quebec City area. During the interview phase, the woman representing patient attendants was on sick leave. We, therefore, interviewed her male replacement. All male participants in this study spoke of group situations in which the majority of members were women.

The interviews lasted on average 1.5 hours. They took place at the respondents' workplaces or, sometimes, in their homes. All the interviews were recorded, following written consent from the respondent.

Several questions were asked (see Appendix 3). Each of these themes generated 10 or so open-ended questions. The main themes addressed during the interviews were:

- significance and description of the shift to ambulatory care and its regional specificities from the perspective of the facility;
- significance and description of the shift to ambulatory care and its regional specificities from the perspective of the regional network of services;
- effects and consequences of the shift to ambulatory care on women's working conditions;
- job qualifications and de-skilling; and
- support and solidarity.

We enjoyed excellent co-operation from the workers, especially given the difficult context many of them were facing. They were acutely aware of the importance of research into the significance and impact of the shift to ambulatory care on women. They all acknowledged the importance of this research and the need for more systematic information in this area.

Social economy

Individual interviews were conducted among women sitting on CRÉS and among representatives of provincial associations of women's groups involved in social economy issues. Five women sitting on the CRÉS for the five regions were interviewed, as were two others representing provincial women's associations. We selected provincial associations that were directly affected by social economy policies. The objective of these interviews was to talk to women who had observed, at close range, the evolution of the social economy project since the demands put forward at the 1995 Bread and Roses March. In general, we wanted to ascertain how these individuals evaluated the content, context and issues surrounding the implementation of social economy policies for both women and the health care sector. The outlines of the individual interviews appear in Appendices 2 and 3.

The interviews were conducted in two stages: the first in mid-February 1997 (four women sitting on CRÉS) and a second at the end of May 1997 (one woman sitting on a CRÉS and two women representing provincial associations). The contexts of these two periods are relevant. In the first, the CRÉS were busy with project selections; in the second, project selection was complete and the CRÉS were already conducting an assessment of the process. These differing contexts resulted in a disparity in the results obtained since the

informants' analysis of issues varied depending on the stage of the process, thus complicating our analysis, as is demonstrated below.

Data Analysis

All the group and individual interviews were fully transcribed and subjected to content analysis. Given that this study was exploratory and that research had to be conducted within definite time constraints and involved long-distance relationships among the researchers in the various regions, we chose a method of analysis that enabled us to adapt to this context while ensuring the internal validity of the information. To do so, we transformed the questions into code names and synthesized each interview, both individual and group, according to question (or code) and according to the three sub-groups (home caregivers, health care workers, women working in social economy structures). By defining the delimitation of the codes for each region, we ensured a logical coherence in the synthesis. We were unable to do the same between regions, due to time constraints. During the synthesis, however, researchers were in communication with one another, and discussed problems linked to the constitution of the codes and the clustering of data. While this approach did not fully respect the rules of qualitative content analysis, it did allow us to go back over the raw data and the syntheses based on the questions (codes) during later analyses, and in this way gradually to validate the choices made.

We then proceeded with synthesizing the data for each region. As a group, we agreed on a new method of clustering information that enabled us to filter the codes and achieve a better overall reading, which also prepared us for the next step of regional comparison. The regional syntheses were presented in a single preliminary report to the Status of Women Canada in March 1997.

Regional comparisons were conducted using the synthesis of the preliminary reports. The regional reports served as the basis for this operation. We are aware that the ideal would have been to return to the raw data and to conduct more refined cross-sectional analyses, based on our hypotheses. This, unfortunately, was not an option, again because of time constraints. However, the fact that the regional syntheses were conducted in great detail and with a high degree of systemization, enabled us to return regularly to the raw material in the archived documents when needed. The risk of systematic bias is virtually nil, and the synthesized material accurately represents the point of view of the women and the few men we interviewed. Once an inter-regional synthesis was completed by one team member, it was submitted to each co-researcher and carefully read, in order to avoid losing elements specific to a region, and to ensure that everyone participated in validating the final results. Comments were integrated into the final document. It is this analysis that is presented in the following pages.

The same approach was used to analyze the portion of our research related to the social economy, although it is important to point out the constraints that had an impact on the results. We have already pointed out that the interviews with the five women sitting on the CRÉS and the two representatives of provincial associations were conducted during two very different periods (prior to and following the implementation of projects funded by the

social economy program). Personal analyses varied greatly depending on positions held, ideological perspectives and the timing of the interviews. Furthermore, given that there are 16 CRÉS in Quebec, a nuanced interpretation of the data is essential. Nevertheless, trends and tensions were detected which, at the very least, reveal the complexity of the process currently under way.

The analytical framework used to process this portion of the material involved four major elements:

- the definition of the social economy as well as the nature, mandate and activities of the CRÉS;
- the projects submitted to the CRÉS and the selection process;
- the link between the social economy and the shift to ambulatory care; and
- the challenges facing women as a result of the social economy.

The interviews enabled us to begin an in-depth study of the challenges of implementing social economy policies in Quebec for women, as well as the consequences in the context of the shift to ambulatory care. We can attempt to focus on the internal functioning of the CRÉS, the process of implementation in the regions and the challenges faced by women in general. More specifically, we have initiated an analysis of the interactions between the shift to ambulatory care, the social economy and women, an analysis that will be pursued in the months and years ahead.

CHAPTER 3 : THE SHIFT TO AMBULATORY CARE AND THE RESTRUCTURING OF HEALTH AND SOCIAL SERVICES: ITS IMPACT ON WOMEN

A Forgotten Reform

Medical innovations in surgery and other types of care (for example, intravenous injection of antibiotics) have paved the way for the shift to ambulatory care — shortened hospital stays and, as a result, longer convalescence at home, with relatives or in a nursing home. In this way, part of the care that was once provided in hospital is now the responsibility of patients themselves or their relatives.

There are a number of conceptual and methodological challenges involved in evaluating the effects of the shift to ambulatory care on patients, their relatives and workers in public health institutions. For the purposes of this research, we did not adhere to the strict medical definition of the shift to ambulatory care, since in Quebec, the changes in medical intervention procedures were intertwined with budget cutbacks resulting in an accelerated restructuring of care. The projected impact of the shift to ambulatory care in strictly medical terms was thus eased, in some cases, by administrative measures (for example, the reduction of waiting lists) and amplified in others (for instance, looking after convalescing relatives at home). It was, therefore, impossible for us to separate the elements that were attributable to medical innovation from those resulting from administrative change. Furthermore, the shift to ambulatory care is part of a series of transformations in institutional responsibility which began some 15 years ago: the de-institutionalization of mental health care and home care programs, for instance. In practical terms, the specific effects of the shift to ambulatory care in relation to these measures are extremely difficult to isolate.

The informants' accounts reflect this reality. They pointed out that changes in the philosophy and delivery of care were confused with multiple reorganization initiatives resulting from budget cutbacks. When asked about the meaning of the shift to ambulatory care, most informants spontaneously referred to “closures and cutbacks”: closures of hospitals, hospital beds and services, and cutbacks in jobs and budgets. Only afterward did they mention elements specific to the philosophy of the shift to ambulatory care: shortened hospital stays, day surgery and increased access to CLSCs which offer a larger range of services.

For our purposes, the shift to ambulatory care includes all the measures enabling the shift of care from hospitals to CLSCs, convalescent homes or patients' homes. The health objectives of ambulatory care include enabling patients to better recuperate at home. The shift also contributes to reduced waiting lists for surgery, and adjustments to the health care system to meet specific needs (e.g., increase the number of chronic care beds) and to the constraints imposed by shrinking budgets (reduction of services and staff).

The Cumulative Effect of Change

Our informants' reflections on the shift to ambulatory care follow. This is not an exhaustive description of the phenomenon but rather a snapshot of their views. As such, we present their perceptions of the changes to the health system, without necessarily comparing them to other available facts on the issue, since our objective here is to better grasp how these women perceive their own situations.

Our data reveal the existence of regional dimensions to health and social services as well as to the social economy. The limited number of individual and group interviews we conducted, however, prevented us from carrying out a more advanced analysis. Each region has its own physical and human geography as well as internal political dynamics. The structures and flexibility of regional institutions explain, in part, variations within and between regions, e.g., between urban centres and rural zones, between metropolitan centres where specialized services are available, and areas remote from these centres where such services are less accessible. Although we have noted these differences, they are not analyzed here, since our objective was to understand the characteristics of the shift to ambulatory care, which were clearly revealed in our analysis regardless of region. Our data were not sufficient, however, to allow us to undertake an analysis within each region.

There are major changes associated with the shift to ambulatory care.

- There is an overall decrease in the length of hospital stays. For example, the length of hospital stays following childbirth has dropped from three and a half days to two or even one day.
- Day surgery is increasing (which entails shortened hospital stays).
- For breast surgery, the hospital stay has decreased from five to two days.
- Out-patient departments are being established.

As a result, CLSCs are experiencing an increase in the number of patients and a reorganization of services.

CLSCs have seen their responsibilities increase considerably, without benefiting from a corresponding increase in budgets and resources. They are becoming the entry and exit points of the health care system, and are developing services for recently hospitalized patients: everything from post-operative and perinatal services to placement services for day surgery patients. These changes are compounded by the increase or multiplication of other responsibilities in the areas of homelessness, mental health, intellectual disability and crisis intervention.

Two sectors, in particular, have been affected within the CLSCs and are being reorganized: general health services and home care services. *Short-term* home care services are being developed and expanded considerably.

We give a lot more baths and provide more personal care... In hospitals, patients basically get one bath, while we'll give them up to five per week. (Homemaker, CLSC, Saguenay-Lac-Saint-Jean)

There has also been an increase in pre-operative care, even though there are often equivalent services offered by hospitals.

These changes have entailed a transfer of nurses from hospitals to CLSCs, the reorganization of work teams, the development of post-operative support programs, the reorganization of medical services (consultations with or without appointment, on-call doctors, the presence of home care workers) and the shift in responsibility for service delivery from institutions to patients or their relatives.

Our informants also associate the shift to ambulatory care with administrative decisions linked to changes in needs and patient profiles (e.g., an ageing population) as well as shrinking budgets.

- The complete transformation of general and specialized hospitals (acute care) into chronic care facilities.

Four hospitals in the Quebec City area alone have been transformed along these lines. This has entailed the massive transfer of staff and patients among hospitals within the area, particularly to CLSCs. The number of nurses in one Quebec City hospital fell from 166 to 68.

- The merging of CLSCs and CLSC teams.
- The merging of nursing homes and CLSCs.

For instance, in the Outaouais, the Petite-Nation CLSC was merged with the nursing home for that area.

- The elimination of several hospital services, e.g., emergency wards and out-patient clinics.
- Hospital closures and mergers.

In Montreal seven hospitals were closed, two of which were transformed into chronic care facilities. Part of Hôtel-Dieu Hospital was transformed into an ambulatory care unit and five downtown hospitals were merged to form the McGill University Health Centre (MUHC).

- Bed closures in most of the hospitals.

The number of beds at the Rimouski hospital dropped from 324 to 185 and will eventually fall to 150.

- Increased operating room closures during Christmas and summer.

- The non-replacement of absent employees in CLSCs and hospitals.
- The concentration of specializations in fewer facilities.
- The increased control over the use of materials and spending.
- Bed closures in psychiatric facilities.

In fact, the shift to ambulatory care is compounded by efforts to de-institutionalize mental health care.

- Reorganization specific to each region.

A new distribution of services is taking place within each region. For example, chronic care beds have been transferred from Lac-St-Jean, where there was a surplus, to Saguenay, where there was a shortage, and vice versa for psychiatry. All obstetrics services were transferred from Hull to Gatineau in the Outaouais.

At the time of our study, the implementation of measures related to the shift to ambulatory care was uneven across Quebec and even within regions. Certain sectors had almost completed their planned transformations, while others were still waiting for resources they had been promised following hospital closures. Several facilities have been making changes for some time now, since the time of the budget cutbacks introduced in 1993. In certain CLSCs, staff increased, in some cases even tripled; in others, nursing positions were frozen or left vacant. We have not conducted a systematic analysis of regional differences in these areas. In fact, what was remarkable was the similarity in the comments made by our informants irrespective of region.

Complementarity of Facilities

These changes call for a new collaboration between health and social services facilities, especially hospitals and CLSCs. There is a definite need for closer collaboration given the responsibility of caring for discharged patients at home.

Co-ordination between facilities, however, is not always what it should be. On occasion, requests for home care never make it to the CLSC. When we conducted our research, some areas did not have social workers on their liaison teams, which ensure collaboration between hospitals and CLSCs. In other cases, home care workers were disappointed to discover that hospitals were discharging patients without having properly evaluated the home situation. Our informants also emphasized that private medical services (such as medical clinics, dental offices and pharmacies) had not yet adapted to the requirements of the shift to ambulatory care. As a result, some areas did not have nighttime or 24-hour service, and discharged patients sometimes found themselves in deplorable situations.

As a result of cutbacks and a general shortage of resources, it has become impossible to offer the full range of services. Furthermore, informants emphasized the fact that certain CLSC services have been eliminated: prenatal classes and postnatal follow-ups which were previously

offered to the general public are now only offered in high-risk cases. Everyone else is directed to the private sector or simply turned away unless they are in dire need. In the same way, blood tests are no longer conducted during home visits but rather in private clinics.

When we see a high-risk case, for instance a premature baby...or a very young mother, we'll put in a call and try to establish contact. In the past this kind of follow-up was automatic for all new mothers. (Nurse, CLSC, Outaouais)

- Transfer of funds to the private sector through direct allowances.

In many instances, CLSCs provide allowances to patients or individuals who can no longer look after themselves to enable them to hire someone to assist them.

- The use of private or community services to fill the gap.

We observed a more systematic reliance on relatives and a greater use of community organizations and private agencies for the delivery of home care. We will address this further on. Public facilities are now referring greater numbers of patients to community or private organizations for:

- advice on accommodation;
- home delivery of meals;
- transportation to the hospital for tests;
- housekeeping; and
- visits by volunteers.

All our informants reported their impression that certain health and social services were being privatized, and that there was an increasing reliance on the community sector for accommodations for seniors as well as home care services. They noted that nurses, technicians, social workers and other health care employees are opening private businesses (providing foot care, electrolysis, hairdressing). They also mentioned the reduction of staff in public health facilities, the deterioration of working conditions and changing conditions for caregivers who must care for a relative at home. Once again, there was no regional difference in the information provided by our informants.

In the following section, we will examine the impact of the shift to ambulatory care on relatives, and in particular on those who have taken responsibility for caring for patients who are convalescing or can no longer look after themselves. We will then focus on the impact of this situation on employees and professionals in the health and social services sector.

Patients, Caregivers and Their Relatives

Shortened hospital stays and the role of relatives and friends in caring for convalescing patients is resulting in the transfer of many duties from health workers to volunteer caregivers in the home. The results of our focus groups in the five regions are presented below. These groups were made up of women who had been hospitalized for an operation or

childbirth, as well as women caring for a relative or friend following a period of hospitalization. In some instances, hospitalization had been planned and in others it was an emergency measure. Our respondents had undergone day surgery or had been hospitalized for longer periods for childbirth or different pathologies (hernia, cancer, gallbladder, etc.). Our objective here was to determine the conditions in which hospitalized women were transferred to a home care situation or in which women either accompanied or assumed responsibility for providing home care to a relative leaving the hospital: conditions of hospital discharge, available help and support, the type of care to be delivered, the impact on their lives, and the financial and human costs involved.

Hastened Hospital Discharges

For all our informants, regardless of region, the very first impact of the shift to ambulatory care was new hospital discharge criteria. The patient's hospital stay is shorter and it appears that a hospital stay period has been designated for each medical condition. If the patient makes a normal recovery, he or she is discharged in that designated time: doctors have strict orders. Complications or certain conditions that previously resulted in an extended hospital stay appear, according to our informants, to have no impact on the time of discharge. For instance, it was reported that a new mother was sent home despite the fact that her baby was suffering from jaundice and puerperal toxemia. Another patient, who had had a quintuple coronary bypass, was sent home after six days despite irregular blood pressure, a leg wound and the concerns of her family.

Last week we were told that my mother-in-law was being discharged from the hospital. We met with the doctor who told us: "I have no choice, these are my orders. My back's up against the wall. If the patient recovers in the designated time, I have no choice." She had a relapse which won her a few more days. (Caregiver, Quebec City)

They go to extreme lengths to get you to agree to bring the patient home and look after them. (Caregiver, Quebec City)

- New standards are applied with little or no flexibility.

In the case of day surgery, the length of the hospital stay is established right from the start, and has the advantage of being clear for all. But for other forms of hospitalization, the actual length of stay often does not correspond to the number of days initially stated by the doctor. In most of the cases described to us, the duration was shorter.

- Shortened hospital stays to free up beds.

The need to free up beds for new patients seems to be a priority. Whenever a patient is pressured to go home, this need always seems to be the justification.

Q. For example, what criteria did you use to determine that she could be discharged this Saturday?

A. They needed her bed.

Q. Oh! They needed her bed.

A. Yes. That's the explanation that was given to a member of her family. They needed her bed, so she had to leave.

Q. Was anything said about the state of your mother's health or her physical condition?

A. I was uncomfortable with the whole situation and I didn't agree. Same with my sister. We felt it would be better for her to spend the weekend there to see how she reacted to the treatment; that doesn't even appear to have been an issue...

Personally, I would have preferred if they'd said we'd have to pay a little something. We would have been happy to do that rather than worry with her at home. (Caregiver, Outaouais)

- Patients discharged in a weak state.

According to our informants, the evaluation of a patient's physical condition when making a decision about a discharge is not thorough and does not seem to be a priority. Sometimes it is simply based on the patient's ability to get up and walk, at times even ignoring dizziness and a generally weak state. Technical aspects of a patient's condition can also serve as criteria for discharge, such as a patient no longer requiring an IV.

Q: How was the decision made that you were ready to go home?

A: It was when I was strong enough to get up and go to the bathroom. The nurse accompanied me to make sure I wouldn't fall, that I wasn't dizzy. Then she told me that if I felt up to it I could go home. (Patient and caregiver, Montreal)

They saw him get up and decided he was fine...so they discharged him. He called me at work, I think it was 9 in the morning and he was already home! (Caregiver, Montreal)

One respondent told us that when it was time for her sister to leave the hospital, following surgery for a breast tumour, she had to have cold towels placed on her face so she would not faint. Apparently she had to free up a bed for another patient.

For childbirth, the patient is checked for hemorrhaging or infection before being discharged. But sometimes mistakes are made.

I gave birth on a Sunday night, and was discharged 24 hours later, at 8 o'clock Tuesday morning... When I told them I wasn't ready to go home, they told me that I was fine and that I could go. At 5 that evening I was readmitted to the emergency because I was hemorrhaging. (Patient, Montreal)

It should be noted that most of our respondents did not receive a clear explanation about the criteria used to decide their discharge. There were complaints about how the decisions were

made. Some were not able to see their doctor; another was discharged following a decision made by the head nurse.

- Discharges made without warning, leaving relatives unprepared.

When patients are discharged without warning, relatives may not have had time to prepare to look after them. Discharges often cause conflicts within the family and with medical authorities. Sometimes, relatives contest the discharge, do not want to take responsibility for the patient or feel unqualified to provide appropriate care. In some cases, patients are “let go” instead of prolonging care.

The doctor even approached me. I told him, my mother is 70, she can't look after my father. My dad is sick, he needs nurses and orderlies to look after him... It was 11 at night and I waited till 5 in the morning and then they wanted me to take him home. I told them no way. I told the doctor and he was really mad at me. He even had to go outside, no coat, and take deep breaths (he was furious), then he came back in and started throwing papers around. He looked at me like he was the devil himself, and to top it off my dad was there, suffering, not wanting to get in the ambulance and return home. (Caregiver, Outaouais).

The weight of responsibility and the feelings of guilt facing caregivers in their new roles can also negatively affect the relationship between caregiver and patient or even poison an already poor relationship between family members. A 62-year-old caregiver described this very situation in caring for the 80-year-old mother she had never gotten along with.

- Relatives unprepared to receive a patient.

In some cases, the hospital checked to see if the patient was accompanied by someone when they were discharged. But this practice is neither prevalent nor sufficient. Hospitals only take the patient's physical condition into consideration, not the situation awaiting them at home.

My mother has leukemia. She fell down and broke a few ribs. Two days later she had a dizzy spell, fell and broke an arm. Then her blood pressure went up and she had to go to the hospital. It wasn't serious and after three days they wanted to send her home. I refused. I told them she couldn't go home, she's all alone, couldn't even dress or feed herself, and that they had to find her a convalescent home. The doctor thought that was frivolous. (Caregiver, Montreal)

As stated above, some patients were not aware that their hospital stays would be shortened and, when discharged, found themselves all alone. They had to organize their departure at the last minute.

Some of the patients interviewed had made arrangements prior to surgery and organized their departure, while others were living through situations which complicated their hospitalization and return home. One of our informants found herself homeless following the floods in the Saguenay in July 1996. Another, who lives alone, had to prepare her own entry and departure from hospital with only two days notice. A third woman, who is divorced, in school and responsible for two young children, found it difficult to organize her departure.

- The family context is not taken into account.

To illustrate the difficulties that can arise from a shortened hospital stay, we present the case of an informant who, following childbirth, had to be readmitted to hospital as a result of hemorrhaging, but did not know what to do with her infant, whom she was not permitted to keep with her at the hospital.

Q: So what arrangements did you make in order to return to the hospital?

A: My spouse helped out.

Q: And the baby?

A: I left the baby at home because I didn't know if they were going to keep me there. I asked if they were going to keep me, but they told me they had to talk to the doctor in charge, who I guess was the one who decided to keep me there. They told me I could have my baby with me, but only if there was a place in the nursery. It turned out that I would have had to keep him in the room with me, so I left him at home. (Patient, Montreal)

Inadequate Assistance and Support

Patients who return home shortly after surgery, an illness or childbirth, are extremely dependent. For a few days, weeks or months, they require help with every aspect of daily life. In addition, they have to care for themselves or ask a relative to help them with increasingly complex treatments in the current context of minimal support from hospitals or CLSCs.

- Inconsistent hospital follow-up.

Some informants reported receiving adequate hospital support when they were discharged, by means of a follow-up phone call the next day or the offer of medicine or referrals in case of complications. Our informants felt strongly about the importance of this kind of support.

*The next morning, we got a call from the nurse at the hospital who had looked after him to check to see if everything was all right. I was happy about this because it meant that at least there was some follow-up, and they left us with a phone number to call in case of emergency or complications.
(Caregiver, Montreal)*

Meanwhile, other informants felt they were not given adequate support or information upon discharge from hospital.

They told him to make an appointment with the CLSC that week, to have his stitches removed. So he made the appointment. It took two doctors; they searched for the stitches and couldn't find them. It turns out he didn't have any! They were dissolving stitches. This was a serious medical error. The hospital made a mistake sending him there when they knew that he had dissolving stitches. (Caregiver, Montreal)

Along with the lack of hospital support, they criticized the fact that they were not consulted about taking charge of caring for relatives at home and that no verification was done to ensure that patients' relatives could cope with accommodating and looking after them. Furthermore, since hospitals no longer dispense medication, prescriptions must be filled at a pharmacy; this is sometimes difficult when patients are released from hospital and are not well enough to carry out this task.

- Inadequate links between CLSCs and hospitals.

The weak link between CLSCs and hospitals was greatly criticized. This situation has sometimes made it impossible for caregivers to obtain urgently needed services and required them to go to great lengths to solicit services, at times making them feel like beggars.

I wasn't notified when my mother was discharged from the hospital so I wasn't able to receive any services before the end of the following week. They don't meet until Thursday to plan their stuff, so I had to wait until the following Thursday. And I also found it hard that it took so long for them to evaluate my mother. (Caregiver, Outaouais)

Some caregivers were highly critical of the inefficiency of the link between CLSCs and hospitals, resulting in longer waits for the necessary services for taking care of a sick relative. In one case, administrative errors also delayed a CLSC's delivery of home care services.

- Responsibility is placed on relatives while patients are still in the hospital.

Cuts in hospital staff have also led to a decrease in care delivered to patients during their hospital stay. Patients must wait to be washed; messes are cleaned up less quickly; and less time and attention is given to them. Consequently; from the moment patients are admitted to hospital, relatives feel the need to compensate for the lack of service.

As a result of our heavy workloads in long-term care, we finally said: "Look, would it be possible to get someone to come help at least at mealtime, or maybe some volunteers, or anyone just to help with feeding?" There were no volunteers and it wasn't possible to hire someone, so they decided to involve the family. Families were called and asked if they could come and feed their relatives. Our reaction was: "Patients pay to come here, and now they're asking their families to come feed them!" I don't think I'd be very amused if I got a call saying: "Look, could you come feed your mother?" And what

happens if it turns out that I can't? Will my mother still be fed?" (Orderly, Montreal)

One morning when I arrived at the hospital — I went every morning — a nurse told him that that day he would have to wash himself. He didn't even have proper use of his arms! She placed a basin in front of him with a wash cloth and soap. He tried. But when he reached for the wash cloth he tipped the basin. I said to my father: "I'll pick that up and we'll wait for her to return. She'll have to finish washing you." Forty-five minutes passed and I finally ended up washing my dad, except in one area. I couldn't...he's my dad and I'm his daughter. (Caregiver, Bas-Saint-Laurent)

Some respondents reported that they were active in chronic care hospitals or private facilities for seniors, which seems to have improved patients' lives and health: they are happier and feel less abandoned. This also contributed to improving the delivery of care.

*Lots of people come to help at mealtime...and to take patients out.
(Caregiver,
Quebec City)*

Due to the shortage of resources within facilities, our informants told us that sometimes they felt like orderlies. In this case, relatives are integrating their volunteer services with those supplied by the hospital.

- CLSCs with less and less to offer.

All our respondents referred to major inadequacies in the services offered by CLSCs. Following their discharge from hospital, many patients felt they did not receive sufficient support: they were obliged to travel to have their dressings changed, hospital evaluations of patients were not considered by the CLSC, there were excessively long waiting periods for CLSC medical services, or CLSCs did not have the necessary information available on home care services. Some ran into administrative red tape which slowed down procedures.

*They told him to make an appointment at the CLSC that week to have his stitches removed. He called his local CLSC to make an appointment and explained that he had just had surgery. They told him he had to come on Tuesday when there was a drop-in clinic, about one week after his surgery. They made him wait two hours in the waiting room and he had to stand the whole time because it was so crowded there were no seats available.
(Caregiver, Montreal)*

One respondent talked about the reduction in postnatal follow-up.

They told me that there was always the local CLSC, but I didn't get any follow-up. Sure, I called, and I was assured that someone would contact me. And, as I told you before, they finally called me when my baby was already

two months old, for his first vaccination. It was kind of too late — my stitches were healed and I was no longer in any pain. (Patient, Montreal)

A respondent from Rimouski received no home care following her hospitalization in Montreal [some 500km away]. Her case was not even forwarded to a Montreal CLSC. She only received a visit from a nurse when she returned to her home in Bas-du-St-Laurent, by which time she no longer needed to see one. Given that specialized medical procedures are only available in Montreal and Quebec City, what will happen to patients who have to travel long distances for treatment? Should they be sent home so quickly?

- The eligibility criteria for receiving services are becoming increasingly difficult to meet.

The first criterion cited by our informants is money.

First, they ask you if you have any money. That's the first question the CLSC asked me when they called me on Friday. "Does she have money?" I let the CLSC know that she has a little, but that she's currently paying a lot of rent. (Caregiver, Quebec City)

The other criterion reported by our informants is availability of relatives. Relatives are becoming the number one recourse, while public services are increasingly a last resort when family members fall short in their home care role or cannot offer certain services.

Last week, when I spoke to her, the first thing she asked me was if we had money and did we have a big family. I told her we had money but as for family...we have a big family, but only two of us live in Quebec City. (Caregiver, Quebec City)

According to our informants, the degree to which individuals are incapable of looking after themselves determines the services the CLSC will offer. Patients who have means and friends or relatives who can help them must be seriously incapacitated for a CLSC to offer its services. CLSCs certainly do not actively seek out relatives and patients to offer their services.

Many respondents also expressed their disappointment with the services they received. For instance, it was not always the same worker who came to the house to provide care, requiring them to re-explain their situation each time. They pointed out that this created difficulties in terms of the continuity of care, especially with regard to very personal care.

Of course, we also received positive feedback. One respondent spoke to us in detail about the help from nurses and the quality of the medical support she received when she took responsibility for caring for her dying husband. In this case, the same nurses were dispatched to help and they were available 24 hours a day, seven days a week. The informant reported that the moral support she received was exceptional as was the time the nurses took to listen to her. In order to facilitate the caregiver's work, the CLSC agreed to supply a hospital bed for use in the patient's home. The quality of medical help was also high, with frequent home visits by a doctor which helped to build a close tie between the

doctor, and the caregiver and patient. In addition to the help received from medical staff, this caregiver was also able to count on support from her children as well as a self-help group she joined shortly after learning that her husband was terminally ill.

A few respondents also reported having called on Info-Santé. While they were grateful for the support, they were often unhappy about having to rely on the telephone to receive services. They preferred a human presence.

- Community organizations continue to play a small role.

Very few respondents mentioned having turned to community organizations for help. Often people are unaware of their existence and the kind of services they offer. But those who did use services provided by community organizations were able to free up a few hours or receive advice on issues such as breastfeeding or discomfort following childbirth.

Caring for the Sick: Another Responsibility for Women

- Caregivers who have no choice.

Our informants felt that more often than not, taking care of the sick was imposed on them.

We only found out on the Friday, the day she was discharged. I didn't have time to get organized for the weekend, and to try to find someone to help because we couldn't leave her alone all weekend. So I went straight over to her house and slept there Friday night, and then Saturday I managed to get in touch with the CLSC, some volunteer arrangement. (Caregiver, Outaouais)

In the above case, the respondent is a 62-year-old woman who became the sole caregiver for her elderly, sick mother. Another respondent, who was recently married, had to resign herself to looking after her sick mother. Both of them were able to call on the help of two or three people in their immediate or extended circle.

In most cases, those who can take responsibility for patients returning home are women. For example, in the case of six of our respondents from Saguenay-Lac-Saint-Jean who were patients:

- five were able to rely on help from their daughters;
- two *also* had help from their spouses;
- one *also* had help from a sister-in-law;
- two *also* had help from a female friend; and
- one *also* had help from a son.

In conjunction with a reduced role of the state in extending services, caregivers are also confronted with the needs and wishes of patients. These wants are often difficult to reconcile with limitations imposed upon caregivers. For instance, an elderly person who does not want to become a burden on her relatives may refuse home care. In other cases, however, patients are determined to return home. In one case, the father of one respondent refused to go to a

nursing home, forcing her to become his primary caregiver since other family members were not available or felt incapable of looking after him.

- Women's difficulty in being cared for.

According to our informants, it is often very difficult, or even impossible, for women to ask for help. They are well aware of the extra work this will entail for their relatives and the debt they will incur by receiving this assistance. In many cases, spouses are not used to, or interested in, caring for and serving them. It is common for women to feel that it is easier when their husbands are the ones in need of care. When they do not have a spouse, women are obliged to call on help from others, which makes them feel as though they are asking for charity or becoming dependent.

My husband will do a little, but in the end he'll make me pay for it. If he works a week, he figures I owe him a month... (Patient, Saguenay-Lac-Saint-Jean)

Furthermore, relatives are not always in a position to help a sick family member and their home environment is not always suitable for convalescence.

When I left the hospital, I went to stay with my daughter for one week. She has three children and was in the middle of painting... I had to sleep in a twin bed, it was very difficult, I couldn't move. (Patient, Saguenay-Lac-Saint-Jean)

The patients we interviewed mentioned that they did not want to bother anyone and did not want to insist on asking for and finding help. They would rather live alone than feel as though they were imposing on someone. Many said they would prefer receiving public services.

I would prefer receiving CLSC services because in my case it's been eight years since I got divorced and not once did I ask for help from my brothers. It's a question of pride. As long as I can look after myself I will. Asking for help is a bit humiliating. (Patient, Saguenay-Lac-Saint-Jean)

Of course this is not always the case, as in the following account by a woman who found refuge with her brother and sister-in-law.

It was either that or a convalescent home. In a convalescent home I would not have been cared for. I would have had to do my own bandages. I don't think the people there would have helped me much, and it would have been like being in a hotel. So, she didn't really have much choice but to take me in. They're the only family I have in Montreal. But they always made me feel at home. I never felt like a burden. (Patient, Bas-Saint-Laurent)

When female patients turn to relatives for help, it is to the female members, often a daughter or mother. Many do not spontaneously turn to a CLSC for help unless a service is offered to them.

- Caregivers are often isolated.

The fact that relatives are often unable or unwilling to assume responsibility for looking after a sick or aged relative can lead to tension. However, in some cases, family solidarity may be shown toward a family member who has taken on caregiving responsibilities (relief, financial assistance or sharing news). Families in which several members share the responsibility of caring for a patient feel privileged and often cannot imagine how they could have done it any other way. The fact remains, however, that many caregivers find themselves completely alone.

- Women who often feel abandoned.

Feelings of abandonment and isolation were frequently mentioned by our respondents.

There's no question you're nervous when you have your first baby. To begin with, I hurt all over. So I was pretty upset. The baby was bawling and I was bawling alongside him [laughs]. It hurt! My belly button hurt! The pain began during the night, I could barely take it. I had a hard time even picking up my baby. My stomach hurt, and they told me that was normal! Finally, my husband went to get my sister. He said: "I'll go get your sister, she'll come and help you." (Patient, Montreal)

Finally, my kids helped me because I was really exhausted. One week. Only one week, and my kids told me that during that week they asked themselves how I managed. (Caregiver, Bas-Saint-Laurent)

Clearly, caregivers are assuming major and complex responsibilities.

Increasingly Varied and Complex Care

Given the pressure relatives are under to take responsibility for post-operative and post-hospital care, combined with the limited support offered by public facilities, they often find themselves not only providing basic care (feeding, clothing, washing) but delivering nursing and even medical care as well.

- Nursing and medical care entrusted to relatives.

Our informants stressed that they were often asked to perform procedures that they felt unqualified for, such as changing bags (colostomy), inserting catheters, insulin injections, dressings, monitoring pressure, clearing a blockage in an instrument, disinfecting wounds.

I had to change the bandages, two of them every day. To do this, everything had to be well sterilized. But a nurse came from the CLSC and showed me how...and every day I cleaned a large stomach wound and rectal wound which took a long time to heal because it was in the rectal area. (Caregiver, Montreal)

Furthermore, certain medical conditions require very intimate care which can be very embarrassing when it involves members of the same family. One respondent reported that her father found the experience very humiliating and their relationship was completely changed.

Sometimes it's frightening. Sometimes, it doesn't smell good. Your father's there and you have no choice. (Caregiver, Bas-Saint-Laurent)

For example, home-based chrono-chemotherapy requires very specific hygiene practices when changing needles. Everything must be sterilized, no dust can be floating in the house and the caregiver must ensure that no one carrying an infectious disease is present. Needles must be changed daily for the duration of the treatment which lasts from four to six days and requires special training from the hospital's oncology department. The use of certain instruments, such as for hemodialysis, is equally complex and involves the risk of instrument failure.

The complexity of some treatments (inserting a catheter, probe or IV, keeping daily records of medication use) often frightens caregivers and makes them insecure.

We're not qualified. You have to be a nurse or doctor. (Caregiver, Outaouais)

Treatments such as hemodialysis also require a lot of time, sometimes a half day or more.

It was already complex to care for elderly persons. For instance, feeding sometimes involves attaching a piece of plastic to the spoon; bathing can require transferring the person from a wheel chair to a board to avoid injury. In addition to looking after the personal care of a patient, caregivers must learn how to deliver nursing care. For example, a cataract operation is relatively simple, but the recovery period at home is not: the patient cannot move for a few days and needs help administering eye drops.

But I wasn't skilled in taking care of an infected wound, I wasn't allowed to...even if I'd received St-Jean Ambulance training [in first aid], I wasn't allowed to touch it. (Patient, Saguenay-Lac-Saint-Jean)

Even the IV that my father has in his arm, he's had the same IV for two weeks. Yesterday, I asked the nurse if she didn't want to move the IV to the other arm or somewhere else. I asked her how long he could have it in. She told me three days, maximum. It's been two weeks since he's had it in his arm, and he had several intravenous injections in the same arm; and he has an arm that he can't even use 'cause of the intravenous injections. We made

them take it out. They put a small thing here, it's for one cc of morphine every hour. (Caregiver, Outaouais)

As we have already indicated, caregivers are increasingly replacing hospital staff, and this process begins before the patient even leaves the hospital.

- Lack of professional support in the delivery of care.

Clearly, the assistance and presence of health care professionals when care is delivered in the home is often necessary. This enables caregivers and patients to provide or self-administer necessary care under supervision, which helps them to feel secure and to adapt. But many caregivers complained that they received little information on post-operative follow-up such as how to deliver care, administer medication or control diet.

I called and asked: "Do I have to have a special diet?" And they said: "We told you when you left the hospital."... "You may have told me, but I don't remember. When I left I couldn't think clearly. You may have told me, 'Eat this, don't eat that'...but it went right over my head." (Patient, Saguenay-Lac-Saint-Jean)

You need people who can answer questions. And it's not your spouse or family that's going to be able to do that. And they need reassurance too. So in the end, we're expected to play a more active role, but they have to spend a lot of time reassuring us. (Patient, Montreal)

Our informants reported that they had to fight to obtain the necessary help, especially once they had returned home. It is not always possible to rely on the regular assistance of a nurse and efforts must be doubled to extend the help received.

- Insecurity and powerlessness when facing problems and complications.

The type of care dispensed often requires knowledge, even training.

We often find ourselves in situations where we have to give medication or care and we don't know if we're doing it properly. (Caregiver, Quebec City)

We're being asked to look after very sick people but we don't have any training. It's not just a question of giving someone a bath, it's regulating their medication, making sure they're all right, checking their pressure. (Caregiver, Outaouais)

It follows from this that caregivers are scared to make a mistake. They worry that they are not doing things properly, and harbour feelings of incompetence and guilt, of insecurity and anxiety with regard to diet, side effects of medication and complications (e.g., wounds that can become infected). Some caregivers panic when the health of the patient deteriorates. The caregivers we interviewed felt that they were not sufficiently informed and that they had

been abandoned. They were sometimes frightened by the responsibility of administering powerful drugs.

She was saying: "My stomach hurts, my stomach hurts." Then one day my sister told her we were going to see a doctor. When the doctor saw her, he explained what we had to do. It wasn't complicated, some compresses and a little bit of ointment which he gave us. Nevertheless, it took time. (Caregiver, Quebec City)

In some cases, complications, such as weakness, infection or other more serious problems, forced some of the patients we interviewed to return to the hospital.

Saturday morning I got up and went to the bathroom...the toilet bowl was full of blood.... It was 3 in the morning, I went back to bed, I was scared...at 6 I got up again to go to the bathroom and again it was the same thing. So I woke up my sister and told her: "Take me to the hospital, fast, I'm bleeding." (Patient, Saguenay-Lac-Saint-Jean)

- The onus of responsibility.

Issues of responsibility and accountability weigh heavily on caregivers. Who will be held responsible for problems resulting from medical complications, an incorrect diagnosis by a caregiver or the inadequate delivery of care? New responsibilities are being transferred to caregivers including monitoring patients (e.g., high blood pressure) which means that various complications could arise (e.g., nose bleeding). Possible legal responsibility is a concern.

Ask them to sign a paper stating that they will be responsible if something happens, because they are. My mother-in-law did that and you can be sure that they kept my grandfather where he was. She asked that they sign a paper stating that there was no danger if he came home. They didn't want to and so they kept him. (Caregiver, Quebec City)

I wrote down the time and the pill that I gave him. I was scared. What if they told me that I gave him too much and he could die. I was scared. (Caregiver, Outaouais)

Hastened discharges, pressure on relatives and friends to take responsibility, specialized and complex treatments, lack of support from the health network, stress and anxiety — that is how the caregivers we interviewed summed up the effects of the shift to ambulatory care. We will now examine the impact of this situation on their standard of living.

A Price to Pay

Both caregivers and patients must assume various expenses.

Your life is turned upside down. People are forced to change their vacation period, husbands take time off uncompensated. It costs the government less and you pick up the tab. (Patient, Montreal)

- Cost of medication.

Shorter hospital stays mean that patients often have to obtain their own medication. At the same time, the new drug insurance plan introduced by the Quebec government forces taxpayers to assume a larger share of the costs. Patients with private insurance report that they have fewer problems in this area. Some situations can become critical, especially for those with few means.

Right now I'm on [student] loans and bursaries...it's not easy because it's not simply medication...I have no insurance, I don't work. (Patient, Saguenay-Lac-Saint-Jean)

For example, the husband of one caregiver had 90 percent of his medication costs reimbursed by private group insurance. Given that his medication costs were approximately \$800 a month, the situation would have been extremely precarious without private insurance. Nevertheless, the patient agreed in the last two and a half months of his life to take an experimental drug for which he had to pay the entire \$500 monthly cost.

- Cost of care and accommodation.

It can cost up to \$10,000 to make a home wheelchair accessible (knocking down walls, etc.).

My father said, "We'll knock down the walls." He was ready to put in 10 grand worth of work. It just didn't make any sense. (Caregiver, Quebec City)

Taking care of a patient can incur other costs. For instance, delivering care related to hemodialysis requires that a room be completely sterilized, a very expensive undertaking.

In other cases, families are obliged to find accommodation in a home for partially self-sufficient patients (appropriate for patients who can still feed themselves), or chronic care hospitals (appropriate for more serious conditions). But major administrative constraints exist: few places are available, financial resources are limited and patient wishes must be taken into consideration.

In families, it's always women who shoulder the burden...while many women now work out of the home, it often falls on women who have just retired or who take early retirement in order to take care of a relative. I've seen such situations: "Well, it doesn't really matter if I retire a few years early...I'll survive...my mother will pay me a small allowance which will make up for the difference..." But if the mother dies earlier than expected, these very women often find themselves left with very little. You know, if I say, "Instead of retiring...let's say at 57, I'll retire at 55, and then six month's later, Mom is

no longer there, I've lost a significant amount of income." It's all fine to say we love them, but at the end of the day it's women who pay the price. I wouldn't say that I've seen tons of cases like this, but then again I also don't see all of them. (Social worker, CLSC, Outaouais)

Private convalescent homes can cost up to \$200 a day. To hire someone to provide day and night home care can run as high as \$1,200 a month. In other cases, individuals, usually women, are hired under the table at low wages. Their income will often be low due to the patient's lack of resources.

Sometimes relatives have to pay rent for a relative who is in hospital or who has been placed in a nursing home until the lease is expired, or pay the penalty for breaking the lease. For low-income individuals this represents a major financial burden and adds to the stress of taking care of a relative.

For me, the nightmarish part had to do with money. I had to break my father's lease in order to place him in a private nursing home. I was responsible for the rent for three months there and for two months at the nursing home. That was awful. I couldn't sleep because I was so worried about how I was going to cope. I don't have any money, I don't work, they can't squeeze blood from a stone. In any event, these were my father's debts. And he was never in debt before this. (Caregiver, Montreal)

These costs can also influence the decision to assume home care responsibilities.

- Additional costs.

There are also a number of hidden costs associated with home care.

The types of things we needed to buy, I'd have to add it all up but it was at least six, seven hundred dollars worth of equipment. Just the damn little quilted pads cost around 20 dollars each, then the little cushions, the chair, we're up to the third cane and now we're looking at a walker. (Caregiver, Outaouais)

The caregiver often uses her own money to help improve the patient's quality of life as well as mental and emotional well-being. These gestures often entail less visible costs such as receiving guests for supper or an activity to cheer up the patient. A *bigger* table means an inflated food bill whenever the patient's relatives come for a meal, and there are additional expenses associated with new clothes and items bought to please the patient.

A Profound Impact on Caregivers' Lives

In addition to financial costs, there is also a human cost associated with providing home care.

- Constant, draining and trying work.

A caregiver has little time for rest. She is often on call 24 hours a day, seven days a week. Her household and personal daily schedule are affected from the moment she gets up in the morning until the time she goes to bed at night. In addition, the patient may require monitoring at night which interrupts the caregiver's sleep.

Sometimes, it is necessary to travel long distances to take care of relatives in the hospital or in their home.

When you have to be on the road for an hour, an hour and a quarter, it's not easy. It's not that far, but it's not easy to travel all the time. (Caregiver, Quebec City)

The workload is even heavier since it is often the same person who visits and provides care to an elderly relative. Caregivers have to reorganize their schedules to take care of a sick relative over a long or indefinite period of time. This burden is of course heavier for older caregivers.

It's like living two lives, your own and the other person's...you have to manage your daily schedule as well as that of the other person. (Caregiver, Outaouais)

Even greater difficulties are involved when taking care of a sick child living outside a metropolitan centre who requires care only available in an urban area. Everything becomes difficult: transporting the child to the city, learning how to deliver care, the anxiety caused by the possibility of complications, loss of work days.

It's not easy. There are days when I just cry, I'm at the end of my rope. There are times when I go to my dad's place and then return home. Not even an hour goes by and the telephone rings and I have to go back. At that point you just lose it. (Caregiver, Bas-Saint-Laurent)

Taking care of a patient for weeks or even months or years when it is a case of palliative care, can be an enriching experience, but it calls for a lot of self-sacrifice. This type of care is characterized by constant worry, intense and ever-present emotion, fatigue, a rollercoaster of joy and pain and ultimately 24-hour availability.

We prepare for birth, and we must also prepare for death. That's part of life. In the end it helped both J. and me to better understand what it was. And to grow closer and live all of the experiences that we had not lived over the last few years and in the years that we lived together...we learned to see things in a different light. It was very rich and very intense! Those two years were like a lifetime... And in the end, for me it was a gift, because I learned to look at things very differently. (Caregiver, Bas-Saint-Laurent)

Asking for and receiving help from relatives whose time is already monopolized by work and family, can be very embarrassing, and can lead to feelings of dependence and indebtedness.

- Increased household duties.

Assuming home care responsibilities can also lead to a considerable increase in housework. In fact, the patient's family, children and friends often do not have much time left over to spend with the patient.

- Physical and mental health are put to a test.

The major effects on the health of caregivers are great fatigue, insecurity and stress, which can also be experienced by the patient. Patients often worry: "Who will look after me and how? What should be done if I have complications? Who will look after my children?"

When home care extends over a long period of time, caregivers report suffering from constant fatigue, exhaustion and insomnia. Some state that certain caregiving tasks require physical strength that they do not possess. For instance, can a 72-year-old woman lift a man from his bed? The physically demanding work can also contribute to exhaustion and even cause injury to the caregiver. This situation led some of our respondents to resort to sedatives and antidepressants.

I've developed arthritis [laughs] from pulling my husband, and pushing him and all that... As I've often said, luckily we have three floors here. Sometimes I'd go upstairs to cry, in a closed room, sometimes it's hard! It's very hard. I'm a nervous wreck. What I try to do is not cry in front of my husband or mother. Despite everything, I laugh with my husband, but sometimes he knows, he can feel it. It's exhausting! Sometimes it's all the paperwork, everything falls on my shoulders, the bank, the payments. (Caregiver, Montreal)

- Sacrificed leisure time and social life.

Caregivers reduce and change their activities in order to have more time for the patient. They feel they are often forced to make choices.

I did volunteer work. But I resigned last week because I have mom, my volunteer family work, as I call it. My volunteer family work is too demanding. (Caregiver, Outaouais)

Yet volunteer work and leisure time are essential to a person's well-being and balance, both for the patient and the caregiver. It is a time to think about other things, to help others and to feel stimulated.

Oh my goodness, I'm so anxious to get better so that I can do all kinds of things ...brunches (at AFÉAS)...we did a play...and there's AFÉAS activities. (Patient, Saguenay-Lac-Saint-Jean)

I participate in AFÉAS, that's my activity. They came to see me this week. Mrs. (X) helped me a lot. (Patient, Saguenay-Lac-Saint-Jean)

- It becomes increasingly difficult, sometimes impossible, to reconcile caregiving, family life and professional life.

Some caregivers are already very busy. One of our respondents looks after her mother, has a full-time job and has her own children to care for. Many have health problems themselves or have difficulty in providing health care to others. Living far from the major cities means having to take days off from work to travel in order to care for a handicapped child.

And when my daughter, who has sclerosis — the poor thing...she was holding herself up against the wall, when I saw that I didn't want her to see that I'd seen, she wouldn't have liked that... I didn't dare ask her for anything and she said to me: "Mom. do you want this, do you want that, do you want me to do the cleaning?" I told her, "no, no."... She doesn't do that in her home, she isn't able...my other daughter came a week later, but she works and has two children... The rest I did myself. (Patient, Saguenay-Lac-Saint-Jean)

Difficulties are even greater when patients have to look after themselves as well as young children.

If one of the spouses has to quit work to look after a relative, it tends to be the woman, who usually has the lower income. If a woman can "allow" herself to leave her job to look after a relative, it is generally because her spouse has a stable income. In doing so, she becomes financially dependent on her husband which can be troubling in itself. Added to this are a woman's feelings of insecurity about her husband losing his job.

In some instances, caregivers are forced to change jobs. In these cases, they lose the benefits they have acquired, they often suffer a drop in salary and their personal interests are neglected. Sometimes, they ask for a leave of absence hoping their employer will understand. This also happens when the relative is in hospital and in need of care.

My mother took her vacation early so that she could come. And my spouse was working too, he was able to get three days off, and you can't afford to take 18 unpaid days off! They give you the first paid but the others are at your expense, and these days I don't think anyone can afford not to work. (Caregiver, Montreal)

Since it is not always possible or desirable for caregivers to stop working or to change jobs, they often become overworked.

- Tensions in the family.

The fact that other members of the family do not share caregiving responsibilities can cause frustration for the caregiver. Why should I be the only one to take responsibility? Kinship is another factor that affects relations between the other members of the family and the patient. Sometimes the patient expects too much from the caregiver, accusing her of not respecting his or her wishes. The patient can sometimes be unpleasant, stubborn, refuse to acknowledge the caregiver's efforts and even refuse necessary treatment. Some caregivers are even in a position where they must care for a violent spouse. In some instances, an elderly relative may try to take control of the caregiver's home.

She was there, just sitting there watching me work; she was telling me what to do. Once I went into the bathroom, turned on the fan and started (hitting) the washing machine, asking myself how I was going to manage. (Caregiver, Outaouais)

Relations between caregiver and patient often tend to deteriorate when they were poor to begin with. In these instances, the caregiver must show even greater patience in order to encourage the patient to recover. Caregivers in this situation often feel even more abandoned, frustrated by the fact that the other members of the family participate so little in the caregiving, disappointed that their efforts are not acknowledged by the patient and let down by the lack of available professional help.

Demands made on caregivers can also cause increased marital tensions or problems with children.

My husband said: "You're always with your mother." I thought: "This doesn't make any sense, how can we keep someone in our house?" Our relationship as a couple was at stake! You know, it ruins other aspects of your life... In this case, it was ruining our home life. (Caregiver, Quebec City)

The lives of those who take responsibility for providing home care are seriously affected, and the need for help and support is deepening. One homemaker believes that providing support to caregivers is now a major aspect of her job.

It's gotten to the point that now when you enter someone's home, you have to provide family support, and then go see the patient, that's what's become difficult about our job. The shift is not a happy story. (Homemaker, Outaouais)

Caregivers are not optimistic about the future.

- A bleak future.

Our informants stressed that assuming responsibility for home care made them feel guilty, that they had a lot or even too much responsibility, that they were often irritable, continuously stressed, rarely acknowledged and appreciated. Some said they felt at times

like they were losing their minds. Others admitted their surprise that at times they hoped medical complications would arise and that the patient's hospital stay would be prolonged.

The caregivers we spoke to expressed fear about their own futures: Would they feel it was incumbent on them to look after their daughter, mother or sister if they were to fall ill, given the knowledge and experience they were acquiring? They had many worries. What medical complications could arise with the patient? Would they be able to see it through? What would the consequences be of assuming caregiving responsibilities on relations with their family and friends, or on their futures?

I don't want any of my children to have to do what I'm doing because I find it draining — physically, mentally and emotionally. (Caregiver, Outaouais)

Some caregivers even reported feeling desperate and they would rather commit suicide than put their children through the same duress, when they themselves became permanently ill.

Caregivers are not alone in their assessment that the shift to ambulatory care has had a mainly negative impact on their lives and on the quality of care offered to patients. Hospital and CLSC employees share this conclusion.

Health and Social Service Workers

The changes associated with the shift to ambulatory care have not affected all jobs and professions in the same way. CLSC homemakers, nurses and social workers, as well as hospital nurses, nursing assistants, orderlies and social workers have all faced increased workloads and a transformation of their practices, but each profession or occupation has had its own experiences.

The Upheaval of Workplaces and Workers' Lives

The initial impact of the shift to ambulatory care on health and social service workers was caused by hospital staff reassignments. Those who were transferred from hospitals to CLSCs or reassigned to new positions or new teams were forced to accept major changes in their work environment. In some regions, orderlies were kept on as homemakers; operating room nurses found themselves in obstetrics or home care; hospital closures and conversions forced staff to move to other institutions. Employees of hospitals that remained open sometimes saw their positions abolished or filled by staff from other establishments.

- Changes under inhuman conditions.

There has been widespread criticism of the lack of respect and decency accorded to workers who were forced to accept transfers. In many cases, transfers were done so quickly that workers were not given time to consider their future. Many women were forced to wait and live in uncertainty for long periods, while others were simply placed on an availability list.

My own cousin who worked in a hospital got bumped and wound up at the Régie régionale because she had job security. They're treated terribly there! They all sit around in a big room — it's like an auction! And when it's time to choose a job...my cousin had five minutes. They gave her five minutes to decide what she wanted. One, two, three, next!... But what's going to happen in the end? I'm afraid some people will crack. (Nurse, CLSC, Montreal)

The people from the Jefferey Hale, Chauveau and Christ-Roi hospitals, were given five minutes to choose where they wanted to spend the rest of their careers. They had none of the details. They didn't know if they were going to get a permanent position in these facilities or if they were going there with job security to be part of the recall list while waiting to be placed. It was outrageous. People with 30 or 32 years seniority... There were people who had started their careers when Christ-Roi first opened its doors who were given five minutes to decide where they would spend the rest of their careers... They were devastated. (Orderly, hospital, Quebec City)

Transfers from one facility to another and the choices hospital staff were forced to make were often difficult and sometimes tragic. Some people who had been working in the jobs of their choice for 15 or 20 years were transferred against their will and are extremely unhappy about their new positions. For many, it is difficult to work in a new environment where there are no familiar faces and they are not part of the existing network. For some nurses, the transfer was positive although they often found themselves in fields completely unrelated to their previous experience. There are also significant differences from one type of workplace to the next. Chronic care hospitals and short-term hospitals offer very different work environments; new staff may find it difficult to adapt to the fact that patients in chronic care hospitals have no hope for recovery.

- Skills and experience that fall by the wayside.

The stability of the past allowed work teams to develop a strong cohesion. But this has been ravaged by staff bumping and, as a result, the experience and skills acquired by teams and staff have been lost. Teams and workplaces have been dismantled; friends and colleagues have been lost.

Some health care providers have been obliged to reorient their careers against their wishes, and have had very little control over their new professional paths. Some accounts tell of workers who were transferred up to five or six times in one year, making their work difficult and discouraging.

There's no question that they were devastated by the difficulties of having to adapt. They were in a state of panic. One woman had been working with infants as a caregiver, and was suddenly bathing the elderly. It's not the same thing at all. (Homemaker, CLSC, Quebec City)

The one who had worked in surgery is in infant care (vaccination) and the one who was in pediatrics now works in home care with the elderly and post-operative patients. They didn't have a choice. (Nurse, CLSC, Saguenay-Lac-Saint-Jean)

The two occupational therapists who arrived this morning, they work at...with children. Now they're being asked to provide home care support for elderly handicapped people. They have absolutely no experience in this area! (Social worker, CLSC, Montreal)

You can sense the insecurity of the people who've been bumped, of those who didn't choose to work in geriatrics. Some people who had been in surgery for years, for example, and who were happy there, had no choice. So when that's the only choice you have, you shrug your shoulders and you do it. There are no other options. This affects your work environment and it affects your attitude vis-à-vis the clientele. (Nursing assistant, hospital, Bas-Saint-Laurent)

These transfers have had a much greater impact on women than men, due to the high number of women in some of these professions (nursing) or occupations (orderlies). In addition, women are generally more vulnerable given that they have less seniority; women tend to have held part-time positions at some point in the past, usually in order to stay home to take care of children. Today, there are fewer and fewer full-time jobs available, and it is becoming ever more difficult for workers to increase the number of hours they work per week.

- Leaving behind a job and a workplace.

Workers must often mourn the loss of their jobs. In addition, the general atmosphere at work is often stressful since each hospital or department closure means yet another staff redeployment process and a new group of workers being bumped. There is a general feeling of insecurity, anxiety, sadness and mourning.

We're forced to readjust. Change! A shift to ambulatory care also means a drastic shift for us! (Nursing assistant, hospital, Bas-Saint-Laurent)

It's really tragic, because for some nurses it's not just the job, it's their home lives and their families. There's a whole side you can't just forget when you're on the job, and because many have lost their jobs, there are some heartless people who say: "Well, at least she's got job security." But a woman who has job security feels very insecure because she doesn't know how long it will last. That's the big question these days. (Nurse, hospital, Bas-Saint-Laurent).

- New staff are not always warmly received.

New workers are not always readily accepted by work teams that have already lost members due to the current restructuring. In some cases, a new employee represents an obstacle for an existing staff member who hoped to fill the position. New staff members also take shifts

away from casual staff who, in many cases, have been part of established work teams for many years. Transfers have caused all kinds of human tragedies.

It's hell! Just one example. The nurse who should have gotten the position that was filled by the new person had to train the new nurse. She had the most seniority of all the replacement nurses. She's been here for eight or nine years, and was probably dreaming of a permanent position. She's on the recall list and she should have been chosen for the position. So, on a human level, she does what she has to. She's very professional about the whole thing. But in her heart, it's very hard. In our hospital, there's a lot of tension with the replacement nurses who are being assigned to new sectors. It's not easy. The replacement nurses were coming here with a very aggressive attitude toward the regular staff. There was no harmony whatsoever. (Nurse, CLSC, Saguenay-Lac-Saint-Jean)

A worker applying for a job posted at her facility must have the same qualifications as transferred staff who apply for the same position. This reduces her chances and leads to frustration. Some workers who were hoping for years to secure a particular position have to give up their dream. In addition, existing nurses are pushed to the bottom of seniority lists by nurses arriving from other facilities.

Of course, not all transfers are negative experiences. Eventually, the dust settles and people adapt to new situations. In the interim, however, relations between workers are less than friendly, and are sometimes outright hostile.

Before, we enjoyed working together. We had parties and went out for drinks after work... There's none of that anymore. It's the holidays and nobody gets together for a drink, there's no Christmas party. Things have really changed... I go to work, I do my job. There's no team spirit like there used to be. The atmosphere just isn't the same. (Nursing assistant, hospital, Saguenay-Lac-Saint-Jean)

She comes to work in the morning feeling terrible. She hasn't slept all night. It's really awful. There's an employee assistance program that was created and I'm telling you, people use it a lot. (Nurse, hospital, Bas-Saint-Laurent)

Many the respondents mentioned that there is a heavy demand for psychological assistance, a sign of general disarray. Some nurses who have lost their jobs would have preferred the option of part-time work rather than having to live through the stress of a drastic change in activity.

Not all of the employees have been replaced yet, and this creates a difficult situation for those who remain. At the time the interviews were conducted, 350 people had not yet been relocated in the Bas-Saint-Laurent region and 26 registered nursing assistants were on availability.

- Many are discouraged by the situation.

Obviously this situation has a negative effect on workplace motivation.

And when you end up working nights, in a department you don't like, those are a few of the reasons why some people decided to retire rather than work in positions they weren't trained for...we have our file reviewed and we pack it in. (Nurse, hospital, Saguenay-Lac-Saint-Jean)

More Difficult Working Conditions

While the impacts of these changes vary from job to job, there are some common repercussions.

To begin with, all face heavier workloads.

As a result of shortened hospital stays, only patients receiving acute care occupy beds in short-term hospitals, while beds in chronic care institutions are reserved for patients who are absolutely incapable of looking after themselves.

In CLSCs, the clientele has been growing steadily without a corresponding increase in resources. There is a greater number of serious cases that must take priority, and staff are expected to provide more complex care since patients are being discharged from hospitals more rapidly.

You know, they wait until the very last moment to send us the terminal phase patients. (Homemaker, CLSC, Quebec City)

When I first started working, in 1979, in a department of 44 patients, you always had seven or eight patients, sometimes nine or ten, who could wash themselves and about 15 or 20 who could feed themselves. So there was a certain number of patients who were autonomous in some of their activities. Nowadays, you're happy if you have one or two patients who can wash themselves. (Orderly, hospital, Quebec City)

In the past, a nurse had five patients...two who were scheduled for surgery the next day, three for surgery that day and one who had had surgery two to three days earlier. Those on either end didn't require care while the ones in the middle did. These days, there's no one at the two ends. You're dealing with five patients who require major and ongoing care. (Nurse, hospital, Saguenay-Lac-Saint-Jean)

Our informants emphasized the increase in the number of people suffering from mental health and cognitive problems such as Alzheimer's disease, multiple risk cases, and people living with HIV-AIDS, some of whom are in the terminal phase and require palliative home care.

Cuts in staff have also led to a general increase in workload and pace, and have created a climate of insecurity for staff members who live under constant threat of losing their jobs.

- There is a widespread increase in workload and pace.

The stress caused by transfers in staff is compounded by a significant increase in workload. Hospital and department closures force patients to turn to other hospitals that have also been affected by cuts in staff. In CLSCs, there have been relatively few cuts, although resources do not appear to have been adjusted to meet the growing demand, and workloads continue to increase.

I worked in home care for six years, and we visited two people a day. Now, home care workers visit five or six people a day. How can you build a relationship with people when you spend less than an hour with each person? You feel like your only role is to drop in and give someone a bath. Home care workers don't have time to escort people or help them with their budgets. There's no time to provide any real support. No time to listen to people. It's just the bare minimum. Basic health care, period. (Homemaker, CLSC, Montreal)

Furthermore, the workload increases as the number of hours worked is cut and time is spent adapting to these changes. All our respondents described extremely stressful working environments in their institutions.

I feel like I'm rushing around trying to do all the case evaluations that come in. Even if there are 15 beds, if there are six discharged during the week, six more are admitted. I'm so busy running around doing evaluations and organizing discharges with the CLSCs that I don't have time to spend with people when they come in. (Social worker, CLSC, Quebec City)

Budget cutbacks, the accelerated work pace and growing numbers of patients have repercussions that are making working conditions increasingly difficult:

- working during lunch breaks in order to cope with heavier workloads;
- staff turnover disrupting existing work teams;
- increased sanctions and grievances; and
- non-replacement of employees on sick leave.

In the fall, I had to cope with a very difficult situation. One of my colleagues was sick and was not replaced. For two months, I had to do the work of two full-time people. I was still expected to do just as well as if I only had my own job. No one sat down with me to try to find a way to reduce my workload. I had to get the work done. Nobody gave me flowers to thank me for all my extra work. (Social worker, hospital, Bas-Saint-Laurent)

- Workers express feelings of loneliness and insecurity on the road.

The working conditions for women who have been transferred from hospitals to home care services at CLSCs have undergone profound change. Nurses and nursing assistants, accustomed to working in teams, often feel insecure in the home care field which requires them to perform their duties alone. In many cases, they must travel long distances to patients' homes.

In health care facilities, structures are in place, it's 8 to 4. But here, sometimes there's no time for lunch or supper...so the network will have to look into this, and set up guidelines. (Homemaker, CLSC, Saguenay-Lac-Saint-Jean)

You've got to welcome them just the same...they've been working in the field for over 20 years. It hasn't been easy for them, they've been used to working in a single unit. Now, they provide care in four or five different places in one day. It's not the same thing at all. (Nursing assistant, hospital, Bas-Saint-Laurent)

Working conditions have never been easy for homemakers who must often cover large areas (sometimes 20 to 25 kilometres between homes) and provide assistance at specific times of the day (meals or bedtime). Now, these women are being asked to work on weekends, and the workload continues to increase.

When I started, (some 21 years ago), at first, I'd have up to five people over 38 hours. Now, you can have 20 people in 35 hours. (Homemaker, CLSC, Quebec City)

- The nature of the work is being transformed.

As we have already mentioned, day surgery results in an increased demand on CLSCs expected to deliver a greater range of services: patient escort, post-operative care, dressings, drops, etc. Nurses are now expected to provide care that was once delivered in hospital: antibiotic therapy, IV and subclavian lines, infusion pump and so on. Furthermore, for some types of day surgery, such as cataract surgery, home care workers must receive specific training, and patients and caregivers must be given appropriate information (how to administer eye drops, diet, changing dressings, etc.).

- Higher risk of error and heightened insecurity of staff.

An accelerated work pace, adapting to new functions and reduced supervision all contribute to an increase in the risk of error, which in turn makes workers feel more insecure about their work.

You're forever afraid of making a mistake, or not having enough time to do what needs to be done, or forgetting something. It's always been like this, but now it's worse with the amount of responsibilities we have had to take on. And the shift to ambulatory care, even home care, involves more acute care which is very stressful...the patient who just had surgery 24 hours ago. (Nurse, CLSC, Saguenay-Lac-Saint-Jean)

For some time now, workers have had to maintain an accelerated work pace in order to meet the demand, provide necessary care and to avoid or reduce waiting lists. They have clearly indicated that they cannot keep up this pace for long.

- Salary reductions as a result of part-time day positions.

The introduction of part-time positions in CLSCs and the creation of night-shift teams has encouraged some employees with full-time night positions to accept part-time jobs in order to continue working during the day, despite the reduction in salary.

- Loss of night-shift premiums due to forced staff reassignment to day shifts.

Salary conditions are a source of frustration for the hospital nurses we interviewed. They feel they are being discriminated against as doctors appear to be unaffected by the measures related to the shift to ambulatory care. Unlike doctors, nurses do not receive additional pay for working during Christmas holidays nor for overtime. These informants wonder if high-ranking decision makers are making any effort to make doctors part of the trend in reductions which affect working conditions and privileges.

- The biggest losers are casual workers whose work hours are being reduced.

The reassignment of staff has also had a very negative impact on casual part-time workers who face reduced working hours. On-call conditions are more rigid (irregular availability with 30 minutes notice), which is particularly difficult for women with children. In addition, these workers have already been penalized by changes to Employment Insurance (benefits are calculated according to the number of hours worked as opposed to the number of weeks).

The women who have been completely forgotten in all these changes are those who are on recall lists, because they were next in line for positions. These people were hoping to get a position as soon as one became available. It was a legitimate process. The person with the most seniority gets it. (Nurse, CLSC, Saguenay-Lac-Saint-Jean)

It's terrible what's happening to them...some of them have left health care altogether to try to find other work. They don't know where to look for work, just to make ends meet. (Nurse, CLSC, Quebec City)

The CLSC nurses we met noted that prevention and health promotion have been replaced by the *day surgery* approach. The emotional and relationship dimensions of care are being replaced by its curative dimension (care vs. cure). For nurses, this raises a number of questions. The first relates to the quality of care, which will be addressed further on. The second question refers to workers' skills and qualifications to which we will now turn our attention.

Unrecognized or Threatened Skills

According to our respondents, the current changes seem to have redrawn the boundaries which serve to distinguish various job categories and professions, and have led to requalification or de-skilling. There is a danger that experience gained by work teams and individuals will be lost. As a result of staff transfers from hospitals to CLSCs and changes in the care provided, people with different training and experience are being asked to perform the same duties. This poor organization has led to conflict and dissatisfaction.

For instance, in hospital departments that have cut orderly positions, orderlies may perceive the arrival of nursing assistants as a threat. What role will these new nurses play? Will they in fact replace the orderlies who were asked to leave? This question becomes more pressing when there are not enough orderlies to do rounds in the morning and at night, or to bathe patients. In addition, some nursing assistants may feel that orderlies and homemakers undermine their expertise as they may be asked to perform nursing duties at a lower wage. We have already stated that the effects vary according to each job category, profession and work environment. Nursing assistants, nurses and, to a lesser extent, social workers were the ones who felt the most threatened. Furthermore, they are divided on several questions. While one union representative for orderlies in Quebec City is satisfied with the retraining of orderlies as homemakers, the regional representative for homemakers from the same region feels that the training is inadequate.

- The duties of homemakers are expanding without considering their experience.

Given that the particular expertise of homemakers is not protected by a professional order, the arrival of new workers from hospitals has created tension and placed excessive responsibilities on senior staff due to the newcomers' lack of experience.

Some women had to work extremely hard. Some were 45 when they did their training. They worked like crazy to be good orderlies and they are good orderlies, you know. Now look what's happening. Along comes someone from a hospital and everything falls apart. What kind of atmosphere does this create within the team? It's very hard. (Homemaker, CLSC, Quebec City)

Other conflicts were also reported. Occupational therapists are attempting to take over bathing services provided by homemakers, claiming that the homemakers are sustaining injuries. For their part, homemakers are demanding that they be given responsibility for feeding diabetics, arguing that they are appropriately trained. Homemakers also feel that they have fallen victim to de-skilling due to the fact that independent workers without specialized training are performing the same duties. They are referring to the purchase of private services which is being encouraged by CLSCs. According to one respondent, homemakers are in the process of losing their role as patient escorts as services are being supplied privately or "under the table."

You want to know what we're losing? What the others are taking from us? Patient escorting. (Homemaker, CLSC, Quebec City)

In some CLSCs, the duties of homemakers are limited to personal care, although this is not always the case. In other cases, homemakers are performing more varied duties (not limited to meals and household tasks) and feel they are in a better position to escort patients.

Our work is more people-oriented... We provide personal care. We have an hour to provide personal care, for example, including travel time. So, let's say it takes 15 minutes to get there and 15 minutes to get back, we have some extra time. We provide the care, but we also have time to talk to the patient. Whereas nowadays there's no time for that in hospitals! That's why people prefer receiving care at

home. They feel less like a number. We have time to chat and that counts for a great deal. (Homemaker, CLSC, Bas-Saint-Laurent)

According to this respondent, homemaker qualifications are being upgraded. Yet, some homemakers are afraid they will be replaced by nursing assistants who have been formally assigned certain nursing functions by law. In addition, some homemakers feel they do not receive adequate recognition or consideration from their professional colleagues, while others are very satisfied with their integration and participation in multidisciplinary CLSC teams. Others even feel greater satisfaction as a result of their new responsibilities (helping relationship and more specialized care), but note that their salaries have not been increased accordingly.

- Social workers feel they are losing their grip on social intervention.

Hospital social workers have noted an overlapping of responsibilities between various players as well as a lack of time for social intervention, listening to patients and acting as patient escorts. Most of their time is now spent doing case evaluations.

When I'm running around doing evaluations and organizing discharges with CLSCs, I don't have time to attend to people who come in. And because I don't have time, it's the priest who takes over. (Social worker, hospital, Quebec City)

Meanwhile, nurses are encroaching on the area of helping relations.

We feel there's a threat, because now nurses are taking special courses, as part of their degree, on the helping relations, the relationship with the family. This is really being promoted and, in addition, nurses are qualified to give medication, take blood pressure, give needles, which we can't do. (Social worker, hospital, Outaouais)

Some CLSC social workers feel threatened by de-skilling. For others, the context of interdisciplinary work means that their field of expertise receives better recognition. All our respondents, however, mentioned that there is a general shift in functions from social workers to nurses. Our CLSC informants also noted that they are becoming less active in social intervention. While case management in home care may be seen by nurses as an additional responsibility requiring new skills, social workers perceive this function as a form of de-skilling, or at the very least as a shift in their activities from social intervention to administrative tasks.

We'll forget how to help people mourn, we'll forget how to do social work. (Social worker, CLSC, Montreal)

- The transformation of the nursing profession.

Nurses also complained that the new organization of tasks restricts their work and affects the quality of the care they provide. Case management, for instance, will lead to task fragmentation among various players. There is concern that the nursing profession, which encompasses the delivery of a wide range of care, is in the process of being broken down into various technical tasks. Is the nursing profession undergoing profound change, or is this the effect of a particular context caused by the restructuring of work? The answer is not yet apparent, but the hospital nurses we interviewed believe that the entire profession is losing recognition, and they feel that the work is becoming less and less rewarding. For their part, CLSC nurses talk of a new definition of their work as a combination of curative and preventive care.

The threat of de-skilling seriously affects two groups: nursing assistants and college graduate nurses. It is important to take a close look at these processes.

- Will nursing assistants become obsolete?

Nursing assistants are in a particularly precarious situation since their position may be abolished in hospitals. In addition, there does not seem to be a role for them to play in nursing homes or in CLSCs. Trapped between orderlies and nurses, they feel their experience and expertise are not being recognized.

Despite the intentions of some Régies régionales, CLSCs have sometimes refused to integrate nursing assistants. In cases where they have been integrated, there has been resistance by existing nurses who want to maintain higher qualification requirements. Non-permanent nurses who had acquired experience, or those who were waiting to be promoted, supported these qualification requirements, since the arrival of nursing assistants or nurses who are graduates of college-level nursing programs would undermine recognition of their training and experience.

This puts a lot of stress on my girls at the CLSC because now they're part of a job category that's being called "nursing assistants," and they've never had to deal with this before. For 10 years they were told that if they didn't have a university degree they were no good. Now, they're being lumped into another job category that says nursing assistants can provide home care. No problem. They can do it. This is a direct result of the shift to ambulatory care which didn't exist before and has created a tremendous amount of tension.
(Nurse, CLSC, Saguenay-Lac-Saint-Jean)

In many cases, nurses and nursing assistants have come to represent a mutual threat. Doctors are also in competition with nurses in the home care field (through CLSCs and private clinics) and in the area of prevention (school visits for example).

- The de-skilling of nurses with CEGEP diplomas.

A bachelor's degree in nursing science is a relatively new requirement, introduced shortly before the shift to ambulatory care. This degree undermines the experience and skills of veteran nurses who hold technical diplomas in nursing science and often have over 20 years

experience. Recent university graduates in nursing enjoy greater recognition than veteran nurses.

Generally, colleagues are suspicious of one another as they struggle to protect their positions. Reorganization and reassignment have created tension between workers and have weakened solidarity. According to our respondents, corporate tendencies are growing and each group is fighting to protect its territory. Accountability is yet another problem arising from poorly defined categories of skills and fields of practice.

- Problems of imputability for all job categories and professions.

Workers are protected in terms of professional imputability provided they perform duties specific to the positions they hold. However, reforms and staff transfers have created problems. There have been claims that, in some nursing homes, orderlies were forced to perform nursing duties beyond the legal scope of their profession (e.g., administering medication and insulin injections, performing rectal examinations).

The distribution of home care duties is still unclear. Managers of CLSCs are not always familiar with the duties performed at home by their various categories of employees. According to our respondents, some members of management think homemakers are able to administer injections, and sometimes ask lab technicians to take vital signs.

Home care workers are also less eager to deal with certain situations. For instance, hospitals have procedures in place for when family members decide to take a patient off life support. At home, families must confront this situation alone. Under what conditions are these decisions made? What is each person's role? How are the roles and responsibilities of homemakers defined in this situations?

Someone from Quebec City comes in with a probe. If you remove it and the surgeon in Quebec City instructed the patient not to remove it before three days, but the patient didn't understand...you remove it and the patient goes back to Quebec City, and the surgeon finds out that a nurse took the probe out...you're responsible. People show up without anything in writing. (Nurse, CLSC, Saguenay-Lac-Saint-Jean)

There is also some confusion regarding *delegated acts*. Some acts are formally delegated to nurses by doctors, or by nurses to nursing assistants. But some CLSCs would like homemakers to be *authorized* to perform acts which, according to one informant, fall under the responsibility of nurses. Some of these acts, however, can only be performed by homemakers outside the hospital setting, since in hospitals these functions are reserved for nurses. Cases in point would be the monitoring of insulin or colostomies. The changing responsibilities of homemakers require new skills. One CLSC offered a two-day training session so these women could perform some of these *authorized* acts, including clapping and tube feeding. However, confusion remains since there are no provincial standards for this transfer of acts. Each CLSC proceeds on a case-by-case basis, and many homemakers are uncertain about the duties they are expected to perform.

The Toll on Workers' Lives and Health

All these changes and new working conditions have taken a toll on the lives and health of workers. According to our informants, transfers have already disrupted the lives of many women. Increased workloads and added responsibilities have led to exhaustion. Furthermore, the changes that lie ahead will continue to foster a climate of insecurity.

- Heavy workloads have led to fatigue and poor health.

Our respondents were virtually unanimous in their affirmation that the reorganization of services has led to a sudden upsurge in burnouts.

October, November and December were terrible at the CLSC. Everyone looked exhausted!... No one felt like talking. People were really unpleasant. We come in to work and we rush around all day. It's become an effort just to come into work. (Nurse, CLSC, Montreal)

What I hear a lot is: "I've had it, I can't take this anymore, I'm burnt out!" (Nursing assistant, hospital, Montreal)

According to our informants, the absence of replacement staff makes it hard for workers to take a needed vacation since it means that more responsibilities will be placed on colleagues. In addition, overtime is often unremunerated.

Some hospital departments seem to have been particularly hard hit by sick leave. According to one informant, at the time of the interview, seven workers from one emergency ward were on sick leave at the same time — three for major depression or ulcers. In another department, nine full-time workers out of ten were said to have been on sick leave in the spring of 1996. Some hospitals, we were told, do not recognize burnouts diagnosed by general practitioners, and require a psychiatric evaluation.

Workers say that in spite of all this they will continue to do their best to fulfil their responsibilities.

It was hard for me to say what I did about quality because, damn, do we ever have heart! That's what I'm realizing. Health workers have a lot of heart! But that's always been women's lot! (Nursing assistant, hospital, Bas-Saint-Laurent)

- Some workers are unhappy about the new work assignments they had to choose.
- An apparent freeze on promotions and employee development, and working conditions at a standstill all have affected morale.
- Stress and insecurity have become common as a result of profound uncertainty about the future.

- There are growing problems related to alcohol and drug abuse.

Fatigue, stress and insecurity have created a climate which lends itself to alcohol and drug abuse. Respondents told us that they have no idea of the scope and time frame of the next series of changes. They described depression and health problems brought on by the stress of adapting to new work teams, new responsibilities and new work methods. They talked about burnout, suicide, depression, stress and anxiety, and colleagues who have taken long leaves of absence or who have quit due to heavy workloads, reassignments or difficulties adapting.

One informant said that out of 24 workers reassigned from one facility, seven or nine were suffering from depression. Informants identified three factors to explain this situation: little or no sense of belonging, difficulty integrating into new work settings where groups already exist and are hostile toward new colleagues, and increased workloads. Some nurses actually preferred to quit their jobs or refuse reassignments rather than deal with extremely stressful situations. Others were resorting to medication in order to cope.

- Physical problems.

Workers are suffering health problems such as back pain, bursitis and other ailments. As the number of patients grows and they become less autonomous, workers spend more time making beds and turning patients.

- Ageing staff must contend with mounting fatigue.

The seniority process means that older workers keep their jobs. Due to the increasingly difficult physical nature of the work, there is a greater risk of accident, especially for orderlies and homemakers. In addition, homes are less well equipped than hospitals (there are no patient lifts, for example), and in hospitals there is less and less safe equipment available to move patients.

- There are higher risks associated with home care due to the number of times patients must be moved and the new context (home vs. hospital) in which care is being provided.

Many respondents told us they are considering retirement as a result of these new working conditions, even though their retirement conditions are not ideal (e.g., a pension equal to 40 percent or 50 percent of their salaries).¹⁰

- The erosion of solidarity among workers.

Staff reassignment and the reorganization of work have created tension and conflict, and have eroded worker solidarity. As a result of bumping, work teams have been dismantled, alliances and friendships have been broken.

I remember when we worked as teams, and at that time, if a team was dismantled, we helped each other out. It was always like that. It was a very healthy environment. Now, the girls feel there's nobody who can help us. So

everyone looks out for themselves. It's the individual who comes first. That's how things are with the nurses nowadays. But it should be the opposite. (Nurse, hospital, Outaouais)

Well aware of the importance of solidarity, some hospital workers told us with sadness that they have no time to help or consult with each other due to the increased workload.

We've become very individualistic. Everyone's looking out for their own interests. It's an "everyone for themselves" kind of attitude. (Orderly, hospital, Outaouais)

- Disrupted personal and professional lives.

The difficulties workers face reconciling their personal and professional lives are not new, but the situation has been exacerbated by the shift to ambulatory care. The climate of insecurity on the job, working conditions (night shifts, on-call, availability requirements and penalties), heightened stress levels, the absence of policies to support mothers (e.g., risk of debt due to nighttime child care) sometimes force women to choose between career and family.

Changes in shifts upset child care schedules and wreak havoc on the daily lives of women. Increased fatigue and stress due to workloads has had a definite effect on the personal lives of these women. An orderly who was used to working night shifts was forced to accept a daytime position. She spoke to us about the effects of this change on her family.

Now that I work days, I have to look into day care which is an additional cost. Now, we have to organize our schedules differently. In the morning, we're rushed. When I worked nights, I received a night shift premium which helped cover some of my travelling expenses like parking. Now, I don't get any extra pay. In other words, it's going to cost me more to work days. (Orderly, hospital, Montreal)

Difficulties reconciling work with domestic and family responsibilities leads to greater fatigue which has a negative effect on workers' relationships with their partners and children as well as on their leisure time. Some hospital nurses stated that the workload combined with insecurity had a major impact on their personal lives. Perpetually tired, many women told us they were unable to relax at the end of their work day.

You know, we really put our hearts into our work. We can't be indifferent to the suffering we see every day. No matter what, it affects us. So when we get home, we really need to unwind. (Nurse, hospital, Bas-Saint-Laurent)

It's easier for people to have a decent social life when they finish their shift at 4 in the afternoon. Now, they're exhausted at the end of their shift (Orderly, hospital, Outaouais)

Job insecurity has led workers to abandon personal projects (workers are selling their new cars to purchase used ones or are selling their homes).

What About the Delivery of Care?

According to our respondents, all the changes made to health and social services undermine the quality of care. Patients receive less attention in hospital; they are discharged from hospital prematurely; home care programs are inadequate due to an insufficient allocation of resources to CLSCs. This situation threatens the proper delivery of services.

I feel like I'm being rushed by the system and I'm really scared of rushing the patients...that's one of my big fears...I don't want to rush anyone, but we're trapped by the shift and we're forced to rush. (Nurse, hospital, Bas-Saint-Laurent)

According to our informants, the effects of premature discharging of patients from hospital vary, depending on the facility and region. Waiting lists are growing while home care services to regular patients are being reduced (priority is given to people leaving the hospitals); services that were once free now carry a fee; private services are being used more and more while prevention programs are being abolished. This perception is completely in line with what the caregivers and patients we interviewed are saying.

- Lack of continuity between hospital and home care services.

One problem frequently identified is the lack of collaboration between CLSCs and hospitals. It appears that the articulation and co-ordination of several aspects of a patient's return home are lacking.

The procedures for hospital discharges still appear to be inadequate. The workers interviewed deplored the poor evaluation of patients who are granted discharges. There is also criticism of the lack of CLSC involvement in terms of planning a patient's return home. The hospital workers we interviewed complained about the fact that CLSC workers are not available to ensure follow-up for patients who have been discharged.

It still happens that we get called once the person has already returned home. It's unacceptable! That means that the minimal conditions for people returning home in terms of the quality of care are not being respected, in spite of the promises made by the Régie régionale. (Social worker, CLSC, Montreal)

Just to give you a few examples, we saw old people returning home who had broken their hips, who couldn't walk and had to be in wheelchairs. There was a little problem...they couldn't get their wheelchairs into their homes. Then there were cases of people who live on the second floor. People stuck in their apartments for months in their wheelchairs. And that's nothing...at least you can try to make other arrangements... What I'm talking about are cases where the wheelchair couldn't be used at all because the hall in the apartment and the

doorway to the bathroom are too narrow. And none of this is verified by the hospital before the patient is discharged. (Social worker, CLSC, Montreal)

It must be emphasized that both the caregivers and patients we interviewed mentioned the same phenomenon.

- No co-operation from doctors.

Some informants deplore the lack of sensitivity and co-operation on the part of doctors.

Doctors don't want to get involved in all this. They're completely unaware, although they should be very in tune. The Régie régionale organized workshops on how to negotiate effectively. They didn't say it outright, but it's clear that they want us to learn how to negotiate with the doctors. (Nurse, CLSC, Montreal)

Communication between CLSC nurses and attending doctors is often difficult.

Often, hospitals prescribe a whole bunch of things; they're a little over-enthusiastic so that they can feel like they're doing their jobs. But very often it's not necessary, and we have to run around filling these tall orders! It's frustrating when you're being asked to do things that aren't needed. (Nurse, CLSC, Montreal)

- CLSCs are unable to meet demand.

A Montreal hospital opened a clinic for infants in response to ongoing problems in postnatal follow-up by CLSCs unable to handle its new role.

In general, it is believed that people are better off convalescing at home. According to our informants, however, the picture is bleak since the quality of care is not up to standard. There is not enough time to ensure the quality of care, and cuts to staff continue as the demand rises. Even vital care is provided expeditiously, and our informants fear that soon there will be no time for basic human caring.

- Deterioration of hospital care.

Hospital workers are concerned about the increase in workload and its effect on the quality of care. As staff numbers continue to shrink, the work pace intensifies. The public is well aware of the situation.

Patients are too polite to say anything, so they say: "I can see you're doing your best." Patients make statements like that all the time. It's good to hear — it makes us feel better. (Nurse, hospital, Saguenay-Lac-Saint-Jean)

And when you've got 10 patients to feed, you can't help everyone at once. So I line them all up, and they each get one spoonful at a time...it's pitiful. You've got to make them eat fast because there are four others who are hungry. You have no choice. (Orderly, hospital, Montreal)

It is clear that patients and their families have noticed a deterioration in the quality of services due to reduced staff and heavier workloads.

I don't know what happened...I was monitored throughout my pregnancy. Everything was fine. But when I gave birth it wasn't the same. There were no services at all. There was very little staff. (Patient, Montreal)

Patients and their relatives also point out the difficulties in obtaining information on their health and the health of their partners.

I was a little upset too. It didn't make sense. He was the last to have an operation, and in his state...I stayed at the hospital until 10 o'clock. I said to myself, they can't possibly discharge him the next morning! It didn't make any sense! I tried to find out from the nursing office. They said they thought they'd probably keep him, but, you know, nothing was definite. (Caregiver, Montreal)

- Less and less time is devoted to preventive care.

Reduced amounts of time allocated to different types of interventions mean less time for patient escorting, assistance to patients and education (in order to change attitudes and practices). As social workers devote ever-increasing energy to evaluations and organizing discharges, less time is spent working with individual patients or finding solutions to problems related to the provision of care.

We took courses on working with terminal patients, but we don't have time to apply any of our skills. Patients who are dying need you to sit down, hold their hand, at the very least. But we don't even have time for that anymore. (Orderly, hospital, Montreal)

- Less time for escorting or listening to patients.

Both hospital and CLSC workers say they do not have time to listen to their patients or to engage in any kind of meaningful dialogue. The nurses we interviewed are not satisfied with the care being provided, as they are expected to do the equivalent of three days work in 24 to 48 hours. This leaves no time for patient education. Shortened hospital stays do not provide social workers with enough time to build ties with patients as they did in the past, which made subsequent contact easier in the event of complications, setbacks or crises. Nurses, nursing assistants and social workers alike complained that they have no time to listen to patients, act as escorts or provide preventive care.

The study clearly revealed that nurses who were providing education, for example on diets for diabetics, simply don't have time for prevention anymore. At best, they sometimes have time for follow-up over the phone! (Social worker, CLSC, Montreal)

[Management told us] with the move toward ambulatory care, with new technologies and the hospital's new mandate, our social mandate has been reduced. Yet the social dimension had just been included in the hospital's mandate with Bill 120. (Social worker, hospital, Outaouais)

- Private agencies have created new problems.

There is high staff turnover in private agencies and, according to our informants, the quality of care is not ensured.

Old people who were bathed once or twice a week, who were regular home care clients, who received excellent patient escort services from homemakers...those days are gone! There are some very sad situations in which people receive services two or three times a week from two or three different people! (Social worker, CLSC, Montreal)

With regard to private services,¹¹ this CLSC homemaker expressed her concerns about the new social economy policies. She is worried about the quality of care provided by people with inadequate training.

An independent worker who goes to a patient's house to listen and provide support, who gets the woman to talk and then the woman starts to cry. She doesn't know how to reassure her. You can't embark on a process you're not trained to handle. (Homemaker, CLSC, Outaouais)

- There is no guarantee that hospital waiting lists will be reduced.

One objective of the shift to ambulatory care is to shorten waiting lists for surgery. According to our respondents, these lists have already been reduced in several places. However, our respondents noted that the concentration of specialties in hospitals can, in some cases, lengthen waiting lists (we were told of one year waiting periods for cataract surgery due to a concentrated specialization of this field in one hospital and its absence in another). Furthermore, emergency ward closures increase the pressure on other emergency rooms in the area, if any exist at all. There are still waiting lists for long-term beds despite the conversion of several hospitals into chronic care facilities.

- Growing waiting lists in CLSCs.

The shift to ambulatory care has lengthened waiting lists in CLSCs for physiotherapy and occupational therapy (particularly in the Bas-Saint-Laurent region) or for home care (particularly in Montreal). Less acute cases are sometimes not even eligible for waiting lists.

According to our respondents, the quality of home care services to regular clients has deteriorated, particularly in Montreal.

Many people who are tired, who need to talk, are put on waiting lists. (Homemaker, CLSC, Outaouais)

Care providers' workloads have increased. Workers don't put people on waiting lists. Instead, they try to squeeze in as many interviews as possible or do as much as they can over the phone, it's the juggling approach. (Nurse, CLSC, Saguenay-Lac-Saint-Jean)

- Patients transferred home.

To make up for the deficiencies of the health network, patients' relatives are expected to "pick up the slack."

We're kind of exploiting the family. It's not official, but it's implicit. Services are being provided at an increasingly fast pace so the demand can be met. As patients are discharged early, it's the family that picks up the slack, usually women. (Social worker, hospital, Montreal)

We have to work more closely "with" the patient's home environment, rather than depending "on" it. Professionals from establishments will have to work more closely with the patient's relatives instead of unloading all the responsibility on them. We cannot relinquish our responsibility...we have to support the family unit. That's very important. (Nurse, CLSC, Saguenay-Lac-Saint-Jean)

Our respondents say that in the absence of public home care, the quality of services will depend on the abilities of individual relatives.

What I've noticed is more psychosocial distress because patients do not always return to harmonious home lives. There may be problems with a spouse or children. When a patient returns home, family members have to sit down and decide how to share the responsibility, but not all families are able to be supportive. (Nurse, CLSC, Montreal)

Several respondents noted that caregivers have trouble providing adequate care and that they must often take care of a sick relative alone. They also noted a rise in the risk of patient abuse. The idea of dying at home may appear serene, but family members are not always prepared to deal with the death of a loved one.

The sister called us to say she wasn't prepared to have her brother return home so soon. But it was too late. The discharge had been signed. Once it's signed, it's signed. (Nurse, hospital, Outaouais)

Reform in Progress: A First Critical Look at the Shift to Ambulatory Care

The following thoughts, expressed in Rimouski, capture the overall sentiment of our informants.

The problem in Quebec is that the shift was combined with cutbacks. Without the cuts, the shift could have been desirable; it would have been terrific because it would have answered people's needs and the same money would have been invested differently. Everything would have been done differently and would have been more closely tied to the patient. I think it would have been more humane. (Nurse, hospital, Bas-du-St-Laurent)

In general, health care workers, caregivers and patients agree with the initial objectives of the shift to ambulatory care: reduce the duration of certain hospital stays, increase chronic care beds, and decrease hospital care in favour of home care. These objectives correspond with the ageing of the population, the need for a better distribution of services and, it would seem, the humanization and de-medicalization of care (for instance, greater patient autonomy and responsibility, faster convalescence at home, the possibility of dying at home).

In the context of budget cuts, however, the shift to ambulatory care runs the risk of achieving the very opposite of its original goals: the increasing role of technology and reduction of care, deterioration of working conditions for caregivers, loss of motivation among health care workers, continuation of a “hospital-centric” and biomedical approach and problems surrounding issues of justice, equity and quality in the delivery of services.

- Desired but compromised reforms.

Our respondents gave a generally negative evaluation of the shift to ambulatory care in terms of the quality of care offered, accessibility of services, health measures, availability of health staff, the future of careers in health care, the solicitation of relatives and the implementation of the reform. Measures that could mitigate some of these effects were proposed.

Short- and Long-Term Effects

We have presented the portrait drawn by the health care workers we interviewed and the caregivers we met in the focus groups. We now present a summary of their views of the changes that have taken place as a result of the shift to ambulatory care.

First, the transformation of the health and social services network has a number of short-term effects.

- An unstable and discouraging situation for health care workers.

Most of the workers we interviewed regarded the situation as an established fact.

I worked in pediatrics for years (in a hospital), and I loved it. I'd leave at 4 o'clock and have the next day off. But if a child wasn't doing well, I'd go in on my day off for a couple of minutes to see how the little one was doing. And I wasn't the only one to do that. Today, you'd never see that. I leave at 4 and you better believe I don't want to be bothered. If that's what they want, that's what they're going to get. They tell us to do only what's absolutely necessary. So that's what they're gonna get from us. (Nursing assistant, hospital, Montreal)

- Lack of continuity between hospital and home care services.

Preparation for the shift to ambulatory care was inadequate. Hospitals discharge patients without involving CLSCs to plan for a patient's return home, and CLSCs lack the necessary resources to help patients once they have left the hospital.

- Overburdened health care workers.

The reduction in staff and increase in patients have resulted in work overload. This is cause for concern in the long term. One has to wonder how health care workers and caregivers are going to be able to continue at this rate.

- Threatened qualifications, unrecognized experience.

The level of frustration and humiliation experienced by workers whose years of skill and experience are not recognized cannot be overstated. Everyone working in the health care sector is worried about their future and whether or not their experience and skill will be recognized.

- Questions of professional imputability and conflicts between different occupations and professions.

Workers with different training, occupations and professions are finding themselves doing the same work which sometimes requires skills they do not possess.

- Deterioration in caregivers' standard of living.

In the vast majority of cases, women find themselves responsible for providing home care, a responsibility that carries a significant price: sacrificed paid employment, a wide range of expenses, health implications. For some women, this can lead to poverty.

- Increased responsibilities and greater difficulties for caregivers.
- Relatives cannot take on all of the responsibility.

Poverty, violence in the home or lack of support can hinder the ability to provide care to a sick relative. Sometimes, a patient's parents or children do not live in the same city. Many

cannot count on a support network. And even if this network exists, it can quickly become overwhelmed and overtaxed.

- Is there a trend toward growing needs and shrinking support?

For demographic reasons, more people will be requiring medium- and long-term care (ageing of the population) and fewer people will be available to provide it due to shrinking family size (fewer or no brothers and sisters).

In a few years who's going to look after us? I have two daughters. Both of them work and will have to do so all of their lives. Who will look after me? I have no idea! (Caregiver, Quebec City)

Care Reduced to Its Most Basic Form

According to our respondents, the de-medicalization and humanization of health care that could have occurred with the shift of activities from hospitals to CLSCs have only been partially realized.

- Emotional and social needs are being relegated to the home.

At the Rimouski CLSC, workers value the opportunity to treat patients at home. This enables them to get to know their patients better, to understand their psychosocial environment and to provide them with more comprehensive and appropriate treatment. It appears that younger patients prefer to convalesce at home.

When patients receive health care workers in their homes there is the possibility of a different power dynamic than that which exists between hospital and patient. In a hospital setting, patients, clothed in skimpy hospital gowns, feel humiliated and tend to accept, on the hospital's terms and territory, everything the doctors and nurses tell them. At home, patients may feel more in control of the situation, their schedule and the conditions under which they receive care.

These positive attributes, however, are contingent on hospitals conducting telephone follow-ups, on CLSCs' abilities to meet demands and on personnel finding ways to maintain quality service. In this context, the provision of care is more complex.

It's important to have a good relationship with the relatives, to know the family members. So when we conduct a visit, it's not enough to just stay 15 minutes because it's necessary to make sure, from A to Z, that everything's all right. It's important to maintain our helping relationship, to maintain our communication with the relatives. We must ensure that confidence is established because we need to be informed of everything that's going on. (Nurse, CLSC, Montreal)

We still work 35-hour weeks, but for that same time period we have more responsibilities. These responsibilities include procedures, the time involved in communication, it's not just...visits, dressings. (Nurse, CLSC, Montreal)

- CLSCs with insufficient resources.

According to our respondents, CLSCs are unable to meet the demand and respond quickly enough; the transfer of positions from one facility to another has only just begun. CLSCs with increased responsibilities have not had a corresponding increase in staff, forcing workers to abandon preventive care and focus on curative care.

When CLSCs lack the resources to meet needs, there is a risk that patients will not receive the care they require when they are discharged from hospital. Post-hospitalization support services are not fully in place, and there is fear that there will be a repetition of what occurred in the 1970s when mental health care was de-institutionalized, i.e., an increase in the burden placed on relatives and a deterioration in the health of patients and caregivers alike.

- Care too often viewed exclusively from a financial and administrative perspective.

According to many of our respondents, care is being bureaucratized and there is an increasing trend toward a “bottom line” approach to health care.

Now, with the shift to ambulatory care, you're not allowed to see a psychiatric patient more than 30 times. After that you're healed! They adopted the insurance model. If you're in the private sector, insurance pays so much for psychological treatment, and so you're given so much, and no more. So we're using a private model, and the message we're getting is we need to work as if we were in the private sector. If we were working in a private hospital we'd have to show a profit. That's the message. We have to think profit. (Social worker, hospital, Montreal)

- Does the changing mission of CLSCs mean the end of preventive care and community outreach?

Due to time constraints, CLSCs are often forced to set aside their preventive work. For instance, a nurse now only visits schools one day a week to do preventive health care. Others no longer have enough time to visit the elderly to prevent overmedication. Growing numbers of patients also militate against preventive care in favour of dealing with the most serious cases. Urgent cases are the priority.

If a family is having problems, there's a one-year waiting list to see a social worker, and I'm not kidding. That's the reality. Which means that the most serious cases are seen first, while those who come to see us because they're beginning to have problems with their child or the child has minor behavioural problems at home or at school, they're not seen right away. They

sit on a waiting list and then six months later the situation comes to a head and the child has to be placed. (Social worker, CLSC, Montreal)

There is also concern that CLSCs are losing their community vision and that preventive and social initiatives are being abandoned in favour of a strictly medical approach. For instance, in a Saguenay-Lac-Saint-Jean CLSC, one employee saw her position as health care worker in the schools eliminated. She was transferred back to the CLSC to provide standard everyday health care. There is a fear that the psychosocial dimension is being abandoned. Will community organization also be sacrificed?

Of course, other CLSC workers have a more positive interpretation of the changes (unlike hospitals, CLSCs are growing) and they enjoy working at the crossroads of curative and preventive care. Despite all the problems the current situation may cause, some respondents feel there are also exciting challenges: new learning opportunities, greater autonomy, multidisciplinary work.

Equity and Democracy

According to our informants, universal access to health care is being threatened. Why should the quality and quantity of care, the resources and services to which patients have a right, depend on the skills, availability and resources of relatives?

- Moving toward a two-tiered health care system: one for the rich and one for the poor.

Many of our respondents view the shift to ambulatory care as the first step in the development of a two-tiered system, one for the rich and one for the poor; in other words, the implementation of a private system and the abolition of a universal and free system. In the future, the wealthy will be able to purchase high-quality, wide-ranging services in the private sector.

For the poor and the middle class, the situation will be quite different. The poor will have rights to services; those with a little money will be referred to private services for which they will have to pay.

It's the same thing at a CLSC, if you have money, you pay the full price. I have a friend whose husband has Alzheimer's disease...and she has to pay full price because her husband had put a little money aside. As long as she has money, she'll have to pay. For the CLSCs there's a certain justice in it. Are they going to give as much to the rich as the poor? The poor have to survive, the rich can afford it. (Caregiver, Quebec City)

This raises the issue of equity: if an individual has put money aside all her life, does that mean her right to public services should be limited?

- Two classes of workers.

Shrinking public services also lead to the creation of precarious and poorly paid jobs in the private and community sectors. These sectors offer services already available in the public sector, thus destroying working conditions in the public sector that were the fruit of many struggles. The danger is that two categories of workers will emerge: one characterized by decent working conditions and the other by low wages, part-time work and job insecurity. Meanwhile, both will be performing identical work.

Some job categories, particularly homemakers, expressed concerns about social economy projects, namely those which involve the introduction of direct allowances.

Our informants reported that health care workers worry that all convalescent care and home care will be privatized, that personnel needs will be met by volunteers or by caregivers without the required expertise. They fear hospital jobs will be replaced by more precarious jobs in community groups.

Casual staff hoping to accede to new positions feel abandoned and condemned to perpetual casual status, despite the fact that CLSCs continue to be understaffed.

- Regionalization

The objective of regionalizing health and social services was to enable greater public input into decisions affecting their regions. Our informants are of the opinion that the cuts implemented in Quebec by the Ministère de la santé et des services sociaux had a greater impact on the reorganization of services in their regions than did their Régie régionale.

Some of our informants, however, believe that there are advantages to the regional structure, not the least of which is the fact that some decisions are made regionally. Residents of the region have the opportunity to express their views and may have an influence because they have easy access to the decision-making centre. In this context, there is the possibility of reversing or modifying certain decisions.

Solutions for Patients and Caregivers

Our informants made a series of suggestions that were not necessarily supported by everyone but are worth noting.

- Lengthen the hospital stays of patients who cannot rely on a good support network at home.
- Pay those who look after sick relatives.
- Open convalescent homes.

Public convalescent homes were proposed as a means to respond to patients' fears of being alone and caregivers' concerns about their ability to provide necessary care. These homes may be an answer to shortened hospital stays for patients who cannot rely on help from relatives or whose convalescence requires more specialized care.

- Inform both patients and their relatives from the moment of hospitalization, or even before, of the available home care services and the kind of help they will require.

Information sessions on regional services should be organized since women are not always aware of available services (especially community services) and services they are entitled to (in CLSCs). Women should be able to plan for and not simply react to emergency situations.

- Organize mutual support groups and respite care.

Our informants expressed the need to organize mutual support groups which provide women with respite and an opportunity to share their experiences. Our respondents also pointed to the importance of respite services that would enable caregivers to take a break. These are only partial solutions to the current problems and could aptly be termed survival strategies.

- Greater accessibility of specialized equipment adapted to home care needs.
- Need for improved communication between the various medical facilities, home care services, patients and relatives.

These last two recommendations are related to the major problems in co-ordinating services. If caregivers are required to do more, they must receive better follow-up and support.

It is important that future research explore the distribution of responsibilities between public, private, community and family services. The increasing complexity of home care and its delivery by relatives and patients themselves, as well as the impact of these demands on the physical and mental health of caregivers must be evaluated.

Solutions for Workers

Our informants proposed no specific solutions to resolve the problems they identified. They did, however, suggest some measures to mitigate or reduce the effects they find the most difficult to contend with.

- Slow down the pace of reforms and better plan the changes.

According to some of our respondents, an evaluation must be conducted before undertaking any further changes.

They call for an end to cutbacks and an increase in health budgets and human resources. Some are also asking that there be a significant transfer of funds to CLSCs and that processes be put in place to ensure real continuity between hospital and home care.

Some respondents also stressed that workers have relevant ideas about restructuring and reorganizing and they need to be consulted, although, so far, employers have failed to do so. One way of mitigating the negative effects of the reform on workers would be to ensure that employers respect regulations and collective agreements so workers who are reassigned do

not feel that decisions were arbitrary. Some respondents, however, expressed a wish for the system to show a little more flexibility, reducing the time and complexity of procedures required for personnel from a given facility to obtain newly created positions or allowing the facility to seek competent personnel beyond the standard lists, if needed.

- Staff transfers based on planning and respect for the employee.
- Supporting employees: measures to take, unions already approached.

Our respondents proposed that support programs be established for displaced, bumped and on-call workers. To try to offset the anguish and disruption caused by bumping, they also suggested that volunteer job exchange programs be implemented. This would help to increase worker satisfaction and, as a result, increase efficiency. Such a program exists at the hospital in Rimouski which, while very small scale, appears to have satisfied the six or seven workers involved.

Unions can and do provide various forms of support:

- listen to workers and answer their questions, direct them to help, try to help them overcome problems;
- explain clauses in collective agreements that can cause frustration (e.g., seniority);
- provide psychological support to help in the transition;
- support employees in their reassignment, help workers make choices;
- communicate employee needs to employers; and
- ensure the presence of a counsellor in each facility to answer workers' questions.

One nurse told us that union meetings designed to provide information, held one evening a week starting in mid-February 1996, enjoyed participation rates of 80 percent, 85 percent and 98 percent.

- Provide training to all employees.

Some CLSC nurses took training courses in order to conduct post-operative follow-up in the patients' homes. It is not possible, however, for workers to undertake lengthy training programs.

Our informants reported that employer support for training is very uneven from one facility to another. At the hospital level, training primarily consists of observing and learning from those who have held a given position for a long time. In one hospital, it was reported that the entire team had to take a mandatory four-day training session. In another, the director only permitted one day of observation before beginning a new job. The worker must therefore often learn how to do things on the job or on her own. In another hospital, training is readily available but employees must share part of the cost.

The Régie régionale in Montreal organized training sessions for workers reassigned to CLSCs. Trainees are then paired with experienced workers for a given number of days to learn the day-to-day requirements of the job. Experienced workers, however, are not always

supported by management or freed from their regular work responsibilities to provide training, resulting in an increased workload.

Our informants stressed, however, that training was only a partial solution.

- Work in multidisciplinary teams.

Work within multidisciplinary teams can help resolve certain problems related to integration into a new work setting or de-skilling. Work teams promote discussion and more effective collaboration among members (nurses, social workers, assistants).

This is the positive side of the shift. You work with other disciplines, you're no longer isolated in your own discipline, in social work or nursing. It's wonderful. (Social worker, CLSC, Outaouais)

CLSC workers are generally grateful for the advantages of working in teams. They report that the quality of care is better when occupational therapists, physiotherapists, home care doctors, social workers and homemakers work together. The constant updating among personnel, especially nurses, accounts for a great deal of the improvement in care. But as in hospitals, CLSC workers denounce the negative repercussions of the increase in their workloads. One CLSC social worker in the Outaouais rated her work environment as “good,” despite increased workloads, because her work team is strong and able to absorb the shock. Their manager also provides them with a degree of flexibility allowing them to adapt to the change.

The support of work teams, however, is only a partial solution. Although in some cases it contributes to a clearer distinction between health care fields and responsibilities, in others it blurs these distinctions. In some CLSCs (in Montreal especially), the increase in the number of patients compromises teamwork or at least makes it more difficult, while elsewhere (such as Quebec City and the Outaouais), team-based organization has helped workers adapt to the changes.

We had a small interdisciplinary team, and our managers showed an interest and effort in making it work. But the team completely crumbled with the shift to ambulatory care leading to very impersonal care and services. Now, you have no idea who saw who and when. (Social worker, CLSC, Montreal)

Communication between facilities helped to make collaboration easier (use of telephone, fax, shorter written documents for patient referrals). Greater discussion, dialogue, consultation and reciprocal assistance between workers of different facilities is emerging in an effort to avoid centralizing work around a single individual.

Solidarity will become increasingly important despite the decentralization. In your work, you have to be open to other professionals and nurses from other facilities. Rivalries between CLSCs and between hospitals and CLSCs are over. Now we complement each other. (Nurse, CLSC, Quebec City)

- Making change a challenge.

One homemaker in Montreal reported that several orderlies who had been reassigned to home care in CLSCs preferred their new work because they felt there was greater latitude and better contact with patients. One nurse reported that some of her colleagues confided that they had wanted to leave their hospital department for some time and felt that now they were in "heaven."

Reassignment to a CLSC can be viewed as a problem or as an exciting challenge (independence, learning, training and constant upgrading). But in order for it to be a positive challenge, the following mechanisms and support must be in place:

- reassignment in a climate of respect and support;
- meetings organized by the employer to help individuals cope with their loss;
- training to smooth transitions; and
- planned changes.

CHAPTER 4: SOCIAL ECONOMY POLICIES AND THE RESTRUCTURING OF HEALTH AND SOCIAL SERVICES

The shift to ambulatory care in the health and social services sectors, combined with major cutbacks in jobs, budgets and infrastructure, is occurring as a new paradigm emerges among women's groups, community organizations and government bodies: the social economy paradigm. The meshing of social economy and the shift to ambulatory care is not coincidental. Government considers these two approaches to managing collective services as the solution to its financial crisis. In the health and social services sector, the social economy has already taken the form of home care services and the reorganization of related jobs. This chapter examines the relationship between the shift to ambulatory care and social economy, based on information provided by seven women with first-hand knowledge.

Certain elements of our methodology should be mentioned. Five of the seven informants are members of a Comité régional d'économie sociale (CRÉS). These advisory authorities are in charge of overseeing the implementation of social economy policies in Quebec's regions. The other two informants, at the provincial level, were asked to give a more global perspective of the situation from their particular milieu: the first woman works with a community organization located on the island of Montreal, and the second is associated with an important umbrella organization of women's groups, also based in Montreal. The information obtained is valuable in that it reflects the informants' perceptions. This information is, therefore, highly subjective. These interviews have allowed us to paint a picture that does not necessarily reflect all women's groups, nor all the players involved in the various CRÉS (the five informants are members of the five different regional committees; there are currently 16 CRÉS in Quebec) or in Quebec's social economy sector. In addition, disparities exist in the information due to the fact that it was gathered at two different points in time (four interviews were conducted in February 1997 and three interviews, including two at the national level, in May 1997). Nevertheless, the information provides us with a realistic overview of the ambiguities and paradoxes that punctuate a process in full evolution — the implementation of social economy policies, particularly in the area of public health and social services.

Social economy is not a phenomenon exclusive to Quebec. It has already been the subject of debate in many countries under various names including the economy of solidarity, alternative economy or the "other" economy (COCÉS: 1996). These terms all refer to the reorganization of economic relations, placing social objectives and the integration of people from marginalized groups before the exclusive interests of the capitalist market. In Quebec, as elsewhere, individuals and organizations or enterprises have been part of the social economy for years, without having necessarily labelled their activities as such. A specific set of conditions, including the Women's March Against Poverty, held in June 1995, led to state implementation of social economy policies. Topping the women's list of nine demands was the creation of a social infrastructure program that included jobs for women. In response to the marchers' demands, the Parizeau government promised a \$225 million envelope over five years. In March 1996, at the Conference on Quebec's Social and Economic Future, Premier Bouchard publicly introduced the concept of social economy as, among other things, a possible

strategy for caring for the sick. Then, following negotiations in preparation for the Socio-Economic Summit in 1996, the government set up a steering committee and a task force on the social economy. Since 1996, social economy has clearly permeated public opinion and has become the inspiration for a widespread inquiry into the reorganization of collective services — influenced by the Quebec government's zero deficit objective.

Following recommendations made by the steering committee on the social economy, the government created regional committees on social economy (CRÉS) charged with overseeing the implementation of social economy policies in the various regions of Quebec — an initiative that is currently under way (Chantier de l'économie et de l'emploi, 1996). Since 1996, these regional committees have engaged in a fierce ideological and practical debate on the very significance and orientation of the social economy policies (Lemieux and Vaillancourt, 1997). Not all the players involved in the debate share the same approach. These divergent orientations derive from different value systems, each of which reflects a particular world view and social vision. The Comité d'orientation et de la concertation sur l'économie sociale (COCÉS) emphasized the creation of long-term, quality jobs in an effort to thwart the temptation to turn the social economy policies into a large-scale employment program for welfare recipients.¹² The Chantier sur l'économie sociale proposes a broader conception, probably due to the fact that the Socio-Economic Summit¹³ constitutes the backdrop of its analysis. In keeping with the 1995 Women's March Against Poverty, women's groups emphasize the importance of responding to social needs, while the state social economy project is largely based on shrinking the role of government. For the ministry concerned, this conception will be influenced by the integration of the jobless into the work force (Ministère de la sécurité du revenu or MSR) or by the institutionalization of community organizations in view of sub-contracting services (Régie régionale de la santé et des services sociaux or RRSSS) (Lemieux and Vaillancourt, 1997: 2-3). In addition to these differences in perception there are divergent interests. Unions fear that the social economy is yet another step toward the privatization of public services. Meanwhile, community organizations consider social economy policies as a real opportunity to fight poverty and marginalization, particularly for women. The debate is, therefore, extremely complex and we offer no solutions. However, we felt it was necessary to provide an overview of the situation in order to gain a better understanding of the ambiguities and paradoxes faced by our informants.

We proceed with an initial analysis of this implementation, after having presented some of the diverging opinions within the CRÉS, based on the perspectives of certain women who play a central role in this process. These same informants then allow us to take a critical look at the implementation of the social economy policies, examining the interrelationship between the shift to ambulatory care, on the one hand, and the challenges faced by women on the other.

The Social Economy: One Paradigm, Many Visions

In a group of players, each person will not necessarily view a given paradigm in the same way. This is true of the CRÉS, since the members of the regional committees are from sectors that do not share the same objectives with regard to Quebec's social economy.

State Social Economy Project

The first generation of CRÉS includes, by definition, representatives from women's groups, different socio-economic sectors and government bodies. Members participate in the committee according to their group's particular conception of social economy. The social economy project is shaped according to the characteristics specific to the various government bodies present on the committees. The MSR's understanding is based on the integration of welfare recipients into the work force, according to a model of employment programs (Programme d'aide à l'intégration en emploi or PAIE and Programme Expérience de travail or EXTRA). In the context of the shift to ambulatory care and cuts to the health and social services sectors, this takes the form of projects that provide services to MSR's clientele. For the Secrétariat au développement des régions, or SDR, the social economy falls primarily within a market dynamic, in order to create viable jobs in regions hard hit by unemployment. It seems, therefore, that the state social economy project will be largely influenced by the financial crisis, the reduction in public spending and a neo-liberal economic philosophy, according to which the private sector and communities must directly assume the costs and management of public services.

Women's Groups and the Social Economy

- Other members of the CRÉS have expressed a particular understanding of the social economy, based on their major concerns, be it regional development, the consolidation of community resources or the integration of marginalized members of our society. However, we do not have sufficient information to allow us to examine systematically the approaches of the 16 CRÉS throughout Quebec.
- All the CRÉS include representatives from women's groups which make them front-line spokespersons on the implementation of social economy policies in Quebec.

The women's groups that serve on the CRÉS propose a conception of the social economy based on the demand for a social infrastructure program with jobs accessible to women as put forward at the 1995 Women's March Against Poverty. This vision was reiterated by the steering committee on the social economy in its report *Entre l'espoir et le doute* (COCÉS: 1996), which proposed that the social economy is based on four characteristics:

- response to social needs;
- creation of real jobs at decent wages;
- establishment of democratically run enterprises with a social mandate; and
- diversified investments, both financial and human.

Women's groups put pressure on the CRÉS to ensure that these criteria are factored into the analysis of each project. As such, they have integrated the social economy into a context of community development.

The important thing is to use the social economy as a tool for regional economic development in the area of job creation — jobs that have a social objective, in that they respond to the very specific needs of a particular

milieu. I may wander to say that the regional committee thinks that the social economy must also bring innovative projects in terms of the distribution of services. In short, for the region, it's a means of developing regional thinking on social objectives. (Regional informant 1)

First, I'd like to tell you how I see the social economy as a whole. I see it as a sector of activity, one of three sectors of development activity... There's the need to help people find jobs, jobs that are rewarding, jobs which will allow people to receive relevant training for what they will be doing in the future while providing useful services to society. Meanwhile, you're selling goods and services that are necessary to the community. Consequently, I think these are two very interesting priorities for the social economy. (Regional informant 2)

One informant noted the diversity of ideas and visions among representatives of groups sitting on one of the CRÉS:

Depending on who you talk to, there is always a particular idea, but the social economy...is not characterized by a single idea...and this has been a problem up until now. Definitions of the social economy are informed by particular interests, which is one of the problems we've had to face within the CRÉS... For instance, institutional partners...view the social economy as a recycling of programs, whereas for us, it's a consolidation of community resources, an opportunity to carve out a place for women in the job market, etc. (Regional informant 3)

These different conceptions go so far as to affect the eligibility of projects, as we will see in the section on the project selection process.

The Heterogeneous and Consultative Nature of the Regional Committees

Regional committees on the social economy (CRÉS) are privileged regional forums that play a role in shaping the implementation of social economy policies.

The Members of the CRÉS

Most of the committees began their activities in the first half of 1996. Committee members received a renewable one- to two-year mandate. It appears likely that the length of the mandates may be revised over the next few years, according to the life span and the membership of the CRÉS. The heterogeneous make-up of the CRÉS is due to the varied backgrounds of the players involved in implementing social economy policies.

- Each committee is made up of approximately 10 members.

Some members are from the regional offices of various ministries and administrative bodies: Régie régionale de la santé et des services sociaux (RRSSS or Régie régionale), Conseil régional de concertation et de développement (CRCD), Société québécoise de

développement de la main-d'œuvre (SQDM), Conseil régional de développement (CRD), Secrétariat au développement des régions (SDR), Conseil du statut de la femme (CSF).

Each committee also includes members from various sectors of society, such as private enterprise, unions, municipalities and community groups.

As a result of pressure by women's groups, particularly the 1995 Bread and Roses March and the report issued by the steering committee on the social economy (COCÉS), each committee must reserve four positions for representatives of women's groups.

Nominations are approved by the SDR, in charge of co-ordinating the CRÉS.

- Committee membership is not uniform throughout Quebec.

In Montreal, for instance, the City of Montreal's role in managing income security requires that it have two representatives, one for the city and the other for the suburbs. The committee also includes a representative from the Ministère de l'immigration. For Montreal, one of the four representatives from women's groups comes from the cultural communities. This gives that sector special attention.

In the Saguenay-Lac-Saint-Jean, Outaouais and Bas-Saint-Laurent regions, representatives of women's groups were nominated by the Table régionale de concertation des groupes de femmes, giving these groups significant political clout on the committee. However, in Montreal, the Table régionale de concertation des groupes de femmes did not exist when the CRÉS was formed, consequently the women on the committee are not accountable to women's groups.

The presence of women is not limited to the four seats reserved for women's groups. One committee, in Bas-Saint-Laurent, actually has a majority of women members which, according to our informant, has a positive effect on its activities. Sometimes, a member can wear two hats, representing both a union and a round table of women's groups.

Elsewhere, as in the Outaouais, the committee is attempting to integrate members from sectors in which it wants to develop social economy projects, such as agriculture, tourism, culture and the environment.

- While the basic structure of the CRÉS, established by representatives of women's groups as well as ministerial and administrative bodies is maintained, each CRÉS is unique, shaped by a particular regional dynamic.
- Each committee is made up of an elected president with an unspecified term. During the first year, the Chicoutimi CRÉS included an agent, while the committee for Bas-Saint-Laurent had an advisor on social economy, and the Montreal CRÉS received technical assistance from government bodies. However, across the board, representatives of women's groups take part in the committee on a volunteer basis, while representatives from other sectors are able to incorporate this activity into their jobs.

We receive absolutely no financing at all. That's part of the problem. The women who participate are taking time away from their jobs. That's why we're saying it's so hard to be available to participate in the work and attend meetings. There's no support whatsoever. (Regional informant 4)

The Budget

Money allocated to the social economy in the regions is disbursed by various government bodies.

- These are not new funds per se and, in general, these sums do not correspond to the \$225 million budget promised by the Quebec government.

The MSR, SDR, RRSSS and the Fonds décentralisé de création d'emploi (FDCE) devote a portion of their budgets to the social economy, which explains why the money is so tightly controlled. In fact, these bodies tend to apply the criteria specific to their respective programs to determine how these funds will be used.

Sometimes, it has been possible to combine several envelopes in order to build up more sizeable budgets. The Saguenay-Lac-Saint-Jean CRÉS received additional funds from the Fonds de développement communautaire; the Outaouais CRÉS associated itself with the MSR, the CRD and the RRSSS.

In broader terms, many bodies have budgets for social economy projects, such as the RRSSS. However, the amalgamation of these different envelopes has not yet been achieved and a great deal of work must be done to create ties between the CRÉS and the various government bodies in order to take joint action in the area of social economy.

- Representation on the CRÉS will undergo important changes over the next few months due to an increase in membership. The number of representatives of women's groups will remain the same, but their relative influence on the committee may be affected. As we will see, new members change the group dynamic and influence how the committees define and manage the eligibility of projects for funding from the envelope earmarked for social economy policies.

CRÉS Mandates and Activities

The mandates of the CRÉS are to promote and consolidate the social economy, on the one hand, and to receive and analyze the eligibility of projects for funding from the budget set aside for the social economy, on the other.

Promoting and Consolidating Social Economy

The interviews did not provide a detailed description of the activities related to promoting and consolidating social economy in the regions.

This aspect of the mandate is carried out primarily through activities such as meetings on promotion, project follow-up by agents or advisors, and the recruitment of representatives able to promote social economy projects in their respective milieu. Most of the CRÉS quickly embarked on their particular initiatives without waiting for professionals to be hired. The first initiative of the Saguenay-Lac-Saint-Jean CRÉS was to organize a symposium in February 1996, designed to determine the public's interest in social economy and to stimulate new projects. In November 1996, the Outaouais CRÉS also held a symposium.

Paradoxically, information was diffused so quickly that the CRÉS did not have all the details on hand regarding the criteria for the allocation of funds.

There were meetings...about five or six. We sent invitations to groups that might be interested. There were a lot of invitations, I'm not sure how many... The meetings were very fruitful, and a lot of people attended — 60 or 70 at each meeting... We explained what the program was, but at the time we didn't have all the information, so I think we may have created false hopes. We told everyone we had the FDCE [Fonds décentralisé de création d'emploi], but we weren't aware that the FDCE criteria had to be applied to the letter. We never told people this, so they didn't realize that we couldn't fund more than \$10,000 per job and we wound up with a lot of projects that couldn't be funded. (Regional informant 4)

Framework for Analyzing Projects

- Each CRÉS receives and analyzes projects based on criteria that is similar in all regions.

The similarity of the criteria is probably due to the fact that, to varying degrees, the committees have borrowed elements of the vision of the social economy that emerged from the work of the COCÉS (including a social objective, democratic process, non-profit nature of the enterprises and creation of quality jobs). This conception can no doubt be attributed to the women's groups whose four representatives form an influential bloc on a committee made up of 10 or so members.

- The CRÉS have a certain degree of latitude in setting project analysis criteria based on the reality of a particular region.

In the Outaouais, the criteria applied by the CRÉS focuses on projects that provide quality employment in rewarding sectors. To avoid the risk of taking over government responsibilities, projects cannot be submitted by public bodies, such as CLSCs or municipalities. In Montreal, issues related to the integration of cultural communities, women living in poverty, school dropout rates and illiteracy were expressly targeted.

- Project analysis is sometimes subject to administrative constraints, such as aligning projects with the standards set by the funding agencies that allocate budgets for the social economy (FDCE or MSR).

Constraints are not the same throughout Quebec. In Montreal and Quebec City, government bodies have had a great deal of leverage in aligning criteria with their standards. This does not seem to have been as clear cut in the Bas-Saint-Laurent, Outaouais or Saguenay-Lac-Saint-Jean regions, even though these regions have access to funds to implement social economy policies that are subject to the funding agencies' standards.

The Challenge of Applying Criteria

The CRÉS have now set project selection processes into motion.

- Some committees had long debates on specific questions such as the basic salary level in Montreal and Quebec City. Some organizations, particularly women's groups, insist on an hourly wage of \$8.30. However, this wage floor was scaled down to the salary favoured by the FDCE.
- Others had to settle the question of funding period based on available resources, which is how the ideal of a three-year funding period was curtailed to two years in Quebec City.

Discussions on self-financing of projects occasionally led to restrictive interpretations of this criterion. In Montreal, for instance, many projects put forward by women's groups were turned down.

It appears that there has been a clash of visions. One vision places emphasis on the market nature of social economy. Its advocates favour projects that offer a guarantee of immediate viability. The informant from Bas-Saint-Laurent noted that the criterion for self-financing in this context does not promote the development of projects designed to provide services to marginalized groups in our society. Another vision places emphasis on projects with social objectives. Women's groups that favour this conception argue that it is necessary to receive financing for a few years until projects are stable enough to stand on their own. The self-financing criterion, as applied in Montreal, ultimately deterred community groups from participating in social economy projects.

What I am given to understand is that community organizations do not want to be part of the social economy. The round table of women's groups is in the process of examining this question. But I think they are quite hesitant and I understand...their fear. Anyway, it's clear that what the CRÉS is currently offering does not apply to them and is of no use to them at all. (Regional informant 4)

The Outaouais CRÉS has attempted to settle the question of the self-financing of projects by recognizing that these projects can be divided into two groups.

Obviously, not every project can be self-financed. This was clear in the analysis we did with the CRÉS. We divided the projects into category 1 and category 2. Category 1 applies to projects that require ongoing state assistance. It may be possible to self-finance certain aspects of women's

shelters or some services, like those related to the environment, but...that's about it. They're always in need of money. So, we're looking at a 10-year period. Then there are the category 2 projects where we can envisage organizations that provide goods or services which can be self-financed in part. For example, we can charge for home care services. If we go to households that can afford to pay for snow removal, or if we help out with shopping, we can charge a fee that will pay for part of our salaries. We're already doing this. But we can't build this up in a year or six months. It takes years of job placement and it will take the Ministère de la sécurité du revenu to come along and decide that part of its envelope will be set aside exclusively for long-term social economy projects. (Regional informant 2)

Both types of projects are eligible and by dividing them into different groups they are not processed on the same footing in terms of the self-financing criterion.

- The criteria adopted during the first year will not necessarily be applied in the following years.

The Chantier sur l'économie sociale is working to reorganize the various CRÉS — widening representation to encompass larger numbers of community groups, unions and co-operatives, as well as reducing representation from government agencies and ministries. As a result of this shuffle, the CRÉS will become relays for the Chantier. The informant from Bas-Saint-Laurent hopes that the CRÉS will not simply turn into regional executors of national directives.

Analyzing projects with groups, interacting with the Chantier, playing the role of relay, because the Chantier wants the CRÉS to become relays for it. We want to be able to determine our own objectives as a CRÉS with its role or relay... We want it to be a two-way street...and not a top-down approach from the experts high up on the ladder right down to the front-line people in the regions. If we become a relay, we want to participate in project follow-up, develop new projects, development orientations. We want to consult with the various partners in the development of the social economy, establish meaningful ties between the CRÉS, the CLD... (Regional informant 5)

Another change to the CRÉS is designed to make the committee an advisory group for the Centres locaux de développement (CLD). It is still too early to predict the effects of these changes. However, it appears that any broadening of the committee will change the group dynamic, such as reducing the relative influence of women's groups on each committee, and weakening the role of the CRÉS in allocating funds to social economy.

Project Selection: Profile and Debate

From their inception (1996-97), the CRÉS received many social economy projects (95 in Quebec City, over 50 in Bas-Saint-Laurent and over 60 in Saguenay-Lac-Saint-Jean), totalling several hundred thousand dollars — perhaps even millions. This raises the question of the selection or eligibility of these projects, since each CRÉS had a limited budget for

1996-97 (approximately \$300,000 in Bas-Saint-Laurent, \$350,000 in Saguenay-Lac-Saint-Jean, the same for the Outaouais and \$700,000 for Quebec City).

The Pitfalls of the Selection Process

The selection process depends entirely on the regional committees.

Each project is submitted to the regional committee for preliminary analysis by the president, agent, advisor or the person delegated for this purpose by a government body. This initial analysis is based on the criteria established by each committee. During a committee meeting, each member studies each project to determine its relevance. In Quebec City, the preliminary study done by a public servant was presented to the CRÉS in the form of a definite decision, leaving no room for further discussion among the members of the committee. The Quebec City informant notes that this process did not allow for any group discussion on the projects submitted. This clearly illustrates that government bodies in certain regions intend to continue to function in the social economy paradigm in the same way they managed their programs.

- Through consensus or a majority vote, the committee determines the amount of money allocated to the project and communicates its recommendation to the organization which distributes budget allocations.

The CRÉS plays an advisory role and is not a formal decision-making body. Its recommendations are made known to the FDCE of the particular region, which manages the social economy budget, hence the impact of the FDCE's standards on the criteria set out by the CRÉS. In fact, there have been serious discussions within the CRÉS to ease the standards imposed by government bodies. During the first year at least, FDCE funds were intended for the sole purpose of creating jobs rather than for consolidation, and sums from the MSR were allocated in terms of the PAIE programs, with the characteristics specific to this program. These standards had a restrictive effect on project eligibility. Women's groups were at the very heart of these debates, which have revealed the extent to which those sitting around the same table have divergent conceptions of the social economy, as was the case in Quebec City.

- Not all projects make it to the CRÉS in the same way.

Sometimes, certain activities, previously funded by the RRSSS or the MSR, are directed to the CRÉS by these bodies. This raises the issue of lobbying to increase the eligibility of a particular project, namely those of national importance such as Défi-Autonomie, and other more modest projects, which formerly received financing from a state body. In Bas-Saint-Laurent, some CLSCs mandated their community development workers to promote the implementation of social economy projects, particularly in the areas of home care services, so the portion of their budget allocated to this activity could be lowered.

It was the CLSCs themselves that set this up. Community organizers were given the mandate to set up community organizations so it would be cheaper,

so that these organizations would do the less gratifying tasks like housework, and the CLSC could look after home care services. (Regional informant 5)

The information obtained from Bas-Saint-Laurent seems to reveal another ambiguity. Although the state social economy project is similar to a large-scale employment integration program for welfare recipients, it can take the form of projects which open the way to reducing state activities and responsibilities. For this reason, many informants are convinced that the CRÉS must proceed with caution and vigilance. Isolated cases may reveal a tendency among government bodies to use the social economy as an opportunity to set up private or community enterprises to replace public services.

- Some CRÉS insist that projects must not replace existing public sector programs and jobs (such as specialized nursing homes) or mandates.

Indeed, the policy of the Ministère de la santé et des services sociaux (MSSS) is to delegate greater responsibility for care to the home and to the community milieu. The form this added responsibility will take within the framework of the social economy is currently the topic of discussion among the CRÉS. Representatives of women's groups insist that the CRÉS reject many of the projects which offer front-line health and social services. But it is often difficult to make a distinction between a front-line service and a service with a social objective that does not replace an existing public initiative. The objective of non-substitution can even extend beyond the public sector.

We don't want to support projects that could displace jobs, say from the public sector to the community or social economy sector.... In any case, I think 75 percent to 80 percent of the people around the table feel that we don't have a big budget anyway. We may get a little more money down the line, but we have to try not to duplicate jobs. Otherwise, we end up creating some jobs and losing others. That's not really making progress. (Regional informant 2)

These projects should not be an opportunity for the Quebec government to favour the sub-contracting of services currently under its responsibility, in the name of its current zero deficit objective. One informant even feels that community groups, particularly women's groups, have a leading role to play in this respect.

This may seem a little radical...but I think the only way that our society can avoid going the route of sub-contracting to the social economy, is by not relying on the government. The government will naturally use the social economy to increase sub-contracting. I think this is particularly evident in the shift to ambulatory care. The temptation is too great and the situation is ideal. The only way we can avoid this trap is through our ethics as community groups. We will have to be self-disciplined. It may be a little idealistic, but the only security we have is our strength as a group. As a group, we have a chance to steer clear of sub-contracting. It's obvious to me that the government will be very tempted to foist onto community

groups responsibility for meeting social needs which continue to grow, for reasons other than state disengagement. (Regional informant 1)

Profile of Submissions and Approved Projects

- Approved projects vary in scope; some are very large scale. In Saguenay-Lac-Saint-Jean, over half of the budget for the social economy went to Défi-Autonomie programs. Most of the projects are more modest and originate primarily from the community milieu.
- The projects presented by profit-based organizations or which represent the replacement of front-line health and social services were rejected.
- The projects that were approved are, for the most part, from the service sector, including homemaking services and day care, residences, community kitchens and catering services, as well as sessions organized by women's centres. Some projects are cultural in nature. Depending on the region, there is a preference for projects that create one or two permanent positions, or jobs mainly intended for women, with the exception of the Défi-Autonomie project. Decisions are based primarily on national criteria, but each CRÉS has its own particular emphasis. According to the informant from the Montreal CRÉS, the focus was on self-financing and the creation of new jobs rather than on the consolidation of existing jobs, which eliminated projects presented by women's groups. Job creation was also the priority in Bas-Saint-Laurent, although less emphatically, which allowed some jobs to be consolidated. However, here again, funding agency standards had to be considered. The jobs created were in the form of enhanced PAIE programs at \$8.30 an hour, renewable for an additional year. The drawback is that the job is renewed, while the same person cannot hold the position for two consecutive years. This structure seriously limits the opportunity for one person to hold a quality job for several years. These regional disparities may gradually disappear if national meetings are held to allow various CRÉS to discuss how criteria should be applied.

Financing

- A project's eligibility for financing from social economy budgets does not affect its admissibility to other government programs. Some projects have received funding in conjunction with the Régie régionale de la santé et des services sociaux. Others must rely on the PAIE program to complete their staffing requirements.
- The financing period is problematic. Each CRÉS allocates sums of money based on an annual budget. However, the committees favour a three-year forecast to enable the enterprise to establish stable jobs. As a result, projects approved for the first year must submit the same project the following year in order to continue operations. But little or nothing is known about the budget for subsequent years, nor about the composition of the CRÉS which affects the criteria used to analyze projects.

As we have shown, the existing processes for the implementation of the social economy policies are complex. What follows is the larger picture of the relationships between the

social economy, the shift to ambulatory care and the challenges their current implementation create for women in Quebec.

The Social Economy and the Shift to Ambulatory Care: Chance or Necessity?

The social economy existed in the health and social services sector long before the emergence of the trend toward ambulatory care. Organizations and enterprises offer services that can be considered complementary to those provided by the health and social services network. These include services related to household help as well as day care and assistance to women who have been victims of violence. The meshing of the social economy and public health services is, therefore, not a new phenomenon.

The Quebec government's sudden interest in social economy (underlined in Premier Bouchard's address in March 1996), however, deserves close attention as it embarks on a major reorganization of the health and social services sector and introduces the shift toward ambulatory care. In fact, the Quebec government has crafted social economy policies and the shift to ambulatory care to fit the mould of state disengagement. The Ministère de la santé et des services sociaux has examined the contribution of the social economy in terms of personal services, more specifically in sectors that would no longer fall under state responsibility. At the moment, these sectors are household assistance, perinatal services, housing for the elderly and assistance to people with disabilities (Gouvernement du Québec, 1997). The context therefore lends itself to expanding the relationship between social economy and health and social services. It comes as no surprise, then, that some of the projects received by the CRÉS for analysis propose services in the health and social services sectors.

Projects Submitted to the CRÉS

Some CRÉS received projects offering services in the area of health and social services.

- Among these projects, a certain number were in line with the move toward ambulatory care.

The CRÉS for Saguenay-Lac-Saint-Jean accepted 14 projects of which several were related to housekeeping services or to the Défi-Autonomie project. A number of housekeeping projects were also accepted elsewhere, including Montreal, Outaouais and Quebec City. The small number of projects accepted in Quebec City in keeping with the move toward ambulatory care can be explained by the minimal financial commitment of the RRSSS to the social economy fund. The situation in Bas-Saint-Laurent stands out because, according to the informant for this region, not a single project closely tied to ambulatory care was accepted by the CRÉS, at least during the first year of operations.

- Other projects did not receive backing from the CRÉS. Our regional informants seemed to indicate that all the proposals that could potentially replace front-line services were rejected: blood tests, changing bandages, nursing or related services, terminal phase care. It seems that in general the CRÉS, which provided us with data, rejected projects that

would have replaced the role, programs and jobs belonging to the public sector, at least during the first year of operations.

We had an important discussion about this, because we were asking ourselves: “Are these services really front-line, such as bandaging and blood tests?” Because, in our opinion, this is clearly not the social economy’s domain. For most of us anyway, I wouldn’t say all, but about 80 percent of the committee agreed on this point. This is part of the mandate of the Ministère de la santé. They may choose to do things differently, but these services should not be provided by organizations that are not responsible for carrying out these mandates. (Regional informant 2)

For instance, the Outaouais CRÉS refuses to finance projects related to home care services, which is a responsibility of the CLSCs. It does, however, accept projects offering homemaking services, particularly housekeeping. The Outaouais CRÉS also refuses to expose itself to issues of accountability, particularly in the area of mental health. In fact, it refused projects related to mental health, leaving it up to the Régie to determine and finance feasible projects. The refusal to finance projects offering front-line services similar to those within the MSSS network is based on the principle that the Quebec government must continue to assume its responsibilities, since it is ultimately responsible for promoting and exercising the basic rights of our society.

The Fear of Substitution

Despite the first-year results of the CRÉS in processing projects related to services traditionally under the MSSS, most informants are fearful that the implementation of social economy policies will allow the Quebec government to disengage itself from certain activities, particularly in the health and social services sectors. One informant maintains that a strong link exists between the social economy and the shift to ambulatory care.

There’s clearly a direct link. The government has invested an enormous amount of energy into human resources to develop all the services related to ambulatory care, both in terms of the steering committee and the Chantier. So the government obviously has a vision of how to go about meeting these needs. I think we can all understand that. (Regional informant 1)

One Quebec City informant goes one step further. She claims that funds invested in the social economy will come from cuts made to the health and social services network.

- Based on the information obtained from our informants, we cannot assert that the Quebec government has established a causal relationship between the shift to ambulatory care and cuts, on the one hand, and social economy, on the other. However, there seems to be a strong belief that any reflection on the role of social economy in our society must take into account the context of cutbacks and the shift to ambulatory care.

We know that the private sector can take on the entire range of services that are not provided by the health care system. Private institutions have already approached local community centres about creating service-based enterprises. And the day is not far off when insurance companies will move into the lucrative market of selling coverage to individuals in need of home care. Given this context, there is a good chance that social economy projects, within the framework of the shift to ambulatory care and cuts to services, will only offer services in the most vulnerable sectors.

I think the shift to ambulatory care essentially means cuts to the public sector. Yes, there are things that could have been done differently. There are also technological advances, less invasive surgery, so people can go home faster. Some say: "A social economy is better than privatization." But in my opinion, the social economy simply winds up with the least lucrative services. Real privatization means private clinics covering 90 percent of health care. They're multinationals that offer antibiotic therapy at home; medication that requires a lot of expertise to administer even in CLSCs; hospital pharmacies make them but we're not equipped because of the volume. So, these companies come along and do it. The private agencies that advertise in our hospitals, you know...there are all kinds...there's insurance involved, including convalescence insurance. There's a huge move toward privatization in the area of health and social services. Some say: "What if social economy transforms these services into community initiatives?" But the social economy is based on household assistance, in complementary sectors that the CLSCs have neglected because they are underfunded.
(National informant 1)

Challenges Facing Women

Social economy policies present major challenges for women — the main consumers and providers of public services. Women make up the majority of workers, volunteers and clients in the area of community services. The development of this sector of the economy will therefore have a major impact on the living and working conditions of women in Quebec. The informants helped us to identify three levels of impacts on women in Quebec as a result of the social economy.

In Broad Terms

Women quickly began analyzing the implementation of social economy policies and their relationship with the shift to ambulatory care.

- Women were critical from the outset.

Granted, the social economy could be an opportunity for women to improve their situation in sectors where they are traditionally underpaid. However, the social economy can also be viewed as a step backward for women. Already in Saguenay-Lac-Saint-Jean, at a conference organized by the CRÉS in February 1996 and attended by many representatives from

community organizations, unions and the private sector, women's groups predicted that the implementation of social economy measures would threaten the advances made by women over the years.

Members of community organizations...were afraid that the government would take something away from them. People were also afraid of the state replacing the social by the economic; I mean that the state would use the social economy to co-opt the grassroots movement... Women's groups were very worried that women would be disempowered in social issues and that the quality of their jobs would deteriorate. (Regional informant 1)

- Many of our informants expressed concern that social economy policies, while not at the root of the process, are taking shape in a context of state downsizing and disengagement, with its financial crisis and budget cuts primarily in the public services sector.

According to our Quebec City informant, women's groups have established a correlation between cutbacks and their situations, particularly with regard to the long-term impact of measures such as cuts to the health and social services sector. These cuts will primarily affect economically disadvantaged groups, especially women. For instance, cuts to the health and social services sector, particularly with regard to home care, will undoubtedly add to the workload of women in the home, as we saw in the chapter on ambulatory care. In broader terms, the colossal effort to reduce the role of government has an immediate effect on women living in poverty. Many women often occupy the most junior positions in the public sector, and where they do not make up the majority of employees such as health and social services, their pension funds have not had a chance to build up. Women also represent the majority of the work force in the community sector (substantially less well paid than the public and private sectors), where yet again they earn less than men. The regional informant for Quebec City believes that cutbacks actually lead to an increase in the clientele of community organizations, which has an impact on staff, primarily women, who are forced to stretch resources beyond reasonable limits. The informant also wonders if the jobs created by social economy policies, in a context of budget cuts, will be poorly paid and less protected than their counterparts in the public sector, to say nothing of job qualification. Another informant is sceptical about the wisdom of abandoning public sector jobs, which already offer guarantees in terms of qualification, remuneration and security, for jobs that do not ensure the same conditions in the social economy sector.

The first time I heard about a "third sector" [the social economy], it was in terms of the Third World. Why has the state chosen the social economy route, rather than developing public services? Why should we buy into this option? Are we going to create higher quality jobs for women if we accept the dismantling of the public sector and the development of the social economy? Maybe their answer will be: "Don't worry, some day you'll unionize and then..." But isn't this a roundabout way of doing things? I guess that's my question. I'm not saying we shouldn't try new things, or that everything referring to social economy is bad. But I think we're avoiding these questions

by saying: "This is the future of the grassroots movement." (National informant 1)

- Not all the informants share the concern that social economy projects will replace public sector jobs.

The national informant 2 feels that it has not yet been proven that public sector jobs will be transferred to the community sector. She recognizes the fact that employees from the public sector are worried, especially those in precarious situations. However, social economy policies should produce satisfactory results in terms of job creation and adequate working conditions for women, in spite of the limits imposed by the standards of the ministries that allocate budgets. At the moment, there is not enough distance in order to take a critical look at the impact of social economy policies in Quebec, and only a systematic study of this question will enable us to sort through opposing opinions on the effects of social economy policies on the job market for women.

- Until now, social economy projects, aside from the production of goods and social services, have been related to the creation and consolidation of stable, well-paid jobs for women.

For one of the national informants, the emphasis on job creation in the evaluation of social economy projects raises the question of the recognition of women's contribution to society. By favouring the creation of jobs in the community sector, there is no recognition of informal contributions and initiatives that do not involve full-time work, such as activism and volunteer work.

There's another thing I'd like to mention...it's important to be concerned about employment, but there is a huge divide in how we understand work and employment. When you're working, you're making a contribution to society and I think that within the community movement, a great deal is accomplished through volunteer work, activism, but if you're unemployed, your contribution is demeaned... It seems that it's acceptable to define people based on their jobs...so this raises questions for women...it's as if we're saying: "Women have to go to work!" There's no doubt that women get more recognition if they're part of the work force. But we don't ask the question: "Why is it that society only recognizes our social contribution if we're part of the work force?" Why is it that women who are active in grassroots organizations don't get more recognition?... I work in a neighbourhood where the unemployment rate is very high. It's terrible because it's such a vibrant community where people are very active...and I think about the people in my neighbourhood who've contributed to society, and developed models of social organization. But these people are not recognized socially because their work wasn't part of a paid job. (National informant 1)

The other informants did not come up with the same analysis. One of them did say, however, that the creation and consolidation of quality jobs for women was one of the demands put forward at the Women's March against Poverty (national informant 2). We

cannot, therefore, criticize the social economy policies for promoting employment. A close look at the second year of activities of the CRÉS will allow a more accurate assessment of the impact of this job creation. We already know that the criteria were handled differently throughout the Quebec regions, and that in some regions, social economy projects did in fact enable the consolidation of existing jobs in the community sector.

- The information obtained seems to converge toward the need for women to regroup in order to protect their gains and to make their voices heard in the social economy and in social economy policies.

This will, however, be difficult since the government seems to be heading in a steadfast direction, despite demands made by women's representatives.

It did not affect the government's fixation on its zero deficit objective, in its attempt to actively recycle budgets or the accelerated de-institutionalization and the shift to ambulatory care, to...spread doubts, fears, anxiety... Because there's no question that the discourse of the Ministre de la santé et des services sociaux is all grist for the mill in terms of the anxiety that's out there...be it the public sector, substitution or out and out forcing welfare recipients to accept jobs in services peripheral to the current public system. (National informant 2)

Interventions made by women have already forced state consideration of women when implementing social economy policies. For the president of the Saguenay-Lac-Saint-Jean CRÉS, the demand by women to consolidate social infrastructures has forced political authorities to recognize that women are a vital force in the grassroots movement and social infrastructure. The need for women, however, to ensure that their definition of the social economy is taken into consideration is becoming increasingly urgent since many government bodies are managing the social economy without any representation of women and their interests. Each CRÉS has seats for representatives of women's groups and the informants seem to think that it is in the interest of women to fill these seats.

It's that we're seen...as players with real power, not just the power of the four women on the committee in relation to the rest of the members, but in terms of all the women we represent. We have to have clear mandates derived from very lucid discussions between women's groups or at least from the people at the table. I'm from the union movement, and it's always easier to defend people when you have a clear mandate. You're not speaking for yourself, and you know just how far people are prepared to go. So the strategy is to keep women's groups informed and to follow a clear path. (Regional informant 4)

The recent mobilization of women has, in fact, earned them a certain credibility and our informants believe that it is to their advantage to participate in bodies that address the social economy. The informant from Bas-Saint-Laurent, however, notes that there are opposing views regarding the presence of women's groups on the CRÉS, some preferring a "no show" policy as an act of opposition to the state conception of the social economy. The *Politique de*

soutien au développement local et régional seems to constitute yet another battleground for women and their views on the social economy. Nothing guarantees that the CRÉS will have a decision-making role, and it is still not known if seats will be reserved for those representing women's interests on bodies such as the Centres locaux de développement, which will certainly have major responsibilities in area social economy initiatives (Gouvernement du Québec, 1997: 18). The regional informant from Bas-Saint-Laurent wonders if women will be forced to make changes to their networks as a result of the new realities created by this policy. The emphasis on the local level, in this case the Municipalités régionales de comté, could have a negative impact on the power gained by women at the national and regional levels. Women's status is not a priority for municipal councillors who serve on the Municipalités régionales de comté. In this context, it may become particularly difficult for women's groups to defend their interests and projects within these local organizations.

In one region...women will sit down with the town's mayor and...there are places where they're not given any consideration whatsoever... Women say: "I don't want to sit down with him, the way he treats us." (Regional informant 5)

Women's Representation on the CRÉS

There are important benefits for representatives of women's groups sitting on the CRÉS — even though achieving them entailed a degree of difficulty.

- Exercises, such as negotiations with representatives of government bodies, and project evaluations based on criteria, such as economic development, job creation and social objectives, represent difficult but fascinating learning experiences, as did the analysis of projects that do not only involve women but other sectors of the grassroots movement.

In my opinion, it's very clear — and this is strictly my opinion although I'm also the spokesperson for other women who were involved on the CRÉS who had started on the COCÉS and women who were involved in the CRÉS who I got to know in our regional CRÉS and others — that the most fascinating, challenging and troubling thing for women was the link with official government structures (government civil servants) and the link with the economic world. Right from the start, some women, including myself, saw the pitfall of being a woman from the grassroots movement, having to judge other community projects, saying "yes" to one, "no" to another... That's a huge responsibility because you're judging your peers. It was a huge task to learn how to consider projects not only in terms of their social objectives and their ability to meet social needs, but also in terms of job creation and economic development. It was a learning experience... Many women across Quebec faced the obligation of reclaiming a place for women within the grassroots movement, insisting on it. It wasn't easy defending the place of women, but also making room for other community interests, that was another learning experience. I think it was very positive. (Regional informant 1)

- Representatives of women's groups must develop their own economic discourse to present to both the CRÉS and to the bodies that will have jurisdiction over development in the context of the new *Politique de soutien au développement local et régional*. To ensure that their point of view is taken into account, women have had to develop strategies and positions among themselves outside of formal CRÉS meetings, as was the case in Bas-Saint-Laurent, and create alliances with committee representatives from other sectors of society. This dynamic was not achieved without difficulty.

We had to learn how to work together. Just because we're all from the grassroots movement or women's movement doesn't mean it's easy. It took some time before we made any progress... I think we're on the right track though. We have an understanding. We believe in dialogue before and after the meetings. (Regional informant 1)

- The fact that four representatives of women's groups, who share basic common interests, sit on the committee allows them to carry a certain weight. They become powerful partners in determining project eligibility.

It depends on the women and the approach to political consultation they've previously developed in their region — like meeting beforehand, coming up with an action plan, identifying their issues ahead of time so that when they meet on the committee they already know where they're headed, but this varies a lot from one region to the other. I think that when women have made gains on the CRÉS it has been due to strong political cohesion, and strong support from their communities, both from women's round tables and larger groups. That way, they were ready to face the civil servants. (National informant 2)

Cohesion between representatives of women's groups is not always a given.

Cohesion among women is not always easy to achieve...sometimes it's hard for us to agree on the message we want to convey because we don't have the same strategies. (Regional informant 5)

As mentioned earlier, representation on the CRÉS will probably be expanded which may adversely affect women's influence on the committees. In the context of this new dynamic, representatives of women's groups will have to double their efforts to protect what they have gained thus far.

- The perspective of women's representatives on the CRÉS must also change in terms of how they deal with projects. To coin the terms used by the informant from Saguenay-Lac-Saint-Jean, women must cease to “beg” for programs and assume the role of “decision makers,” not only for projects strictly involving women, but also for projects evaluated with other social players, obliging them to confront problems, impose their ideas and make compromises.

In Montreal, for instance, despite a desire to promote favourable working conditions for women, representatives of women's groups were unable to prevent a restrictive interpretation of the self-financing criterion.

*We had good discussions about salary. We wanted a minimum wage of \$8.30 and we were told that this was impossible because it contradicted FDCE standards...the Fonds décentralisé de création d'emploi, which is our main source of funds, is a fund that already existed for financing...it existed to fund private enterprises as well as non-profit organizations and in reality, the criteria were so rigid that it only served private organizations. So they stuck us with the same fund, with the same criteria and they told us to finance the social economy with it. So they told us that \$8.30 was not acceptable since it contradicted the FDCE criteria. But we did manage to demand adequate salaries, comparable to the market. I'd say we've managed to finance salaries that hover around \$8.30 minimum. Even though there's nothing on paper, the wage was respected. And when we discussed the criteria, I think that the major stumbling block, which we're still dealing with, is that in Montreal projects have to be self-financed in part, so that means that priority should be given to projects that have commercial or economic content. For example, a group that offers catering services, which means there's an economic spinoff, and we had a whole bunch of meetings about it and finally, women gave in... In the end we all gave in because we were worn out!
(Regional informant 4)*

- Participation on the CRÉS may have forced women to make certain concessions, but it has also allowed them to take part in discussions that have had an impact on the analysis of project eligibility and the overall understanding of the social economy. This would not have occurred had women not been present to insist on it.

In fact, it was representatives of women's groups who insisted that projects offer quality jobs with above minimum wage salaries. The presence of a bloc of representatives also forced government representatives to relax the application of certain standards. It is therefore in women's best interests to sit on the CRÉS, and perhaps more generally to participate in forums that address the general social economy issues.

At a certain point, we asked ourselves (by "we" I mean the women who followed up on the March. There were three on the steering committee and three who represented the community sector in a larger sense and women from the regions): "Are we in or out...do we take part in the debate or do we get out?" It's clear that the women's movement...in terms of the March and the women who were the most representative of women in the regions decided not to resort to the "no show" policy. The "no show" policy is too risky in the current debate because it gives the government the upper hand to use the social economy to create forced labour with welfare recipients and companies, and to proceed with the disengagement of the state with regard to

services. So if women had taken a chance with the “no show” policy, they would have taken too great a risk. (Regional informant 1)

The social economy...opens the door to an economic sphere or economic recognition, economic enhancement... For one or two years we remained on course, for example, in terms of demanding a minimum wage above the poverty level... So, that was positive. I think it's positive to see dedicated women in action who join forces in order to exercise their power. (National informant 2)

At the moment, social economy policies appear to be the backdrop for determining, in part, the profile of services offered to the public (whether they are delivered by the public, private or community sectors). Since women constitute the main clientele of these services, it is in their interest to play a key role in defining essential community needs, and to take advantage of these forums to put forward a progressive vision of social economy.

It means putting forward our vision, a progressive vision of social economy...it means insisting on our vision and on the importance of this area, while creating quality jobs that do not replace what the state is already doing. To be able to preserve the border that exists between these two spheres. (Regional informant 4)

Women's Participation in Projects

- Each social economy project could present opportunities for women to make gains on the job market.

Although not all the informants provided details on the subject, we know that 75 percent of the jobs created through projects approved by the Montreal and Outaouais CRÉS were filled by women. But will future committees uphold the same guiding principle? These projects may allow the integration of women into traditionally male niches, such as agroforestry and the environment. The CRÉS have a leading role to play in this respect, since the natural tendency may be to hire men in sectors that require physically demanding work. Nevertheless, many of the projects submitted and approved create vital roles for women: a community garage, a solidarity fund for women in conjunction with AFÉAS, Défi-Autonomie, services in rural areas, kindergarten day cares and drop-in day cares, and a number of projects geared toward helping women overcome poverty or enter the work force. However, social economy policies must not be used to create “job ghettos,” an expression used by the informant from Montreal. Jobs must offer good conditions and attractive salaries, which will allow people, particularly women, to overcome poverty and re-enter the work force after several years' absence. These jobs must be viable on a long-term basis with the possibility of becoming unionized. Yet the informants feel there is cause for concern. On the one hand, service fees in a context of self-financing may adversely affect women's demands for free and universal access to services. On the other hand, social economy carries a fundamental ambiguity: while some of our informants feel this economy is taking shape within a context of budget cutbacks

that affect women's jobs in the public sector, others believe that it opens a door to women to enter the work force through community sector jobs with above minimum wage salaries.

- Other contradictions punctuate the implementation of social economy policies.

For instance, there is the danger that funds paid out to social economy projects will be assimilated with funds from programs such as PAIE and EXTRA. Rather than allowing community groups to mobilize, this type of approach could lead to competition between organizations. The informant from Bas-Saint-Laurent noted that women's groups were perceived by community groups as monopolizing social economy budgets. Our informant also confirmed that these tensions lead women's groups to form closer alliances with civil servants rather than with other community groups.

*Generally, you feel more support from civil servants than community groups.
(Regional informant 5).*

Conclusion

This analysis clearly demonstrates how important it is for women to understand social economy fully and to analyze it critically. Although most of our informants agree with its basic premise, they are nevertheless wary and feel that caution is in order. The vision of the social economy shared by women, particularly following the March Against Poverty and the report issued by the COCÉS, does not appear to be in line with the state vision and project. State policies which generally took the form of a large-scale job entry program, at least during the first year, have met women's interest in consolidating social infrastructures and investments in this area.

For the informants, it is not at all clear that the CRÉS responded to women's demands for a social infrastructure program during the first year of activities.

In terms of our experience in Montreal, I don't think there was anything of any interest to women, maybe the outcome was better in other regions...just a few marginal projects. I'm not saying they weren't interesting and would probably have been implemented...through other sources of financing. I don't feel that we revolutionized much or affected any major change. (Regional informant 4)

Off the cuff, I'd say that we're miles away! I think that if I were one of the women directly involved in the follow-up of the March I'd be even more...aggressive in terms of that issue. The demand made by women was very clear, even the demand in terms of social infrastructure was clearly a demand to consolidate what is being done and what was being done with respect to meeting needs. It's very clear that our regional committee on the social economy, as well as other committees, did not address this question adequately in terms of what women had asked for. It's clear that women were faced with negotiations very quickly, as well as with sharing power with the people from government. They weren't prepared for this. Right from the start, we could not stick to a feminist discourse and a women's discourse within the

CRÉS. We had to engage in a broader discourse with greater focus on economic development, otherwise there would have been a standstill. It wasn't part of the mandate that the government had assigned to the CRÉS. (Regional informant 1)

Instead, representatives of women's groups had to negotiate in order to defend their interests in the context of economic development, job creation and the creation of enterprises pursuing social objectives.

Generally, the implementation of the social economy in Quebec through the CRÉS has forced women to deal constantly with ambiguity. For instance, even if the funds committed to social economy are not new and must adhere to certain program directives, the presence of women's representatives on these committees has enabled them to defend certain principles, particularly that of pursuing social objectives and of attributing the majority of jobs to women. In some cases, interesting projects pursuing social objectives have even been dismissed due to a market economy analysis, which emphasizes self-financing or job creation as expounded by the philosophy of employability programs. Despite the informants' perception of the government's unenthusiastic response to the demands for social infrastructure presented at the Women's March Against Poverty, a few projects do in fact help individuals escape the vicious circle of social assistance, or provide services to women victims of violence, or assistance to single-parent families, etc. For their part, social economy policies run the risk of promoting the notion that social profitability is based solely on full-time employment, failing to take into account the development achieved by women through informal, volunteer or part-time work. This also raises the question of the social recognition of women who are not part of the paid work force. From another perspective, little is known about the community sector's reaction to the logic of a market economy (fixing fees and financing). For this reason, research involving the relevant players is urgently needed to provide women's groups with the information on the notion of social profitability.

All the informants demonstrated that women must take a critical approach to both the shift to ambulatory care and social economy policies. The implementation of these methods for managing collective services has serious consequences for women. Analysis of each of these phenomena has only just begun, and will only be complete if it takes into account the reciprocal effects of the implementation of the shift to ambulatory care and social economy policies in a context of a rapid reduction of state intervention. Once more detailed information is available, we will be in a position to better define the role of women's groups in the social economy sector, particularly in the context of the restructuring of Quebec's health and social services system.

GENERAL CONCLUSION

The partnership between AFÉAS and the researchers helped, once again, to bring to the forefront the invisible work done by women in health care, and to situate this work in a larger context of new social relations marked by the impact of government policies around the social economy and the effects of the restructuring of health and social services.

In a recent document, the Conseil du statut de la femme predicted that the trend toward ambulatory care would have a major impact on women (CSF, 1996b: 20). The results presented here confirm these apprehensions. According to the findings of other researchers, the precipitated discharge of patients from hospitals and changes in the management of health care affect women in different ways (Armstrong et al., 1996, Glazer, 1990). For the most part, women caregivers, patients and workers were generally in favour of some of the initial objectives of this reform, such as the shift to ambulatory care with the appropriate reassignment of resources and more personalized services provided to patients in their homes. The provision of services at home may, in fact, be more empowering for patients who can regain control of their lives more easily in a familiar surrounding than in a hospital setting. These women did, however, come to the conclusion that budget cutbacks have led to a deterioration in the working conditions of volunteer women caregivers, a reduction in access to care and to an erosion of the quality of that care.

The shift to ambulatory care, as we know, rests upon the assumption that women will be available to take responsibility for providing care to relatives. However, we have come to the conclusion, as have others before us, that there is a price to be paid as women are expected to carry the physical and mental burden of providing care, while their participation in the job market and social life is greatly reduced (Armstrong and Armstrong, 1994).

The physical and social environments have an impact on health, and we know that many women live in difficult economic conditions (poverty and isolation). In addition, women usually depend on health and social services to a larger extent than men and for longer periods. How will we provide care for these women? In fact, this is a question that women who are themselves caregivers are asking, since they often feel uncomfortable with the notion of receiving care from a relative. Furthermore, few resources are available to take care of those who look after their own health care needs. (This is the case for single mothers, for example.) Patients and caregivers will both be affected by the shift to ambulatory care, as patients will be sent home sooner based on standards that remain very vague. This shift also means a lack of continuity between hospital services and home care, and a greater demand for autonomy and skill in treating illnesses. This situation is extremely difficult for the sick as well as for caregivers who cannot turn to the private sector to compensate for the abolition of, or reduction in, services. For victims of violence against women, the situation is particularly bleak.

Our respondents emphasized several times that caregivers do not have adequate training to provide the care now required in the home. Furthermore, they often feel overwhelmed by the

number of tasks they must provide as they take on the responsibility of procedures and treatments once carried out by hospital staff. Our study confirms that the work assigned to caregivers seems to have changed radically, far exceeding the level of basic health care (housekeeping, basic personal care and minor nursing care). Now, it easily includes the administration and control of complex nursing procedures which, in a hospital setting, are under the jurisdiction of doctors and nurses (Glazer, 1990: 480).

In addition to the trend to transfer the delivery of health care from employees to relatives, a widespread phenomenon throughout North America and Europe, we are also witnessing the transformation of labour processes within establishments. Institutional transformations aimed at maximizing employee productivity are taking many forms, including increased division of labour, consolidation of tasks, a faster work pace, and the de-skilling and requalification of certain jobs, without appropriate salary increases (Glazer, 1990: 483). The situation for women as professionals and workers in the health and social services network is deteriorating just as rapidly as they face major changes to working conditions: instability, work overload, de-skilling, unrecognized requalification, and changes in fields of practice. Casual workers hoping to fill job openings are facing permanent job insecurity.

The hospital and CLSC staff we interviewed believe they must redouble their efforts to meet demand while maintaining quality services. Ambulatory services and home care services are on the rise in CLSCs, and some workers consider this a challenge. The complementary role of CLSCs and hospitals, and the interdisciplinary nature of CLSCs have become vital. Services are now available on expanded schedules, and some services, such as Info-Santé, are well established. Home care services, however, are becoming more demanding, requiring greater time and effort. CLSCs are placing greater emphasis on cure, as preventive services go by the wayside. In addition, psycho-social needs seem to have been forsaken in favour of reorganizing medical services to deal with the most urgent cases.

Due to the lack of resources, links between hospitals and CLSCs have not been established fast enough, nor are they as solid as they should be. Ultimately, it is the people in need of health care who pay the price when CLSCs do not have adequate resources to meet their needs. The most vulnerable (the elderly, the homeless, people living alone or single parents) run the risk of not receiving the care they need when they return home.

Although our informants agree with the principle of the social economy, they feel that caution is in order. It is not at all clear that the CRÉS have managed, during their first year of activities, to meet women's demands successfully, allowing women to be empowered in the social economy sector. Instead, representatives of women's groups have had to manage ambiguity and, through negotiation, defend their interests in a political context marked by the the creation of enterprises with social objectives. Nevertheless, a few projects will help women free themselves from the vicious circle of social assistance, or will provide services to women or support to single-parent families. However, many projects with interesting social objectives have been rejected as a result of a selection process that favours self-financing and job creation. As such, the social economy runs the risk of failing to take into consideration the work done by women on an informal, volunteer or part-time basis.

Analysis of this situation is still in its earliest stages and must continue. Will the combined impact of the trend toward ambulatory care and social economy policies break down existing forms of oppression against women, or will it create new ones (Elson and Pearson, 1981)? Women are omnipresent in the management of the private sphere. This places them in a weak political and economic position, particularly when the proposed policies promote the creation of new economic spaces and increase the pressure, or even the obligation, of assuming responsibility for the sick.

One has to wonder how caregivers and workers will manage to keep up the current pace, given that health care needs are rising as resources decrease. Under what conditions will further restructuring of services occur and at what cost? Further research which focuses on the invisible work of women is imperative. It is equally important to determine accurately the impact of the current situation on health and the impoverishment of women. A large-scale debate is in order.

RECOMMENDATIONS

Following this general overview of the impact of the restructuring of the health and social services system and, more specifically, Quebec's shift to ambulatory care, we have a number of recommendations for provincial and federal government bodies as well as for institutions under their jurisdiction. Some of the recommendations are based on the informants' accounts, and others are the fruit of our own analysis and understanding of the current situation.

Although some of these recommendations are intended primarily for the Quebec government, they apply equally to other Canadian provinces, with the necessary adaptations specific to the organization of each province's system.

1 - Gender-based analyses

This study on the impact of the restructuring of Quebec's health and social services system on women has revealed some alarming facts.

We recommend, therefore, that the Ministère de la santé et des services sociaux du Québec, the corresponding ministries from the other provinces and Health Canada ensure that gender-based studies are conducted on the impact of various reforms to the health and social services sector in order to determine their effects on women and to implement any necessary corrective action.

2 - Access to services

All citizens, women and men, are entitled to equal access to health care and social services that adequately meet their needs.

We, therefore, recommend that the Ministère de la santé et des services sociaux and health and social service institutions provide the public with more detailed information on the range of services available to support home care situations.

We also recommend that the Régies régionales or corresponding regional bodies in charge of co-ordinating health and social services ensure the effective continuity of care between hospitals, CLSCs or their equivalent in the area of home care.

3 - Acknowledge and support the needs of women working in the system

This study revealed problems in the co-ordination of the various stages of the reform with regard to health care workers, and the need to provide them with better support.

We recommend that the Régies régionales, or the corresponding regional bodies in charge of co-ordinating health care and social services, organize more effective staff transfers and demonstrate greater respect for the people affected by these transfers.

We also recommend that institutions ensure better supervision and systematic training for employees assigned to new duties.

We recommend that institutions set up voluntary job exchange programs.

Last, we recommend that unions maintain or set up assistance programs for employees who are displaced, bumped or on-call.

4 - A system that does not rely on relatives but considers them as one of several players

Studies (Garant and Bolduc, 1990; Glendinning, 1991; Guberman, et al. 1991, 1993), including this one, clearly show the negative effects of conferring on the family the central role in the restructuring of the health and social services sector.

We recommend that the Ministère de la santé et des services sociaux as well as corresponding provincial and federal ministries provide necessary funds to CLSCs and other such facilities to ensure that the burden of the move toward ambulatory care does not fall primarily, or even solely, on the shoulders of relatives.

We recommend that the Ministère de la santé et des services sociaux, in collaboration with other ministries concerned, ensure that services and programs are put in place as an alternative to relatives assuming responsibility for the provision of health care. These services and programs should allow the community to take responsibility for patients: convalescent homes, physical changes to the home environment, transportation to doctor's appointments, minor care facilities, respite services, etc.

We recommend that the federal and provincial ministries of health and social services ensure that evaluations are carried out of the costs assumed by relatives (medication, equipment, physical changes to the home environment, transportation, etc.), and that an assessment be made of the impact on relatives and on the quality of care as a result of the transfer of costs once assumed by the state (for example, reduced doses of medication to cut expenses). The ministries must take corrective action wherever necessary.

We recommend that the CLSCs or corresponding bodies and hospitals lend out specialized equipment adapted to home care free of charge.

We recommend that the Ministère de la santé et des services sociaux and the Régies régionales provide adequate ongoing funding to groups that provide assistance and defend the rights of caregivers, and that they ensure that such groups are organized if they do not already exist.

We recommend that enterprises be encouraged to set up and consolidate support programs as well as policies on work shifts and holidays, thus enabling caregivers greater flexibility to organize their work schedules.

Last, we recommend that federal and provincial labour standards be modified to take into account the provision of care to relatives (for instance, paid family holidays).

5 - The need for a debate on the remuneration of caregivers

This study sheds light on the need to develop guidelines that recognize the work carried out by family caregivers and to reflect on the issues related to the transfer of paid work to the unpaid domain of the home.

There are, however, major issues involved in the trend toward assigning monetary value to social relations.

We, therefore, recommend that women's groups, unions and other bodies concerned with this issue examine the viability of providing financial compensation to relatives responsible for home care.

The members of our research team do not share a unanimous interpretation of these measures. It is our opinion, therefore, that a serious debate is in order to address issues such as the ones outlined below.

To begin with, these measures may bring about many difficulties, such as:

- the extreme difficulty of administering them in an equitable fashion;
- the serious risk that they will reduce the role of caregivers and confine them to the home; and
- the risk that they will create third-rate jobs that are poorly paid with no benefits and that are not subject to labour standards.

Furthermore, the limits of collective responsibility and of the place and role of families in society must be considered.

If programs of this kind are in fact put in place, several guidelines should be used to shape these measures:

- They should be universal rather than tied to the income of patients and their relatives.
- Remuneration should be based on the market value of the work.
- Participation in a program of this kind must be voluntary (allowances must not become an additional pressure forcing women to take responsibility for health care).

- The person receiving a salary should not be obliged to provide services and take responsibility for dependants 24 hours day, seven days a week; the person must continue to receive support as well as public and community services.
- Similarly, the dependent person must not be denied access to public services to meet needs that are unfulfilled by relatives.
- The program must ensure that patients and their caregivers are entitled to regular evaluations of their situations and to the maximum assistance required: psychosocial support, training, regular contact with other people in the same situation in order to talk about their experiences, reduce their isolation and exchange services, and re-entry into the work force, etc.

Furthermore, community services and direct allowance programs for patients that can be used independently to purchase services of their choice must also be examined.

In conclusion, it is our opinion that the variety of measures to be implemented must first and foremost favour the optimal adaptation of services to the needs of patients and their relatives.

6- Clearer guidelines in terms of professional liability and the assignment of tasks: a look at professional de-skilling and conflicts of jurisdiction

Several informants mentioned problems regarding the threat of de-skilling which weighs heavily on groups of women workers; conflicts of jurisdiction between various employment bodies; and professional accountability for tasks performed in the home. Experience, recognition of skills and the type of tasks assigned to these women influence their motivation, the value and meaning of their work and, ultimately, the quality of the services and care provided. In addition, the assigning of tasks seems to be occurring without any clear guidelines, to the extent that caregivers are being asked to perform duties they are not authorized to carry out.

We recommend, therefore, that the Ministère de la santé et des services sociaux, in collaboration with professional orders, associations and unions examine this issue which has a definite impact on working conditions and the quality of care.

APPENDIX 1: DISCUSSION FRAMEWORK FOR FOCUS GROUPS WITH CAREGIVERS

- I- Context of hospital discharge**
 - Criteria used.
 - What was evaluated?
- II- Context of the decision (to assume responsibility for providing care)**
 - What were the circumstances of the decision?
 - Players involved in the decision and situation.
- III- Access to formal, informal and private services**
 - What kind of help and support was received?
 - How did it help?
 - What was lacking and what were the difficulties?
- IV- Impacts on daily life**
 - Impacts on personal and social life.
 - Impacts on family and/or relationships with partners.
- V- Impacts on paid work, studies, activism, volunteer work, leisure**
 - Impacts on mental and physical health.
- VI- Impacts on caregiving**
 - Nature of the caregiving work.
 - Quality of the caregiving work.
 - Intensity of caregiving work.
 - Complexity of caregiving work (skill, training).
 - Relationship with relative receiving care.
- VII- Impacts on mental and physical health**
- VIII- Costs incurred**
 - Direct costs (associated with the care itself).
 - Indirect costs (example: loss of personal income).
- IX- Survival strategies**
- X- Overall evaluation, needs identified, long-term impacts**
- XI- The role of AFÉAS**
 - What kinds of collective action and demands should be undertaken?
 - What can AFÉAS members do (support and training)?

**APPENDIX 2 : DISTRIBUTION OF FOCUS GROUP PARTICIPANTS
ACCORDING TO REGION, AFÉAS MEMBERSHIP AND ROLE IN CAREGIVING**

Region	Ratio AFÉAS/other	Caregiver	Patient	Other**
Sag.-Lac-St-Jean* (N=8)	5/3	1	6	1
Outaouais* (N=6)	0/6	4	1	1
Montreal (N=8)	4/4	4	3	1
Quebec City (N=6)	6/0	5	0	1
Bas-St-Laurent (N=4)	2/2	2	2	0
Total: 32	17/15	16	12	4

* For the Saguenay-Lac-St-Jean and Outaouais regions, one of the participants was male.

** This column indicates the participants who were included in the focus groups but did not fit perfectly in our eligibility criteria.

APPENDIX 3: FRAMEWORK OF INTERVIEWS WITH HEALTH CARE AND SOCIAL SERVICES WORKERS

1. REGIONAL PORTRAIT/SHIFT TO AMBULATORY CARE
(in this section we were looking for regional specificities)
 - a) **The shift to ambulatory care**
 - 1.1 What does the shift to ambulatory care in your region mean to you? What are some typical situations?
 - 1.2 Could you describe the reorientation or reorganization in hospitals or CLSCs? Where? How is it happening? Who is affected? *(in terms of work teams, workers and patients)*
 - 1.3 Is the organization (or organizations) where your members are working abandoning or transferring any aspect of its mandate? *(e.g., the CHRR is abandoning chronic care)*
 - 1.4 Can you describe the services or aspects of services that have been abolished or cut back in hospitals and CLSCs, over the last two or three years? Where? How? *(e.g., operating room closures, bed closures)*
 - 1.5 Are the periods when services (except emergency services) are suspended, for instance during Christmas holidays, summer, spring break, more frequent than in the past?
 - 1.6 Are there growing waiting lists for surgery, admissions, specimen collection or other external examinations, general care or treatments? (X-rays oncology), etc.
 - 1.7 What are the major effects that you have observed in the delivery of care?
 - Are these changes desirable?
 - Explain the advantages and disadvantages.
 - 1.8 In your opinion, what measures should be taken to ensure that the shift to ambulatory care is not detrimental to health and social services workers? *(lobbying, advocacy, fiscal measures, media campaign, collaboration with labour or women's organizations)*
 - b) **The network**
 - 1.9 Does the shift to ambulatory care entail major change in the organization of health and social services? What is the nature of this change?
 - 1.10 Could you describe the complementarity of the services delivered by various workers **before** the shift to ambulatory care? *(hospitals, CLSCs, nursing homes, community or private organizations, people's homes)*

- 1.11 Can you describe the complementarity that exists today?
- 1.12 Have there been any more transfers of care from one organization or site to another in the recent past (in the last six months)?
- 1.13 How is this transfer of care carried out in terms of human resources? Have there been, or do you predict, any shortages in resources? (*e.g., the transfer of care from hospitals to CLSCs*)
- 1.14 The regionalization of health and social services structures has accompanied the shift to ambulatory care.
- Has this helped the situation, mitigated the negative effects or, to the contrary, has it exacerbated the negative effects?
 - Explain.

2. THE EFFECTS ON THE WORKING CONDITIONS OF HEALTH CARE AND SOCIAL SERVICES WORKERS

a) Consequences for workers

- 2.1 Are employees being pressured to voluntarily terminate their employment, to take early retirement or to work part time? Is support offered in these cases?
- 2.2 Are personnel being reassigned within public facilities (hospitals and CLSCs) or to other facilities in health care and social services, or toward the private or community sector (due to job cuts, layoffs, facility closures)?
- 2.3 Are reassignments disrupting the distribution of responsibilities and professional liability? (*e.g., in hospitals, CLSCs, nursing homes or people's homes*)
- 2.4 What are the effects of reassignment or "bumping" on work teams and their environment?
- 2.5 What are the consequences of reduced staff (or reassignments):
- on workers' tasks?
 - on wages?
 - on workers' health and safety?
- 2.6 Do the new tasks or responsibilities resulting from the shift to ambulatory care have an impact on how workers reconcile their private and family lives with their professional lives?
- 2.7 In general, have there been any changes in working conditions? If yes, elaborate.
- 2.8 How will new jobs created by the social economy sector affect the labour market in your field?

b) New job qualifications and de-skilling

- 2.9 Do reassignments require new skills? Which ones?
- 2.10 Do reassignments require new or additional training?
- 2.11 Have mechanisms been put in place for this training or retraining? If yes, what is the timeframe? Is this overseen by the organization or does the worker have to organize it herself?
- 2.12 In general, has there been a de-skilling of your job? If yes, elaborate.
- 2.13 Do workers complain about the new responsibilities they are being given? Do these new responsibilities require skills they do not possess? Is their experience taken into account? Do they find their new responsibilities “harrowing”?
- 2.14 Do some workers consider certain aspects of their new responsibilities to be positive (humanization of care, learning new jobs, defining new relations with patients, families and other health care workers)?
- 2.15 In general, how would you evaluate the quality of care delivered (medical and other) since the changes caused by the shift to ambulatory care?
- 2.16 How do you think new social economy policies will affect the delivery of care in the context of the shift to ambulatory care?

c) Support and solidarity to be forged

- 2.17 Currently, how can workers “adapt” to these situations?
- 2.18 Does the union or association provide services such as professional training, legal aid, employee outplacement, negotiating equitable early retirement packages, etc.?
- 2.19 Do you think that special clauses will be negotiated in the next collective agreement to protect your members differently in the future?
- 2.20 Do you think that reassignments may have broken workers’ solidarity? Women’s solidarity?
- 2.21 Do relations exist between your union or association and the other workers affected by the shift to ambulatory care?
- 2.22 Is there an existing solidarity or common front that will help to mitigate the effect of the shift to ambulatory care?

**APPENDIX 4: DISTRIBUTION OF HEALTH AND SOCIAL SERVICES
WORKERS INTERVIEWED, ACCORDING TO REGION, POSITION,
FACILITY AND SPECIFIC EXPERIENCE RELEVANT TO THE STUDY**

Region	Position	Facility	Experience
Saguenay-Lac-St-Jean (N=7)	Nurse	Hospital	Experienced worker, union representative
	Nurse	Hospital	Experienced worker, union representative
	Social worker	CLSC	Experienced worker
	Nursing assistant	Hospital	Experienced worker
	Nurse	CLSC	Manager
	Homemaker	CLSC	Experienced worker
	Nurse	CLSC	Experienced worker

Region	Position	Facility	Experience
Outaouais (N=10)	Social worker	CLSC	Experienced worker
	Social worker	CLSC	New worker
	Social worker	Hospital	Experienced worker, member of a national committee
	Nurse	CLSC	Experienced worker, retired
	Nurse	CLSC	Experienced worker, call-back list
	Nurse	Hospital	Experienced worker, union representative
	Nurse	Hospital	Experienced worker
	Orderly	CLSC	Experienced worker, union representative
	Nursing assistant	Hospital	Experienced worker, union representative
	Homemaker	CLSC	Experienced worker

Region	Position	Facility	Experience
Montreal (N=7)	Nurse	Hospital	Experienced worker, member of a national committee
	Nursing assistant	Hospital	Experienced worker, union representative
	Orderly	Hospital	Experienced worker
	Social worker	Hospital	Manager
	Nurse	CLSC	Experienced worker
	Homemaker	CLSC	Experienced worker, union representative
	Social worker	CLSC	Experienced worker, member of a national committee

Region	Position	Facility	Experience
Quebec City (N=7)	Co-ordinator, social services	Hospital	Manager, member of a national committee
	Nurse	CLSC	Experienced worker, union representative
	Nurse	Hospital	Experienced worker, union representative
	Social worker	CLSC	Experienced worker
	Nurse and program director	CLSC	Manager
	Homemaker	CLSC	Worker, regional representative
	Orderly	Hospital	Experienced worker, union representative

Region	Position	Facility	Experience
Bas-St-Laurent (N=7)	General manager, RRSSSR	RRSSS	Manager
	Co-ordinator	CLSC	Experienced worker
	Co-ordinator	CLSC	Experienced worker
	Nurse	Hospital	Experienced worker, union representative
	Registered nursing assistant	Hospital	Experienced worker, union representative
	Social worker	Hospital	Experienced worker
	Homemaker	CLSC	A few years experience
Total: 38			

APPENDIX 5: FRAMEWORK OF INTERVIEWS WITH CRÉS MEMBERS

1. CRÉS mandate and role.
2. Composition; members; organizations and individuals.
3. CRÉS activities (project selection, symposia, etc.).
4. Are other organizations besides the CRÉS involved in the social economy? If yes, which ones and what are their mandates?
5. How does the CRÉS define the social economy?
6. Differences between the social economy and sub-contracting; between the social economy and community groups.
7. In your opinion, what is the role of the social economy in relation to the restructuring of health and social services and the shift to ambulatory care?
8. Have projects already been selected? If so, which ones? If not, why?
9. Project selection process:
 - Criteria and priorities?
 - Role and work of the social economy agent?
 - How was consensus achieved?
10. Projects in the field of health and social services:
 - Presented?
 - Accepted?
12. How has the decision-making process within the CRÉS contributed to the advancement of women?
13. What would you identify as major issues for women with respect to the development of the social economy and of social economy policies?
14. In your opinion, are there links between the budget cutbacks in health and social services and the development of the social economy and of social economy policies?
15. Has consultation within the CRÉS addressed the demands voiced at the Women's March [1995 Bread and Roses March]?

APPENDIX 6: FRAMEWORK OF INTERVIEWS WITH REPRESENTATIVES OF PROVINCIAL ASSOCIATIONS

1. What role have you played in the social economy and social economy policies?
2. What is your evaluation of the social economy and social economy policies?
 - generally
 - evaluation of the regional experiences of the CRÉS
 - establishment of CRÉS
 - decentralization of budgets
 - equity standards
 - funding of women's and community groups by means of social economy policies
 - partnerships between women's groups and regional authorities
 - evaluation of the national experience in social economy policies
 - *Entre l'espoir et le doute* [1996 report of the Comité d'orientation et de concertation sur l'économie sociale (COCÉS)]
 - Economic Summit
 - Chantier sur l'économie sociale
 - how does the social economy address the demands made at the Women's March [1995 Bread and Roses March]?
3. In what way does the social economy contribute to the advancement of women and women's groups?
 - how is it negative for women and women's groups?
4. What are the major issues related to social economy policies facing women and women's groups?
5. In your opinion, what is the place of the social economy in relation to the restructuring of the health and social services network?
6. What are your views on the social economy and social economy policies in relation to regionalization? In relation to income security reforms being put in place?

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ENDNOTES

¹ The term “caregiver” is used here to designate those responsible for looking after relatives or friends who are sick or have lost the ability to look after themselves. We believe the more common term used in Quebec of “natural helper” masks the value of the work performed by these individuals as well as its social relevance.

² The AFÉAS has 22,000 members in 450 local groups across Quebec. Founded in 1966, it is a mutual support organization based on exchange and solidarity that lobbies for the defence of women’s rights and demands. For example, the AFÉAS has been involved in girls’ education, women’s poverty and pensions. Since its inception, the AFÉAS has lobbied for the recognition of the invisible and unpaid work women perform full time or in addition to their paid jobs. This work encompasses caring for children as well as the sick, disabled or elderly. The organization has also made progress in the areas of recognizing women’s experience and skills, the status of wives in family businesses and the adoption of the Quebec law on family patrimony. Following completion of this study, the AFÉAS plans to survey its members’ needs with regard to the shift to ambulatory care and identify necessary corrective action. It also plans to develop a strategy to remedy the problems identified and to work toward the recognition of the invisible work expected of women.

³ Canada Health and Social Transfer, Health Canada (1997) table 1A.

⁴ It is important to recall here that Quebec’s health and social services system was built in the 1960s during the Quiet Revolution. At the time, the government took direct responsibility for the health and social services system and invested in human resources and institutions. The health system gradually evolved toward a truly public health network as recommended by the Castonguay-Nepveu Commission: universal and free health services were established.

⁵ Regionalization is, in effect, a form of decentralization that goes beyond the concept of development in which administrative regions are mere executors of the administrative and political decisions made in Quebec City. Regionalization is based on the ideal of joint action taken by local and regional collective actors who increasingly are taking responsibility for choices and decisions affecting their communities. In this way, regional representatives are linked to the decisions, implementation and management of government operations.

⁶ These boards replaced the Conseils régionaux de la santé et des services sociaux (CRSSS) which were considered to have a number of shortcomings, including overrepresentation of specific interests at the level of the boards of directors. The boards of directors of the new regional boards are elected by universal suffrage. It is hoped that greater public participation will guarantee greater transparency in the decision-making process. Power at the regional level was consequently consolidated since the boards preside over decisions regarding the development and management of the system. Charged with program planning and budget allocation based on the social and health care needs of each region, the regional boards will also contribute to decentralizing the health and social services networks while, it is argued, bringing decision-making closer to the communities they serve. Since 1996, the regional boards defined territories within their geographical areas and invited their partners to establish territorial bodies (or Tables) that would co-ordinate all services. The regional boards thus became regional bodies on health and social services. To ensure that role, the regional boards must recognize both the importance and influence of community groups in the delivery of direct services, prevention and public awareness services, as well as their specific philosophies and approaches. In addition to allowing community groups to participate in the decision-making processes and including them in this process, the regional boards are also responsible for allocating subsidies to community groups within their territories.

⁷ Many of these terms may be unfamiliar to the reader. For more details, please see the glossary.

⁸ In spring 1996, at the suggestion of the Quebec government, a number of regional committees on the social economy (CRÉS) were established in each administrative region. These committees focused on defining criteria and objectives that would establish eligibility for financing projects with funds allocated through social economy policies. Parallel to this, the new social economy progressively acquired its credentials as it found

itself in the spotlight at the Conférence sur le devenir socio-économique du Québec. The Chantier de l'économie sociale initiated work on defining the specifics of the social economy within Quebec's economic system. All these activities culminated at the Socio-Economic Summit in Quebec City in October 1996, where the government and several of its social partners discussed economic strategies. During the Summit the mixed character of Quebec's economy was recognized as well as the role the new social economy could play in this context. This sector won credibility as an integral part of the Quebec economy both in the public and private sectors.

⁹ Government measures in the area of the social economy were also tied to the regionalization of government programs and services (Côté et al., 1995). The new Politique de soutien au développement local et régional transformed the patchwork of decision making within each region: certain bodies changed mandate or structure (for example, regional development councils, CRDs and MRCs), others were progressively dismantled and finally others were created (for example, the local development centres, CLDs and CLÉs). This policy specifically targets the economy and employment. It groups services and merges certain government mandates with the objective of establishing a single service centre in each region in the areas of employment and business support. Mechanisms are established to promote consultation and partnership among different regional actors. These are, in fact, local and regional bodies that become accountable for service management. At the heart of this reform is the local and regional articulation of government policies and programs. The end result is that each region must equip itself with a development plan adapted to its own needs and specificities.

¹⁰ Our interviews were conducted before the retirement program was introduced by the Quebec government in 1997.

¹¹ In some cases, CLSCs offer allowances to patients so they can hire staff to provide care and assist in household tasks.

¹² The committee's report does not limit the definition of social economy to this issue, but it does devote several pages to it (pages 35-44). According to the committee, the social economy's objective is to respond to social needs and to create real jobs in democratically run enterprises with social objectives that enjoy a range of financial and human investments (COCÉS, 1996: 31-57).

¹³ Social economy refers to activities and organizations based on collective entrepreneurship which adhere to the following principles: provision of services to members or to the population, self-management, democratic decision making, primacy of persons and work over capital in the distribution of profits; participation; individual and collective empowerment and responsibility (L'économie sociale en chantier, vol. 1, no 2, August 26, 1996).

Figure I
 INSTITUTIONS AND SERVICES QUOTED
 (Health and Social Services)

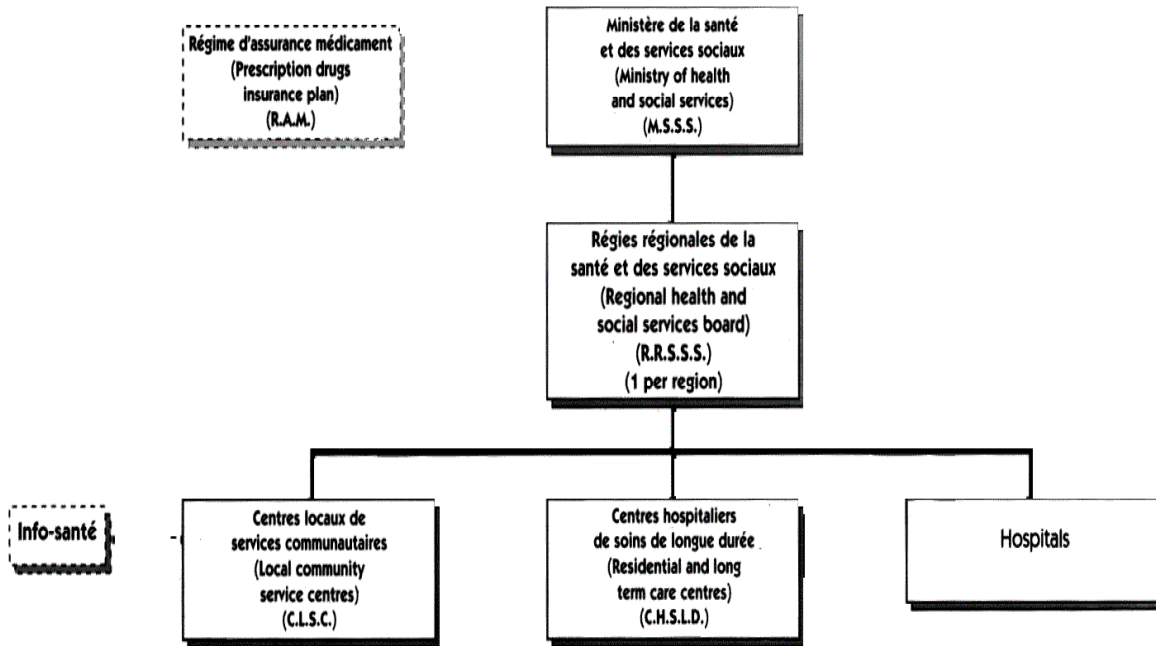
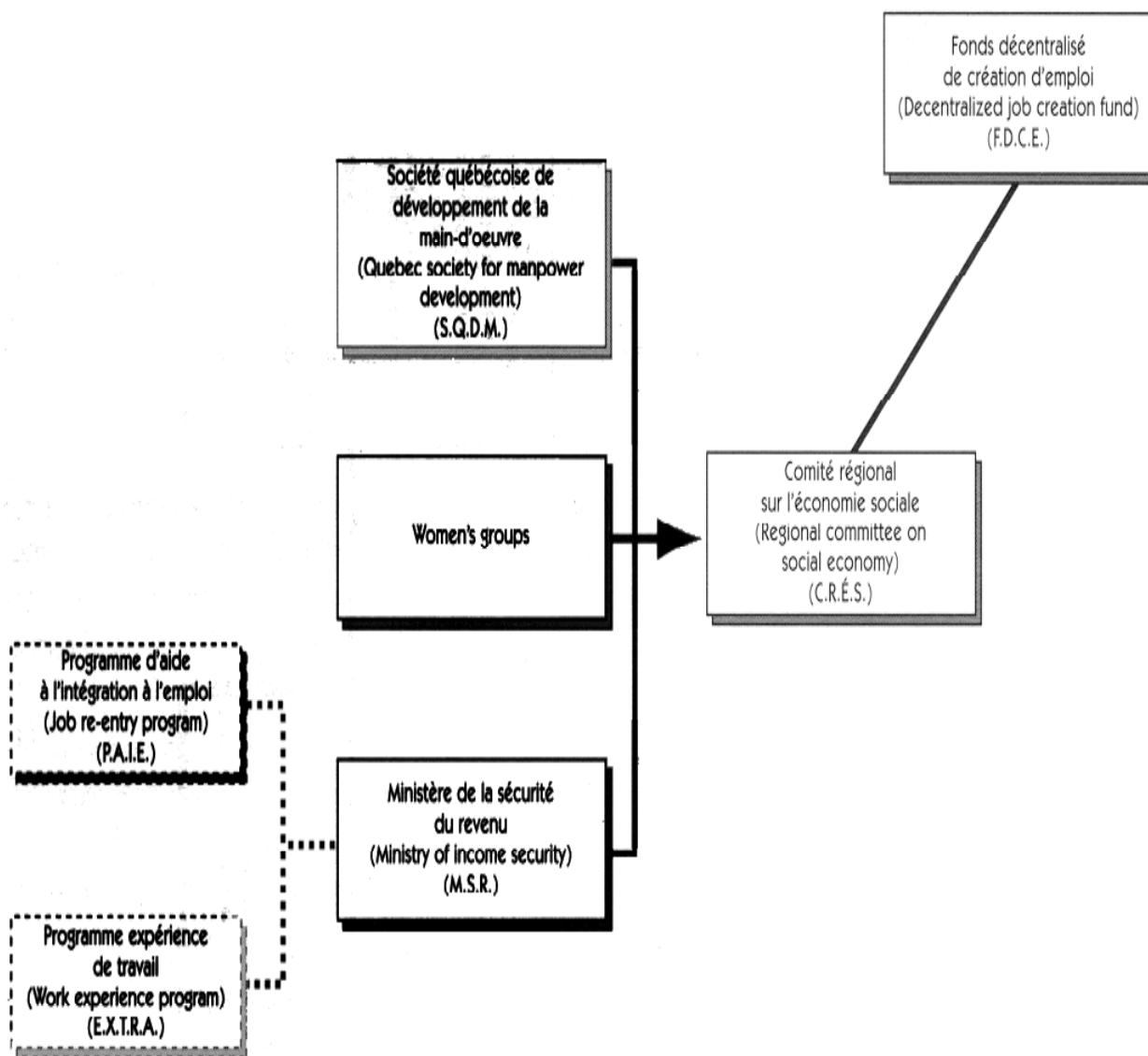


Figure II
 REGIONAL AUTHORITIES AND PROGRAMS QUOTED
 (Economic Development)

1996-1997



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