# CANADIAN HEALTH CARE REFORM:

# CRITICALLY AND GLOBALLY CONSIDERED

BY

SARAH LESPERANCE

**Submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirement of the degree**

**OF**

**MASTER OF SOCIAL WORK**

**Sarah Lesperance © 2006**

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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## Abstract

This thesis critically considers Canadian health care reform from a broad perspective in light of the myriad of forces that shape health policy conversations. Informed by the political economy perspective, the analysis draws attention to the broader political, economic, social and historic context of Canadian health care, and contemplates the power structures and interest groups at play in health care policy processes. This includes an examination of general Canadian health care reform initiatives and specific primary health care reform recommendations in the 2002 Romanow Report. Methodologically, a series of critical questions were answered through literature review and in application to specific text. Proposed health care reforms have also been assessed in relation to equity, in terms of their expected potential contributions to fairness and social justice. Findings indicated that health care reform recommendations tend to be interpreted through, shaped by, and reflective of the language and intent of economic globalization, a trend that has detrimental effects on equity. Future directions for health care policy are briefly considered.

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# Chapter 1: Overview of Thesis

Canadian medicare came into existence during the ascension period of the welfare state. Following the Second World War, many countries around the world prioritized the development of public health services. Single-insurer, public health care systems support the redistributive role of the state, as public medical services are provided to all citizens according to need, rather than ability to pay. Despite its progressive success in providing medical and hospital services to Canadians, medicare has been the target of considerable reform efforts since the 1980s. This trend has been mirrored in other public health care systems around the world. The international parallels and contradictory elements of Canadian health care reform accentuated the need for a critical and global analysis. In particular, the phenomenon of globalization has been found to be particularly influential in its commitment to neo-liberalism, a pro-market ideology favoring economic fitness above social concerns.

The ideologies and goals of neoliberalism are supported by interest groups with powerful political and financial backing. Effectively, these interest groups have come to shift the nature of public policy to the extent that economic priorities now dominate international and domestic policy-making processes. In Canada, neo-liberalism's predominance has facilitated the retraction of the welfare state and the application of market-based solutions to the public sector (Shields & Evans, 1998). Canada's health care system has inevitably been affected. Amidst a flurry of "crisis" accusations, medicare is "under attack" for being expensive, poorly managed, and in need of significant reform.

Neo-liberal solutions in health care invariably include the freeing of health markets, which critical social theorists have warned are antithetical to the objectives of medicare (Armstrong, 2001; Barlow, 2002). Since most Canadians cherish and support medicare, neo-

liberal advocates in government and in business find it politically risky to eschew medicare in principle (or at least in rhetoric) (Kenny, 2002). As a result, medicare reform efforts tend to be *indirectly* shaped by the individualist and for-profit goals of capital.

> In the name of prevention, health promotion, evidence-based decision-making, and the determinants of health, governments [have] reformed health care in ways that frequently reinforce the dominant medical model and transfer more responsibility for care to individuals and to the private, for-profit sector. (Armstrong & Armstrong, 2003, p.207)

The problem with these contradictions is that they muddy the way that health care reforms are argued and presented. While considering health care policy statements, I initially found myself confused by a range of competing definitions and contradictory references. Medicare reform appeared to be debated haphazardly. As a result, this thesis represents my attempt to make clearer sense of previously inexplicable health care reform proposals. The analysis stems from a critical analysis which interprets policy statements as political arguments that "strategically portray issues so that they fit one causal idea or another" (Stone, 1989, p.283).

It also became apparent that to understand Canadian health care reform, I needed to understand it from a global perspective. Prigoff (2000) notes that "few social workers have challenged the economic doctrine and the economic policies prompted by neo-liberal economists" and challenges social workers to learn more about globalization (p.88). However, pursuing a global understanding of domestic health care reform is not a simple task. Armstrong and Armstrong (2003) suggest that in order to understand health care reforms critically and globally, researchers must consider the medical model, health determinants, for-profit incentives, and political and economic forces and tensions (p.207). Based on these recommendations, I have pursued a political economy analysis of health care reform in Canada. Although far from exhaustive, this critical review considers globalization and the way it shapes domestic definitions of health care problems and solutions. In light of social work's responsibility to progressive

social policy and greater equality between social groups, I have also used equity, or fairness, as a standard against which to assess Canadian reform efforts. The main theoretical underpinnings of this analysis are summarized below:

**Critical Analysis:** Critical analysis adopts a reflective stance in the face of multiple views and contradictory arguments, and in this thesis, has allowed health care debates to be seen as more than a simple conflict over facts and figures (Dant, 2003). Critical analyses' "active and systematic attempt to understand and evaluate arguments" also shapes the structured mode of questioning within this thesis (Mayer & Goodchild, 1990, p.4). By stepping behind the "face value" of health reform conversations, critical analysis allows one to challenge dominant assumptions about the nature of society, "in rejection of obedient research tamed by political convenience, social favor, and professional ambition" (Epstein, 2001, p.413).

**Through the Lens of the Political Economy Perspective:** Theories of the political economy perspective have also been key analytical tools in this thesis. The political economy perspective demands an understanding of a variety of factors, including "global political and economic forces, the state, government, social classes, public administration, policy making, and the distribution of resources between and among populations" (Wermuth, 2003, p. 21). This broad and critical approach also asks, "Who benefits?", and pays attention to the distribution of resources and power within society (Armstrong & Armstrong, 2003). This perspective has assisted in a critique of dominant health policy initiatives and how these have been "taken charge of by the collectivity" (Foucault, 1980, p.166).

**Equity as a Benchmark for Analysis:** Rooted in a progressive social work approach, selected health care reforms have also been critiqued for their expected impacts on equity. In this thesis equity is understood in terms of fairness and that basic "gut reaction to the very clear and unfair differences" in the health levels of different socio-economic groups (Gilson, 1989, p.323). Research has shown that individuals of low socioeconomic status experience significantly poorer overall levels of health, and succumb to chronic illnesses, disability and death at younger ages than those with greater wealth, power and prestige (Braveman & Gruskin, 2003; Whitehead, 1992). An equity-based analysis of health care reform is endorsed by the World Health Organization and the social work Code of Ethics (Canadian Association of Social Workers (CASW), 1994; CASW, 2003; World Health Organization, 2000).

Supported by these guidelines, this thesis asks a series of questions regarding the forces, conditions, ideas and power relations that underlie and shape Canadian health care policy reforms. The hope is to make the "invisible aspects of reform visible" (Armstrong & Armstrong, 2003, p.4). These questions have been applied to the general Canadian context, and to specific primary health care policy reform recommendations outlined in the 2002 Romanow Report. The key research questions are:

1) What are the driving factors or influences shaping reform?

This question allowed for a consideration of the broader ideological, political, economic, social and contextual drivers that contribute to health care reform (Drache & Clement,

1985). This question also led the analysis toward an exploration of the global context, and helped expose the interest groups that underlie policy initiatives.

2) What definition of "health" is being represented?

The way a subject is defined can vary depending on the context and the speaker. This question helped to develop an analysis of confusing and contradictory references to "health" in Canadian and international health care conversations. It also helped to match up the underlying voices and interest groups aligned with these various definitions of health. Specifically, the medicalized model, the market-based model, and social models of health were considered.

3) What "problems" and "solutions" are identified?

In addition to shaping our definitions of health, the presence of broad social, political and economic drivers and power dynamics contribute to how health care problems are interpreted and how health care solutions are formed. This question looked at problem interpretation within the health care debate, considered the causal connections between these problems and their proposed solutions, and critically considered the underlying interests and preferences that shape policy processes (Stone, 1989, 2002).

4) Does this proposed approach to reform enhance or detract from equity?

Consistent with the social justice objectives of social work, Canadian health reform initiatives have also been critically considered using equity or fairness as a lens. This question critically considered how particular interpretations of health reforms "are used

for particular (political) purposes" and whether policy initiatives were likely to contribute to equity or not (Gilson, 1989; Hastings, 1998, p.194).

Consideration of health care reform is a daunting task; understanding health care reform can be even more elusive. In fact, this thesis has itself been limited by the fact that a sufficient consideration of *all* elements shaping Canadian health care reform is impossible in one text. Nonetheless, this thesis represents my attempt to link together the various national and international factors shaping health care reform in Canada. The recommendations in the Romanow Report have been included to help illustrate the ways in which particular policy statements can indirectly reflect dominant ideologies. Through critical consideration, I found that the health care reforms reviewed were *unlikely* to support equity and social justice. Rather than passively accept that particular patterns of policy are necessary or inevitable however, this questioning approach has helped to support an understanding which may allow credible alternatives to be considered in the future (Langmore, 2001).

Following the introduction in Chapter One, Chapter Two provides an overview of medicare in Canada from a domestic perspective. This review includes the history and development of medicare, as well as an overview of more recent reform trends. Chapters Three and Four outline the theoretical and methodological elements of this thesis. Chapter Three explores the nature of critical policy analysis and introduces the political economy perspective. This chapter also explores the nature of equity and settles on a definition of this concept which is used as a standard of assessment in this thesis. Chapter Four lists the specific research questions and provides theoretical background for each. This chapter also includes a review of the texts consulted. Chapters Five and Six encompass the main analytical chapters of this thesis. Chapter

Five critically considers Canadian health care reform in general, building links between globalization, health care reform and equity. Chapter Six specifically considers primary health care reform recommendations in the federal Romanow Report, also through a critical, political economy lens. In closing, Chapter Seven discusses the findings of this analysis as they related to social justice and future directions in health care policy.

## Chapter 2: Health Care in Canada

This chapter briefly reviews the historic development of Canadian medicare, and introduces the trend toward Canadian health care reform in recent years. Despite historical support for a public health insurance plan in Canada, medicare emerged intermittently within a climate of controversy and compromise (Armstrong, 2002). In fact, forty years spanned between the first promise of medicare (an expressed Liberal election promise in 1919) and its eventual reality (Heeney, 1995).

Consistent with a political economy perspective, which Coburn (2001) notes is intended "not to describe events but to attempt to understand", this overview of early Canadian medicare helps to set the stage for later analysis (p.45). This chapter considers Canadian health care from a purely domestic perspective, while noting some contributing political and economic factors. It is in later chapters (Chapter Five and Chapter Six) where I link this account of medicare to the international health policy context.

### Canadian Medicare

Heeney (1995) has accumulated a fascinating compilation of stories depicting the medical experiences of early Canadians. In it, she reminds readers that "life without medicare was vastly different than the life we know now" (Heeney, 1995, p.viii). One contributor, Jean Woodsworth, recalls growing up in pre-medicare Canada during the Depression years.

> The cost of medical care was one of the most painful situations many people faced. Proud and needy people visited the one doctor available only in times of extremity. Recently, I heard that during these years, one-half of Canadians never in all their lives received any medical attention. That seems a very high percentage to me, but perhaps that [was] because the doctor in our community was caring and very hardworking. Many patients paid him in chickens, eggs, potatoes or apples. Some were unable to make any payment. It was a situation which was devastating for both patient and doctor. The patient had to beg for medical attention for himself and loved ones. The doctor must have been

overstocked with food articles beyond the needs of his family, but without the ready cash for taxes, car upkeep, or clothing for his family. (Heeney, 1995, p.ix)

Without public medical care, only the wealthy could afford Toronto's private Wellesley hospital[1], whereas the poor languished and died (at mortality rates of 85 to 95 percent) in unsanitary and overcrowded church and charity hospitals (Barlow, 2002). This was a time when the ideological influences of Upper Canada[2] predominated. There was a general acceptance of the family as the primary socio-economic unit (and source of welfare) and a belief that poverty was a result of individual, as opposed to social, failure. The idea of a national public health care insurance plan had only intermittently surfaced on federal and provincial government agendas prior to 1940, and there was little social consensus or political motivation to push the issue forward (Armstrong, 2003).

The end of the Second World War, however, set the stage for a new set of ideological priorities. There was a growing public demand for compensation of sacrifices made during the war, and general political motivation to avoid a return to conflict (Armstrong, 2002). Following its active administration of the war effort, the state was compelled to continue its interventions during peacetime. Governments were seen as necessary to prevent the hardships of another depression, "to play a crucial role in the economy and the creation of social rights", and to ensure that all citizens had access to basic social goods, including health services (Broadbent, 1999, p.23). Medical services provided to soldiers had demonstrated that expanded access to medical technology and hospital-based health services could be quite beneficial, and this helped shift the focus of public health care conversations to the social and political forefront by the early 1940s (Armstrong, 2002; Dickinson & Bolaria, 2002).

Two federal Canadian reports released in 1943 - the Report on Social Security for Canada (Marsh Report) and the Report of the Advisory Committee on Health Insurance (Heagerty

Report) – outlined strong arguments in favor of a national health care plan (Barlow, 2002). The reports emphasized the need to pool risk and distribute the costs of ill health, and proposed national health care initiatives to assume a "public responsibility for individual economic security and welfare" (Marsh, 1975, pp.9-10). At the 1945 Federal-Provincial Conference on Reconstruction, legislation for a national hospital insurance plan was proposed. However, concern about federal incursion into provincial jurisdiction[3] and conflict over taxation mechanisms derailed this initiative (Dickinson & Bolaria, 2002). Meanwhile, private interests (including insurance associations, business organizations and the Canadian Medical Association) argued for a private hospital and medical insurance system based on voluntary participation in commercial insurance plans (Fuller, 1998).

In parts of the West, agrarian collective values and concern for the group intermingled to produce a counterforce to free-enterprise individualism and political wrangling in the East (Barlow, 2002). In 1946, under the leadership of Premier Tommy Douglas and the newly-elected Co-operative Commonwealth Federation (CCF), Saskatchewan introduced a compulsory, universal, state-financed and state-administered hospitalization insurance plan (Dickinson, 1993). This insurance plan ensured that all provincial residents had access to basic hospital care as needed, regardless of their financial means. Following the apparent successes of such a plan, four additional provinces introduced public hospitalization plans in the next few years (Dickinson & Bolaria, 2002).

Based on the success and public popularity of provincial hospitalization plans, the federal government passed the Hospital Insurance and Diagnostic Services Act in 1956. This legislation created an official framework for a nation-wide public insurance program for hospital care by setting out a cost-sharing structure whereby provinces had the option to agree to meet certain

performance and administrative criteria[4] in exchange for cash or tax-based support (McGilly, 1998). Although the medical profession was wary of public insurance, minimal professional resistance followed the introduction of the Act, since it guaranteed physician incomes (hospital bills are paid consistently under a public insurance plan) and minimally impacted professional autonomy (Armstrong, 2002; Dickinson & Bolaria, 2002). By 1961, all provinces had enacted legislation that met the agreed-upon standards of the Hospital Insurance Act, effecting universal, public access to hospitals in Canada.

As medical services were increasingly accessed outside of hospitals, the federal government expressed intentions to introduce a similar insurance program to cover physicians' services. However, this proposal created such initial conflict that it wasn't to become a reality "until ten contentious years later" (McGilly, 1998, p.183). Once again, Saskatchewan made the first move and in 1961 implemented a provincial medical care insurance program (Barlow, 2002; Houston, 2002). Doctors in Saskatchewan vehemently resisted this move, and went on strike protesting potential encroachments to their professional autonomy, with the expressed support of the media and the business community (Dikinson & Bolaria, 2002). But public interest prevailed on the side of a public insurance plan, and in the years that followed Alberta (1963), Ontario (1965) and British Columbia (1967) also introduced provincial medical insurance plans (McGilly, 1998).

In 1964, the federally appointed Hall Commission reported that the majority of Canadians valued and desired universal, comprehensive health insurance (Barlow, 2002; Heeney, 1995). Following provincial initiatives and the Hall Commission recommendations, the federal government passed the Medical Care Insurance Act in July 1966. As with the Hospital Insurance Act, the Medical Care Insurance Act allocated federal funding for provincial medical care

insurance programs on a 50-50 cost-sharing basis, provided that funds allocated to health care were spent according to federal guidelines (Barlow, 2002). These guidelines were also similar to those introduced for hospitalization insurance: public administration, uniform access and coverage, minimal residency requirements, and coverage of all Canadians (McGilly, 1998). By 1972, all provinces and territories had opted into the program (Barlow, 2002; Dickinson & Bolaria, 2002).

The 1984 Canada Health Act later brought hospital and medical insurance together into one legislative package, generally referred to as "medicare". Under the Canada Health Act, provinces are granted flexibility to tailor provincial health care systems to local needs; the effect is not one uniform health care system, but many systems, united in principle by adherence to the five parameters of medicare (Armstrong, 2002).

**Shifting Commitments**

Almost as soon as it was established, medicare began to face a series of assaults. Starting in the late 1970s, the federal government began to scale back its 50-50 cost sharing commitment to the provinces, citing economic recessions and growing debt/deficit levels as the reasons for this retraction (McGilly, 1998; McQuaig, 1995).

In 1977, the federal government introduced a block payment arrangement, Established Programs Financing (EPF), which reduced its share of medicare expenses and uncoupled federal transfers from provincial expenditures[5] (Dickinson & Bolaria, 2002). These changes benefited the federal government by capping healthcare transfers, but left provinces with little recourse to address provincial demand and their own health care spending fluctuations. Although a number of provinces were initially better off under EPF funding, federal transfers failed to rise as fast as health care expenditures over time, and many provinces were left to cope by limiting services or

finding other sources of funding (McGilly, 1998). The federal cost-cutting trend continued into the 1980s and 1990s.

> In the mid-1980s, federal transfers to the provinces were reduced to 2 percent *below* the rate of growth of the GNP. In the early 1990s, further reductions in federal government transfers to the provinces were introduced. Under that formula, federal transfers were frozen for a period of two years at 1989-90 levels. In 1992-3, they were allowed to increase at a rate 3 percent *less* than the rate of increase in the GNP. (Dickinson & Bolaria, 2002, p.24)

In 1995, both the Established Programs Financing and the Canada Assistance Plan[6] were replaced by the Canada Health and Social Transfer (CHST), which marked another reduction in total federal transfers to the provinces. The provinces again responded by reducing their own provincial social service and health expenditures and by deinsuring and limiting health care services (McGilly, 1998).

The Canadian public reacted negatively to this extended period of cutbacks and service reductions, citing concern over diagnostic and therapeutic service delays and reduced access to physician services (McGilly, 1998). Health care providers also responded critically to cut-backs, and there were a number of doctors' and nurses' strikes throughout the 1980s and 1990s, as well as increased user fees and extra billing to offset the reductions in health care funding (Dickinson & Bolaria, 2002). With growing waiting lists and expanding user fees, there was a new public concern about two-tiered health care, which led to a general public and political outcry over the "crisis" in health care (Armstrong & Armstrong, 2003; Kenny, 2002).

**Recommendations for Reform**

During the late 1980s and into the mid 1990s, the federal and provincial governments appointed various task forces, commissions, boards of inquiry and working groups to review the status of the healthcare system. Most inquiries expressed concern regarding rising healthcare

costs, and examined these costs in relation to medicare's responsiveness and ability to improve health status (Shah, 2003). The impact of these task forces was a trend towards regionalization, hospital reductions and downsizing, and general reductions in the number of health professionals during the late 1980s and mid 1990s (Shah, 2003).

Between 1997 and 2000 federal spending in health care gradually increased, although this did not necessarily reduce public concern and political alarm regarding the viability of medicare. In 1997, all levels of government restated their commitment to the principles of medicare, an impetus accompanied by a $1.5 billion increase in federal cash transfers to the provinces for health care (Dickinson & Bolaria, 2002). In 1999, a further $11.5 billion in federal funding (distributed over three years) was announced, in addition to increased tax points transfers to the provinces (Dickinson & Bolaria, 2002). These additional transfers, as well as the infusion of $20 billion into the health care system following the 2000 First Ministers' Meeting, muted public concern about the funding crisis in health care somewhat; however these new contributions did not restore pre-cut-back funding levels. Continued rising health care costs and poor economic growth during the 2001 economic recession reintroduced political and public concern about the sustainability of health care in Canada (Sullivan & Baraneck, 2002).

Between 1996 and 2001, the federal and provincial governments responded by appointing a new series of commissions (Shah, 2003). These inquiries were meant to answer questions posed by many Canadians: How sustainable is medicare over the long term? How can health care problems be solved? How much will it cost? During the five years between 1996 and 2001, a series of provincial and federal commission reports on health care were released.

The provincial reports include:

- *Caring for Medicare: Sustaining a Quality System*, by the Commission on Medicare, Province of Saskatchewan, 2000-2001. (Commissioner, Kenneth Fyke)
- *A Framework for Reform*, by the Premier's Advisory Council on Health, Province of Alberta, 2000-2001. (Commissioner, Hon. Don Mazankowski)
- *Les solutions émergentes*, by the Commission d'étude sur les services de santé et les services sociaux, Province of Quebec, 2000. (Commissioner, Michel Clair)
- *Health Renewal*, by the Premier's Health Quality Council, Province of New Brunswick, 2000-2002. (Chair, Michel Leger)
- *Looking Back, Looking Forward*, by the Ontario Health Services Restructuring Commission, Province of Ontario, 1996-2000.

The national reports include:

- *Canada Health Action: Building on the Legacy: Final Report of the National Forum on Health*, by the National Forum on Health, Government of Canada, 1994-1997.
- *The Health of Canadians – The Federal Role. Volume Six: Recommendations for Reform*, by the Standing Senate Committee on Social Affairs, Science and Technology, Government of Canada, 2001-2. (Chair, Sen. Michael Kirby)
- *Building on Values: The Future of Health Care in Canada*, by the Commission on the Future of Health in Canada, Government of Canada, 2001-2002. (Commissioner, Roy Romanow)

The content of each report is briefly summarized in Appendix I.

**Overview of Reports**

When the Hospital Insurance and Diagnostic Services Act (1957) and the Medical Care Insurance Act (1966) were passed, hospital and physician services made up the core of Canadian

health care. However, funding cut-backs, hospital restructurings, technological and pharmaceutical advances have increasingly shifted medical services into the community (Sullivan & Baraneck, 2002). Medicare has since evolved into a mixture of pharmacological cures, community-based services, home care, and extended care services, superimposed onto the pre-existing system of hospitals and medical care (Shah, 2003; Sullivan & Baranek, 2002). Many of the federal and provincial reports outlined note systemic problems with this evolution, and suggest a range of operational changes and funding modifications in response.

In particular, these reports emphasize that there are inconsistencies between the health care needs of Canadians and medicare's service delivery style. Recommended solutions therefore generally converge around changes to the public health care system to make it more responsive to changing health needs, to make it more accountable to the public, and to make it more efficient in operation and outcome (Sullivan & Baraneck, 2002). As such, the reports share a basic ideological commitment to an expanded version of medicare and offer solutions aimed at modernizing the health care system (Sullivan & Baraneck, 2002; Tuohy, 2002). These reports also consistently include attention to the need to re-assess financing issues and to re-consider health human resources planning (Fooks & Lewis, 2002). Generally showing a "broad consensus on the priority areas for decision making", these reports converge on nine reform themes as outlined by Fooks and Lewis (2002):

1. A focus on population health
2. Financing the health care system
3. Primary care reform
4. Regionalization of service delivery
5. Pharmaceutical policy

6. Health human resources planning
7. Quality improvements and infrastructure supports
8. Governance and accountability mechanisms
9. Home care and extended care services

Some reports differ in terms of implementation plans however. There is agreement that better planning mechanisms are required for health human resources; however, there is disagreement about how to integrate systems at the national level or how to make use of non-medical personnel (Fooks and Lewis, 2002). And although most reports emphasize the need for more money in the public system, there is variation in terms of how to increase revenues. For example, the Romanow Report emphasizes the need for renewed public financing in the form of increased federal support (Canada, 2002a), while the Mazankowski Report recommends a diversified revenue stream of government support, plus user-payments including increased health premiums[7] and medical savings accounts[8] (Alberta, 2001). The Fyke Report also identifies cost-pressures in health care, and while it recommends increased financial investments, it also suggests that greater efficiencies within a reformed quality-oriented health care system are key to financial savings in the long term, and that "spending more on the current health care system without addressing its underlying problems would be irresponsible" (Saskatchewan, 2001, p.73).

***Focus on primary health care:***

One area of particular focus in these reports is primary health care reform[9], which is emphasized as a key element in streamlining Canadian health care, and a precursor to other health reforms. Within the context of Canadian health care policy, primary health care is generally defined as a patient's first access to the health care system, and generally this access is

available through physicians, although a key initiative of primary care reform proposals is to include other health practitioners as part of the primary care team. Through primary health care, patients in need of medical services gain access to the rest of the medicare system, including specialists or hospital care, as required. Currently, most primary care in Canada is organized around private, solo or small group physician practices, where fee-for-service remuneration is the norm. For many reasons which will be explored in more detail, there has been a growing interest in Canadian health policy circles regarding the need for reform in the arena of primary health care. Two of the predominant and recurring goals of such reforms include the desired end of more accessible health care services, and improved overall health status of the population through preventative services.

**Closing**

Medicare was born during the post-war period in Canada. After overcoming jurisdictional barriers, professional and private objections, medicare emerged to provide public hospital and physician services based on citizenship and need, not financial ability. Periods of economic instability and growing government deficits have highlighted new concerns about cost escalation and financial scarcity, and Canada's health care system has been targeted by a series of reform recommendations. These reform trends are represented in the provincial and national reports introduced in this chapter, which emphasize the need to re-assess services provided under medicare, and the need to make medicare more cost-effective and more accountable. This chapter has explored these events from a domestic perspective; future chapters will situate these events within the context of broader, international trends.

# Chapter 3: The Case for Considering Health Care Reform

## Critically, Globally and Equitably

> Today, medicare is the focus of constant newspaper headlines and healthcare policies are central to the platforms of all political parties. Some want the existing system strengthened, others argue for more privatization, and some feel that medicare can only be preserved if it is reformed or transformed. (Coburn, 2001, p.45)

The current trend towards health care reform, as introduced and explored in Chapter Two, requires closer consideration. While there seems to be agreement regarding the need for reform of the health care system, there is a range of opinion about what reform initiatives mean, and in what direction they are leading Canada's health care system. Engaging in this policy debate could potentially involve examining the logic of the proposed solutions, considering each of the options outlined in the national and provincial reports reviewed in the previous chapter. Important questions to answer may include: What benefits might be realized from reforming home care services? What is the best way to bring about desired primary care outcomes? What are the feasible funding alternatives, given a commitment to a public insurance system? These kinds of questions are important, and could help to analyze reform alternatives in according to their potential benefits and outcomes. Traditionally, public policy making has been defined in this way, based on the assumption that through research and knowledge development, progressive solutions to a range of social problems can be found.

However, understanding and assessing Canadian health care reform alternatives may not always be such a straightforward task, and assuming it to be so may cause more problems than it solves. So, rather than searching for the "correct" or "most rational" policy solution in the health care debate, this thesis has adopted a critical perspective, in pursuit of a constructive way of *interpreting* political debates and reform perspectives (Armstrong et al., 2001; Coburn, 2001;

Leonard, 1997; Stone, 2002). Part of this constructive interpretation involved going beyond the Canadian health care policy sphere and exploring the possible ways that local trends are linked to broader global trends. Rather than assessing empirical health information, this thesis instead filters recommendations through a critical perspective, asking, "Who is saying this?" and "Who benefits from this?" Stemming from social work's commitment to social justice, this analysis also assesses the relative value of health care reform recommendations according to their contribution to fairness.

Setting the backdrop to the inquisitive nature of this thesis, this chapter reviews and presents the theoretical models and parameters that guide the analysis. In brief, these include the critical perspective, the political economy perspective (which incorporates an analysis of globalization and its effects), and a commitment to equity as a standard of assessment. These three are explored in turn.

**Critical Perspective**

Traditional, positivistic policy-making began with the assumption that there was an unproblematic relationship between knowledge about the world and the world itself (Fisher & Forester, 1993; Hastings, 1998). Although this model of thought has long been central to the social sciences, it has been threatened by the sometimes-suspect "progression" of rationalism and the realization that hurtful practices can be justified by these principles (Rosenau, 1992).

A critical alternative to positivistic policy making can be found in social constructionist approaches. In objection to totalizing theories, critical social constructionism "cautions us to be ever suspicious of our assumptions about how the world appears to be" and challenges assumptions that there is a straightforward relationship between knowledge and reality (Burr, 1995, p.3).

A social constructionist epistemological position proposes that understandings of reality are "constructed" through the daily interactions between people in the course of social life (Burr, 1995, p.3). This approach suggests that policy issues and problems are not pre-existing givens, but are defined through a process of selection and construction that occurs through societal processes (Hasting, 1998, p.194). The processes by which *problems come to be seen as problems* depend on how "situations come to be seen as caused by human actions and amendable to human intervention" (Stone, 1989, p.281). For example, the problem of too long waiting lists is recognized as a problem because there is a shared social sense that people should receive medical services sooner than they do. The truth or actuality of these concerns is not the point, since "truth" rather than being an objective and consistent entity, is understood as the outcome of currently accepted ways of understanding the world.

The social constructionist approach has roots in the French poststructuralist theory and as such, language plays an important role in meaning-making, since language can be used to advance and to legitimize selective accounts of the character of the world (Burr, 1995; Hastings, 1998; Phillips & Jorgensen, 2002). Swiss linguist Ferdinand de Saussure[10] was among the first to note that there is an *arbitrary* connection between linguistic categories and their representative constructs (Burr, 1995; Hastings, 1998). For example, the link between the word "tree" and the actual living object is a selective and arbitrary choice: an object with branches and leaves could just as well be called a "car" if there was a shared understanding of this alternate meaning. Language choices therefore, are understood to be profoundly affected by how the world is *seen* in the first place (Lemke, 1995). From a social constructionist perspective, the way that policy decisions are made can therefore be understood as a *process of argumentation*. Through the use of selective language, successful policy making depends on constructing (or arguing) shared

understandings of what's real (Fisher & Forester, 1993). Rather than simply objective occurrences, policy problems are created through the "process of image making", whereby images serve to attribute "cause, blame and responsibility" to a given situation (Stone, 1989).

Language and power are also inexorably linked. One of the most influential figures in the social constructionist tradition, Michel Foucault[11], claimed that our common-sense understanding of the world is intimately bound up with power. This occurs through particular discursive practices, which have the ability to create, define and uphold certain accepted or normal ideas about social life (Hastings, 1998). As these ideas are drawn upon, they frame actions in particular ways, such that language and ideas have the ability to construct and shape the rules of social relations (Foucault, 1972). Those that exert power do so in alignment with these accepted ideas, since "the power to act in particular ways, to claim resources, to control or be controlled depends on the 'knowledges' currently prevailing in a society" (Burr, 1995, p.64). For example, the power of a police officer to pull someone over for a speeding ticket is intrinsically linked to shared social beliefs in the need for law and order, and a shared understanding of police officers as entitled to regulate other citizens. Without these commonly-accepted beliefs, a person wearing a hat and a badge would exert little power.

Social policies can also be understood as stemming from practices that sustain accepted systems of belief (Hastings, 1998). From this perspective, policy making depends on the construction of shared meanings of reality, and policy outcomes are shaped by the dominance of some particular versions of reality (Fisher & Forester, 1993; Hastings, 1998). For example, policy measures to provide paid maternity leave to new mothers in Canada are dependent on a shared belief that maternal care is important in a child's first year and that mothers are the preferred providers of this care. Rather than simply logical, objective statements, policy

statements can therefore be understood as "strategically crafted argument[s], designed to create ambiguities and paradoxes and to resolve them in a particular direction" (Stone, 2002, p.8). From this orientation, it is not necessary to retrieve policy from the "irrationalities and indignities of politics" (Stone, 2002, p.7); instead, policy development is acknowledged, analyzed and critiqued as an *inherently political event* (Fisher, 1993; Hastings, 1998; Hillyard & Watson, 1996; Rosenau, 1992). In other words, policy must be considered as part of its political, economic and ideological context, within which policy "issues" are created, identified and prioritized. The prioritization of particular policy issues also reflects the preferences of powerful interest groups:

> …policy and planning arguments are intimately involved with relations of power and the exercise of power, including the concerns of some and excluding others, distributing responsibility as well as causality, imputing praise and blame as well as efficacy, and employing particular political strategies of problem framing and not others. (Fisher & Forrester, 1993, p.6)

From a critical perspective, it is possible to consider these various "problem interpretations" and assess their likely impacts, given the interests represented and the political preferences that underlie the seemingly benign nature of policy development. By "standing back and responding to events and actions which have occurred" (Dant, 2003, p.1) from a multi-layered perspective, this thesis has aimed to understand how Canadian health care reform trends reflect particular ideologies and values, and to recognize those interest groups most likely to gain a lose as a result of particular policy choices (Chambers, 1986; Mayer & Goodchild, 1990). The political aim of critical analysis is to disrupt the oppressive effects associated with institutionalized and dominant discourses, and to comment on social processes which participate in the maintenance of structures of oppression (Phillips & Jorgensen, 2002). Health care policy analysis can considerably benefit from this approach, especially given the conflicting voices and interests at play in current health care debates and reform recommendations.

**Political Economy Perspective**

Critiquing the language of policy initiatives is a starting point from which to assess social processes and priorities (Fairclough, 1992; Phillips & Jorgenson, 2002). To more fully interpret policy initiatives, it is helpful to build links between the "grand issues" of social policy, which relate to the fundamental structures of political and economic life, and the "ordinary issues" of social policy, such as the reformation of medicare in Canada (Wharf & McKenzie, 1998, p.9). Such attention to the overlap between broad political-economic issues and local health policy is considered necessary to enhance social work policy endeavors (Langmore, 2001; Prigoff, 2000). Prigoff (2000) has also suggested that for Canadian social workers to be effective as policy makers and practitioners, they need to understand and acknowledge global trends, events and influences. However, as Coburn (2001) points out, the connection between grand and ordinary issues can be too easily overlooked in Canadian health care policy considerations.

> Today, with the welfare state in Canada under attack (McQuaig, 1992, 1995), the changing economic context of recession or international competition is often given as explanation for the contemporary restructuring or downsizing of medicare or for threats to the principles of medicare from forces pushing for privatization. Yet the links between such broad factors as globalization and current events in health care are seldom explained. For example, it seems to be currently assumed that particular political bureaucratic actions are direct responses to obvious fiscal crises, hence, presumably do not need explanation. This however, simply ignores what should be explained about the relationship between economics and politics. (Coburn, 2001, p.47)

The political economy perspective provides the theoretical guidelines which facilitate a systematic assessment of grand social policy issues. Supporters of the political economy perspective would also argue that this broad analysis must begin at the global level, drawing "links between broader social structures, such as globalization, and more immediate and practical concerns such as the fate of medicare" (Armstrong et al., 2001; Coburn, 2001, p.45). In addition to building links between global and local policy issues, the political economy perspective also

allows for a layered analysis of multiple factors, including individuals, historical events, states, modes of production, ideologies, discourses, and civil society.

> As a paradigm, the political economy perspective provides a way to understand the dynamic relationship between people within a specific society by identifying how that society has unfolded historically and, in particular, how its economic system is organically linked to the social/cultural/ideological/political order. (Drache & Clement, 1985, pp.viii-x)

These components are included in the analysis, not as stand-alone variables but interrelated parts of the same whole (Armstrong et al, 2001). From this perspective, Canadian health care reform is understood as multi-layered and contextual, and as more than a set of technical policy documents. As Coburn (2001) notes, the political economy approach can help explain how economic, political, and social changes at the national and international levels are linked to Canadian health care reform.

The political economy perspective draws on liberal and Marxist intellectual streams of thought and studies the laws and relations of the capitalist system: either critically from the Marxist perspective or uncritically from the traditional, liberal (neo-liberal) view (Armstrong et al. 2001; Drache & Clement, 1985; Ravenhill, 2005). The critical view analyzes the impacts of dominant production models and social class dynamics (Ravenhill, 2005). Influenced by social constructionism, the critical view also draws links between ideology and power, in that the predominant common-sense understanding of the world is understood to be strongly influenced by those with economic and political power (Armstrong et al., 2001). Coburn (2006) notes that a *critical* political economy approach is based on "the notion that people within a society may or may not have an accurate idea of how their society actually works" and therefore in order to have validity as a model, it must "challenge (be critical about) current perceptions, beliefs, ideologies, and ideas and also contribute to asking questions about how things could be different" (p.60).

A critical political economy approach based in materialism emphasizes that the world that people live in shapes their ideas and accepted notions of common sense; social formations and beliefs are considered dependent on dominant production models and economic structures (Coburn, 2006). In Canada, of course, the dominant mode of production is capitalism, essentially, an economic system where the production and distribution of goods (and some services) depends on invested private capital and profit-making (Pearsall & Trumble, 1996). Although capitalism has focused on capital investment and the pursuit of profit since the early industrial period, it has changed in shape and nature over the past fifty years or so (Ross and Trachte, 1990). Whereas earlier periods of global exchange were characterized by national economies and international trade between semi-autonomous states, today's economic globalization represents a paradigm shift, as marked by the "openness of national economies with respect to trade and financial flow" (McBride, 2001; Mishra, 1999, p.ix; Ravenhill, 2004). Global capitalism is therefore understood to have a distinct impact according to a critical political economy perspective (Coburn, 2006). Therefore, in order to understand Canadian health care reform, a closer understanding of globalization is required. In the following section, globalization is briefly introduced. A closer analysis of the impact of globalization on Canadian health care reform will follow in Chapters Five and Six.

***Globalization:***

There is no question that the term "globalization" - used so often as a pop culture buzzword and a key descriptor in all manner of international discussions - has staked its lasting claim in our collective vocabulary. For a word so casually referenced by trend watchers, politicians, business leaders and street protestors alike, its actual definition is less obvious.

Though a standard definition may be elusive, globalization can be characterized by the increased flow of goods and services, capital, labour and information worldwide (Canada, 2002a, p.233).

Throughout the first half of the twentieth century, global competition, when it existed, focused on gaining control of resources in colonized regions (Prigoff, 2000). Trading between states was limited according to the preferences of national autonomy and the localized base of most corporations (Teeple, 2000). In contrast, globalization, or the "new capitalism" as McQuaig (2001) describes it, has been characterized by the international fluidity of social, economic, political and ideological influences and the increasing interconnectedness of national and international economies (Coburn, 2001; McBride, 2001; Ross & Trachte, 1990). No longer exclusively limited to the sphere of one nation state, capitalism has moved into a "global" phase, and represents a new version of economic organization short-handedly referred to as "globalization" (Ross & Trachte, 1990).

Among the observers of globalization, there are multiple views as to its relative worthiness. Wiseman (1996) identifies three categories of response: champions, competitors and challengers. The champions are those that actively support the increasing interconnectedness of economic systems worldwide (Wiseman, 1996). In Canada, the champions of globalization are those neo-liberal-leaning policy groups including the C.D. Howe Institute, the Fraser Institute, and the Business Council on National Issues (now known as the Canadian Council of Chief Executives) (Rice & Prince, 2000). These groups, who "are fully and unashamedly committed to enhancing the global power of corporations and reducing the legal and political regulatory power of the nation state" (Wiseman, 1996, p.116), feel that globalization is inevitable, positive and supportable, and believe that efforts should be made to enhance world market integration (Friedman, 2000). One of their assertions is that global markets can most effectively distribute

resources as markets are increasingly liberalized, and as the tide of economic prosperity rises (Armstong, 2002).

Competitors, on the other hand, are skeptical of globalization's claims, but tend to accept the need for trade liberalization in the interests of competitive advantage (Wiseman, 1996). Rice and Prince (2000) suggest that the competitors represent the dominant view in Canada, given that this perspective serves the interests of dominant groups which benefit financially from trade liberalization.

Globalization and its international trade priorities have also been questioned by many critics in the social policy community who point to its negative effects, including growing economic prioritization, shifting class relations, greater social inequalities, and a general erosion of public services (Coburn, 2001; Prigoff, 2000; Rice & Prince, 2000; Teeple, 2000; Shield & Evans, 1998). These challengers "contest the basic assumptions of economic globalism" (Rice & Prince, 2000, p.134) and suggest alternatives to fiscal imperialism (Wiseman, 1996). Competitors tend to pursue strategies for global social and political institutions which will provide some counterbalance to economic hegemony, and which will provide "substance to the values of sustainability, social justice, and democracy in an age of global power" (Wiseman, 1996, p.126-7).

In the interests of social justice and "in rejection of obedient research tamed by political convenience" (Epstein, 2001), this thesis adopts a challenger perspective in response to economic globalization, noting and drawing attention to some of the real effects of this social, political, economic and ideological phenomenon. To be critical in this way however, requires a starting point, or a preferred "view of the world and how it is and how should be, including how we, and others, should act" (Dant, 2003, p.1). In this thesis this starting point can be found in the belief

that health care reforms should contribute to greater equity, or social fairness, to be considered worthwhile.

**Equity**

The early, national phase of capitalism was also a time of social and political support for strong state intervention in the economic and social arena (Armstrong, 2002). The welfare state emerged in recognition that capitalistic economic systems inherently depend upon and support economic inequalities. Social supports, including employment insurance, public pensions, social assistance and medicare, were therefore introduced in Canada to pool risk and to redistribute resources (McGilly, 1998). Publicly-funded health care systems within the context of a fully-developed welfare state have also been considered an essential counterweight to the market's unfair distribution of resources (Canadian Center for Policy Alternatives (CCPA), 2002a).

Publicly-funded health care systems are ideologically supported by the social-democratic worldview, which acknowledges that socially-determined production and distribution conditions play a role in wealth allocation and illness patterns (Johnson, 2002; Waters, 2001). Rather than advocating individual solutions, illness is understood as "primarily a socio-economic phenomenon and not a natural-individual phenomenon", a state that requires collective responsibility and collective solutions (Chernomas, 1999, p.i). The social-democratic worldview and its understanding of distributive justice are based on the idea that benefits and burdens in society should be assigned as if from a common source (Rawls, 1971). According to concepts developed by philosopher John Rawls, distributive justice is based upon the preference of rational persons, who could hypothetically pick their society of choice before birth. With no guarantee or foresight regarding their social and economic position, a rational person would most likely choose to live in a society that was the least bad. A least bad society is one where, despite the

existence of social and economic differences between people, inequalities are distributed in such as way as to not selectively favor any one person over another, and in such as way that the *least advantaged* members in society receive the *most benefits* (a concept known as the difference principle) (Rawls, 2001).

Because poor health is unequally distributed among persons, often striking without warning or apparent justice, it is a type of social burden characterized by its unpredictability, in that most people cannot "plan" their future health outcomes. Because poor health is also most heavily felt by the poorest members of a given society - research clearly shows that least advantaged members in society have the poorest overall levels of health, succumbing to chronic illnesses, disability and death at younger ages and using the health care system more frequently (when it is a *public* health care system, it must be noted) than those with greater wealth, power and prestige – it is a social burden that can be equitably balanced by the difference principle (Whitehead, 1992; Braveman & Gruskin, 2003). For a rational person, with no guarantee of his/her future state of health or socio-economic status before birth, the most just society would be one where all persons have equal opportunity to be healthy, and where those with the worst health will be most supported (Chang, 2003). Because publicly-funded health care systems redistribute resources in such a way as to provide the most benefits to the least advantaged members of society, they operate in principle as progressive social systems according to the difference principle, while optimizing equity in health (Williams et al., 2001).

Paired with a "commitment to emancipatory forms of analysis and action" critical social work is characterized in theory and in action by a commitment to redistributive social change (Fook, 2002, p.5). Targeting equity, social work policy initiatives likewise include recognition that "social inequities are considered just to the extent that they result in compensating benefits

for the least advantaged person in society" (CASW, 2003). As such, social workers are expected to reflect the difference principle. In policy and practice, these expectations are manifest in social work's efforts to support public health care systems within the context of a working welfare state.

The World Health Organization (WHO) also recommends the pursuit of equity according to the difference principle, advocating a reduction of inequalities between the best and worst off members of any given community:

> The health system… has the responsibility to try to reduce inequalities by preferentially improving the health of the worse-off… The objective of good health is really twofold: the best attainable average level – goodness – and the smallest feasible differences among individuals and groups – fairness. (WHO, 2002)

In line with these recommendations, the pursuit of equity or fairness in health can be defined as the attempt "to eliminate disparities in health between more and less-advantaged social groups" (Braveman, 2003, p.182). Bravemen (2003) also points out that because equity is a normative concept[12], and is based on a subjective assessment of health differentials *as unfair*, it can be difficult to measure (p.182). However, when equity is defined according to equality, it can be easier to measure and assess. This is because the process of measuring *equality* can be somewhat straight-forward, for example, either there is a difference in the measured morbidity rates of two population groups or there isn't. The decision to take measurements one step further and to label difference as inequity is the step that requires interpretation (Chang, 2002; Whitehead, 1992).

Because this thesis supports the pursuit of redistributive outcomes, where the positive outcomes of a capitalistic system are more evenly distributed throughout society, analysis will be based on the premise that health differences that "systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage", are unfair and unjust

(Braveman & Gruskin, 2003, p.254). The operationalized definition outlined by Braveman and Gruskin (2003) has been adopted in this thesis.

> For the purposes of operationalization and measurement, equity in health care be defined as the absence of systemic disparities in health... between social groups who have different levels of underlying social advantage/disadvantage – that is, different positions in a social hierarchy. (Braveman & Gruskin, 2003, p.254)

Based on this definition, if there are great differences in the level of health enjoyed by those as the highest socio-economic levels, as compared to those at the lowest socio-economic levels, then equity, or fairness, is considered to be in jeopardy.

This definition of equity in health is also closely linked to human rights principles and the belief that all people should be guaranteed access to the "highest attainable standard of health", as reflected by that level of health enjoyed by the most socially advantaged group in society (Braveman & Gruskin, 2003, p.255). Although not all persons may have *equal* health status (for example, consider physically abled and physically disabled persons), the pursuit of equity in health "is concerned with creating equal opportunities for health, and with bringing health differentials down to the lowest level possible" (Whitehead, 1992, p.434). In other words, equity exists when there is more or less equal opportunity for all population groups to be healthy. Braveman and Gruskin (2003) highlight the need for equal opportunity to be healthy as a key component in health equity and as a key measurement of social justice.

> The notion of equal opportunities to be healthy is grounded in the human rights concept of non-discrimination and the responsibility of governments to take the necessary measures to eliminate adverse discrimination – in this case, discrimination in opportunities to be healthy in virtue of belonging to certain social groups...Equal opportunity to be healthy refers to the attainment by all people of the highest possible level of physical and mental well-being that biological limitations permit, noting that the consequences of many biological limitations are amenable to modification. (Braveman & Gruskin, 2003, p,255)

This thesis has considered whether proposed health care reforms are likely to contribute to or detract from equity. As noted by Whitehead (1992), equity must be considered en route towards a truly universal health care system, since "national health policies designed for an entire population cannot claim to be concerned about the health of all the people, if the heavier burden of ill-health carried by the most vulnerable sections of society is not addressed" (p.431). Conclusions about equity in this thesis are therefore based on whether health care reform proposals are likely to enhance the fairer distribution of health resources in such a way as to reduce systemic disparities in health. The inclusion of social and economic determinants of health in this analysis considers whether health care reform proposals support or detract from other health-inducing factors such as income, social supports, and general living conditions in households and communities.

**Closing**

The last few decades have marked a period of considerable stress for health care systems around the globe, leading to an almost universal search for methods of effective health care delivery and cost-effective reforms (Shah, 2003). The critical stance adopted in this thesis stems from the belief that globalization and its outcomes are essential considerations in making sense of these ordinary health care policy issues (Armstrong et al., 2001; Coburn, 2001). In this analysis, health care reforms have been made more "transparent" (Armstrong et al., 2001, p.x) and understood as linked to international trends, as well as state, government and class interests (Coburn, 2001; Wermuth, 2003). The political economy approach therefore has oriented this thesis toward a broad critique of global capitalism and the ideology of neo-liberalism. As well, it helped to focus attention on equity issues in health care reform (Armstrong et al., 2001). The next

chapter outlines the specific research questions answered in this thesis, as well as a study of the relevant texts supporting this analysis.

## Chapter 4: Methodology

The aim of this thesis has been to explore Canadian health care reforms critically from a political economy perspective, to consider the potential links between localized debates about health care and globalization, and to consider the likely impacts on equity that may result. Based on these intentions, this work has been guided by the following four research questions:

1) What are the drivers or motivations - including social, political, economic and ideological forces - behind health care policy choices and decisions in Canada?
2) How is "health" defined in Canadian health care?
3) How are health care "problems" and "solutions" being explained, justified and defined in Canadian health care?
4) Are these health care reforms likely to contribute to greater equity?

The first question reviews Canadian health care from the broad perspective of social, political, economic and ideological forces. The second and third questions identify and explore health care reform recommendations and seek to understand how health care conversations are shaped, used to influence public perception, and express the interest of dominant groups. The fourth question considers reforms in light of their contributions to social justice from a progressive social work perspective.

In this thesis, these four research questions are applied 1) to the Canadian health care context in general, and 2) to primary health care reforms outlined in the 2002 "Romanow Report" (This refers to the final report submitted by the federal Commission on the Future of Canadian Health Care, under the direction of Commissioner Roy Romanow.) The review of the health care debate in general is intended to provide an overview of health care in Canada and to identify some of the factors which contribute to any one set of arguments within this arena. From this

perspective, health reforms have been considered not only in terms of health care systems and health care services, but also in terms of the broader determinants of health. The review of the Romanow Report's primary health care reform recommendations is intended to analyze a specific set of health policy recommendations and to critically consider the broader forces at play in one statement of health policy priorities. The Romanow Report was chosen over others for its national scope and for its public accessibility and familiarity.

The four key research questions were developed in advance of the analysis outlined in later chapters. These questions operated as a guide, shaping the chosen avenues of exploration and directing critical inquiry in certain directions. In addition to the four main questions, a number of supplemental questions were also developed to help target the inquiry. These questions and sub-questions emerged from a theoretical base that included: the political economy perspective, a critical approach to policy analysis, and a commitment to equity principles (Armstrong et al, 2001; Hastings, 1998; Gilson, 1989). These questions are reviewed in more detail below.

**1) What are the drivers or motivations - including social, political, economic and ideological forces - behind health care policy choices and decisions in Canada?**

Rein and Schon (1993) use the term "nested context" to indicate the manner in which policy issues and government initiatives "exist in some policy environment, which is part of some broader political and economic setting, which is located, in turn, within an historical era" (p.154). Rather than occurring as stand-alone events, policy issues are understood to be historically nested within a broader context. In the same way, the political economy approach, as outlined by Armstrong et al. (2001), appreciates the intimate linkages between politics,

economics, ideologies, history and power, emphasizing that these factors must be understood as interrelated elements in the policy environment. This first question has allowed for a consideration of these interlinked policy drivers in more detail. Specific areas of inquiry are highlighted in the following set of sub-questions:

a) What are the ideological drivers behind policy reforms in Canadian health care?
b) What values are being represented?
c) Which voices/interests speak the loudest? Which are unheard?
d) How does power come into play within this context?
e) What are the political and economic drivers behind policy reforms in Canadian health care?
f) What are the social and contextual drivers behind policy reforms in Canadian health care?

*Noticing Ideological Drivers*: Commonly-accepted patterns of thought are linked to shared social agreements regarding how things ought to be done in a given context. These patterns of thought may also be understood as ideologies. An ideology is "a more or less consistent set of beliefs about the nature of the society in which individuals live, and about the proper role of the state in establishing or maintaining that society" (Johnson, 2002, p.13). These collectively shared beliefs affect how social services such as medicare are shaped. Through an exploration of dominant ideological influences in Canada today, this thesis will look at how commonly-accepted patterns of thought are shaping Canadian medicare.

*Exploring Values*: Values shape decisions and outcomes: when values are put into action they generally seek to transform a given context towards some ideal or preferred outcome (Johnson, 2002). Therefore, it is important to explore the underlying and dominant preferences shaping health care reform, and to understand why different courses of action are prioritized over others. This is not a straightforward task, since values "[run] deep, rarely surfacing", and tend to be "revealed only indirectly and imperfectly though the political process" (National Forum on Health, 1997, p.10). Still, Giacomini et al. (2004) emphasize that values must be critically considered if a policy researcher is to "understand what is really being said", in light of the social, political and economic context, which inevitably "shapes the meaning of declared values" (p.22).

*Power and Interest Groups*: As a mechanism for wading through contesting viewpoints, nested health conversations may be further interpreted by looking at the underlying power structures and influential forces (Rein & Schon, 1993). This thesis therefore also explores the voices and interest groups that shape how health care conversations are expressed and debated, and pays particular attention to their relative degrees of power and influence. The aim is to "reveal some of the means by which we have constructed our collective understanding of reality" (Boyes, 2001, p.85) and to better explore the power-based influences behind health policy reforms (Fisher & Forester, 1993).

*Considering Political and Economic Drivers*: Ideologies are linked to politics and economics because political cultures and economic preferences are shaped by socially accepted and shared beliefs (Johnson, 2002). The ideas we share inevitably impact our understanding of government, social priorities and civil society (Armstrong et al., 2001). It is within this policy terrain that

causal interpretations are constructed and viable solutions regarding health care priorities are politicized (Stone, 1989). The influence of power also plays a role because political influences effectively bracket the range of acceptable economic and social scenarios up for consideration:

> Within any given society, certain policies are seen to be legitimate, others not; debate, competition for authority, and the actual implementation of policy will generally occur within the boundaries of acceptability defined by political culture. (Johnson, 2002, p.13)

*Social and Contextual Drivers*: Health care policy decisions are shaped by the historical and contextual elements of the surrounding environment. This includes not only the values, ideologies, political preferences and economic persuasions explored above, but also the historical, social and environmental contributors to the policy space of the health care debate. Changes in the health care system are shaped and driven by trends including demographics, perceptions of health care needs, and systemic elements of the health care system itself (Armstrong et al., 2001).

**2) How is "health" defined in Canadian health care?**

Coherently presented arguments perform ideological work by cueing the listener to understand what is being said in a particular way (Fairclough, 1992). Rather than being neutral and objective, health conversations are shaped by context, vested interests and the chosen health definitions employed. To consider health conversations critically, this second research question and its related sub-questions (as noted below) considered the ways that health is defined:

a) What language is used in defining health?

b) What voices/interests subscribe to each definition?

c) Is one particular definition predominant?

Political economy and social constructionist approaches to policy analysis are based on the understanding of policy issues as constructed entities, rather than pre-existing givens (Armstrong et al., 2001; Stone, 1989). The ways that policy makers talk about and understand "health" has implications for how health care debates are pursued and understood.

The concept of "framing" helps to explain how policy conversations/narratives are influenced by broader policy discourses and power differentials, and can be understood as follows:

> ...framing is a way of selecting, organizing, interpreting, and making sense of a complex reality to provide guideposts for knowing, analyzing, persuading, and acting. A frame is a perspective from which an amorphous, ill-defined, problematic situation can be made sense of and acted upon. (Rein & Schon, 1993, p.146)

The "framing" of a policy issue is not a neutral or objective act. Rather, a chosen frame is based on a particular interpretation of events and a preference in terms of how to operate in a given context. Inevitably, these preferences are also linked to power-based interests (Hastings, 1998; Rein & Schon, 1993). The result is that certain interpretations of health will tend to dominate, according to the interests of the most powerful voices in a given context. In order to shed light these concepts within the health care reform context, this thesis has considered a range of health definitions, and explored the links between these definitions, their related ideological preferences and power-based influences.

**3) How are health "problems" and "solutions" explained, justified and defined in Canadian health care?**

The framing of a particular policy issue within the broad social, political, economic and ideological context has implications for how policy "problems" are defined and recognized and

how policy “solutions” are interpreted and acted upon (Stone, 1989). This third research question was also expanded into a series of sub-questions to guide inquiry:

a) What are the expressed or implied problems in health?
b) What are the recommended solutions?
c) Will adopting these solutions solve these problems?
d) Are there problems, causal connections, solutions that are being overlooked or ignored?
e) What voices/interests are being represented/overlooked?
f) Is it likely that these solutions will be implemented?

*Considering the Construction of Policy Problems and Policy Solutions*: Rather than a strict interpretation of the “facts”, social policy problems can be understood as “causal narratives” or preferred stories which assign responsibility and pursue control through a particular interpretation of events (Stone, 1989). Generally, narratives "include a temporal ordering of events in an effort to make something out of those events" (Sandelowski, 1991, p. 162).

The important point to recognize is that not all policy narratives come to the same conclusion in *making something* of observed events. At every level in the policy interpretation process, be that personal, scholarly or political, different people tend to “see different things, make different interpretations of the way things are, and support different courses of action regarding what is to be done, by whom, and how to do it” (Rein & Schon, 1993, p.147). Unlike traditional ethnographic accounts that aim to incorporate realistic descriptions within a scientific paradigm and characterize language as representative of singular meanings, a critical analysis is more skeptical about the idea of a singular “truth” and views personal and political stories as

"deeply constructive of reality, not simply a technical device for establishing meaning" (Riessman, 1993, p. 4).

Understanding policy stories as "argumentation" or as carefully crafted arguments therefore requires policy research to "avoid radically separating epistemological concerns (the claims made 'within' the argument) from institutional and performative concerns (how in *deed* the argument is made)" (Fisher and Forester, 1993, p.5). In this *constructive* sense, policy stories are understood to embody particular ideas about causation, and policy politics is recognized as involving the act of "strategically portraying issues so that they fit one causal idea or another" (Stone, 1989, p.283).

*Interests, Power and Implementation*: Fisher & Forester (1993) point out that "the institutionally disciplined rhetorics of policy and planning influence problem selection as well as problem analysis, organizational identity as well as administrative strategy, and public access as well as public understanding" (p.2). In a similar manner, dominant policy interpretations and causal stories have broad implications in the field of policy analysis. Stone (1989) suggests that despite good intentions expressed by policy-makers pursuing the "true" cause of social problems, the policy struggle is more about promoting particular ideological interests. In practice, policy recommendations represent subjective choices and the presence of dominant interests has important implications for those voices that are heard versus those that are overlooked in the policy-creation process.

**4) Are these health care reforms likely to contribute to greater equity?**

Critical analysis a method usually employed in the critical exploration of a research question with the intent of correcting an injustice or inequality in society (Phillips & Jorgensen, 2002). An injustice may be something that is identified as a problem by individuals or groups in society, or it may be identified by the researcher who wants to deconstruct a misrepresentation between reality and the ideological view people have of reality (Phillips & Jorgensen, 2002).

The aim of taking a critical approach in this thesis has been to increase understanding in terms of health care policy development, to alert policy makers to the consequences of their actions, and to point towards the possibilities for resistance and change. In this sense a critical approach can offer a path towards enhanced democratic deliberation, where through a thoughtful, informed and argumentative approach to policy analysis, "citizens can learn, and policy and planning analysts can promote that learning" (Fisher & Forester, 1993, p.7)

To do this methodically, this fourth research question considered the potential contributions that recommended health care solutions were considered likely to make to equity or fairness. In addition to the main research question, a series of sub-questions helped to guide this analysis:

a) How do these definitions of health and health problems and solutions address the goal of social equity? or do they fail to do so?
b) Will these proposed changes potentially increase, decrease or leave equity unchanged?

Within this thesis, equity has been defined as "the absence of systematic disparities in health... between social groups who have different levels of underlying social advantage/disadvantage" (Bravemen & Gruskin, 2003, p.254). This definition is rooted in a social justice perspective and views health differences caused by systemic and unequal access to

resources, as inherently unfair. Where there are significant and systematic differences in health among those at high socio-economic levels, as compared to those at low socio-economic levels, then equity is considered to be in jeopardy. This analysis therefore considers the expected outcomes of reform trends and proposals on the health care "rankings" of various socio-economic groups. This assessment is based on the critical assessments and conclusions of various researchers, as well as consideration of primary data sources.

In considering the potential contributions of proposed health care reforms, this analysis also noted the degree to which the broader determinants of health have been incorporated within health policy reform recommendations. The assessment guideline was based on the understanding that there are a broad range of determinants that contribute to health (beyond health care alone), and that poverty and social inequity must also be addressed if health reforms are to be considered fair to all members of society (Braveman & Gruskin, 2003; Whitehead, 1992).

**Primary Health Care**

With critical policy analysis, it is also possible to examine the features of texts themselves, with the goal of examining how social discourses are activated textually and to provide backing for particular analytical interpretations (Hastings, 1998; Phillips & Jorgensen, 2002). The four research questions were also posed in relation to primary health care reforms as specifically outlined in the 2002 Romanow Report:

1) What are the drivers of primary health care reform as identified by the document?
    a) What are the ideological drivers identified by the document?
    b) What values are identified as guiding primary care reform?
    c) What political drivers are alluded to?

d) What are the identified social and contextual drivers?

e) What are the stated economic drivers?

f) How do power and power differentials play a role?

g) Which voices/interests speak the loudest? Which are unheard?

2) How is "primary health care" defined in the document?

a) How does the document refer to, reference and talk about 'health'?

b) What language is used?

c) Does the document highlight one particular definition predominantly? Or, does the document adopt a combined definition?

d) How close to the "spirit" of the definition does the document stay (or stray)?

e) What voices/interests also subscribe to this definition?

3) What are the problems and solutions as identified by the document?

a) How does the document state, either implicitly or explicitly, the problems and solutions in primary health care?

b) How clear is the link between the stated problems and the stated solutions?

c) Will adopting these solutions solve these problems? (or will a different situation likely be created altogether?)

d) Are there problems, causal connections, solutions that are being overlooked/ignored?

e) What voices/interests are being represented by these stated problems and solutions?

f) What voices/interests are being overlooked by these stated problems and solutions?

g) Can these solutions be implemented easily?

h) It is likely that they will be implemented? (Why or why not?)

4) Throughout, how have the issues of equity been addressed or ignored?

This critical review of primary health care reform recommendations as they are presented and argued in the 2002 Romanow Report is relevant to this work for a number of reasons. First, this analysis allowed for a closer look at a specific policy reform document and the processes of policy "argumentation", including what is said, how arguments are presented, what references are cited, and how conclusions are drawn (Fisher & Forrester, 1993). Second, primary health care is often variably defined by the Canadian public and policy analysts (Canada, 2002a; Mable & Marriott, 2002). A closer look at the range of definitions of primary health care may therefore help to illustrate the multiplicity of factors which shape and influence the parameters of primary health care policy development. Third, despite ongoing initiatives and recommendations for change, very little has been accomplished in terms of primary care reform (Hutchinson, Abelson & Lewis, 2001). The basic structure of primary care organization, funding and delivery (private, fee-for-service, solo and small group) has generally remained intact. A closer analysis of the drivers and factors which have shaped primary care initiatives has also helped to shed some light on this inertia. Fourth, in addition to looking at the Romanow Report itself, this analysis has also facilitated a look *beyond* the report. Primary health care reforms in Canada are recognized to be shaped by broader world events and trends; by taking a look beyond the details in the report, this thesis has allowed for an analysis of those factors that have been excluded or overlooked in an

official policy document. And finally, since primary care is about access to health services, and because it often includes direct efforts to incorporate preventative care and health promotion in the delivery of these services, primary health care reform can also be an important indicator of equity (or lack thereof).

**Choice of Documents**

The choice of materials depends of the research question, the researcher's knowledge of the relevant material in the social domain of interest, and accessibility (Phillips & Jorgensen, 2002). The materials chosen for review in this analysis are outlined below:

*Canadian Health Care Context in General:* The review of the Canadian health care reform context in general is drawn from a number of sources, including provincial and national health care reform documents outlined in Chapter Two, a range of summative and critical health reform documents and social policy commentaries (Annas, 1995; Barlow, 2002; Bolaria, 2002; Browne, 2000; CCPA, 2002a 2002b; Canadian Health Coalition; 2005, 2002; Canadian Health Services Research Foundation (CHSRF), 2002; Chernomas, 1999; Clarke, 2000; Coburn, 2006, 2001; Evans, 1997; Federal, Provincial, Territorial Advisory Committee, 1996; Fooks and Lewis, 2002; Giacomini et al., 2004; Hayes & Dunn, 1998; Kenny, 2002, 1997; Lexchin, 2001; Poland et al., 1998; Powell & Wessen, 1999; Public Healy Agency of Canada, 2005; Rice & Prince, 2001; Sanger, 2001; Shields & Evans, 1998; Shah, 2003; Sullivan & Baraneck, 2002; Tuohy, 2002; Tuohy, 1999; Williams et al., 1999). A range of primary data sources were also consulted (Canadian Institute of Health Information, 2006a, 2006b, 2005a, 2005b; Canadian Health Services Research Information, 2005, 2003; Carlson et al., 2004; Devereaux et al., 2002; EKOS,

2002a, 2002b, 2000; Mustard et al., 1995; Statistics Canada, 2004; World Health Organization, 2000).

Critical analysis is drawn from a range of critical and political economy perspective sources (Burr, 1995; Coburn, 2001; Dant, 2003; Doyal & Pennell, 1979; Drache & Clement, 1989; Ennis, 1985; Epstein, 2001; Fasko, 2003; Fook, 2002; Labonte et al., 2005; Labonte, 2003; Langmore, 2001; McQuaig, 2001, 1999, 1995, 1992; Midgley, 2000, 1997; Navarro, 1986, Raphael, 2001; Waitzkin, 1979; Wermuth, 2003; Williams et al., 2001). Pat and Hugh Armstrong have written and edited a number of books and collected essays which examine Canadian health care reforms from a critical economy perspective; their work is drawn upon heavily in this analysis (Armstrong & Armstrong, 2003, 2001; Armstrong, 2002, 2001; Armstrong et al., 2003, 2001, 2000).

The analysis of equity contributions is drawn from a range of critical health researchers who generally support the pursuit of equity and health (Bernstein et al., 2001; Braveman & Gruskin, 2003; Deaton, 2001; Donner & Pederson, 2004; Donner, 2000; Gilson, 1998, 1989; O'Keefe, 2000; Wagstaff & Van Doorslaer, 1993; Whitehead, 1992; Wilkinson, 1996).

For a complete listing of materials used, please see references at the end of this work.

*Primary Health Care Reforms:* A set of government documents refer to the need and preference for primary health care reform in Canada (Alberta 2001; Canada, 2002a; Canada, 2002b; Canada, 2002c; Fooks & Lewis, 2002; New Brunswick, 2002; Ontario, 2000; Quebec, 2000; Saskatchewan, 2000). However, since a complete review of all provincial, territorial and federal reports in beyond the scope of this thesis, the specific focus is narrowed to the Romanow Report (Canada, 2002a).

The Romanow Report is a 356 page document that was the outcome of a Royal Commission established by the Prime Minister in April 2001 to inquire into and undertake dialogue with Canadians on the future of Canada's public health care system, and to make recommendations to enhance the system's quality and sustainability (Canada, 2002a). Of this full report, one chapter (or 21 pages) is specifically devoted to primary health care reform. (An outline of the Romanow Report's specific recommendations for primary health care reform is provided in Appendix II.)

The Romanow Report was chosen for two reasons. First, because it is a federal rather than a provincial report and it includes voices from multiple segments of the Canadian population. This claim of multiple representation is based upon the range of reports submitted to the Commission itself (Canada, 2002a). It should also be noted that this report included significantly more public forums and received more feedback in both written and oral form, than any of the individual provincial or territorial reports. Second, the Romanow Report has been chosen because of its accessibility and publicity in comparison to other key federal reports: the report is frequently referenced and cited by policy analysts, government officials, health interest groups and the media. It was also a focal document in the 2004 Health Accord negotiations.

During recent negotiations regarding health care funding and reform in Canada (2004 First Ministers Meeting), the Romanow Report was used as the benchmark against which the failure or success of the talks were evaluated. In addition to inviting the ongoing commentary of author Roy Romanow, in terms of the "outcome" of the talks, the media and Prime Minister Paul Martin emphasized that the Romanow Report should be consulted as *the* guide for future health care reform and development.

**Consideration of Methods**

Studies and practice approaches that choose to avoid a critical stance in terms of power differentials that underlie the policy decision-making process, "play, by default, ceremonial political roles that engender cherished social values or at least the ideological preferences of the powerful" (Epstein, 2001, p.417). Without critical analysis, the power imbalances inherent in the creation and maintenance of knowledge can be overlooked, and inadvertently reproduced in oppressive policy decisions and perspectives.

According to Fine, Wies, Weseen and Wong (2003), social work researchers have an obligation to consider social issues in such a way that enacts their "responsibilities toward a sense of social justice" (p.168). A critical approach is consistent with the social justice values of social work practice and policy which include ethical responsibilities to social justice, specifically, to "advocate change, a) in the best interests of the client, and b) for the overall benefit of society, the environment and the global community" (CASW, 1994). The dominant approach to understanding “health” in Canadian society may not be the most equitable one, especially if health can be better served by addressing its broader determinants. As a result, a critical approach to looking at health care can be very useful for social work research because it provides a tool with which to question and challenge the status quo.

Hastings (1998) notes that research which analyzes connections between linguistic structures and the social nature of knowledge may be questioned for its legitimacy. This is due to the fact that any account of how language is constructed is in and of itself a construction, in the same way that policy analysis as well as policy making must be acknowledged as a form of “argumentation” where particular constructions of social issues are used for particular political purposes (Fisher & Forester, 1993). By this critique, this thesis can be viewed as an interpretive

and purposeful form of knowledge construction itself. This understanding also raises questions about the ability of the researcher to uncover the parallels between her own reading of text and those readings made by people with different experiences and in different social positions (Hastings, 1998).

In response to these concerns, Potter and Wetherall (1987) suggest that it is sufficient to acknowledge the constructive nature of research in the presentation of findings. However, Hastings (1998) recommends that research data, analysis and conclusions are presented in a manner that makes the researcher's interpretations and claims transparent, and Lemke (1995) prefers the route of reflexivity, where personal details are shared to assist the readers in "positioning" the author.

It is clear that my own social position (including gender, ethnicity, education, socio-economic status, and cultural influences) has shaped this work by influencing the questions asked, the interpretations expressed, and the final reporting and analysis. My own bias, specifically in favor of greater social equality, enhanced democratic participation and emancipatory social reform, has also invariably had an influence on this research and findings. As such, has been important to maintain what Naples (2003) calls "strong reflexivity", where I have remained open to being challenged about my own authority as author of the thesis.

Such openness to contradiction has been pursued by actively looking for inconsistencies in the reviewed texts, including an active search for references that may challenge my findings. Triangulation, through literature review and committee checks (in terms of the direction, methodologies and implications of this analysis) have also been invited to support, verify and challenge the findings of this approach (Franklin & Ballan, 2001). Another potential safeguard can be found within a transparent audit trail, which traces the theoretical and methodological

influences and decision branches occurring throughout the course of this analysis (Merriam, 2002).

Critical research can be evaluated in light of its political implications and the usefulness of the results that are produced (Strega, 2003). Phillips and Jorgensen (2002) suggest that critical researchers also need to consider the ethical outcomes of their research, and the ways that results may be used as a resource in social engineering. Part of the assessment of this thesis therefore depends on whether the information "produced" is effective in supporting progressive social work practice. In this sense, findings must answer the question, "Will this research help someone make better decisions, plan programs, teach, develop policies, engage in social action, empower others?" (Merriam, 2002, pp.19-20) According to these criteria, if this research reinforces dominant and individualizing ideologies about health, in ways that marginalize equity-enhancing approaches to health, then its usefulness may be questioned.

## Chapter 5: Considering Canadian Health Care Reform Critically and Globally

There is consensus among critical health policy researchers regarding the assertion that international trends have had huge influences on publicly-funded health care systems around the world (Armstrong et al., 2001; Barlow, 2002; Coburn, 2001; Sullivan & Baraneck, 2002; Teeple, 2000). To understand Canadian health care reform, it is therefore necessary to step back and consider the situation from an international perspective.

> Health care reform has seldom been a strictly local matter... foreign influences and external pressures have seldom been absent. Health care reform, then, has to be understood within an international context. (Armstrong, 2002, p.11)

In this international context, economic globalization plays an undeniably influential role in Canadian health care reform.

> In many ways, the global economy now has a greater impact on the lives of people around the world than the actions and decisions of their own governments...To understand what is truly happening to Canada's public health care system, we must look to the global forces that are undermining universal health care everywhere. (Barlow, 2002, p.162)

By linking globalization to medicare reform, this chapter focuses on the first analytical task of the thesis in an examination of the pressures shaping domestic health care policy in Canada. In particular, this analysis draws attention to the way that medicalized and market-based approaches to health reforms reflect broader economic and ideological trends, and how these approaches undermine equity in health care. To begin, I will consider globalization, what it is, what its effects are, and the interest groups it represents.

### Shifting Economic Priorities and Globalization

The period following the Second World War was marked by relative global economic prosperity and cooperation. Aiming to rebuild war-torn economies and to restore social order, many western nations engaged in cooperative ventures. A number of international bodies,

including the Organization of Economic Cooperation and Development, the General Agreement on Tariffs and Trade, the World Bank, the International Monetary Fund, and the World Health Organization were created at this time to coordinate the emerging international financial system and to develop a range of cooperative health strategies throughout the world (Armstrong, 2002; Rice & Prince, 2000). Hoping to avoid a repeat of the dire financial straights and the worldwide depression that preceded the war, many western countries also adopted a preference for social infrastructure investments and interventionist economics, known as Keynesianism (Armstrong & Armstrong, 2003; Johnson, 2002; Prigoff, 2000).

Keynesianism, named after its founding economist, John Maynard Keynes, is demand management economic approach, which legitimizes active government intervention in economic markets, to stimulate demand (through spending) when the economy slows, and to slow demand (by accumulating surplus) when the economy booms (Johnson, 2002, p. 166). Keynesian economic policies are consistent with the implementation of welfare measures to protect wage earners and support the financial exigencies of life. Government-led interventions into the economy are intended to even out the highs and lows of the capitalist business cycle, while state-stimulated job creation helps to combat unemployment (Mulvale, 2001). This interventionist approach held sway in government bureaucracies for at least two and a half decades following the Second World War (Mulvale, 2001).

During this period the economic and social functions of the state were predominantly inwardly-focused. Most Western countries maintained strict control over capital movement across their boarders and had the ability to fix national exchange rates, as supported by the post-war Bretton Woods Agreement[13] (Mishra, 1999). Localized businesses were characterized by semi-automated modes of production and protected product markets. Workers were generally

employed from within the confines of the nation state, where they enjoyed a relatively high degree of social security and union representation. These conditions made it possible for the nation state to maintain a steady base of taxation and to effectively enforce labour and market controls (Teeple, 2000). The combination of these factors, along with post-war economic prosperity, ensured considerable economic predictability and created an environment of autonomy and control. This was the ideal environment in which to manage the large scale social and economic interventions necessary for Keynesianism. With an ideological commitment to government intervention, a range of publicly provided social welfare programs were created in advanced capitalist countries[14], within what came to be known as the Keynesian welfare state. These social programs included "contributory and universal public pensions, allowances for families with children, better access to health services and post-secondary education, child-care provisions, social housing, and improvements in financial assistance to the poor" (Mulvale, 2001, p.12). In Canada, this mix included public insurance coverage for hospital and physician services (medicare).

The two and a half decades of global economic prosperity and cooperation that followed the war were dramatically interrupted by an international oil and energy crisis. Peaking in the mid-1970s, this economic crisis was manifested in a prolonged occurrence of "stagflation", whereby both unemployment and inflation persist simultaneously. Under Keynesianism, stagflation has the effect of causing high levels of government debt and deficit accumulation (Johnson, 2002). The combination of economic hardships and high levels of government debt led critics to question earlier interventionist approaches to economic management, and "complaints arose that the economic system could no longer function with ever-increasing levels of taxation to support the welfare state apparatus" (Rice & Prince, 2000, pp.83-84). Frustrated with high

levels of government control over the economy, for-profit interest groups in society grew impatient with interventions that did not support their goals. As they applied considerable pressure for change, a shift in political interests occurred and "Conservatives [began] seeking an alternative economic policy framework" (Prigoff, 2000, p.83). In the decades following 1975, a shift in economic preferences began to erode Keynesian commitments, and many nation states moved away from the role of domestic economic management to make more space for market-based growth (McBride, 2001). Keynesian economic priorities were gradually replaced by monetarism, an economic approach where governments are expected to influence economic growth through control of the money supply and inflation rates, *not* through social spending (Johnson, 2002).

At the same time international organizations such as the World Trade Organization (originally the General Agreement on Tariffs and Trade), the World Bank and the International Monetary Fund rose to new prominence (Teeple, 2000). Initially created to enhance post-war financial reparations, these international organizations began to "play a much more proactive role in determining the basic rules for the new global economic order" (Waters, 2001, p.82). In particular, these organizations served to enhance, support and propel the global liberalization of trade. Trade opportunities became increasingly prioritized in international policy circles as a result of the advocacy and influence of these international organizations. In response to these changing economic conditions, for-profit business organizations grew in size and economic influence. Rather than remain confined to the nation state, business operations expanded exponentially, as newly-forming international corporations adopted computer-automated modes of communication and developed extensive global networks of production, management and distribution (Model, 2003). The loosening of controls over financial capital was also facilitated

by decisions to end U.S. dollar convertibility[15] in the 1970s. This decision undermined the post-war Bretton Woods Agreement, which had previously placed some control on global commerce. As the trend toward market-liberalization persisted, a new economic reality - defined by global capital markets, huge financial cash flows and international commerce – came into existence (Langmore, 2001; Robinson & Tinker, 1997). Whereas earlier periods of global exchange were characterized by nationalized economies and international trade between semi-autonomous states, the new, global capitalism – globalization for short - is marked by global capital markets, expansive international trade and international economic organizations.

**The Ideologies of Globalization**

The post-war period was one of nation-centered development. This orientation and focus was influenced by the social-democratic worldview that helped to shape the development of the social welfare state (Mulvale, 2001). Social democracy is a political ideology rooted in Marxism, which emphasizes a program of gradual legislative reform of the capitalist system in order to make it more equitable and humane. Despite its popularity in the post-war period, a "major turning point in philosophy and practices at the international and national level" (Armstrong, 2002, p.16) occurred in the 1970s. At this time an ideological shift occurred, as Keynesianism and social collectivism were overcome by the principles of economic monetarism, the legitimation of globalized trade, and the pro-market ideology of neo-liberalism (Prigoff, 2000). It is no surprise that globalization and neo-liberalism co-occurred at this turning point; in fact, neo-liberalism and globalization are so intricately intertwined that they have been described as twin elements of the same aim:

> ...economic globalization has been shaped essentially by the politics and ideology of neoliberalism, so that it could almost be characterized as neoliberalism writ large.

(Mishra, 1999, p.ix)

Neo-liberalism is the resuscitated monetarist descendent of classical liberal ideology, and is based on the ideas of economist and philosopher, Adam Smith (1723-1790)[16], who argued for the freeing of markets in early industrial England as a way of reducing the tyranny of post-mercantilist government monopolies (McBride, 2001). Smith believed that economic success required free markets (which he felt should be laissez-faire or "let alone") to allow buyers and sellers to concurrently determine the most equitable price for goods (Johnson, 2002). This "perfect market" – one of open competition, voluntary transactions and unfettered operations – was expected to bring the most benefit to the greatest number of people in society (Macarov, 2003, p.71; Prigoff, 2000). Jeremy Bentham[17], supported Smith's ideas, and argued that the market was uniquely able to provide the greatest happiness for the greatest number. Together, Smith and Bentham provided the theoretical legitimation for the acquisitive, capital-amassing society that existed during the earliest stages of capitalism in post-industrial England (Prigoff, 2000).

However, Smith's perfect markets failed to materialize as theorized. The fault lay in the assumption that markets would remain open and democratic. As national conglomerates acquired dominant market share under protection from the state, it became clear that Smith and Bentham had "failed to see that monopoly might not be solely a prerogative of the Crown but might be established by private ventures also" (Prigoff, 2000, p.35). It was a mistake to assume that free and self-determining markets would be devoid of exploitation. Despite the failures of early market theorizing, advocates of neo-liberalism have reintroduced these classical liberal ideologies to legitimize market-based economies today (Johnson, 2002).

Neoliberalism embraces the market system as the fundamental cornerstone of optimal economic and social policy (Prigoff, 2000; Robinson & Tinker, 1997; Wheelan, 2002). From a neo-liberal perspective, economic globalization is viewed as a positive force and efforts to enhance world market integration are applauded as means towards optimal economic benefits and prosperity (Friedman, 2000). Because markets are considered superior (to planned economies), any state-led interventions[18] into the workings of the market are considered barriers to efficiency and effectiveness. In fact, the only suitable roles neo-liberalism prescribes for government include, 1) the moderation of inflation (by maintaining strict control over the money supply, in other words, economic monetarism) and, 2) the facilitation and legitimization of free markets (Frankman, 1997). Neo-liberalism's devotion to the market is so sincere, that anything even resembling a "cooperative, collective, nationalized, or even governmental" initiative is viewed as subversive (Macarov, 2003, p. 75). This creates a policy environment where public programs are under attack for being inefficient and unwieldy. State governments face considerable pressure to embrace monetarist fiscal policies, to limit controls on foreign investment, to liberalize trade, and to deregulate national economies in favor of increasing privatization and international commerce (Fuller, 1998; Langmore, 2001; O'Keefe, 2000). As neoliberalism advocates the preferences and demands of internationalized capital, it is has come to convey "the now blatantly expressed ideology that the desire for self-gain by individuals, and for profit by business entities, is not only the most reliable and strongest motivation for efficient operations, but the only one" (Macarov, 2003, p.74).

**Power Play**

Neo-liberal pundits portray globalization as "a natural, external and inevitable trend to which we must adapt or risk economic decline" (Rice & Prince, 2000, p.133). However, global

economic markets do not simply create themselves: they exist as the result of economic planning and political will (Prigoff, 2000). When considered critically, it is clear that economic monetarism favors the interests of business enterprises and the economic elite. Careful control of the money supply prevents inflation, which is undesirable to business since it increases labour costs and threatens profitability. The ascendancy of economic monetarism can therefore be understood to be shaped by the "interests of business people who wanted assurances that intervention by government would be confined to activities which promoted the interests not of the unemployed or vulnerable sectors of the population, but of the entrepreneurial sector and its political allies" [19] (Prigoff, 2000, pp. 83-84). Globalization and neo-liberalization must therefore be understood as representative of the political will of certain influential groups in society.

> Globalization... includes not only market forces, but also cultural aspects as well as public and private power relationship. For globalization is also about the... imposition of certain power relationships. (Rice & Prince, 2000, p.132)

The growing liberalization of world economies and the expanded influence of trade-based international organizations have allowed corporate bodies previously limited by their national status to considerably expand their range of operation and influence. The transnational corporation has emerged as the corporate body best suited to this global economic milieu (Model, 2003; Teeple, 2000). Unlike its multinational predecessor, the transnational corporation is distinguished by its high flexibility and lack of national base. Moving freely around the globe, these organizations have found profitable footholds in an economic system that supports the pursuit of international commerce, corporate-friendly taxation, state production incentives and minimal labour costs (Waters, 2001).

These interests are supported by trade agreements which consolidate corporate power within a legal framework. Since the 1970s, there has been an increase in the number and

complexity of binding agreements between nations, including the North American Free Trade Agreement (NAFTA), the ongoing Free Trade of the Americas Agreement (FTAA), and the European Union (EU). These agreements formalize rules on global competition and support the reduction of domestic trade barriers to trade. They also sanction commercial aims, in the form of economic deregulation and the privatization of public enterprises, and do so at the expense of social and environmental concerns (Rice & Prince, 2000). The bias in favor of enterprise is hardly subtle. While transnational organizations suffer only "mild guidelines on [their] ethical conduct", the nation state is severely restricted by trade agreements to the extent that "each new agreement limits government's ability to solve social problems" (Rice & Prince, 2000, p.136). For example, the 1993 North American Free Trade Agreement grants "national treatment" status to corporations of other member countries. The enforcement of national treatment status effectively sanctifies competition so that a member one country cannot favor its domestic providers, even if this protectionism is in the interest of its citizenry (Barlow, 2002).

The prioritization of trade interests paired with the liberalization of capital endeavors a limited commitment to national policies. Transnational corporations increasingly rival the nation state in terms of their economic size and influence. As a result, they can effectively influence national policy decision by withholding financial investments until favourable (i.e. pro-business) conditions are provided (Langmore, 2001; Teeple, 2000). These maneuvers can be observed in the growing prevalence of "social dumping". Social dumping occurs when conglomerates "[move] or [threaten] to move operations to locations with lower wages and working conditions, less social protection and regulation and lower taxes" (Mishra, 1999, p.7). Pressured to accommodate these capital demands, the nation state has wavered in its commitment to the social-democratic welfare state project (Mulvale, 2001; Teeple, 2000). Governments are therefore

increasingly likely to pursue policy choices that are "not necessarily the most appropriate reflection of national economic and social priorities" (Langmore, 2001, p.15). As social policy prioritizes economic priorities, the role of social policy in and of itself is called into question.

> Boundaries between domestic and international considerations in policy making are blurring. Canada's welfare state has become a battleground for the struggle over continental and international economic development. Given the dominance of international economies, the role, value, and techniques embodied in national social programs are called into question. Even the methods and processes used within the public policy discourse are criticized. Globalization helps for the economy to take precedent over social welfare. (Rice & Prince, 2000, p.131)

This shift has been helped by forces beyond the scope of global capital itself. Various political interests within the nation state have played a principle role by actively responding to neo-liberal pressures in favor of fiscal management and social services reduction (McBride, 2001; McQuaig, 1999). Although the dismantling of the welfare state in Canada has been advocated by organizations representing the interests of large corporations, political forces on the right, including the federal Conservative party (most significantly between 1984 through 1993), have also played a significant role in its demise (McQuaig, 1993). This includes the Liberals, who despite their "promise to revitalize the social programs that had been launched by their party in the postwar era", also served to further dismantle the welfare state in Canada in the years following their majority election in 1993 (Mulvale, 2001, p.11). Agreements in favor of trade liberalization have also historically been lobbied and promoted by corporate interests in Canada who benefit economically from such agreements (Fuller, 1998).

As the economic elite benefit from the political and ideological embrace of globalization, the shift toward economic prioritization has resulted in real losses to both domestic markets and the domestic labour supply. Within a Keynesian economic state, a nation could implement social protections and enhance employment levels through spending. However, within the open

economy of globalization, the nation state's control over national economic policy is restrained, and "the Keynesian approach of reflating the economy to stimulate growth and job creation becomes untenable" (Mishra, 1999, p.20). Trade unions have also lost considerable ground in the struggle to counter-balance the demands of capital. Union strength in Canada and worldwide, has also been undermined by persistent unemployment, industrial job losses, public sector cut backs and anti-union legislation (Leys, 2001; Mishra, 1999; Teeple, 2000). The effect is a working class with depleted power and fractured interests, which can do little to counteract the interests of the international industries (McQuaig, 1992). The growth in non-unionized and part-time work has further contributed to a growing inequality between households. The global labour force tends to be distinguished by large income gaps between the top and bottom earners in society. There are many who suffer from chronic underemployment and the inability to make ends meet, while globalization's winners in managerial and professional sectors enjoy huge gains in real income and consumption-based quality of life (Armstrong, 2002; Gills, 2002; Waters 2001).

Despite arguments claiming that governments are powerless in the face of globalization, governments have played an active role in the liberalization of trade and the dismantling of the welfare state (McBride, 2001). The lament of powerlessness is more accurately a cover that legitimizes the favoring of some sectors of society at the expense of others (Frankman, 1997). Globalization has effectively stripped away many of the basic democratic and citizenship entitlements guaranteed under the Keynesian welfare state. In societies organized by the principles of markets, the freedom to participate is "really only the freedom of those who have enough money to demand what they need or want" (McMurty, 1997, p.178). The power to affect political and economic decisions has become more directly related to the amount of wealth and money people possess (Prigoff, 2000). Civil liberties, including freedom of speech, religion,

security, movement, assembly, protest, and due process of law, have also been depleted[20]. These liberties, which are "popularly understood to be God-given, inalienable or absolute", are in fact highly dependant on a working welfare state and the organized resistance of subordinate classes (Teeple, 2000, p.114). Because economic globalization favors certain segments of society at the expense of others, Frankman (1997) critiques globalization, and its realignment of political and economic priorities, as a neo-liberal "war or sorts", waged by the privileged against the powerless.

## Medicare in the Mix

Medicare is certainly not exempt from the influence of these international economic, ideological and political trends. Like other elements of the Keynesian welfare state, medicare has been confronted "by an array of political forces aimed at restructuring, reinventing, or otherwise shrinking the public sector" (Shields & Evans, 1998, p.7). This process of restructuring and reinventing has manifested in a growing focus on health care reform, and the perception that Canadian health care is in some way broken and requires "new" solutions. As the following analysis will indicate, the atmosphere and nuances of Canadian health care reform reflect the economic prioritization of neo-liberal ideologies, the growing influence of international trade agreements, and the expanding rhetoric that emphasizes markets and for-profit mechanisms as solutions in the "repairing" of health care. This occurs within a global context where the medical model has been prioritized in terms of how health is understood. The effect of these preferences can be seen in health care problems and solutions that are increasingly defined according to medical market ideals. The following sections critically outline how Canadian health care reform is shaped by globalization and explore the ways in which equity is undermined as a result.

**Government Re-Defined**

As neo-liberal ideologies took hold during the late 1980s and early 1990s worldwide, the dominant discourse that emerged "pointed to the unfettered marketplace as the mechanism best suited to generate economic growth and distribute wealth" (Mulvale, 2001, p.14). In this context, the market "increasingly [became] the standard of effectiveness and efficiency for the delivery of all services", including government administered social services (Poland et al., 1998, p.795).

The adoption of market mentalities among government services took the form of a new pro-business template for public sector management. Coined the "New Public Management", this prescription reflected neo-liberal convictions that state bureaucracies were "broken and needed fixing, and that private sector solutions were the key" (Savoie, 1995, p.112). The advocated solution lay in a new version of "entrepreneurial government", one based on competition and consumer-driven reform (Osborne & Gabler, 1993, p.xix). Strong supporters of entrepreneurial-style government, Osborne and Gaebler (1993), advocated for public sector management based on ten markedly business-like principles, suggesting that governments should: 1) steer rather than row (i.e. set policy instead of delivering services directly); 2) empower communities to solve their own problems; 3) encourage competition rather than monopolies; 4) operate by mission rather than rules; 4) fund outcomes, not inputs; 5) leverage change through the market; 6) inject competition into service delivery; 7) earn money rather than spend it; 8) meet the needs of the customer, not the bureaucracy; 9) decentralize authority; and 10) invest in preventing problems rather than curing crises. Variations on this theme were actively pursued by both traditional conservative governments and also by more liberal welfare state advocates, as seen in Britain under Margaret Thatcher and Tony Blair, and in the US under Ronald Regan and Bill Clinton. In Canada, Brian Mulroney and Jean Chrétien also embarked on public service renewal reforms

with the aim of "getting government right" (Savoie, 1995, p.112); these reforms prioritized competitiveness and business principles at the expense of redistributive concerns (Savoie, 1994; Shield & Evans, 1998).

In a public service domain increasingly shaped by the goals of neo-liberalism, part of "getting government right" included a commitment to economic monetarism, which demanded an almost-manic attention to balanced government budgets as *the* primary public service goal. As part of these austerity measures, funding cut-backs ran rampant through the Canadian public sector during the 1990s. These cut-backs were presented as a painful-but-necessary response to reassure international financial bodies and bond rating houses who were becoming uneasy about the rapid expansion of federal debt loads (Rice & Price, 2000; Sullivan & Baraneck, 2002). This argument followed business logic in its assertion that debt and deficit financing were unnecessary drains on government revenues. The World Bank (WB) and the International Monetary Fund (IMF) also blamed governments for their failure to tame large debt and deficit levels, and demanded that states withdraw from both the ownership of the infrastructure and the provision of services to citizens in order to offset this imbalance. Their recommendations stemmed from the argument that state monopolies are costly, inefficient and interfere with economic development (Armstrong & Armstrong, 2003). In particular, the WB and IMF pursued and promoted change in the form of "structural adjustment", which was a loan condition developed and imposed on cash-strapped developing countries. Structural adjustment policies recommend (and in developing countries, are based on conditional provocations) the reduction of trade barriers, the privatization of government-owned enterprises, and reductions in government spending on social services - including reductions in public health care spending (Macrov, 2003).

## Health Care Re-Defined

Social services austerity measures can be linked to shifts in the way that health care services have been defined in Canada. As neo-liberal influences spread, health care reform increasingly adopts the language of the market.

Fueled by the expressed need to tame debt and deficits, the Canadian federal government initiated a series of funding cutbacks to health care during the 1980s and 1990s (as was reviewed in Chapter Two). For example, whereas federal government transfers for health care (as a share of provincial government's expenditures on health care) represented 43.7 percent in 1980, by 1990 they had dropped to 33.9 percent, and even further to 29.3 percent by 2000 (Lazar & St-Hilaire, 2003). In response, provincial spending on health care also began a trend of steady decline during the mid 1990s. Data from the Canadian Institute for Health Information (CIHI) illustrates this trend: during the early 1990s, average provincial spending was still on the rise (5.8% increase annually between 1990 and 1992), but by 1993, spending dropped by 0.6 % from the previous year, with decreases continuing in 1995 (-0.7%) and 1996 (-0.9%) (CIHI, 2002a). Sullivan and Baraneck (2002) note that this decline in real provincial spending for health care represented the first such decline in health spending in Canadian history, following a long history of growing provincial spending since medicare's inception. As a consequence of reductions in federal transfer payments, hospital and medical services experienced considerable downward pressure, "but the squeeze was also felt across all of the publicly financed health care sector" (Sullivan & Baraneck, 2002, p.25). To manage funding cuts provinces generally moved toward greater regionalization of health services administration, hospital reductions and downsizing, and reductions in the number of health professionals employed (Shah, 2003). With the strain of service and funding cut-backs impacting the general population, complaints and concerns about

medicare's accessibility and sustainability increased, and a series of task forces were struck to propose health care system reform recommendations. Government commissions at both the federal and provincial levels issued a number of health care reform reports (see Appendix I for a complete listing), which showed a "broad consensus on the priority areas for decision making" (Fooks & Lewis, 2002). In addition to sharing a basic ideological commitment to public health care, most of these reports included recommendations to make medicare more responsive to changing health needs, to make it more accountable to the public, and to make it more efficient in operation and outcomes (Fooks & Lewis, 2002; Sullivan & Baraneck, 2002)

While espousing the concept of sustainability of a not-for-profit public health care system, many of these reform recommendations tend toward cost containment strategies, often based on market principles. Reflecting the sway of neo-liberal ideologies and official government sanctioning of the entrepreneurial principles of new managerialism, "health and health care become increasingly defined by both politicians and corporations as business enterprises, and even more frequently as profitable" (Armstrong et al., 2001, p. ix; Poland et al., 1998). For example, the Mazankowski Report, which recommends changes in Alberta's health care system, adopts a decidedly pro-business approach in its model of health care reform. The Report emphasizes that "Albertans are concerned about…Getting maximum value for every dollar spend on health care" and in response to this concern, recommends the introduction of "competition and choice" as well as "an innovative blend of public, private and not-for-profit providers" (Alberta, 2001, p.10). Although Canada has been unique among OECD nations in its resistance to formalizing market-based health care in practice, the use of market language in the arena of health care and health care reform is well established (Kenny, 2002; Tuohy, 1999). The language of illness is frequently juxtaposed by metaphors of the marketplace, including for example,

references to patients as "consumers", physicians as "providers", and health care as an "industry" (Annas, 1995; Kenny, 2002; Pellegrino, 1994). For example, the Mazankowski Report recommends a "90 day care guarantee" to ensure that health care "customers" receive reasonable access to necessary medical services (Alberta, 2001, p.42).

**Motivating Factors**

The process whereby health care services adopt the language and principles of a business is shaped by international trends. One of the ways that this point can be illustrated is by critically considering the factors and interest groups which have contributed to the previously noted climate of public sector cutbacks and subsequent reform initiatives. In particular, it is important to recognize that high government debt and deficit levels in Canada have *not* been caused by social spending. Rather, what was called the "debt crisis" and blamed on public service inefficiencies and lack of adherence to business principles was more accurately the result of "the way debt is financed and the way taxes have been reduced for some corporations and individuals" (Armstrong & Armstrong, 2003, p.7). As Mulvale (2001) explains:

> [t]he government's so-called fiscal crisis of the later 1980s and early 1990s was largely the result of the increase in service charges on the public debt due to high interest rates (which benefits creditors such as banks), and the decrease in government revenue from corporate taxes (which benefits large companies). (p.226)

As economic growth slowed in the early 1980s, the "bust was blamed on social spending and used as a justification for cuts in spending as well as for a move towards a 'free market' system" (Armstrong & Armstrong, 2003, p.7). Rather than an exercise in accuracy, the "increasingly powerful mythology of social spending as the root cause of growing government deficits and debt" emerged and was propagated because it *served the interests* of particular powerful groups in society (Mulvale, 2001, p.226). In particular, this misconception supported the move toward

for-profit and market-based incursions into many public arenas, including health care. In Manitoba during the 1990s, for example, the Conservative government, under Premier Gary Filmon, launched a series of ineffective projects[21] that turned control of portions of the province's health care system over to private/for profit corporations. One such experiment involved contracting out a portion of Manitoba's home care services to an American-based multinational, Olsten Health Services, on the assertion that privatization could save the province as much as $10 million in costs (CCPA, 2000a). However, it turned out that this move was rooted primarily in the Filmon government's ideological commitment to privatization, because Olsten proved to be untrustworthy (it was revealed that Olsten was under investigation in the United States for improper Medicare billing), and ineffective (contracting out to Olsten saved the province no money) (CCPA, 2000a; Scarth, 2000).

Deliberate funding reductions have also created a climate of crisis and incompetence in the public sector and opened the door to private solutions. For example, funding cut-backs to the federal Health Protection Branch[22] have left Canada's public drug monitoring agency increasingly dependent on a "rescue" in the form of financial support from the pharmaceutical industry (Lexchin, 2001). To satisfy its new funders, the Health Protection Branch has become increasingly concerned with "keeping the industry satisfied", often at the expense of its own mandate to protect the health of Canadians (Lexchin, 2001, p.41).

Understanding the link between health services reductions and international corporate preferences is not difficult to do when medicare's profitability potentials and the relative size and influence of corporate interests are considered. Global expenditures on health are approximated at more than $3 trillion (US) annually, which represents a market significantly large enough to warrant the attention of for-profit interests representing the health services, pharmaceutical and

private health insurance corporations (Fuller, 1998). Whereas more than half of this amount is spent annually by governments to provide public services, the remainder is spent by individuals and employers to purchase services privately (Fuller, 1998). In other words, $1.5 trillion of the world's health care spending it currently *outside* the realm of the for-profit marketplace, and basic business sense dictates an interest in this as yet, untapped market share. In 2004 in Canada, public expenditures on health care represented 70% of total expenditures on health (a proportion that translates into approximately $98.8 billion) (Canadian Institute for Health Information, 2006a). Canada's 70% of public expenditures on health lies slightly below the 73% average of thirty countries reviewed by the Organization for Economic Co-operation and Development (OECD) (OECD, 2006). Although Canada's 2004 percentage of public expenditures has dropped from 74.5% in 1990, it still ranks considerably higher than in the rest of North America: United States (45% in 2004) and Mexico (46%) (OECD, 2006). And for-profit companies operating to the south of our boarder are particularly interested in this untapped market. From a for-profit perspective, Canada's public spending on health care represents "a potential market to be opened by a variety of means – lobbying, competition, technological penetration (e.g. 'gifts' of equipment with major current spending implications), and advertising" (Leys, 2001, p.84). Nelson (1999) notes that American for-profit interests have described Canadian medicare as "one of the largest unopened oysters in the Canadian economy" (p.7).

Although there has been considerable public resistance to for-profit business practices in health care, private spending in Canada has been on the rise. While inflation-adjusted public spending per person on health declined by 2% between 1992 and 1996, private sector health spending (includes out-of-pocket spending by individuals, spending by commercial and not-for-profit health insurance plans) grew by almost 14% over this period (CIHI, 2006b). In the years

following, from 1997 to 2004, although public spending increased (at an average rate of 4.9% annually), private sector spending grew at a faster rate (at an average of 5.4% per year) (CIHI, 2006b). It can be noted that these increases in private sector spending represents a step away from notions of solidarity and risk pooling, as a growing number of health care needs are individualized, commercialized, and privatized.

It must also be noted that the multinational corporations and the for-profit health services that would prefer that a greater proportion of Canadian spending occurs in the private sphere, are also large enough to influence the nation state. Although the majority of hospitals in the United States are private non-profit, huge for-profit insurance companies dominate the market in paying for care, and their emphasis on competition, business practices and "consumer choice" invariably play a role in shaping health care reform trends in Canada (Armstrong et al., 2003). Multinational health maintenance organizations (HMOs) in the United States, which are predominantly owned by commercial insurers with a primary interest in profitability, have long sought to expand their influence into Canadian markets, in the interests of expanding their profits by taking advantage of the lucrative potential for private insurance coverage in Canada. The influence of these HMOs is not slight, considering that in 1994 the ten largest HMOs reported a combined $10.5 billion in liquid assets (Fuller, 1998). In addition to private insurers, other health industry players, including drug companies, are significantly large enough to influence the direction of health care reform. In 2002, for example, the world's top ten[23] pharmaceutical companies had total drug sales that reached over $600 billion (CAN); the top five had a combined net worth of twice the total GNP of all the countries of sub-Saharan Africa (CCPA, 2004). Up against the interests of health transnationals of this magnitude, public health care programs face considerable pressure as well as critique (Fuller, 1998).

The influence of multinational health services organizations are is reinforced through the authority of international trade treaties that favor corporate interests above and beyond social, environmental and cultural concerns (Shrybman, 2002). International trade treaties negotiated by the World Trade Organization (WTO) contain the potential to override the ability of national government's to safeguard health care as a public service. For example, the WTO's General Agreement on Trade in Services (GATS) is an internationally-binding agreement geared toward the prioritization of private interests in the services trade. GATS contains the ability to limit government monopolies that enable the delivery of public services such as education, welfare and health care (Sanger, 2001). Technically, public services provided by government are eligible for exemption; however Canada has listed health care for *inclusion* in the GATS (Barlow, 2002).

These agreements are most concerning from a Canadian health care perspective because they contain the potential to force open public health care services to allow entry by foreign private, for-profit health care corporations (CCPS, 2002a). In North America, these influences are most keenly felt under the North American Free Trade Agreement (NAFTA), which Shrybman (2001) notes "should be seen as an integral element of a larger trade agenda that is intended ultimately to be incorporated within the WTO" (p.1). For example, under NAFTA, currently exempt monopoly services, once privatized, would no longer qualify for trade exemption status (Barlow, 2002)[24]. These shifts have important implications for health care reform, since it is now the case that international trade decisions (a matter of exclusive federal jurisdiction) can potentially override the jurisdictional responsibility that provinces have for health.

> The effect of these international developments [World Trade Organization and NAFTA] has been to bring about a fundamental transformation of Canada's constitutional landscape. Thus, matters of provincial competence, such as the delivery of health care services, must now be consistent with Canada's international trade obligations, unless the province is willing to brave the consequences of retaliatory trade sanctions, and foreign investor claims. While the latter may be brought only against the federal government, it is

> unrealistic to imagine that a provincial government would emerge unscathed should a tribunal award substantial damages against Canada because of actions taken by a province. (Shrybman, 2002, pp.13-14)

In this regard, trade treaties have the ability to limit the policy choices federal, provincial and territorial governments can make in relation to the health care system, and provide the critical elements corporate interests need to expand private service delivery in health care on a global scale (Barlow, 2002; CCPA, 2002). Unfortunately, there are minimal protections for health care implicit in NAFTA as it currently stands. International trade and public interest lawyer Steven Shrybman (2001) emphasizes that Canada is relying on "qualified and ambiguous reservations... to shield its health care policies from the full brunt of NAFTA investment and services disciplines" (p.15). These minimal protections mean that Canadian health care reform must not only be considered nationally, but internationally as well.

> [W]e must proceed very cautiously with domestic reform, lest we lose the protection of trade safeguards that apply to non-conforming measures that were in place when these trade agreements were established. Under NAFTA, reform is a one-way street in favor of liberalization. (Shrybman, 2002, p.15)

Put simply, health care services are susceptible to market and international trade influences because "medical services are expensive, which means there is money to be made" (Macarov, 2003, p.79). As Evans (1997) emphasizes:

> ...there is, and always has been, a natural alliance of economic interest between service providers and upper-income citizens to support shifting health financing from public to private sources. (p.427)

Within Canada, these pro-market voices have been expressed most directly by Canadian businesses and well-funded neo-liberal coalitions - including the National Citizens' Coalition, the Fraser Institute, and the Canadian Council of Chief Executives (Barlow, 2002). The Fraser Institute, for example, advocates for competitive markets in health care (including user fees, private insurance, and private hospitals that compete for patient demand), while discouraging

continued reliance on monopoly-insurer, monopoly-provider health systems (Fraser Institute, 2002). As a result of the growing influence of these pro-market interest groups within Canada and on an international scale, since the early 1980s, state-provided health care systems have been under growing pressure to reduce the role of state provision and to make more room for private capital (Donelan et al, 1999; Leys, 2001, p.66; Powell & Wessen, 1999). While these activities may not necessarily reflect a "conspiracy", they certainly *do* reflect "a goal with a plan" (Fuller, 1998, p.7). And that plan invariably includes access to Canada's piece of the global health care market.

**Indirect Influence**

Medicare enjoys strong political support in Canada on a number of fronts[25] and has been described as "the best protected social program in Canada", despite global pressures toward government services retraction (Williams et al., 2001, p.8). As a result, it has been suggested that market-based interests are shaping public health care reform *indirectly*:

> [r]ecognizing this [high degree of public support for medicare], politicians of all parties have declared medicare a sacred trust and have avoided frontal attacks on Canada's best-loved social program...Instead, they have initiated a process that is transforming and undermining the system in ways that are frequently difficult for Canadians to see or oppose. (Armstrong & Armstrong, 2003, pp.1-2)

One of the ways in which this has occurred is through health care reform efforts that fail to uphold the viability of the public health care system – through a lack of implementation, a lack of inclusiveness, or gaps in services provision. Reductions in federal funding during the late 1980s and early 1990s led provinces to become more creative with their health care dollars, and in many cases, to limit services in order to curb health care spending. In some cases, spending was reduced by discontinuing certain services under medicare, as when Manitoba de-listed regular eye examinations (with the exclusion of children). This move excluded eye exams from the

definition of medically necessary[26] services under medicare. Effectively what this meant was that eye exams were no longer covered by provincial funding and this service would have to be purchase privately by individuals, or by private insurance coverage, if at all. Whereas provincial spending on health care dropped during the early 1990s (-0.6 % in 1993, -0.7% in 1995 and -0.9% in 1996), the growth of privately financed services experienced a continuous upswing (CIHI, 2005a). From 1990 to 1999, for example, private sector health expenditures increased at an average rate of 5.48% (CIHI, 2005b).

In some case, these health reforms were indirect, as in Manitoba and Saskatchewan where reforms during the 1980s and 1990s tended to move the delivery of medical services outside the traditional hospital realm and into the community. Although this shift did not always involve the exclusion of coverage under medicare, it did certainly have the effect of shifting the costs of care in many cases:

> Take physiotherapy and occupational therapy, for example. As is the case in all provinces, in Manitoba they are considered insured services when provided on a physician's referral in a hospital. However, these services are not insured when provided in private clinics, although many clients have their fees covered by private insurance or by the Manitoba Workers' Compensation Board. Many people patronize these private clinics rather than wait months for treatment in a hospital, even if they have to pay the $35-to-$40-per-visit fees out of their own pocket. (CCPA, 2000a, p.14).

The concurrent trend in private spending can be noted, as in Manitoba during the 1990s, private health care expenditures increased at an average annual rate of 6.9% (CIHI, 2005b). These shifts represent the creeping and indirect privatization of health care costs and in many cases, the privatization of health care work as well. Health care reforms that shift care to the household and volunteer community require family members and women in particular, to take on extra care work without pay or training (CCPA, 2000a). In this manner, privatization aims can be attained indirectly. Macarov (2003) elaborates:

> ...it should be noted that privatization is sometimes attained not by outright sales or transfer, but by deliberately allowing services to run down, by erecting barriers to access, by withholding information, and by making the receipt of benefits so difficult and demeaning that the public has little alternative but to turn to the private sector. (p.71)

As the site of public services have been modified and as the scope of services have been scaled back, gaps have been filled by a growth in private services (Fooks & Lewis, 2002). For example, in Canada between 1992 and 1996, private sector spending on health care increased at a rate of 14% (as compared to public spending which declined by 2%); although public spending increased from 1997 to 2004 (at a rate of 4.9% annually), private sector spending grew at a faster rate (averaging 5.4% per year) (CIHI, 2006b). It should be noted that the private delivery of health services is not new in Canada. Medicare is a health insurance scheme that is publicly financed through tax dollars. A significant portion of its services have been historically delivered and administered by the private, not-for-profit sector (Library of Parliament, 2001). This includes private delivery of health care services by independent doctors and other professionals, and the operation of not-for-profit hospitals and other facilities[27]. And although some government money has gone to for-profit institutions, most of it – up until recently, has gone to not-for-profit providers. However, there is growing concern regarding the for-profit privatization of delivery and the adoption of for-profit practices in health care.

> The big difference now, however, is that for-profit firms are being allowed or invited to deliver these publicly-funded services and the not-for-profit ones are adopting management strategies taken from these corporations (CCPA, 2000a, p.5).

In Alberta and Ontario, for example, the direct inclusion of for-profit delivery of health care has been most actively pursued. Ontario's Harris government embarked on a province-wide restructuring, under the guidance of Finance Minster Ernie Eves, through which it actively invited proposals from for-profit firms interested in providing government services. Following on the heels of a $800 million cut to hospital budgets in the late 1990s, it has been suggested that the

Harris government intended to create a “crisis” in health care, in order to justify the introduction of a “privatized” solution (CCPA, 2000a). Indeed, this technique has been noted elsewhere as a mechanism of pro-market governments looking to welcome the for-profit sector to health care:

> The primary objective of neo-liberal policy is to reduce the role of government. The cutting of social programs has a two-fold effect. First, it opens the door to the private sector in areas formerly the sole preserve of government. The second effect is that the cuts will create a crisis in these areas the solution to which, it will be argued, is privatization. (McQuaig, 1995, p.42)

In Alberta, the introduction of legislation to allow the conversion of two hospitals from non-profit to for-profit status took these aims even further. Argued as a response to varied health care ills of hospital bed and physician shortages, waiting lists, and crowded emergency rooms, the Klein Conservative government made explicit two-tier headway with its controversial Bill 11. Not only did Bill 11 allow the public financing of insured services to be provided by for-profit hospitals, it also allowed for quicker access to insured services in exchange for an additional private fee. Given that not everyone can afford to pay such a premium for medically necessary services, these moves violate both the universality and accessibility requirements of medicare (CCPA, 2000a).

The lack of federal intervention into Alberta’s violations of the Canada Health Act illustrates the pro-privatization agenda that resides in Ottawa. As such, health care privatization can be understood as linked to the federal and many provincial governments’ preferences for an export-oriented economy (Fuller 1998). A 2000 Canadian Centre for Policy Alternatives (CCPA) (2000a) report notes that the role of Health Canada, which took a lead role in enforcing the national standards of the Canada Health Act up until the early 1990s, subsequently had been relegated to a narrow range of responsibilities. The diminishment of Health Canada’s role as a watchdog for medicare coincided with the expansion of the health sector responsibilities of

Industry Canada, which includes the role of promoting growth and expansion of the private health industry (CCPA, 2000a). In light of these act which prioritize trade and market preferences, many of the decisions to pursue funding cuts, service reductions and changing sites of care (especially in pro-liberalization provinces) can be interpreted as *deliberate acts*, intended to create a vacuum of services, a problem which can then be "solved" by subsidiaries of global, U.S.-based multinational corporations (McQuaig, 1999). Williams et al. (2001) suggest that by making changes in the "less visible, less politically motivated, and highly fractioned terrain of the society as a whole", it is possible for governments to more easily "avoid their fiscal and moral obligations to universal access without the intense political confrontation that any forthright assault on medicare would inevitably provoke" (p.10). Mishra (1999) calls this "social policy by stealth", where the *principle* of universality is rhetorically endorsed, but deficit constraints and funding cutbacks erode the possibility of such an approach in actuality (p.47).

**Medical Focus**

In addition to being shaped by the values, preferences and ambitions of the marketplace, health care in Canada reflects and reinforces the dominant medical model (Armstrong & Armstrong, 2003). This focus is not unique to Canada. Throughout much of the world the medical view of health and disease predominates, along with medical authority over the content of medical care, patients, other health care occupations, and health care policy generally (Clarke, 2000; Friedson, 1970; Poland et al., 1998).

Canadian health care is therefore predominantly focused on a medicalized service-delivery approach. The medical model describes illness as a technical defect within the human body-machine, and as such, medical treatment predominantly attends to individual patients and

their bodily functions[28] (Bolaria, 2002). A "cure" is provided when the bodily break-down is restored to normal or near-normal functioning.

This medicalized focus is reflected in medicare's overriding prioritization of hospital and physician services, and its conception of health as supported by technological advances and specialty medical practice (Shah, 2003). Critics point out that this approach entrenches, "as central to the system, the very aspects of health care that are the most expensive, most intrusive and most technologically driven" (Kenny, 2002, p.60). Critics also point out that medicalized models of health care give minimal attention to health-generating preventative measures or to the economic, political and environmental context of disease causation (Clarke, 2000; Bolaria, 2002; Waitzkin, 1979; Williams et al., 2001).

It should also be noted that this medicalized focus of medicare excludes prescription drugs which are not considered part of the Canada Health Act's definition of medically necessary. The result is a patchwork of provincial and private insurance plans that take the place of any comprehensive national pharmacare plan, which essentially means that Canadians achieve coverage in a manner entirely dependent on where they live and work. Still, this lack of consistent attention to pharmaceuticals under medicare does little to quell the need for drug-based cures: in 2005, Canadian retail sales of prescribed and non-prescribed drugs totaled $24.8 billion (CIHI, 2006a). When considered in terms of total health spending in Canada, these sales represent the second largest category of spending at 17.4% (CIHI, 2006a).

The long-standing authority of the medicalized approach - along with the growing pace and intensity of medical interventions, heavily-marketed drug therapies and emerging technological discoveries - has contributed to a sociological context of high public expectations. Despite the fact that 88% of Canadians and 85% of Americans reported that they were in good,

very good, or excellent health in 2003 (Statistics Canada, 2004), they still live in a sociological context that pathologizes discomfort while prioritizing medicalized solutions. As such, North Americans are characterized by a "progressive decline in [their] threshold for tolerance for mild disorders and isolated symptoms, along with a greater inclination to view uncomfortable symptoms as pathologic – as signs of disease" (Barsky, 1998, p.187). The tendency towards the "medicalization" of everyday life can also be noted where medical science and technology have developed more power to intervene in human life (consider surgery on fetuses, for example) and have also re-defined the scope of what we consider to be "medical". As medicine expands its range of influence, beyond broken limbs and open-heart surgery, into the domain of personality and physical-enhancement treatments (including drug therapies for shyness, pattern baldness, and arousal dysfunctions), there is a growing expectation that medical science can provide cures for an expanding set of human ailments. Kenny (2002) notes that these trends have been facilitated by neo-liberalism, individualism and the secularization of modern society, such that "medical science and technology have become something to *believe in* for fundamental answers to life's really tough questions" (p.89).

Because there are considerable profits to be made in medicalized cures, especially marketable ones, health care multinationals also encourage this trend. This encouragement takes the form of lavish advertising, professional perks, direct-to-consumer advertising, and face-to-face sales representatives (CCPA, 2004). Direct-to-consumer advertising (DTCA) has been noted as particularly influential in the medicalization of human experience, as non-medical problems become defined and treated as medical illnesses (Mintzes, 2002). Their effectiveness is evident when patients specifically request advertised, brand-name drugs and when physicians prescribe medications in tandem with drug company product promotions (Kenny, 2002). Although direct-

to-consumer advertising is still prohibited in Canada (as it is in most industrialized countries, with the exception of United States and New Zealand), Canadian exposure to American television and print media is significant enough to warrant critical attention to the potential effects of the profit-based promotion of prescription drugs (Mintzes, 2006). Mintzes et al. (2003) found that DTCA does influence Canadians and American physicians similarly. Although an American sample reported more exposure to advertising and more requests of advertised drugs when compared to a Canadian sample, the prescribing rate was equally high for the two countries. Two-thirds of patients received DTCA drugs from their primary care physicians when they asked specifically, regardless of whether those patients were Canadian (72% of patients in Vancouver sample) or American (78% of patients in Sacramento sample).

Medicalized conceptions of health also help to shape the way that public policy solutions are formed. High-speed and technologically advanced notions regarding health influence our interpretations of what the Canada Health Act means by "reasonable access" to care, while also skewing the definition of what services are considered "medically necessary". A survey completed in 1995 found that approximately one third of Americans (33%) and Canadians (27%) agreed that "modern medicine can cure any illness with access to advanced technology"; although the majority of survey respondents (64% of Americans and 71% of Canadians) alternatively agreed that "many illnesses cannot be cured by any treatment", a majority (62% of Americans and 66% of Canadians) also agreed that "health plans should pay for treatment even if it costs a million dollars per life" (Blendon & Benson, 1995, p.226). These minority beliefs in the infallibility of modern medicine, paired with the majority belief that expensive care is necessarily worthwhile care, shape an approach to health care reform which prioritizes care dominated by physicians, hospitals, technology and specialty medical practice. The predominance of

medicalized conceptions of health is reflected in a tendency to focus primarily on medically-based health solutions (Armstrong & Armstrong, 2003; Fooks & Lewis, 2002).

## Considering Equity

From a market perspective, health is a commodity negotiated through the exchange of buyers and sellers so that its cost, price, availability and distribution can be determined competitively (Hertzlinger, 1997). In a health care market, consumers shop around for the best medical services, and purchase these services as needed and as afforded (Williams et al., 2001).

However, health markets fail to distribute health care resources fairly and equitably. These inequities occur because health care does not respond to market incentives in the same ways as other goods and services. In fact, the market metaphor "conceals the inherent imperfections of the market and ignores the public nature of many aspects of medicine" (Annas, 1995, p.745; Canada, 2002b). This is because free markets are predicated on the condition that buyers and sellers enter into transactions freely, with complete information and autonomy, an assumption that does not hold when it comes to health services. The need for health services is rarely voluntary or chosen, since few people plan to have a major life illness. Health markets also fail because physicians and patients are not equally informed when it comes to the exchange of health services. Physicians possess highly specialized medical information and determine the course (and cost) of treatment; in turn, patients are relatively "unable to determine for themselves the type of health service that they need" and must rely on professional expertise and referrals (Canada, 2001, p.30). Similarly, health markets are not suited to distributing services with demand unrelated to price (Annas, 1995, p.745). For example, health services are not selectively chosen according to price as a new car may be; emergency surgery is in demand because there has been an emergency, not because emergency surgery is "on sale". Illness is also uncertain in

its timing and impact, and the need for health care cannot be planned for. Finally, market-based models of health care institutionalize value assumptions that are inconsistent with fairness. Market models legitimate self-interest and competition, and normalize "unequal treatment based on unequal ability to pay" (Pellegrino, 1999, p.254). As such, markets inevitably distribute health resources unevenly, so that the poor and sick, who can't afford to purchase top-quality health care services, are relegated to second status levels of care.

The inequities inherent in market-based health services are compounded by the fact that the people *most likely* to need services are also those who are *least likely* to be able to access them. Health and income are inversely and intrinsically linked. In Canada for example, individuals living in the poorest 20 percent of communities are more likely than the well-off to die from just about every disease (Coburn, 2001; Wilkins et al., 1989). A 1995 study in Manitoba found that the ratio of the death rates of the poorest Manitobans (in the lowest quintile) to the death rates of the wealthiest Manitobans (in the highest quintile) was 160 to 100 (Mustard et al., 1995). Based on their greater health needs, members of the poorest group of Manitobans were also found to be the highest users of health care services. When compared to the wealthiest Manitobans, this group disproportionately needed hospitalization for pregnancy complications (26 hospital days per 1000 pregnant women as compared to 7), and for injury-related medical services (85 hospital days per 1000 people as compared to 50) (Mustard et al., 1995). In other words, health is "not a level playing field", it varies widely and inversely with socioeconomic status (Evans et al., 1994).

> We know that the rich are healthier than the middle class, who are in turn healthier than the poor. We have seen that higher incomes are related to better health, not only because of the ability to purchase adequate housing, food, and other basic necessities, but also because a higher income means more choices and a feeling that people have more control over their lives and that a feeling of being in control is basic to good health. (Townson,

1999, p.50)

As Townson (1999) indicates, the ill-effects of socio-economic status can also be compounded by other factors. These other factors, known as the determinants of health, include income and social status, social support networks, education, employment and working conditions, social environments, physical environments, personal health practices, healthy child development, biology and genetic endowment, health services, gender and culture (Marmot & Wilkinson, 1999). Health determinants interact to create additional health disparities for those poor who are also socially disadvantaged by gender, age, disability, or membership in a disenfranchised racial, ethnic or religious group. For example, in a Manitoba report on women, income and health, Donner (2000) notes the ways in which the links between income and health take on further significance when women's health is considered. In particular, women are more likely than men to experience poverty (29,000 more poor women than poor men in Manitoba in 1999) and experience more ill-health as a result of this socioeconomic disadvantage; whereas further health-related problems are experienced by women who are also Aboriginal and poor, for example (Donner, 2000; Statistics Canada, 1999).

Because health care markets are dependent on the ability to pay for health care services, the poor face a double challenge in a private health care system: 1) they suffer poorer health due to their low socio-economic status, and 2) they are often unable to pay for the care they do need. The "cushion" of private health care is also often unavailable to the poor. In the United States, for example, the majority of citizens require private insurance to cover the cost of physician and hospital services. Although public insurance is provided for the poor (Medicaid) and for those 65 and older (Medicare), data collected for the survey estimated that about 11% of Americans did not have any form of health insurance. A 2002-3 Canadian/American population health survey

noted that 13% of Americans reported an unmet health need (during the year prior), and that cost was the most commonly cited reason for that unmet need (Statistics Canada, 2004).

As a result, Canadians have historically worked to provide an alternative to market-based medicine. These alternatives stem from the recognition that "when humans are at their most vulnerable and exploitable, they need much more secure protection than a business ethic can afford" (Pellegrino, 1999, p.254). Such aversion to market-based health care motivated the initial emergence of medicare:

> The corporate imperative to return high profits to investors was identified by an overwhelming majority of the nation's people as a moral question during the long years leading up to the introduction of medicare. Simply put, Canadians viewed the idea of making money from the misfortunes of the sick or the needs of the disabled – whether themselves of their neighbours – with repugnance. Thus the struggle that led to the establishment of medicare was fought on the grounds of compassion, equity, access, and fairness, where it remains to this day. (Fuller, 1998, pp.10-11)

The fact is that Canadian medicare provides more equitable care than its private insurance, for-profit counterparts (CCPA, 2000b; Olsen, 2002). Noted health economists emphasize that single-payer, publicly administered health-care systems are optimal on equity grounds given that public health care plans provide universal coverage and benefits to all members of society, regardless of where they live, where they work, or what they earn (Evans, 1984; National Forum on Health, 1997).. This equality of access as provided by a public health care plan is quite different from the type of "equality" offered within a for-profit health care system. As one California nurse quoted in Armstrong et al., (2003) explains:

> Every patient is neglected. That's the irony. And that's what most of our legislators don't understand – most of the people in general – is that when it gets to the level of nursing in the hospital the person who is taking care of the patient 24 hours a day – our neglect is not selective – everybody gets neglected. (p.30)

A systemic review of for-profit health care delivery in both in-patient and out-patient facilities confirms these comments, finding that the risk of death is 2% higher for such patients,

as compared to non-profit facilities (Devereaux et al., 2002). Despite assumptions by neo-liberals that competition will force health care organizations to develop more efficient work organizations and practices, research suggests that faster throughput and denial of care take precedence over efficiency in care (Armstrong et al., 2003). Investor-owned nursing homes are more frequently cited for quality deficiencies and lower standards of nursing care, and investor-owned hospice-care homes provide less care to the dying as compared to non-profit alternatives (Carlson et al., 2004; Harrington et al., 2001). As such, for-profit health care is more likely to lead to inequitable service modifications including skimming (only accepting healthy patients) and under-servicing (delaying services to cut costs) (Williams et al., 1999).

Canada's single public-payer mechanism also keeps health-care related administrative and transaction costs to a surprising minimum, while doing a good job of controlling overall health care costs, especially in comparison to its private insurance counterparts (CCPA, 2000b; McGilly, 1998; Olsen, 2002; Sullivan & Baraneck, 2002). For example, in 2004 Canada spent $3,165 USD per capita on its total health spending, much less than the United States, which spent $6,100 USD per capita (OECD, 2006). Public health care systems control costs by sheltering "hospitals from the need to compete with other providers and from the need for costly management and accounting infrastructures" (Fuller, 1998; Williams et al., 2001, p.9). HMOs, the dominant private insurers in the United States, consume 19% of their budgets for overhead as compared to 13% in non-profit American plans, 3% for the US Medicaid program, and 1% in Canadian medicare (Woolhandler, Campbell & Himmelstein, 2003). Profits are also significant cost contributors in competitive health care systems. Profits are essentially surplus health care dollars that end up in individual investor or management pockets, rather than being spent on health care. Armstrong et al. (2003) note that it is not unusual for the CEOs if American for-

profit HMOs and hospital chains to receive seven-digit salaries topped up with "stock options worth in excess of $100 million" (p.21). Remuneration of this sort inevitably cuts into the monies available for care and reduces the efficiencies of the health care system. The active pursuit of profit also tends to have diminishing returns on the quality of health services, as evidenced in lower expenditures on health care personnel, shorter periods of hospitalization, less charitable work performed, and increased fraudulency in reporting procedures among private insurance counterparts (Olsen, 2002).

Although medicare, within the context of a working welfare state, has historically served as a redistributive equalizer in Canadian society, the recent prioritization of market-based reforms increasingly threaten its equitability. This is because a market-based systems are predominantly concerned with opportunities for profit-making, with little room or reason to consider the equitable redistribution of economic resources (Johnson, 2002). In fact, capitalistic systems *depend* on inequality to create affordable labour pools and to support the concentration of wealth in the hands of a few elites.

> If it could be said that capitalism, as an economic system, is second to none in its capacity to create great wealth, it must also be said that capitalism both needs poverty in order to do so, and paradoxically, creates new poverty and further deepens existing poverty as a result. (Macrov, 2003, p.65)

The expansion of globalization and the retraction of the welfare state in the last three decades have exacerbated levels of inequality worldwide (Coburn, 2001; Mishra, 1999). As corporate interests prevail and scour the globe in search of the lowest possible material and labour costs, "globalization enriches the haves and exploits that have-nots, leading to greater and greater economic disparities in society" (Macrov, 2003, p.115). Wermuth (2003) notes this trend:

> Societies are becoming less equal: Inequality within countries is increasing sharply, and inequality among countries is increasing as well. According to the United Nations, in 1960 the 20 percent of people living in the richest countries had thirty times the income of

the poorest 20 percent. By 1997 that figure had risen to seventy-four times. (Wermuth, 2003)

Despite expanding economic opportunities for capital between 1980 and 2000, Weisbrot et al. (2001) found economic growth per capita declined in all countries, and declined most rapidly in the poorest 20% of nations. Essentially, what has failed is the neo-liberal rhetoric that promises that economic growth will bring prosperity to all. Glowing promises of globalization and trade liberalization have been translated into a "globalized" labour force distinguished by large income gaps between the top and bottom earners in society, an increasing concentration of women in the low-skilled/low-paid work force, and job creation increasingly limited to temporary employment opportunities (Gills, 2002; Waters 2001). In the United States, these income gaps can be clearly noted. For example, despite a period of economic expansion in the U.S. between 1977 and 1999, the lowest 60 per cent of households experienced an actual *decrease* in after-tax income during this period, whereas earners in the top 5 per cent of households saw their incomes rise by 56 percent and the top 1 percent grew exponentially by 93 percent (Bernstein, Mishel & Brocht, 2001). As such, there clearly is a gap between globalization's "winners" and "losers".

In Canada, these trends are also well-documented. Although the 1990s was a decade that heralded new economic growth in Canada, these gains were not translated into real benefits for most Canadians. Comparing incomes of Canadians over a thirty year span, Yalnizyan (1998) points out that between 1970 and 1996 the pre-tax income ratio between the richest 10% and poorest 10% of Canadian families had increased from 21:1 to 314:1. Two years later, Yalnizyan (2000) noted that "Canada's growing gap has become a slippery slope" (p. ii) with middle class families losing further ground, and the number of poor families growing and becoming poorer over time. Comparing these trends over a 9 year period, Yalnizyan (2000) notes:

> Between 1989 and 1997, the proportion of families raising children who earn less than $35, 388 grew from 30 to 35 per cent. The very bottom of the income scale grew the fastest; the poorest 10 per cent of families earned less than $11,567 in 1989. By 1997, that number swelled to 14 per cent. (p. ii)

It seems that income inequality is also linked to the degree to which a nation embraces the practices and principles of globalization. A 1999 study of forty developing and least developed nations found that trade openness (liberalization) actually increased poverty, with those countries that liberalized the most rapidly faring the worst (Rao, 1999). In 1991, the United States – despite its comparative international wealth - had one of the highest rates of absolute (as well as relative) poverty among the developed nations; in comparing 15 countries, Kenworthy (1999) found that only Italy, Ireland, Australia and the United Kingdom had higher rates. It seems that neo-liberalism and inequality are therefore closely linked, and they are also *proportionately* related, as Coburn (2006) notes:

> Increases in inequality have been particularly pronounced in those nations adopting more stringent neo-liberal or market-oriented politics and policies. In the early 1990s the United States, Australia, Canada and the United Kingdom stood at the top of the income inequality ladder, while Norway, Sweden and the Netherlands were at the lowest. (pp.69-70)

Given how income and health are related, it is not difficult to understand how globalization can be linked to growing health disparities on an international level. A globalization "scorecard", measuring health, income and development indicators during the globalizing period (1980-2000), noted that life expectancies declined (for all but the wealthiest 20% of nations) during this period, while infant and child mortality rates increased, especially in the poorest 40% of nations (Weisbrot et al., 2001). Globalization is also linked to changing disease patterns. Traditionally, diseases such as malaria and tuberculosis tended to decline and/or disappear as countries become more developed; however, with globalization, these patterns have shifted, and there has been a recurrence of these diseases among the poorer members of some of the richest

countries in the world (Waters, 2001). Despite neo-liberal proselytizing that health will improve with globalization and the liberalization of trade, underdeveloped countries are not showing overall increases in levels of health. Rather modern diseases have increased dramatically (including cardiovascular disease, diabetes, and illnesses related to aging and obesity) in the past two centuries, while the levels of traditional diseases have remained high (Waters, 2001).

The extent to which a country adopts neo-liberal policies and practices also has characteristic impacts on health, similar to those noted for income above. For example, Canada, with its lower rate of income inequality than the United States, also has lower infant mortality rates, and lower income-related health differences than the U.S. (Coburn, 2006; Ross et al., 2000). In terms of infant mortality, 5.4 children died (per 1000 live births) in Canada in 2002, while in the United States, seven children died (OECD, 2006). In fact, infant mortality rates in the United States are so high when compared internationally, that in 1996, the infant mortality rates in the poorest neighbourhoods in Canada were better than the national rate of infant mortality in the U.S. (Coburn, 2006; Statistics Canada, 2000). Still, Canada's health status does not fare so well when compared to European countries with an even more equitable distribution of wealth: in 1996, infant mortality rates in the richest Canadian neighbourhoods were not much better than the national average rates in Sweden (Coburn, 2006).

As globalization encourages and exacerbates income inequalities, disparities in health are also growing. A large-scale British study found that not only were disparities in health closely linked to disparities in wealth and income, but that government policies over 20 years of Conservative rule co-occurred with a *systematic widening* of the health gap (Shaw et al., 1999). For example, from 1981 to 1995 the study found that standardized mortality rates in the highest socio-economic group decreased from 76 to 68, whereas mortality rates in the lowest socio-

economic group increased from 155 to 178 (Shaw et al., 1999). And the existence of a public health care system is not alone sufficient to overcome this trend. Canada's ranking in the World League tables of infant mortality dropped from 9th in 1960 to 12th in 2000 (of 18 nations with the number one being the nation with the best infant mortality rate) (Coburn 2006). Despite the fact that all Manitobans have access to universal health care, a 2003 Manitoba study noted that the gap between the most healthy and the least healthy Manitobans had also grown over a fifteen year period. The authors, Brownell et al. (2003) note these disparities:

> Between 1985 and 1999, the health status gap that exists between residents of Manitoba from areas with the least healthy populations compared to the most health populations widened...The widening of the health status gap appears to be due to improvements in health for residents of areas with the most healthy populations, whereas the health status for residents of areas with the least healthy populations remained unchanged. (p.73)

Coincidentally, this gap was found to be linked to the growing gap between the richest (most healthy) and poorest (least healthy) Manitobans – with income and unemployment levels found to be key indicators of health - over the same time period (Brownell, et al., 2003). As income disparity has grown in Manitoba and worldwide, so has health disparity.

The reality is that inequality affects the health of *all* people, not just those who live in poverty. The differences in life expectancy among nations are found to be more clearly related to the level of inequality than to absolute wealth as defined by Gross Domestic Product (Wilkinson, 1996). Wilkinson (1996) compiled research showing that communities and nations with greater economic inequality have higher mortality rates than those with less economic inequality. In a review of research that supports the links between community malaise and inequality, Raphael (2001) cites an American study, Kennedy et al. (1998), which links income distribution, socioeconomic status and self-related health differences among 50 American states:

> In regard to the overall inequality hypothesis, those living within the most unequal state had a 25 per cent greater chance of reporting poor or fair health even after controls for

> household income, sex, race, education level, body mass, and smoking status. The investigators also found that the effects of income distribution on self-related health were not limited to the lowest-income groups; those in the middle-income groups in states with the greatest inequalities income rated themselves as having poorer health than those in middle income groups in states with the smallest inequalities. (p.234)

What these findings illustrate is that inequality makes for unhealthy communities. And more money doesn't necessarily mean better or more care. Although the United States spends 15% of its considerably large economy on health care, it still has over forty million people without insured access to care, and has lower life expectancies and higher infant/maternal mortality rates than most developed countries (Yalnizyan, 2006). As societies become more divided economically, there is a deterioration of social capital, evidenced in diminishing degrees of social cohesion and citizen commitment to society (Deaton, 2001; Kawachi & Kennedy, 1997). As the elites become fearful of the expanding masses, there is a parallel increase in coercive forms of social control (including police, military and imprisonment), growing restraints on democratic governance, as well as the dismantling of universal social rights (Teeple, 2000).

On the other hand, strong redistributive income, health and education policies have been shown to offset the negative effects of the inequities of neo-liberalism (Global Social Policy Forum, 2001). Navarro (1998) notes that neo-liberalism's disparities are linked to the type of welfare state present in a country: the greater the supports, the lower the disparities. It is not a coincidence therefore, that growing Canadian inequality in health and income has co-occurred with reductions of social safety nets and cut-backs in government funding. In a review of poverty, income inequality and health in Canada, Raphael (2002) notes:

> In Canada, government policies of reducing social safety nets, decreasing eligibility for benefits, and reducing the absolute level of these benefits have served to both increase the incidence of poverty and remove the means by which those living in poverty can sustain themselves. This shift has occurred in part as a result of the reorganization of the income tax system by which the well-off have had their tax rates decreased, providing less resources for governments to provide social assistance benefits and social services to

those in need. (p.9)

The presence of social policies that reduce risk (of unemployment and of illness, for example) defend individuals against the accumulation of risk, and help to improve overall levels of health. When countries reduce their levels of publicly funded social supports citizens are more likely to experience sudden and unexpected reductions in their living standards, and to experience a feeling of loss of control over their lives (Bartney, Blane, & Montgomery, 1997). Historically, the social and health-related effects of economic inequality had been buffered by the presence of strong social programs in Canada, however, reductions to these programs since the early 1990s have weakened these protections (Townson, 1998). The move towards retractions in the public safety nets in general, and in medicare in particular, have important implications for the health of people living in poverty (Bartley, Blane & Montgomery, 1997). The potential disruption from a major life event like a chronic illness is felt most keenly by those who are poor. And in those provinces where the reductions have been the most severe, the health impacts have been the greatest. For example, in Alberta, one of Canada's wealthiest and most conservative provinces, the infant mortality rate in 2002 measured at 7.3 per 1,000 live births, greater than the U.S.'s infant mortality rate for the same year: 6.9 (Coburn, 2006; OECD, 2006). In comparison, Canada had an infant mortality rate of 5.3 in 2003, whereas Norway had only 3.4 mortalities per 1,000 live births in 2003 (OECD, 2006).

As international commercial pressures increasingly emphasize the goals of market principles, it has been increasingly difficult to ensure that equity concerns are recognized in the health reform process. Regarding conversations about the future of health care, O'Keefe (2000) notes that "the health-care rationing debate" in its "brisk commitment to problem solving, pushes equity into the background" (O'Keefe, 2000, p.168). This de-prioritization of equity can be

linked to the assertion of globalization's economic preferences. Neo-liberalism not only undermines social-democratic and redistributive principles, it also reinforces the philosophy of individualism (Mishra, 1999, p.46). It has also been found that higher-income earners in particular have shown reduced political support for universal public programmes, and tend to favor of private health care and insurance instead (Labonte, Schrecker, & Gupta, 2005). These shifts have inverse effects on equity, since market-based systems of health *concentrate* costs on the ill, who are also among those least likely to be able to pay (Reinhardt, 1996). Reinhardt (1996) also notes that health systems are in essence, redistributive mechanisms, providing access on the basis of need. As such, the shift away from equity in health care reform parallels the broader shift away from the prioritization of the redistributive role of the state towards greater support of market principles.

Without equity as a focus, health care reforms embrace the language of "efficiency" (Gilson, 1989). The impact of this shift can be observed in the promotion of improvements in aggregate health status, often by way of market mechanisms, as opposed to the reduction of systemic disparities in health between groups with different social status. The second best status of equity as a policy goal is also evident in the way that Canadian health reforms attend to medical interventions and medical system reform, instead of intersectoral collaboration and broader social programming (Armstrong & Armstrong, 2003; Gilson, 1998). Health care reforms which focus primarily on pursuing the efficient use of health care resources also overlook the broader debate regarding the value of publicly-funded health care systems per se (in terms of their contributions to equity), effectively undermining "the need to defend and justify continuing public sector expenditure on health care" (Gilson, 1998, p.1892).

The equitability of Canada's public health care system is also at risk in light of more recent health care developments which have opened up more space (ideologically and practically, as the province of Quebec is concerned), for the provision of parallel, private services in health care. In 2004, Jacques Chaoulli, a Quebec doctor and George Zeliotis, his patient, challenged sections in the Quebec health and hospital insurance laws that make private health insurance illegal. They claimed that because delays in the public system placed health at risk, they should be allowed to purchase private insurance and to access private health services. Although both the Quebec trial judge and the Quebec Court of Appeal dismissed the claim, the Supreme Court of Canada struck down Quebec's ban on private insurance for publicly insured services in June 2005. In February 2006, Quebec responded to this ruling by introducing care guarantees for certain surgical procedures. In a case where these care guarantees are not met, Quebec also promised to pay for private surgeries and to allow for the purchase of private insurance.

The potential for these decisions to impact on equity in health care is considerable. In particular, the ruling to allow the purchase of private insurance and the use of private clinics disproportionately benefits those who can afford to pay for this alternative. Those who are poor and ill are systematically excluded from such an option. As the Charter Committee on Poverty Issues (CCPI) notes in its June 2005 press release following the Chaoulli decision:

> Those who seek private health insurance are those who can afford it and can qualify for it. They will be the more advantaged members of society. They are differentiated from the general population, not by their health problems, which are found in every group in society, but by their income status. (p.1)

Two-tier health care further depletes public health care and leads to inequity of access by drawing human resources and money away from the public system, creating longer waits for public users in particular, while those with less medical need but more money can jump the line.

Although the Supreme Court decision was made with the expressed intention of protecting the rights of "ordinary Canadians", the Canadian Health Coalition (2005) notes that the Supreme Court ruling, "argues forcefully for the rights of private health insurers while at the same time arguing that the poor have no constitutional right to health care" (p.1). As such, the Supreme Court's references to rights fail to reflect notions of equity as rooted in human rights, and are rather, an argument in favor of more individualized conceptions of health care. Charter Committee on Poverty Issues president Sarah Sharpe also critiques the ways in which this ruling has overlooked the rights to universal health care for "ordinary Canadians":

> We are left to wonder whether the 15% of Canadians who live below the poverty line, people with disabilities who struggle to make ends meet, women working in low-wage jobs trying to feed their children, and many others of us who cannot afford private quality care do not qualify as 'ordinary Canadians'...so our rights don't count. (p.1)

Although McIntosh (2006a) notes that Quebec's actions – including the partial lifting of the ban on private insurance, the announcement of care guarantees and its retention of the ban on dual practice for physicians – "are far less than it could have done had it chosen to actively facilitate the development of parallel private system" (p.10), the outcomes of the Chaoulli decision have made considerable contributions to the privatization trend in Canadian health care reform. As CCPA (2000a) notes, privatization in health care can happen in a variety of ways; specific to the Supreme Court decision, it can be noted that privatization is occurring, given the way that the Quebec government has agreed to "pay for a service, but turn[s] it over to the private for-profit sector" (p.4). Shrybman and Mitchell (2005) also note that despite the fact that the Chaoulli decision may have few legal consequences (in that the ruling is currently limited to Quebec), its more serious implications are political ones, as pro-privatization forces pressure other provinces to abandon single-tier health care. Canadian researchers have long pointed out the pitfalls of private payment for health care services, which redistribute the costs of illness

*down* the pay scale such that the rich and healthy gain, and the poor and sick lose (Evans et al., 1994; Rachlis & Kushner, 1994). Each step that Canadian health care reform takes towards two levels of health care, one for those who can pay, and one for those who cannot, is a step away from equity and the redistributive principles that medicare has embodied since its inception.

## Chapter 6: Critically Considering Primary Health Care Reform

This chapter considers how Canadian primary health care reform fits within the international health care reform context as outlined in the previous chapter. Primary health care reform is considered by many researchers to be part of broader neo-liberal pressures shaping the reorganization of health care services worldwide (Armstrong et al., 2001; Browne, 2000; Donner & Pederson, 2004). In particular, this chapter focuses on the ways in which primary health care (PHC) reform recommendations outlined in the 2002 Romanow Report have been interpreted in a social/political/economic environment shaped by economic globalization. This includes an exploration of the ways in which the Romanow Report has been influenced by the reconceptualization of health as an individualized/medicalized commodity and a general lack of political motivation to implement its recommendations. Potential impacts on equity are also considered.

### Introducing the Romanow Report

In late November 2002, the Romanow Report - the 356 page outcome of the Commission on the Future of Health Care in Canada – was released. During the 18 months prior to the release the Commission analyzed reports and research on medicare, heard submissions from interested parties and individuals, organized expert roundtable sessions, conducted national and international site visits, commissioned independent experts, met with foremost health and health policy experts, Premiers and health ministers, and engaged "tens of thousands" of Canadian citizens in consultations across the country (Canada, 2002a, p.xv). The goals of the Commission were to:

> … inquire into and undertake dialogue with Canadians on the future of Canada's public health care system, and to recommend policies and measures respectful of the jurisdictions and powers in Canada required to ensure over the long term the sustainability of a universally accessible, publicly funded health system, that offers

> quality services to Canadians and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment… (Canada, 2002a, p.xi)

Chaired by once-Saskatchewan-Premier, Roy Romanow, the Commission issued an interim report in February 2002 and the final report in November 2002 (Canada, 2002a; Canada, 2002c). Confident that the medicare system contained the potential to meet the needs of Canadians, "now and in the future", the final report (hereafter called the Romanow Report) emphasized the need to "take the next bold step of transforming it into a truly national, more comprehensive, responsive and accountable health care system" (Canada, 2002a, p.xv).

The Romanow Report was released in the midst of intense Canadian scrutiny of medicare and alongside seven other national and provincial reports on health care. (Between 1996 and 2001, a total of eight health care reform reports were released in Canada. Appendix I contains a complete listing of these reports.) A series of polls researching Canadian attitudes towards health care found that 68% of respondents felt that the "quality of medicare had deteriorated over the past two years" (p.7) (prior to 1999), and 93% of respondents felt that federal and provincial governments should make health care a "high priority during the next five years" (p.3) (EKOS, 2000a). Spurred by this growing public concern about the viability of health care, along with the problems created by a series of federal funding cut-backs and reductions to provincial services, the Romanow Report and other federal and provincial Canadian reform reports were all looking for ways to address and resolve the growing sense of "crisis" in health care.

The Romanow Report clearly was a report intended to enhance and expand medicare. The Report emphasized that Canadians were "deeply attached to the core values at the heart of medicare", and that steps needed to be taken to transform Canadian medicare "into a truly national, more comprehensive, responsive and accountable health care system" (Canada, 2002a,

p.xv). Recommendations in ten critical areas were based on the objective of strengthening the Canadian medicare system in order to "renovate... medicare and adapt it to today's realities" (Canada, 2002a, p.xvii).These ten critical areas for reform included:

1. Health Care, Citizenship and Federalism;
2. Information, Evidence and Ideas;
3. Investing in Health Care Providers;
4. Primary Health Care and Prevention;
5. Improving Access, Ensuring Quality;
6. Rural and Remote Communities;
7. Home Care: The Next Essential Service;
8. Prescription Drugs;
9. A New Approach to Aboriginal Health; and
10. Health Care and Globalization.

The Report's recommended changes in health care were extensively outlined according to the principles of dedicated leadership, system reform and stable funding. Among Canadian groups and coalitions committed to ensuring that Canada's public health care system remains public, the Romanow Report was generally welcomed with enthusiasm (CCPA, 2002; CHC, 2002; CFNU, 2003). The Canadian Health Coalition (CHC) issued a press release on November 28, 2002, calling the Romanow Report "a milestone in the history of Canada's best loved social program" (CHC, 2002, p.1). Urging First Ministers to act quickly to implement the Report in full, the CHC praised the Romanow Report for its recognition of Canadian priorities:

> Today, Canadians are proud of the work of the Romanow Commission. They see and hear themselves reflected in this Report. Medicare belongs to the people of Canada and not to corporate and government elites. Mr. Romanow has tabled a plan from and for the Canadian people – grounded in ethics and based on evidence – to fix Medicare's problems and secure its future. (CHC, 2002, p.1)

The Canadian Centre for Policy Alternatives (CCPA) also expressed its support; CCPA economist Armine Yalnizyan applauded the Report's recommendations for change, noting "the Romanow Report is a clear rejection of the status quo and a pragmatic step in the right direction to secure the future of health care" (CCPA, 2002, p.1).

Many of these responses were based on the acknowledgement that the Romanow Report made a series of important recommendations needed to ensure the long-term sustainability of a public health care system in Canada. The Report recognized that access to timely and universal medical services was an important determinant of health, and its recommendations were built around the goals of making medicare more relevant and more sustainable in the long term. In particular, the Report included recommendations for the expansion of current universal public health services to include home care, long term care, pharmacare and a delivery approach based on prevention (Canada, 2002a). Rejecting privatization trends in health care, the Report also made recommendations for "governments [to] seek the best solutions within the public system and ensure that adequate resources are available and services are accessible to all" (Canada, 2002a, p.8). As such, the Romanow Report made a strong case for re-distributive equity, by advocating for a viable publicly funded health care system to ensure accessible, high quality health care services provided according to need, not the ability to pay.

**Context is Critical**

This is not to say that support for the Report was unanimous, neither was the support from the groups listed above unequivocal. The Romanow Report also had its critics, particularly from those provinces and political alliances which have characteristically supported private alternatives in public health care. Alberta Premier Ralph Klein and Quebec Premier Bernard Landry both severely criticized the Report; from the perspective of these provinces, the Report's recommendations that provinces be accountable for health care spending was challenged as an invasion of the provinces' jurisdictional responsibilities for health care (Laghi, 2002). The province of Ontario, the Canadian Alliance and the Bloc Quebecois also critiqued the Romanow Report for similar concerns (Bueckert, 2002).

What these responses, especially in contrast to the others noted above, help to indicate is the way that policy issues are selectively framed. As Rein and Schon (1993) point out, "framing is a way of selecting, organizing, interpreting, and making sense of a complex reality to provide guideposts for knowing, analyzing, persuading, and acting" (p.146). Rather than occurring as stand-alone events, the Romanow Report's policy recommendations are nested in a broader political and economic setting, which is characterized by the influences of trade conglomerates and corporate players in health care, the favoring of economic elites, and the individualized reconceptualization of health care strategies as a series of pro-business strategies (Fuller, 1998; Armstrong et al., 2001). In addition to the voices of supporters for public health care, neo-liberal ideas and portrayals also played a huge role in how the Romanow Report recommendations have been selected, organized, interpreted and implemented.

In order to understand this context a little more fully than introduced in the previous chapter, it is important to consider the ways in which health care reforms are linked to the shifting nature of production patterns. During the first half of the twentieth century, it was commonplace for production companies to focus on localized, massive-scale operations (Teeple, 2000). Know as the "fordist" era, this early industrial period was named to reflect the mass production assembly lines perfected by Henry Ford and the Ford Motor Company. As global events shifted in the 1970s, these production patterns changed. The increasing diversification of trade required methods of manufacturing that were more flexible than mass production allowed (Teeple, 2000). The growing fluidity of capital and enhanced competition of international product markets forced corporations to make radical adaptations to achieve global economies of scale and to meet specialized consumer demands. And so, during the post-fordist era, "tailor-made" manufacturing emerged:

> The last two decades have witnessed a crisis of the fordist model...These entailed significant transformations in the organization of production, a shift from the mass production of standardized goods and services in large vertically integrated factories and organizations to diversified production of more specialized goods and services in more streamlined, horizontally integrated, units of production. (Browne, 2000, p.29)

This trend toward systemic integration in private sector manufacturing operations has been linked to a specific shift in public administration (Shields & Evans, 1998; Teeple, 2000). In particular, many public endeavors have been "re-engineered" along the lines of private sector preferences during the last few decades (Browne, 2000, p.30). This has occurred in tandem with the growing ascendancy of neo-liberal ideologies and economics, and the belief that business solutions are "correct" and "best" for all administrative actions.

The term "new public management" emerged in the 1980s and 1990s to describe this modified prescription for government and state-run administrative activities (Savoie, 1994). Osborne and Gaebler (1993) were among the early advocates of new public management's version of entrepreneurial government, and in their seminal work, *Reinventing Government*, Osborne and Gaebler (1993) recommended that governments adopt more market-based and private sector solutions, including support for "competition between service providers", and attention to "earning money, not simply spending it" (pp.19-20). From this perspective, state bureaucracies are considered to be inherently unwieldy and inefficient and in need of private sector and market-based revitalization. Whereas Keynesianism had previously prioritized redistribution and interventive government controls, trends towards new public management recommended instead that governments do less. From this perspective, governments are expected to transfer their responsibilities to the private sector where possible, and where they continue operations, to find "new instruments to deliver public goods and services as inexpensively and efficiently as possible" (Shields & Evans, 1998, p.61). The result is evident in the growing

privatization of many once-public services and the greater adoption of the goals of "efficiency" and "effectiveness" in the public arena (Armstrong et al., 2000, p.27).

Given this prioritization of neo-liberal ideas and ideals, it is no surprise that conservative provinces such as Alberta and Ontario are fundamentally at odds with the redistributive recommendations in the Romanow Report. In public health care in particular, the pressures and tendencies of neo-liberal ideological shifts have led to a general restructuring of how health care services are delivered and organized. In contrast to their earlier, more rigid, expert-led and hospital-based forbearers, health care systems have been under pressure to become more diversified, consumer-focused and population specific (Browne, 2000). It is within this context that the key components of Canadian medicare – including public provision and universal access on the basis of need – are undermined and increasingly called into question. And it is within this context, of funding restrictions and health care reform that the Romanow Report and its primary health care recommendations are interpreted and considered.

**Primary Health Care**

In September 2000, Canada's premiers and the prime minister agreed that primary care improvements were a key element of overall health care reform and renewal (First Ministers' Meeting, 2000). A set of federal and provincial commissions on health care, released between 1996 and 2001 (see Appendix I), were consistent in recommending reforms to primary health care (Alberta 2001; Canada, 2002a; Canada, 2002b; Canada, 1997; New Brunswick, 2002; Ontario, 2000; Quebec, 2000; Saskatchewan, 2000). Many of these recommendations emerged in response to complaints that the primary health care system was poorly organized (including lack of coordination between health professionals, lack of access to services), inappropriately funded and predominantly focused on illness instead of prevention (Fooks & Lewis, 2002; Armstrong &

Armstrong, 2001). Reform proposals are therefore intended to create a more integrated, relevant, community-based and accessible health care system.

The Romanow Report, as one of these key reform proposals, notes that primary, or first line services, to be integral to an efficiently operating public health care system (Canada, 2002a). Far from being peripheral, the Report considers primary health care *to be* health care. Citing the World Health Organization's definition, the Report emphasized that "primary health care is 'the central function and main focus'" of the health care system (Canada, 2002, p.117; WHO, 1978). The proposed reform of Canada's primary health care system is also viewed as cataclysmal. The Report views primary care reform as essential to *transforming* the public health care system:

> ...primary care is not a single program that can be designed, developed and implemented. Primary health care is about fundamental change across the entire health care system. It is about transforming the way the health care system works today – taking away the almost overwhelming focus on hospitals and medical treatments, breaking down the barriers that too frequently exist between health care providers, and putting the focus on consistent efforts to prevent illness and injury, and improve health. (Canada, 2002a, p.116)

The Romanow Report highlights a number of different factors as responsible for the need for primary health care reform in Canada. One factor is the restructuring of the hospital system (Canada, 2002a). The Report notes that the imbalance in design and delivery of health care services caused by hospital restructurings and by cut-backs in emergency departments led to an increase in the need for comprehensive, after-hours and community-based health care. Primary health care reform is expected to fill the health care gaps caused by the retraction of hospital-based health services (Canada, 2002a).

Another related factor involves human resources. The Report emphasized that the uneven supply, distribution and scope of practices of health care providers meant that the skills of both doctors and nurses were not being used to their best capacity (Canada, 2002a). Primary health care reform was therefore presented as an outcome of and a response to the mismatch of human

resource skills and health needs. Shifting opinions and policy trends were also introduced as factors shaping the move to systematic primary health care reform.

> There is almost universal agreement that primary health care offers tremendous potential benefits to Canadians and to the health care system. The majority of policy experts and health care professionals consider primary health care to be an absolute priority... Canadians, too, appear to support primary health care change... At the public consultations and expert roundtables, a remarkable number of people told the Commission that they would like to see the development of a complete and effective primary health care system. (Canada, 2002a, p.115-116)

The Report also presents reform as motivated by an increased awareness of health prevention and of the role that non-medical health determinants play in improving wellness.

> There is a growing awareness that many illnesses can be prevented if people take better care of their health....There is also a growing understanding that broader determinants of health such as lifestyle factors, adequate housing, a clean environment and good nutrition have an important impact on the health of individuals and communities, and also hold tremendous potential for improving health and preventing illness. (Canada, 2002a, p.128)

And finally, the Report also considered primary health care reform to be politically motivated, noting that federal, provincial and territorial ministers have "agreed to work together on a primary health care agenda" as of September 2000 (Canada, 2002a, p.115).

**Problems and Solutions as Outlined in the Romanow Report**

In order to introduce analysis which follows in this chapter, this section summarizes primary health care reform recommendations as they appear in the Romanow Report. To summarize, the 2002 Report emphasized that reform was needed to address concerns that primary health care services were fragmented, poorly remunerated, incommunicative, and inappropriately focused on medical cures (Canada, 2002a). As outlined in the Report, the problems in primary health care include:

1. Specialization/Fragmented Service Delivery: The final Report found individual practitioners and treatment sites to be excessively disjointed. As practitioners become

increasingly specialized, they are characterized by inflexible work arrangements and the lack of shared responsibilities. As a result, patients were lost in a maze of compartmentalized "silos" of health care service (Canada, 2002a, p. 119). Unlike the preferred ideal of a seamless continuum of care, fragmentation was considered a damper on quality patient care, to negatively impact staff morale, and to be a main contributor to "needless costs" in primary health care (Canada, 2002a, p.122).

2. **Inappropriate incentives**: The Romanow Report also noted problems physicians and other health care provider compensation. The traditional practice of remunerating physicians on a fee-for-service basis was seen to create a "perverse incentive to focus on the quantity of services rather than the quality of services in order to maximize a physician's income" (Canada, 2002a, p.124). In addition, the Report found a lack of appropriate mechanisms "for paying other health care providers" such as nurse practitioners and social workers who also work in primary health care settings (Canada, 2002a, p.123).

3. **Lack of health information**: The Romanow Report noted that comprehensive, timely and accurate information was generally unavailable to practitioners and patients (Canada, 2002a). The result is that patients are unable to make informed choices, health practitioners have difficulty staying informed and providing continuous care, and the quality of primary health services suffer. Lack of information was also seen to block efforts to coordinate prevention and address community needs, as it impedes the ability of policy makers to "assess the impact of different approaches on improving the quality of primary health care services" (Canada, 2002a, p.123).

4. **Predominant focus on hospital and medical care**: And finally, the Report found that primary health care services tended to be unduly focused on hospital-based, medical treatments (which were seen as "costly" and "invasive") at the expense of prevention and health promotion activities (Canada, 2002a, p.118). Specifically, the Report critiques the lack initiatives regarding "behaviors such as smoking, lack of physical activity, poor diet, and alcohol use [which are seen to] have profound effects on health, largely because they are related to the leading causes of death, illness and disability" (Canada, 2002a, p.129). Because prevention has the potential to offset the treatment of costly diseases by stopping them before they start, the Report notes that its neglect is an unnecessary drain on scarce health care resources (Canada, 2002a).

To respond to these problems, the Romanow Report suggested broad changes to primary health care systems nationwide. (See Appendix II to review the recommendations as they appear in the Romanow Report.) These recommendations included team-based service delivery models that focus on illness prevention and population health. The Report also recommended that primary health services be made available through accessible, decentralized, and community-based organizations (Canada, 2002a). Although not all provinces were expected to implement identical primary health care reforms, a few key elements are outlined. These include:

- Comprehensive medical, nursing and health care services that combine disease prevention and health education;
- Services provided to both individuals and to communities as a whole including public health and health promotion programs;
- Services organized to address the needs and characteristics of the population that is being served;

- Teamwork and interdisciplinary collaboration working within primary care organizations or networks of providers;
- Accessible services available 24 hours a day, 7 days a week; and
- Decision-making decentralized to community-based organizations (Canada, 2002a).

The Report notes that full implementation of a nation-wide primary health care system is problematic in that it challenges "entrenched practices in the prevailing culture of our health care system" and goes against the grain of "powerful interests and long-standing privileges" (Canada, 2002a, p.119). To overcome potential implementation delays, the Report recommended a specific federal Primary Health Care Transfer[29], conditional on four primary health care conditions or "building blocks", including: 1) continuity of care, 2) early detection and action, 3) better information on needs and outcomes, and 4) new and stronger incentives to achieve transformation (Canada, 2002a, p.121). Because rigidity was seen as an obstacle to implementation, the Report did not advocate one single model of primary health care; rather, these four conditions are expected to be met through a variety of approaches, according to the needs of each community.

"Continuity of care" conditions were recommended to reduce fragmentation and to improve system integration. These measures included recommendations for primary health care case managers to "guide individual patients through the various aspects of the health care system and co-ordinate all aspects of their care" (Canada, 2002a, p.122). They also included proposed "care networks", which are health management programs for the chronically ill.

"Early detection and action" measures involved the integration of public health measures with front-line medical care, enabling primary health care to play "an important role in

preventing illness and injury, and improving health over the long term" (Canada, 2002a, p.123). Specifically, the Report recommended dedicated promotion strategies to "make Canada a leader in reducing smoking and obesity", to "improve physical activity across Canada", and to develop a national immunization strategy (Canada, 2002a, p.128). These early detection and action recommendations are considered as linked to growing public and professional awareness of the role of prevention, as well as a "growing understanding that the broader determinants of health…have an important impact on the health of individuals and communities" (Canada, 2002a, p.128).

"Better information on needs and outcomes" included recommendations regarding electronic patient records, shared databases, and information resources for practitioners and patients (Canada, 2002a). These measures are expected to provide linkages between different types of care and different professionals, and were presented as key elements within the recommended model of seamless primary health care[30].

"New and stronger incentives" were outlined to respond to the problems of inappropriate financial incentives, poor staff morale and declining quality of care. Better remuneration incentives were suggested to enable "health care providers to work in primary health care settings and be paid appropriately for the comprehensive care they provide" (Canada, 2002, p.123). Although it did not commit to any specifics, the Report mentioned that these new incentives may potentially include mixed payment schemes (some combination of capitation and fee-for-service) for physicians. To resolve any contentious arising from such recommendations, the Report also suggested that the Health Council of Canada sponsor a National Summit on Primary Health Care. Through this summit and other research activities it was expected that the Health Council could "expand primary health care research on controversial issues such as the remuneration of health

care professionals, work organization, funding of primary health care organizations, and registration (rostering) of patients" (Canada, 2002a, p.127). Other recommended incentives included a commitment to long-term funding, better staff recognition, improvements in work-life conditions for providers, and new opportunities for professionals to provide quality care to patients.

The Report also indicates that primary care reforms are expected to reduce long-term health care costs.

> It is impossible to put a dollar figure on these benefits, but there is every reason to believe that primary health care would not only save Canadians money in terms of their future investment in the health care system but also improve health and save lives. (Canada, 2002a, p.116)

These cost savings are linked to better systemic efficiencies, to "reduce costly and inefficient repetition of tests and overlaps in care provided by different sectors and different providers" and to "replace unnecessary use of hospital, emergency, and costly medical treatments with comprehensive primary health care available to Canadians 24 hours a day, 7 days a week" (Canada, 2002a, p.116). A focus on prevention is also expected to reduce long-terms health care costs, to reduce the high health care costs associated with smoking, obesity and sedentary lifestyles.

**Romanow in Context**

At first glance, these proposed reforms are appealing on many levels. Primary health care systems in Canada are in need of reform. A 2002 poll found that most Canadians were in favor reforms that would lead to a more integrated, accessible and preventative primary health care system (EKOS, 2002b). The Romanow Report's focus on change in primary health care acknowledged these concerns, and outlined recommendations for a more accessible, relevant and

community-focused primary health care system. In particular, primary health care reform has been noted as needed to close some of the gaps in health care caused by hospital reform and cutbacks (Armstrong & Armstrong, 2001). The Canadian Federation of Nurses Unions (CFNU) applauded the recommended primary care reforms "as crucial to the best provision of services" in health care (CFNU, 2003, p.2).

Armstrong and Armstrong (2001) note that primary health care reform as it is presented in many health care reform documents is inherently appealing on many levels:

> ...definitions [of primary health care] suggest a common commitment to serving whole persons, close to their homes where everyone knows their names and circumstances. They suggest as well an emphasis on keeping people healthy and, when this fails, on providing a smooth and comforting transition to appropriate treatment. Defined in this fashion, primary health care is easy to support. (p.4)

However, in a *constructive* sense, these primary health care policy recommendations are understood to embody particular ideas about causation, depending context, ideological preferences and power differentials. What this means is that the policy politics of primary health care reform involves "strategically portraying issues" to fit preferred outcomes (Stone, 1989, p.283). As a result, the broad and encompassing definitions of primary health care are "more a statement about ideas and relations than they are about structures and practices" (Armstrong & Armstrong, 2001, p.4). In response, it has been possible to find links between the statements of primary health care reform, and the context within which primary health care reform is presented and interpreted. In the Romanow Report, these links have been noted in a number of areas as outlined below.

***A mis-aligned focus on prevention:***

The Romanow Report noted that primary health care needed to shift its traditional focus on hospital-based, medical treatments towards prevention and health promotion activities

(Canada, 2002a, p.118). Specifically, the Report recommends action to improve physical activity and immunization, and to reduce obesity and smoking. These are not new ideas. In recent years, curative, physician-dominated health conceptions have been challenged by an ideology that stresses the prevention of illness and health promotion, and an integrated, holistic model of health (Browne, 2000). These shifts have been influenced by the growing understanding that within advanced capitalist countries, national levels of health are "at least as highly related to prevailing general social conditions as they are to the size of the health-care system" (Armstrong, et al., 2001, p.1). In Canada for example, the 1974 Lalonde Report (A New Perspective on the Health of Canadians) emphasized that healthier lifestyles, better nutrition and a healthier physical environments played a greater role in health than the advancement of medicine (Lalonde, 1974). Federal health experts subsequently tried to turn that understanding into policies and programs, and the Lalonde Report bore a series of issue-specific social marketing campaigns (aimed at modifying individual behaviors, such as alcoholism, for example).

A further shift in this understanding occurred when health came to be understood as influence by the broader non-medical determinants of health including: gender, class, socioeconomic status, social supports, education, employment, environment (both physical and social), biology, race, ethnicity, child development, personal health practices, and social services (Marmot & Wilkinson, 1999; Shah, 2003). Academics, health policy analysts and provincial governments increasingly acknowledged these non-medical determinants of health, and devoted greater attention to understanding how disease was embedded in economic, social and cultural contexts (Hayes & Dunn, 1998). The 1986 Epp Report (Achieving Health for All) for example, broadened the emphasis of health promotion to include environmental determinants (Epp, 1986). During the early 1990s, the Federal-Provincial-Territorial Advisory Committee on Population

Health published a report that focused even more specifically on the impact of social and economic determinants (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994). In recent years, the universal re-examination of how to provide more effective health care while limiting rising costs, has also drawn greater focus toward the evidence of health-related inequities among people living in poverty, as well as to the need for disease prevention and health promotion (Shah, 2003). In this context, medicare's traditional focus on hospitals and physician services has been criticized for being costly and for lacking a preventative focus.

> In tandem with the shift from fordism to post-fordism, the curative model of health care has been called into question and there has been greater (at least rhetorical) emphasis on the socio-economic determinants of health. Critics of medicine pointed out that the latter had developed an exclusively bio-medical pathology and lack a socio-economic perspective on the causes of disease. Instead of pumping resources into a system designed to cure people once they become sick, and which treats them as the passive recipients of medical wizardry, this line of thinking stresses both the need to prevent illness in the first place and empower citizens to deal with disease themselves. (Browne, 2000, p.33)

These trends are evident in the emphasis that the Romanow Report places on prevention and the health determinants in its primary health care recommendations:

> There...is a growing understanding that broader determinants of health such as lifestyle factors, adequate housing, a clean environment and good nutrition have an important impact on the health of individuals and communities, and also hold tremendous potential for improving health and preventing illness. Primary health care organizations need to pay more attention to the impact these broader determinants of health care have both on individuals and communities. (Canada, 2002a, p.128)

Although the determinants of health are included in many Canadian health care reform proposals, Chernomas (1999) notes the lack of systemic inclusion of non-medical determinants in Canadian health care policies.

A study by the Canadian Policy Research Network notes that Canadian health policy has been engaged in a 25 year struggle to balance the demands of the health care system on one hand,

and investments in population and the non-medical determinants of health on the other (Legowski & McKay, 2000). This study asserts that Canada's perennial emphasis on medicalized health care reform has detracted from policies designed to prevent poor health, which have been further hampered by: fiscal restraint concerns, jurisdictional issues arising from the variable federal-provincial-territorial responsibilities for health, and the tendency of governments in Canada to favor policies addressing narrow, issue-specific, time-limited strategies (Legowski & McKay, 2000). Noting these barriers to addressing the non-medical determinants of health, the report also notes:

> Many of the influences on health lie outside the policy domain of departments of health. Attempts by departments of health to influence such areas as employment, housing and education have been branded as "health imperialism". While there is no doubt that cross-departmental and cross-jurisdictional efforts in this direction are necessary to implement policies that respond to population health research findings, many barriers stand in the way of fostering a willingness within other departments to incorporate or cooperate with a health mandate. (Legowski & McKay, 2000, pp. vii)

As a result of this depriortization of health determinants in practice, Gilson (1989) notes that preventative health policies instead tend to reflect "an underlying assumption that ill-health is often and only the result of the individual's actions of lack of action" (Gilson, 1989, p.324). This assumption can be illustrated by comments found in a Globe and Mail Article that explored parallels between income and health. One interviewee – a Toronto lawyer and real-estate developer - who maintained his health by working on a hobby farm, said that he was not surprised by studies that indicated that wealthier people lived longer: "In my experience, people with higher income are achievers, and they're not afraid to make tough decisions, including eating a healthy diet and exercising" (Picard, 2004). The assumption that people live longer because they are "not afraid to make tough decisions" is a false one. Wealthy people are not healthy because they "are achievers"; wealthy people are healthier because they have access to a

huge number of resources and supports that the poor cannot access, such as fitness memberships, child care, hazard-free workplaces and adequate housing.

The "assumption that ill-health is often and only the result of [a] individual's actions and lack of action" (Gilson, 1989, p.324) is also present in the Romanow Report. The Report suggests that healthier populations can be achieved "if people take better care of their health" (p.128) and if "healthy living conditions and the adoption of healthy lifestyles" (p.129) are encouraged. Without mention of the supports needed to ensure that all Canadians have access to these healthy living conditions, the Report recommends a series of targeted health promotion strategies, including "reducing smoking and obesity", "improv[ing] physical activity", and developing a national immunization strategy (Canada, 2002a, p.128). These recommendations are presented without any critical consideration of the structural and contextual factors that contribute to an individual's ability (or opportunity) to achieve such goals. In a critique of the Romanow Report, the National Coordinating Group on Health Care Reform and Women also notes:

> The Report stresses the importance of increasing disease prevention efforts through individualized lifestyle changes and higher rates of immunization. While it acknowledges that factors beyond lifestyle and the health care system – the social determinants of health – make significant contributions to individual and population health, the major recommendations for disease prevention are not to reduce poverty, improve the state of the environment or enhance social inclusion but rather to increase physical activity, reduce smoking and increase immunization (Armstrong et al., 2003, p.30).

Despite the emphasis that the Romanow Report has placed on the social and economic determinants of health, governments have reduced their commitment to equalizing social conditions to contribute to greater health (Armstrong & Armstrong, 2003). Given the contextual influences of globalization and neo-liberalism, it can be noted that the propagation of health as an individual responsibility supports broader neo-liberal aims. Individualized health reforms provide one way to create the façade of effecting change, while reducing political and public attention to

service reductions. As Browne (2000) points out, "By spreading and legitimizing the view that individuals are the authors of their own good or bad health, such ideas could even be used to legitimize cuts to public health care" (p.33). The focus on personal health behavior is also preferred because it supports the neo-liberal aims of low-cost government and individualized responsibility, while shoring up the commercial aims of preventative health-product providers:

> For the state, there is a clear advantage to this emphasis on personal behavior. First, it is a relatively low-cost strategy that has support from a broad spectrum of publics. Second, although tobacco and alcohol manufacturers have complained, the lifestyle approach leaves corporations relatively free of state interference and creates new markets for those selling those low-fat and high-fibre products, and those exercise machines. Third, it creates the appearance of government action on health promotion while placing the responsibility firmly on the individual. Fourth, it promotes an ideology of individual responsibility rather than of collective responsibility. (Armstrong & Armstrong, 2003, p.43)

The effect is that the Romanow Report's preventative health care recommendations "fit" with predominant tendencies to assign medical and individual solutions in health care reform. This reductionist approach tends to focus mainly on objective, curative and interventionist tasks, where behavior patterns and individual consumption trends (such as smoking or weight gain) are linked to health outcomes. Without a commitment to developing healthy living conditions through the more equitable distribution of social resources, the achievement of healthy lifestyles will only be available to those individuals and families with the financial resources to do so.

***Influential surroundings:***

In addition to reflecting individualized and medicalized conceptions of health as predominant in the broader context, the Romanow Report's primary health care recommendations are also being interpreted in a context that is sometimes discordant that the Report's objectives. Despite the Report's intention to primary health care reform as essential to the "continuity and coordination of health care and health care services", its recommendations

have been interpreted in a social/political/economic environment shaped by globalization (Canada, 2002a, p.116). As such, there is potential for these recommendations to be misinterpreted, misapplied, or completely ignored.

Noting that primary health care has been hobbled by fragmentation, inappropriate incentives, lack of communication, and a failure to focus on patients, the Romanow Report recommended *systemic* reform to transform the nature of Canadian health services (Canada, 2002a). However, a critical interpretation requires attention to the ways in which the public sector "restructuring discourse" has been used to "push change along a neo-liberal path" (Shields & Evans, 1998, p.41). Browne (2000) points out that the act of organizational restructuring may potentially have the indirect effect of supporting private interests, especially when it changes the way that public services are conceptualized and delivered. This happens, for example, when governments provide and pay for a service, "but manage and deliver it along the lines of a commercial, for-profit enterprise" (Browne, 2000, p.3). Primary health care reforms in particular may be motivated by the pressure for health services to operate in a more business-like manner, "with talk of one-stop shopping becoming commonplace" (Armstrong, 2002, p.22), and with primary care group practices applauded by health management consultants as providing a more sophisticated business model than individual practice (Armstrong & Armstrong, 2001).

One of the ways that primary health care reform recommendations in the Romanow Report may possibly be misconstrued to reflect privatization goals is through the Report's repeated references to cost-savings. The Report emphasized that primary health care reforms have the potential to save money in three ways:

- **Greater systemic efficiencies:** The Romanow Report notes that primary health care reform has the potential to "reduce costly and inefficient repetition of tests and overlaps in care provided by different sectors and different providers"(Canada, 2002a, p.116)
- **Reductions in unnecessary use:** The Romanow Report notes that primary health care reform has the potential to "replace unnecessary use of hospital, emergency, and costly medical treatments with comprehensive primary health care available to Canadians 24 hours a day, 7 days a week" (Canada, 2002a, p.116).
- **Fewer illnesses due to preventative measures:** The Report notes that "with deliberate actions to prevent illness and injuries, promote good health, and give people access to appropriate care, better use can be made of available resources, and costs can be contained" (Canada, 2002a).

This focus on cost-containment in health care reform is not new. In fact there have been various recommendations suggesting that Canadian health care reform can be implemented through targeted change, as opposed to huge cash infusions. Rachlis (2004) for example has argued that Canadian health care reform can be implemented by encouraging the spread of innovative best-practices, rather than through privatization or lots more health care spending. Saskatchewan's Fyke Report also recommended quality improvements to ensure cost savings, as a precursor to any health care funding increases (Saskatchewan, 2000). Primary health care reform in particular is also often recommended as a way of controlling health care costs (Canada, 2002a; Canada, 2002b; Saskatchewan, 2000). Generally, primary health care savings are expected to be achieved via the streamlining of health care resources and staff, limits on the upward escalation of physician salaries, and a health-enhancing focus on prevention (Armstrong & Armstrong, 2003).

Attention to cost-containment in health care in and of itself is not a problem, since it represents an important component of ensuring sustainability in the public health care system. Although public health care systems make efficient use of public resources and provide optimal health insurance coverage, especially when compared to for-profit and privately-based alternatives, there are always potential areas where additional cost-savings or efficiencies may be realized (Olsen, 2002; Rachlis, 2004). However, a commitment to cost savings can be a problem when it is inaccurate, when it overlooks other issues such as equity, or when it indicates that economic interests are being prioritized above and beyond other social concerns, including health.

In a publication series entitled "Myth Busters", the Canadian Health Services Research Foundation (CHSRF) refutes broad claims that prevention and promotion will always help the health care system save money. For example, despite the fact that studies suggest that millions of dollars in direct medical care could be saved if people were more active (Katzmarzky et al., 2000), the CHSRF (2003) notes that there is little consideration in these calculations of the costs of implementing health programs, the costs of treating injuries that result from exercise, and the cost of treating for age-related conditions as healthy people live longer. Another commonly assumed area of cost savings is the area of disease prevention. Again, the CHSRF (2003) notes that by preventing fatal diseases such as heart attacks and strokes, costs to the health care system may increase, as people live longer and become more vulnerable to (potentially more expensive and longer lasting) conditions such as mental illness, respiratory disease and joint and bone problems. To conclude, the CHSRF notes that there is sketchy evidence to prove the cost-effectiveness of prevention:

> Leading longer, healthier lives is in itself justification for disease prevention and health promotion. And it is important to remember that just because something costs money

> doesn't mean it isn't cost-effective. Thus, the supporters of health promotion and illness prevention don't need to depend on cost-saving rhetoric to make their arguments, and they probably shouldn't, because the evidence is simply not there. (CHSRF, 2003, p.2)

Under the sway of neo-liberalism however, the goals of cost-containment and restraint in health care reform have the tendency to become primary reasons for change, regardless of findings such as these. Shields and Evans (1998) therefore note that restraint as a goal of health system reform needs to be critically understood for the ideological preferences it may potentially represent.

> It is important not to view restraint simply as a fiscal policy measure. Restraint also embodies a set of values. The ideological role of restraint is particularly evident in its neo-liberal versions. The promotion of government policies under the name of restraint conveys to large sections of the population not just notion of public sector fiscal practices but also a set of social values...Translated into a public administrative context, this means less state and more individual reliance. (Shields & Evans, 1998, p.40)

Although the Romanow Report is decidedly against the goals of greater privatization in health care[31], it is a policy document that exists within this broader context. As such, these cost-containment arguments have the potential to be misinterpreted and/or misrepresented. And unfortunately, the Report does little to address these potential misinterpretations, especially in terms of how primary health care versus hospital based medical services are viewed in cost terms. From a for-profit perspective, hospital based services are preferred (this is where there is money to be made) over community-based primary health care. Despite recognition that private alternatives are inefficient ways of delivering health care services, the Romanow Report fails to acknowledge that containing costs are not necessarily a goal per se, when there are potential profits to be made.

The Report's recommendations also have potential to be misinterpreted in reference to changes to the way that health care providers work and interact, which is outlined as follows:

> Health care providers are becoming increasingly specialized and there is a long-standing tradition of carefully guarding their professional scope of practice. The development of primary health care runs against this trend and demands flexible working arrangements and shared responsibilities among health care providers. (Canada, 2002a, p.119)

In particular, the Report recommended the formation of primary health care teams, where nurse-practitioners and other professionals "work together..., co-ordinate care..., and share responsibility" (Canada, 2002a, p.135).

Recommendations to include non-physician professionals in primary health care teams have been advocated and applauded by a range of health care professionals and by nurses in particular (Canada, 2002a; Armstrong et al., 2000). Labour restructuring in primary health care has the potential to interrupt traditional patterns of power and influence, whereby physicians make all the decisions for patient care and the role of nurses and other health care practitioners is limited at best. There is also clear evidence available to suggest that interdisciplinary teams in health care can more effectively manage illness, especially chronic illness. For example, the Canadian Health Services Research Foundation, in one of its "Evidence Boost" publications, notes that "evaluations of interdisciplinary care consistently find that patients who receive care from allied health professionals in addition to their primary care physicians fare at least as well as those receiving care from their doctors alone, and many studies find significant improvements" (CHSRF, 2005, p.2). In contrast to individual physicians, who are often under time constraints with their patients, interdisciplinary teams (involving physicians, nurses, nurse practitioners, and/or other allied health professionals, have also been found to offer more effective care through a clinic setting and through telephone support[32] (Hunkeler et al., 2000; Mynors-Wallis, 2000).

Suggestions to introduce other health practitioners into primary health care appeal to an ideology of community health intent on breaking down barriers between health care and social services, especially given the ways that nurse practitioners and other professionals have the

ability to bring a new perspective to medical practice (Browne, 2000). However, from a critical perspective it is important to note that changing the way that health care professionals work can potentially support neo-liberal goals. In Ontario, for example, the introduction of nurse practitioners has been pursued, not for the inclusive incentives generally associated with interdisciplinary teams in health care, but for the sheer goal of cost-effectiveness. Nurses and nurse practitioners were found to provide a less-expensive alternative to physician care. As Browne (2000) notes:

> The cost-containment perspective has been especially influential in the debate about nurse practitioners in Ontario: "The arguments for cost-effectiveness were particularly attractive to provincial governments across Canada which were trying to control health care costs, and this became evident in report after report by government appointed committees." The holistic, community health discourse has provided a progressive veneer to the discussion, but has not been the determining factor. The emphasis has been on the curative model of health care and on the relative cost of physicians and nurse practitioners, rather than on the broader caring function and the benefits to patients of more holistic medicine. (p.73)

***Implementation implied:***

In a public opinion poll conducted just shortly after the Romanow Report was released, Canadians expressed support for the recommendations, but were uncertain about how decisively senior governments would act, or whether they would provide the resources needed to implement the Report (EKOS, 2002a). Time has shown that these concerns have not been without foundation. Despite the expected benefits of an expanded primary health care system – including more continuous care, reduced gaps in health care services, and community-focused and community-responsive care – primary health care reforms in general, and Romanow's recommendations in particular, have been slow in coming (Hutchsion, Abelson, & Lavis, 2001; Lamarche et al., 2003; Pascal, 2006; Rachlis, 2004).

In considering the reasons why, Fooks (2004) notes that the structure and design of Canadian health care, along with a lack of supports required for policy implementation have

contributed to the slow pace of change in primary health care. Fooks (2004) also found that reform tends to be delayed by the disjointed nature of Canada's health care system and the sometimes less than complete commitment to change (among politicians and practitioners). Rachlis (2004) has likewise pointed to the role that political wrangling between the provinces and the federal government can play in lengthening these delays:

> [T]he promise of Romanow's cross-country treks seems destined to be unfulfilled. The commission held twenty-one days of public hearings and heard six hundred presentations from individuals or organizations. Two thousand other Canadians sent the commission formal submissions and over ten thousand forwarded emails and letters. Over twenty thousand completed on-line surveys. Canadians said passionately they wanted to keep a public system and modernize it. But there is no room for democracy, and even less for evidence once the first ministers start jawing. (pp.41-42)

A well-known characteristic of Canadian health care politics, this federal-provincial-territorial discordance and the "inability of both orders of government to take collaborative federalism and policy interdependence seriously" has been recognized as a threat to healthy public policy in general, and primary health care reforms in particular. (Fooks, 2004; McIntosh, 2004, p.27).

It has also been noted that federal funding increases, granted with minimal targets and conditions has been a culprit (Rachlis, 2004). With the 2000 health accord, for example, only 7 per cent of new health money was tied to specific reform outcomes (approximately 4 per cent for new medical equipment and 3 per cent for primary health care reform) (Rachlis, 2004). Although the Romanow Report pressed for targeted funds over two years, including a rural and remote-access fund, a diagnostic services fund, a primary health care transfer, and additional packets of funds for limited home care and pharmacare programs, Canada's most recent health accord (2004) provided health care with a $41 billion "fix it for a generation" funding, but did very little to tie this funding to specific outcomes (Canada, 2002a; Pascal, 2006). Without specific outcome goals, the Romanow Report had noted that primary health care reform was unlikely to occur,

given the ways that change goes against the grain of "powerful interests and long-standing privileges" (Canada, 2002a, p.119).

This acknowledgement of "interests" and "privileges" may help to illustrate primary health care reform delays even more critically. A recent commentary by Charles Pascal, former Ontario deputy minister of the Premier's Council on Health, alludes to the source of these implementation delays:

> A true Canadian tragedy is in the making as the findings of the Commission on the Future of Health Care in Canada seem to have evaporated from the ranks of our political, media and legal hierarchies, and commercial interests invade the very heart of publicly funded medicare. (Pascal, 2006)

In a health policy context influenced by the priorities of globalization, the lack of implementation in primary health care reform can be critically interpreted as a deliberate decision to allow the public health care system to move closer to a state of disorder and ineffective care, such that private solutions may be offered up at the "new" solution. The recent (January 2006) election of a Conservative minority government in Canada also does little to ensure that the health-care-system-sustaining potentials of the Romanow Report will be brought to the political forefront any time soon, especially given that Tony Clement as the appointed federal Minister of Health, has had a long-standing commitment to privatization, deregulation and the creation of for-profit hospitals in health care as exemplified during his previous employment as Ontario's Health Minister (CMAJ, 2006). Although federal leader Stephen Harper and his Conservatives have declared rhetorical support for a universal, single-payer health care system in Canada, they have done so in the form of "care guarantees"[33], which contain an inconsistent potential to undermine medicare (McIntosh, 2006b). These Harper wait-time guarantees include Chaoulli-like "promise[s] that public insurance will foot the bill for Canadians who received medical treatment at a private clinic or in another jurisdiction because they couldn't get care quickly enough at

home" (Sands, 2006). Such guarantees have the adverse potential to feed into privatization trends, as they tend to lengthen waiting lists and drive up public health care costs. To meet wait-time criteria under care guarantees, patients are referred more quickly to wait lists (including cases of uncertain diagnosis or low-level priority). This trend has the adverse effect of increasing the wait lists, encouraging more referrals to private care, and in the end, costing the public system more than would be the case otherwise.

**Considering Equity**

The Romanow Report identifies equity as part of its commitment to a universally accessible, publicly funded health care system (Canada, 2002a). In the Report, equity is defined as "access to health services", whereby fairness is achieved by providing health care services "based on need and need alone, not on other factors such as wealth, origin, the region where people live, their gender or their age" (Canada, 2002a, p.48). There is a difference between defining equity in terms of access to medical services and defining equity in terms of access to resources in society. One ways this distinction can be illustrated is through an examination of the *type* of primary health care the Romanow Report recommends.

The Romanow Report defines primary health care as "first-contact", community-based health care services provided by multi-disciplinary teams of health care professionals, accessible to patients around-the-clock, with a focus on health promotion and illness prevention strategies[34] (Canada, 2002a, p.117). Although this is a common way to define primary health care[35], it is not the only way, nor is it the most equitable way.

An alternate definition was initially provided by the World Health Organization, in its Alma-Ata Declaration of 1978, which defines primary health care not simply as an integral part of the health care system, as the Romanow Report does, but also as "an integral part…of the

overall social and economic development of the community" (WHO, 1978). This broad definition requires that medical services include the "full participation" of community members "in the spirit of self-reliance and self-determination" (WHO, 1978). In full, the WHO definition of primary health care reads as follows:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (WHO, 1978, pp.1-2)

The Romanow Report borrows a line from this definition of primary health care, in emphasizing that "primary health care reform is 'the central function and main focus' of the health care system" (Canada, 2002a, p.117, with reference to WHO, 1978). However, it does not follow the concepts of this broad approach to completion. Macdonald (1993) points out that primary health care as defined at the international conference of Alma-Ata was intended to create significant change in the planning of health services, *far beyond* a basic reorganization of primary health care services:

> ...as presented by the international Conference of Alma Ata in 1978 and developed in a variety of contexts since, PHC [primary health care] is much more than an addition to existing health services... It is a reorientation of all health services towards the health needs of communities, both local and national. This reorientation can have dramatic consequences on health care resources allocation, on priorities in planning and on the attitudes of health personnel. The vision of PHC presented by Alma Ata challenges many existing ways of thinking and practice in health services throughout the world. (p.14)

More specifically, this Alma-Ata "reorientation" includes the adoption of system-transforming participation based on equitable power sharing, intersectoral collaboration backed by the political will to address the multiple determinants of health, and equity in the sense of an

active concern for justice and the redressing of the balance of health resources in society (Macdonald, 1993, p.14). These are significantly different aims than those cited by the Romanow Report, despite the fact that the Report references this WHO definition.

The reason this distinction has been introduced into this assessment is because it helps to distinguish key differences when terms like "primary health care reform" and "equity" are used in different contexts. Wading through "broad and encompassing definitions" of primary health care, Armstrong and Armstrong (2001) emphasize the need to pay close attention to the *detail* of actual reform recommendations (p.4). The World Health Organization defines primary health care as participatory, intersectoral and equity-based. Because it emphasizes that reform be linked to an active concern for justice and the redressing of the balance of health resources in society, it has the potential to minimize the health differences between various socio-economic groups (Macdonald, 1992). The Romanow Report's use of the term primary health care reform refers more narrowly to a version of *primary medical care* reform where medical services are re-organized, access improved and preventative care introduced. The Report's recommendations aim to transform the way that medical services are offered, but these are *not* reforms that have the potential to overcome the social inequities that create health disparities in the first place. The difference lies in the way the term equity is used and defined. The Romanow Report measures equity in terms of people having fair access to the public health system, not in terms of fair access to resources in society.

Gilson (1989) points out that to reclaim equity as a goal, health care policy reform needs to be based on the general agreement that differences in health status are unnecessary, avoidable and unfair, and then needs to find wide-ranging policy solutions to address these inequalities. When health care reform becomes focused on systemic efficiencies and cost-effective health

strategies, the impact is a depoliticized debate about health and health care reforms, where too often "equity as a broad social goal is, thus, forgotten" (Gilson, 1989, p.324). The result is then, that without attention to the broader structural determinants of health and basic issues of social equity, primary health care "is not particularly problematic or challenging" (Macdonald, 1993, p.14). With only partial implementation, the WHO version of equity-based primary health care becomes equated "with primary medical care or simple curative services with the addition, perhaps, of a prevention programme represented by an immunization service or a water sanitation programme" (Macdonald, 1993, p.14). This is what is seen in the Romanow Report and the overall impact is that its primary health care reform recommendations fail to adequately support equity and fairness, as a result. As Donner and Pederson (2004) note, there are much broader possibilities in future directions for primary health care reform:

> One can imagine how different the solutions and priorities would be if the problem had been framed as one of health inequities (including for example, inequalities based on sex, socio-economic status, migration experience, Aboriginal status and disability), with an improved primary health care system as part of the solution. (Donner & Pederson, 2004, p.7)

**Closing**

Although this chapter has explored the potential connections between primary health care reform and broader social/political/economic events, this analysis may not be as clear as it could have been, had I chosen to review another health care reform document that included more directly obvious neo-liberal references towards market-based mechanisms and individualized solutions in health care (see Alberta 2001; Canada, 2002b; Ontario, 2000). Nonetheless, the Romanow Report was chosen for analysis early during the research phase of this thesis due to its greater public and policy popularity. But as a result of this early (and somewhat un-meditated) choice, it has been difficult at times to show the links between the Romanow Report and some of

the more explicit neo-liberal trends of globalization. Most notably, these links have been difficult to find because in many ways, the Romanow Report is diligent in its attempts to reinforce and support the principles of Canada's cherished public health care system.

From a critical perspective however, it is important to question a document that has had such a considerable influence in health care policy reform conversations in Canada. The Romanow Report is also a policy document of considerable influence and primary health care reform is presented as a key element in broader reform recommendations. Because social workers are often cited as potential team members in interdisciplinary primary health care models, it has also been informative to asses these recommendations according to the goals of social work, including a specific focus on equity. In the places where the Report and global economic trends do overlap, this analysis has provided a good example of how international ideological trends can influence a set of policy recommendations that in principle, aim to support the public health care system. And in places where the Report and global economic trends diverge, it has helped develop questioning reflexes to consider the Report's recommendations from a critical perspective, and to ask "Where are these changes likely to lead?" and "Who is likely to benefit as a result?"

## Chapter 7: Reflections and Conclusion

In Canada, the birth of medicare was rooted in a national post-WWII commitment to social-democratic principles and the building of the Keynesian welfare state. At this time, economic, political and social factors converged to support the creation of programs which could buffer the hardships of free market forces. The resultant mixed society contained commercial systems alongside a public sector, which was intended to limit marketability of some services and guarantee social supports that the free market could not provide (McMurty, 1997). Because illness occurs randomly, the "most just" society was understood to be one where basic access to medical services was uncoupled from cost. Chapter Two reviewed the development of medicare in Canada, which emerged over the course of twenty years following the end of the Second World War, to provide publicly insured hospital and physician services to Canadians regardless of ability to pay.

But medicare does more than simply provide basic medical services; it also helps to make all Canadians *equal*. Public health care systems support the progressive redistribution of resources by providing the most benefits to the least advantaged members of society. As such, medicare serves to moderate the inherent inequalities and risks of capitalism, and enhances the ability of all people to actively participate in democratic society[36]. In Canada, the presence of a publicly insured health care system and basic citizenship are therefore intimately intertwined:

> The right to health and to care is enshrined in Canadian law and in the covenants of the United Nations. It is a vitally important part of citizenship. It exemplifies the fact that we are all *equal*: each an every one of us has the right to be looked after, regardless of race, creed, or *ability to pay*. But it also helps *make* us equal; because everyone receives care when needed, we are all healthier, and therefore better off for it. (Browne, 2000, p.9)

To put it plainly, democratic systems are more effective when everyone has equal access to health services.

As this thesis has illustrated, however, by the 1970s political, economic and social commitments to Keynesian-style market moderations had waned. General support for Canada's public health care system also shifted. Chapter Five outlined the ways in which global capitalism has re-shaped the policy environment such that the language and recommendations of health care reform are increasingly re-cast to align with private sector ideologies, interventions, and goals. Chapter Six outlined a critique of one portion of the Romanow Report and noted the ways that market-oriented ideologies have also shaped primary health care reform. Although the public health care system still enjoys considerable public support, this thesis found that international neo-liberal influences have reshaped the nature of policy recommendations from *within* the public sector.

The problem with the application of market-based approaches to public health care systems is that they are inconsistent with the redistributive aims of medicare. Privatization and private sector solutions in health care are more likely to lead to inequity, in terms of greater health and social disparities between social groups. This occurs because market solutions re-couple the link between health and ability to pay. And as access to health becomes more dependent on access to resources, democracy is threatened:

> Privatization shrinks that space in which citizens are protected from the impact of the market by transforming goods such as health care into commodities. Privatization thus threatens social rights, and with them democracy. Where the social welfare state de-commodifies basic goods such as health care and education, privatization re-commodifies them. (Browne, 2000, p.13)

Although medicare has historically weathered struggles between its advocates and critics, Fuller (1998) notes that "today, the stakes in the ongoing tug-of-war between a public, non-profit health care system and a private, for profit one are higher than they've ever been" (p.5). The situation is complicated by a growing non-critical acceptance of market solutions, ignorance

regarding critical failures with health markets, and a lack of analysis regarding pro-market vested interests (Kenny, 2002). Leys (2001) points with caution to the potential outcome of a blind acceptance of market principles in health care.

> Failing a serious turnaround in public thinking, however, the project to re-establish a "market society", including the further commodification of health care, will continue. In that case, we will eventually have forgotten what health care was and have become used to the idea that health treatments are commodities like car repairs among which we must choose and for which we are individually responsible. (Leys, 2001, p.84)

In approaching health care reforms from a critical stance, this thesis is a beginning step in a search for credible and equitable alternatives which move beyond ideas of market-based health care. It is a first step because, as Bryant, Raphael and Rioux (2006) note, "it is essential that the policy process – especially the policy change process – be understood" before alternatives can be recommended (p.379).

And so, in essence, this thesis has been completed in pursuit of *understanding*. In some ways, understanding has been achieved in terms of simply completing the work associated with this master's thesis. More importantly however, this understanding has been achieved through a greater appreciation of the extenuating factors which incite and propel health care reforms in Canada. Health studies certainly do represent a complex field and are linked to a wide range of phenomena, as Bryant, Raphael and Rioux (2006) suggest. In particular, these phenomena are summed up by the term globalization. But understanding globalization has not been simple. Rather, it was a task I found to be overwhelming, frustrating and discouraging at times. I was surprised by the degree of determination needed to simply begin to *comprehend* these issues in the first place. However, spurred by the belief that social workers need to understand economic theories and realities in order to participate actively in transformative change, I persisted (Prigoff,

2000; Teeple, 2000). The following passage by Langmore (2001) was a strong motivator in this search for links between globalization and health care reform:

> We cannot simple passively accept the assertion that social destruction is an automatic result of economic policy, nor that particular patterns of policy are necessary. Effective social analysis and prescription requires a rigorous understanding of economic constraints and the imaginative capacity to formulate feasible alternatives. This certainly does not mean acquiescence to the constraints perceived by some economic policy makers. Rather, it involves knowing enough to be able to argue for credible alternatives. (Langmore, 2001, pp.17-18)

When comparing my pre-thesis understanding of Canadian health care reform to my current understanding, I realize some degree of "knowing enough" has been achieved. Whereas, I once believed that policy making could be straightforward and logical, I now understand it as Stone (2002) does, defined through the intermingling of social, political and economic structures. I can see the ways that health reform recommendations are shaped by social expectations, shared impressions of common-sense solutions, powerful economic incentives, and the quirks of human nature. I can also recognize a shift by my newfound understanding that health reform is hardly an objective activity pursued to achieve the "best society" for all Canadians. I see how it too, is influenced by politics, economics and history. In an age of global capitalism, many health care reform recommendations are diametrically opposed to Rawls' (1971) references to a "best society", as neo-liberal influences pressure reform toward individualized, medicalized and market-based outcomes.

And I can recognize a final shift in my insight into the language and arguments used in public policy making. In some areas of reform, I have been able to recognize how references to health determinants are used to justify restrictions to the public health care system. Although a cursory read of materials "as they are presented" may have once suggested to me that progressive change was occurring, a critical read now reveals that the opposite is in fact true. This

understanding has instilled in me the need to ask critical questions of health care reforms and policy processes in general.

Despite these understandings, however, it would be inappropriate to suggest that my insight into the factors influencing health care reform is complete. In fact, I actually find myself surprised at how little I have been able to cover in a part-time commitment to research and analysis during the past few years. Health care reform is surprisingly multi-layered and complex, especially when critical and international factors are drawn in to the analysis. It is not hard to understand how busy social workers, facing the multiple demands of work and the need for immediate solutions, may find it too burdensome to take the time to critically consider globalization and its influence on health care reform. Despite the luxury of time and study, this thesis represents a beginning understanding, one which can only been deepened through further research and critical analysis.

## Moving Towards Equity

Although this thesis has not been primarily focused on the search for health care reform alternatives, this chapter will close by considering potential directions for health care reform and research. Paired with a "commitment to emancipatory forms of analysis and action" critical social work is characterized in theory and in action by a commitment to redistributive social change (Fook, 2002, p.5). As such, these directions are those that are most likely to support equity.

For one, there is a need for health care reforms to adopt a *broader focus*. This thesis has illustrated the ways in which government focus and policy making in health care is primarily focused on the health care system. This focus influences the way that health care problems are defined and solutions are found.

> Despite the variety of conceptual paradigms and emerging finding available for considering these issues, most of the research and professional health care preoccupations remain strangely narrow, focused on the biology of disease, individual risk factors for these afflictions, and identifying and evaluating the efficacy of medical treatments. Not surprisingly, then, public understandings of key health issues – such as the causes of diseases and the organization of the health care system – are also narrowly focused on access to health care professionals, length of wait for treatment by specialists, and adopting lifestyle approaches to prevent disease. (Bryant, Raphael & Rioux, 2006, p.373)

Gilson (1998) notes a careful identification and analysis of the determinants of health must be included in health policy initiatives if equity is to be achieved as a policy goal. Health needs to be defined as more than the absence of illness and disease, to also include "the capacity to realize aspirations and access opportunities for human fulfillment" (Bryant, Raphael & Rioux, 2006, p.374). Armstrong and Armstrong (2006) also suggest that by applying the determinants of health to health services provision, alternative care models – that move beyond the dominant medical model – may become a reality.

And while policy action to promote equity in health care *services* distribution is important, this alone is not sufficient to create systemic equity. Ill-health is caused by multi-faceted and complex factors, and it is necessary that equally-complex and wide-ranging policy packages are developed to address health inequalities (Bryant, 2006). Policy action therefore needs to be broader than the health care system itself. It requires attention to public policies that ensure income security, employment security, housing security, and food security, among others (Bryant, Raphael & Rioux, 2006). It also needs to consider decision-making procedures that include broader representation (Gilson, 1998). Another important direction in health care reform is that the provision of health services needs to remain *uncoupled from the ability to pay*. This thesis has illustrated the ways that neo-liberalism, in its trend towards greater commodification of all resources, has profoundly negative influences on health and health care (Coburn, 2006). To ensure that equity is part of future health care reforms, health services need to be provided as a

right of citizenship, not as a market good. These alternatives are most achievable in social-democratic nations that have well-developed public services which break the link between receiving a benefit and having to pay for it.

> Social democratic welfare regimes...are more likely to create the conditions necessary for health than is the case for other welfare regimes...These include equitable distribution of wealth and progressive tax policies that create a large middle class; strong programs that support children, families and women; and economies that support full employment. They do so through more generous programs and services to their citizens in the form of universal entitlements. (Bryant, Raphael & Rioux, 2006, p.380)

Raphael (2002) notes that health workers also need to consider poverty as a public health issue, if equity is to be realized in health care reform. Despite clear evidence that poverty is linked to health problems, the emphasis in Canada remains one of viewing poverty as an individual issue, rather than one that needs to be addressed at the public policy level. And while there is government recognition that poverty is a determinant of health (Health Canada, 1998), discussions in health care reform tend to exclude mention of the role that government policies play in creating poverty and influencing health (Raphael, 2002). One exception noted by Raphael (2002) is the City of Montreal's 1997 report on social inequities and health where the links are clearly identified and actions for change are recommended (Lessard, 1997). In particular, the report notes:

> For anyone interested in public health, social inequities in health must be a major concern. But we know that the solution is not to invest more in the health system or in new technologies. These inequities must rather be met head-on; and well-targeted actions must be undertaken to ensure that they will not become worse. (Lessard, 1997, p.20)

Yalnizyan (2000) notes that there are a number of ways to address the impacts of income inequality, should the political will exist to make such changes. In particular, Yalnizyan (2000) notes the need to close a number of "gaps" that support income inequality, including employment-based disparities, ideological distance from the ideas of social redistribution, lack of

low-income supports, the diminishment of universal common goods (including housing and health care), and provisions that allow for the unequal accumulation of wealth.

One of the first steps in achieving this goal may require a recognition that governments are not powerless to respond to events occurring on an international level (Steinmo, 2002). Although globalization has placed considerable pressure on the autonomy of regional governments, Langmore (2001) stresses that governments still have the ability to access a range of policy alternatives[37] and to provide quality services for their citizens. McBride (2001) emphasizes that nation states, as the initial architects of neo-liberal reforms at the national level, can and should pursue more socially-balanced change, including prioritization of democratic decision-making, recognition of economic pluralism, capital regulation, and emphasis on equality in international economic agreements. Some authors have also suggested that a system of international governance in needed to correct the current inequities and health inequalities of economic globalization (Frankman, 1997; McMurty, 1997; O'Keefe, 2000; Teeple, 2000). In considering these alternatives, it is helpful to recall that political will can, and has been historically, more influential than once-binding arrangements. Historically, public policy in support of health has frequently been the result of social movements that arise from expressed needs of the population (Bryant, Raphael & Rioux, 2006).

In a review of the links between socioeconomic status and health, Mustard et al. (1995) note that it is important to not confuse the task of developing health targets (in terms of health promotion and illness prevention) and reforming health care services (which are intended for the treatment of disease). Arguing instead that the two are one in the same, I can concede that it still is important to consider changes that can occur from *within* the health care system, and to recognize these changes as somewhat distinct from broader systemic changes to address equity.

They are distinct in the sense that internal health care reforms generally refer to the ability of people to *access* relevant and needed health care services, measuring equity in terms how easy it is for all people to get the services they need, when they need them.

Whitehead (1992) notes that equity in health care (as distinct from equity in health) can be addressed by ensuring three basic standards in health care service delivery: 1) equal access to available care for equal need; 2) equal utilization for equal need; and 3) equal quality care for all. The first – equal access for equal need – implies that entitlement to health care services be universal, and that there is a fair distribution of these services throughout a country, based on the health care needs and accessibility of each area (Whitehead, 1992). In addressing such concerns, for example, the Romanow Report noted that depending on where a person lives, there are real inequities in the way that Canadians benefit from the public health system – particularly, "serious disparities between people who live in the northern part of Canada versus the south and between people who live in Atlantic Canada and the rest of the country" (Canada, 2002a). Reforms which resolve these types of geographic disparities can be one important part of improving equity from within the health care system, to ensure that health status is not disproportionately disadvantaged by regional location.

Whitehead's (1992) second requirement for equitable health care reform – equal use for equal need – draws attention to situations where the use of health care services may be restricted by social or economic disadvantage. In particular, this may require that an even greater share of health care services be directed to those in lower socio-economic groups, to ensure that access relative to need is possible (Mustard et al., 1995). The promotion of healthy lifestyles and preventative health measures should also be done with recognition of income, noting that some groups in society face greater restrictions than others in their lifestyle choices.

In addition to fairness in access and fairness in utilization, Whitehead (1992) also notes that a third requirement in health care be met – equal quality care for all. This requirement pinpoints the need to ensure that every person has an equal opportunity to be selected for health care attention, and that this selection process is based need as opposed to wealth or social influence (Whitehead, 1992). Equal quality care also implies that health care providers will put the same commitment into all services they provide, regardless of the socio-economic status, gender, or cultural background of the patients they encounter.

Another part of the way that equity can be realized in health care delivery is through a genuine commitment to decentralizing power and decision-making, to encourage people to participate in every stage of the policy-making process (Whitehead, 1992). It is clear that action to improve health is most effective when the participation and understandings of citizens are incorporated into health care reform (Williamas & Popay, 1997). Primary health care reforms in particular have the potential to offer care responsive to communities' and providers' needs in ways that recognize what determines health and care, especially in relation to disadvantaged and vulnerable groups (Armstrong & Armstrong, 2001). For example, in a review of women, income and health in Manitoba, Donner (2000) notes that Manitoba health care service providers can increase their ability to address the needs of low-income women by working collaboratively with them "to find the most appropriate ways to have their voices heard in the broader public policy arena, and to recommend positive changes to existing services" (p.57). As such, collaborative plans and action for health care reform are more likely to be based on what communities identify as their own needs, as opposed to solutions imposed from the outside.

In the search for equitable reforms in health, it must also be recognized that health researchers and advocates have much to offer by *identifying health issues* for public discussion

and appropriate policy responses (Bryant, Raphael & Rioux, 2006; Gilson, 1998). Social constructionist approaches to policy interpretation emphasize that language both shapes and is shaped by societal practices (Fairclough, 1992; Hastings, 1998; Lemke, 1995). Although it is difficult for talk alone to change an entrenched system of power, economic and political influence, critical research can play a role in disrupting common and unquestioned assumptions of how society is and should be (Bourgeault, 2006). As neo-liberal influences in Canada are contested by increasingly sophisticated, trade-knowledgeable and internationally-focused non-governmental organizations, there a likelihood that these voices will help disrupt public acquiescence to market-based health reform by outlining alternative paradigms. Social work research can play a role in ensuring that issues of equity and social justice are included in these analyses (Oliver, 2003). At the very least, it can act as an "alert" - to document and draw attention to where equity is being overlooked. Although words alone may seem limited in the face of globalization and its cadre of supporters, there is hope that perhaps "the power of ideas can transform the ideas of power" (Gilson, 1998, p.1895) to the extent that health equity may one day be more clearly included as a key objective in Canadian health care reform.

## Endnotes

[1] Wellesley Hospital opened in 1912.

[2] The mainly English-speaking region of Canada north of the Great Lakes and west of the Ottawa River; Upper Canada was a colony of Britain from 1791 to 1841.

[3] Since health care is designated as an area of provincial jurisdiction, provinces are responsible for the make-up and administration of their own health insurance plans (Library of Parliament, 2001). The only nationalizing policy options available to the federal government therefore, are to implement budgetary mechanisms (whereby funding is linked to certain program requirements), or in some cases, to attempt to influence public opinion and political pressure in a certain direction (Dickinson & Bolaria, 2002). Among other forces and influences, these jurisdictional parameters have both hindered and characteristically shaped the development of medicare.

[4] These criteria served as national standards in the development of hospital insurance delivery and included: a uniform minimal package of covered services; universal coverage; portability of eligibility from province to province; public accountability; and no charge to users (McGilly, 1998).

[5] Most significantly, EPF provided federal transfers in the form of block grants: sums independent of actual provincial expenditures (McGilly, 1998). Provincial health expenditures above the rate of growth of the gross national product were also exempt from cost-sharing (Bavis & Skogstad, 2002).

[6] The Canada Assistance Plan was a program through which the federal government supported public assistance on the basis of expenditures.

[7] Health care premiums were first introduced in Alberta in 1969; residents of Alberta pay set-rate monthly premiums which in 2001 amounted to $34 per month for individuals and $68 per month for families (Alberta, 2001).

[8] The Mazankowski report recommends a modified medical savings account whereby a set amount of health care dollars are allocated to individuals on an annual basis, which are then used to "pay" for insured health care services during the year. Once all the funds in a medical savings account are depleted, then individuals would be required to pay a "premium supplement" which is basically an additional monthly health premium as a percentage of their income (Alberta, 2001, p.59).

[9] Since the World Health Organization's International Conference on Primary Health Care in 1978, there has been an interest in primary health care methods and approaches. During the 1970s, several Canadian alternatives to conventional solo physician practice emerged in Quebec (Centres locaux de services communautaires (CLSCs)) and Ontario (Health Service Organizations (HSOs) and Community Health Centres (CHCs)); and in the mid-1980s, a number of provinces undertook policy initiatives to support an expanding role for non-physician primary care providers (Hutchinson, Abelson & Lavis, 2001). By the mid-1990s, all Canadian provinces had undertaken primary care pilot and demonstration projects, pursuing a range of innovations in organization/governance, funding/remuneration and delivery arrangements. Between 1997 and 2001, the $800 million federally-funded Health Transition Fund supported numerous projects across Canada to test and evaluate innovative ways to deliver health care services, including primary health care models (Marriot & Mable, 2002).

[10] Ferdinand de Saussure (1857-1913), known as the father of modern linguistics; his focus on language as an "underlying system" inspired later structuralist approaches to interpreting language use (Crystal, 1998, p.830).

[11] Michel Foucault (1926-1984), a French philosopher who sought consistently to test cultural assumptions in given historical contexts (Crystal, 1989).

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[12] A normative concept refers to some parameter which defines or establishes a norm, or a customary behavior. Therefore, equity is highly dependent on the "norms" of the context, and in this subjective state, it can be difficult to define concretely.

[13] In the first three weeks of July 1944, delegates from 45 nations gathered at the United Nations Monetary and Financial Conference in Bretton Woods, New Hampshire. The delegates met to discuss the postwar recovery of Europe as well as a number of monetary issues, such as unstable exchange rates and protectionist trade policies. The delegates at Bretton Woods reached an agreement known as the Bretton Woods Agreement to establish a postwar international monetary system of convertible currencies, fixed exchange rates and free trade.

[14] Variations on the them of the Keynesian welfare state emerged in advanced capitalist countries in North America, Western Europe, Australia and New Zealand (Mulvale, 2001, p.12).

[15] The US decided to end convertibility in 1971, and the US, in 1974, and Britain, in 1979, decided to abolish capital controls.

[16] Adam Smith (1723-1790), a Scottish economist and philosopher, who became famous for his influential book, "The Wealth of Nations", published in 1776. His book and ideas launched the economic doctrine of free enterprise, and contained the argument that self-interest and unbridled market forces guide the most efficient use of resources in a nation's economy.

[17] Jeremy Bentham (1748-1842)

[18] Perhaps not surprisingly, albeit ironically, interventions "in specific situations such as in loan guarantees, strategic incentives, or deferred taxation for business interests" are wholeheartedly supported by neo-liberalism's advocates (Rice & Prince, 2000, p.137).

[19] Milton Friedman, professor of economics at the University of Chicago, emerged in the 1970s as a principle spokesman for the interests of business people, and played a considerable role in supporting pro-business ideologies.

[20] The reduction in these liberties is marked by increasing reliance on coercive forms of social control including police intervention, military efforts and imprisonment (Teeple, 2000).

[21] These projects included: 1) the decision to turn contract out part of the province's home care workforce to the Olsten Health Services Corporation, as US-based multinational; 2) the plan to privatize hospital food services; and 3) the implementation of a SmartHealth program to computerize health-care information. All three of these projects were soon reversed based on the failures of these private incursions and public outcry (Scarth, 2000).

[22] Health Protection Branch is the arm of Health Canada in charge of drug monitoring and approvals.

[23] These include: Pfizer, GlaxoSmithKline, Merck, AstraZeneca, Aventis, Johnson & Johnson, Novartis, Bristol-Meyers-Squibb, Pharmacia and Wyeth.

[24] For example, Alberta introduced provincial legislation (Bill 11) in September 2000 that allows for-profit hospitals to provide surgical services under the provincial health plan; under the exact text of many trade treaties, this legislation provides a potential opportunity for American health services providers to challenge medicare's public insurance monopoly as an unfair trade advantage. Further, there is concern that once private health-care corporations of this sort are allowed to establish themselves in Canada, agreements like NAFTA would prevent the "discrimination" of additional (i.e. American) competitors, and then, with the market effectively opened up, the Canadian government would be prohibited from re-introducing public health services on the basis of non-competitiveness (Williams et al., 2001).

[25] The prevailing view among Canadians is that publicly-funded health care services are valuable and preferred over for-profit alternatives (Barlow, 2002; Canada, 2002a). Physicians and employers also benefit from a public health care system. Physicians gain considerably from a public health system that "solidifies medical dominance by covering doctor's services to the exclusion of services rendered by other health care providers"; physicians also enjoy relative autonomy under Canadian medicare and earn

guaranteed incomes that average between three and five times that of other working Canadians (Fuller, 1998; Williams et al., 2001. p.8). Hospitals also benefit from public health care; the predominance of hospitals within health services and persistent public demands for greater capacity are related to medicare's prioritization of institutionally-based medical services (Williams et al., 2001). Unionized industry employers in Canada are another group that support medicare for the competitive advantage it provides; public health insurance allows these Canadian industries to avoid the high private insurance costs paid by their US counterparts (Williams et al., 2001).

[26] The Canada Health Act (1984) also defines two types of services, insured and extended. Insured or "medically necessary" health services include hospital, physician and surgical-dental services that provided to eligible residents of a province or territory; extended health care services include some long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services (Library of Parliament, 2001). The distinction is that medically necessary health services are fully insured by provincial health insurance plans and must meet CHA criteria, whereas extended health care services do not. Extended health care services operate outside of medicare, and do not need to meet the same rigorous criteria in terms of public administration, comprehensiveness, universality, portability and accessibility (Library of Parliament 2001).

In the early history of medicare, this distinction did not create discrepancies in provincial health care plans, since most health services were provided by the hospital and physician. However, this focus has since changed.

[27] Some private laboratories, clinics and ambulances have also been permitted, although they have to be regulated and licensed to qualify for public funding (CCPA, 2000a).

[28] The knowledge base of modern medicine is founded on the work of prominent bacteriologists and the germ theory of disease; this conception rests on the idea of specific etiology, whereby each disease is assumed to have a specific cause, which when analyzed, can be located and treated at the cellular level (Bolaria, 2002). Historically, the germ theory helped to prevent the spread of infectious diseases and improved medical practice in general (Clarke, 2000).

[29] Another mechanism of change was the recommended National Summit on Primary Health Care, to "mobilize concerted action across the country" (Canada, 2002a, p.125).

[30] The Report commits an additional chapter exclusively to information recommendations, Chapter Three is titled, "Information, Evidence and Ideas".

[31] There are some exceptions, however. There has been criticism of the Report's reference to ancillary services, such as laundry, food preparation, cleaning and maintenance, as appropriate for delivery in the private, for-profit sector (CLC, 2002). Armstrong et al. (2003) point out that for-profit delivery of ancillary services is linked to increased rates of infection within institutions which put both providers and patients at risk. Further information can be found at: Andrew E. Simor et al. (10 July 2001). The evolution of methicillin-resistant staphylococcus arueus in Canadian hospitals: 5 years of national surveillance. *Canadian Medical Association Journal, 165*(1), 21-31.

[32] Hunkeler et al. (2000) found that nurse telephone follow-up care for patients improved clinical outcomes of antidepressant drug treatment after 6 months.

[33] Steven Harper's new government is closely focused on "five priorities" which include: 1) accountability (including transparency on spending), 2) lower taxes, 3) crime prevention, 4) child care (in the form of individual payments to mothers) and 5) health care guarantees.

[34] In some cases, primary health care refers to the point of first contact between a patient and a health care professional (usually a doctor), where the "traditional medical model of response to illness" is the focus of service provision (Mable & Marriott, 2002, p.1; Shah; 2003). Generally, a shorter version of the term, "primary care" is used to distinguish this purely patient-doctor interaction. Primary health care, on the other hand, has come to represent more than a basic medicalized response, also recognizing "the broader determinants of health and… coordinating, integrating, and expanding systems and services to provide more population health, sickness prevention, and health promotion, not necessarily just by

doctors" (Mable & Marriott, 2002, p.i). In the Romanow Report, where primary health care reform is expected to transform the health care system and provide a new focus on illness prevention and health promotion, this broadened definition of primary health care appears to be in use.

[35] This definition is generally quite consistent with how primary health care is commonly defined in Canadian health policy. Health Canada, for example, also uses the terminology of "first contact", and defines primary health care as "the first point of contact for Canadians with the health system, often through a family physician" (Health Canada, 2001). The Fyke Report defines primary health services as "the first point of contact", and additionally draws attention to the community-based aspects this kind of health care, further describing primary health care as "the basis to address the main health needs of individuals and communities" (Saskatchewan, 2001). The Canadian Health Services Research Foundation refers to primary health care as "a set of universally accessible first-level services", and in addition points to its preventative and supportive potentials, describing these services as those "that promote health, prevent disease, and provide diagnostic, curative, rehabilitative, supportive, and palliative services" (Lamarche, 2003, p.2).

[36] Good health makes democracy possible since it enhances the ability of all citizens to form opinions, to share views, and to participate in public life (Browne, 2000).

[37] Given that "government choice" has been the "principle influence on the pace and direction of international integration" (Langmore, 2001, p.14), then potentially, alternative choices are still within the range of consideration. Langmore (2001) notes the potential revenue benefits of economic globalization, including opportunities for greater economic growth and revenue, which could potentially be used to increase the extent and quality of government services (Langmore, 2001).

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## Appendix I: Federal and Provincial Reports Summarized

**Provincial Reports**

- *Caring for Medicare: Sustaining a Quality System*, by the Commission on Medicare, Province of Saskatchewan, 2000-2001. (Commissioner, Kenneth Fyke)

This one-member Commission was appointed by the Premier of Saskatchewan in June 2000 to identify key challenges facing the province in reforming and improving medicare; to recommend an action plan for the delivery of health services; and to make recommendations to ensure the long-term stewardship of a publicly funded, publicly administered Medicare system. Commissioner Kenneth Fyke completed his final report in April 2000.

The Fyke Report highlighted the cost-saving efficiencies of a team-based approach to health care service delivery and recommended maintenance of taxation-based financing, implying that Saskatchewan's 40% commitment of provincial dollars to health care reflected sufficient and sustainable levels of funding (Canadian Health Services Research Foundation, 2002; Saskatchewan, 2001). The report also emphasized the need for quality improvements by increased reliance on research and the development of provincial quality control standards.

- *A Framework for Reform*, by the Premier's Advisory Council on Health, Province of Alberta, 2000-2001. (Commissioner, Hon. Don Mazankowski)

This twelve-member Council was established by the Premier in January 2000 to analyze the challenges facing Alberta's health system. Chaired by the Honourable Don Mazankowski, the Council completed its report in December 2001.

The Mazankowski Report concluded that Alberta's health system required fundamental change, and suggested a range of modifications to ensure its sustainability (Alberta, 2002; CHSRF, 2002). The Report emphasized the need for organizational change, including new

models of comprehensive primary care. To ensure financial sustainability, the Report recommended variable premiums and medical savings accounts to increase direct payment by individual users. Quality improvements were also recommended, including better information to guide decision-making, more standards and goal-setting for care providers, and more investment in research and information technology.

- *Les solutions émergentes*, by the Commission d'étude sur les services de santé et les services sociaux, Province of Quebec, 2000. (Commissioner, Michel Clair)

This nine-member commission was established in June 2000 by the Minister for Health and Social Services to hold a public discussion on the issues facing the health and social service system in Quebec and to propose solutions for the future. Health and social services are under the jurisdiction of one government department in Quebec, and as a result, the scope of the final report includes child and family services as well as health care (Fooks and Lewis, 2002). Chaired by Michel Clair, the Commission completed its final report in December 2000.

The Clair Report was lukewarm to negative on whether public funding would be able to accommodate services expectations in health care, especially in the area of long term care (CHSRF, 2002; Quebec, 2000). The Commission advocated continuing reliance on public dollars, but due to pessimism about long-term care funding, it also advocated shared public and private long-term care insurance. The report called for managerial and organizational reforms, suggesting that services should be remodeled into Family Medicine Groups with quality of care as the major goal, and with an enhanced emphasis on disease prevention and health promotion.

- *Health Renewal*, by the Premier's Health Quality Council, Province of New Brunswick, 2000-2002. (Chair, Michel Leger)

This 14-member Council was established in January 2000 by the Premier to develop an action plan to move to a system of regional health authorities; to oversee the implementation of a health care report card and other quality reporting measures; and to assist in the development a Patient Charter of Rights and Responsibilities. Chaired by Michel Leger, the Council completed its report in January 2002.

The Council recommended that a holistic approach be adopted for the renewal of the entire health care system, in order to achieve a sustainable, community-based and person-focused system, capable of continuous response (New Brunswick, 2002). In order to achieve this, the Council advised a retraction from the "management by program approach", and a shift towards coordinated and integrated services and participatory change fueled by service providers and users of the system (NB, 2002, p.9). The Council targeted objectives in four areas: 1) an integrated and accessible health care system, 2) improvements to management structure and accountability, 3) greater commitment to rights and responsibilities (specifically for patients), and 4) program improvements (in the areas of short and long term care, pharmaceuticals, ambulance services, public health, mental health and rehabilitation care).

- *Looking Back, Looking Forward*, by the Ontario Health Services Restructuring Commission, Province of Ontario, 1996-2000.

This 12-member Commission was established in 1996 to make decisions about hospital restructuring; to provide advice to the Minister of Health about health services in need of reinvestment; and to make restructuring recommendations to improve the quality of care, outcomes and efficiency, and to create an integrated health services system. The Commission issued numerous directives and reports throughout its four year mandate and completed a final summary report in March 2000 (Ontario, 2000). Recognizing the "changing hospital landscape",

the Commission recommended the amalgamation and closure of hospitals, the creation of hospital networks, the more-efficient use of hospital resources, and a more appropriate balance between hospital and community based care (Ontario, 2000, p.6). Recommendations regarding this rebalancing between hospitals and communities included a need to reinvest resources in home care and long-term care. Although primarily focused on restructuring Ontario's hospital sector, the Commission also dealt with other health care sectors as important components of population-based health care system (Fooks & Lewis, 2002). As to the long-term vision of the health care sector in Ontario, the Commission made recommendations regarding the need for an overall integrated health services system including primary care reform as "the connector to the rest of the system" and improved information management and accountability measures (Ontario, 2000, p.7).

**National Reports:**

- *Canada Health Action: Building on the Legacy: Final Report of the National Forum on Health*, by the National Forum on Health, Government of Canada, 1994-1997.

This twenty-four member forum was established by the Prime Minister in 1994 to involve and inform Canadians and to advise the federal government on innovative ways to improve the health system and the health of Canada's people. The final report was completed in 1997.

The National Forum Report concluded that the Canadian health care system, while sustainable, required "intelligent" reform and the more effective and efficient use of resources to ensure its long-term survival (Health Canada, 1997, p.1). The Report highlighted the need for investments in improving the health of children, collaborative work between governments, and the infusion of new federal funds to aid health care reform. In order to adapt to new realities, the

Report recommended that publicly funded services be expanded to include all medically necessary services (home care and drugs were specifically mentioned) and that primary care funding, organization and delivery be reformed. The need to support evidence-based innovations was also specifically mentioned.

- *The Health of Canadians – The Federal Role. Volume Six: Recommendations for Reform*, by the Standing Senate Committee on Social Affairs, Science and Technology, Government of Canada, 2001-2. (Chair, Sen. Michael Kirby)

This eleven-member Committee of the Senate of Canada was authorized in March 2001 to examine: the principles that underlie Canada's publicly funded health care system; the historical development of Canada's health care system; health care systems in foreign jurisdictions; the pressures and constraints facing Canada's health care system; and the role of the federal government in Canada's health care system. Chaired by Senator Michael Kirby, the Committee issued five volumes of interim reports and completed a final report in October 2002.

The Committee's final recommendations, as outlined in Volume Six, suggested a need for:

1. Restructuring of the hospital and doctor system to improve efficiency and effectiveness in providing timely and quality patient care;
2. Treatment guarantees with a specific maximum amount of wait time for major hospital and diagnostic procedures;
3. Expansion of public health care insurance to include coverage for catastrophic prescription drug costs, post-hospital home care costs, and palliative care;

4. A strengthening of the federal contribution and role in the area of health care infrastructure (including health care information systems, technology, evaluation, human resources, research, wellness promotion and illness prevention);
5. The need for additional federal revenue administered in a transparent and accountable manner; and
6. Recognition of the potential consequences of a lack of additional federal revenues in the health care system (Canada, 2002b).

- *Building on Values: The Future of Health Care in Canada*, by the Commission on the Future of Health in Canada, Government of Canada, 2001-2002. (Commissioner, Roy Romanow)

This one-member Royal Commission was established by the Prime Minister in April 2001 to inquire into and undertake dialogue with Canadians on the future of Canada's public health care system, and to make recommendations to enhance the system's quality and sustainability (Canada, 2002a). According to the Minutes of the Committee of the Privy Council, the Commission was expected to:

> … inquire into and undertake dialogue with Canadians on the future of Canada's public health care system, and to recommend policies and measures respectful of the jurisdictions and powers in Canada required to ensure over the long term the sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investments in prevention and health maintenance and those directed to care and treatment… (Canada, 2002a, p.xi)

Over 18 months the Commission analyzed existing reports and research on medicare, invited submissions from interested parties and individuals, organized expert roundtable sessions, conducted site visits (both nationally and internationally), commissioned independent experts, met with foremost health and health policy experts, Premiers, and health ministers, and engaged "tens of thousands" of Canadian citizens in consultations across the country (Canada, 2002a, p.xv). Chaired by Roy Romanow, the Commission issued an interim report in February 2002 and the final report was completed in November 2002 (Canada, 2002a; Canada, 2002c).

Confident that the medicare system contained the potential to meet the needs of Canadians, "now and in the future", the final report emphasized the need to "take the next bold step of transforming it into a truly national, more comprehensive, responsive and accountable health care system" (Canada, 2002a, p.xv). The Romanow Report emphasized that Canadians were "deeply attached to the core values at the heart of medicare", and that steps needed to be taken to transform Canadian medicare "into a truly national, more comprehensive, responsive and accountable health care system" (Canada, 2002a, p.xv). The final report included 47 key recommendations in ten critical areas including:

1. Health Care, Citizenship and Federalism;
2. Information, Evidence and Ideas;
3. Investing in Health Care Providers;
4. Primary Health Care and Prevention;
5. Improving Access, Ensuring Quality;
6. Rural and Remote Communities;
7. Home Care: The Next Essential Service;

8. Prescription Drugs;
9. A New Approach to Aboriginal Health; and
10. Health Care and Globalization.

Recommendations in these ten critical areas are based on the objective of strengthening the Canadian medicare system and the belief that this is possible to "renovate our concept of medicare and adapt it to today's realities" (Canada, 2002a, p.xvii). This renovation was based on dedicated leadership, system reform and stable funding (http://popups.ctv.ca).

In terms of leadership, the Report recommended that the federal commitment to universally-accessible, publicly-funded health care should be clearly articulated in the form of the Canada Health Covenant, and that a Health Council of Canada should be established by the provincial, territorial and federal governments to foster co-operation, measure performance and provide recommendations for health care reform. As well, the Report suggested that Canada should play a more active leadership role in international efforts to assist developing nations in strengthening health care.

In terms of system reform, the Report recommended amendments to the Canada Health Act to cover the cost of most home care services and prescription drugs, to clarify coverage for diagnostic services, to create a program to allow caregivers to spend time away from work to care for ailing family members, to set up a national immunization program, to enhance the role of primary health care services, to manage wait lists more effectively, to make all health records electronic, and to launch a national campaign to reduce smoking and encourage weight loss.

And in terms of stable funding, the Report recommended the creation of a Canada Health Transfer to allocate federal money to the provinces separate from regular education and welfare

transfer payments, and advocated for the pooling of resources for Aboriginal health in order to provide stable, predictable health-care funding for Aboriginal peoples in Canada.

## Appendix II: Primary Health Care Recommendations in the Romanow Report

The final Romanow Report made 47 recommendations in total; 6 of them apply specifically to primary health care reform. These are as follows:

***Fast-Tracking Primary Health Care Change***

Recommendation 19:

The proposed Primary Health Care Transfer should be used to "fast-track" primary health care implementation. Funding should be conditional on provinces and territories moving ahead with primary health care reflecting four essential building blocks – continuity of care, early detection and action, better information on needs and outcomes, and new and stronger incentives to achieve transformation.

***Building National Momentum, Attacking Obstacles and Reporting Progress***

Recommendation 20:

The Health Council of Canada should sponsor a National Summit on Primary Health Care within two years to mobilize concerted action across the country, assess early results, and identify actions that must be taken to remove obstacles to primary health care implementation.

Recommendation 21:

The Health Council of Canada should play a leadership role in following up on the outcomes of the Summit, measuring and tracking progress, sharing information and comparing Canada's results to leading countries around the world, and reporting to Canadians on the progress of implementing primary health care in Canada.

***Strengthening the Role of Prevention***

Recommendation 22:

Prevention of illness and injury, and promotion of good health should be strengthened with the initial objective of making Canada a world leader in reducing tobacco use and obesity.

Recommendation 23:

All governments should adopt and implement the strategy developed by the Federal, Provincial and Territorial Ministers Responsible for Sport, Recreation and Fitness to improved physical activity in Canada.

Recommendation 24:

A national immunization strategy should be developed to ensure that all children are immunized against serious illness and Canada is well prepared to address potential problems from new and emerging infectious diseases.