Exposing Privatization

Women and Health Care Reform in Canada

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Edited by

Pat Armstrong
Carol Amaratunga
Jocelyne Bernier
Karen Grant
Ann Pederson
Kay Willson

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Introduction

What is happening in Canadian health care reform? What does it mean for women? Given the government, academic and media concern with health care, you would think there would be an easily accessible answer to the first question. And given that women make up 80 per cent of health care providers, paid and unpaid, and a majority of patients, you would expect the question of the impact on women to be at the top of the agenda. But you would be wrong.

This is the conclusion we came to after investigating both issues. The we is the National Coordinating Group on Health Care Reform and Women, a collaborative group that brings together the five federally funded Centres of Excellence for Women's Health, the Canadian Women's Health Network and Health Canada's Women's Health Bureau. Our mandate is to coordinate research on health care reform, identify gaps in the research and take steps to fill those gaps, and finally, to translate this research into policies and practices.

The complexity of the task became obvious when we realized that all of us were talking about different reforms, depending on where we lived and what kind of work we did. Home care, for example, means one thing in Manitoba and another in Ontario. Who pays for, who delivers and who gets home care, under what conditions, are questions with different answers in each province – although the two provinces face similar pressures and often get similar advice. Moreover, reforms are significantly changing home care in both provinces and doing so at a rapid pace. Yet it is not easy to find out the precise nature and extent of these reforms, let alone what they mean in practice, especially for women.

In order to carry out our mandate, we first needed a better grasp of the nature, form and content of reforms across Canada. We also needed to know more about the global context and the pressures – as well as the models for reforms – coming from outside the country. Equally important was the question of the impact on women and indeed, whether or not reformers were investigating the issue at all. Because we could not find easily accessible answers to these questions, we decided to commission a series of papers.

In order to commission the papers, we had to develop a framework for the collection of information – a lens through which to select, sort and assess what was available from varied sources. After extensive discussion of many

alternatives, we decided to use privatization as our central frame. Like health care reform, privatization has many meanings. In keeping with our objective to capture the central features of health care reform and its impact on women, we use the term more broadly than in the traditional economic sense.

For the purposes of this project, the privatization of health care refers to several different policy directions, all of which limit the role of the public sector and define health care as a private responsibility. According to our definition, the privatization of health care includes:

- privatizing the costs of health care by shifting the burden of payment to individuals;
- privatizing the delivery of health services by expanding opportunities for private, for-profit health service providers;
- privatizing the delivery of health care services by shifting care from public institutions to community-based organizations and private households;
- privatizing care work from public sector health care workers to unpaid caregivers; and
- privatizing management practices within the health system by adopting the management strategies of private sector businesses, by applying market rules to health service delivery and by treating health care as a market commodity.

Privatization in the health care system can occur both in the payment for health care services and in the provision of health care services. We defined services and providers broadly. For example, we included unpaid caregivers in the category of providers, the provision of medical supplies as a service and medications as an essential part of care delivery. By defining privatization in this way, we hoped to cover the entire range of reforms across the country.

Privatization was the frame for capturing health care reform but we also had to make clear what we meant by "women." Just as we recognize that there are considerable differences across the country in terms of reforms, we recognize that there are considerable differences among women in terms of the way they connect to health care. We know that women are the main providers of care, whether or not the care is paid, institutional or home-based. Women are also the main recipients of care, especially among the elderly. Although women are involved in much of the daily decision-making about health care, they are much less visible among senior policy-makers and managers. We are interested in what consequences reforms have for women as providers and patients, and their impact on women's participation in the decision-making process. At the same time, we are aware of the significant differences among women related to their physical, social, economic, cultural/racial locations and their age and sexual orientation. These, too, must be considered in assessing the consequences of reforms. Which women are affected, in what ways, by which reforms were central questions for our work.

Because we want to link research to change, we also asked the authors to search out both positive and negative reform strategies, keeping in mind that reforms may work for some and not others.

This book brings together the commissioned work to expose the many faces of health care privatization and what we know about its impact on women[1]. It begins with the international context for health care reform and then moves from coast to coast, setting out what we know about the reforms that are underway and about their impact on women. It is a survey based on the existing information and an analysis of the gaps in our knowledge. It is important to note that health care reform is an ever changing phenomenon. As this monograph goes to press, new policy changes are under way around the country. These reforms are not included in the discussions that follow, but the analyses here do reveal patterns that, in all likelihood, pertain to more recent policy changes. We hope it will not only inform but spur action in research, policy and practice.

Pat Armstrong
Carol Amaratunga
Jocelyne Bernier
Karen Grant
Ann Pederson
Kay Willson

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1. The texts of the initial papers can be found on the Canadian Women's Health Network Website, www.cwhn@hn.ca.

The Context for Health Care Reform in Canada

Pat Armstrong

Introduction

Health care reform has seldom been a strictly local matter. Canada has developed some unique reform strategies and adapted others to suit its particular circumstances – and Canada is not without influence abroad, particularly in the areas of health promotion (Pederson, O'Neill and Rootman 1994) and gender-based analysis. But foreign influences and external pressures have seldom been absent. Health care reform, then, has to be understood within an international context.

This article seeks to contextualize current reforms, outlining some of the international and national pressures and influences that shape strategies to change health care in Canada. It then looks at the new paradigm for health care that is dominant in the international and national arenas.

The Aftermath of War

The International Stage

The Second World War set the stage for radical health care reform. Most countries involved in the war emerged from it with large state sectors, huge debts and a population that demanded better conditions in return for the sacrifices they had made for the war effort. As Malcolm Taylor put it, "There was a mood of rebellion against the universal risks of unemployment and sickness, disability and old age, widowhood and poverty."

Women were very much a part of this rebellion. In Canada, "CCF women, for example, demanded leadership training programs, publicly accessible birth control clinics and equal pay laws as early as the mid-1930s" (Bashevkin 1998, 19).

Although Allied governments feared massive revolt and a return to high unemployment in the aftermath of war, they were not driven simply by these fears. There was optimism about state intervention, based on Keynesian economics and the experiences of the war years. There was also a new view of cooperation among countries. For centuries, the increasingly global economy had prompted calls for some kind of international regulation. But it took the Second World War to convince decision-makers "that industrial countries, in particular, were too advanced, specialized, and interdependent to contemplate genuine, lasting improvements in economic welfare after the war without re-establishing some sort of new economic order" (Panic 1995, 38). Equally important, they saw the task as "too important and urgent for the postwar recovery to be left to the slow, haphazard processes of the markets, whose limitations had been exposed in the interwar period" (ibid.). Among the various women's movements, there was "great hope not just for women's advancement but also for social improvement via active good government" (Bashevkin 1998, 19).

According to one analyst of the period, "the powerful vested interests that might have resisted this successfully were too shell-shocked and marginalized by the disastrous turn of events in the 1930s and early 1940s to put up much of a resistance" (Panic 1995, 38). At the same time, there were multiple opportunities for investment and profit-making available in the wake of the war's destruction and with the development of new technologies, as well as generous government infrastructure support for business.

A variety of organizations resulted from the Bretton Woods agreements of 1946-47 and the establishment of the United Nations. The World Bank and the International Monetary Fund (IMF), officially specialized agencies of the United Nations, were intended to coordinate the international financial system. The World Health Organization (WHO), the United Nations Children's Emergency Fund (UNICEF), the United Nations Development Fund (UNDP) and the United Nations Population Fund (UNFPA) were designed to develop a range of health strategies throughout the world. As the Constitution of the World Health Organization made clear, there was a shared understanding that the "health of all peoples is fundamental to the attainment of peace and security, and is dependent upon the fullest cooperation of individuals and states" (in Koivusalo and Ollola 1997, 7).

Most industrialized countries developed or expanded public health care services, placing a particular emphasis in North America on the most expensive – hospital and medical care. By 1995, in 20 out of the 29 countries surveyed by the OECD "more than 70 per cent of total expenditure on health takes place in the public sector" and in seven of them, the public share was over 80 per cent (OECD 1992, 131). A significant sector of the labour involved in care was paid, and it included a growing number of women. Although critiques of the medical model were not absent, the primary issues were framed in terms of access to existing health care services that were assumed to provide quality care.

There was, in these health discussions, a recognition of different health needs for women, although women were not central participants in the international agreements or in the organizations they set up. At least one obvious women's issue was given priority – maternal and child health (WHO 1998, 11). This reflected the tendency to define women's health needs in terms of their reproductive capacities, and to address the issue more in terms of controlling women than of empowering them (see Stein 1997). In the dominant paradigm of the period, difference was often understood as biologically determined inferiority, and solutions offered in terms of a western medical model.

Matters related to women as paid and unpaid providers were not central concerns in these international debates, and it is difficult to find documentation of discussions at the international meetings about the division of labour within or outside health care services. Women did not simply passively accept the dominant paradigm, however. Many women benefited from the development of initiatives in such areas as public health and public care services, nutrition and sanitation initiatives, as patients, providers and decision-makers. Paid jobs in health care grew, and along with them, the strength of many women.[1]

Canadian Initiatives

It was in this context that Canada reformed postwar health care services. There was a strong federal state, buttressed by a Keynesian philosophy and by experience that supported state intervention. There were new technology- and hospital-based services that demonstrated the benefits of effective treatments and cures.

There was also a restless population demanding access to the health services that had become increasingly inaccessible in the prewar years and increasingly expensive in the postwar ones. And as employment expanded there was a labour movement growing in strength and numbers, a movement committed to a social wage that included health care. Various women's organizations were also part of the increasing pressure for public care, as women struggled to defend not only their own interests in terms of access to care but those of their families as well.

At the same time, there was a relative absence of for-profit services or even of insurance companies involved in health care. Nine out of ten hospitals were non-profit in 1955 (Dominion Bureau of Statistics 1957, 267). A significant proportion of insurance was also non-profit, with Blue Cross leading the pack. Large companies faced increasingly strong labour groups demanding health benefits and a public plan promised to reduce their direct costs. As a result, the corporate sector offered only limited opposition to state involvement.

There was strong evidence to support the need both for more services and for public care. Significant proportions of the population had no insurance coverage, and the uninsured stayed in hospitals longer than the insured, primarily because they went for care only when they were very ill. Given the high cost of care, the government often ended up paying for the uninsured.

Research on insurance indicated that even those with coverage had only part of their bill paid for by the company, particularly if the coverage was provided by a for-profit firm. At the same time, research found that voluntary insurance schemes added significantly to hospital expenditures (Taylor 1987, 111).

These pressures combined to set the stage for a public health care plan. Health care was defined more as a social good than as a market commodity. The discourse was about shared risks (Marsh 1975, 9-10) and "public responsibility for individual economic security and welfare" (quoted in Taylor 1987, 50).

There was, of course, controversy and compromise. The first postwar federal/provincial conference on health care failed to reach agreement. Foiled at the conference table, the federal government used its spending power first to fund research, training and hospital construction. Then it promised to pay half the cost of hospital insurance and later, medical insurance. Finally, the 1984 *Canada Health Act* brought hospital and medical insurance together, forbidding user fees and opening the door to care outside hospitals and doctors' offices. The provinces were far from universally supportive at any stage of these developments. The Conservative premier of Ontario went so far as to claim at one point that the new "Machiavellian scheme" was "one of the greatest frauds that has ever been perpetrated on the people of this country" (ibid., 375).

Such opposition encouraged the development of a plan based on principles set out at the federal level rather than on a detailed plan that each province would follow. In the end, the *Canada Health Act* is only thirteen pages long, and that includes text in both official languages. As a result, there is not one system but many systems, each with the possibility of adapting to local needs. The provinces and territories have used their spending power to shape regional, municipal and organizational developments, but significant choices remain at each level.

Opposition from various quarters also encouraged the development of a plan based on an insurance model rather than a provider model. The government responded to the concerns of provider organizations by leaving services in their hands. Under this model, "private insurance is implicitly or explicitly forbidden and there is no opting out of paying taxes for the public system" (National Forum on Health 1997b, 16). Although the insurance plan must be publicly administered, there is no requirement in the *Canada Health Act* that the services be provided by a non-profit firm.

Another result of public health insurance was the expansion of choice, especially given the additional criteria of universality, accessibility and comprehensiveness. Because governments funded services rather than individuals, and did not provide services directly, there was a range of options available for many women. Patients could choose among service providers and seek consultations from more than one kind of service. Coverage was thus portable for service to service and job to job, and alternative means of delivering care were available in many areas. This was particularly important

to women because they often encounter providers who dismiss their symptoms or respond in ways that reflect stereotypes and cultural values that are inappropriate to an individual woman's needs. Moreover, women are more likely to have short-term employment and portability from job to job is critical to ensure continuity in care.

Medicare also led to an enormous expansion in access to services. Access improved for those most in need (Enterline *et al.* 1973), and the majority of these were women. At the same time, the number of jobs for women grew dramatically. Between 1951 and 1961, the number of women in the health services labour force increased from 107,063 to 205,284 (Dominion Bureau of Statistics 1966, table 12B). By 1991, more than a million women worked in health and social services, representing 16 per cent of the entire female labour force (Statistics Canada 1993, table 1). This expansion in the broader public sector contributed to the development of strong professional and union organizations among women – organizations that have successfully fought for better conditions and relations at work and for the recognition and defence of the skilled nature of their labour (see Armstrong, Choiniere and Day 1993; Armstrong 1993).

A women's health movement also emerged. Women were active in public and occupational health, in demanding access to services, in offering health education and in promoting self-regulation, as well as better conditions, for paid care providers. They stressed what today would be called the determinants of health and health promotion, albeit often framed by middle-class women for the poorer classes. By contrast, much of the initial focus of the postwar movement was on a critique of medicine, in terms of the emphasis on a medical model, on medical power and on institutional care. Self-help, empowerment through shared knowledge, and alternative therapies were central strategies in the movement that began in the 1960s (see, for example, Kleiber and Light 1978; McDonnell and Valverde 1985; Montreal Women's Health Press 1968). It expanded to challenge the entire paradigm dominant in health services and the assumptions made not only about women's bodies and women's relations but also about their work.

Empowerment, community, self-help, alternative therapies, disease prevention and health promotion and rights have all been central to the discourse around the women's health movement. The movement began to stress both sameness and difference (Bacchi 1990), both women as actors and women as a group who have few choices to make. The emphasis has been increasingly on connections rather than on isolated individuals, on emotions as well as on reason, on needs as well as on wants, on multiple rather than on single strategies, and on the concrete along with the abstract or general (see, for example, Harding 1986, 1991). Context matters. So do relations with others. These relations, and locations, are understood to have a profound impact on health in general, and on choice in particular.

While these could be described as the main features of the dominant paradigm in the women's health movement, it should be recognized that there

is no single, unified movement. Controversy, debate and new theories have been central to the critiques of existing practices and to proposals for the future. These differences become most evident around specific issues such as the introduction of midwifery programs and of new reproductive technologies.

After the Welfare State

The Emerging Paradigm

For 25 years after the Second World War, what has been described as the postwar consensus largely held (Bashevkin 1998, 19). But by the early 1970s, the international agreements that reflected a Keynesian approach had begun to unravel. Both the United States withdrawal from the gold standard and the increases in petroleum prices marked a major turning point in philosophy and practices at the international and national level. While there is disagreement over the cause of this change, there is little dispute that a new philosophy guided international development (Mendelson 1997).

In contrast to the Keynesian approach, the new neo-liberal paradigm placed its faith in a "free economy and a strong state" (Alan Walker quoted in Martin 1993, 46). The theory called for a dismantling of the welfare state, but not for a weak state in such areas as control of the money supply or moral authority. As Martin points out in his exploration of public sector reform, it "is not *whether* or not the state intervenes in the economy that has changed but *how*, and to whose benefit" (Martin 1993, 48). The emphasis on free markets required positive intervention by the state to maintain the conditions for the free market and for social order. This means deregulating much of economic activity and regulating more of labour and personal activities. Margaret Thatcher, for example, argued that social decay required strong government to support a return to principled morality (Bashevkin 1998, 22). "Special interests" such as women's groups were often seen as part of this decay (Shields and Evans 1998, 17). At the same time, the belief in market mechanisms supported the move to privatize public corporations or contract out services in the public sphere and to apply for-profit principles to the public sector that remains. It assumed that because of competition, the for-profit sector is necessarily efficient and effective – in contrast to public sector organizations, which are defined as bloated, bureaucratic and ineffective.

In this paradigm, the market is seen "as a provider of economic efficiency and as a guarantor of a sense of individual freedom and responsibility" (Taylor quoted in Martin 1993, 48). Each firm and each individual, pursuing their own interests, would stimulate the economy, eliminate waste and expand choice. Unlike Keynesian theory, which assumed shared risks and the right to collectively provided supports, the neo-liberal approach focused on freedom from economic interference. Equity was the result of each person facing the same market conditions. The benefits would "trickle down" to the disadvantaged, providing far better results than universal programs that were defined as encouraging dependency and stifling choice (Bashevkin 1998, 28). However, under these strategies large numbers of women throughout the world have seen

their conditions deteriorate, while only a minority has experienced the trickle (Sparr 1994).

The new stress on the private sector coincided with failures in and critiques of the public sector. The OECD, for example, lists as factors leading to "the reappraisal of the rationale for government intervention" both "a perception that the public sector performance was inferior to that of the private sector" and "citizens' demands for improved responsiveness, choice and quality of service" (OECD 1995, 19). The collapse of the Soviet Union, and the accompanying notion that state expansion was a central cause, helped fuel this development. In their influential book, *Reinventing Government* (1992), David Osborne and Ted Gaebler maintained that "market-oriented governments" should 'steer', not 'row' or run things" (281). In this new framework, citizens are increasingly described as customers "who can choose in a market-like fashion between different service providers" and community choices are defined mainly as individual consumer ones (Pierre 1995, 56).

Women's groups were among the most active critics of government services. For instance, they objected to the medicalization of daily life supported by a government-funded hospital and physician system. Although both physicians and hospitals remained outside government hands in many countries, state policies clearly played a critical role in how care was delivered and in the extent to which, and the manner in which, women participated in decision-making. Medical schools and other forms of education for health providers came under attack for both the exclusion of women and for the way women were included. Similarly, the male bias in the definitions, content, methods and models in state-supported medical research was exposed. The quality of care became a central concern as women pointed to the considerable variations in such areas as caesarian rates and the failure to monitor physician practices. At the same time, policies and practices seldom took differences between women and men, or those among women, into account. The effectiveness and appropriateness of treatment became a central concern. Women were critical of governments' failure to support alternative therapies and alternative ways of delivering care, as well as of the limited attention paid the determinants of health and primary care. Lack of integration and continuity in services was also raised as an issue, along with the White, European, male health model that dominated care services. Equity that involved recognition of differences, especially in terms of context, capacity and power – not simply equal treatment – was a major goal. So was social justice, and women's groups pointed out it did not always result from public intervention (see, for example, Boyd 1997; Brodie 1997).

Although women were amongst the most critical of public sector health interventions, they did not necessarily support private sector solutions. Susan Sherwin, for example, persuasively argued "that the institution of medicine has been designed in ways that reinforce sexism, and the effects of medical practice are often bad for women" but remained committed to "reforming rather than rejecting" many (although not all) existing health care arrangements

(Sherwin 1992, 6). Women's groups particularly objected to the role for-profit companies played in drugs and devices, demanding greater government control (see, for example, McDonnell 1986; Overall 1993; Rehner 1989). They demonstrated that interventions had a differential and often inappropriate impact on women as citizens, patients, providers and decision-makers. And they have been successful in demanding a gender-based analysis of all such interventions.

Their success is not without contradictions, however. Take the example of reproductive rights. Rosalind Petchesky (1995) argues that the 1994 Programme of Action of the Cairo International Conference on Population and Development,

> enshrines an almost feminist vision of reproductive rights and gender equality in place of the old population control discourse and retains a mainstream model of development under which that vision cannot possibly be realized (152).

She goes on to explain that the Programme represents the success resulting from years of effort by women's groups around the world to "gain recognition of women's reproductive and sexual self-determination as a basic health need and human right" (ibid.). Yet the Programme not only failed "to address the real implications of privatization" (156), but went so far as to make a commitment to "increase involvement of the private sector" (157). In Petchesky's words,

> the Cairo document promotes the very privatization, commodification and deregulation of reproductive health services that, by its own admission, have led to diminished access and increasing mortality and morbidity for poor women, who constitute "the most vulnerable groups" in both developing and developed countries. (ibid.)

Another contradiction has to do with both the discourse surrounding reform and the demand for change. As Rekart (1993) makes clear, there is a great deal of overlap in the language used by a range of groups involved in reform. Those seeking to dismantle the public system and those seeking to preserve it, albeit through changing forms, share a discourse around community and health promotion, continuity and integration, informed consent and self-help, accountability and empowerment, quality and effectiveness, primary care and local control, choice and equity. Yet both groups mean quite different things by these concepts. The risk is that, in the context of a dominant paradigm that promotes market methods and delivery along with individual responsibility, it will not be women's understandings that prevail. Instead, women's language and critiques may be used to encourage support for strategies that deny their goals. Just as those involved in the reform of mental health services found their critiques used to justify de-institutionalization that left many without care and those that remained in care with often worse

services (see Simmons 1990), so are women's groups seeing their arguments used to justify market solutions to health service problems (Armstrong 1996).

The Debt/Deficit Pressure

Debt and deficits emerged as a major problem during the post-welfare state period. Governments throughout the industrial world were spending more than they were taking in each year, leaving them with deficits on an annual basis and debt loads over time. Undoubtedly the situation was serious, as more and more tax dollars went to pay interest on the debt.

There have been great debates about what caused these fiscal problems. In the dominant theory, we need look no farther for the explanation than the welfare state itself. The debt was caused by inefficient state bureaucracies (see Ruggie 1996, ch. 1), as well as by what the OECD described as "demands of public sector staff" (OECD 1995, 19). Public choice analysts in particular saw bureaucrats protecting their own interests rather than protecting the public. The theory assumes such interests inevitably lead to expansion, although the significant variation among states in terms of expansion would tend to deny this claim (see, for example, Sainsbury 1996; Ruggie 1996). Certainly the for-profit sector has these tendencies. Indeed, because the aim of the for-profit sector is growth, it is difficult to see how privatization will lead to contraction. It is the case that unionization spread in the public sector during this period. Brought together in large, public sector workplaces, women in particular had demanded better wages and conditions of work. However, they had started from very low levels indeed and wages, especially at the top, are often significantly lower in the public sector than in the for-profit one.

The dominant theory also found the explanation for the debt in overspending on social services, services that simultaneously created dependencies while undermining the incentive to work. Too many people saw the social wage as a right and benefits were too generous. Abuse was rampant, especially among lone-parent women and the users of health care, the majority of whom are women. There was not enough emphasis on responsibility and individual initiative. At the same time, regulation of the market and high taxes, combined with strong labour and high wages, acted as a disincentive to investment. Yet two economists examining the growth in debt in Canada concluded that "Expenditures on social programs did not contribute significantly to the growth of government spending relative to the GDP" (Mimto and Cross 1991, 1). Instead, the debt was largely the result of the way it was financed, of interest rates and of the reduction of taxes on some areas. Moreover, Canada has quite low employment taxes compared to other industrial countries and our overall tax rates compare favourably with those in the United States, suggesting high taxes cannot explain much of the debt in industrial countries (Armstrong and Armstrong 1998, table 6.5).

It is nonetheless important to note that unemployment rose throughout the industrial world after changes in monetarist policies in the 1970s. This in turn contributed to rising social expenses. But it is debatable whether or not this rise was caused by the welfare state alone. In *Public Sector Change and the*

Crisis of Governance, the authors argue that it was "the contradictions of monetarist fiscal policy mixed with the Keynesian welfare state system that necessarily produced the political economy of public debt" (Shields and Evans 1998, 23). Whatever the cause, the rising unemployment rates also served to limit the strength of labour and women's movement demands on both governments and corporations.

Certainly health expenditures continued to grow, as they had throughout the postwar period, and these expenditures are not as directly related to unemployment. According to the OECD, it was "the pace of technological development in the health sector, and the demands of governments to constrain both total spending and the rising expectations of consumers" that were major factors leading to health care reform (OECD 1996, 7). But the data also indicate that the most rapidly rising costs were those related to sectors dominated by for-profit management and those that involved private, rather than public, expenditures. Indeed, public health systems have been the most successful at cost control (Brouselle 1998, 52). This would suggest that the problem was not exclusively to be found in the welfare state expenditures. Employment and labour costs did rise, although not at the same rate. This money, moreover, cannot be treated simply as an expense. The mainly female labour force contributes directly to the economy by spending their earnings and paying their taxes.

The debt, combined with new pressures to compete globally as a result of liberalized trade policies, is frequently offered as a reason to reduce public expenditure on health care, especially now that deficits seem to have largely disappeared. However, as economist Harold Chorney demonstrates, debt burdens were not nearly as high as they were in the immediate postwar period when governments chose to develop the welfare state (Chorney 1996, 358). There are still choices today, as the variations in national strategies attest (see Sainsbury 1996).

The Limits to Care

Another factor encouraging reform was a growing conviction about the limits of public care (Blomqvist and Brown 1994). This idea about limits took at least two forms. The first had to do with the notion that the demands on health care were unlimited, especially in the face of an aging population (Lawrence 1996, 12). According to Struthers, the issue is far from new. As early as 1941, Toronto hospitals started discharging elderly patients into nursing homes as a way of saving money. Politicians began talking about the "astounding increase in the number of persons living beyond 65 years of age," describing it as "the greatest social problem of our day" (Struthers 1997, 174, 196). The same language is being used four decades later to talk about the need for restraint (OECD 1996, 11). Yet Henry Aaron points out in his presentation to the OECD that "the aging of populations cannot account for much of the growth of health care spending" and the effect varies significantly from country to country (Aaron 1996, 52). Countries have had significant numbers in the oldest age groups without bankrupting their public systems. Aaron

argues that the "most important demographic influence behind rising costs is declining birth rates" (ibid.) because of the impact it has on the ratio of elderly to non-elderly. The majority of those in the elderly population and all of those who bear children are women – so policy that looks to these demographic factors for explanations of rising costs is necessarily looking to women.

Few of these discussions about the unlimited demand for care link this demand to advertisements produced by the for-profit sectors promising wonder cures for everything from memory loss to sexual dysfunction, from cancer and infertility to incontinence and hot flushes. More common is a focus on doctors and the claim that they use their power to create demand in order to enhance their incomes. As the OECD document on *Health Care Reform* notes, "government efforts to control costs have been hampered by a reluctance to withdraw the power conferred on doctors to decide what medical care is necessary and appropriate" (OECD 1996, 7). Women's groups too have been critical of over-treatment, linking this to fee-for-service payment as well as to the medical model.

Another limit that is increasingly part of health care reform discussions relates to the determinants of health and the impact of health care on health. As the Preface to *Why Are Some People Healthy and Others Not? The Determinants of Health Of Populations* puts it, "the effectiveness of traditional medical care as a determinant of health and well-being has been coming under increasing scrutiny" (Evans, Barer and Marmor 1994, xii). Women's groups have been particularly active in pointing out the need for policies that look not only at the prevention of disease and the promotion of health but at conditions such as poverty and employment that have a profound impact on health. They have also been central to a critique of current health practices. The risk here is that the arguments will be used to reduce investment in health care without either changing the way the remaining care is delivered or addressing the determinants of health inside or outside the health care system (Robertson 1998).

Technology

Technological change has helped treat more diseases and prolong life. The consequence of this may be greater medical costs, as more people survive with significant medical problems that are treated with expensive technologies and care. Women's groups have been ambivalent about these technologies, especially in the area of reproduction (Rehner 1989).

While on one hand, they may create possibilities; on the other, the technologies may limit opportunities for healthy lives not only for patients but for providers. Technologies have an equally contradictory impact on cost. The increased intensity of services is a major factor in rising health costs. And estimates indicate that "one third of the increase in intensity was due to new technology and two-thirds was due to small technological improvements" (Abel-Smith 1996, 27). At the same time, technologies have helped reduce institutional costs by making more ambulatory care possible. Technologies

have also contributed to the shortening of patient stays, in that new methods have made possible less invasive surgery as well as more care in the home.

However, as women in particular have pointed out, the cost savings may be mainly realized through a shifting in care responsibilities from publicly funded institutions to private homes, where it is mainly women who provide the care (see, for example, Armstrong *et al.* 1994; Aronson and Neysmith 1997; Chappell 1993; Glazer 1993). In addition, the shifting of care to the home sends the risks of care to the home, along with the expenses. Both providers and patients may be at risk. For the patients, untrained providers may inadvertently provide inadequate or inappropriate care. Home conditions may be unsafe, not only in terms of exposure to bacteria and viruses, but also in terms of a hostile environment. For providers, lack of training may result in injuries, and increased stress. Even those providers who have the skills may find themselves at risk in isolated environments, with few technical or social supports. Moreover, technologies have important implications for how health care is conceptualized and for power and control as well as for ethics and access. As Abby Lippman (1998) points out in her discussion of geneticization,

> While research, services, and policy networks that validate women's experiences as a way to promote their health are set in motion (for example, the five recently funded Centres of Excellence for Women's Health Research in Canada), parallel developments associated with geneticization are likely to present a formidable challenge to maintaining health issues as collective and political rather than individual and medical. (65)

Increasingly, choice in health care is being talked about in terms of consumer preferences and customer satisfaction surveys. The discourse in the new paradigm is that of the market, with talk of one-stop shopping becoming commonplace. In a book subtitled *A Blueprint for Canadian Health Care Reform*, for example, the authors recommend that "The Physician should shop on behalf of his [sic] patient to provide the best possible service at the most effective cost" (Jerome-Forget and Forget 1998, 15).

Health Care as a Business

The new paradigm in a host of international organizations and agreements is exemplified by the fact that the World Bank, rather than the World Health Organization, has increasingly taken the lead in health sector development (Koivusalo 1997, 18). Debts incurred in the wake of the 1973 rise in petroleum prices and of lending, borrowing and investment practices left many countries faced with structural adjustment programs established by the World Bank and International Monetary Fund (IMF). The imposed guidelines promote market-oriented, open economies, reduced state support and privatization of services (see ibid.; Scarpaci 1989). Even the guidelines for gender-based analysis that are increasingly part of the international package specify privatization as a basic tenet of health care reform.

Searching for new areas for investment and profit growth, corporations have found that health care is in many ways an "unopened oyster" (Peterson 1997, 299; see also Fuller 1991 and Nelson 1995). In many countries, most services have been provided by the state or by non-profit organizations, leaving plenty of room for expansion by for-profit firms. Until relatively recently, the United States also had a large proportion of public and non-profit organizations involved in health care. But this has changed rapidly. "By 1994, for-profit health maintenance organizations had more enrollees than their not-for-profit counterparts, which had previously dominated the scene." Hospitals too increasingly became for-profit, often as part of a Managed Care package. Hospital saw their aggregate profits increase by 25 per cent in 1996, with aggregate profits rising from $5.6 billion in 1988 to $21.3 billion in 1996 (Bellandini 1998, 68). The profit growth reflects the movement of large corporations into the health sector and the mergers and consolidations that have taken place as they seek to eliminate the competition through both vertical and horizontal integration. In the United States, over half the population enrolled in HMOs are in the four largest firms (Thorpe 1997, 343). Similar patterns are evident in the very profitable drug industries: industries that have been the subject of extensive critiques for their impact on women.

This kind of consolidation, especially under a paradigm that favours markets, gives such corporations significant power. In his introduction to a special issue of the *Journal of Health Politics, Policy, and the Law*, Mark Peterson (1997) points out that:

> At the table of health care decision-makers, capitalists – investors, shareholders, and the managers of capital markets – thus demand greater recognition, and by the nature of their activities, wield increased control over both public and private policy agenda. (299)

At the same time, choices are reduced for both providers and patients as firms seek greater control over costs. Their influence is evident not only within the United States but also within the international organizations such as the World Bank, where the United States has significant power. It is evident as well in international trade agreements that stress the liberalization of markets, including those covering health care, and that limit state intervention in health services.

Models for Health Care Reform

Efficiency and Choice

While reform is not new, what marks the difference between current reforms and those of the past is a paradigm shift. The new paradigm is a business paradigm, based on a belief in market strategies and for-profit managerial techniques. It assumes a definition of health as a market commodity and of patients as consumers. Although it is acknowledged that "the health care sector lacks some of the basic features of a 'free' market," it is assumed that "the introduction of market-like mechanisms creates incentives for improving efficiency, and possibly also effectiveness and quality, depending on the

competence and expertise of the purchaser" (Christie 1996, 14). The imperfections of the health care market can be addressed by "managed competition," defined by the OECD (1992) as

> government regulation of a health care market which uses competition as the means to achieve efficiency objectives within a framework of government intervention designed to achieve other policy objectives such as equity. (10)

There is, then, an acknowledgment that markets do not lead to equity when left on their own and that not only state intervention but public financing is required. It is also recognized that "systems based on market principles, notably the United States system, are far from optimal when it comes to allocating resources" (Jönsson 1996, 8). At the same time, this recognition is combined with an assumption that efficiency produced by competition is necessarily good and results in both greater choice and efficiency.

A popular response to these contradictory concepts, at least among those supporting a business approach, is an internal market, where funds and some regulation would still come from government but more of the rest would be privatized and allocated by market mechanisms (Jerome-Forget and Forget 1998, 12). Within this internal market model, privatization takes various forms.

One form is the separation of purchaser from provider; that is, governments no longer provide services. Instead, they purchase them from competing providers. This is intended to increase efficiency by encouraging providers to compete with each other for the health care market and to provide governments as well as patients with choices. Canada already has such a separation, given that governments do not directly provide most services and doctors are not employees of the state. However, there has not been a tradition of competition among these providers for patients or financing.

There are several problems with this competitive model in addition to the ones of equity acknowledged by the promoters. First, competitive behaviour "may not always make medical or scientific sense, since close co-operation with a broad range of colleagues over a broad range of areas is necessary for goods results" (Christie 1996, 14). Women in particular have stressed the need to develop teams in an effort to address the full range of health issues, and such competition could undermine cooperation of this sort. The lack of competition among Canadian health providers has also supported coordination activities across services. Second, competition is more expensive. It increases administrative and other costs, as the American system demonstrates (Himmelstein and Woolhandler 1994). Deber *et al.*, for example, conclude that "competition and markets for services perceived as necessary appear to increase costs, rather than constrain them" (Deber *et al.* 1998). Third, competition encourages unnecessary duplication. It requires a host of providers who do the same thing and thus means there are extra services that can lose the competition. Fourth, competition can lead to monopolies, as the

winning providers eliminate the competition (Jönsson 1996, 39). In many areas of countries such as Canada, there will not be a range of providers to compete in the first place. Indeed, the problem is not one of selecting among services but one of encouraging services to locate there, especially in rural and northern areas. Fifth, competition often means lack of continuity. It can result in fluctuations in the supply of services and in the provider. Sixth, the privatization of services often creates the need for greater government regulation, as well as the need for governments to continue to operate in the unprofitable areas and provide for people that the private sectors avoid. Those most likely to be left out are poor women and those with disabilities. It thus may mean more rather than less government intervention and less choice. Equally important, it may lower quality because "the producer with the lowest price may not necessarily be the one who gives best value for the money" (ibid.)

Another form of privatization – one that could also be classified as a purchaser/provider split – is the contracting out of services. In this approach, hospitals or governments contract out all or part of a service to those who bid on the job. Contracting out has all the problems of the purchaser/provider competitive model. In addition, there is no reason to believe that contracting will lead to savings in the long run. While competition and the transfer of services to private providers may reduce short-term costs, there is evidence to suggest this is short-lived. As Starr so succinctly puts it, "the contractors could scarcely be expected to exert less pressure for higher spending than do the much maligned public employees" (Starr 1987, 5). Instead, contracting may primarily lead to rising demands and increasing influence from for-profit firms. Struthers' research on Ontario long-term care facilities certainly bears this out (Struthers 1997). Moreover, the contracting out of services can undermine both continuity and institutional memory. Loyalty to the main organization is also harder to maintain. And while contracting out can increase flexibility, it may reduce the capacity to monitor performance and reorganize overall service processes (Starr 1987, 7).

Partnerships are yet another form of privatization. Instead of, or in addition to, selling state organizations or contracting out services to the lowest bidder, governments promote partnerships between public and private sector organizations. These may be voluntary and non-profit or for-profit. The idea is that shared expertise and resources can be brought to bear on service organization and delivery. As Rekart (1993) points out, such partnerships can push voluntary or public agencies to conform more and more to for-profit practices. This could have some positive results but the emphasis may be on cost more than on service, and alternative ways of providing care that have been promoted particularly by women could be eliminated. Partnerships also shift the balance of power. This too could be positive and/or negative for providers and patients. The partner with more resources is likely to end up with more power, and this more powerful partner is more likely to be a for-profit organization, especially in the context of a business paradigm.

An additional problem with partnerships is confidentiality. Because they are assumed to operate in a competitive setting, organizations may resist making decisions and information public. Public accountability is more difficult when organizational practices are not readily transparent.

In searching for efficiency under the new reform paradigm, health care organizations are also adopting management techniques developed in the for-profit sector. Indeed, the problems are frequently seen as managerial ones that can be solved through the expertise of managers. Women's groups have been among those concerned about the lack of continuity and integration in the health care services. They have also suggested there was waste and inappropriate hierarchy in the system. Better management could help address these concerns.

However, there is not a great deal of evidence to support the assumption that the for-profit techniques are necessarily more efficient or that they are applicable to the health sector (Armstrong *et al.* 1997). And there is growing scepticism about the downsizing, flexible labour practices, just-in-time production and flattened-hierarchy strategies many private firms have adopted. There is, however, evidence to indicate that costs savings are achieved primarily through lower wages, poorer quality care and a shifting of costs along with responsibility to patients (Glazer 1993; Deber *et al.* 1998). Private, for-profit providers are also less likely to have unionized staff and often hire part-time or casual labour (Starr 1978, 7). This should not be surprising, given that most of service costs are labour ones and that for-profit firms need to add on profit to their bill. Equally important, their efficiencies are sometimes achieved through a denial of care, or through a careful selection of the least demanding patients. In short, the savings result more from paying the mainly female providers less, offering them less training or transferring care to the unpaid, usually female providers in the home than they do from the elimination of waste.

Central to the new paradigm is the notion that governments should not do what the private sector could do. Combined with pressure to cut government expenditures and eliminate unnecessary care, it has led to state withdrawal from some areas of care and to the failure to cover some new areas or technologies. In the absence of the state, private and often for-profit organizations move in to fill the gap. This form of privatization goes beyond the purchaser/provider split because the cost is borne entirely either by private insurance or by the individual.

Effectiveness and Accountability

Just as governments have increasingly looked to market mechanisms and market management for solutions to perceived problems with efficiency and choice, so too have they looked to market mechanisms and the for-profit sector for methods designed to increase effectiveness and accountability within the public sector.

One such method is the use of direct payments for services, variously called co-insurance, cost-sharing or deductibles. The assumption is that

patients will value services more and use them more wisely if they have to pay something for the service. User fees are thus supposed to reduce abuse while bringing more money into the system. In a similar vein, parallel private and public services are promoted as a means of reducing waiting lists, making the rich pay and increasing resources in the public system. Economist Robert Evans refers to such user fees as "zombies," strategies that were discredited long ago yet keep arising in spite of their inadequacy (Evans *et al.* 1994).

A series of Canadian studies have demonstrated that user fees neither reduce abuse nor lead to more effective use of health services (see especially Barer *et al.* 1994). The main reason is that:

> health care isn't like other products and the "market" for health care cannot be analyzed the same way as the market for shoes and VCRs....people do not often have sufficient notice in advance to make correct judgements about necessity. This is precisely why they consult physicians. (Stoddart *et al.* 1993, 7)

What user fees do is tax the sick, the disabled and the frail elderly, a majority of whom are women and many of whom are poor women. They increase administrative costs and bureaucratic processes and sometimes put more money in doctors' hands, without changing much about the way health care is delivered.

Nor do parallel private and public systems reduce cost, bring more money to the system or even increase access. Research in Manitoba on cataract surgery found that private clients served to increase costs without significantly improving access. Moreover, they tended to decrease efficiency, at least in terms of physicians who worked in both the private and public systems (DeCoster and Brownell 1997). British research indicates that "far from improving access, privately financed care appears to worsen it" (Deber and Swan 1998, 335).

Another important approach to effectiveness that has emerged in recent years is evidence-based decision-making. Throughout the OECD countries, there is increasing stress on scientific evidence and on accountability defined in terms of numerical measurement. In the new paradigm, "effectiveness means doing the right thing, at the right time and in the right way," based on the assumption that it is possible to determine scientifically precisely what that is (Christie 1996, 13). Managerial practices assume "if you can't measure it you can't manage it," based on the assumption that everything that is important can be counted and can be counted accurately (Newcomer quoted in WGHSU 1994, 16). What counts is what can be counted, or measured or determined through randomized trials. Management science is united with medical science, to allow greater control over providers and patients alike.

There is little dispute that such evidence is essential in both clinical and policy decisions. Indeed, women's groups have frequently called for more evidence and used such evidence in making arguments for reform. But

evidence, and the new emphasis on evidence-based decision-making, is a gender issue for a variety of reasons.

What constitutes evidence is a gender issue, as are the problems or areas addressed, the definitions as well as the methods used and the conclusions drawn. Two kinds of evidence are privileged in health reform. The numerical data of the sort that measures such things as number of beds and nurses per population, such processes as length of stay, required nursing time and outcomes, and such attitudes as patient satisfaction. But no number is innocent, as Deborah Stone (1997) so succinctly put it. What is counted, how it is counted, how it is processed and what is done with what is found are value-laden choices, ones that are frequently biased against women or at least fail to take their interests, their locations and their critiques into account. Indeed, the very privileging of quantitative data conflicts with gender-based analysis.

The second kind of privileged evidence is clinical. Here the gold standard is the randomized clinical trial. But as those who argue for gender-based analysis have demonstrated, the standard has too often been set on trials conducted with a 70 kilogram male (Laurence and Weinhouse 1997, 5). More attention has been paid to this bias than to the bias in the numerical data, perhaps because it is so obvious. However, efforts to address the problems have too often been restricted to including women in trials, and the bias that arises from problem selection, methodologies and the categories used for analysis have been a much less frequent concern (Oakley 1990).

Yet both kinds of evidence are assumed to be objective. Central to gender-based analysis is a critique of objectivity, both as an ideal and as a practice. Of course, feminists are not alone or even original in their contention that all evidence is socially constructed by social beings, based on culturally bound notions of value and limited by the particular context in which the evidence is developed. What is much less common is the positive value feminists place on recognizing the locations of the researchers, their personal experiences and knowledge acquired though experience. Nor are feminists original in their suspicions of numbers. Like other critical theorists, feminists have recognized the complexity of social phenomena and attached particular importance to the context in which data are collected. Feminists move beyond the kind of criticism such theorists make, however, when they stress the gender-specific nature of the scientific gaze and the critical aspects of health care rendered invisible by the emphasis on quantitative methods (see, for example, Armstrong 1998; Moss 1996; Stein 1997; Sherwin 1998).

A gender-based analysis, then, does not reject evidence. Nor does it restrict concepts and methods for evidence gathering to those associated with qualitative approaches or to what Nelson calls "the socially created cognitive category of 'feminine'" (Nelson 1995). Indeed, calls for gender-based analysis often draw on quantitative sources to demonstrate the need for such analysis. For example, statistics have been used to establish the female domination of care work, the connections between reductions in public services and the expansion of women's unpaid care work, the preponderance

of women among patients and those who take family members for care, and the unequal position of women in the health care field. Statistics have also been used to reveal the systemic discrimination imbedded in the market and to show that women enjoy better access in public health systems. However, feminists see "the pursuit of precision alone, without richness, as a vice" (Davis and Hersh quoted in Nelson 1995, 30). In the feminist perspective, there is rarely a single, right way, right time or right thing to be done.

The issue in evidence-based decision-making is larger than the problem of limited methods and subjects. It is also the transformation of the evidence available into formulas for care. Such formulas not only undermine the provider's decision-making power – as indeed they are often intended to do – they increase the likelihood that equity will be defined in terms of sameness, with everyone subjected to uniform care. Feminists in particular have stressed the importance of recognizing context and differences, history and values, in making the health care decisions that are as much art as science. Within the context of a business paradigm, evidence may be used more to control and limit than to improve quality of care based on individual locations and choice.

Basing everything on evidence has the additional risk of transforming what are political choices into technological ones to be made by experts; in other words, to revert to the model women have been so critical of in the past. There is, of course, a problem with stressing diversity and individual decision-making to the extent that no generalization is possible. In gathering evidence, "the issue then is not that all intervention is bad but rather what kind of intervention was involved, when, for what reasons, on what women and performed by whom" (Mitchinson 1998, 136, 138). The evidence should then be used as the basis of decision-making, not as the decision itself.

Canadian Reforms

Canada has been an active participant in these international developments, sharing many of the assumptions and values that are central to the new paradigm. Like other nations, it has been faced with a large and growing public debt, along with large and growing health care costs. By 1995, the debt load represented 26 per cent of federal spending, while "federal program spending net of transfer payments was only 19 per cent" (Swimmer 1996, 1). Provinces and territories too had debts and deficits. And a much bigger share of their budgets went to health. Such debts have been an important catalyst in, and justification for, reform.

The solutions in Canada, like those internationally, were sought in market and management mechanisms. As Gene Swimmer (1996), in *How Ottawa Spends*, says, the cuts

> have been portrayed as a change in philosophy toward reducing the role of the federal government by devolving responsibilities to other levels of government and to the private and voluntary sectors; reducing transfer payments to provinces, individuals, and businesses; applying

> private sector management techniques to those federal government activities that remain. (1-2)

Like the authors of *Reinventing Government*, the Canadian federal finance minister in 1995 made a commitment to "getting government right" (Martin 1995). The Program Review undertaken by all government departments had a "partnership test" that asked, "What activities or programs should or could be transferred in whole or in part to the private or voluntary sector?" (Paquet and Shepherd 1996, 25). Provinces such as Alberta and Ontario went further than the federal government in stressing that individuals should be responsible for their own welfare (ibid.). Governments in all jurisdictions in Canada, however, have regularly reaffirmed their commitment to the *Canada Health Act*. Paradoxically, "getting government right" through private-sector managerial strategies and some privatization has frequently been presented as the only way to save the public system in the face of rising costs, rising demands and the limits of care. But there remains a significant remnant of the philosophy that guided the welfare state in the platforms of political parties. And women in particular continue to show strong support for their public health care system.

International Agreements

State support for trade liberalization and privatization, combined with a continuing commitment to some form of public involvement in health care, is evident in the negotiations of trade agreements.

There is some disagreement about the extent to which health care falls under the trade agreements. According to Judy D'Arcy, president of CUPE, the union that represents a large number of female health care workers, the original Free Trade Agreement (FTA)

> explicitly allows for American private sector management of all hospitals (general, children's, psychiatric, or extended care), ambulance services, various types of clinics, nursing homes, homes for the disabled, single mothers and the emotionally disabled, together with all aspects (i.e., not just the management) of other social services like medical labs. (D'Arcy 1998, 19)

The FTA permits the management of any public health care service by American-owned profit-making groups, even when most of the money still comes from the Canadian taxpayer.

Monique Bégin, former Minister of Health and Welfare Canada, has argued that this means "any American business could come and buy Canadian hospitals and take over their management. Hospitals are not government services and are not excluded from the free trade agreement" (Bégin 1998). In areas such as nursing homes, rehabilitation services and medical laboratories where for-profit services are already established, the door is wide open to American firms. Indeed, such corporations have moved quickly to expand in all these areas. Colleen Fuller (1993) maintains that private management firms have not yet taken over the hospital sector primarily because the *Canada*

Health Act's requirement for public administration has provided some protection. However, with the federal government collapsing funding for health care into the Canada Health and Social Transfer, the *Canada Health Act* may provide less protection against for-profit takeovers in the future.

While the federal government was altering the funding for health care, it negotiated a new free trade deal that supersedes the provinces. NAFTA "will eventually bind provincial and municipal levels of government to its rules" (Maher 1993, 13). The proposed Agreement on Internal Trade was intended to help this process by eliminating trade barriers among provinces. Under such an agreement, opening one province to for-profit American firms could mean that every province was open to such business. British Columbia has been particularly hostile to this development, fearing that a move by one province to welcome for-profit health care or professional groups would mean that no province could resist (McKenna 1996, B1; Fuller 1995, 11).

Although NAFTA seemed to protect areas designed for a public purpose, it also set up a process to review excluded services such as health, "to determine the extent to which they constitute indirect subsidies to Canadian trade" (Maher 1993). Given that cars cost more to produce in the United States in large measure because of health care benefits, it is possible that Canadian medicare could be defined as an unfair subsidy. Under NAFTA, governments had until March 31, 1996 to submit a list of programs and services they wanted to shield from NAFTA rules. Fearing that market principles would prevail in the very lucrative health care field, the Canadian Health Coalition launched a campaign to protect medicare. They were joined by several provincial governments. But perhaps the most effective advocacy came from a legal opinion commissioned by the Coalition. Bryan Schwartz, an advocate of free trade, challenged the federal claim that health care would be protected under NAFTA. According to this Winnipeg professor of law,

> To the extent that NAFTA applies to a health sector, it would permit for-profit United States 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." (Schwartz 1996, 1)

As long as services are fully funded from the public purse, they may be protected. As soon as services are de-listed or even when user charges are allowed, "NAFTA may guarantee the right of United States commercial enterprises to enter the market or expand their presence" (ibid.). The "grey" areas such as physiotherapy that involve both public and private money are particularly at risk. This opinion was supported by Barry Appleton, a Toronto-based international trade lawyer, and by a variety of community groups as well.

The campaign by this coalition of church groups, seniors' organizations, student federations, anti-poverty organizations, women's organizations and unions was successful in drawing attention to the danger of the reservation