SHIFTING THE GOAL POSTS AND CHANGING THE RULES

THE PRIVATIZATION OF THE CANADIAN HEALTH CARE SYSTEM

by

FIONA CHIN-YEE

B.A., MCGILL UNIVERSITY, 1977

Thesis
submitted in partial fulfillment of the requirements for
the Degree of Master of Arts (Sociology)

Acadia University
Fall Convocation 1997

© Copyright by Fiona Chin-Yee 1997

National Library of Canada

Acquisitions and Bibliographic Services

395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque nationale du Canada

Acquisitions et services bibliographiques

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence

Our file Notre référence

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-23686-2

Canada

ACKNOWLEDGMENTS

I would like to take this opportunity to thank those people who have helped and supported me through this process. I wish to thank Dr. Ann-Marie Powers who, as my advisor, mentor and friend, has encouraged me to get 'the job' done in a timely fashion. I thank Dr. Tom Regan whose friendship and advice have been an inspiration.

Special thanks goes to those who have been so helpful and encouraging, Jan Catano my 'soul sister', Ian Johnson and Mike McBain who are always there to answer questions or discuss issues, Linda Forbes, Rosemary Gribbin and Ann Costello for their friendship and encouragement. I want to thank all of those people who gave freely of their time and expertise in focus groups, interviews and through the survey.

Finally, thanks to my family for 'putting up' with a distracted mother and partner. They and I hope that life will get back to normal "when I finish my thesis!"

Table of Contents

Page

Acknowledgements iv

Figures and Tables vi

Abstract vii

Introduction 1

Chapter One -- The Context 6

What kind of system do we have in Canada and Nova Scotia
and how is it different from the United States?
What are the ideological tools of globalization
and how do they impact on our health care delivery system?
Who won the 'Cold War'
and why does the answer profoundly affects our health care delivery system?

Chapter Two -- Theoretical Framework 53

Modeling the pressures on the Canadian health system.

Chapter Three -- Methodological Framework 75

Chapter Four -- Presentation of Research Data 80

Research Question:
Perceived Philosophy of Privatization
Efficiency
Control of Expenditures
Utilization of Health Services
Increased funding
Erosion of Equity of Access
Winners And Losers For Increased Privatization Initiatives
Most Appropriate Funding Mechanism for Helath Care System
Perceived Influence of Trade Agreements on Health Care System

Chapter Five -- Discussion and Conclusion 120

References 133

Appendix I Survey 137

Appendix II Respondents' Expertise 143

Figures and Tables

Figures
Figure 2.1 Pressure Exerted By The Convergence Of Interests 70
Figure 2.2 Changes In The Public /Private Ratio 1975 - 1992 73
Figure 4.1 Will Privatization Erode Equality Of Access? 111
Figure 5.1 Prefered Financing For Health System 129

Tables
Table 1.1 Breakdown of Health Expenditure by Financial Source 18
Table 1.2 Public-Private Split in Health in G-7 38
Table 1.3 Comparison of Public Spending in the Social Sector as % of GDP 49
Table 1.4 Public Share in Total Health Spending in G-7 51
Table 4.1 Categories Of People Involved In The Study 80
Table 4.2 Philosophical Reasons Given To Privatize Health Care Services 82
Table 4.3 Will Privatization Initiatives Increase Efficiency? 93
Table 4.4 Services That Could Be More Efficient If Privatized. 96
Table 4.5 Will Privatization Initiatives Control Public Expenditures? . . 100
Table 4.6 Will Privatization Initiatives Reduce Utilization Of Services By Patient? 103
Table 4.7 Will Privatization Initiatives Reduce Utilization Of Services By Health Care Professional? 105
Table 4.8 Will Privatization Initiatives Inject New Funds Into The Health System? 108
Table 4.9 Respondents Assessment of The Winners From Privatization Initiatives In Health Care 113
Table 4.10 Respondents Assessment of The Losers From Privatization Initiatives In Health Care 114
Table 4.11 How Should We Finance Our Health Care System? 115
Table 4.12 Which International Trade Agreements Affect The Government's Ability To Provide Health Services In Canada. 118

ABSTRACT

This thesis uses a structuralist framework to examine the pressures that are being exerted on the Canadian health care system. The analogy that is used refers to a playing field. By shifting the location of the goal posts and changing the rules of the game, the old goal posts disappear and their objectives become irrelevant. The thesis asks those people who actively seek to influence government social policy, what their perceptions are on the benefits and problems caused by increased privatization initiatives in the Canadian health care system.

A number of critical themes have emerged from this study. From a structural perspective there are three key points: the position of the health care system within the public system; the position of the public system within the emerging framework of the national government and the position of the national government within the global economy. From an ideological perspective the theme centres on the analysis that is coming from both the 'new' right and the 'new' left. The management theme is of the relative importance of 'evidence' in the development of public policy designed to meet the goals and objectives of the health care system. The theoretical model of the convergence of interest demonstrates the pressures that are creating an environment where the goals and objectives of the Canada Health Act have become obsolete. It appears that in recent times the 'goal posts' have moved and the rules of the game have changed. Finally, the question returns to the challenge of maintaining the public's trust in the Canadian health care system.

Introduction

In recent years, many questions have been asked about the Canadian health care system: Is it over funded? Is it under funded? Is it too comprehensive? Too inclusive? Too accessible? Is it one tiered or two tiered? Is it too political? Is it responsive to certain sector needs? Who should profit from it? This work arises from the most basic question: What is the most dangerous threat to Canada's health care system? The answer is simple:

The most dangerous threat to Canada's health care system is a waning of the public's trust.

The desire to fund the health care system is based on the public's trust that this is a 'good'[1] system. The respect given to health care professionals is based on trust that they do a 'good' job. The faith to give one's body or the body of a family member over to the ministrations of the system is based on trust that 'good' will be the outcome, including the 'good' that comes from a dignified and respectful death.

The trust relationship between the public and their government sponsored health care system is threatened. The threat comes from the continuing pressure to privatize health funding and management. This pressure has been increasing in recent years as governments shed responsibility for provision of social services and private enterprise seeks to maximize profits from the social sector. The goals have shifted and the rules of the 'game' have changed.

A couple of years ago at a meeting of the Canadian Health Coalition in Ottawa, the representative from Alberta brought a bumper sticker that said: "If Ralph Klein is the solution—What the hell is the problem?" The solution, like research, is only as good as the question posed. Without a clear definition of the problem it is impossible to evaluate the solutions. During these days of intensive change we are being presented with a set of solutions based on the concept of privatization. So the question has to be rephrased: "If

[1] I define 'good' as that which has the most benefit and does the least harm to all citizens.

privatization is the solution—What is the problem?" The rush to privatize government-owned endeavors and government services is the identical twin of a second global phenomenon, the rush to create the 'micro' national government. Together these twins are having a profound effect on the way nation states work.

From 1919, when a national health program was first discussed in Canada, the issue of private sector involvement in health care has been vigorously contested between those promoting public and private sector involvement. These contestants have been viewed both as the solution to the crisis and as the cause of the crises. In 1984 the Canada Health Act responded to this crisis. The debate continued to be hotly contested in 1985 when Greg Stoddart and Roberta Labelle undertook an extensive review of the arguments for and against privatization initiatives in the Canadian system of health care. Their work, Privatization in the Canadian Health Care System (1985), forms the basis for this thesis, as the issue of privatization rages once again in 1997.

This thesis seeks to find ways of looking at the complex health care system of Nova Scotia that will give insight into the questions that need to be asked. The purpose of this study was to ask those who seek to influence public policy what their perceptions were of the ideology of privatization. To do this, the same questions that were posed by Stoddart and Labelle in 1985 were used in 1997. The variables used to evaluate the respondents' perceptions are: efficiency; control of spending; utilization of services; access to new funds; and equity. The respondents were also asked to identify winners and losers from privatization initiatives; to comment on their understanding of the effects of trade agreements on the health care system and to indicate their preference for a funding mechanism to maintain the system defined by the Canada Health Act.

The analysis begins with the questions asked by Stoddart and Labelle in 1985 and returns to these questions to hear the opinions of the respondents. These questions must reflect the primary objective of the Canadian health care system, as stated in the Preamble of the Canada Health Act:

> It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of the residents of Canada and to facilitate reasonable access to health services without financial or other barrier (Section 3 of the Act).

I conclude this introduction with the following seven stories. They are reminders of this objective. They can be kept in the back of the mind, while puzzling over such complexities as TQMs, NAFTA and the pros and cons of corporate concept of 'managed care.'

Story One. In Life Before Medicare (1995), Mary Louise Matheson tells the following story: "During the forties and early fifties Perry Ronayne and his wife were having and bringing up their children in Halifax. Times were tough and there wasn't much money. Perry was working on the CNR trains and was often away for days at a time. Their second infant was born at home and seemed to have difficulty nursing from the beginning. The doctor didn't come to the house when they called because they still hadn't paid the bill from the birth of their first child.

As the days and weeks went by the situation did not improve. The baby would drink some milk and then throw most of it up. Advice was sought from well-meaning friends, because there was no money for the doctor's fee. All kinds of efforts were tried to help this baby. When the baby was almost two months old, Perry came home from work with enough money to take the baby to the Halifax Infirmary Hospital. The pediatrician on staff that night checked the emaciated child gently.

There was a minor problem, with the baby's upper digestive system, that was apparently not at all uncommon and easily fixed. But it was too late. The baby was starving to death and not even intravenous fluids could save her at this late stage. She died soon afterwards" (p.78).

Story Two. My husband's family is from the West Indies. The family is large and can be seen as a microcosm of the social structure of the Island. His Aunt is a country woman, with little formal education and a life that was filled with back breaking work. Through the years she worked alongside her husband running a little bakery in a village in the hills above Kingston. She birthed and raised six sons and cared for her husband as he went blind and then died. Nothing was ever gained for nothing in the lives of these country women. Four of her sons had settled in Toronto, so in the 1970s Aunt came to live in Canada. She has a number of medical conditions that are treated in Canada. On more than one occasion she has written to the Canadian Government to give thanks for the care she has received. "I have never worked for you in this country, but you have given me my new eye-glasses, thank you." The existence of our health care system is not taken for granted by many new immigrants to this country (Reflections by the author).

Story Three. From Yarmouth an elderly man phoned the Canadian Pensioners Concerned office in Halifax, he wanted urgent advice. This story was retold to me by the senior who answered the phone that day. The man's wife had been discharged from the hospital with a surgical wound in her groin that needed to be drained at regular intervals during the day. The home care nurse had shown the man how to do this on a number of occasions, but he had difficulty in retaining the instructions and was unable to attempt to do the procedure. He was calling CPC to find someone who could explain the procedure

to him step by step over the phone. At eighty-five he was finding this level of care giving too much to comprehend. The senior I spoke with was very frustrated. "The Family is there for all the needed supports for their sick relative, but that support cannot be to provide the professional care themselves" (Personal communication with a Canadian Pensioners Concerned board member, 1997).

Story Four. Debbie Kelly is the very able leader of a new group called Coalition against Health Care Cuts. Her wellspring of energy comes from the death of her father. This man was released from hospital in Halifax to die at home. The home care did not cover the full extent of his illness and family members were needed to provide the 24--hour care he needed. Although he was in intense pain and had to rely on assistance for all personal care there was no registered nursing care assigned. The family was responsible for the care of his surgical dressings and all his medication including administration of morphine. After a number of visits, phone calls and emotional pleas to the Home Care Coordinator, Debbie's family obtained a 24-hour home care service for the final two days of his life. The pain, the lack of dignity, the pleading, the grief have come together to create a very powerful speaker on the effects of the cuts to the system. The costs to Debbie and her family have been and continue to be very high (Debbie Kelly, personal communication, March 1997).

Story Five. In December a man in Saint John had a severe stroke. His condition was terminal and he was not expected to live long. He was discharged from the hospital to the care of his family. His wife was a 'young' senior in her seventies. She asked the discharge doctor about home care and was told there would be no home care for at least ten days, after which time there would be provision for care—but December was a difficult month due to the holidays. She inquired for private home care services, and was told she would be lucky to find any due to the time of year. She did find an agency who could supply 24--hour care. Her daughters came in from other areas of the province to help. The cost of Registered Nurse care is $25 per hour, that is $600 per day. He died a month later. The emotional and financial costs to the family have been severe. As the daughter said, "What can we do to ensure that these financial burdens don't fall on our children . . . What will be left in 30 years?" (Family member, personal communication, March 1997).

Story Six. This story was told to me by a physician from the QEII Health Centre in Halifax. A man was admitted from Charlottetown with kidney failure. The man's story was a simple one. He had suffered from severe tooth ache and had gone to see his dentist. The dentist had required a set of x-rays. Due to the expense of the x-rays and the lack of a dental plan, the man waited until he had the money. On seeing the x-rays the dentist saw that many of the teeth had abscessed and that they needed to be extracted. The full fee for this procedure and the follow up would be in excess of $1,000. While the man saved for this expensive treatment, he was taking pain killers in great quantities. The effect of the excessive use of pain killers over an extended period of time has resulted in permanent damage to his kidneys. This man will be hospitalized until he can get a transplant (Personal communication, March 1997).

Story Seven. In 1990 I was sitting in the tiny office of Hope Cottage for a meeting with members of the Hope Cottage staff, the North End Community Health Clinic and the Home of the Guardian Angle/Single Parent Centre in Spryfield. In the course of the meeting news was exchanged. A young woman had given birth. This baby was very premature and in the intensive care unit at the Grace hospital. The cost at that time for the sickest babies was $5,000 per day. The new incubators were said to cost the same as a small Honda car. "How can it be?" said one of those present. "One day's costs for this baby could prevent other young women (from) having a premature birth."

While these seven stories are anecdotal, they are also the life experience of these families. They, together with my own insights and observations based on over fourteen years as a community animator engaged in health care initiatives, are used to discern what is public trust. Each story represents a straw. They blow in the wind of the communities' consciousness, but as they get more numerous and stories of successful interaction with the health system get fewer, they begin to be more than anecdotes—they become part of the communities' collective realities. They are the straws of the system's 'camel's back,' affecting the level of public trust in the system. The task is to understand the system, to look at its stresses and to find ways to address the life experiences of the citizens. Solutions must be found that will enable the Canadian social structure to once again support a health care system based on the primary objective of the Canada Health Act.

Chapter One

The Context

Current advice for the researcher recommends the framing of the research question within the wider context and then to concentrate on a micro portion of the question. It is the relationship between the broad context and the micro context that determines what is in fact the micro context. In Nova Scotia, our health care system seems overwhelmingly large and complex, however, in the scale of the global economy, our health care system is a small microcosm of reality - an example of the questions facing the global systems. Our very smallness has been and will continue to be one of our greatest assets in the struggles that lie ahead.

Our social programs are influenced by global forces, so that to examine them in isolation from the global reality is too obscure and confuses the potential impact. The social conscience of Canadians is like the melody in a symphony. It can be subsumed by the larger and more aggressive forces, hopefully to reappear with greater clarity to remind the world that there is intrinsic value in respecting and enabling all our citizens. It is the purpose of this chapter to name these forces so we can recognize their potential power, for if we fail to recognize them we will end up fighting the wrong battles and will lose the war.

To focus this research I asked three questions: What kind of system do we have in Canada and Nova Scotia and how is it different from the United States? What are the ideological tools of globalization and how do they impact on our health care delivery system? Who won the 'Cold War' and why does the answer profoundly affect our health care delivery system?

What kind of system do we have in Canada and Nova Scotia and how is it different from the United States?

To understand our health care system we need to look at its history and development and we need to view it in relation to the system that has developed in the US. Both the Canadian health care system and the American system developed in tandem

from the mid-Nineteenth to the mid-Twentieth Century. It was only in 1860 that medicine was recognized as a profession in Canada: before this doctors were on the same level as others in the healing professions. Most doctors practiced in the Eastern provinces and the Eastern states. The largely rural hinterland of both Canada and the US had significantly fewer doctors and the population was far more likely to use the services of herbalists and midwives, than make the long journey into a town to visit a doctor. By 1869 the College of Physicians and Surgeons of Ontario was established and doctors began to organize. This organization was the backbone of the evolving Canadian Medical Association (Rands, 1994). The American Medical Association had already been formed in 1846 (Starr, 1982). The pressures for control of the delivery of health services by the medical profession were the same on both sides of the border. In fact there has always been a close relationship between the American Medical Association (AMA) and the Canadian Medical Association (CMA). By 1885 all non-medical healing practices came under the jurisdiction of organized medicine and all practicing physicians in Ontario had to be licensed by the OMA.

The one consistent theme for both the AMA and the CMA has been their need to control the provision of services, and their distrust of any government intervention. At all stages of development both organizations have vigorously opposed all attempts by government to develop medical delivery systems.

> In 1934 the Association passed a program known as the "AMA Ten Principles" which set out guidelines for medical societies in regard to the implementation of health insurance. The AMA, followed by the CMA, demanded that any medical service plan be under the control of the medical profession, and that the medical profession be solely responsible for the character of the services provided. It insisted on doctors' rights to choose patients. It also insisted that the costs of medical services be paid by the patient (Rands, 1994 p. 37).

However, in both countries the public called for government programs to offset the costs of health care. The Wagner Bill introduced in the US federal system in 1939 called for $35 million in grants to the states to finance public health services. The AMA organized the National Committee for the Extension of Medical Services to counter this bill. By 1943 the Wagner bill was dead. In Canada, as early as 1916 rural physicians in

Saskatchewan were working for a salary under the Rural Municipalities Act. This move was severely criticized by the CMA. By 1929 health insurance had become a political issue especially in the depressed areas of the country - the Western provinces,

> A *(CMA)* Committee on Economics was appointed to study the issue and formulate a coherent statement for the Association. In 1934 the CMA released its Plan for Health Insurance in Canada. The Association contended that the state should provide funding for medical services for indigent persons, but that people who could afford it should be responsible for their own health insurance. Not surprisingly the health insurance plans endorsed by the CMA were voluntary and private (Rands, 1994, p. 35).

In 1935 the Ontario physicians established the Medical Welfare Plan that received funding for the care of 350,000 people. Both the CMA and the AMA were concerned that health insurance would affect their autonomy and would only support plans that were private. The CMA worked closely with the government to plan a health insurance system. In 1943 they declared that the only acceptable plan would be one that was based on the voluntary health insurance plan. By 1948 the College of Physician and Surgeons in Saskatchewan passed a resolution in favour of state funding of health insurance. During the same year the Medical Society of Nova Scotia had established a plan in order to prevent the imposition of a government initiative.

> This professional body's hostility to state intervention in the health system in both the United States and Canada was and continues to be based on physician remuneration. Fee-for-service payment allows doctors to control their incomes. Under it they can increase their cash flow simply by increasing their patient load. The CMA continues to argue that third party involvement in the financing of health care interferes with the professional freedom of doctors (Rands, 1994, p. 45).

It is clear, however that by 1956 there were differences between the AMA and the CMA. In that year the AMA tried to prevent passage of an amendment to the Social Securities Act:

> The Association contended that the extension of Social Security benefits to disabled persons aged fifty or more would lead to complete national health insurance, with coverage for hospitalization, medical treatment and drugs. The AMA regarded national health insurance as the end to medical freedom.

> Medicare was initially the overriding political issue. In 1958 a congressman from Rhode Island introduced a new and extremely modest proposal covering only hospital costs for the aged on Social Security. The AMA undertook a massive campaign to portray a government insurance plan as a threat to the doctor-patient relationship (Starr, 1982, p.368).

In Canada the CMA wanted to develop an integrated health care system that included preventive, curative and rehabilitative services. These would include diagnostic facilities, hospitals, chronic care centres and home care programs. They wanted these established though an independent non-political commission and in close collaboration and control with the CMA. However, as Stan Rands points out, the CMA insisted that improving the quality of services must not come at the expense of physicians' ability to generate their desired income levels. Hence physician organizations had a vested interest in controlling the plans. In Saskatchewan on July 1, 1962, the first universal and publicly funded program came into effect, the Medical Care Plan. On the same day Saskatchewan physicians withdrew all services except for emergency care in designated hospitals. The strike continued until an agreement was reached twenty-three days later. The Saskatchewan plan was the beginning of a universal state funded health insurance program in Canada.

In Second Opinion, Michael Rachlis and Carol Kushner point out the differences between the Canadian and the American medical care systems,

> Canada does not have socialized medicine; in point of fact, 95% of our doctors work for themselves, not for the state, and 90% of our hospitals are private, non-profit corporations. What we do have is a publicly funded system which pays private providers, as opposed to a largely privately funded system, which is what the Americans have . . . A recent New England Journal of Medicine article pointed out that the administrative costs of private insurance in America represented 10% of expenditures on health (Rachlis, Kushner, 1989, p.39).

From the physicians' view point the need to control their professional lives and their earning potential has been paramount. There is a direct link between control of earning potential and control of utilization of health services. Health reform initiatives in both Canada and the US are looking at ways of containing and managing utilization patterns of service delivery. In Canada, these initiatives are presently within the publicly funded

system and relate specifically to physician remuneration. Ideas like capitation[1] for physician fees, salaries and a variety of blended forms of payments, are already common among physicians teaching and working at academic centres. In the US the reforms are centred within the privately run, managed care corporations, which are introducing capitation of fees payable, salaries and a variety of other initiatives including a number of punitive measures to encourage physicians to control costs. The difference between the two systems can be better seen from the perspective of the payers. They are defined through the publicly funded insurance system in Canada and the private insurance plans in the US. Before moving to the insurance industry it is necessary to remember that more than 20% of the population in the US has no access to medical care, as Ralph Nader points out.

> In the US 40 million people, many of them children, have no health care insurance at all, and another 30 million are grossly underfunded. Our system is full of co-payments, deductibles, exclusions, fine print, and loopholes that cause incredible aggravation and sorrow among families in the US . . . The longest waiting period is when you don't have any money to pay for health care in the US. That's a long, long, wait (Ralph Nader, CCPA Monitor, February 1996).

The philosophy behind the American insurance system is quite different from the system that evolved in Canada. In fact Canada's experience is much closer to that of the European experience as Paul Starr indicates.

> America had taken a different road to health insurance from the one taken by European societies, and it arrives at a different destination. The original European model began with the industrial working class and emphasized income maintenance; from that base, it expanded in both its coverage of the population and its range of benefits . . . So instead of an insurance system, founded originally to relieve the economic problems of the workers, America developed an insurance system originally concerned with improving the access of middle-class patients to hospitals and of hospitals to middle-class patients. An insurance system developed under the control of the hospital and doctors that sought to buttress the existing forms of organization (Starr, 1982, p.331).

In 1977 the Canadian federal Parliament passed the Established Programs Financing Act. This act instituted block funding for health and post secondary education to the provinces.

---

[1] Capitation is a payment mechanism used for physicians.

This funding established a firm basis for funding Medicare that was equitable across the ten provinces and two territories. To strengthen the ability of the poor to access health care services, in 1984 the Canada Health Act was passed. This legislation has five principles: to be universal, comprehensive, portable, publicly funded and publicly managed. The single-payer system is the primary difference between the American and Canadian health care systems.

Robert Sherrill, in The Madness of the Market (1995), indicates that the concepts of 'health' and 'care' have been removed from this trillion dollar medical-complex in the US. He notes that patients are referred to as 'revenue-centres' and employee insurance plans as 'patient feeder systems. In 1982 Paul Starr noted that the idea of the health centre had been replaced by 'profit-centre'. From the evidence of these works, it will be a future in which medicine will often seem to be little more than just another mean, rapacious part of capitalism.

In the United States, the insurance companies hold a very powerful position within the medical-industrial complex. The reason for this wealth and power stems back to the passage of the McCarran-Ferguson Act of 1945. This act grants the insurance industry immunity from federal antitrust laws. Its power is huge and is arrogantly independent of Congress. Linda Lipsen, the legislative counsel for the Consumers Union underscores the power of this lobby, "So politically powerful is the industry that in 1980 it succeeded in convincing Congress to bar the Federal Trade Commission from even studying the insurance business."

Stories about high premiums for health insurance abound, along with their exclusion riders, such as the 'pre-existing illness' clause. Premiums can be raised, after the policy has been bought, to 'incredible' heights to cover major illnesses. One 'high risk' employee can make it very difficult for small businesses to get coverage for all their employees. Seniors are at risk for 'hard sell' tactics. The result has made health insurance the third biggest expense for the average US citizen after food and shelter.

It is a myth that the public hospital systems receive a greater share of public funds than the private for-profit institutions in the US. The private institutions are very adept at

receiving grants, matching funds and incentives to build new wings and buildings as well as getting government investment in equipment. This bleeding of resources has resulted in the less corporately capable public institutions becoming run down and extremely under-resourced. The private for-profits are famous for their billing mistakes that are always in favour of the hospital. The quality of care or the access to care is reliant on the patient's ability to pay. Hospital corporations work closely with their multiple funders - the insurance companies and the State programs such as Medicare and Medicaid. Care is cut off when the maximum payments have been paid. The mechanism of over billing for insured patients to pay for those who have difficulty in paying was thought to be a ploy of the public system. However, in reality the for-profits do this even when their service to indigent patients is approximately 2% of their work load. The practice of bumping patients that are on state assistance or who are not covered by a plan is illegal in most states. As Sherrill notes,

> Free-market ideologies might argue that private hospitals have no obligations to offer free care to anyone. But that argument pales against the reality of billions of government grants and taxpayer subsidies the hospital industry is built upon, not to mention all the public expenditures on private medical schools and scientific research (Sherrill, 1995, p.49).

George C. Halvoeson, in Strong Medicine (1993), tells of the statistics of iatrogenic deaths and death caused by negligent care. He describes a situation in a Rhode Island hospital that had a hundred per cent death rate for its cardiac patients. "Not one survived to leave the hospital . . . These 185 consecutive deaths were invisible as far as the health care system was concerned. They were individually reported and then simply forgotten." This example tragically demonstrates the lack of evidence for increased effective or efficient delivery of service within the for-profit hospital system in the United States.

The for-profit hospital system includes a number of very large hospital chains. They have a ruthless bottom line policy and are accountable not to their patients, workers or local government, but to their CEOs and shareholders. The corporate agenda is forcing a shift of resources from the care system to the profit margin. This is resulting in lay-off of trained staff and the hiring of temporary staff on a permanent basis. Many of

the temporary staff are hired though personnel chains. These chains are notorious for the provision of unskilled labour.

The situation in the mental health hospitals is even more disturbing. The lack of care coupled with the total lack of accountability has lead to incidents of fraudulent billing to the system on a gigantic scale. For example, one hospital claimed that a 13-year-old boy had received 634 therapy sessions within a two month period - including forty-one in a single day (Sherrill, 1995)!

Sherrill reinforces the reality that physicians in the US have greatly benefited from the advent of both Medicare and Medicaid. This is a system that has allowed them to hike their rates for these government-sponsored programs as opposed to the current rates paid out by the insurance companies. Neil Postman in Technopoly: The Surrender of Culture to Technology (1993) outlines the problems of over-doctoring. Postman states, "Patients may be justifiably worried by reports that quite possibly close to 40 percent of the operations performed in America are not necessary." He notes that some statistics show that there are more deaths per year that are the result of surgery than occurred in the war in Vietnam. He points out that during medical strikes the mortality rate declines.

The drug companies top Robert Sherrill's list for being the most 'rapacious' within the medical-industrial complex. Their motivation is greed resulting in the "average wholesale price of drugs in the United States (being) 32 percent higher than in the next most expensive country, Canada" (Sherrill, 1995, p.60). Given these very high prices, it is interesting that the Pharmaceutical Research and Manufacturers of America estimated that 72 million Americans had no insurance coverage for drugs. In addition, tax breaks for research and development are used to produce drugs that are copy cats of other drugs. New and significant drugs are few and often developed through funding by the US government. Up until 1990 the US government could not get a price break for the bulk purchasing of drugs for Medicare or Medicaid. In 1990 a bill passed in Congress which enabled these programs to negotiate a price break. In response the drug companies simply raised the price of their brand name drugs. There are some very unhealthy

relationships between university departments and the drug companies enabling them to challenge the FDA.

The last of the big players in the US system are the health care conglomerates. These are known as Health Maintenance Organizations (HMOs) or Preferred-Provider Organizations (PPOs). Paul Starr describes the failure of state governments to establish a comprehensive regulatory system, coupled with a piecemeal approach to managing monetary crises that result in cost cutting and turning back programs to the private sector (Starr, 1982). The growth of the HMOs over the past 15 years is the result of the consolidation of health care delivery, insurance and drug manufacturers into six giant conglomerates. The result is a consolidation of the medical-industrial complex in the hands of a few giant corporations, centralizing power and resources.

This massive consolidation of the private health care facilities is having a drastic effect on the publicly run facilities in the US. The private facilities routinely 'dump' low income patients onto the public system. While this is illegal, it is still a very effective way of getting rid of those who cannot pay. There are two tactics: the closing of the emergency room, so that indigent patients have no place to be admitted; and secondly, to reroute them knowing that it is very unlikely that the organization will be prosecuted. The danger to the US system can be found in the total control that HMOs have over all aspects of the medical industry. This results in far less choice for the consumer. Sherrill illustrates the irony of the role of competition between the HMOs. In a society where free markets are supposed to thrive, the HMOs are consolidating their interests in large oligopolies—with little regard for choice or competition. The pure irony of this is that those consumers who have had to buy into these HMOs are not getting their services at a reduced rate. They have significantly higher insurance rates than other areas. In California, for example, where 80 percent of all employees are covered by HMOs, their costs are on average 19 percent higher than the national average. In these areas of high rate of HMO saturation, the doctors are in a state of panic. They risk being excluded from the system unless they sign up with one of the companies, thereby restricting their freedom to act independently. In many cases the doctors are required to sign a document

swearing not to reveal any information about the practices or operation of the HMO. Practitioners are being silenced and patients have no rights or recourse.

Who are the winners in this system? The answer is twofold: the Chief Executive Officers and the shareholders. In 1995 the CEO of 'US Healthcare' is reported to have been paid $10 million. The other beneficiaries of this new found money making machine are the army of administrators and accountants, advertisers and legal advisers. These are the new bureaucracy of this private system. It is noted that in Consumer Reports, 1992: "Canada's national health care plan covers 25 million people - giving them not only medical and hospital care but long-term care, mental-health services and prescription drugs for people over 65 - and yet employs fewer administrators than Massachusetts Blue Cross which covers 2.7 million."

It is clear from Sherrill that the motivation behind the rise in health care costs in the US is based on greed. This greed is evident at every level of the medical industry. However, the motivational factor of individual greed has given away to a much more organizational and structured corporate greed of the large emerging oligopolies. These companies, like Columbia/HCA Healthcare Corporation represent the greatest threat to the Canadian system. They are huge, centralizing forces that are creating 'mega' institutions. The Canadian health system is viewed as another market t be controlled. Due to the apparent fragmented understanding of our system by decision makers we may allow these corporations to get a toe-hold in Canada. Given what we have seen from the for-profit system of health care delivery in the US it is difficult to imagine that there are many people and organizations in Canada looking to the US for direction. But as Ralph Nader pointed out in the CCPA Monitor,

> Yes, Canadians have some concerns and complaints about Medicare. You want to improve it. And you can improve it by reducing unnecessary procedures and putting more emphasis on prevention. You will not improve it - you will destroy it- if you open the door to the corporatised, deprofessionalized, gouging, bottom-line style of health care that we are saddled with in the US. Our greedy insurance companies are eyeing the Canadian market of 30 million people, and are working with right-wing politicians and business executives in Canada to scuttle your public health insurance plan and replace it with the horrendous privatized American system (Ralph Nader, CCPA Monitor, February 1996).

The system that developed in Canada was similar to the European model of integrated social programs for all the citizens. The universality of Medicare was matched with universal income security programs, for the elderly and the disabled, a universal income supplement for families with children and universally accessible unemployment insurance, through which all levels of government contributed to income maintenance for the very poor. This mix of programs recognized the citizen as an individual worthy of support and respect.

That development came to an abrupt halt during the nineties. We have lost the universality from all these programs except for Medicare. Where it once stood as part of this integrated system, it now stands alone and in its loneliness is vulnerable. Family allowances are gone, Old Age Security and the Guaranteed Income Supplement's universal coverage were lost in August 1996, and will be replaced by the Seniors' Benefits Plan in April 1997. The universality of the unemployment system was lost in April 1996 as was the Canada Assistance Plan. Disabilities pensions have been reduced and are awaiting review. Other programs that looked after the needs of the citizens, such as the Cooperative Housing Program of Canada Mortgage and Housing will be phased out by April 1997. The Established Programs Fund and the Canada Assistance Program were merged to form the Canada Health and Social Transfer, April 1996. By the year 2015 it is estimated that there will be no more transfers of money from the Federal government to the Provinces. The transfer of funds for these programs will be replaced by the calculation of income tax points to the provinces, but the ear-marked funding will be gone. The fear is that with the loss of the federally-funded programs it will be difficult to maintain standards and portability of services for all Canadian citizens.

The ideology that fostered the variety of social programs that formed what we were proud to call our Social Safety Net is now gone. The new ideology that has taken its place is based on either a classic neo-conservative model or a classic neo-liberal model. I am not sure which one. The reality is that the role of the citizen has lost out to the dualism of deserving or undeserving, or, of a have-consumer or have-not consumer. The motivation behind the provision of medical services is based on the 'business' or profit model, a model that is familiar in the American health system.

The Canadian health legislation is dominated by the Canada Health Act of 1984. This Act combined in legislation the Hospital Insurance and Diagnostic Services Act of 1957 and the National Medical Care Insurance Act [Medicare was enacted in 1968 and fully operational across the country by 1971.] The Canada Health Act enshrined the Five principles of Medicare: universality, accessibility, comprehensiveness, portability and publicly administered. The Canada Health Act ensures all Canadians access to services provided through hospitals and the medical profession. Section 3 of the act states:

> It is hereby declared that the primary objectives of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers (Canada Health Act, 1984).

The criteria for gaining 'reasonable access' to health care services is based on what is considered 'medical necessity.' This gives the gate keeper role to the medical profession. Given this restriction, the Canadian Health Care system is based on provision of services based on medically defined need, with no financial barrier between provider and citizen. This should mean that the sicker the individual the greater the access to the system. Therefore, those who are not sick do not 'need' to access the system. This puts a different slant on accessibility from a purely universal system (Birch, 1995).

Canada, through its provinces and territories, is a decentralized country. The responsibility for the provision of health services is shared by both federal and provincial levels of government. Traditionally, this has meant that the federal responsibility is:

- to enforce the Canada Health Act;
- to collect taxes and distribute funds for health care services across the country;
- to maintain standards and licensing of health related products and review environmental toxins through the Health Protection Branch;
- to directly care for the health of particular segments of the population (for example, First Nations and the Armed Forces).

> Strictly speaking, the term "Medicare" refers to our system for insuring the costs of physician services. But today it is widely understood to encompass all publicly financed health care services, including those in hospitals or long-term facilities, as well as drug benefit programs, home care, and other services (Rachlis, Kushner, 1994, p.39 1n.).

It is the responsibility of the provincial government to provide for the delivery of the services that are to be funded through the public purse. This is a provincial responsibility and there is some variation among provinces as to how this responsibility is met. The programs that must be funded through the public system continue to be those programs that are delivered through the hospital system and by medical personnel.

The funding of the system is shared by both federal and provincial governments. The following table is a break down of health expenditures.

Table 1.1
Breakdown of Health Expenditures by Financial Source
1975 - 1994

	1975			1994			Avg. Annual Compounded Growth 75-94	
	Public $mil	Private mil	Ratio	Public mil	Private mil	Ratio	Public %	Private %
Hospital	5,196	316	96:4	24,206	2,293	90:10	8.4	12.2
Other inst.	796	328	71:29	4,952	2,138	70:30	10.1	10.4
Physicians	1,813	27	99:1	10,222	100	99:1	9.5	7.1
Other prof'ls	135	766	15:85	847	5,346	14:86	10.1	10.8
Drugs	158	916	15:85	2,929	6,250	32:68	16.6	10.6
Other	1,264	540	70:30	8,905	3,773	70:30	10.8	10.8
Total	9,361	2,893	76:24	52,061	20,401	72:28	9.5	10.8

Source National Health Expenditures in Canada, 1975-94. Quoted in National Forum on Health Canada Health Action: Building on the Legacy. 1997, p. 15.

There are three clear messages from Table 1.1. The first is the dominance of public funding for hospital and physician services over other areas of health care delivery. The second is the drop in the ratio for public funding for hospital services, other institutions and other professionals, and the rise in the public funding for drugs resulting in an overall

second is the drop in the ratio for public funding for hospital services. other institutions and other professionals, and the rise in the public funding for drugs resulting in an overall drop in the ratio over 20 years from 76:24 to 72:28. The third message is that although most Canadian provinces have undergone many 'health reform' initiatives, nothing much has changed.

The Canadian Health system is in a period of intense health reform. This time was predicted by Tommy Douglas in 1982, "When we began to plan Medicare, we pointed out that it would be in two phases. The first phase would be to remove the financial barrier between those giving the service and those receiving it. The second phase would be to reorganize and revamp the delivery system - and of course, that's the big item. It's the big thing we haven't done yet."

As we have seen, the Canadian health care system has always existed with a high degree of tension between the governments and the physician organizations. From its inception both at the provincial level, through Tommy Douglas, or at a national level, through Lester B. Person, Medicare was always seen as being a system that needed to be developed.

> The scope of benefits should be, broadly speaking, all the services provided by physicians, both general practitioners and specialists. A complete health plan would include dental treatment, prescribed drugs, and other important services, and there is nothing in the approach we propose to prevent these being included, from the start or later. If this were the general wish. We regard comprehensive physicians' services as the initial minimum (Pearson, 1965).

At all stages of the development of the Canadian health care system there have been calls for change. This began with the knowledge that the removal of the financial barriers between the provider and the patient was only the beginning of system design. However, there was no mechanism to oversee the distribution of Canadian doctors into traditional under-serviced areas. There were no evaluation methods put in place to see if the services being provided were effective, safe or necessary. Health costs began to spiral, health status improvement stagnated and the economy in the Seventies experienced a recession.

From the beginning of Medicare the physician power-base has been effective in looking after their own needs. Their guardian role for access to the system, the preservation of their unique position as the sole providers of medical care, the income differential they enjoy and the unique position they occupy in decision making for the system are some of the areas of physician influence. The most direct manifestation of this is the fee-for-service mechanism of payment.

> Doctors spend too little time with people who are really sick. Even in a city like Toronto with thousands of family doctors and more than one hundred walk-in clinics, public health nurses find few physicians willing to make home visits to the frail elderly or to take on patients with AIDS, schizophrenia, or other difficult medical problems. The great British general practitioner and primary care theorist Julian Tudor Hart referred to this phenomenon as the 'inverse care law': "The availability of good medical care tends to vary inversely with the need for it in the population served" (Rachlis, Kushner, 1994, p.177).

Even though it has been modified through the introduction of managed care facilities in the US, by global budgeting, capitation and population based funding in many European countries, the fee-for-service funding mechanism is common in most jurisdictions. This payment system is difficult to predict, to plan or to hold practitioners accountable, as Robert Evans points out.

> The short-hand story, then, is that despite their diversity, health care systems in every society have all evolved without mechanism to assure accountability for effectiveness, efficiency, and appropriateness of care provided. The response of providers to every issue, every problem, every question, has been, 'We must meet needs - Give us more' (Evans, 1993, p.17).

The health reform initiatives that have been implemented in most Canadian provinces and which are also reflected in the federal government's cuts to the Canadian Health and Social Transfers is based on cutting cost. This deficit reduction model of health reform is the first reality of health reform. The major cuts can be found in the facilities sector, the primary target being hospitals. While there has been systematic mismanagement and waste within the hospital system,[2] the cuts to hospital budgets are being borne primarily by the health care workers.

[2] This has been documented by all the Commissions of Inquiry, Royal Commissions on health services that have taken place in all provinces within the past 10 -12 years.

> Approximately 75 percent of hospital budgets are for personnel, meaning you can't make deep cuts all at once without laying off employees. . . .As of April 1993, over ten thousand nurses had been laid off and nearly twenty thousand other hospital workers were collecting unemployment insurance. In the meantime, the nurses who still have jobs are run off their feet (Rachlis, Kushner, 1994, p.245).

Along with the lay-off of full-time workers come the phenomena of part-time work, casual workers and multi-skilled workers. All of these are a cost saving to the institution.

> In public hospitals 42 percent of the RNs worked part time in 1990, while this was the case for 56 percent of those employed in for-profit institutions. In addition, many of the RNs counted as working full-time did so on an irregular basis. Of the nurses with nursing jobs in 1993, 14 percent were casual employees. By employing people part-time or on a casual basis, employers save money in two ways. First they often pay fewer benefits and lower wages for these employees. Second, employers pay part-time workers only when they work and employers can hire them to work only at peak demand. Moreover, people who are working for short periods of time can work harder than those employed for more hours (Armstrong, Armstrong, 1996, p.113).

The second reality of health reform initiatives has been the utilization rates of hospital beds, and the resulting closure of hospital beds. Funding was allocated to hospitals based on a per diem rate for the number of beds that they had available. The following quotation is from the Nova Scotia Royal Commission on Health Care,

> Analysis of bed to population ratios helps to explain the different hospital expenditure trends. The national ratio of general hospital beds per 100 population has steadily declined (from 1976 - 1986). In Nova Scotia the ratio increased from six beds per 1000 population in 1976 to seven beds per 1000 in 1982. By 1986, bed supply decreased to 6.6 beds per 1000 - a figure more in line with the national average of 6.7 beds per 1000, but well above the 4.5 acute care beds per 1000 population recommended by the Nova Scotia Council of Health in 1972. A second factor contributing to differences in hospital expenditure trends is the use made of hospital beds. Nova Scotia's occupancy rate of 75 percent for general hospital beds in 1986 is low compared to the national average of 84 per cent, although it is in line with those of other Atlantic provinces. This rate suggests a surplus of general hospital beds in the hospital system and an opportunity for re-allocating resources to other types of services (The Report of the Nova Scotia Royal Commission on Health Care: Towards a New Strategy, 1989, p.22).

In 1994 Michael Rachlis and Carol Kushner found that formulas for planning for hospital beds were getting very lean, "Now the provinces are talking about 'magic numbers' for their bed supply. Ontario is aiming for 3.5 acute-care hospital beds for every 1000

people. British Columbia has targeted 2.75 beds per 1000" (Rachlis, Kushner, 1994, p.239). The speed with which permanent staff have been laid-off and hospital beds have closed has created a severe crisis in the delivery of service in the health care system. This crisis did not exist a decade ago. The deficit reduction driven health reforms have simply added a new service crisis without addressing the underlying problems of a system driven by the medical model.[3]

The maxim of 'less is best' is being applied to publicly funded aspects of the Canadian health system. The privately funded system is expanding with the limits being set by what the 'market can bear.' The dilemma that faces the Canadian health care system, is how to manage the retreat of the public sector, without opening the whole system to the market forces that dominate the US system. As we have seen with the American system, cost savings to the private system do not result in increased funds for the public program, or in increased levels of service, but in increase margins of profit. With no public provision of service, cost savings in one part of the health care system have great difficulty in being redistributed to another part. As we have seen in Table 1.1 there have been savings to the system, but not much redirection has been possible. For example, it is not the responsibility of a hospital corporation to care for the needs of citizens who are not yet patients - so health promotion or public health initiatives are not seen as fiscal priorities. The link between poverty and illness is not one that can be addressed by an institution whose mandate is to treat people and get them through the system as soon as possible.

The methodology currently used by many of the managers with the public health care system relies on the corporate model. This is having a profound effect in two ways;

- the adoption of corporate ways of doing business;
- the contracting out to private companies, work that traditionally was done by institutional employees.

[3] The medical model focus on individual disease entities and presumes to 'fix' these entities in isolation from the whole biological organism.

The corporate agenda within the public health sector is in the management of services. The adoption of 'business principles' such as "if you can't measure it, you can't manage it" abound throughout the system. Mission statements of institutions are superseded by the 'business plan'. Accountability for decisions is fragmented, with more accountability resting on the shoulders of lower level workers, with none of the corresponding control being attributed. More and more areas of the public sector must find ways to 'pay for themselves'. Cost recovery is an important element of service provision. The lure of attracting funds from sources outside the single payer public insurance system is a recurring theme.

An example of this corporate mentality can be found in the Queen Elizabeth II Health Sciences Centre in Halifax. Nine institutions have been merged into one organization over the past few years: The Victoria General Hospital, the Camp Hill Hospital, The Infirmary, The Abby Lane Hospital along with Veterans Memorial, The Civic Hospital, The Rehab Center and the Cancer Treatment and Research Centre. The final phase of the consolidation took place in 1997 with the merging of the Infirmary and the Victoria General. With 6000 full time equivalent employees and a payroll of $230,000,000, this hospital corporation is the largest employer in the province and represents 38% of the health budget for Nova Scotia. The following is from Mission Possible, a public document containing information on the QEII's business plan:

> The QEII has identified over $47M in strategies that will effectively address our fiscal challenges, while preserving patient care programs. The price of achieving improved quality and reduced cost through the previously mentioned strategies will be felt in both dollars and employment. It is estimated that merge and operational efficiencies will result in the reduction of 500 positions over a four year period (1996/97 to 1999/2000). Labour adjustment strategies will include early retirement, voluntary reductions and the non-filling of vacant positions to lessen impact on job loss (QEII. 1996, p.34).

The bulk of these savings are coming from reducing staff and out-sourcing work. These are short term measures that do not take into account the role of the health care system to promote the 'physical and mental well-being of the residents of Canada,' to quote from

the Canada Health Act. The QEII as a major employer[4] has responsibilities to the workforce, to the surrounding community, as well as to the well-being of the total system. The savings that are incurred from this business plan are being off-loaded onto other segments of the health and social services system. The off-loaded services will be picked up by the private companies that are looking to expand their business.

Another example of questionable savings comes from the Nova Scotia Pharmacare program for seniors. This is managed through the Insured Programs Division of the Department of Health and is accountable to the Seniors' Pharmacare Board. Of the $82 million dollar cost to this program, 38 per cent was contributed by seniors through premiums and co-payments, to an amount of $31 million. The government expected that the senior's share would be fifty per cent. The premiums are $215 per person, based on a sliding scale for those seniors who receive the Guaranteed Income Supplement. The co-payment is 20% up to a maximum of $200. In December 1996 approximately 4500 of the province's seniors had not paid their premiums (Mail Star: 12 December 1996). By the middle of December the government declared that registering with the plan would be optional (Mail Star: 16 December: 1996).

Pharmaceuticals, especially prescription drugs, are an essential part of the health care system. Access to the appropriate medication is as 'medically necessary' as access to physician or hospital care. However, pharmaceutical drugs have not traditionally been seen as a part of the overall health system as have hospitals and physicians. They have developed outside the 'public good' part of the system and have been seen primarily as commodities to be traded at the highest price that the market will bear.

These two traditions, providing health care as part of the 'public good' and the profit making of the pharmaceutical companies have created a situation that has resulted in prescription drugs being excluded from comprehensive health plans and from health reform initiatives. A discussion of Pharmacare without an understanding of trends in the pharmaceutical industry would prove to be frustratingly circular.

[4] The QEII is the largest employer in Atlantic Canada, with 6,000 workers on staff (QEII, 1996).

Canada and the United States are the only countries in the G-7 that do not have a national drug plan, although this has been a recommendation of the National Forum on Health, 1997.

> The World Health Organization has urged member countries to develop and implement National Drug Policies (NDPs) and many countries have attempted to do so. Countries have addressed the issues in different ways, reflecting different contexts in each, and several have made substantial progress. However, there are also growing threats to progress, lost opportunities, and challenges. In many ways, the environment for progress has deteriorated due to intentional or unintentional changes in international and regional trade regimes, policies promoted by multilateral and international institutions, economic recession since the late 1980s and altered global pharmaceutical trends. The problems that are appearing as a result of these trends are shared by virtually all countries but are especially acute in the Third World (Hamrell, Nordberg, 1995, p.6).

Pharmaceutical drugs in Canada are regulated through the Federal Department of Health, through the Health Protection Brach and through legislation. In Nova Scotia the provincial drug policies have been geared towards seniors, those receiving a disability pension and through the Department of Social Services to citizens on social assistance. The Seniors program is the largest part of the drug policy and accounts for $82 million in 1996/97, about 7% of the provincial health budget. The cost of pharmaceutical drugs for the total population is estimated at 15% of health care expenditures - the same percentage for medical services.

There are a number of major issues facing the use of pharmaceutical drugs.

- Costs of over medication or inappropriate usage;
- pharmaceutical poisoning;
- cut backs in hospital coverage of drug costs;
- costs to the uninsured;
- cost of Bill C-91.[5]

Other issues include:

[5] Bill C-91 represents the act of the Canadian Parliament for the Patent Protection of Pharmaceuticals.

- the role of the corporate sector in regulating drug prices and drug development;
- the role of pharmaceutical companies in academic centres.

According to many studies, including the recently published Pharmacare Report (1996), Nova Scotia seniors take more prescription drugs than most other provinces. The over medication of seniors has been a concern to both advocacy groups and the Nova Scotia government since the Royal Commission Report, 1989. This over medication adds significantly to the costs of the system. Besides over medication there are other problems, such as not receiving the appropriate medication at the appropriate time and the failure to take the course of medication as directed. The following are two stories that illustrate the complex role that pharmaceutical drugs play in the medical care system.

> The first story concerns an elderly woman of 87 who suffers from arthritis. She is a very active woman and lives independently most of the year, but lives with her daughter's family during the winter months. One day in February 1997, she was very unwell and was admitted to hospital. The family was concerned as her condition did not improve, she had been unwell but alert. Now she was confused and incoherent. One of the factors causing her so much distress was her personal cleanliness. They requested that the Demerol medication be reduced and phased out, and that she be able to use a bed pan when necessary. The family was informed that the woman was senile and an adult diaper was necessary, the Demerol was necessary as she was causing a 'disturbance'. The patient in the other bed in the room, explained that the woman had constantly requested to use the bed pan and this was a cause of great irritation to the night staff. The family demanded that the Demerol be discontinued and hired a Licensed Practical Nurse to be with her at night to be able to ensure that she could use the bed pan. Once the Demerol was discontinued the woman was again lucid and less anxious (Family member, personal Communication, March 1997).

The second story concerns three women and the issue of anti-rejection drugs for transplant patients.

> On December 12, 1996. A CBC news report briefly told of a young woman from the US who had been one of the early, successful recipients of a heart transplant. Her recovery went very well and she was maintained in good health in part by the anti-rejection drugs that she took every day. Following her 19th birthday, she no longer qualified for Medicaid in the US. The anti-rejection drugs cost approximately $600 per month. By the age of 24 she could no longer afford to carry the debt accruing from the drug purchases. She stopped taking the rejection drugs - on December 11, 1996 she died - aged 24 (CBC Radio Morning News; December 12, 1996).

I told this story to the focus group I held with the Midwifery Coalition and said I thought this could not happen in Canada. The next two sections of this story come from Canada.

> A young woman in Ontario had to have a double lung transplant at the age of 24. She lives with her mother and as a dependent, she is covered by her parents' drug plan. Now at 28, she wants to be married, but she cannot as her husband-to-be does not have a health plan, and they cannot afford the anti-rejection drugs. Although her life expectancy is not very long, she cannot afford to be married (Conversation with woman's friend, Midwifery Coalition Focus Group, January 1997).

I thought about this and decided to ask a friend who had had a liver transplant about the coverage for her anti-rejection drugs.

> There are two drugs that she needs for her anti-rejection therapy, one is provided at the Clinic, the second one is covered by her husband's health plan. She presumes that the most expensive drug is being covered by the Clinic. The possibility that these drugs would not be covered was a cause of great concern to her. "Obviously they're covering the one that is the most expensive because most people would be very hard put to pay for it - there are a lot of people out there who do not have drug plans and may not have plans at all. But is it fair that they don't plan to carry this through to the end and supply the drugs until their dying days, is it fair to give them transplants?" (Interview with transplant recipient January 1997)

Too much, too little or wrong medications are costing the economy in many ways. So are the costs of drugs, costs of treatments to combat inappropriate drug usage, lost productivity due to ill health, and lost productivity for family care providers to care for those who become ill. Removing cost as a barrier to access to pharmaceutical drugs cannot happen in a vacuum, but has to be viewed as a tool within an integrated system of health care service delivery.

Pharmaceutical poisoning is another emerging problem of the health system. Mary Murray, chair of the Australian Department of Health's PHARM Committee, in Development Dialogue, states that similar problems exist in her country:

> In Western Australia, between 1981 and 1982, the rate of hospitalization due to therapeutic poisoning had doubled; the rate for those over 65 had more than doubled. Each year, an estimated 30,000 people were admitted to hospital due to medicine-related problems (1995, p.180).

Michael Rachlis and Carol Kushner have found the same pattern in Canada. They estimate that at least 3 per cent up to a possible 10 per cent of all hospital admissions among people over fifty are due to drug reactions.

> At least 200,000 illnesses among people over sixty-five are due to bad reactions to drugs that are often not needed . . . In an essay on adverse drug reactions and the elderly, it was estimated that 30,000 hip fractures in the United States every year are related to psychotropic drug use. They estimate that the annual direct cost for medical care alone totals $1 billion(US) (Rachlis, Kushner, 1994, p129).

Nova Scotia's prescribing practices are amongst the highest in the country. It can be deduced that with a hospital budget of $560 million we spend between $16.8 and 56 million dollars on care for over-prescribed drugs or complications from drug usage. This does not take into consideration the cost to the system for the under-prescribing of needed medications.

Rachlis and Kushner point out that the most under-prescribed drugs are those for high blood pressure. The Nova Scotia Health Survey 1995, states that of the twenty-two percent of Nova Scotians with high blood pressure, only a quarter had the condition under control with appropriate treatment. That could translate into 152,500 Nova Scotians with untreated or under treated high blood pressure—giving an increased risk to heart disease and stroke (The Nova Scotia Health Survey 1995).

There are two direct effects of hospital cut backs on the use of prescription drugs. One involves the early discharge of patients causing the hospital coverage of drugs to be off-loaded to the individual. This means that the costs are then up either by the private insurance company or out-of-pocket expenses. The second effect is the lack of coverage for routine drugs for patients who are entering hospital for treatment, resulting in patients bring in their own drugs for such chronic conditions as high blood pressure. This represents a shift of funds from hospital budgets to other budgets, that is to the Pharmacare program, the private insurer or from out-of-pocket expenses.

The National Forum on Health estimates that forty-four per cent of Canadians receive some form of coverage though public plans. These people are covered by private insurance, most often as part of employment benefit packages, but twelve percent of the

population has no coverage and will pay for all their pharmaceutical expenses. The public share of pharmaceutical coverage has grown over the past 5 years. However, not all prescription drugs are covered and each province has a variety of ways in which they list the drugs covered, and many have policies for the utilization of the cheaper alternative. For example, this trend has resulted in Reference Based Pricing in British Columbia.[6]

In most cases the public or private insurance plans have some form of premium or co-payment. It is worth noting that the premium payments by employers are usually reserved for full time employees, and these premiums give a tax advantage to the employer.

> The result is that private insurance is correlated with income, not with need. A survey in 1995 (CROP Council, 1995) found that 75% of Canadians earning more than $65,000 a year had private insurance, dropping to $68% in the range of $40-60,000, 42% in the $20-40,000 range and 7% below $20,000. Partly as a result, per capita out of pocket drug expenses of high income households are on average lower than those of lower income households, and much lower as a share of income (Lexchin, 1996 quoted: National Forum on Health, Canada Health Action, 1996 - Paper Directions for Pharmaceutical Policy in Canada, p.4).

According to a study by the Conference board of Canada, sixty-five percent to seventy-five percent of all claims to private health plans are for the purchase of drugs. Due to this increase in the usage of these benefits, many private insurance companies are looking for ways to reduce costs. Being included are such short term measures as cost-shifting to employees, as well as, long term measures for health education and more integration with both providers of health care and pharmaceutical companies. These long term measures are leading to the integration of large insurance companies, health management organizations and the pharmaceutical companies.[7] This is the trend in the United States (MacBride-King, 1995).

---

[6] Reference Based Pricing is a system under which drugs with different chemical compositions, but which respond to the same clinical problems can be assigned to a 'reference-class.' The lowest cost for each reference class is used as the base price paid for the prescription.

[7] In Nova Scotia there is already some integration of private management of health services. Maritime Medical Care has the contract with the Department of Health to manage Insured Professional Services. MMC operates the Blue Cross insurance for the Maritimes, manages the Pharmacare program and will be taking over a large share of the emergency response capability for the province.

The simple fact for those who are uninsured is that they do not get the drugs that they might need. The costs to the system for under utilization have been well documented. There are many stories of families, especially the working poor, who cannot fill prescriptions for themselves and their children. They have to make the choice between food and drugs. The second profound effect of this lack of coverage is the real fear felt by many recipients of social assistance of giving up welfare to take a minimum wage job and to lose their right to a Pharmacare card.

Bill C-91 is the Federal legislation that protects the rights of the patents for the pharmaceutical companies. This legislation enacted in 1992 overturned the policy of compulsory licensing of drugs, Bill C-22, with a 20 year patent protection for new drugs from the generic drug companies.

> Dr. Stephen Schondelmeyer estimated the cumulative cost of the legislation to be $3.6 to $7.3 billion in constant dollars by the year 2010. The $3.6B figure takes into account only the known products on the market when the legislation was passed. The $7.3B figure takes into account drug products that Dr. Schondelmeyer assumed would be introduced each year beginning in 1993. This analysis found that the annual cost of delaying the introduction of products that were on the market at the end of 1992 will continue to increase beyond the year 2000 (Queen's Health Policy Research Unit, 1996, p.3).

The Queen's Health Policy Research Unit, in its study on the impact of Bill C-91, concluded that if Canada was to return to the patent protection under the old Bill C-22[8] the health system would save between $6.0 - $9.4 billion. With 10 years protection the system would save between $4.1 and $6.5 billion. However, the patent protection was raised to 25 years, as is being requested by the Pharmaceutical Manufactures Association of Canada, the added cost to the system would be between $3.5 and $6.0 billion. Much has been written on the effects of this legislation and it is especially topical as 1997 is the year when there is a review of C-91. The battle is between the name brand pharmaceutical companies and the generic drug companies. Lost in the shuffle are the real and legitimate concerns of citizen advocacy groups that see the total commodification of the medication component of the health system as a threat to the development of an

---

[8] Under Bill C-22 the patent protection was seven years.

integrated system of health care delivery that is consistent with maximizing the health potential of all Canadians. Bill C-91 has had a profound effect on the development of a sustainable Pharmacare program and will continue to be a factor for the foreseeable future.

The ways in which the deficit reduction induced health reform initiatives have been managed, along with the resistance of the pharmaceutical industry to being governed by social policy, demonstrates the vulnerability of the health care system in Canada to private business. This private component is what makes the Canadian health system so vulnerable to the multilateral trade agreements. The corporate culture is the same, the managers of the publicly funded hospital corporations speak the same language and share the same culture as the mangers of the for-profit hospital corporations.

The synergy of the two systems will make them difficult to tell apart. Once it is difficult to articulate the difference between the US system and the Canadian system, it will become difficult to defend the Canadian system, a system that rations services on the basis of 'need,' as opposed to one that rations on 'ability to pay.' This is the most significant difference between the two systems.

In this brief review of the health systems in the United States and Canada, I have attempted to separate our similarities from our differences. Both systems are dominated by their payer structures and it is this that constitutes the greatest difference. Both systems are reliant on private health care providers for the provision of service. There has been a mix of for-profit and not-for-profit hospitals in the United States and primarily not-for profit hospitals in Canada. The Canadian system is based on access to services based on medical need and the US system is based on access to services based on the ability to pay. Both systems are looking for ways to restrain or ration utilization. The US model of rationing based on ability to pay is at odds with the universal nature of the

Canadian system. In Canada we must develop methods of rationing that are consistent with the Canada Health Act and the principles of Medicare.

National governments are responsible for national social programs, which are traditionally paid for from the general tax system. However, there is a global movement to limit the scope of national governments, to curb social programs and to promote the 'rights' of the individual and or the corporation to maximize profit at any cost. An understanding of these global movements is essential to understand the external pressures that are being exerted on the Canadian health care system.

What are the ideological tools of globalization and how do they impact on our health care delivery system?

Globalization can be defined as the framework within which the trans-national corporations can function to their fullest potential. It is necessary to understand that there has been a significant shift from an understanding of the trans-national corporation to an understanding of the global corporation. The language to describe the trans-national is limiting to its further development. The word 'national' indicates that at a variety of intersections there are relationships with nation-states. Between the company and the nation state there are beneficial agreements. The movement to an understanding of a global economy has the effect of removing the nation-state or national government from the equation. Therefore globalization supports the concept that resources will be managed on a global level by those corporations with the power to control the ownership of, and access to, resources. These resources include raw materials, production, labour, distribution and patterns of consumption.

> The world is experiencing a watershed economic transformation as great as the industrial and agricultural revolutions. It is characterized by the transfer of economic power from nation-states to giant trans-national corporations who operate outside of national law; the creation of huge trade blocs; and an emerging global workforce, in which workers everywhere directly compete with one another (Barlow, Robertson, 1994, p.62).

The economies of the trans-national corporations are significant in the world economy. Almost three-quarters of the world's nations have economies that are smaller than the leading forty-seven trans-nationals. From the World Investment Report 1993 we learn that one-third of the world's private-sector productive assets are controlled by the trans-national corporations and that 80% of the world's trade is conducted through the trans-nationals who control 80% of the world's cultivated lands for export crops (World Investment Report 1993). The threat from this globalization of the world's economy comes from the lack of political structures that can call these large organizations to account. They are accountable to no nation-state and relate only to people through their shareholders. The rights of a shareholder in no way resemble the right of a citizen.

> They seek a "world without borders," a euphemism for a tightly controlled corporate system in which they do not have to consider the effect of their actions or decisions on any country (Barlow, Robertson, 1994, p.62).

If Barlow and Robertson are correct and "government regulations that benefit the citizenry are a direct threat to trans-national growth and independence," then it benefits these corporations to encourage any policy decisions that decrease regulations that restrict production and trade, and increase the private sector control over resources. Therefore, one of the primary tasks of those acting in the interests of these corporations is to reduce the size and the influence of national governments. Since the 1980s there has been tremendous pressure put on all governments in Canada to downsize and privatize a majority of their functions. As an example of this in the summer of 1996, John Manley, Canadian Federal Minister for Industry, said to Mike McBain of the Canadian Health Coalition, "What you are seeing is the greatest demobilization of government since 1945" (Michael McBain, personal communication, October 1996).

World Trade Organization's (WTO) Director-General, Renato Ruggiero called on the international community to work together to promote global integration. In Korea on 15 April 1997 Ruggiero said, "It is our responsibility - governments, international organizations and the private sector alike - to deal with the reality of globalization in a cooperative and constructive way. We are confronted with the task of building a new global architecture. The challenge is not simply to design institutions to manage friction,

but to find ways to harness our collective powers to address broader global problems in a coherent and constructive way" (available at http://www.wto.org. Posted 15 April, 1997). This global architecture is built with the tools of the private sector. National institutions are an anathema in this privatizers' world.

In 1988 Oliver Letwin wrote Privatising the World, A Study of International Privatisation in Theory and Practice. This is a simple guide into the world of the privatization lobby.

> The international trend toward privatisation is much easier to describe than to explain. It cannot be fitted into the traditional picture of policy formation, which begins with agreed objectives and progresses through options to decisions, because in this case there is no single authority with a single set of objectives . . . The proponent of privatisation begins with the supposition that, all other things being equal, it is likely that the state will not be a good manager of any given commercial entity . . . The decision to privatise is made by politicians and administrators, not by businessmen or financiers - it is, in other words, made by people whose primary concern is with the role of government and the formation of public policy. One should not, therefore, be surprised that the wish to change the operation of government is frequently one of the main motives of a privatiser (Letwin, 1988, pp. 27-29).

Citizenship carries with it a set of rights and responsibilities. A small shareholder has no rights and no recourse against the large shareholders. In a democracy a citizen has the right to vote, and state ownership is an essential element in national control of resources. Why would national governments be willing to give up control of their resources? There are two answers to this question: one is the corporate 'carrot' and the other is the corporate 'stick.'

The carrot that the corporate class dangles before the government is an elegant invention, a simple answer to a government's complex reality. The rationale takes on missionary zeal—*'Therefore, privatize your publicly owned resources, production and services, reduce your workload, reduce taxation and let the 'invisible hand' of the market separate the 'good' from the 'bad', meanwhile the proceeds from these sales will reduce your national debt and the voters will be happy.'* Listen to John Redwood, a Member of Parliament in the Thatcher Government:

> The most difficult thing of all about privatisation is that it requires a cultural shift in government itself . . . It is extremely difficult in any government anywhere in the world to get something done quickly and well. The first challenge for a privatization programme is to break that mold. To do that you need to identify a small team of ministers and civil servants who are dedicated to the process and to appoint an adviser who will be the ruthless custodian of the timetable (Foreword in Letwin, 1988, p. xi).

There is a sense that the goals of the nation state and the goals of the trans-national corporation become one and the same. Renato Ruggiero, WTO Director-General goes one step further in insisting that the public must be educated to the global reality.

> The success of the multilateral system and the increasing globalization of the world economy make all the more important the need for all countries to maintain trade openness and firmly resist any domestic pressures aimed at going back to old practices of protectionism. It has been shown on many occasions that trade restrictions are not the right answer to domestic problems such as trade deficits. We must all help the public in all countries understand that measures which may unduly restrict trade will also restrict their own prospects for employment and growth, and may also affect the multilateral trading system which has been fundamental in economic success (Renato Ruggiero, Korea, 15 April 1997, archived at http://www.wto.org).

The 'carrot' trades in illusive promises, but governments who do not listen are reminded of the stick.

The corporate 'stick' is based on intimidation. *We can bankrupt your economy, lower your credit rating, transfer your wealth, close your plants, lay off your citizens, and if you are really unhelpful we can send in our troops and destroy your land.* The instruments of this intimidation are the international institutions that were set up to add stability to the global economy: the International Monetary Fund, the World Bank and the trans-national trading agreements such as the North American Free Trade Agreement (NAFTA). To date these instruments are used to keep underdeveloped countries under control, countries like Jamaica under Michael Manley,[9] the Cuban boycott and now the Helms-Burton Agreement, the Falklands war, the Iraq war, Shell imperialism in Nigeria, the list goes on. In countries like Canada the tactics are more subtle - the

[9] Under Prime Minister Michael Manley the Jamaican economy was ruined by the bauxite industry and the IMF.

harmonization of the national economy with the corporate agenda. The following is a series of quotations from Barlow and Robertson 1994:

> Canada is experiencing an unprecedented corporate-led assault on the sense of collective responsibility upon which the country was founded . . . Increasingly, we are adopting the American definition of welfare as charity for those unable to make it in a system that goes largely unquestioned, and moving away from our traditional view of welfare as a protection for the community as a whole. We are becoming a harder people, less compassionate about the unemployed, less responsible to one another (Barlow, Robertson, 1994, pp. 94-97).

The Canadian health system with its network of private providers is vulnerable to the pressures of the market place, in ways that are more threatening than a system with a tradition of public provision of services. The Canadian proximity to the United States coupled with the trends to 'harmonization' of trade and investment practices increases this vulnerability. The following is a discussion of the synergistic relationship between the private sector and the multinational movement.

The jump from privatization to globalization is a simple matter of arithmetic. The private sector actor with the most resources can outmaneuver the smaller actor. This is done through mergers and takeovers, or in the cases of the small operators, left to 'the invisible hand' of the market. In Privatizing the World, Letwin gives nine reasons to privatize. He sees these as the basis of arguments that any government will use - at different times and in a differing order.

1. The effect on the nature of government
2. The effect on operational efficiency
3. The effect on fiscal deficits and national debt
4. The effect on subsidies and distortions
5. The effect on regulation and deregulation
6. The attraction of overseas capital
7. The effect on the domestic capital market
8. The effect on employee involvement
9. The effect on the social and political landscapes.

These arguments will also be used by lobby groups to entice a national government to adopt a pro-privatization policy. Herschel Hardin, in the Privatization Putsch (1988), explains how the ideological argument works.

- Sell off publicly owned companies to reduce the amount of public money used to support them - the Invisible Hand of the Market will sort out the winners from the losers. The large corporations win over the small local or national companies.
- Use the capital from the sale to reduce the national debt. Pay back the international investment firms and banks.
- Free up industry from the constraints of government to grow in an invigorating environment of competition and the rules of the free market. Reduce regulations that support such concepts as safety, efficacy and appropriateness.

The agents of change for the global corporations are the treaty organizations, the World Trade Organization, the Organization for Economic Community Development, the International Monetary Fund and the World Bank. The most powerful tools available to the trans-national corporations are controlled by their allies at the International Monetary Fund, the World Bank and the World Trade Organization. These organizations are the equivalent of the United Nations for trans-national integration.

Understanding the impact of trade agreements on the Canadian health care system is important, because they have changed the economic environment within which national social systems exist. The critical point is that once the provision for publicly funding a universal health care system is removed, health care will cease to be 'in the public good'[10] and will revert to the status of any other service commodity. The ability for a national government to remove a sector from the private sphere to the public sphere will be non-existent.

The Canadian social sector is particularly vulnerable through the intersection of three trade agreements: the Agreement on Internal Trade; The North American Free Trade

[10] The phrase "in the public good' is a legal term that seeks to define those government programs which are established for the general well being of the citizens.

Agreement and the Multilateral Investment Agreement. This vulnerability is due to the particular nature of the Canadian health care system. Unlike other OECD countries, Canada's universal health care system is based on a system of public insurance. This is the single-payer system. The providers of health care services do not form part of the public sector, but are rooted in the private sector. Traditionally, the health care institutions, such as hospitals and nursing services have been non-profit private sector organizations. Medical care is contracted out to individual physicians on a fee-for-service basis. The for-profit sector encompasses companies that provide ancillary services, such as security, nutrition, cleaning, diagnostic testing and materials management. The most powerful for-profit sector within the medical-industrial complex in Canada is the pharmaceutical corporations.

Table 1.2
Public-Private Split in Health Care in the G7

	Financing and Provision	Exclusions in Social Insurance
Canada	Financed mainly by taxation. Mainly Private providers.	Sanatoria, out of hospital dental care, non-hospital drugs (some exceptions for seniors), varying degrees for prostheses, spectacles, hearing aids, and treatment in private hospitals
France	Financed mainly by social insurance. Mixed public and private providers.	Spectacles, dentures and replacement dental treatment.
Germany	Financed mainly by social insurance. Mixed public and private providers	Virtually none
Japan	Financed mainly by social insurance. Mixed public and private providers	innoculation, health check-ups, private rooms, eyeglasses and health promotion activities for the elderly
Italy	Financed mainly by social insurance. Mixed public and private providers	Virtually none
United Kingdom	Financed mainly by taxation. Mainly public providers.	Dental care and optical care (except low income groups) low cost pharmaceuticals
United States	Financed mainly by voluntary insurance. Mainly private providers	Medicare (Parts A and B) exclude long-term home care, out-patient pharmaceuticals, routine eye care and dental treatment.

Source: adapted from OECD Policy Study No.5 (1994b.p1) and OECD Policy Study No.7 (1995b). Table 17, from Arthur Stewart, Crossing the Rubicon, 1996

The Canadian health services delivery system has far more in common with the system in the United States than with other G-7 countries. Table 1.2 illustrates these differences.

There are two effects that result from this reliance on the private sector. First, the reliance on the private sector for provision of health care services is resulting in a clash of managerial cultures. The rationale for the provision of these services and the stated outcomes are not the same. The private sector is dominated by large health corporations that operate within the broader context of the corporate world. The corporate reality is to streamline production and offer a range of services based on high production, low cost and uniformity of nature. The culture is unable to accommodate variety and diversity or to respond to variables that are outside its narrow focus. Second, the corporate world has become global in focus. The new structures that support globalization are rapidly consolidating the control mechanisms to ensure trade and investment liberalization and protection of property rights, both locational and intellectual. These control mechanisms are based on agreements that require national governments to give equal access to their markets to any corporation. Protectionist practices based on local requirements or interests are seen as violations of the agreements and sent to international dispute resolution bodies for adjudication. The net effect of these agreements will be to discourage decisions based on local requirements.

There are currently three trade agreements that can have profound effects on the health care system. Together they create a global culture that will make individual pro-national social programs very vulnerable to private sector incursions. The agreements are The Agreement on Internal Trade, the North American Free Trade Agreement, and The Multilateral Investment Agreement.

The Agreement on Internal Trade (AIT) in and of itself is a simple mechanism for increased free movement of commercial and industrial trade between the Canadian provinces and territories. This free movement will enable economies of scale to be developed to increase the efficiency of production, distribution and consumption. Within the AIT the special provisions for the protection of the social sector would be withdrawn. That means that non-provincially based companies and interests can compete with provincially based companies and interests for the provision of services. Within the

Canadian economy the unilateral effect of this agreement would be the increased centralization of resources, with increased marginalization of opportunity as one moves further from the centre.

The second agreement that impacts on the Canadian health system is the North American Free Trade Agreement. The NAFTA seeks to open the markets for increased commercial, industrial and trade opportunities across North America, including Canada, the United States and Mexico. The provisions of the NAFTA are such that no national or sub-national government can discriminate against any company that has the right to do business within this trading bloc. The NAFTA does have a mechanism to protect services categorized as 'for the public purpose.' These include health, social services and education. However, there is no definition of the phrase 'public purpose' in the agreement. Without a clear definition any treaty challenge will go to a trilateral dispute resolution mechanism for adjudication.

> [Prof. Bryan Schwartz][11] confirmed that NAFTA is full of gray areas. He concluded that these gray areas will likely encourage US providers to put political and economic pressure on Canada to open up large areas of the health care sector. A clear conflict of interpretation exists between Canada and the US on the meaning of "a public purpose." A case is bound to be referred to a dispute-settling panel. One of the parties will win, and one will lose (Canadian Health Coalition, 1996b, p.3).

In his legal opinion, Bryan Schwartz outlines the ways in which the international trade treaties - NAFTA (North American Free Trade Agreement) and GATS (General Agreement on Trade in Services)[12] will limit Canada's sovereignty over internal decision making.

> To the extent that NAFTA applies to the health sector, it would permit for-profit US enterprises to enter and operate in Canada. Annex II of NAFTA shields health care from the full force of NAFTA, but only to the extent that "it is a social service" that is maintained or provided "for a public purpose." Annex II probably protects physician care that is covered by provincial health plans. But if a province permits even a few Canadian doctors to operate outside of the publicly-

[11] Prof. Bryan Schwartz is a professor of international law at the University of Manitoba.

[12] The GATS is now operated under the World Trade Organization WTO.

> funded insurance plans, the door may be open for US enterprises to enter in large numbers and manage clinics on a purely commercial basis. (Schwartz, 1996, p.1)

The AIT opens trade across Canada, and the removal of provincial protection for the social sector makes this sector vulnerable to a treaty challenge from the NAFTA. Schwartz explains that under GATS counties must accord 'national treatment' to foreign individuals and companies in the areas that the country chooses to list. Under NAFTA the national government must provide access under its regulations, unless the sectors are exempt by 'reservations.' These 'best treatment' clauses are contained in Articles 1202 and 1203 of the NAFTA.

> The proposed changes to the AIT could result in a weakening of Canada's health and social service reservations made under the NAFTA. This could lead to immediate demands by American and Mexican interests seeking access to Canada's protected health and social service markets (Appleton, 1996, p.2).

The third agreement is the Multilateral Investment Agreement (MIA). This is a landmark agreement that seeks to re-define the rules and compliance measures for foreign investment and trade. The vision of both the World Trade Organization and the Organization for Economic Community Development these two international organizations is to harmonize the relationships between their organizations and the World Bank. The need to liberalize trade and investment agreements in order to facilitate the free movement of capital and trade between borders is seen as essential to the continued growth of the global economy. This new agreement will change the rules for corporate ownership and minimize the role of national governments to intervene on behalf of their own interests. Information on this agreement can be found on the Web sites of both the WTO and the OECD. This agreement has not generated much public attention. The following was posted in March by Victor Menotti, on a list server managed by Bob Olsen.

> The treaty would give trans-national corporations expansive new rights and powers and burden nations with new obligations owed to corporations. It would require nations to give foreign investors access to all economic sectors. It would abolish the power of citizens and governments to control the entry, conditions, behavior, and operations of trans-national companies in their country. This right is especially vital for developing countries as it would effectively close the possibility of domestic capacity building . . . The International Forum on

> Globalization, a group of eminent economists and leading social and environmental activists which met in San Francisco to review the proposed treaty, calls on governments of the world to reject this treaty and asks concerned citizens to spread the word about its harmful potential impacts on their communities (posting on 4 March, 1997 from bobolsen@ARCOS.org).

This agreement is being managed by the WTO and the OECD and will be signed by their member countries. This agreement seeks to officially link trade with investment. That is, the right of a corporation to trade is linked to the rights to invest. This convergence of multilateral interests in trade and investment requires member national governments to comply with regulatory mechanisms that remove protectionist barriers for the free movement of capital and resources. At the same time they protect the property rights of non-national interests. This agreement has the ability to create the kind of 'nurturing' environment that will encourage the rapid globalization of capital and resources. It removes the ability of national and sub-national governments to make decisions based on local requirements and requires that the interests and property rights of the non-national companies have prior rights over those of the local economies.

Through the interplay of these three agreements, it will be increasingly difficult for national and provincial governments to change the 'rules of the game' or to adjust these trade rules to benefit local requirements. The health care system, that is the responsibility of the provincial governments, under the umbrella of the Canada Health Act, will face strong pressures to increase the 'flexibility' of their funding mechanism. These pressures will be held at bay by the interpretation of the phrase 'for the common good,' as long as the single-funding system supports the principles of Medicare. Given that Canada has no tradition of direct service provision through the public sector, any such future incursion by the public sector to provide services could be seen to violate these agreements, sending them to an international forum for settlement.

Bryan Schwartz argues that once foreign providers of health services are operational in Canada, public health policy becomes compromised. It will be increasingly difficult to offer programs or services that are provided by the public sector, and nationalizing any part of the health system will be impossible. NAFTA requires that any changes that adversely affect the private operators will be compensated by the

offending government. Barry Appleton[13] agrees, "In the attempt to reduce barriers to trade globally and domestically, Canada may find itself in conflict with its efforts to maintain its distinctive health service and social service sectors. Canada's international agreements give certain rights to foreign bodies operating in Canada. Canada cannot unilaterally alter these rights. Once foreign bodies are allowed into the Canadian marketplace, it becomes difficult to place restrictions or control on their operations"(Appleton, 1996, p.12). The Canadian health system will be in need of protection from those corporations who control 80% of the global economy.

Heather Menzies in Who's Brave New World cautions us:

> Public governance and regulation are being replaced by market, corporate and corporatist regulation in everything from communication and information highway policy to foreign affairs. A joint Senate-House of Commons report on Canadian Foreign policy began by stating: "Globalization is erasing time and space, making borders porous and encouraging continental integration. In the process national sovereignty is being reshaped and the power of national governments to control events, reduced"(Menzies, 1994, p.41).

Who won the 'Cold War' and why the answer profoundly affects our health care delivery system

The question, "Who won the Cold War?" is one of vital importance. Victory and defeat are concepts that seem to be relatively clear. In a sporting event there are published rules, adjudication, a defined space and time and recognizable contestants. Given all these factors we can determine the winners from the losers. In politics, as in war, none of these factors appear clearly defined. Their definitions come following the crisis and are written by the perceived 'winners'. Sometimes the true 'winners' are sidelined and other forces claim the victory. Public health is an example of this; the medical profession takes full credit for the decline in the mortality and morbidity rates in developed countries during this century. The reality is that clean water, effective sanitation, nutritious food and access to a living wage have had and continue to have the most profound effect on human health.

---

[13] Mr. Appleton is the Managing Partner of Appleton & Associates International Lawyers.

> While access to health care is a valuable privilege, it would appear that other aspects of the health/socio-economic relationship need to be manipulated in order to engender desirable improvements in longevity, namely, the social environment of the poor, lifestyle tendencies, health attitudes and health behaviours. (Bolaria and Dickinson (Eds.) 1994, Trovato p.52)

According to such diverse authors as the RAND Corporation's Francis Fukuyama and Toronto Star columnist Richard Gwyn, the United States easily defeated the Soviet Union in the Cold War. Who in the United States defeated the Soviet Union, was it free-enterprise, was it the huge industrial-military complex, was it purity of ideology?

In his book The End of History and The Last Man, Fukuyama triumphantly announces that capitalism has defeated communism. In Nationalism Without Walls, Gwyn is less enthusiastic, "The United States while winning the Cold War, crossed the finishing line badly winded." John Kenneth Galbraith in The Good Society, sees the end of the Cold War as the defeat of post colonial imperialism, the super battle of the superpowers for control of the developing nations:

> There was the hope in the Soviet Union and the paranoiac fear in the United States that the less developed lands of the planet would make Communism, not capitalism, their approved choice. The extension of superpower influence to the new and poorer nations was thus seen as the new form of imperialism . . . The breakup of the Soviet Union, the downfall of Communism and the end of the Cold War brought this rule of error to an end (Galbraith, 1996, p.127).

Henry Mintzberg, of McGill University, recently wrote in the Harvard Business Review:

> Capitalism did not triumph at all, balance did. We in the west have been living in balanced societies with strong private sectors, strong public sectors and great strength of the sectors in between . . . The belief that capitalism has triumphed is now throwing the societies of the West out of balance, especially the United Kingdom and the United States (Mintzberg, 1996, p.75).

With so many diverse opinions on the issue, I think it is fair to say that outside the industrial-military complex, there are few who support the idea that the US's military might won the war. In fact the end of the Cold War, according to Galbraith, had no effect at all on the burgeoning budgets of the military establishment, "the end of the Cold War was an impressive fact; it did not affect the continuing claim of the military establishment on money and the executive and legislative support that provides it" (Galbraith, 1996,

p.99). The amount of ideological and national energy that has gone into defining the United States as the world defenders against Communism, may come back to haunt them. The end of the Cold War may have marked the end of the ideologically expressed 'nation-state'. According to Thomas Naylor, an economist at Duke University, "Our nation is no longer manageable. The time has come for both individual states and the federal government to begin planning the rational downsizing of America" (Quoted in Gwyn, 1995, p.116). But the potential dissolution of the US is not our main concern at this time.

Fukuyama claims capitalism downed communism. Mintzberg says that is preposterous. Galbraith seeks to define capitalism:

> Capitalism in its original eighteenth and nineteenth-century design was a cruel system, which would not have survived the social tension and the revolutionary attitudes it inspired had these not been a softening, ameliorating response from the state. In recent times there has everywhere been strident oratory, from those in personally comfortable economic positions or addressed to those so favoured, that has regretted and condemned the modern welfare state; those so speaking would not now be enjoying a pleasant life in its absence. (Galbraith, 1996, p.113)

Fukuyama, in his assertion that capitalism has won, denies the links between the two following models of statehood, the liberal democratic state and the social welfare state:

> A generation or more ago, there would have been a broad consensus, among social scientists, of a largely one-way causal relationship between poverty and family breakdown, flowing from the former to the latter. Today people are much less certain, and few believe that the problems of the contemporary American family can be fixed simply through the equalization of incomes. It is easy to see how government policies can encourage the breakdown of families, as when they subsidize single motherhood; what is less obvious is how government policy can restore family structure once it has been broken . . . A liberal state is ultimately a limited state, with government activity strictly bounded by a sphere of individual liberty (Fukuyama, 1995, pp.353-357).

Mintzberg states that balance not capitalism is the true winner. Balance describes the pluralist democracies that have developed in Western nations during this century. This balance recognizes the coexistence between the energy of the free market and the social conscience of the welfare state:

> Let us not forget that the object of democracy is a free people, not free institutions. In short, we would do well to scrutinize carefully the balance in our societies now, before capitalism really does triumph (Mintzberg, 1996, p.83).

James Coleman, in his book, The Asymmetric Society (1982), examines four types of political systems: Divine Right, Genossenschaftstheorie, Soviet State, and Pluralistic Democracy. State socialism is here defined in ways that are very compatible with the philosophy of Rousseau, that all sovereignty resides with the natural people who through a social contract give this power to a central state apparatus, and from that apparatus they will receive all other corporate functions. In pluralist democracies, sovereignty originates with natural persons. Only a portion of this sovereignty is transmitted to the central state; other functions are transmitted to other corporate actors. The central state operates in a way that allows for the natural person to exercise some control over the other corporations, i.e., in government agencies such as health and safety standards legislation, enforceable labour and benefits codes, environmental protection. Coleman states that there is a drift of power within the socialist state back to the people. He gives the example of the Solidarity movement in Poland as an example. Also there is a drift towards more state control within a pluralistic democracy, given the increase in state regulations as an example. The drift in pluralistic democracies to more state control is being met with vigorous opposition. This is seen in the US with the defeat of the Equal Rights Amendment (ERA), the inability of governments to enforce environmental protection laws. The final example is that of the failure of Clinton's national health care system initiative.

Coleman makes a very interesting point when he looks at the similarity between the system that runs a large corporation and the systems that run state socialism. However, it is interesting that since The Asymmetric Society was written the Cold War is over and state socialism has collapsed in the most dramatic fashion. The neo-corporate model seems more likely to succeed in the USSR than an evolution to a pluralistic democracy. The question to ponder is, "Is our own system on the brink of an equally dramatic collapse? Are the rights and the responsibilities of the natural people

who are living within our democratic nation states being undermined by the multinational corporations and their authority structures?

We know that military power did not win the Cold War. The question is, did the success of our Western pluralistic democracies win over the ridged totalitarianism of the Soviet State, or did corporate capitalism subsume the ideological importance of socialism? The question is not to be answered for its own sake, but the future of our pluralistic democracy rests on the perceptions our leaders have of who has won. If they believe that our pluralistic democratic system has won an ideological battle, then we retain an understanding that the state plays a valid and vital role in the development of the well-being of its citizens. Social programs such as Old Age Security, Disability Pensions, Unemployment Insurance, Child Care, education and training opportunities and the development of a universal health care system are all possible.

If they believe that corporate capitalism has subsumed this ideological battle, then we are in grave danger, for corporate capitalism does not need the nation state, corporate capitalism does not recognize citizenship, corporate capitalism will need to subsume our pluralistic democratic system - and the battles will be fought by corporate takeovers of the services provided by governments. The citizen will have been made redundant and the role subsumed by the 'consumer'. Each individual will have to compete in the marketplace for available services and for available resources. Social programs will be seen as softening the population when the rule of 'survival of the fittest' prevails.

> The long-standing political assumptions of the Cold War have become irrelevant and North-South relations, dominated so often in the past by unnecessary polarization and a dialogue of the deaf, have changed irrevocably. From the perspective of the multilateral trading system, we now face a dual task of extending the reach of the system geographically to make it truly global, and of ensuring that it remains effective in the face of growing complexity in international economic relations (Ruggiero, 1995, archived at http://www.wto.org).[14]

[14] Mr. Renato Ruggiero, WTO Director-General, 16 October, 1995 in the Paul-Henri Spaak Lecture at Harvard University, Boston, USA.

For the WTO the era of globalization has arrived and it is the 'duty' of all governments to provide a 'nurturing' environment for the expansion of global economies.

We can hear the war cries calling for the end of government, for the establishment of 'virtual' governments, of downsizing of the federal and provincial service sectors. The collapse of our democracies will be as sudden and as dramatic as the fall of the Berlin Wall. But this need not happen - for those who hear the war cries can respond, as Coleman suggests,

> Unless we begin to direct ourselves to the question of what kinds of social structures we are inventing and thereby coming to inhabit, we may permit social structures that are very difficult to change - because once an actor is in existence it has strong interests in survival, and will direct its resources toward that survival (Coleman, 1982, p.29).

Discussion

Trans-national corporations exist in a 'virtual' world. They create structures and laws onto themselves. Without accountability to any one nation state, the trans-national corporation exists within a 'fourth' dimension that has profound effects on the rest of the world, but is immune to the effects of this world. Flexibility is an essential element of the emerging structure of the trans-national. In the eyes of the World Trade Organization globalization has arrived. The drive to reduce national government interference in the free-flowing activities of the global corporations is being reinforced by new multilateral trade and investment agreements. In the three dimensional world that is occupied by national governments and their citizens, there are some constants that are required to provide essential services. These essential services include: a health care system, an educational system and a system of income security. People within a democratic nation state are citizens. They can be workers, home-makers, entrepreneurs, pensioners, students, children, the 'idle rich' or the 'indigent poor'. However, they are not labour commodities to be hired or discarded by a corporate whim.

Through the constancy of the social service programs, nation states have developed systems of wealth distribution. Trans-national corporations have no mandate to distribute wealth. The coalescing of wealth is the goal. Acquisition of resources, control of resources and their systems of acquisition and the amassing of wealth are the

goals. The tools for this acquisition are developed through the use of power that the control of resources gives the corporation. The challenge that faces the leaders of national states today is in resisting the allure of the power and control of these virtual organisms. However, the pressure for these leaders to create their own 'virtual' government structures has blinded them to the possibility that they are the masters of their own future insignificance.

Trends in health and social spending have been part of the governmental responsibilities of most developed countries for the past century. These services have undergone cycles of decline and rebuilding. Health care discussions have not been confined to the last 20 years of this century. In most Western countries some form of health and social program has been instituted. Canada was no exception. Publicly funded and administered health care insurance programs were introduced across the land with the Hospital and Diagnostic Act (1957) and the Medical Services Act (1966), with all provinces administering Medicare by 1971. The Canada Health Act was proclaimed in 1984. Table 1.3 uses three indicators to compare Canada to other countries according to the amount each spends on social programs, as a percentage of GDP. Universality and accessibility are key to most systems in the other G-7 countries.

Table 1.3
Comparison of Public Spending in the Social Sector as % of GDP

	Health	Income Security 1	Education 2
Canada	7.4	11.9	7.1
France	7.3	20.5	5.5
Germany	6.0	16.8	4.1
Italy	6.2	18.5	5.1
Netherlands	6.8	23.0	5.6
Sweden	6.2	26.3	7.5
United Kingdom	5.9	18.5	5.1
United States	6.2 (7.4)	9.4	5.3

Source: 1993 OECD data with exception noted below.

1. *1990 expenditures on pensions, unemployment benefits and other income support schemes*

2. *1991-1992 expenditures on all levels of education. 3. Including tax expenditures re: private insurance.*

Quoted from National Forum on Health Dialogue 1996

These countries have a variety of systems that mix both public and private financing, and provision of services by both public and private providers; the exceptions are the US and Canada. (McCarthy, Rees, 1992).

As health care becomes seen more and more as a commodity there will be more demand for private access to the quick-fix medical services. Jane Coutts, health policy reporter, spoke with Derek Smith, the executive director of King's College Hospital in London, UK. Mr. Smith outlines the kinds of procedures that are most commonly accessed though the private system:

> Mr. Smith says, there's the fact that private insurers don't like to pay for expensive kinds of care that are actually the bulk of the work hospitals do -- things like caring for people with chronic diseases or AIDS. Cream-skimming, as health economists call it, is a feature of most private systems: they concentrate on high-profit, quick-turnover surgery, such as cataract, joint replacement or coronary-artery bypass operations, leaving difficult, long-term, expensive care -- often the diseases with which the very poorest in society are most affected, such as diabetes -- to the public system (Globe and Mail, B1, June 24, 1997).

Increased access to private funding and private health care facilities does not reduce the pressure on the public system, as the high cost chronically ill patient remains within the public system. It has been demonstrated in the UK and the US there is no direct correlation between a decline in public spending and increased appropriate utilization of services. Different populations utilize different services, and ability to pay affects the ability of these populations to access services equitably.

The health care system in Canada developed as an integral part of the overall mix of programs that became our social safety net. While we spend more of our GDP on health care services than other G-7 countries, except for the US, we do have a universally accessible program for health care delivery. However, we spend less of our GDP on combined social programs than many of the G-7 nations, except for the US. The Health Care system in the United States developed to meet the needs of the middle-class and the elite and became one of the most profitable sectors of the economy. The poor and the elderly receive the care that is designed to discourage any 'indigent' behaviour. The US spends more of its GDP on health care delivery than any other country. However, there

are approximately seventy million Americans who are uninsured or under insured for health care. The US spends the least on its mix of social services of all G7 countries except for Japan (Rachlis, Kushner, 1994).

There is a decline in the public share of health care spending. Table 1.4 shows this trend. Again the exception is the United States. This is due to the expenses incurred through the use of the private system of providers and the increasing costs of private for-profit insurance coverage (Purchase, 1996).

Table 1.4
Public share in total health spending in the G-7, 1975-1992 (%)

	1975	1980	1985	1990	1992
Canada	76.4	74.7	74.7	73.1	72.2
France	77.2	78.8	76.9	74.5	74.7
Germany	77.2	75.0	73.6	71.8	71.5
Italy	86.1	81.1	77.1	77.8	75.2
Japan	72.0	70.8	72.7	70.8	71.2
United Kingdom	91.1	89.6	86.3	84.4	84.4
United States (Including tax exemptions for employer contributions)	41.5 (49.5)	42.0 (50.2)	41.4 (49.4)	42.2 (50.2)	45.7 (53.7)

(Source: adapted from OECD Health Policy Study No 7 1995. Table 3: From Health Canada figures, Arthur Stewart has calculated that public funding of health costs in Canada had dropped to 71.8% by 1994 and continued to decline. (Quoted from Stewart, 1996)

The United States with its expensive and inefficient system of health care delivery is still used as a benchmark. While it is not an attractive model from a social welfare perspective, it is very attractive for private enterprise.

> The USA is frequently used as a comparison country, particularly because of its leading economic position. Yet the USA health system is markedly different from those in the EC (European Community) countries. For example, most European countries showed a rising pattern of expenditure on health care (indicated by the percentage of GNP spent) during the 1970s and a flattening in the 1980s. In contrast the proportion of GNP spending on health care in the USA in the 1980s continued to rise. The small proportion, around 40%, of health care expenditure that comes from public sector funds in the USA is in marked contrast to the

> European average of around 80% . . . In financing health care, a system dominated by private medical practice, 35 million Americans - about one in six people - have no health insurance or protection against medical expenses (McCarthy, Rees, 1992, p.76).

The flip side of the coin of decreased public funding is the increasing levels of private spending for health care services. Where the services are profitable the utilization rates are rising. The medical-industrial complex is the fastest growing economy in the United States, outstripping the growth in the industrial sector by three to one (Lexchin, 1996). This growth is controlled by fully integrated trans-national corporations, including the insurance companies, pharmaceutical companies and the managed care organizations (Starr, 1982: Sherrill, 1995).

The ideology that will protect the Canadian health care system comes from an understanding of how this program, designed for the public purpose, is part of the overall social fabric. It is a structure that ensures each citizen the opportunity to reach his or her full potential. This means that the social programs for Canada cannot become trading chips in the negotiations between Departments of Trade, Industry or Foreign Affairs.

Chapter Two
Theoretical Framework

The thesis seeks to understand how those persons who influence health policy perceive the role of increased private sector involvement in health care service. The analysis has two objectives, to understand the changing environment within which the health system operates, and to understand the underlying perceptions of those who influence public policy.

The theoretical framework is a pastiche of ideas from the following thinkers: Umberto Eco's (1987) understanding of crisis; James Coleman's (1982) analysis of the asymmetric society; Paul Starr (1982), Pat Armstrong and Hugh Armstrong's (1996) work on the corporatisation of medicine and the reprivatization of the household; Greg Stoddart's and Roberta Labelle's critique of the privatization of financial responsibility for health services (1985); Henry Mintzberg's (1996) discussion of managing government and governing management; John McKnight's (1993) action-oriented work with communities after the withdrawal of both the state and the commercial-industrial complex; Marshall McLuhan's (1980) ideas on the speed of change; Heather Menzies'(1996) analysis of 'social Tayoralism', the fragmentation of work and its effect on workers and families. Finally, Trevor Hancock's (1993) Mandala for Health model influensed my thinking.

We hear constantly of the crisis in health care. We are told that we live in a rapidly changing world and the price for this speed of change will be paid by those not able to keep pace. Technology has made it possible for our senses to be bombarded daily with messages that are based on assumptions which we are asked to believe are correct. While different political organizations have variations of policy, the drift of political decisions is remarkably consistent - big government is bad, big business is good.

Umberto Eco defines crisis as "a moment of transition in which something that held before doesn't hold any longer and there is not yet something new" (Eco, 1987 p.12).

These moments are not unique to our time. However, it is our response to this accelerated 'rhythm' of crisis that is the problem. The real social and cultural crisis is due to the fact that the culture of this time is unable to accept this challenge (Eco,1987).

In The Asymmetric Society (1982), James Coleman gives the example of the fate of the villages in the Andes following the fall of the Inca. Villages had been held together by the structural integrity of trade and communications of the Inca Empire, and when this failed the villages became isolated, poor and vulnerable to the new social structure of European invasion and colonialism. The villages, as essential elements of the structure of the empire, had become obsolete within the structure of colonial Spain. Similarly, our structures are changing. For example, we are being placed in a situation where the evaluation of health outcomes used to be based on such concepts as health status, prosperity and equity of our population. These are rapidly being replaced by evaluations based on TQMs (Total Quality Management) that look at measurement outcomes for each fragmented piece of work or system. The contradictory nature of the TQM system is outlined by Pat and Hugh Armstrong in Wasting Away (1996).

> Measurement based on the transformation of work into numbers necessarily involves at least the conceptual fragmentation of tasks into discrete units that can be counted. It is much more suited to Taylorist approaches to work organization than to the theories that argue for multiskills, an educated workforce, and integrated processes (Armstrong and Armstrong, 1996, p.123).

Henry Mintzberg speaks of the myth of measurement. The change of focus for outcomes has a profound effect on the ability to address the stated goals of the system. With the structure in place for a TQM evaluative process, it will become easier to change the goals of the system. The old structure that supported the wider goals of the old social system has become obsolete.

Given the crisis, the speed of change, the bombardment of technological messages, the inevitability of political decisions that seem to have nothing to do with stated program objectives and everything to do with the withdrawal of the welfare state, I took Umberto Eco's advice and stepped aside from the debate.

> Sometimes the role of the philosopher, of the sociologist, is to say 'in this moment there is no global answer to that problem because the answers you present as

> global were not such', that doesn't mean that there is no political answer, no local intervention . . . I believe that at a certain point it can sometimes - not always, not regularly - be a political duty to say 'I refuse this political discourse because it's false. Don't try to involve me in these games.' (Eco,1987, p. 19).

The task is to understand the structure within which the health care system is trying to survive, and to ask questions that can lead to an understanding of how to reposition the 'goal posts' of the health care system to address the WHO definition of health written in 1986.

> Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members (Quoted in Chu, Simpson,1994, p.4).

The role of the sociologist, James Coleman suggests, is to "describe that structure which we all inhabit, and which we call a social system"(Coleman,1982, p.1). The importance of this description at this time is that we have moved from one form of social structure to a very different one, without a full appreciation of what has changed, and why. When the structures change, then so does the balance of the relationships within the structures. It is possible that the relationships have changed without all of those involved in these relationships understanding what is happening.

According to Coleman, throughout most of our history the basic social structure has been the extended family. The extended family model with its hierarchical and patriarchal system was the basis for most European social systems. This hierarchical and patriarchal system held each individual rigidly in place. But each person had a right to that place, as each person has a place within the family structure. So the structure was based on absolute authority devolved through a rigid system of authority.

> The family is a corporate actor of the old form, it has an internal structure composed of persons, not positions. The continuity of the family depends on the continuity of membership of the particular persons who make it up (Coleman, 1982, p.120).

The 13th century saw the introduction of the charter towns and the rise of the guilds and the possibility of a freeman class. The laws of the time were all centered around the individual person, so any action that was to be taken against a charter town was incorporated into the law, with the charter town council being seen as a 'fictional' individual. At this point the rights and responsibilities ascribed to an individual were now able to be ascribed to this new corporate entity.

> The point of it all is this, the law has facilitated, and technological developments have motivated, an enormous growth of a new kind of person in society, a person not like you and me, but one which can and does act and one whose actions have extensive consequences for natural persons like you and me. . . . What these changes suggest is a structural change in society over the past hundred years in which corporate actors play an increasing role and natural persons play a decreasing role. It is as if there has been extensive immigration over this period, not of persons from Europe or Asia or Africa or South America, but of men from Mars - a race of persons unknown in history (Coleman, 1982, pp. 9-13).

The emergence of democratic government by the 20th century did not redress the balance in favour of the natural persons. Power coalesces towards the large and powerful and away from the small and weak.

> If the power of an actor in a transaction is largely a function of size, then we can expect that the fraction of the value added which will go to a given partner will be large if it is larger (i.e., more powerful) than the corporate actor, smaller if it is smaller than the corporate actor. If the corporate actor is more powerful than any of its partners, then it will be a "value sink," absorbing surplus value for its own growth. . . . Value will drift toward those nodes that are most powerful, which ordinarily means the largest nodes. . . . This drift of value means also inequality . . . And it means that inequality among corporate actors has a natural tendency to increase (Coleman,1982, p.23).

As the relationship between these corporate actors becomes separated from the relationships within the corporation and between the corporate actor and individual citizens, the corporate actors have less and less interest in the relationships between individual citizens.

This can be contrasted with the old structure, in which those with authority also had responsibility for those under them. How this responsibility was exercised was dubious, but the present structure gives no responsibility for the 'whole' person to any

corporate body. All that remains is the relationship between the natural person and his or her position as employee to the corporation. Marxist theory calls this "the contractarian political philosophy of liberalism." Harold Laski (1917) called it "the philosophy of 'possessive individualism', which allowed a man to sell his freedom in return for a money wage." This has resulted in the separation of the individual from the old corporate structure of the extended family, while limiting membership in the 'new corporate' structure to a simple commodity trade - work for wages. Heather Menzies, in Whose Brave New World? (1996), gives many examples of the effect on both workers and citizens of the new structures that are made possible by communications technologies,

> Technological change in the late industrial period went far beyond the issue of changing tools of production. It was altering the larger social environment, including the basis for making a living. Justice Samual Freedom of Manitoba argued that in a society that called itself just and democratic, it was morally wrong to treat people as simply a labour "commodity," to be arbitrarily dumped as redundant (Menzies,1996, p.152).

The period of change we are currently living though is similar in magnitude to the beginning of the Industrial Era. We can learn from history as we face the end of this era. It is important to be cognizant of the changes to the social structure within which we live. As Coleman points out:

> Unless we begin to direct ourselves to the question of what kinds of social structures we are inventing and thereby coming to inhabit, we may permit social structures that are very difficult to change - because once an actor is in existence it has strong interests in survival, and will direct its resources toward that survival (Coleman,1982, p.33).

The structure that supports the private for-profit system in the US is demonstrated in Paul Starr's work. In The Social Transformation of American Medicine (1982), Starr clearly identifies the 'corporate' actors in the US health care system prior to 1970. The United States' dual programs of Medicare and Medicaid were the product of intense struggle between the limiting lobby of the American Medical Association and the popular pressures placed on all state governments. The system which developed, including the two publicly financed programs and the many privately financed plans, proved to be inefficient, ineffective and very expensive. In 1969 President Nixon described the

situation as a crisis. In 1970, Fortune Magazine stated that the US medical care system "stood on the brink of chaos."

> Whether poor or not, most Americans are badly served by the obsolete, over-strained medical system that has grown up around them helter-skelter . . . the time has come for radical change (Quoted in Starr,1982, p.381).

Using Coleman's analysis of the asymmetry of society, it is easy to see that the two corporate actors, the state and the health provider organizations, developed systems that seemed to address the issues that most affected them at the time, cost containment of the system while maintaining the right of the individual practitioner to maximize income. In doing so, they failed to develop programs that would give equitable benefits to individual citizens and at the same time be sustainable by those citizens through the taxation system. This was not their goal.

As the crisis deepened other corporate actors entered the debate: the employers, who were paying employee health insurance, the insurance companies, and the unions. The debate became polarized by ideology at a time when the liberal fortunes were on the wane and the neo-conservative forces that produced the Reagan presidency were on the rise. The crisis in the medical system could be interpreted as a result of the mismanagement of the publicly funded programs. The burden of paying for these programs was borne by those who would not benefit from them. This resulted in what Starr has called the 'Reprivatization of the Public Household.'

> The consequences of reprivatization, if it can be carried out, are almost certainly going to be different from the public's expectations. In its rejection of 'big government' the public seems to be expressing a desire to return to older, simpler ways... But at least in medical care, the reliance on the private sector is not likely to return America to the status quo, but rather to accelerate the movement towards an entirely new system of corporate medical enterprise (Starr,1982, p.419).

By 1980, the corporatisation of the American health care system was well under way. This was accomplished very quickly by the single-mindedness of vision on the part of large corporations that understood the mechanics of the market. Starr wrote in 1982,

> Medical care in America now appears to be in the early stages of a major transformation in its institutional structure . . . Corporations have begun to integrate a hitherto decentralized hospital system, enter a variety of other health

> care businesses, and consolidate ownership and control in what may eventually become an industry dominated by huge health care conglomerates (Starr, 1982, p.428).

The system based on rationing of services based on ability to pay was the traditional US model. This model, which has become the cost containment model of the US medical-industrial sector has not resulted in a more equitable system of health service delivery because it is not based on the criterion of need. Based instead on commodities trading and profit making, it has resulted in high rates of return on investment for both senior management and the shareholders. It is a model that Starr points out has very effectively resisted public accounting and public regulations. This corporate culture has infiltrated the publicly funded organizations so that they too are trying to restructure by cost containment and rationing.[1]

> A corporate sector in health care is also likely to aggravate inequalities in access to health care. Profit-making enterprises are not interested in treating those who cannot pay. . . A system in which corporate enterprises play a larger part is likely to be more segmented and more stratified. With cutbacks in public financing coming at the same time, the two-class system in medical care is likely to become only more conspicuous. . .The failure to rationalize medical services under public control meant that sooner or later they would be rationalized under private control. Instead of public regulation, there will be private regulation, and instead of public planning, there will be corporate planning. Instead of public financing for prepaid plans that might be managed by the subscribers' chosen representatives, there will be corporate financing for private plans controlled by conglomerates whose interests will be determined by the rate of return on investments (Starr,1982, p. 448).

When looking at health care, Henry Mintzberg, a management consultant states that there is not a role for the private free-market sector. The pressures of supply and demand do not serve the client/citizen well. Mintzberg sees grave danger in the creation of a 'micro' government. However, he is ambiguous as to the role of health care within the public sector.

> The client relationship is perhaps more complicated. It is not clear that those professional services widely accepted as public - certain minimum levels of education and of health care, for example - are particularly effective when offered directly by government, let alone private business. Neither one on its own can

[1] The example of the Oregon Experiment comes to mind.

> deliver all the nuanced requirements of professional services. Markets are crass; hierarchies are crude. Non-owned organizations or in certain cases, cooperatively owned ones, may serve us better here, albeit with public funding to ensure equity in distribution . . . .
>
> An organization without human commitment is like a person without a soul. I believe this conclusion applies especially to client-oriented professional services such as health care and education, which can never be better than the people who deliver them. We need to free professionals from both the direct controls of government bureaucracy and the narrow pressures of the market competition. That is why non-ownership and some cooperative ownership seem to work so well in those areas (Mintzberg,1996 pp.78-82).

Mintzberg identifies three assumptions that underlie management:

1. Particular activities can be isolated - both from one another and from direct authority. Mintzberg's critique, "How many policies in government today can simply be formulated in one place to be implemented in another, instead of being crafted in an interactive process involving both politics and administration" (1996, p.78).

2. Performance can be fully and properly evaluated by objective measures. Mintzberg's critique, "Consider the myth of measurement, an ideology embraced with almost religious fervour by the Management movement . . . Measurement often missed the point, sometimes causing awful distortions . . . The fact is that assessment of many of the most common activities in government requires soft judgment, something hard measurement cannot provide" (1996, p.78).

3. Activities can be entrusted to autonomous, professional managers, held responsible for performance. Mintzberg's critique, "We are so enamoured of this cult of heroic leadership that we fail to see its obvious contradictions . . .our obsession with Management belies a good deal of the reality out there. Consequently, it distorts serious activities, as in the case of many public school systems that have been virtually destroyed by the power of the managerial hierarchy to direct classroom activities without ever having to teach anyone" (1996, p.79).

Mintzberg has five models of government, he chose what he calls the 'normative control model' as best serving social programs. This model exemplifies a different

concept of the world. The normative-control model is not about systems but about 'soul'. Control is normative - that is rooted in values and beliefs. The concept is of *public service.* "The motto might be Select, Socialize and Judge. But the key to all is dedication, which occurs in two directions: by and for providers of the service. . . The model allows for radically different microstructures. It's more missionary, egalitarian and energized, less machine-like and less hierarchical"(1996, p.81). Government management needs to be 'eclectic,' as it deals with all aspect of life. Above all, government desperately needs life force (Mintzberg,1996).

In Privatising the World, A Study of International Privatisation in Theory and Practice, Oliver Letwin (1988), outlines the ideological nature of the privatization movement. It begins to take shape when there is a synergy between politicians and the corporate sector. Without the political will within the government the privatization ideology cannot be operationalized. Privatization is the tool for changing the role of government; it takes a single minded commitment to the ideology to give politicans the necessary 'political courage.'

> Perhaps the biggest example of political courage has been in relation to jobs in nationalized industries. The arguments of the critics - that privatization would entail massive job losses - would have seemed to be thoroughly justified if governments had attempted to privatize companies while they were dramatically over staffed and had left the private sector to do the hard work of reducing manning levels. In practice, therefore, governments which have been serious about privatizing those industries which suffer from significant over-manning have had to take the step of reducing the numbers of jobs while the industry remained in public hands. In New Zealand, the socialist government has exhibited such courage to an extreme extent, making deep cuts in the workforce of industries such as the coal mines as part of the 'corporatisation' process, so that the companies will be able to prosper once they are reliant on private sector funding (Letwin, 1988, p.71).

To move from the earlier forms of privatization to a full scale privatization program, 'political courage' is essential. The early forms of privatization are contracting-out of government services, deregulation of activities previously dominated by the public sector and sale of public assets to existent private sector companies.

> These methods create only a limited interest in favour of privatization . . . but none of these are serious interest groups, capable of making or breaking a government or political party. It is too easy for the opponents of privatization to appeal to the unions and to the 'public interest' when seeking to re-nationalise activities being conducted by private sector companies as a result of contracting out, deregulation or trade sales . . . Using two high-profile techniques, the management-employee buy-out and the public offer, Mrs. Thatcher has brought into play two vital interest groups as allies of privatization, employee and small investors (Letwin, 1988, p.89).

The creation of a special interest group is very important—this special interest group is not the small investor. John Redwood MP, a former member of the Thatcher Cabinet, is quoted,

> "The most difficult thing of all about privatization is that it requires a cultural shift in government itself. . . . It is extremely difficult in any government anywhere in the world to get something done quickly and well. The first challenge for a privatization programme is to break that mould. To do that you need to identify a small team of ministers and civil servants who are dedicated to the process and to appoint an adviser who will be the ruthless custodian of the timetable" (Letwin, 1988, p.xi).

The timetable is critical. The speed at which the privatization moves is such that any opposition is left in total disarray.

> Nevertheless, timetabling is vital. The complexities of a public offer are sufficient to deter any government from engaging in the exercise unless there is a timetable which gives the process impetus and sets deadlines for decisions and negotiations. The length of these timetables can, of course, vary widely from case to case . . . In the Jamaican case, the entire exercise took some 12 weeks (Letwin, 1988, p.99).

In 1985, Greg Stoddart and Roberta Labelle prepared a study for the Federal Ministry of Health and Welfare called <u>Privatization in the Canadian Helath Care System</u>. The Canada Health Act had just been enacted but at that time the Provincial governments were permitting health care providers to charge user and facilities fees for services that were publicly insured. This practice was seen by providers as fostering 'patient participation' in the delivery of health care services and was seen by the federal funder as an attack on the issue of equity. The debate over the privatizing of financial responsibility for health services underlay the real issue of control.

> The nature of control of resource allocation decisions, however, is much more complex and is at the heart of the privatization debate... all health care systems are mixtures of 'command' and 'market' mechanisms, thereby fragmenting control and rendering issues of who controls which activities of paramount importance (Stoddart, Labelle, 1985, p.3).

In this thesis I again ask the questions that Stoddart and Labelle asked in 1985. Their focus was on the issues of control, efficiency, utilization, equity, access and standards. They point out the two effects private sector involvement induces are: the privatization of financial responsibility and the corporatization of the health sector.

In 1985, the model of augmented private financing for publicly insured services as a viable method for increased effectiveness in the publicly funded system was rejected. The rationale that effective management was only available through the private sector was rejected. The notion that privatizing financial responsibility would decrease access and diminish equity was found to be true. The privatization of any form of service would mean increased vigilance from government to set and maintain standards and such activity would reduce any operating savings that the private firm might generate. Stoddart and Labelle recognized the potential for more for-profit management within the hospital sector and the private management of public insurance programmes, but they did not see these initiatives as being central to creating the solutions to the concerns over efficiencies and utilization of services.

> Analyses of specific avenues for privatization of financing and management in terms of their expected impact on a defined set of public policy objectives, however, suggested that the often asserted benefits of privatization were largely absent, or were unknown and possibly suspect. In addition, privatization of financing through extra billing and user charges was found to impact strongly and negatively on the equity objective (Stoddart, Labelle, 1985, p.68).

Stoddart and Labelle stated that in 1985 privatization initiatives sought to contain public costs and add more funding flexibility to the system. However, these initiatives do not address the underlying problems facing the Canadian health system and the health care system of all developed countries. These concerns centre around the structural problems of the system, "the separation of (clinical) decision-making authority over production/utilization decisions from the financial responsibility of paying for the levels

and types of input use and service utilization that result from those decisions" (Stoddart, Labelle, 1985, p.68). In 1997 we still have not found the mechanisms to create the necessary structural linkages.

> Efficiency issues and structural problems can be addressed within the confines of a "public" system through the introduction or expansion of new organizational models for delivering care and through changes to the incentive structure of current reimbursement methods (Stoddart, Labelle, 1985, p.68).

The focus of the discussion has centred on the relationships between corporate actors. These power dynamics are central to continued growth of the medical-industrial complex. The individual and the family have faded from view. Individuals exist only as an addendum to the story of the battles to be fought and won. However, it is the individual or the family who is experiencing the availability or the lack of access to the health care system. For James Coleman, the family is the prototype of the old structure. It is still seen as the basic unit within our own society. In fact nearly everyone comes from a family setting. The extended family was the norm until the Second World War. In sociological terms, natural persons were ascribed membership in the family. Now the emphasis is on membership within the corporate setting. These differences have special implications for the young and other dependents. What we are seeing is the continuing fragmentation of the family at the same time as the family is required to accept the reality of the withdrawal of the welfare state.

The family is the place where dependency is nurtured. The person with the authority that is inherent in the hierarchical structure of the family also assumes responsibility for those dependent persons under that authority. Who is dependent? The young, the old, the sick, the infirm and those unable to maintain themselves were included. As we have seen before, "Authority over a person implied responsibility for that person's welfare"(Coleman, 1982, p.126). The family held the responsibility that has been assumed, to some extent, by the welfare state within the new structure. The corporate actors are interested in access to the healthy, adult, able-bodied individuals who will exchange their freedom for wages. So for these individuals the exchange is beneficial and increases the sense of freedom, but it leaves others in society unprotected.

> For the family has been, throughout history, the essential communal unit within which "income" from outside was diffused from those who "earned" it to dependents (Coleman, 1982, p.126).

Coleman's argument is that as the family is fragmented and the value of each individual as a productive member of the family is diminished, then the family structure will collapse. But with the collapse of the family who will care for the dependents? In the wage economy, the earnings belong to the individual not to the family unit. In this framework looking after dependents becomes a drain on an individual's income. As the state takes over the care of the elderly and the education of children, both are removed from the family centre for a considerable amount of time, diminishing the relevance of the family. But where is the structure to maintain the old and young with the retreat of the welfare state?

In the old structure, the primary economic model was based on the family unit. Production, households and child rearing all happened in the same place. The spread of the modern corporate company, with its need for wage earners, has replaced this reality with a reality that fragments the tasks and the location of these tasks. This has had a profound effect on the viability of the family, the role of women within the structure and the place that children, the elderly and infirm now occupy in the home.

The relevance of the family within the corporate structure may be diminished, but the family has always responded to the needs of its dependents in the best way it can. There are two separate forces at work, both are derivatives of the modern corporate structure. The desire of the corporate employer to hire particular 'pieces' of an employee is conceptualized by Heather Menzies, in Whose Brave New World?" (1996), as 'social Taylorism' at the micro-level of the workplace. This results in treating workers as 'commodities', to be picked up and discarded with little regard to the individual's need for work/income. The second force at work is the withdrawal of the welfare state, the returning of all responsibilities for an individual's well-being to the family. We have an interesting contradiction that requires workers to travel to find work, leaving family and community, and at the same time be responsible for the care of the family and the community structures that care for people. The commodification of the individual's work

to be accessed at the whim of the corporate employer allows for no social or financial stability on which to plan to care for the dependents of that individual. In 1980 Marshal McLuhan commented,

> Excessive speed of change isolates already-fragmented individuals and the accelerated process of adaptation takes too much vitality out of communities . . . It might even be said that at the speed of light man has neither goals, objectives nor private identity. He is an item in the data bank - software only, easily forgotten - and deeply resentful (Quoted in Menzies, 1996, p.14).

It seems to me that while the corporate companies have been consolidating their enterprises and setting the rules for their workers, the family unit has become totally fragmented. The norm, that each tiny nuclear family lives in isolation from others, has benefited the mass market. The down side has been the alienation of the natural person from any environment that has a nurturing role. The isolation of mothers from others has led to their need to participate in other social roles - such as members of the work force. This too has benefited the mass market by increasing the worker pool and making the purchase of services and products necessary to offset the time spent away from family production.

> The principal economic and social activities had left the household and had taken with them the psychic sustenance that such activities provide; and the sensible alternative for women was to follow those activities into the work place, to recapture the sustenance they provide - despite the fact that this meant reducing one's attentions to children and child rearing . . . The problems remain, however for the one remaining set of family members whose principal locus of activities is the home - that is, children (Coleman, 1982, p.131).

The reality of the modern family—that the burden of care is being placed on the backs of unpaid women—is a central concern of Pat Armstrong and Hugh Armstrong in Wasting Away (1996),

> Instead of psychosocial benefits from being cared for by a close relative, patients may feel additional stress. They may worry about being a burden and about the health or skill of the caregiver. Furthermore, the care that relatives must now provide often involves an exposure that many find difficult to handle in a family context . . . . While homes can offer warm, comforting environments, they are not necessarily havens in a heartless world that offer means to independence and support. Isolated and under stress, family caregivers may take out their frustrations on the care recipients. When caring ceases to be voluntary but rather

> becomes a necessary and never-ending burden, violence can result. . . . Even if the caregiver does not intend to harm, they may unintentionally do so through ignorance and in the absence of people to help (Armstrong and Armstrong, 1996, p.142).

It is into this family structure, functional or dysfunctional as it may have been made by the social and economic forces, that the burden of care for children, the old, the chronically ill, the disabled or the convalescent is placed. From the philosophy of smaller government (along with the withdrawal of the welfare state), comes the movement to increase the levels of private responsibility for financing health care. This is the current reality facing families and citizens. A family's self-sufficiency is based on income, and income is based on paid work, and paid work has become controlled by the corporate sector.

John McKnight, community development worker from Chicago, argues in Community and its Counterfeits (1994) that since both government and the corporate sector have abandoned the inner cities, the communities have to create a new set of relationships that can maximize the potential of their citizens.

> But as people have come to realize that these ways of trying to draw that big system back, the abandoning institutions back, are not working, then they come to a third recognition and that is, whatever will happen here will happen because of us . . . we don't have a lot of experience with how you reinvent community. By that we mean a place populated not with consumers, but with people who are citizens with the capacity to produce (McKnight, 1994, p.12).

Heather Menzies looks at the reverse-strike phenomenon that began with a pacifist social activist, Danilo Dolci in Italy in 1956. This is the community taking-up the challenge of the right to work. While this idea is very risky, in that it encourages community members to work without the ability to pay them, it gives back community/citizen determination in the same way as McKnight's neighbourhood is trying to do in Chicago.

> Acting on the reverse-strike idea that people have the moral right to define what work is necessary and to do it, these community organizations could work with Ontario welfare recipients and create a community dialogue around the work that should be done (Menzies,1996, p.161).

These ideas from McKnight and Menzies are only legitimate when it is the community, the citizens, who have the control over the decision making and the outcomes. Any other manifestation of these ideas would be manipulation and very dangerous to the rights of both citizens and community.

The final theoretical analysis that informs this research is that of the building of sustainable communities. Health care systems are faced with two dilemmas, the challenge to restructure and contain costs, and the need to respond to the increased risks to citizens and communities posed by the socio-economic, political and cultural conditions of industrialized societies. This call for a new vision of health has been pioneered by Trevor Hancock, (1993) and Ilona Kickbusch (1989). The key characteristic of the 'ecological' model is an understanding of the interconnectedness of the physical and social environments and the health of people. Trevor Hancock developed what he called the Health Mandala model of health, an ecosystem approach. This model seeks to integrate action-oriented public health policy through inter-sectoral cooperation. This model recognizes the value of workers, family members, dependents, children, old or young. In many ways the sustainable communities model is the opposite of the corporate image of the 'global village.' Sustainable communites have a reason for exisitng, they are there to nurture their inhabitants from a perspective that spans the past, the present and the future. Marcia Nozick in No Place Like Home (1992) states that the glue that holds communities together is their authentic culture that has grown out of and can embrace diversity. The corporate image of community may possibly be the 'gated' communities where property value is more important than human value.

In brief, for the analytical framework I took Coleman's (1982) understanding of the importance of the structure within which society functions - change the structure and the goals and objectives of the old structure can no longer be supported, they are abandoned. From Eco (1987) I gained insight into the nature of crisis and the necessity for governments to face the challenges presented by changing structures. From Mintzberg (1996) and Pat Armstrong and Hugh Armstrong (1996) I can differentiate between the efficiencies of micro-managed components of the system and the macro management for

the efficiency of the whole system. From Oliver Letwin I learned of the importance of political will in operationalizing the privatization ideology, which comes from the political desire to change the role of government. Paul Starr (1982) gave me the background to the corporatization of the American health care system, and its potential impact on the Canadian system. From Heather Menzies (1996), Pat Armstrong and Hugh Armstrong (1996) I have an understanding of the effects of structural changes on the lives of workers and families. With Paul Starr, these authors have demonstrated for me the effects of the trend towards the 'privatization of the home' and the effects of state and corporate downloading on citizens. John McKnight (1994) required me to think about those whom both the state and the corporate sector have abandoned, and of the options open to these people to provide for their own survival. McKnight's analysis emphasizes the growing gap between the haves and the have nots. Trevor Handcock and Marcia Nozick ground the thesis in an understanding of what is the meaning of 'health' within the health care system.

From all of these thinkers, I have borrowed ideas to develop a theoretical analysis that seeks to illustrate the structural framework within which the Canadian health care system is operating.

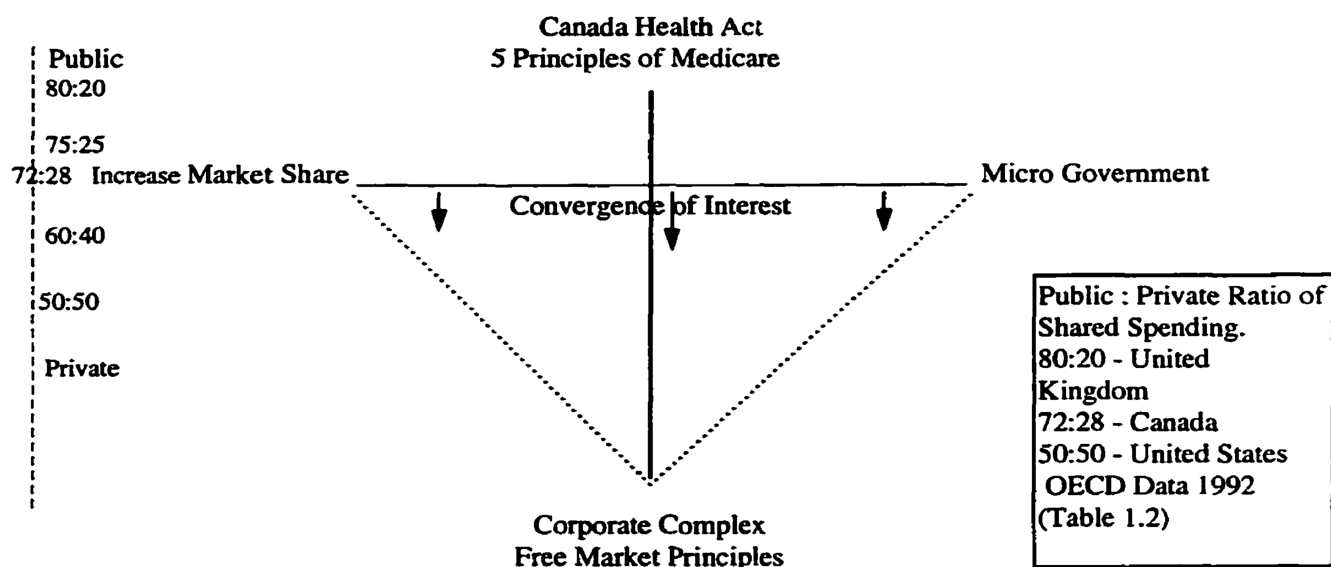
Modeling the Pressures on the Canadian Health Care System.

The analytical model borrows from the image of the playing field—it does not focus on the 'levelness' of the field, but rather on the goal posts and the shooting zone. Like any playing field there are two sets of goal posts. However, in this model there are other goal posts located along the side lines. These are referred to as the re-focusing goals. A convergence of interest unites these goals. This combined force is very effective in 'changing the rules of the game.' It exerts a downward pressure moving the 'game' away from the old goal posts, ultimately rendering the old goals obsolete and re-focusing the 'game' on the new goal posts. The two primary sets of goal posts are the two poles of the vertical axis, the two re-focusing goals are located on a horizontal axis and can intersect the vertical axis at varying points.

1) The Canada Health Act: '. . . to protect, promote and restore the physical and mental well-being of the residents of Canada and to facilitate reasonable access to health services without financial or other barrier' (Section 3 of the Act).
2) The profit motive of the major health corporations: From the mission statement of Interhealth Canada Limited: "To maximize profitable opportunities for Canadian companies engaged in health goods and services"(Quoted in Decter, 1994. p.231).
3) The goal of creating a micro-government, based on deficit reduction and off-loading of any services that can be provided through the private sector.
4) The goal of increasing the market share by increasing the utilization of profitable health services, especially in the provision of private insurance premiums and contract management.

Figure 2.1 demonstrates the convergence of interest between those in power who advocate for a smaller role for government and those who reinforce the corporate goal of increasing the market share of profitable health care services. These combined interests exert a downward pressure on the system.

Figure 2.1 Pressure Exerted by the Convergence of Interests



Public : Private Ratio of Shared Spending.
80:20 - United Kingdom
72:28 - Canada
50:50 - United States
OECD Data 1992
(Table 1.2)

The vertical axis to the left indicates the public/private ratio in public spending. The horizontal axis shows the convergence of interest between the public sector and the private sector players. What is off-loaded by the public sector, can be offered for-profit by the private sector. The line that represents this convergence of interest defines the shooting zone. The farther the health policy initiative is from the goal post of the Canada Health Act, the more difficult it is to 'score' or achieve the stated goal of the player.

As the horizontal axis slips down the vertical axis, the shooting zone for public policy becomes farther from the goal. In other words it becomes more difficult to design public health policy to address the goals and objectives of the Canada Health Act. As policies are designed to meet fiscal and governmental downsizing targets the old goals posts become obsolete. The rules of the game have changed, making public policy initiatives focus on a corporate health industry goal of maximizing market share of profitable health services.

There are four public policy areas that are immediately effected by the change in the government focus. These are, rationing of services, redistribution of wealth, care of the poor and control of information.

a) Rationing of services. Under the Canada Health Act health services are rationed on the basis of need. The act provides for the 'reasonable access' based on 'medical need.' Therefore the more need demonstrated the more access is required. This is the brake placed on the principle of universal access. If those with higher needs are also poor, then we can expect that the poor will have the right to access the system more frequently. In a market driven system, rationing is based on ability to pay. The more an individual can pay the more services can be accessed. Medical need is not a criterion. If the rich have more funds then they have the right to access the system more frequently.

b) Redistribution of wealth. Under the Canada Health Act the public funds for the health care system come from revenue generated by general taxation. The general tax rate is graduated. This enables those with more resources to contribute more of those resources than those who have fewer resources. The poor have need to access the system more frequently than the rich. This creates a mechanism for wealth redistribution. In the

market driven system, the system is paid through private contributions to insurance programs, which are accessible to those with adequate incomes and inaccessible to all other. Given the market nature of insurance the rates are developed on the principle of 'what the market will bear.'

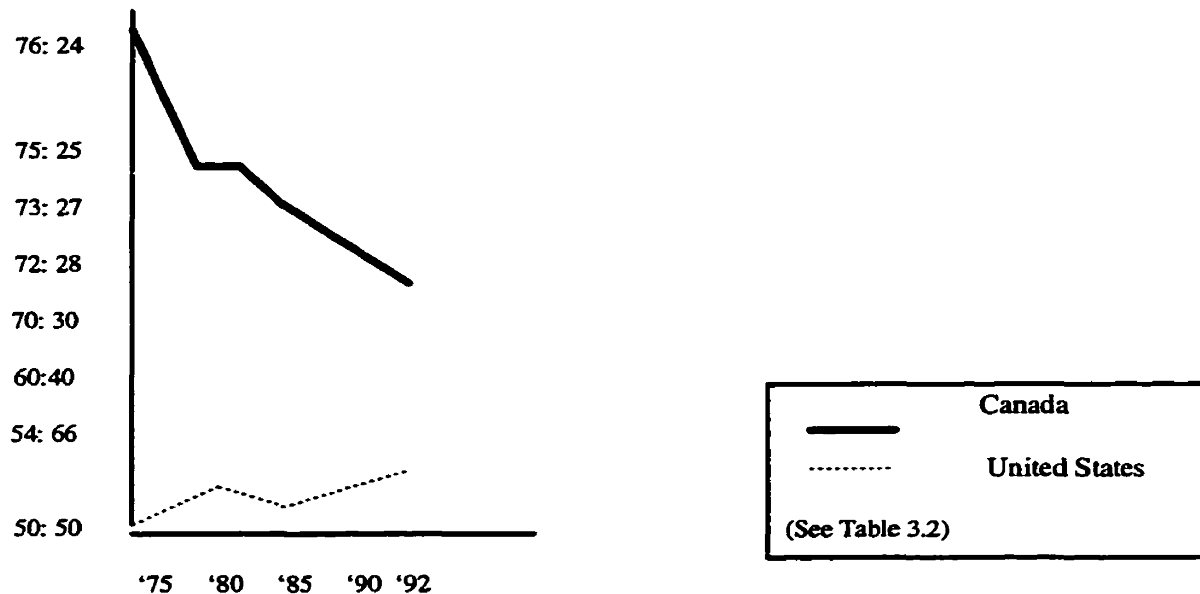
c) Care of the Poor. The Canada Health Act expressly removes the financial barrier from access to health services. While there may be other barriers, such as location, education, work environment, etc. these are not exacerbated by inability to pay. The bottom line is that any resident of Canada can expect to receive health care services. In the market system, only those who can afford to pay have the ability to access health services. The wealth of an individual depends on the individual's ability to find paid employment. As both the state and the corporate sector cut back on the numbers of people that they employ, the number of those who do not have an income increases. As health services are linked to ability to pay the poor are doubly abandoned.

d) Control of information. This is a 'sleeping variable.' As the illustration of the Inca villages given by Coleman (1982) suggests, information and communication are the life lines of any governance system. The control and ownership of information will determine the ability of a player to operationalize a policy initiative. The control of the dominant mechanism of communication and information transfer will determine the future of the health system. The kind of information that is collected and the objectivity of its analysis is predetermined by the subjective goals set by those who control the system.

Within a climate of change there is a re-focusing of the goals of the system. It is easy to see how one set of goals can be replaced by another. In this case, the primary goal of the Canada Health Act is replaced by the goal to create a micro-government. None of the health policy initiatives will be designed to address 'the promotion of the physical and mental well-being of the residents of Canada.' They will be designed to meet the requirements set forward by the drive toward deficit reduction and the redirection of government involvement. The structure will no longer be able to address the objectives of an obsolete goal, a goal will have been abandoned. On the other hand

the goals of the medical industrial complex are best served by a freeing of resources to increase the market share in the services that are profitable. There will be increased utilization of services that people value enough and have the ability to pay for, and a decrease in utilization of those

Figure 2.2 Changes in the Public /Private Ratio 1975 - 1992



services that do not create the necessary profit margins, regardless of the benefit of either service to the mental and physical well being of the citizen. Figure 2.2 compares the diminishing sector spending in health services in Canada to the increasing public sector spending for health in the United States. The reality of this graph indicates that the principle of inclusion that is the corner stone of the Canada Health Act is being changed to the principle of abandonment. This abandonment has been demonstrated by McKnight (1994) in the United States. Thirty five million US citizens have no health insurance and another 35 million are under insured (McCarthy, Sian, 1992, Nader, 1996)

The emerging structure of governance has lost sight of the goals and objectives of the Canada Health Act. The new structures are based on the corporate model of increasing utilization of goods and services that command a high rate of return on investment. The structures are being driven by a convergence of interest between the advocates for minimal government within the national legislative assembly, and the multi-national corporations that seek to maximize profits from the burgeoning market in health care services. These services will be traded on the world market and be accessible

to the highest bidder. Under these conditions it will be very difficult to enforce national standards, to implement national programs and to continue to prohibit private insurance coverage. The care of the sick, the old or the poor will be obscured by the provision of services for those who have the resources to pay.

Chapter Three

Methodological Framework

Action Research is the basic methodological framework that informs this research. This methodology is consistent within the feminist perspective and the action research that has become part of my way of being. The action component comes from my desire to 'find out' what is happening within the health care sector and to use that information as the basis for moving forward a social action agenda that respects the 'health for all' concept. The definition for action research comes from Women's Research Centre, Vancouver 1987:

> Action research is the systematic collection and analysis of information for the purpose of informing political action and social change (Barnsley, 1987, p.2).

The methodological tools used to inform this research included participant observation, content analysis, focus groups, semi-structured interviews and electronic survey. They are listed in their chronological order.

Participant observation is the most unstructured form of field research. I have sought out opportunities that have enabled me to listen to and communicate with those who seek to influence public policy. This form of research was essential for me to begin to frame the questions and to find the analytical framework to process the data. As Earl Babbie describes:

> [The researcher] attempts to make sense out of an ongoing process that cannot be predicted in advance, making initial observations, developing tentative general conclusions that suggest particular types of further observation, making those observations and thereby revising his conclusions and so forth (Babbie, 1975, p.195).

These opportunities included working with the Canadian Health Coalition, the Options: Social Action Coalition, the Provincial New Democratic Party advisor on health policy development, the Provincial Progressive Conservative Party's Round Table on Health and the Dartmouth Community Health Board Planning Committee.

I looked at the kinds of printed material that were available to the public. This entailed collecting many of the recently published reports on health initiatives particularly

from the Department of Health, but also from the key stakeholder/provider groups. I also clipped all articles on any aspect of health from the Halifax Herald and the Sunday Daily News, from 30 August 1996 to 31 March 1997. These data enabled me to understand the kind of material that was available to the public, and the range of opinions that can result from this knowledge. From a feminist perspective, it is interesting to look at what is not reported and whose voices are missing in either the government reports or in the newspapers, to ask why some topics get a lot of coverage and others are ignored.

Focus groups facilitate the discussion of specific questions by enabling participants to react to the questions and to the responses of the participants. The focus group format is useful in getting feedback from participants on the appropriateness of the questions, and on any problems with comprehension of either the topics being discussed or the language used in the question construction. The target population for this research is those who are involved in making or influencing public policy on health. Three focus groups were held: the first with the policy analysts of the primary provider groups; the second with board members from the Midwifery coalition; and the third, with board members from the Nova Scotia Division of Canadian Pensioners Concerned. These groups were chosen as they are all actively involved in making or influencing public health policy. The Canadian Pensioners Concerned represents the group that has the most need of the health system, and the Midwifery Coalition was chosen because many are interested in alternative medicine and subsequently have chosen to pay for the health services that they receive. Each focus group was recorded and extensive notes were taken. The tapes were transcribed and coded under headings consistent with the survey questions.

Seven persons were interviewed during six sessions. Three of the interviews were conducted by the researcher and three by an investigative reporter. All interviews were recorded, transcribed and coded. The questions from the interviews focused on specific aspects of the privatization of financial responsibility and on the corporate opportunities that are unfolding in the health sector. The interviewers were looking for information on recent privatization initiatives from a provider, a management and a patient perspective.

Those interviewed included respondents: one from the Department of Health, two from hospital administration (one regional and one tertiary hospital), two labour representatives, one private for-profit business operator and a transplant recipient.

A survey tool was developed, based on the work of Greg Stoddart and Roberta Labelle (1985). The target population included: the stakeholder provider groups; community activists in health, social justice and the environment; consumer advocates; provincial departments; non-government organizations; academics and the business community. The survey form can be found in the Appendix. The potential respondents were chosen from groups, organizations and institutions that have an interest in public policy. The responses from the survey respondents are presented in table form. This information is useful in indicating the frequency distribution (Babbie, 1975) of the responses from this particular group of individuals. However, as the numbers surveyed are not sufficient to create any statistical significance, generalizations to the total population cannot be made. Individuals, as well as institutions were approached, they do not represent a scientific sample of the possible individuals interested in policy development, therefore the findings are not statistically significant. A list of the organizations represented by the respondents can be found in the Appendix.

Sixty surveys were sent out by electronic-mail. The respondents were asked to forward the survey on to two or three other people interested in the research. I sent the survey to five community activists for pre-testing. Their comments were incorporated into the final version. The primary criticism was that the survey required in-depth knowledge of the system, but that this should not prove to be a problem as the target population was presumed to be knowledgeable. The survey sought to get an understanding of the target population's perception of the benefits and challenges posed by privatization initiatives in health. Of the sixty surveys sent out, thirty (50%) surveys were returned, ten (17%) bounced back, E-mail address unknown or changed. Three people (5%) indicated they did not have enough knowledge to complete the survey. Four (6%) indicated they were too busy at the time, five (8%) communicated a willingness to complete but were not

received by the deadline. Twelve persons (20%) received the survey but did not communicate.

The survey tool was very useful in reaching a wider population. The limitations of the survey method focused on the length of time the respondents needed to take to fill it out, along with the in-depth knowledge that they had to bring to the task. However, time did not permit thirty interviews to be undertaken and transcribed. The results represent an interesting set of data that identifies questions that can be studied in more depth at a later date.

The electronic mechanism worked well with the following comments:

1) The use of electronic surveys is cheap and the open question responses are readily available within a text format.
2) Many of those within the target population have access to E-mail, some very recently.
3) Lack of familiarity with the medium, and a higher comfort level with using pen and paper.
4) Some of the community networks cannot read forms and these needed to be printed out and faxed back.

When using an action research methodological model, it is necessary to clearly position the researcher within the context of the work. As noted, my perspectives are grounded in a socialist-feminist critique, within a growing awareness of the ecological public health paradigm.

> Knowing where you come from, who and where you are, and knowing and controlling where and how you want to go: this is an ideal starting point for self-determination. It means you're able to evaluate your options, and make conscious and informed decisions suited to meeting your own needs. (Sainnawap, 1993, p.3)

I have attempted to balance my bias by talking to many people from different ideological backgrounds. However, my understanding is that the goal of the public health system is to build on the capacities of citizens, to address the challenges faced by citizens in their individual lives, within their families, their neighbourhoods or communities. As the system is of and for citizens, I cannot subscribe to an ideology that replaces citizens with a passive consumer class.

While many commissions, reports and government directives support a community-driven approach, there has been a backlash against many citizen advocacy groups, including labour unions, who seek to be part of the planning for change. The problem I faced was that the reports, the studies, the 'words' all indicated this was the direction to follow -- from the Ottawa Charter onwards. Government actions often belied the 'words.' The community development model was proposed and accepted as the vehicle for change, but it is hospital administrators who are charged with the work. The views of the community were sought out, but these voices never reached the board rooms. Critics of government action were called 'special interests,' 'whiners' and 'bleeding hearts.' The voices that counted were not from the social/justice community but from the business community.

Once the voices of social justice, of communities, of families and individuals, of workers and of patients are silenced -- only the corporate voice is heard -- the voice of corporate management and corporate philanthropy. It can become confused with the voice of the people. Statements start appearing that suggest that the community is uninterested, does not understand or is content to be passively managed. Maybe it is time we learned to listen to the 'sound of silence.'

Chapter Four
Presentation of Research Data

Research Question: What are the perceptions of people who seek to influence public policy on the privatization initiatives that are affecting the Canadian health care system? To answer this question a total of 51 people were directly involved in the research. Three persons attended a focus group and completed a survey. The survey method was discussed with the focus groups and pre-tested by three community-based health educators. Table 4.1 describes the categories of respondents, the method of data collection and the gender breakdown.

Table 4.1
Categories of people involved in the study.

Category	Research method	Number	m	f
Policy analysts for provider organizations:	Focus group	5	2	3
Board members of seniors' advocacy organization	Focus group	6	2	4
Board members of midwifery advocacy group	Focus group	6	0	6
Hospital administrators	Interviews	2	1	1
Labour representatives	Interview Survey	2 3	 1	2 2
Private for profit health organization	Interview	1		1
Transplant recipient	Interview	1		1
Health care providers	Survey	6	0	6
Academics and researchers in Health field	Survey	5	2	3
Community activists	survey	9	3	6
Government employees Department of Health official	survey Interview	7 1	4	3 1
Total	3 individuals participated in both focus group and survey	54 - 3 = 51	15	39

A focus group was held with the policy analysts from the Medical Society of Nova Scotia, the Registered Nurses Association of Nova Scotia, the Nova Scotia Association

of Health Organizations and the Nova Scotia Government Employees Union. Other focus groups were held with board members from the Canadian Pensioners Concerned, Nova Scotia Division and the Midwifery Coalition of Nova Scotia. Seven persons were interviewed, two health administrators, one Department of Health official, two labour representatives, one business person and one transplant recipient. All the focus groups and interviews were taped and transcribed.

In 1985 Greg Stoddart and Roberta Labelle studied the assertions, evidence, ideology and options offered by the privatization initiatives that were current in the Canadian health care system. They asked a series of questions to guide their research into the literature that was available in 1985. Stoddart and Labelle did not use empirical data in 1985. However, in 1997, I have decided asked these questions to a number of Nova Scotians who seek to influence public health policy. In the analysis I ask the data: Do the conclusions reached in 1985 still stand today? What has changed since 1985? How do the respondents differ in their opinions?

The data are presented in the following categories:

- perceived philosophy of privatization
- efficiency
- control of expenditures
- utilization
- increased funding
- erosion of equity of access
- winners and losers for increased privatization initiatives
- most appropriate funding mechanism for health care system
- perceived influence of trade agreements on the health care system

Each category will begin, where appropriate, with a summary of the work presented by Stoddart and Labelle, in 1985. The first question asked the respondents to describe the

underlying philosophy of privatization and uses the work presented by Oliver Letwin in Privatising the World (1988); the final three questions ask about winners and losers, funding and the effect of the trade agreements, which were not included in 1985 study.

Perceived Philosophy of Privatization

Respondents were asked to describe the philosophy that supports the concept of privatization. This question required the respondent to speak from an 'emotional' standpoint and to define that emotional reaction with a pragmatic response to the current reality. As a result, in the focus groups this struggle revealed that there are many components to privatization. The word 'privatization,' could mean profoundly different things to different people—all of whom may be under the illusion that they are talking about the same issue.

The following table reflects the categories that were outlined in Privatisating the World (Letwin, 1988). The survey respondents were asked to identify the philosophy or reasons used to promote privatized health care services. They were not asked if they agreed with these reasons.

Table 4.2
Philosophical Reasons Given to Privatize Health Care Services

Category	Number of responses
1. The effect on the nature of government	5
2. The effect on operational efficiency	12
3. The effect on fiscal deficits and national debt	1
4. The effect on subsidies and distortions	0
5. The effect on regulation and deregulation	4
6. The attraction of overseas capital 7. The effect on the domestic capital market	5
8. The effect on employee involvement	3
9. The effect on the social and political landscapes.	10

1. The effect on the nature of government

Respondents were very aware of the effect of a pro-privatization philosophy on the nature of government. One government employee stated, "Corporate philosophy, based on belief that private sector can do it better and cheaper, also is based on belief that government should not do anything that could be done by private sector." This was echoed by a community activist who expressed concern, "Over the belief that the state or government is not competent to deliver services and has little place in ensuring the health or well-being of the population." The narrow focus of the nature of government is of grave concern to the labour movement, and is seen in the larger global context. "[Privatization is] part of the corporate and right wing agenda to undermine and cut back on public services and social programs, to increase corporate power and profits."

The mix of public and private provision of services and payment mechanisms has always existed in Canada. A labour representative identified a significant and negative change: "Privatization has a new currency, a new meaning in the current context. It means deficit reduction. Down sizing, re-engineering are the buzz words we are hearing. It is used in its potential implications for the broader context." In a focus group this argument was counted. There was concern from a health services provider that the deficit reduction strategies are creating a more centralized government planning and payment system for health services, not less government. "When I think of privatization, I think more of the public/private partnership. You have public control and standards that are set publicly, with community participation. But right now we have more and more of our health system being defined by government because of fiscal restraint and fiscal control. I see the government taking a higher and higher degree of centralized control."

The seniors made a distinction between the for-profit corporations and non-government but not-for-profit organizations such as community health centres. The question was not so much private versus public, but for-profit versus not-for-profit. The not-for-profit organizations such as community health centres and cooperative health clinics did not seem to carry the same 'bottom-line' connotations of the for-profit companies. " There seems to be a varying opinion as to what privatization means to

government. To some in government, privatization means the running of organizations by non-profit groups but to someone else it means the running of organizations for profit."

The idea that a more private system would offer choice was a difficult one for the seniors in the focus group: "Although we have better nutrition, better housing and a healthier population --as we are moving away and the system is being dismantled and if we lose the pieces: hygiene, nutrition, employment, transportation—then we lose the health system. What difference is there going to be between where we were [before Medicare] and where we will be?"

2. The effect on operational efficiency

The effect on operational efficiency was seen by many respondents as the primary rationale for increased private sector involvement. However, as one academic/researcher put it, "There is a belief that services provided privately can be done more efficiently and effectively than can be done publicly. Note that a philosophy does not necessarily imply proof." This emphasis on efficiency worried a community activist who stated, "The goal of privatization is to cut spending while making systems more efficient. I, however, believe that cutting doesn't necessarily mean greater efficiencies through streamlining. The first and foremost goal of the health care system is to provide quality care to all Canadians. Once this goal is defined, you work towards objectives on how to run the system, keeping this in mind."

In the current climate of fiscal restraint, there was a debate on the effect of policy on health 'outcomes'. One policy analyst points out, "The government does plan on outcomes, but on the outcomes that they want. Government's desired outcome now is a balanced budget and to spend less, in terms of GDP, on health." Another analyst agreed with this perception, but added, "There is a concentrated effort by the corporate sector, led by such institutions as the Fraser Institute and the CD Howe Institute, bodies that have risen in stature over the past few years. They have mounted a concerted and on-going attack on anything that is associated with the public sector, with the view to changing the public mind set on the services that people have enjoyed. We hear phrases such as 'we

cannot afford it.' Privatization is part of the international approach to what is called the corporate agenda. It is the systematic undermining of the role of the public sector." This argument was contested by an understanding that business principles were responsible for the increased efficiency of the private sector. The sense was that as a tool, privatization of services or management could lead to more efficient use of resources. "So business principles are more what I see when I hear the word privatize . . . I used to see greed, now I see efficiency." They looked for an understanding of the ratio or mix of public and private service. "Services delivered only by public sector can be delivered by the private sector. Privatization is an expression of that ratio, of that mix."

In the seniors' group, the understanding of privatization was based on a business model, a bottom-line mentality and a for-profit system. "People think of privatization as business." "They think of for-profit." "It is pay for service, either from your resources or through private insurance." The example of the 'for-profit' pharmaceutical industry was given, "Definitely for-profit. The profits from the drugs go directly to the drug manufacturers." This emphasis on profit versus efficiency rankled a member of the midwifery coalition, "I think in apocalyptic terms . . . when I hear of health care facilities in the States that have to handle 2,600 different health plans. Is this efficient? When I hear privatization, I leap past all the interims and focus on our 'next door neighbour's' horrible end results."

The business community has a very different approach to the issue of efficiency. The private sector can offer quick, timely reactions and can be very flexible to meet the needs of the institution. "To react quickly, swiftly to change and with the opportunity to be able to network with other interested partners. I think that we are partners with the hospital, we are not removed to the point where we don't have an interest in it." The word adrenaline was used frequently to describe the kind of energy the private sector brings to an institution. "But the adrenaline from this private sector (initiative) has been so powerful, that if we just become an internal department of the hospital we would not attract the attention and have other private sector people calling us."

3. The effect on fiscal deficits and national debt.

One survey respondent mentioned the effect on fiscal deficits and national debt. A government employee responded in the survey, "[Privatization is] government succumbing to the corporate agenda and deficit hysteria. They do this by shifting democratic and moral responsibility for the 'expensive' health care of citizens onto the private, profit-motivated business sector."

Deficit reduction as an effect of privatization, government spending and deficit reduction strategy formed a large part of the discussions for the policy analysts. "There is a rosy view of the past, with everything just going along. This is a myth. What was emerging was the huge budgets and deficits. This can no longer continue. The federal government doesn't want to pay as much as it used to. If you want to pay less, then you must find people who are willing to work with less money, so you dumb the work down. Along the axis of the continuum of care, you have the innovations and the ability to use the high tech care—you can achieve things and cut at the other end of the system. What we are seeing is the split between high tech and low tech care. Spend more on the high tech and less on the lower end of the spectrum of care. As you look toward privatization you can start to look at the link between how you offer services and how they are paid for. There is a very clear linkage and understanding this linkage will have a profound change on how you fund things. Privatization is the result of people looking for different ways to pay for care."

4. The effect on subsidies and distortions.

No one specifically mentioned the effect on subsidies and distortions within the economy.

5. The effect on regulation and deregulation.

The effect on regulation and deregulation was discussed in relation to the 'dumbing down of the system' and the need for regulations. The whole discussion was on the 'dumbing down' of the system. De-skilling and multi-skilling are the precursors of the philosophy of re-engineering. This was addressed by labour, government, academic/researchers and health care professionals. A labour representative said, "The

philosophy seems to be to use any private sector group that is willing to provide any service cheaper. They have little concern about regulations, quality or safety." The concern around improving and maintaining regulations and standards was expressed. The tensions are such that there is a considerable lag in the creation of standards and regulations for operation. However, an academic/researcher pointed out that many health related services are not necessarily best provided for by the state system. "It may be appropriate to differentiate between essential services that fall under the notion of universality and those that may increase choice and quality of health-related service, but are not basic to maintaining or enhancing the health of Canadians."

The debate with the midwifery coalition focused on the ability of a private model of health delivery to impose a 'double -standard' of care based on ability to pay. This double standard will benefit those who have money. This was seen as an access issue as those with money will not have to wait for service. However, it was thought that this would reduce the quality of care to everyone else. "Services are hard to get and you have to wait for a long time now. If they are private and you have the money, you can get them right away. No waiting six months for access to labs or services, or even waiting in the waiting room of the doctor's office." While waiting for services was seen as a problem of the current system for some focus group members, others perceived this in a more positive way. "I don't mind waiting, as I know my doctor is giving quality service. She sees only 2 or 3 patients an hour. I have more concerns over costs and access. That is the major problem for consumers with privatization."

The other issue concerning regulations came from the policy analysts. This was interpreted as an issue of control. One of the policy analysts contended, "Control of the services is more important, as you could have a completely publicly funded system that essentially did not control any of the services." Another analyst followed with, "Control is a key variable as to who owns the system, who operates the system....I think since 1972, what we have had essentially was what we call Medicare, we have been in a battle to maintain the system instead of expanding it."

A hospital administrator had grave concerns with contracting services to private companies. These concerns were linked to the issue of accountability. The problem with the contracting out is that the job of ensuring that standards are met. Accountability of the care provided is still the responsibility of the hospital administration and governance body. "I think the issue of standards is that the deliverer (the Regional Board or whoever) has a responsibility to encourage that standards are kept at a level. I don't think they can delegate that responsibility and I'm not quite sure how you can separate the contracting-out from the accountability. I would rather avoid contracting to direct-care givers. How do you ensure the level of professionalism that's necessary to ensure that high quality and high standard services are given to people all the time, everywhere?"

6. The attraction of overseas capital.
7. The effect on the domestic capital market.

These two categories were combined as the issue was access to investment. There was an understanding that foreign and domestic investment was a direct effect of privatization. There was a clash of opinions, a number of respondents felt that the 'invisible hand' of the market had no place within the provision of health care services. "The belief is that the private sector will do things more efficiently and the 'market will decide' what services are offered at what price," stated one health care professional. The profit model was not seen as either an effective mechanism for efficiency or effective delivery of 'medically necessary' services. A community activist stated, "Privatization by its very structure is geared to maximizing profits as its first goal, which will lead to a very different sense of delivery and comprehensive quality of care." There is the understanding of the reality that some sectors of the health system will benefit from increased investments and profit making.

Privatization means that there are increased investment opportunities for health businesses. One senior noted, "A number of home care companies have come into the province with poor service. They are the wrong people, providing the wrong service. Focus needs to be taken off the providers and put onto the needs of people."

8. The effect on employee involvement

The effect of employee involvement was mentioned in many different ways, from the phenomenon of 'dumbing' the system, to the withdrawal of the public sector. "All health-related services need not, should not, or can not be the sole responsibility of the government and the taxpayer to provide. . . [other health workers can benefit from a differentiation] between essential services that fall under the notion of universality and those that . . . are not basic." The respondent had the understanding that the public sector was expensive. For example, the public sector workers are well paid and have lucrative benefit packages. This is enough of a reason to privatize. "Services are considered to be able to be delivered more cheaply on a private rather than a public system basis. This is because the private option is considered to be less costly to government, i.e. benefit plans, salary levels, institutional support system, are all considered to be higher or more expensive when delivered by government." There was a comment from a government employee, that indicated that the culture of privatization affects the worker as well as others in the community. "For the health consumer, workers, services and society's compassion have become secondary."

Privatization has some very real effects for labour. "I am concerned from the workers' perspective. Insecurity, devaluing and de-skilling, these are the kinds of things I think. This is my emotional reaction of where it seems to be going." Employee professionalism was seen to be compromised by one hospital administrator. The example was the Health Staff Inc. contract at the Queen Elizabeth II Health Sciences Centre. "The hospital has an obligation to direct its work force. If its ability to direct that work force has been compromised by an employment contract, well this just should not happen. . . . In my view the head nurse must ultimately have a say as to who is going to work on her floor." The important issue here was both control and professionalism of the workforce. The kinds of behavior and the work ethic of the nursing staff have ensured a high quality care. "You do have to recognize that the reason we've had as good a system as we've had, even with all its faults, is there's been a fairly high degree of professionalism that has set the standard for people to achieve and we don't want to take that out of the system."

9. The effect on the social and political landscapes.

The philosophy of privatization, based on the 'the invisible hand' of the market has a profound effect on the social and political landscape. "It is both ideology and political action to encourage, promote and support the movement toward privately owned and operated goods and services, and away from government or direct public ownership and operation," states one health care professional. This sentiment is echoed by a community activist. "Privatization promotes a philosophy that is individualistic and believes each person should be responsible for ensuring their own financial well-being, and for caring for themselves."

During the debate with the policy analysts, the dichotomy that faces government was revealed. The model of the medical industrial sector is seen as having increased efficiency based on the 'bottom-line' doctrines. This is very attractive to government. They see this model as the answer to very difficult funding problems and rising costs. "In health, government is entering into the one area people do not want privatized, and government doesn't know how to deal with this. They reduce service and increase user or license fees for others. Now, we see the result of this concentrated attack on the public sector. What this means is you get 'dumb down' service and you are in and out of the hospital. Now you have to look after the sick relative or parent, the people the family has to look after now are a lot sicker. People do not want governments to extend these services to the private for-profit sector."

An administrator noted that the important issue is the control of the system under public ownership. The regional health board must have the courage to mange the system regionally. The issue of the provision of primary care is essential and the community boards are an important element. "You need to get the community health boards going and eventually get a buy-in from a large portion of the community, but must ensure that all the community is included. The provincial government has the responsibility of ensuring the provision of all health services under the Canada Health Act." There is no necessity to hand over the management to the private sector. There is no reason to import an American system. These alternatives are attractive as an easy answer to complex

problems, "It's a compulsion really. Just a manipulation by politicians to avoid taking responsibility."

The private sector analysis is quite different. They see a very important role for private initiatives and are not interested in destroying the current system. One business woman stated she does not like to think of this as an 'us' and 'them' situation. There are many ways in which the private-sector can enhance the public-sector, while maintaining the public-sector. She believes that the private-sector supports a role for the public-sector, especially in health and education. However, she feels there must be a way to meet as partners. "I think the role is a collaborative effort to make sure that all our social systems are well taken care of and protected." At the same time the goal of the private company is to turn a profit. The dual roles of protector and profit maker were not seen as contradictory.

There are a variety of philosophies behind the concept of privatization. These speak to the variety of effects that can be anticipated from increased private sector intervention. The philosophy becomes interwoven with the perceived effects. However, the prevailing philosophy, especially around the effect of efficiency, has had a profound effect on the relative value placed on private sector 'efficiency' and public sector 'efficiency'. The need to evaluate efficiency against the primary objective of the public system is seen as appropriate. These are not the same as the objectives of the private initiatives. This difference is often lost in the debate. The battle between 'big' government and 'big' business has created stereotypes that have obscured the reality of the hybrid system of health care in Canada. It has changed the focus from promoting, protecting and restoring health to reducing costs. This has allowed for a considerable shift to occur that rationalizes the change from 'big' government to 'big' business, leaving very little room for flexible, innovative approaches that seek to address the primary objective of the Canadian health care system. There is an understanding that this is a national and global shift that is taking place within the provincial context of the Nova Scotian health care system.

Efficiency

Stoddart and Labelle asked, "Will increased privatization of management improve efficiency in production of hospital services?" Their study focused primarily on the experience of hospitals, both investor-hospitals and non-profit institutions. They looked at the private management initiatives undertaken by the public National Health Service in Britain and they reviewed data from the Hawkesbury Hospital in Ontario that was privately managed. Stoddart and Labelle cite a study undertaken by Kralewski *et al.* (1984). This study conducted in the US looked at twenty hospitals over a six year period, three years before the initiation of the contract and the first three years following the contract.

> The most disappointing finding, in our view, is that contract management does not appear to improve the hospitals productive efficiency. This implies that management firms are unlikely to generate societal benefits. They may improve an individual hospital's financial health but only at the expense of those paying higher charges and higher insurance premiums (Quoted in Stoddart and Labelle, 1985, p.19).

Following a lengthy review Stoddart and Labelle determined that there are very limited benefits to the privately managed systems. The profits were gained primarily through more expensive services, especially ancillary services and the off-loading of the sicker patients on to the publicly funded system. They state:

> If hospitals do increasingly turn to private management firms to solve their economic problems, then they [as well as the government and the public] should be aware that a potential cost of their decision might be an altering of service mix and a decrease in the accessibility to services for more 'costly' patients. The number of inter-hospital patient transfers and the travel time between facilities for patients with complicated cases might both conceivably increase. The evidence from the US suggests that private managers are able to 'skim' the least cost cases and are quite successful at it (Stoddart and Labelle, 1985, p.26).

Their conclusion was that efficient management is not a skill set that is exclusively in the private sector. Public administrators can and do have access to the necessary skill sets to manage all aspects of the system.

In 1997, the theme of increased efficiency speaks directly to the perceived value of more private sector involvement. Efficiency was seen as a possible benefit from

privatization. However, it is viewed by the majority of respondents as limited and short term. Long term planning of an efficient system looks at the needs and potentials of both the citizens using the health care services and the workers staffing the services. This was not seen as an objective of the private sector. The idea that only in the private sector can services and programs be managed efficiently was questioned. The idea that the private sector would in fact increase inefficiencies within the over all system was expressed, and doubts about the mechanism for evaluating efficiencies were mentioned.

The following tables are very revealing in understanding the perceptions of the respondents. Table 4.3 shows that over half the respondents of the survey saw some level of increased efficiency. There was total disagreement on the possibility of increased efficiency between those in the academic/research community and in the labour community. All the academic/researchers surveyed indicated that privatization initiatives would increase efficiency, and all the labour representatives indicated that no efficiencies would be realized. The health care professionals can see areas where there is increased efficiency, but the perception of the government employees is that efficiency will be limited in scope. Members of the health care professions and community activists differentiated between specific efficiency and the over all efficiency of the health care system, as indicated in the two right hand columns of the Table.

Table: 4.3
Will privatization initiatives increase efficiency?

Group	No response	Will increase efficiency	Will not increase efficiency	Will not increase efficiency of system
Responses	3%	53%	34%	10%

The two groups that see the most benefit in efficiency from increased privatization are the academic/researchers and the health care professionals. One academic/researcher responded, "It seems to me that the services that should be privatized to improve efficiency would be services that are not directly related to patient care—i.e. parking, cleaning and human resources management."

The seniors did not subscribe to the notion that the private sector would provide services more efficiently. "Cheaper at what price? For whom is it cheaper?" This was followed by the statement, "Privatization usually results in higher price." There was an understanding that the system in the US is private and less efficient than the system in Canada. The group wanted to disassociate the discussion of efficiency from the wider discussion of the outcomes of health care. "It's not what you spend, it's the value you get. This is linked to public health. There is a problem of always focusing on the fiscal side, not on care."

The members of the Midwifery Coalition are advocates for 'alternative' health care. This kind of health care service is not publicly funded. They speak from the experience of using a private service. However, they did not see the midwives as 'for-profit' operators. "Presently they are grossly under-paid and under-supported." The issue of efficiency in the private sector was not relevant to their experience. Their concerns were focused on the debate of managed care. This care is determined by such external influences as regulations affecting malpractice insurance. The discussion focused on the medical model of health care delivery. "They'd rather pay for someone to have a heart transplant than to pay the money so that people could have a healthy diet." The same held true for low income women, "Same with pregnancy, how much would it cost to give women enough oranges and milk to ensure that their babies will weigh more than 7 pounds.? It costs $5,000 a day to keep them alive in an intensive care unit." Effective or appropriate care is important, not the efficiency issue.

There was a range of opinions offered by the policy analysts. However, the majority did not think there would be an overall increase in efficiency of the health system thorough privatization, in fact the reverse would be true. "As events have shown there is no link between efficiency and the private sector. It would work the other way. It would seem to me that when you have companies that are for-profit this adds extra costs. Unless you change the mix of services that are offered, or you take away the costs that are associated with providing the service. That is to lay-off workers. That creates other problems in terms of efficiency and even productivity. This privatization is all against the notion of non-profit administration, it is anti-worker and anti-public."

Another opinion questioned the goal of efficiency. "There is the question of appropriateness of the efficiency model. Yes, this probably improves efficiency but the question is, are they effective services? Application of business principles to hospital management makes services more efficient, but does not address effectiveness, appropriateness, accountability of services. Is efficient service the best possible service?" One hospital administrator who was negotiating a private sector takeover of casual staffing, believed that out sourcing of management would be more efficient than could be achieved in-hospital.

Expediency and perceived efficiency were very important in the decision to contract out this service. Due to the complexity of the hospital mergers that were taking place, the management of the casual pool took a low place in the hierarchy of tasks. "We have so many initiatives here at the QE II with the merger and new hospital, that it certainly was one of many issues. But it wasn't one we had a lot of time to spend on. . . So when the proposition was made to me from Health Staff, it seemed like a win-win situation for everyone." There will be savings in two ways: first, a time saving for the nurse-managers. They will be able to use their time more efficiently. Secondly, there is a saving in labour costs. "This initiative saves office space, saves setting up a whole other infrastructure here in the QE II. I mean we are trying to move as much out as we can to more appropriate places. It is more appropriate that this be done off site. We are in the market for trying to downsize everything we are doing here and move it out to the best place to have it done. It makes sense to go there."

Labour representatives see the contracting out of services as a direct attack on the public sector. The union officials saw this as a trend towards the contracting out of many services that werc presently done by hospital workers. "The members of the public should be concerned. Health care is a public service and when you contract public services out, you are not allowing for a continued level of care that is delivered by employees of institutions. There have to be people who are there on a regular basis to allow for an adequate assessment of people."

The academics see benefits right across the board, from security and parking through to management of professional staffing. They see benefits from a non-patient-care perspective and a direct-care perspective. The health care professionals are more likely to focus on the non-patient-care services and see less of a role in the direct-care areas, especially in the area of management of health care professional staffing. A health care professional noted that, "It can all be privately managed in theory, in the US it is the reality." The community activists are willing to look at limited private initiatives from non-patient to direct care sectors. A community activist explained, "Efficiency is not the issue, values are. Services that are rich in values (e.g. caring) should not be privatized, because there is little incentive to reflect society's values if privately run." Labour sees no efficiency to be gained from a worker perspective, "The profit motivation has no place in the delivery of health care." Government employees can concede some benefits from non-care areas but not to direct care. One government employee responds, "All my answers pertain to only a few areas where I think privatization would provide as good or better service at a better price." Table 4.4 looks at specific functions that respondents thought could benefit from privatization.

Table 4.4
Services that could be more efficient if privatized:

Group	Security	Cleaning/ laundry	Nutrition	Diagnostic labs	Staffing M.D & nursing
Positive responses	48%	38%	28%	24%	10%

One policy analyst noted that privatization is not an end in itself, it is a tool to create greater efficiency. Speaking from the position as an employer, "With a private company I generated the contract. I was the party that was in control in relation to quality. There was far more accountability to performance, reporting and financial results than when we are dealing with employed staff. The private company has so much infrastructure and ability to be flexible that our infrastructure did not have."

From Table 4.4 it becomes evident that nutrition services and diagnostic labs may not be seen as giving direct patient care. These two areas are currently under review as potential beneficiaries of a more private role. One health care professional cited a short

case history of the privatization of a hospital nutrition service, "I guess it depends what you mean by efficiency and efficiency at what cost. I have no doubt that costs will come down and that management systems will be much more efficient, but what will be lost? Possibly concern with the more human aspects of health and medicine, and certainly, decent jobs, salaries, and benefits. I have seen food service management companies take over the dietary departments of hospitals. Cafeteria food and variety improves dramatically, cafeteria income improves dramatically, and staff are very happy. On the other hand, patient food services deteriorate drastically, and in one case, the dietitian, employed by the FSMC,[1] was no longer allowed to have anything to do with the dietary department. Rather than acting as an advocate for the patient, she had to act as an ambassador for the FSMC."

Two other areas were mentioned that would benefit from an increased role. Materials management is an area that has traditionally been managed though a variety of contracts, but may benefit from consolidation under one contract. Clinical research is an area that is seen as being a potential net importer of funds to an academic health centre. These funds come from contracts with the pharmaceutical industry, issues of control were not raised.

By removing security, cleaning and laundry from the table the overall acceptance of the concept that privatization improves efficiency by those surveyed drops to 28% for efficient nutrition delivery to 10% for medical and nurse staffing. In all groups, respondents expressed concerns over the evaluation mechanisms used to assess efficiency. A number of respondents stated that privatization would decrease efficiency in the overall system. Others questioned the evidence used to support the efficiency claim.

The community activists were more concerned about the effects of privatization on the overall social fabric. "I have a basic problem with the question, I think efficiency is not the issue. Probably efficiency would improve for most of these areas, in the short term and very locally. I don't think that the efficiency of the province or of the nation

[1] Out-sourced food services company.

would increase. The result could be more people will be collecting UIC and welfare. I think that just looking at efficiency is a very narrow view." Another community activist respondent added, "It may, in the short term reduce costs to the public purse, but ultimately it is the public that will be paying." However, as one policy analyst questioned, what are the costs of an 'efficient' system to the overall health system? "Desirability and appropriateness should be in there too. Maybe [privatization] has capacity to improve efficiency but at what cost? Other costs to society can occur but we can ignore them if they don't accrue to the health budget."

Finally, the question of who 'owns' efficiency and who is committed to long term efficiencies was expressed. "I really think that you should evaluate a public system on an ongoing basis to adjust it. I am not sure why a thoughtful planned public system couldn't provide the same efficient services when it comes to staffing and resources. Current employment models in the private sector do not offer the consistency and commitment to employee training and well being, such as part time work, low wages, etcetera."

Since 1985 there has been a shift in thinking. A number of respondents, particularly academic/researchers and health care professionals find evidence that private sector involvement will increase efficiency within the health care system. There is an active movement within the business community to aggressively follow a pro-private agenda. However, community activists, labour and government employees were far more concerned about the possible effects of micro-efficiencies on the overall functioning of the health system. The seniors were unanimous in their rejection of efficiency as a result of increased privatization. The Midwifery Coalition members, from their experience of access in to private health care, did not see any increased efficiencies, especially in the areas of outcomes such as increased health status for mothers and infants.

While there has been a shift in thinking, the majority of respondents saw a very limited role for private sector involvement. Stoddart and Labelle's arguments still hold in 1997. What has changed is that some very influential people are willing to experiment with an increased, if limited, role for the private sector. The unanimous rejection of privatization as a tool for increased efficiency by both seniors and labour appears to come

from their sense of the history of social programs in Canada. The community activists were very skeptical of any changes that affected the direct care of patients.

Control of Expenditures

Stoddart and Labelle asked, "Will increased privatization of financing control public expenditure?" In 1985 Stoddart and Labelle found no evidence to suggest that the introduction of private funds to the health system controlled public expenditures. The effects of such private initiatives as user-fees, facilities' fees or co-payments have a number of effects on the system. The introduction of user fees increase the costs to the individual. This can increase patterns of under-utilization, causing a delayed cost to the system. The most insidious effect from the imposition of fees and co-payments is on the insecurity of the public. This results in the re-emergence of the call for private insurance to cover uncertain financial risks of illness. They stated, "It is difficult to believe that a ban on private insurance could be maintained in the face of extensive extra billing for relatively large proportions of patients' bills" (p.31). The two examples they give are from the United States and Australia. The presence of a public and private sector as is the situation in the United States, has resulted in the development of the most expensive health care system in the world. "The US experience with just such a system and its inability to achieve any significant overall expenditure control, strongly advises against starting down such a path" (p.31). The Australian example demonstrates the ease with which their national insurance system Medibank can be dismantled.

> Policy changes to replace Medibank were deliberate and forceful manipulations to encourage private coverage, and were motivated more by ideological preferences about the structure of the health care system than by considerations of the effect of alternative private /public mixes on its effectiveness and efficiency (Deeble, 1982; Najman and Wester, 1984). In fact, although both academic and official analyses were conducted on issues of performance (and were generally critical of the voluntary private system on both efficiency and equity grounds) evidence played only a minor role in policy decisions (Stoddart and Labelle, 1985, p.31).

In 1997, the respondents were asked if privatization initiatives would affect control of public expenditures. The seniors did not see that control of public expenditures was the issue. However, they raised three associated issues. First was the

perception that the government lacked funds for the present system. The second issue was the present costs to the system. Publicly funded care is almost exclusively provided by doctors and nurses. Doctors are a very expensive part of the current system. The third issue was the cost of the private providers. The debate focused on the home care companies. There was a warning from one senior concerning the emotional aspects of health care, "Health care can cause emotional overload and this can be exploited by a private company." While the majority of respondents did not think that privatization initiatives would control public expenditures, there were some dissenting opinions.

Members of the Midwifery Coalition did not feel that more private sector involvement would save the system money. Their direct experience includes having to pay for a service outside the system. This has two effects. First, the cost to the individual can be prohibitive so that a service may not be used. "Income definitely affects the decision. I almost didn't choose a midwife because of the problem of income." Secondly, a service that is publicly funded has the credibility of the system and has a place within the system. "Being publicly funded carries with it credibility and a requirement that the system accommodate the practitioner."

Table 4.5 shows that the majority of those surveyed did not think that privatization initiatives would control public expenditures. The policy analysts were unanimous in their opinion that no savings would be made to public expenditures. "User fees won't decrease expenditures. Privatization will indicate preferred vs. average treatment." Government employees did not feel that expenditures would decrease but there could be savings in the short term. "I have never seen this happen." "Evidence has

Table 4.5
Will privatization initiatives control public expenditures?

Group	No response	Will control expenditures	Will not control expenditures
All responses	3%	30%	67%

shown just the opposite." While the academic/research respondents felt more positive that savings could be achieved, they were cautious: "It probably will not control it, but it will help to reduce it." "It will by definition. Government will not be willing to spend

more funds if they are reducing the services they are paying for. Control is easy. Managing the impact of control is much more difficult."

The labour respondents were also unanimous in their disregard for the possibility of savings. This was voiced by a concern about an increased demand for the services that were funded. "It will increase administration costs and the burden on individuals, families and communities. We need only look to the US to show how expensive and inefficient increased privatization will be." The health care professionals were also reluctant to see the potential for savings. "There is not a direct relationship between privatization and more funding control, it depends on many factors." "I answered both yes and no, because sometimes proper control is not put on the contract costs any more than on the 'in-house' costs." Finally, one respondent noted that if government withdraws completely from the provision of services, then savings will be made. "Obviously, if the government is no longer paying for health care, there is no public expenditure in this area."

The community activists tended to view the whole system, not just a sector of the system. The majority did not think that savings would accrue. "I think that the answer is yes if you look at the bottom line of the hospital. If you look at the bottom line of the health and social service sector, then I believe that the public expenditure will increase in the long run." There was the comment that this has not been the case in the US. Two respondents commented on the transfer of public funds from the public system to the private sector. "It will just take funds now available from the health system and move them into the private system. It will especially affect community-based programs and all aspects of health not directly related to sickness care." "No, because it will be public dollars that are used to pay private businesses to provide services."

In 1985 Stoddart and Labelle did not find any proof that private funding would control public system costs. However, they reported that lack of evidence was not enough to prevent the ideology of privatization to control the agenda. In 1997, cost savings to the public system through privatization initiatives were not seen as a possibility by the majority of respondents.

Two aspects of privatization were of concern. One was the withdrawal of government from both the provision and funding of health services. If this was the case, then there would be savings in the public health sector. The withdrawal of health sector services was viewed by others as an inefficient saving, as the effects of this withdrawal will be felt in other areas of the public sector, such as social services and education. The second aspect was government withdrawal from service provision, but funding for private sector provision of services. In this case there was great skepticism expressed.

Utilization

Stoddart and Labelle asked, "Will increased privatization of financing reduce the utilization of ineffective and/or unnecessary services?" In 1985 Stoddart and Labelle did not find any evidence that clearly indicated that private funding would reduce ineffective or unnecessary services. What they did find was that funding decreases all levels of utilization of services for those who cannot afford them, and does not affect the unnecessary services for those who have the extra funds. The primary point made by these authors was that while the initial contact is initiated by the patient it is the physician who orders the service. However, the services that are utilized are prescribed by the physician, therefore it is unrealistic to expect penalties imposed on the patient can affect the kinds of the services offered by physicians. Stoddart and Labelle pointed out one study, from the States, that did find savings to the US Medicaid program with a co-payment.

> Overall that co-payment had its intended effect, even though they reported significantly lower utilization rates for immunizations, pap smears and obstetrical care in the co-pay group (Stoddart and Labelle, 1985, p.36).

They concluded "The claim that changes to patients will improve the effectiveness of the health care system by reducing inefficacious and/or unnecessary utilization—even for the portion of utilization that is patient-determined—remains unproven" (Stoddart and Labelle, 1985, p.37).

In 1997, the majority of respondents indicated that utilization of services will not be reduced by private funding initiatives. The respondents were asked if they thought that increased privatization would affect the utilization of health services by both the patient

and the health professional. There is the understanding that reducing utilization in one service area can increase utilization in other areas. This results in making the overall system more expensive. The issue of utilization must be linked to the issue of appropriateness of care. Access denied by ability to pay will encourage under-utilization by some patients who need the services, and do nothing to deter patients or providers from utilizing unnecessary services. Utilization patterns have to be linked to outcomes on a very broad scale to determine if there are cost savings to be made.

Of most concern to the respondents was the inappropriate under- utilization of services by those who cannot afford the private payment structure. Table 4.6 shows how the respondents saw these effects. The majority of respondents indicated that introducing

Table 4.6
Will privatization initiatives reduce utilization of services by patient?

Group	No response	Will reduce utilization	Will not reduce utilization	Encourage inappropriate utilization
All Responses	0%	27%	53%	20%

a private payment mechanism for services would reduce utilization and or would encourage inappropriate utilization. Those who said this would not reduce utilization indicated that in the long run more services may be needed. One government employee noted, "I don't believe there is misuse of the services now. There will be increased use of services in the long run—as I don't think people will check out small problems if there is privatization." An academic/researcher said, "It could reduce utilization. Having to pay for insurance and services may cut down on utilization of unnecessary services, the concern is that people wouldn't access necessary services because of the cost." A health care professional stated, "In some cases it will—but it will also reduce access to essential services."

Increased utilization of services is a very important aspect of any private sector business plan. The criterion for access is based on ability to pay. Given that ability, there are many services that could be offered. Currently home care companies are looking to

create these opportunities for increased utilization. There are plans to expand the client base to support staffing for home care and to non-traditional sites. "We've been thinking about opening home care centres where the public could come in and talk to us about things, to enable them to get home care. We can staff these centres, they can get the device or whatever equipment, they can get advice and they can get service at the home from the nurses. So acute care nursing is in that environment, it is such a value added service."

The discussion of utilization with members of the Midwifery Coalition centered on how decisions to use and to provide services are made. The group had great skepticism with the idea that there was any rationale to utilization decisions. They believed that people will utilize the services that are available to them whether or not they are in fact the most appropriate services to use. The providers will support utilization of the services that they provide, whether or not that service is the best for the situation. The question of utilization of services was seen as a very emotional issue. Decisions had to be made when the user of the service was most vulnerable. One woman spoke of its emotional impact. "The lens is gut emotion and guilt which are the basis on which way too many decisions are made about health care. All of the things to do with pregnancy such as fetal monitoring, tests—are all gut emotion and potential guilt."

The policy analysts focused on the issue of where the money is spent. From a patient perspective, increasing the private funding of health services will mean that those without the money will utilize services when they are much sicker—an added cost to the system. For those with the funds, the utilization patterns will remain the same.

More respondents were ready to believe that privatization initiatives would reduce utilization of services by health care professionals. Table 4.7 shows that privatization initiates were more likely to affect the utilization patterns of health care professionals.

Table 4.7
Will privatization initiatives reduce utilization of services by health care professional?

Group	No response	Will reduce utilization	Will not reduce utilization
All responses	0%	37%	63%

The labour view is that there is no evidence that overall expenses will be reduced: "In fact the opposite seems more likely and there is growing evidence to show this." The academic response is based on the reduction of the utilization of particular services in the short term, but not in the long run: "Cost and utilization by provider, it could tighten controls and accountability. Right now there is no incentive for physicians to reduce service provision." A health care professional agreed, "Privatization of financing does not provide incentives for physicians to cut down on procedures etc. The more they do, the more they make. Some will increase, some will do what is necessary, and some will be conscious of the patient's financial capability."

The issue that privatization would improve appropriate utilization was met with skepticism by the policy analysts. "It never crossed my mind for a minute that the point of privatization was improved outcomes. Privatization is to cut costs, to improve efficiency, to improve service delivery—it is totally separate from the 'doing it right versus the doing the right thing' argument. . . . [A very efficient hospital] could carry out functions that are both arbitrary or unnecessary. Whether the service is necessary or unnecessary is an entirely other issue." A health care professional pointed out the reality of the private system in long term care. "My experience is in private nursing home care. Public facilities are the route of choice when the patient has no money. The minute there is money, the option of private homes becomes viable. As a health care professional, I am looking for a bed for a patient."

The seniors' discussion centred on the appropriate use of services. The current system has built-in problems, such as over-reliance on two kinds of health professionals, doctors and nurses. The question was how to change the current system to meet the needs of the future. When asked about the past, the seniors spoke of significant under-

utilization of services due to lack of funds. "You had to be really sick before you saw the doctor." This inappropriate use of the system by under-utilization was matched by some over-utilization of the system to-day. They expressed concern with the over-medication of seniors today. Both under-utilization and over-utilization creates "poor medical practice."

Finally is the issue that the savings to one part of the health sector can have more expensive effects in other areas. "When you look at the background, still there is very little planning going on. Other countries spend more on social services, including health than we do in Canada. It is a question of where to put the money." The problem with looking at utilization of individual services is that the big picture of continuity of care is missing.

In 1985 and in 1997 there is no evidence to support the claim that there would be a net decrease in costs to the system by introducing private sector initiatives. The issues that need to be addressed center on appropriate 'cure' and the 'care' services within an integrated social framework.

Increased funding

In 1985 the question posed was, will increased privatization of financing inject needed funds into a currently under funded system? Stoddart and Labelle attempted to separate some of arguments used to defend the need for increased funding from the private sector. The key to their argument was the 'need' for funds to contribute to the effectiveness of meeting the population's needs, these included issues of access, effective care and equity. The validity of these 'needs' had to be demonstrated and this was done by examining the mix and level of services available. If need can be demonstrated in either the mix or the level of service then the question is: should this come from the public purse and not be reliant on private funds? In reality the results of private funding, especially in terms of user or facilities' fees, can be seen in increased levels of income for health care professional, primarily physicians. The downside to a mix in public/ private funding mechanisms can be seen in the increased costs of health administration. Stoddart and Labelle point out,

> Sole-source public funding of the Canadian health care system has seen to date the only successful mechanism for controlling costs and exerting pressures for rationalization of facilities and utilization. It should not be abandoned carelessly (Stoddart and Labelle, 1985, p.41).

Technology is driving the pace of change, specially within the hospital. The increased expenditures associated with these technological changes are placing increased pressure on hospital budgets. Finally, Stoddart and Labelle examine the tensions between the funders and the providers. These tensions are based on the problem of control. Each of the partners believes that they have legitimate right over control of funding or control of utilization of services. The injection of private funding would do nothing to address these tensions. The task has to be the linkage between funding and the appropriate utilization of care. They concluded this section with the reminder, "However, any proposals for change to the system must recognize the importance that Canadians place on the goal of equity as well as those of efficiency and effectiveness" (Stoddart and Labelle, 1985, p.44).

In 1997 the respondents were asked if private initiatives would increase funding to the health system. Three quarters of the respondents did not believe that privatization would inject new funds into the system. The question is where the new funds would go to: not to the current system, but directly to meeting individual needs. However, as one labour respondent pointed out, private provision or funding of services means that for many there will be an increased burden of costs: "It will increase costs for individuals, families and governments and only increase funding to make a profit for well-paid individuals."

The majority of respondents did not think that there would an injection of funds to the system. More funds would be needed, but they would go to private operators, not to the public system. Some felt it would in fact increase costs to the government and others felt that the increased funds would come from the pockets of the consumer. This was already a reality for some patients who are discharged early from treatment. The following table represents the responses. There was also concern that this would affect equity of access to certain services. Two health care professionals felt that the system would be more efficient if such services as Pharmacare and dental care were

included under the public, single payer system. Access to these services is based on a need to pay, and results in under-utilization by many families. Table 4.8 indicates that the majority of those surveyed did not agree that new funds would be available to the health system.

Table 4.8
Will privatization initiatives inject new funds into the health system?

Group	No response	New funds	No new funds
All Responses	3%	20%	77%

New Funds for primary health care, home care, Pharmacare, illness care, diagnostic services, clinical research and dental care.

The community activists agreed with labour and could find no reason to believe that new funds would be available to the public system. "Opposite effect most likely. Privatization will inject more funds into private pockets not the public system." Another activist suggests, "No, the funds would go to particular services rather than the system as a whole (as taxes now do). The redistribution of resources within the system would be hampered—especially as those best able to pay would be best able to influence the distribution of resources."

The issue of increased funding was presented within the framework of reduced public sector services. Many of the seniors have direct family experience of the private pay-for-service system. Stories of hotels in Halifax, Truro and Sydney providing convalescent care services for early discharge patients were shared. "The Holiday Inn and the Lord Nelson hotels are providing some rooms for patients on an interim basis, following chemotherapy. But there is no care. These hotels might want to get into that business. The Lodge for patients at the Cancer Treatment Centre is not open on weekends, so patients have to go elsewhere." This analysis was support from the business community.

The business woman interviewed is looking at a number of contracts in other areas of Nova Scotia, Canada and the United States. "I have a very strong business agenda and have been developing some other markets . . . There are some wonderful opportunities both in Canada and across the boarder." Hotels, that are offering health

care services are seen as a growth industry. Calgary and Antigonish were mentioned as locations. "In Calgary a group of nurses have organized and are operating two floors of a local hotel, they're doing this in Antigonish as part of the early discharge service. People go to the hotel and it is staffed by nurses. It is a wonderful interim between leaving the hospital and going home. I am developing business opportunities for these nurses. I've been to a hotel and talked to them and am evaluating the risks, the costs and the opportunity."

The policy analysts saw two distinctive themes in the discussion. First, the system has sufficient funds. It is the allocation of these funds that is the problem. "This would depend on how you looked at [increased funding]. We have far worse health status than other countries. What does that say? That we are doing the wrong things." Health funding is not linked to outcomes in health status. Second, increased private sector funds would only increase activity in areas where there is under-utilized capacity. "We can only work so hard and throwing more money at it will not make the system run any better. This does not mean that it is not going to happen. This is the flip side of the situation in the UK where five to seven percent of the services are privatized. You have the option of having the gall bladder operation done right away or of waiting for some months for the system. We have excess capacity within the hospitals right now to do this."

There are two spill over effects that were evident in the 1980s and are of particular concern in 1997. The reductions in staffing are resulting in a demoralized and stressed work force, and secondly the dramatic effects of the trade off between 'care' and 'cure' within the institutions. The flight from providing 'care' has resulted in a large private industry being set up with private home care companies and hotels offering specialized nursing care for convalescent patients. Concern for the effects of privatization on equity of access was expressed in 1985. The same concern was expressed by all categories of respondents in 1997.

Erosion of Equity of Access

The 1985 question was, "Will increased privatization of financing erode equity of access across income classes?"

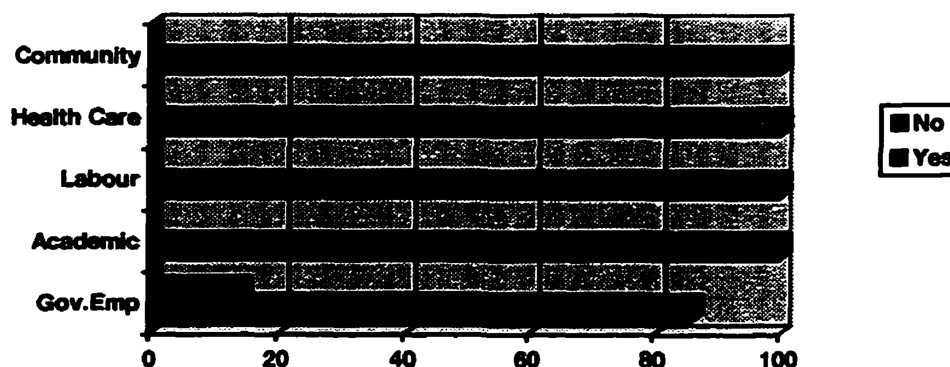
Stoddart and Labelle clearly state in 1985 that the fundamental objective of the publicly funded health care system was to remove financial barriers from access to health care services. Any privatization of funding will have a detrimental effect on the ability of the poor to both access services and to comply with the care protocols set out by the health care professional. They noted the correlation between, age, income, health and poverty. They expressed the concern that those very people who have legitimate need to access the health care system would be prevented from doing so, based on their ability to pay. The argument that such individuals would be able to access the system, based on identification through a means test was seen as unworkable. The reality would be, as it is in the United States, that hospital and health care professionals who charged fees would be reluctant to take on patients who did not have the ability for co-payment. The sick would find it increasingly difficult to receive any care.

Stoddart and Labelle reviewed studies that had looked at the effects of the practice of extra billing for physician services in Canada. One of the examples that they give comes from Alberta, a province with a strong tradition in favour of co-payment for health services.

> The Alberta College of Physicians and Surgeons has stated that its traditionally strong support for extra-billing has been 'shaken' by the discovery that 800 practitioners are charging supplementary fees to the patients on welfare (Shepherd, 1985). In its annual report to the profession, the college stated, "Should extra-billing persist, and current mechanisms for determining exemptions prevail, equal access to medical care across income classes will undoubtedly be eroded" (Stoddart and Labelle, 1985, p.49).

They concluded that the socially disadvantaged, the poor and the elderly will be the most adversely effected by the introduction of private funding for health services.

Figure 4.1
Will Privatization Erode Equality of Access?



In 1997, ninety-seven per cent of respondents felt that privatization initiatives would erode equity of access to health services. The poor, the unemployed, the old and those with low paying or part time work would be the hardest hit. Only one respondent reported that privatization of funding would not affect equity. Figure 4.1 demonstrates this agreement.

Such comments as this one from an academic were typical, "Any fee structure will have a negative effect on the poor." A labour respondent said, "A multi-payer increased private system is the death knell for universality and equity of access, and creates more indirect costs to government." Private funding initiatives would affect equity. For some there would be a choice as one member of the midwifery Coalition mentioned, "In my case I would have the choice to buy private insurance. I might not want to but I would have the choice."

A health care professional used the current example of access to dental services. "Dental services are now almost exclusively funded through private insurance, most frequently as a benefit of employment. According to Canadian Dental Association polls, the highest percentage of persons with insurance ever recorded is about 52%. This is a significant number of persons who do not receive regular dental care." A community activist used the same example, "If you have a low paying, or part time job, many of which do not provide health insurance. Three of my family members, for example do not have dental coverage and that is very expensive. Privatization will penalize the poor."

The Seniors compared the issue of privatization of financing for health services with the private system that was in place before Medicare. "The people didn't use the system because they couldn't afford it and suffered dearly." Even in the business community there was concern over equity. The idea of a completely profit driven system was not a comfortable one for one business woman interviewed. "If it becomes completely profit driven there will be short cuts and there will be change. Change in not always universal and it's not always fair—but I don't think that's the way we're trying to move in Canada." However, the argument is inconsistent with the drive to maximize profit. "I don't think there should be a profit driven health care system. I think if the private sector can provide services without changing or impacting people's roles in the public sector and even by enhancing them, reducing costs and they make a profit. I really don't see what everyone is concerned about, they're not impacting anything negatively."

All systems have a varying degree of equity of access. The question is: What is the level of inequality that the government is willing to accept? "It seems that we will put up with inequalities based on where we live, such as Meat Cove or Sydney, but we don't want inequalities based on financial ability to pay." The arguments put forward by Stoddart and Labelle in 1985 are relevant in 1997.

Winners And Losers From Increased Privatization Initiatives

The respondents were asked to identify those who would win from increased privatization initiatives. The list was complied from readings by Starr (1982) and Sherrill (1995). It is very clear who the losers will be. The chronically ill, those without the kinds of jobs that give out benefits, and health care workers will all be less well off under a private health care system. Three respondents specifically indicated the poor will suffer. The winners are more complex, different individuals may benefit in specific instances, but overall the costs will increase for all who need the system. Table 4.9 reviews the responses for the 'winners'. The big winners are the private care provider, their shareholders, the private insurance companies, management consultants and other professionals such as lawyers. The beneficiaries of a more private system are those who can directly profit from the provision of health services. The for-profit operators, their management and the

companies that service the corporate sector. In the broad sweep, the winners are the shareholders and private corporations and the losers are everyone else.

Table 4.9
Respondents Assessment of
the winners from privatization initiatives in health care.

Winners	All resp.	Winners	All resp.
Citizens	7 (23%)	Dept. of Health	10 (33%)
Patients	6 (20%)	Private providers	28 (93%)
Family of patients	5 (17%)	Shareholders	29 (97%)
Doctors	11 (37%)	Private insurance com.	24 (80%)
Nurses	5 (17%)	Management consult.,	25 (83%)
Other health prof.	7 (23%)	Other professionals	21 (70%)
Other health workers	12 (40%)	The economy	5 (17%)
Hospital corporations	18 (60%)	The workforce	7 (23%)

The idea that a private company can manage the system more effectively was questioned by one of the policy analysts, "Why can't changes be done internally without that private partnership?. . . Why do they hire a private company to do this? The technology is obviously there, so presumably the [hospital] could have done it themselves just as easily." This idea was contested by the concept that the 'entrepreneurial drive' that a private company brings does not exist with the mix of institutional employees. "We tried and did not find them. Quite possibly they exist and we were just not matched." It appears that sometimes it is just easier to hire an outsider than to "sit down and go through the process."

One academic respondent felt that individuals in all categories would be winners and others would be losers. A health care professional agreed, "From citizens to hospital corporations there will be winners, gains in quality of care, and increases in availability of service. Competition equals survival of the fittest, so bad practitioners and hospitals will be weeded out. In some respects everyone wins, in others we all lose with increased private sector involvement." A labour respondent stated, "The big winners are the health industry, the corporate sector and their allies in government and management." One business woman saw no distinction between the health care worker and the entrepreneur. "I always considered nurses as clinicians. I had not realized that there is a whole other group, a very large majority of nurses who are business clinicians. They are business

women primarily. They want help to change their situations, but didn't know the avenues and the vehicles to do it. They are really fired up and excited."

Community activists saw the potential winners and the problems created, "No waiting lists for those who can pay i.e. cataract removal. Jobs will be threatened, less pay due to re-engineering, lower workers for cost efficiency. Workers displaced in competition for low-paying jobs." Table 4.10 demonstrates the responses indicating the 'losers.'

Table 4.10
Respondents Assessment of
the losers from privatization initiatives in health care.

Losers	All resp.	Losers	All resp.
Citizens	26 (87%)	Private Providers	0
Patients	28 (93%)	Shareholders	0
Family of patients	26 (87%)	Private insurance com.	0
Doctors	18 (60%)	Management consult.,	0
Nurses	24 (80%)	Other professionals	2 (6%)
Other health prof.	24 (80%)	The economy	14 (47%)
Other health workers	23 (77%)	The workforce	17 (57%)
Hospital corporations	4 (13%)	No Losers	1 (3%)
Dept. of Health	12 (40%)	The Poor	3 (10%)

One community activist advocated the role of the cooperatively owned businesses. These could provide service and maintain the system: "If cooperatively owned businesses (owned mostly by employees) were used to provide services, there is probably a good chance that social values would be incorporated also the profit would be distributed more equitably, which itself affects health."

On the subject of physicians was the following comment: "What you are seeing is an evolution of the physician as employee or contractor." Some physicians do not want to live with this. The individuals who can benefit will work for particular kinds of private clinics: "There will be some specialties and professions that will be losers, because of their inability to change the focus of their practice, they will have difficulty. Other physicians are very entrepreneurial. For example ophthalmologists outside the academic centres receive about 43% of their income comes from private sources. So a switch for them will not mean as whole heck of a lot. But take a pathologist—he doesn't perform a

service that is in demand by a lot of patients." The loss of a publicly controlled system would mean a radical change, "very few winners, the system will lose, certainly the workers. A shift to privatization means an undermining of the values of the public sector." The idea was expressed that the withdrawal of the public sector will increase the overall gap between the rich and the poor.

There is a higher consensus on who would be the losers from increased privatization initiatives. Ninety-three percent of respondents indicate that patients would lose, 87% said family members would also lose. One government respondent indicated there would be no losers, and three respondents specifically indicated the poor would lose. "The big losers will be the general public, government and public services in general." A health care professional pointed out some of the hidden problems: "Citizens, patients, family members and all health care professionals will lose due to decreased control of system, inequalities in accessing services, potential increase in preventable deaths for treatable chronic disease." A community activist contends that a more private system will change the dynamics of income and resource distribution in the country, "Redistribution of money—more in hands of rich and corporations."

Most Appropriate Funding Mechanism For Health Care System

The respondents were asked what is the most appropriate funding mechanism to support the five principles of Medicare.

Half of the respondents felt that to preserve the principles of Medicare full funding of the health care system should come from general taxation. Table 4.11 illustrates these findings.

Table 4.11
How should we finance our health care system?

Group	No response	100% gen tax	Private Ins/ except for poor	75/25 gt/private Insurance	Other Mix gt/private Insurance	Mix gt/ health tax or premium
All responses	1 3%	15 50%	1 3%	3 10%	2 6%	8 28%

One respondent felt the traditional formula of 75:25 was correct. Another 27% indicated a mix from general taxation and/or a special health tax. One respondent suggested private insurance for all except the poor and 2 respondents were looking for a different mix with more than 25% private funding. The following are some of the comments:

- "100% from general tax is the best, but maybe Canadians would want to pay a special health tax to ensure the principles of Medicare" (Labour representative).
- "The fairest and most efficient method of financing is through a progressive tax system, combined possibly with employer taxes where necessary to find a health service in particular" (Labour representative).
- "75-25% I think I would start there, decrease tax burden, increase personal accountability of use" (Health care professional).
- "Private insurance could be available for those who could afford to pay for surgery to avoid long waiting lists—cataract, knee replacements, hip replacement and cosmetic surgery" (Community activist).
- "Introduction of private insurance etc. reduces accessibility for some, contrary to principles of Medicare" (Community Activist).
- "Funds must be redirected to primary care and community-based services" (Health care professional).
- "In the US health care is a commodity. In Canada it is a public responsibility to provide health care" (Policy Analyst).
- "When it comes to health care programs and health taxes we are at the short end of the stick. The federal government allows only certain health care programs into the communities. . . .It would be nice to govern our own health care. I guess that's why they had the Royal Commission on Aboriginal Peoples" (Academic/researcher).
- "We all pitch in and provide a universal health system for everyone." This is based on a sense of collective responsibility. Once there is a private/public

partnership there are extra costs to the individual and there is a sense that people would get both 'poorer and sicker' (Senior).

The majority of respondents saw the potential of continuing with the primary source of funding coming from general taxation. This was based on the principle that health care services are a collective responsibility. However, there were many comments that indicated that there is some funding of unnecessary services, over-use of some services and the under-funding of other services. The funding mechanism is linked to what should be paid for, and how to pay for the services. The issue of the fee-for-service payment mechanism was mentioned, as was the establishment of clinics and funding for primary and community based services. A number of respondents commented on the cost-effectiveness of the single payer system.

One respondent concluded the survey with, "Health care is no place to pursue profit. Quality, universal health care, provided publicly, should be our right. Privatization promises to return us to the days before Medicare—not to advance our thinking on the delivery of our services. This more recent debate demonstrates the need for more public control, accountability and democratization. What also seems to be lost in health services are caring, direct services and not industrialized production processes." This idea was challenged by the private sector who see room for profit-making. This company is profit motivated and expects a margin of profit between ten to thirty per cent. "Our company is absolutely a profit driven business corporation." Nevertheless this business woman also feels that the public health care system is an essential part of the Canadian social network The question is, "Who funds the ten to thirty percent profit margin?" The answer appears to be the tax-payer.

Perceived Influence Of Trade Agreements On The Health Care System

The respondents were asked if they felt that trade agreements could affect the delivery of health care services in Canada.

At least one third of all respondents did not feel that they had enough information to comment on the potential impact of trade agreements on the Canadian health care system. Of those who had the knowledge, the NAFTA appeared to present the greatest

potential for impact. The Internal Agreement on Trade was of concern, as was the World Trade Organization. The impacts of these agreements were all expressed as negative. They open up the potential of an 'Americanized' system and the fear of the commodification of health care services. The comments refer to a sense of unease over the trade agreements. The respondents indicate that they think the health system is vulnerable. One government employee admits, "I have only experience with NAFTA, not with the others. I am very concerned about the export and control of health care, and of it being taken over by American [health] companies. I am concerned with private insurance companies undermining the national health care system." This was followed by a comment from a second government employee. "Any trade agreement that allows private corporations to deliver service (will affect the system)." A labour representative states, "They open the door to unrestricted corporate takeovers and intrusions into all aspects of health care delivery. They would change health care services to health care industries and effectively end Medicare as we have know it." A community activist asserts, "They open Canada to 'invasion' of private HMOs, competition that they claim will provide services for less." Table 4.12 shows the respondents' concern on three trade initiatives.

Table 4.12
Which international trade agreements affect the government's ability to provide health services in Canada?

Group	Internal Agreement on Trade	NAFTA	World Trade Organization (GATT)	Do not know/ no response
# of positive responses	10	16	7	10

One health care professional noted a concern with the Internal Agreement on Trade. "The Internal Agreement on Trade promotes portability of professional services across provinces through national certification rather than through provincial systems."

The Canadian Pensioners Concerned were the most informed and concerned about the trade agreements, especially the NAFTA. "If we put our health care under private

organizations, then we are under NAFTA and that means we have no control, we lose control. That's bothersome because I do not think we look at NAFTA very often. For example Bill C-91, the drug bill, may remain as it is because of NAFTA." The idea that there is more of a separation between 'health' and 'health care' was also raised. The former Minister of Health, Mr. Dingwall talks about health, but the Minister of Industry talks about 'health care.' "On the issue of Bill C-91 the federal government will use John Manley, Minister of Industry, Trade and Commerce to deal with that issue as opposed to David Dingwall. This tells you what has happened, it has now become a commercial approach as opposed to a medical one."

A number of respondents mentioned one impact would be the changes in the values and principles on which the Canadian health system is based. The loss of national control over the system was also of concern. There was concern over the impact of the Internal Agreement on Trade and of the international agreements supported by the World Trade Organization.

Chapter Five
Discussion and Conclusion

A number of critical themes have emerged from this study. From a structural perspective there are three key points: the position of the health care system within the public system; the position of the public system within the emerging framework of the national government and the position of the national government within the global economy. From an ideological perspective the theme centres on the analysis that is coming from both the 'new' right and the 'new' left. The management theme is of the relative importance of 'evidence' in the development of public policy designed to meet the goals and objectives of the health care system. The theoretical model of the convergence of interest demonstrates the pressures that are creating an environment where the goals and objectives of the Canada Health Act have become obsolete. It appears that since 1985 the 'goal posts' have moved and the rules of the game have changed. Finally, the question returns to the challenge of maintaining the public's trust in the Canadian health care system.

Structural Perspective

We must inhabit the structures we create. Therefore, Coleman (1982) advises we should be very careful about what we create. In most of the western democracies, following the Great Depression and the Second World War there was a concerted movement to formalize, through government action, social justice policies that would re-distribute wealth and enable all citizens to live with dignity. As Starr (1982) has explained most social and health programs in Europe were founded on an understanding of the economic and health status of the working classes. The exception was the United States. The progressive, social democratic forces in the US did not prevail. The creation of their health care system was based on providing opportunities for the middle class to access medical care and for the medical-industrial complex to access the resources of the middle classes. The Canadian system has borrowed from both continents. The philosophy comes from the European model, the creation of nationally funded programs that meet the needs of the people and re-distribute some of the wealth of the nation. The provision of services comes from the US model, enabling the citizens to access the

medical-industrial complex and giving the medical establishment a monopolistic access to the people.

In Canada we have developed a hybrid system whose underlying structural integrity comes from the integration of social programs to "promote, protect and restore the mental and physical well-being of the residents of Canada." However the structural bases of the provision of services are based on medical intervention. The integrity of the patient/physician relationship carries a higher priority than the integral relationship between the health care system and the citizen. The clashes between these different sets of relationships create the pressures that appear to threaten the system. The fuel for these clashes is money and control of money. For example, within the 'patient/physician' relationship there is a very defined power imbalance. The physician has the knowledge and expertise and the patient wants the benefits of that knowledge and expertise. In a private system knowledge and expertise are available to the highest bidder. The one with the resources can control others accessing these resources. The professional independence of the physician is based on his/her ability to determine the fee structures for the services rendered. Therefore the physician can set the terms of the relationship and terminate that relationship if the terms are not acceptable. The ability to terminate the relationship has been fostered by the fee-for-service payment mechanism. The fee-for-service payment has created an environment where the patient contracts with the physician for a very specific set of services. However, the public health system tells the citizens that the goal of the system is the promotion and protection of the overall health of all the people. Therefore we have a system that looks at the broad determinants of health but the primary contractors do not have the overall health of any one patient as their responsibility. They are contracted to perform discrete functions on particular body parts for a set sum of money. The more discrete functions, the more money, rather than the more healthy citizens the greater the overall productivity of society.

The second structural theme is the position of the public system within the emerging framework of the national government. From Oliver Letwin (1988) and Herschel Hardin (1988) we learn of the dramatic shift from the acceptability of 'big'

government to the acceptability of 'big' business. The subtitle of the current thesis is 'The Privatization of the Canadian Health Care System.' However, we have learned that privatization is not an end in itself, it is a tool for the radical transformation of the role of government. Social programs account for a substantial percentage of government expenditure. Government expenditures are paid for through taxation. Taxation is seen as an assault on the freedom to control wealth and resources, as it is a mechanism for wealth re-distribution. The control of wealth and resources has been moving from nationally based individuals and corporations to globally-based individuals and corporations. The fragile link, made by the European proponents for social programs, between the well-being of the workers and the well-being of the nation has been severed. The well-being of the global corporation is based on unregulated access to commodity markets -- including labour commodities. These corporations have no encumbering responsibility for the preservation of any particular commodity at any particular moment in time. As the link between labour and production has been minimized, the link between the sustainability of a corporation and the sustainability of a community is now non-existent. As national governments identify their fortunes and futures within the global economies, they will have to promote policies that favour the rights of the global corporation over the rights to a sustainable future of the citizens and their communities. These policies are represented by the creation of the 'virtual' governments and the integration of global corporations though international trading agreements.

The third structural theme is the position of the national government within the global economy. As the national governments race to divest themselves of control over the wealth and resources of the nation they are creating an environment where the role of government will become obsolete. Like the 'rain-maker' or druid of past eras, the role of politician as instrument of 'government' will be a shadowy figure lost in the mists of time. As the role of politician is integral to our democratic system, there will be a severing of the link between the citizens and the governance of the state or whatever entity replaces the state. Citizens have given the role of guardian of the natural and human resources to the government. The government sell out of these resources ties the future of the citizens to the global corporations. These ties will be of extreme importance

to the citizens and their communities, but will be of very little importance to the global corporation. The relationship will be similar to that of the colonial 'absentee landlord,' who had no idea or interest where his wealth was being generated, except that it was his wealth. Given this possible reality it is very difficult to see the future development of a publicly-funded social safety system. To protect the present system, citizens must support a viable and strong role for government, one that has the size and the strength to balance the emerging multi-national and global corporations.

Ideological Perspective

From an ideological perspective the theme centres on the analyses that is coming from both the 'new' right and the 'new' left. The voices of the 'new right' are transmitted though such organizations as the World Bank, the World Trade Organization and the International Monetary Fund promoting the de-regulation and 'liberalization' of trade and investment opportunities. The winners are the big global corporations and the losers will be everyone else. Some will lose more dramatically than others. But there will be a systematic abandonment of many communities by both the state and the corporate sector. The voices of the 'new' left are looking for a way to integrate social policy within the merging reality of globalization. However, the 'new' left is very new and its alliances and methodology are not tested. The advantage of the 'new' right is that it is not new at all; it is simply the return to the rapacious capitalism of the 18th and 19th centuries.

The ideology of globalization requires the demobilization of the nation-state, the end to restrictive regulations and free reign for the 'invisible hand' of the market to ensure the survival of the fittest. The tools to be used are privatization of the state-run productive and service assets; the dismantling of the social welfare state; and 'freeing' up of the global labour force. The danger to our publicly funded, universal, accessible, portable and publicly managed health care delivery system comes from the for-profit health organizations, especially those from the United States.

The ideology that will protect the Canadian health care system comes from an understanding of how this program, designed for the public purpose, is part of the overall social fabric; it is a structure that ensures each citizen the environment to reach his or

her full potential. This means that the social programs for Canada cannot become trading chips in the negotiations between Departments of Trade, Industry or Foreign Affairs. How will the 'new' left find this path?

One very interesting dichotomy that emerged during this study, is the tension between representatives of labour and the academic community. Together these two groups form the major constituency for the New Democratic Party or 'the left' in Canada. The labour representatives are both skeptical of the benefits of privatization initiatives and fearful of their consequences. The other group that related very closely with labour's analysis was that of the Canadian Pensioners Concerned. Both the seniors and labour appeared to draw on their personal and learned history of social action in Canada. The academic community was far more willing to take a wait-and-see attitude, to look at the potential benefits to particular parts of the health care system. The reconciliation between or at least the ability for these groups to work together and develop new models of service delivery, within the overall framework of the public system, will demonstrate the ability of the 'new' left to gain the sufficient strength to counter the pro-corporate forces of globalization. The 'new' left must continue to speak for those citizens of other countries who have already been disenfranchised by the 'new' right. We have a collective responsibility to create sustainable communities throughout the world.

Management of 'Evidence'

The management theme concerns the relative importance of 'evidence' in the development of public policy designed to meet the goals and objectives of the health care system. Stoddart and Labelle (1985) begin their conclusion as follows:

> It often seems unlikely that the privatization debate in Canada will ever be resolved, and certainly not without considerable difficulty. In part, this is because empirical evidence on important questions is often lacking . . . Yet, as evidence accumulates, the grounds of debate shift, with the sometimes discouraging results that the important, indeed the critical question to be answered becomes one for which the evidence is unavailable. While evidence can and does play an important role in public policy debates, by restricting the number of admissible hypotheses and narrowing the range of potential disagreement, it would be naive to expect evidence to resolve what are, in the end, often matters of ideology (Stoddart, Labelle, 1985, p.68).

The management of evidence is not simple, and neither is the control of the parameters of evidence. The question "what evidence is admissible?" is as important here as in a court of law. The structural differences between the goals of the system and the goals of the practitioners again become important. The system needs evidence about overall health status of the citizens; however the practitioner collects evidence about discrete function. This problems highlighted in 1985 are the same in 1997:

> Canadian proposal for privatization do not address the issue of structural linkage, and in general avoid the central questions of allocative efficiency (i.e. the contribution that current levels and types of service utilization make to improved health), even though there is reason to believe that this area may afford the greatest potential for improvements in system performance. On the contrary, proposal for the privatization of financing are for the most part attempts to escape fiscal pressures to evaluate or change existing styles of practice, by introducing new sources of funds to expand resources commitments, i.e. to increase total expenditures on health care (Stoddart, Labelle, 1985, p. 68).

The evidence collected by service providers relates to the individual services rendered. To use the law court analogy, it is like a lawyer's files getting mixed up. He tries to defend the client with an evidence set that belongs to a completely different case -- but he keeps on trying, working hard to the point of exhaustion -- a case he can't win. This is the problem of using units of measurement generated by Total Quality Management, as opposed to generating policy based on health status surveys.

The respondents to this study are very aware of the impact of privatization on the ability of the government to enforce the Canada Health Act. The community and labour activists are acutely aware of these impacts on the overall system and on the spill-over effects onto other social sectors. There is more of a willingness and wait-and-see attitude on the part of the academic/researchers and the health care professionals. This comes from their detailed understanding of the many individual components of the system. Those academics and health care workers who look at the whole picture have expressed cause for concern. The government employees are largely skeptical of the rationales put forward by the pro-privatization forces. Of the fifty-one persons who were involved with this study, only one respondent was uncritical of the privatization movement. All others, including the president of a private sector health company voiced concerns for the system.

By using the same questions in 1997 asked in 1985, twelve years later, we see that conclusions reached by Stoddart and Labelle are still valid. They concluded that the usual arguments proposed with privatization initiatives -- efficiency, control of expenditures, decreased utilization and increased funding -- were not supported by evidence.

> Analysis of specific avenues for privatization of financing and management suggested that the often asserted benefits of privatization were largely absent, or were unknown and possibly suspect. In addition privatization of financing through extra billing and user charges was found to impact strongly and negatively on the equity objective (Stoddart, Labelle, 1995, p.68).

The compulsive belief that private sector management of financing will solve the problems that face the health care sector is based not on the evidence but upon ideology. If we take as given that the health care system is striving to attain the goals and objective set out in the Canada Health act we can easily see that the introduction of these private sector measures will not assist in achieving these goals.

In 1997, efficiency is still perceived as the primary reason for the drive towards an increased role for the private sector in health care. The fact that there is very little evidence that private management does result in overall efficiencies to the system is over looked in favour of the demonstrated micro-efficiencies that can be seen over the short term. As we have seen in Chapter Four, the respondents were divided in their understanding of the potential increased efficiency of a more private system. The concern that the overall efficiency of the system would suffer was articulated. Their comfort level was with the privatization of non-patient care areas of service delivery. However, the focus of efficiency on the overall system has shifted. Now there is a focus of efficiency on the measurably managed parts of the system. The call for evidence-based planning does not appear to include the need for evidence of increased efficiency to the system as a whole.

Two thirds of the respondents in 1997 did believe that the private funding initiatives would control costs for the public system. The community activists were very aware of the effects to the whole system, while the health care professionals were more

inclined to think that some funding benefits could be realized. An interesting question would have been to ask the respondents if they thought that the government would listen to their advice. The initiation of private funding would have the effect of increasing utilization of preferred treatment adding to the over all costs of health care and the administration costs would increase. The respondents agreed with Stoddart and Labelle that increased private funding could have an overall negative impact that results in the transfer of public funds to those who can access service through the private system. "The evolution of health care delivery has been characterized by the development of complementary, cost-increasing services rather than to substitute, cost-decreasing ones" (Stoddart and Labelle, 1985, p.33).

In 1997, the majority of respondents agreed with Stoddart and Labelle that private funding of health service would not reduce the utilization of ineffective services. Twenty per cent of the respondents were very concerned with the problems of inappropriate utilization. For example, under utilization results in increased cost to the system in the long run. The potential is for an increased or continued over utilization by those who have funds. This would act as a transfer of wealth towards those with funds. The scenario is like this: for a small percentage of the costs an individual can access the system to benefit from the state payment of the greater percentage, while a poor individual can not raise the initial small percentage so is denied the benefit from the state share of the costs. The benefit transfer is based on ability to pay, not based on demonstrated medical need.

A number of the respondents questioned the need for additional funds in a system that is already richer than many other national systems. The cuts to the Canadian health care system have been made very quickly, before changes to the system had been put into place. An example is the closing of convalescent beds in hospital before a home care program was in place. This confusion over the availability of services was of grave concern to the seniors in the study.

In 1997, the majority of respondents did not think that private financing would inject funds into the system. They agreed with Stoddart and Labelle that private funds

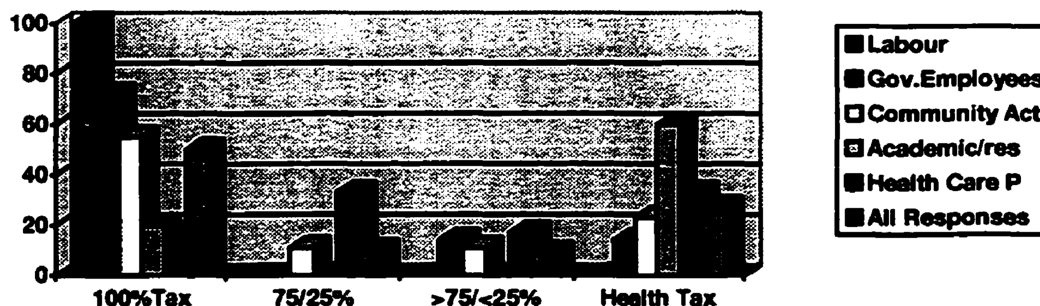
would go to private providers, that the increased funds would come from the pockets of individuals who may or may not afford the additional costs. The concerns over the current off loading of services from the publicly funded system caused great concern to many respondents. The flight of funds from the provision of 'care' was expressed. They also called for a linkage between funding and appropriate utilization of care. This was expressed in the call to put money into the primary care system, dental care and pharmaceuticals, especially for life saving drugs that are not currently covered by the public health care system.

The respondents were aware that the single payer system is the most efficient mechanism for health are funding. It is a system that addresses the issue of equity that has become the hall mark of Canadian health care. In 1997, nothing has changed. 97% of respondents believed that private funding for health care would erode equity of access to health services. They stated that the poor, the unemployed, the old and those with low paying or part-time work would be the hardest hit. The understanding that the single payer system was the most efficient, that health care was a social and collective responsibility was expressed. If equity is a goal that is important to this health care system, it cannot tolerate any introduction of private funding mechanisms.

The respondents were asked to identify the winners and losers from increased privatizing initiatives. The winners included the health care corporations, the patients who can afford to pay, some health care professionals, shareholders, management companies, insurance companies, companies specializing in advertising or law. The losers included patients, families, the old, the poor, the economy and the work force.

The following figure demonstrates the respondents preferred financing for the health system:

Figure 5.1
Prefered Financing for Health System



The respondents saw a very important role for government in the paying for health services through the tax system. The most favoured tax mechanism was from the general taxation, the second was for a mix of general tax and a special health tax. However, like Stoddart and Labelle in 1985, they recognize that the single payer system is the most cost effective and efficient. The rationale for the special tax was to provide some stability for the health system. This idea, however has a built in misunderstanding. All taxes are governed by politics. It would be as difficult to raise the rate of a health tax as it would be to raise the rate of the general taxes. Therefore, the health system would be no more protected. The downside would be that some individuals might resent paying this special tax and find ways of tax avoidance (Birch, 1995).

A number of respondents did not have enough information to respond to this question. However, of those that did respond, all felt a degree of discomfort with the ability of these agreements to adversely affect the health system. The concern stems from the collective understanding that health is a social service, a 'public good,' not a tradeable commodity. There was concern that the 'public good' aspect could be traded away, and once gone would be difficult to get back.

In 1985 and 1997 the evidence was not there to support privatization initiatives in funding or management of the Canadian health care system. In fact, in both 1985 and 1997 there was overwhelming evidence that these private initiatives would have very serious consequences for many sectors of the population and would structurally change

the health care system making the attainment of the primary objective of the Canada Health Act impossible.

The Convergence of Interest

If there is no evidence that private sectors initiatives solve the problems facing the health care system, then what is the driving force? This thesis has attempted to show that there is a convergence of interest and of ideology between those within government and those within the corporate sector who work for radical changes within the very structure of government. The forces that support the creation of 'micro' governments share a common ideology. Privatization is simply a tool to achieve this change in government. With the privatization of the funding and delivery of services, access to health care and the rationing of health care will be determined by the ability to pay. Cost efficient measures will be instituted to ensure that the high volume services will be geared to short term, curable disease or conditions. Long term, chronic or incurable disease or conditions will hold a secondary position, as it is often these patients and their families who have difficulty is finding the adequate resources to pay.

With a micro government the focus of policy will be turned away from the provision of services to the citizens. The focus will be replaced by attracting and complying with the investment and trade requirements of the global corporations. The goals and objectives will be quite different. The goal post will have moved and the rules of the game be changed.

The significant difference between 1985 and 1997 has been the radical shift in the balance of power from nation-states to the global economy. The international trade agreements are more relevant and more significant that the national and sub-national regulations based on protection of national or sub-national interests. The NAFTA and the upcoming Multilateral Agreement on Investments are designed to be as one analyst has said, 'the bill of rights and freedoms' for the global corporations. The balance between a strong public and a strong private sector will be destroyed, and with that destruction threaten the ability for democratic institutions to continue. What public sector

institutions we lose now will be very difficult to re-nationalize in the future. That is the most significant legacy of the international trade agreements.

Public Trust

We return to the first question asked by this thesis. What is the most dangerous threat to the Canadian health care system? The answer is still the loss of the public's trust, but the knowledge gained from this study indicates that the public -- the citizens -- will have to become more aware of the benefits of an integrated approach to social programs, including health care. It is important to know what 'you've got, before it's gone.' There are two very different paths open to us at this moment, two possible directions. Choice is still an option. The first direction is the one promoted by the pro-privatization lobby and appears to be in the ascendance at the moment. This lobby sees the potential for the 'cash cow' of the health care system being made freely available to them for the maximizing of profits and the minimizing of extraneous expenses -- such as caring for the very sick , the very frail or the very poor. These 'fish' are seemingly unaware of the huge global corporations that are waiting to subsume them. The naiveté demonstrated by the president of the health business interviewed for this study, that we can maintain the publicly funded system and at the same time she can actualize a ten to thirty percent profit margin annually, is shared by many private sector operators and investors. There is no understanding that the public system is a very delicate balance between public sector funding and private contractual providers, based on a primarily not-for-profit basis. This has been demonstrated by the willingness of policy makers to change the structure of the health care system to one more in line with the US system. Change the structure and the framework that supports the structure will have to change.

The second direction is to maintain this balance and enhance it by expanding the public funding and not-for-profit basis into three areas of health care: the primary care system; the provision of prescription drugs, and the management of home care. In doing so we create a health care system that is without doubt universal and accessible to all the residents of Canada, and is being maintained for the 'public good' with no exceptions or

loop-holes that can be debated or sanctioned by any non-national dispute-resolution mechanism.

If we can put to rest the question of private sector involvement in health care funding and management, and if we can listen to the Canadian public that has stated over and over that it wants its health care system maintained and strengthened, the public will once again feel a pride in and a trust in its health care system. We will also be able to take a serious look at the traditional 'fault' lines and pressures within the system and address new initiatives within a spirit of confidence that the government will not be selling the system 'down the river'. In this way we will be able to re-establish the goal posts of the Canada Health Act and change the rules so that the game of 'promoting, protecting and restoring the mental and physical well-being of the residents of Canada' can begin in earnest and progress though the twenty-first century.

References

Armstrong, Pat, & Armstrong, Hugh. (1996). Wasting Away.
Toronto: Oxford University Press.

Babbie, Earl. (1975). The Practice of Social Research.
Wadsworth Publishing.

Barlow, Maude, & Robertson, Heather-Jane. (1994). Class Warfare
Toronto: Key Porter Books.

Barnsley, Jan. (1987). Action Research For Women's Groups.
Vancouver: Women's Research Centre.

Birch, Stephen. (1995). Private Partnerships in Health Care Confernce
Toronto: Insight Information Inc.

Bogdanich, Walt. (1991). The Great White Lie - Dishonesty, Waste And Incompetence In The Medical Community. New York: Touchstone.

Canadian Health Coalition (1996a). A Prescription for Plunder.

Canadian Health Coalition (1996b). Intervention in NAFTA.

Chu, Cordia, & Simpson, Rod. (1994). From Vision to Practice.
Toronto: Centre for Health Promotion.

Coleman, J. S.(1982). The Asymmetric Society,
Syracuse: Syracuse University Press.

Dector, Michael B. (1994). Healing Medicine.
Toronto: McGilligan Books.

Douglas T.C. (1992). Interview For Film 1982: Folks Call Me Tommy.
Quoted in A Saskatchewan Vision for Health.

Eco, Umberto. In Conversation with Stuart Hall (1987). Writers and Politics.
Bill Bourne (Ed.), Voices Series. London: The Hobo Press.

Evans, Robert. (1993). Our Bill of Health, Alberta Health.

Fortune Magazine. (January 1970). It's Time to Operate. (Quoted in Starr, Paul. 1982).

Fukuyama, Francis. (1995). Trust, The Social Virtues and the Creation of Prosperity.
New York: The Free Press.

Galbraith, John Kenneth. (1996). The Good Society.
New York: Houghton Mifflin Company.

Gwyn, Richard. (1995). Nationalism Without Walls.
Toronto: Maclennan and Stewart.

Halvoeson, George C. (1993). Strong Medicine.
New York: Random House.

Hamrell, Seven & Nordberg, Olle (Eds.). (1995). Development Dialogue. A Strategy Paper. Making National Drug Policies a Development Priority (5-24). The Journal of the Dag Hammarsjold Foundation, 1995:1

Hancock, Trevor. Health, Human Development and the Community Ecosystem. (1993). In Health Promotion International . 8 (1).

Hardin, Herschel. (1988). The Privatization Putsch.
Halifax: The Institute for Research on Public Policy.

Kickbush Ilona. Good Planets are Hard to Find - Approaches to an Ecological Basis for Public Health. (1989). In V. Brown (Ed.), In A Sustainable Healthy Future: Towards an Ecology of Health. (pp. 7-30). Latrobe University.

Letwin, Oliver. (1988). Privatising The World, A Study of International Privatisation in Theory and Practice. London: Cassell.

Lexchin, Joel.(1995). Income Class and Pharmaceutical Expenditure in Canada: 1964-90. Revue Canadienne De Sante Publique. 87 (1).

Lexchin, Joel (1996, November). Drug firms wallow in Profits.
The Monitor: Candian Centre for Policy Alternatives.

Lexchin, Joel. (1997). Paper Directions for Pharmaceutical Policy in Canada.
Canada Health Action . Ottawa: National Forum on Health.

MacBride-King, Judith L. (1995). Managing Corporate Health Care Costs.
The Conference Board of Canada.

McCarthy, Mark & Rees Sian. (1992). Health Systems and Public Health Medicine in the European Community. London: Royal Collage of Physicians.

McKnight, John. (1993). Building The Community From The Inside Out.
Chicago: ACTA Publishing.

McKnight, John. (1994). Community and its Counterfeits.
Toronto: Ideas Transcripts. CBC Radio.

McLuhan, Marshal. (1980, January 7). Living at the Speed of Light.
Toronto: Macleans Magazine.

Menzies, Heather. (1996). Whose Brave New World?
Toronto: Between the Lines Press.

Mintzberg, Henry. (1966, May-June). Managing Government, Governing Management.
Harvard Business Review.

Murray, Mary. (1995). Australian National Drug Policies. Development Dialogue.
The Journal of the Dag Hammarsjold Foundation, 1995:1 149-189.

Nader, Ralf (1996, February). Stop Americanizing Medicare.
The Monitor: Candian Centre for Policy Alternatives .

National Forum on Health. (1996). The Public and Private Financing of Canada's Health
Ottawa: Health Canada.

National Forum on Health. (1997). Direction for a Pharmaceutical Policy in Canada.
Ottawa: Health Canada.

Nova Scotia Royal Commission on Health Care. (1989). Towards a New Strategy.

Nova Scotia Health Survey. (1995). Department of Health. Nova Scotia.

Nozick, Marcia (1992). No Place Like Home. CCSD. Ottawa.

Pearson, Lester B. (1965). First Ministers' Conference in Ottawa .
Quoted in the National Forum on Health. (1997). Canada Health Action
Building on the Legacy.

Postman, Neil (1993). Technopoly: The Surrender of Culture to Technology.
New York: Vintage.

Purchase, Bryan. (1996). Competitivness of the Canadian Health System.
Kingston: School of Policy Studies, Queen's University.

Rachlis Michael, & Kushner Carol. (1989). Second Opinion,
Toronto: Harper & Collins.

Rachlis Michael, & Kusher, Carol. (1994). Strong Medicine.
Toronto: Harper & Collins.

Rands, Stan. (1994). Privilege and Policy.
Saskatoon: Community Health Cooperative Federation.

Ruggiero Renato, (1996, 16 October).
The Paul-Henri Spaak Lecture at Harvard University.
Available http:// www.TWO.org

Ruggiero Renato (1997, 15 April). Speaking in Soul, Korea.
Available http:// www.TWO.org

Sainnawap, Bill. (1993). Aneshenewe Machitawin, Human-Centre Community Development. Toronto: Participatory Research Group.

Sherrill, Robert (1995, January 9). The Madness of the Market. The Nation.

Starr, Paul. (1982). The Social Transformation of American Medicine.
New York: Basic Books, Inc. Harper Colophon.

Stewart, Arthur. E. (1996). Crossing the Rubicon? Cost Containment and Privatization in G7 Health Care Systems. Kingston: School of Policy Studies Queen's University.

Stoddart, Greg & Labelle, Roberta J. (1985). Privatization in the Canadian Health Care System. Ministery of National Health and Welfare.

Queen's Health Policy Research Unit. (1997). The Economic Impact of Bill C-91 on the Cost of Pharmaceuticals in Canada. Queen's University.

Queen Elizabeth II Health Sciences Centre. (1996). Mission Possible Transforming the QEII 2

Webb, Beatrice. (1978). My Apprenticeship. (2nd. ed.). Cambridge University Press.

World Investment Report. (1993). Transnational Corporations and Integrated International Production. New York: United Nations Publications.

APPENDIX ONE
Survey Form - Formatted for Electronic Mail

To:

From: fchinyee@cycor.ca (Fiona Chin-Yee)
Subject: Survey on Privatization Initiatives

Greetings from Fiona Chin-Yee.

I have been looking into a variety of initiatives that are introducing more private sector involvement in the delivery of health care in Nova Scotia. This research is being done toward a Master's thesis in Sociology at Acadia University. I have sent this survey out to approximately 60 individuals, representing community activists, health advocates, health care workers and professionals, government, labour, political parties and the business sector.

I have two requests for you:
1) Please take a little time in answering the following questions.
2) Send this E-mail onto one or two others who work in your field.

I realize that this is an added task during your already hectic schedule - especially at this time of year - but I do appreciate your cooperation. I am very interested in your comments and any examples or stories you have to share.

Please return through E-mail by April 1, 1997.

If you are unable to complete this, please reply by E-mail as soon as possible.
Thank you.

Privatization of Health Care Services in Nova Scotia

HOW WOULD YOU DESCRIBE YOURSELF FOR THE PURPOSES OF THIS SURVEY?
(Please check the appropriate answer)

___ Doctor
___ Nurses
___ Other Health Care Professional
___ Heath Care Worker
___ Community Activist
___ Labour Activist

___ Regional or Community Health Board Member
___ Health Care Provider Organization employee
___ Government employee
___ Political Party worker
___ Business person
___ Other________________

Definition: Privatization refers to the transfer of responsibility of and/or for the provision of services from the public to the private sector.

1.How would you describe the philosophy that supports the concept of 'privatization'? (Give an example if that is more appropriate)

2. Will increased privatization of management improve efficiency in production of hospital services?
The following are some examples of private management initiatives, please check off those whom you think would improve efficiency.

___ security / parking
___ nutrition services
___ Cleaning / laundry
___ Diagnostic Labs
___ Staffing of nurses
___ Staffing of doctors
___ Staffing of other practitioners
___ Managed Care Companies
___ Other (Please identify)

Comments and stories:

3. Will increased privatization of financing control public expenditure?
___ Yes
___ No

Comments/stories

4 Will increased privatization of financing reduce the utilization of ineffective and/or unnecessary services?

Reduce utilization by the patient
___ Yes
___ No

Reduce utilization by the health professional
___ Yes
___ No

Comments/stories:

5. Will increased privatization of financing inject needed funds into a currently underfunded system?
___ Yes
___ No

The following are some examples of health care programs, please check off those whom you think would benefit from an increase in private funding.
___ Primary Health Care
___ Home Care (therapeutic)
___ Home Care (personal Care)
___ Pharmacare
___ Care of the elderly
___ Care of Children
___ Care of AIDS patients
___ in-hospital care
___ diagnostic services
___ Other (please identify)___________________________

Other Comments/ stories:

6. Will increased privatization of financing erode equity of access across income classes?
___ Yes
___ No

The following are some examples of financing initiatives, please check off those whom you think would erode equity of access:

___ Out of pocket expenses by patient

___ Payment through private medical insurance
___ Payment through work related medical insurance
___ Co-pay or user fees
___ Facility's fees
___ Registered Medical Plans
___ Other (please identify)

Comments/Stories:

7.Who would be the winners from increased private sector involvement?
Please check off those whom you think would be winners:
___ Citizens
___ Patients
___ Family Members
___ Physicians
___ Nurses
___ Other health professionals
___ Other health sector workers
___ Hospital corporations
___ Department of Health
___ Private providers of services
___ Shareholders of private companies
___ Private Insurance Companies
___ Management Consultants
___ Other professionals
___ Financial consultants
___ Advertising consultants
___ Law firms
___ the economy
___ the workforce
___ Other (please identify)

Comments/Stories:

8.Who would be the losers from increased private sector involvement?

Please check off those whom you think would be losers:
___ Citizens
___ Patients
___ Family Members
___ Physicians
___ Nurses
___ Other health professionals
___ Other health sector workers
___ Hospital corporations
___ Department of Health
___ Private providers of services
___ Shareholders of private companies
___ Private Insurance Companies
___ Management Consultants
___ Other professionals
___ Financial consultants
___ Advertising consultants
___ Law firms
___ the economy
___ the workforce
___ Other (please identify)

Comments/Stories:

9. Do you think trade agreements can, in any way, affect Canadian governments' ability to provide health care services to all Canadians?
The following are some examples, please check off those you think would affect our health care system:

___ The Internal Agreement on Trade (Between the Provinces)
___ The North American Free Trade Agreement (NAFTA)
___ The World Trade Organization (used to be the GATT)

Comments/stories:

10.How should we finance our health system to preserve the principles of Medicare? Please check off one of the following:

___ 100% from General Taxation, (Federal and Provincial)

___ 75% from General Taxation 25% mix of private insurance
___ Less than 75% from taxation,___ mix of private insurance
(Please indicate what percentage)
___ Special health tax or government-sponsored health premiums
___ 100% Private insurance for all. No public financing
___ Private insurance for all except the very poor and the very old
___ "Medi-Gap" insurance to top-up public funding
___ Registered Medical Savings Plans
___ Other (please identify)

Comment/stories:

This completes the survey questions. If you have any other comments on the health care system that you feel should be included, please feel free to express yourself:

Other Issues of concern:

Thank you for your time.

If you would like me to E-mail you a copy of the completed thesis
___Yes ___ No

Appendix II
Respondents' Expertise

Focus Group Membership

Policy Analysts Focus Group:

Nova Scotia Government Employees Union
Nova Scotia Association of Health Organizations
Registered Nurses Association of Nova Scotia
Medical Society of Nova Scotia
Note taker: Jan Catano

Canadian Pensioners Concerned

Board Members
Note taker: Marilyn Worth

Midwifery Coalition of Nova Scotia
Note taker: Jan Catano

Interviews

Senior official in Nova Scotia Department of Health
Interviewer: Fiona Chin-Yee

Senior hospital administrator, Western Region
Interviewer: Fiona Chin-Yee

Transplant recipient
Interviewer: Fiona Chin-Yee

President of private Sector health company
Interviewer: Mike Tutton. CBC Radio reporter

Senior hospital administrator, Central Region
Interviewer: Mike Tutton. CBC Radio reporter

Two officials with Nova Scotia Government Employees Union
Interviewer: Mike Tutton. CBC Radio reporter

The Areas Of Expertise Represented By The Survey Respondents.

The survey respondents were asked to complete the survey from their own perspective, not officially representing the views of their organizations or institutions. However, they were approached as they do represent a body of knowledge and experience. Individuals representing business interests, such as the Chamber of Commerce, Community Economic Development Councils and private health companies were approached but there was no response. Respondents came from all health regions except the Northern Region.

Health Care Professionals

Nursing
Social work
- seniors focus
- children focus

Dentistry
Health promotion
Nutrition

Labour

Nova Scotia Government Employees Union
Nova Scotia Nurses Union

Government Departments

Health
- Provincial
- Federal

Social Services
- Disabilities
- Family Violence Prevention

Caucus
- NDP
- Progressive Conservative

Academic/Research

Centre for Health Promotion
Epidemiology
- Aboriginal health

Health Education
Health economics
Heart Health

Community Activists

Women's organization
Mental health
Community mental health
Public health organization
Environmental organizations
Community health boards
Midwifery.