

**Healing a Crisis of Overaccumulation: How Canada's Public Health
Care System is Being Undermined through Accumulation by
Dispossession**

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No one aspect of federal or provincial policy has proven to be as widely and invariably supported by most Canadians as is the public health care system. Despite the much publicized woes with overcrowding, long waiting lists, and the sustained ideological attack on the ability of the public sector to be innovative and efficient, in poll after poll Canadians continue to affirm their desire to maintain universal access to health care coverage. For instance, while privatization is one option for fixing the problems with health care, as much as 69 percent of Canadians surveyed in 2002 said they would pay more to expand the public services available, and a slightly smaller majority said they would even pay more just to maintain the existing system.¹ These 2002 figures represent an echo across time, as support has scarcely dropped from its high of 80 percent in favour of the creation of a national health care plan back in 1951.² These numbers affirm that the system of public health care in Canada is highly important to most Canadians.

However, while Canadians may support the current system, which is essentially a tax payer funded public insurance and administration plan along with the historically private not-for-profit delivery of services, there are many ways to fulfill this ideal that rely to a greater or lesser extent on the corporate sector. While there are five principles of Medicare (universality, accessibility, portability, public administration and not-for-profit services, and the insurance of all 'medically necessary services'), there are many rival images of how this service can be

¹ CBC News, Canadians Willing to Pay More to Support Health Care, Poll Shows, Tuesday May 28, 2002. <http://www.cbc.ca/news/story/2002/05/27/health_survey020527.html>

² Colleen Fuller, Caring For Profit, Canadian Centre for Policy Alternatives: Ottawa, 1998, p. 39.

delivered. At one end of the spectrum health care would be a fully de-commodified public service (similar to the education system); and on the other side, public health care insurance would exist along side the private for-profit delivery of services in private clinics, the privatization of support services, and the use of public-private partnerships in the provision of new health care infrastructure. Yet while it is clear that the more that health care is turned into a commodity the further away from those five principles one gets, policy changes within the past two decades are pushing public health care in Canada towards privatization rather than maintaining or furthering de-commodification. This has serious implications for the meaningful provision of public health care, and is additionally problematic given the current international pressure to convert services into exchangeable goods through the NAFTA and GATS agreements.

While the internal erosion of the Canadian public health care system is a complex issue that can be studied in a number of ways, it is the position of this paper that the array of reforms that have been made to the Canadian health care system within the past two decades are best explained when situated within the context of larger shifts in the social structure of accumulation³ in Canada. When considered within the debt/deficit hysteria of the mid-1980s through to the latter years of the 1990s, severe cuts in government expenditures along with a sustained ideological attack on the role of the state in the economy have led to a severe hollowing out of many social programs, the privatization and commercialization of public goods, the initiation of regressive taxation, and the introduction of free trade in areas hitherto protected since the time of the National Policy. While these shifts in Canadian policy may seem drastic,

³ A social structure of accumulation is a set of mutually reinforcing social, economic, and political institutions and cultural and ideological norms that fuse with and facilitate a successful pattern of capital accumulation over specific historic periods. Taken from William I. Robinson, A Theory of Global Capitalism, The John Hopkins University Press: Baltimore, 2004, p. 74.

this country is not alone in its reforms, and when considered in conjunction with the crisis of global capital accumulation that occurred in the 1970s, these policy shifts represent an effort to carve out new areas for profitable investment. Thus, while the focus of this paper is the Canadian health care system, an understanding of privatization, commercialization, and the undermining of the universal provision of public goods should consider how these policies are manifestations of a process of neoliberal restructuring.

This argument will be illustrated in a series of steps. First, a theoretical discussion of how crises are endemic to capitalism and how the state is crucial in the restructuring process will be provided. Next, the paper will discuss the creation of public health care in Canada with an elaboration of how, despite overwhelming support for decades, the Canadian public had to wait until the postwar era for the implementation of public health care during a more accommodating regime of accumulation. Following this, the paper will examine how the principles of the Canadian public health care system, while still relatively new, were soon undermined in the late 1970s through to the end of the 1990s when neoliberal restructuring was taking place, first with underfunding and then with creeping privatization through public-private partnerships and the privatization of support services. Finally, the paper will comment on the currently existing health care system within the context of what is now neoliberal orthodoxy, and how provincial experimentation with forms of privatization threatens the entire public health care system given the strength of the NAFTA and GATS regulations.

Crises in Capitalism and State Involvement in the Structuring of a New Accumulation

Regime

What Canadians have come to understand to be their public health care system is the outcome of many years of negotiation, compromise, and decisive action on the part of the federal government, all of which are ultimately a reflection of how the wider social structure of accumulation within a country constrains and facilitates public policy. As a result, the health care system in Canada has always been something of a work in progress, with few moments of stasis within its relatively short existence. Given this constantly evolving set of policy arrangements between the federal and provincial governments, we may nonetheless distinguish two significant periods within the twentieth century which have contributed to not only the constitution of the current health care system within Canada, but also a whole host of other social programs and areas of public intervention within the domestic economy.

These two eras, roughly 1929-1945 and 1970-1984, correspond to moments of crisis within global capitalism which have played decisive roles in the construction of new modes of accumulation, and therefore of new social structures for public policy. As we will see, the replacement of one social structure of accumulation with another represents an intentional restructuring process whereby the state responds to a condition of overaccumulation⁴ by providing a policy framework around which a new regime can be formed.

In this sense, the two main crises witnessed in the twentieth century are not unique but are instead an endemic feature of the internal contradictions produced by expanded reproduction itself.⁵ Thus, the periodic crises inherent in capitalism do not lead to a collapse of the system but

⁴ “Overaccumulation within a given territorial system means a condition of surpluses of labour (rising unemployment) and surpluses of capital (registered as a glut of commodities on the market, as idle productive capacity, and/or as surpluses of money capital lacking outlets for productive and profitable investment).” David Harvey, “The ‘New’ Imperialism: Accumulation by Dispossession”, in Leo Panitch and Colin Leys, eds., Socialist Register 2004, Merlin Press: London, 2003, p.64.

⁵ Michael Hardt and Antonio Negri, Empire, Harvard University Press: Massachusetts, 2000, p. 222.

instead represent moments in which social reaction operates to resolve the problematic features of one mode and replaces them with a shift to what Harvey calls a ‘new plane’ of accumulation which structures new and, hopefully, more successful domestic arrangements.⁶ This new plane will typically involve the following elements: the penetration of capital into new spheres of activity (by reorganizing pre-existing forms of activity along capitalist lines), the creation of new social wants and needs, and a geographic expansion into new regions.⁷ While geographic expansion and spatial reorganization have been commonly recognized ways to absorb surplus, Harvey also adds the concept of temporal displacement in order to account for long term investments in physical and social infrastructure, which he terms ‘spatio-temporal fixes’.⁸ He describes how this process absorbs surplus in the following way: “temporal displacement [encourages] investment in long-term capital projects or social expenditures that defer the re-entry of current excess capital values into circulation well into the future; and spatial displacement... open[s] up new markets, new production capacities and new resources, [and new] social and labour possibilities elsewhere”.⁹

The transformation of a crisis of valorization into a new plane of accumulation is crucially dependent on the state. Historically, the modern state and the capitalist mode of production emerged together out of previously existing feudal relations in Western Europe, a process which served to functionally separate public power from private power through the division of labour. Under this arrangement, “the state comes into being as the arena for public, general concerns, representing the interests of all,... civil society [(the sphere of material life)],

⁶ David Harvey, *Spaces of Capital: Towards a Critical Geography*, Routledge: New York, 2001, p. 241.

⁷ David Harvey, *Spaces of Capital: Towards a Critical Geography*, pp. 241-242.

⁸ Leo Panitch and Colin Leys, eds., “The New Imperial Challenge,” *Socialist Register 2004*, Merlin Press: London, 2003, p. 63.

⁹ *Ibid*, p. 64.

then, becomes depoliticized.”¹⁰ Therefore, this functional separation operates as a conservative tendency whereby protest and criticism is largely directed at the organs of the state rather than at the contradictions that exist between the logic of the abstract market and that of human need, and between use value and exchange.¹¹ As a result, through its position of relative autonomy from the capitalist class, the public policy of the state operates to transform crises into a more or less accommodating class compromise by producing a framework around which a new social structure of accumulation emerges, thus diverting direct attacks on the sphere of material life itself. However, while these institutionalized compromises can seldom be perfect, the contradictions inherent in a capitalist society “[are] less visible in periods when a balance, however temporary, has been achieved”¹²

The Creation of Public Health Care in Canada

Of particular relevance for the study of health care in Canada, the resolution of the first period of significant crisis (which lasted from roughly 1929 to 1945), forged a decisive shift in the direction that social policy had been heading. While a growing public interest in Canadian health policy was initiated in the late nineteenth century through the advent of serious epidemics, including as influenza and tuberculosis, the economic and health impacts of the Great Depression fostered a public sentiment in favour of a “humanitarian concern for our fellows”.¹³ This public concern is the result of what Guest has termed a ‘residual’ system of social security that existed

¹⁰ Derek Sayer, “The Critique of Politics and Political Economy: Capitalism, Communism and the State in Marx’s Writings of the Mid-1840s”, *Sociological Review*, 33 (2) 1985, p. 231.

¹¹ J. Saurin, “The Global Production of Trade and Social Movements: Value, Regulation, Effective Demand and Needs,” in A. Taylor and C. Thomas, eds., *Global Trade and Global Social Issues*, Routledge: London, 1999, p. 226.

¹² Barbara Cameron, “Social Reproduction and Canadian Federalism,” in Kate Bezanson and Meg Luxton, eds., *Social Reproduction: Feminist Political Economy Challenges Neo-Liberalism*, McGill-Queen’s Press, 2006, p. 47.

¹³ Colleen Fuller, *Caring For Profit*, p. 51.

prior to 1940 which was marked by a reliance on the family and the private sector (including the charitable sector) as a “first line of defense”.¹⁴

While the residual system of social security had always proven inadequate for the most marginalized, the massive amount of unemployment and destitution that accompanied the stock market crash of 1929 meant that relief for the poor and the sick fell on the municipalities which were on the verge of bankruptcy themselves, and unemployment ‘insurance’ was left up to soup kitchens and private charities.¹⁵ As a reflection of the health problems experienced at this time, 44 percent of the young army recruits during the Second World War were rejected due to ill health, matched by a similar percentage of unhealthy people working the production lines during the War.¹⁶ These rejection rates, along with dismal infant mortality rates, rates of death as a result of communicable disease, and a high incidence of ill health among children, led Canadians to “seek and demand alternatives”.¹⁷

However, despite the desires of the public, it would take some two decades for these demands to be fully met. As history has borne out, public health care in Canada would not prove feasible until favourable structural and ideational arrangements were in place. These arrangements would ultimately take the form of a class compromise which guided the ‘Golden Age’ of capitalism.

The domestic arrangements that emerged after the end of the Second World War represent a firm rejection of the disastrous reliance on the market and non-profit sectors to provide social protection during the Depression, all of which had ultimately led to “widespread

¹⁴ Dennis Guest, The Emergence of Social Security in Canada, UBC Press: BC, 1980, p. 1.

¹⁵ Colleen Fuller, Caring For Profit, p. 20.

¹⁶ Ibid, p. 27.

¹⁷ Ibid, p. 28.

disillusionment with capitalism”.¹⁸ As the Depression wore on, the collapse of the labour market and functioning exchange relations resulted in two distinct social reactions: one, a direct attack on capitalism which called for the socialization of the means of production, and another which called for massive state intervention in the economy to resolve the crisis.¹⁹ The latter option was taken, manifesting in the rise of Keynesian domestic economics in the 1930s.

Keynesian economics, with its focus on full employment, counter-cyclical demand management (ensuring the purchasing power of the population during economic downturns), and state expenditures on public works projects, began in Canada with the 1935 introduction of legislation to cushion the blow of the Depression, namely with the implementation of the Employment and Social Insurance Act, the Minimum Wages Act, and the Limitations of Hours of Work Act.²⁰ Furthermore, with the outbreak of World War Two, the federal government dramatically increased its role in directing the economy: price controls were introduced to curb inflation, the distribution of supplies was rationed, and many crown corporations were created so as to provide necessary goods or to provide services not offered by the private sector.²¹

While some of the initiatives introduced during the War would be relaxed in 1945, the sacrifices of Canadians during the War along with the recent memory of the Great Depression combined to form the basis of widespread support for a Keynesian class compromise in the postwar era. However, while efforts to create a social safety net in Canada were already

¹⁸ Barbara Cameron, “Social Reproduction and Canadian Federalism,” in Kate Bezanson and Meg Luxton, eds., Social Reproduction: Feminist Political Economy Challenges Neo-Liberalism, p. 58.

¹⁹ Ibid.

²⁰ Ibid.

²¹ Stephen Clarkson, “The Peripheral State: Globalization and Continentalism,” in Uncle Sam and Us, University of Toronto Press: Toronto, 2002, p. 20.

underway, the introduction of a national system of equitable access to health care services was much slower going.²²

During the 1930s and 1940s Canadian health care insurance was subject to wide provincial variation, with all provinces having some form of private-for-profit insurance available, some having cooperative insurance plans, and some with physician- or hospital-sponsored health insurance, yet many Canadians (including children, those with chronic health problems, the poor, and the unemployed) were left without coverage.²³ The situation was much different in Saskatchewan and BC, however. Under the leadership of Tommy Douglas, in 1947 the government of Saskatchewan introduced the first universal health insurance scheme in Canada. Douglas' feelings that access to health services ought to be rightly considered "an inalienable right of being a citizen" were shared by those of the BC government, and they followed suit in 1949 with the introduction of universal hospital insurance.²⁴ However, while "a broad segment of Canadian society supported a public health program", and in this regard Saskatchewan and BC provided a model for others to follow, national sentiment remained divided on many key issues including "whether such a scheme should be universal or for low-income earners only, whether doctors should be paid on a fee-for-service or salaried basis, and about the appropriate role for the state in insuring or providing health care services".²⁵

Ultimately this debate would only be resolved once the political will was in place on the part of the federal government, largely as a result of the conflictual nature of the Canadian constitutional arrangements which stipulated that "provinces were to establish, maintain, and

²² Colleen Fuller, *Caring For Profit*, p. 12.

²³ Colleen Fuller, *Caring For Profit*, pp. 31-34.

²⁴ *Ibid*, p. 38.

²⁵ *Ibid*, p. 13.

manage hospitals, asylums, charities and eleemosynary [charitable] institutions”.²⁶ Thus a national health care program would have to arise within the restrictive context of British North American Act, resulting in much inter-provincial division on the issue.²⁷ Furthermore, the interests of powerful private for-profit insurance companies coupled with doctor led resistance through bodies such as the Canadian Medical Association, would stifle the creation of a comprehensive national health care plan until the mid-1960s.

With overwhelming public support for Medicare undeterred, a variety of proposals for a system of national health care emerged between the end of the Second World War and the mid-1960s. These were distilled into three categories in the 1964 Hall Commission report. First, the approach favoured by the Canadian Medical Association and the private insurance companies was the ‘insurance approach’ which would divide Canadians into those who were insurable and those who were not, with the public sector subsidizing those who were not. However, the Hall Commission found that between 54 and 75 percent of Canadians at the time would qualify for some form of subsidy assistance, which the Commission felt would “pose a formidable task in terms of organizing administrative machinery, [and impose] extra costs which Canadians [could not] afford”, and furthermore that the means tests imposed on Canadians seeking assistance under this model would be “contrary to the dignity of man”.²⁸ The second approach would be a ‘health services approach’ which would treat health in a similar fashion as education: fully public and universal in terms of coverage, provision, and infrastructure, with doctors earning a salary from the state rather than charging fees. While groups such as the Canadian Labour Congress

²⁶ Ibid.

²⁷ For example, the Dominion-Provincial Conference of 1945, was the first national conference which discussed the implementation of a national health care system, and talks would collapse in 1946 when the four prairie provinces clashed with the other six, led by Ontario, on issues relating to jurisdiction, tax collection, money, and cost sharing. Colleen Fuller, *Caring For Profit*, p. 30.

²⁸ Colleen Fuller, *Caring For Profit*, p. 55.

firmly supported this second option, it was rejected by the Hall Commission on the grounds that it would be “a system in which all providers of health services [would be] functionaries under the control of the state”.²⁹ Ultimately the approach Canadians received, and that which was recommended by the Hall Commission, was a compromise between the two options: public expenditures devoted to the provision and administration of health care insurance which was restricted to the coverage of care received by hospitals and doctors, along with the private not-for-profit provision of such services.

The legislation which formed the public health care system in Canada came in a series of steps. First, the Hospital Insurance and Diagnostic Services Act, initiated in 1957, fully insured inpatient hospital services through a federal-provincial cost sharing agreement in which the federal government agreed to split 50 percent of the hospital costs with the provinces through a grant-in-aid formula.³⁰ Next, in 1966 the Medical Care Act was instituted to insure doctors’ services, with all costs met by general tax revenue. Finally, on July 1 1968 the Medical Care Insurance program went into effect, which combined the two into one cost-sharing formula covering all “necessary” hospital and medical services.³¹ This legislation imposed five cost-sharing conditions: universal coverage (all Canadian residents were covered), accessibility (no hindrance through a means test or extra charges), portability (all Canadians should receive services anywhere in Canada), comprehensiveness (all ‘medically necessary’ hospital and physicians’ services were covered), and public administration (each provincial plan was to be

²⁹ Ibid, p. 57.

³⁰ Ludwig Auer, Douglas E. Angus, J. Eden Cloutier, Janet Comis, Cost Effectiveness of Canadian Health Care, Queen’s-University of Ottawa Economic Projects: Canada, 1995, p. 5.

³¹ Ibid, p. 6.

administered on a non-profit basis without the involvement of the private sector).³² By 1971 all provinces had universal health care.

Crisis and the Neoliberal Restructuring Process

The accumulation regime established during the postwar era was incredibly successful while it lasted, for as McCormick suggests, this was “the most sustained and profitable period of economic growth in the history of world capitalism.”³³ However, by the mid-1970s growing problems with the Keynesian compromise were becoming increasingly evident around the world. While high rates of growth, productivity, employment and wages, and profitability were all salient characteristics of the decades following the Second World War, by the mid- to late-1960s domestic capitalism had entered into an economic downturn.³⁴ For example, between 1965 and 1973 the rate of profit in the US fell by 40.9 percent in the manufacturing sector, and by 29.3 percent in the private business sector.³⁵ Given the centrality of US capital in the postwar order, this downturn in profitability is not only of global significance, but is also of special concern for Canada given its ‘branch-plant’ status.³⁶ In addition, since the success of Keynesian domestic policy was based on a high growth and productivity model which afforded trade-offs for subordinate social groups, a nascent restructuring campaign began to emerge which promoted the belief that this economic downturn indicated that the Keynesian class compromise was now

³² Roy Vogt, Whose Property? The Deepening Conflict Between Private Property and Democracy in Canada, University of Toronto Press: Toronto, 1999, p. 185.

³³ Thomas J. McCormick, America’s Half Century: United States Foreign Policy in the Cold War, John Hopkins University Press: Baltimore, 1989, p. 99.

³⁴ Ray Kiely, The New Political Economy of Development: Globalization, Imperialism, Hegemony, Palgrave Macmillan: New York, 2007, p. 62.

³⁵ Robert Chernomas and Ardeshir Sepehri, “Is Globalization a Reality, a Tendency, or a Rationale for Neoliberal Economic Policies?” Globalization, 2(2) Fall, 2002, p.1.

³⁶ Leo Panitch, “Dependency and Class in Canadian Political Economy,” Studies in Political Economy, (6) Autumn, 1981, p. 284.

becoming a fetter on profitability, ultimately leading to the initiation of several significant policy changes in the early 1980s.

Two significant aspects of this restructuring included the rise of monetarism and neoliberalism. Insofar as monetary policy is concerned, a new era of supply-side economics, known as monetarism, initiated a sharp break from the previous method of demand management and its accompanying high-growth model. This new policy aimed at encouraging investment rather than consumption began when Federal Reserve chairman Paul Volcker responded to the macroeconomic problems in the US with a tight monetary policy that pushed interest rates up to unprecedented levels and led to a deep recession in 1981-2.³⁷ A similar path was taken in Canada, with real interest rates climbing from negative or low levels in the 1970s to 6 percent in the 1980s, and peaking at 9 percent in 1990, with interest rates remaining around 4-6 percent in the 1990s.³⁸ While creditors benefit from high interest rates, debtors, including large government debtors, can face a solvency crisis virtually overnight when interest rates are increased so dramatically.

Thus, the interest rate response to rising inflation levels worsened the burgeoning global recession and created the very conditions needed to justify the introduction of a neoliberal shift in the social structure of accumulation in the 1980s and 1990s. While it became commonplace to suggest that neoliberal policies such as regressive taxation, capital liberalization, trade liberalization, and privatization were a solution to the faltering Keynesian welfare state, in practice these policy changes have served to undermine the ability of the welfare state to properly function. Rather than accepting the standard description of neoliberalism as the solution to the problems of Keynesian economic policy, we may instead suggest that neoliberal

³⁷ Thomas Lairson, and David Skidmore, International Political Economy: The Struggle For Power and Wealth, Thomson Wadsworth: Canada, 2003 pp.104-105.

³⁸ Stephen McBride, Paradigm Shift, 2nd edition, Fernwood Publishing: Halifax, 2005, p. 100.

tactics had the result of exacerbating the economic slump and eliminating viable options for repair of the welfare state. This is especially true when we examine how the newly cemented system of public health care in Canada would be undermined almost as soon as it had begun.

Paving the Way for Privatization: The Financial Erosion of Medicare

While all provinces had finally implemented a system of universal public health care by 1971, the federal-provincial cost sharing that was a key feature of the viability of the principles of the arrangement would only last until 1977, when the federal government implemented of the Federal-Provincial Fiscal Arrangements and Established Programs Act (EPF). The EPF served to replace the fifty-fifty cost split between the provinces and the federal government in the area of health and post-secondary education, effectively rolling both of these transfers into a new block-funding formula in which federal contributions for these areas of social expenditure were to come in the form of partly cash and partly tax points transferred to the provinces.³⁹

The effects of this policy were twofold. First, the block-funding policy operated to decentralize funds and therefore devolve political power to the provinces.⁴⁰ Second, under the EPF increases in federal funding were tied to growth of GNP rather than the previous mode of tying federal funding to increases in real costs.⁴¹ Thus the initiation of the EPF in 1977 represents a significant departure from the previous funding structure both in terms of the value of the amount transferred and in terms of the ability for the federal government to enforce national standards since the provinces were given more power over the allocation of the funds.

With the federal capacity for oversight reduced along with its willingness to tie health care funding to cost increases, from 1977 onward a significant amount of provincial variation emerged, with some provinces beginning to permit 'extra billing' and the imposition of user fees

³⁹ Stephen McBride, *Paradigm Shift*, p. 107.

⁴⁰ Ibid.

⁴¹ Ibid.

by both doctors and hospitals.⁴² Given the obvious contradictions that this created with the basic principles of the public health care system, namely universality and accessibility, several public inquiries were initiated, including the Health Services Review of 1980, which “revealed strong support throughout Canada for a system of universal health care without extra user charges”, prompting the review’s commissioner to claim that if “extra-billing is permitted... it will, over the years, destroy the program, creating... [a] two-tiered system incompatible with the societal level which Canadians have attained”.⁴³ The federal government responded to the findings of this review and to public concern with extra-billing in the form of the 1984 Canada Health Act, which further restated the five principles of health insurance, and provided for “withholding from the cash payment to a province of an amount equal to the total amount of extra billing permitted, and/or the amount of user charges authorized by the province”.⁴⁴

Although we may broadly say that neoliberal restructuring had been initiated in the late 1970s and early 1980s,⁴⁵ in Canada such policies lagged behind the global trend setters. For instance, while the creation of the EPF is in line with the overall trend of decreasing federal support for public goods, Clarkson has characterized the period of 1972 to 1984 in Canada as period of increased national autonomy which saw an introduction of federal policies aimed at re-establishing federal control over the economy.⁴⁶ Within this context, we see that while the Canada Health Act was proclaimed law in 1984, it had actually been introduced into the House

⁴² Roy Vogt, Whose Property? The Deepening Conflict Between Private Property and Democracy in Canada, p. 186.

⁴³ Ibid.

⁴⁴ Ludwig Auer, Douglas E. Angus, J. Eden Cloutier, Janet Comis, Cost Effectiveness of Canadian Health Care, p. 9.

⁴⁵ For instance, in 1975 securities’ trade in New York were deregulated followed with the 1979 British abolishment of exchange controls, as well as various other liberalization programs enacted under Regan and Thatcher in the early years of the 1980s. Thomas Lairson, and David Skidmore, International Political Economy: The Struggle for Power and Wealth, p. 107.

⁴⁶ Stephen Clarkson, “The Peripheral State: Globalization and Continentalism,” in Uncle Sam and Us, p. 25.

of Commons in 1983 under the Liberals, which constrained the Conservatives from making changes to it given that it was introduced right before the upcoming election.⁴⁷

This period would end, however, and a decisive shift in favour of neoliberalism in Canada would be made, with the release of the Macdonald Commission report in 1985. While not all recommendations were implemented, some pertinent areas include the following: the use of monetary tools to manage the economy as opposed to the Keynesian style of managing supply and demand, expenditure cutbacks, a devolution of power for the delivery of services, market liberalization, free trade, and a rejection of Canada's historical commitment to an active state in favour of that of limited government.⁴⁸

The adoption of these neoliberal principles had a dramatic effect on federal health care funding in Canada. Following the release of the Macdonald report, the federal government imposed ceilings on EPF payments in 1986, 1990-91, 1991-92, and a freeze on health care expenditures from 1992 to 1995.⁴⁹ However, federal spending on health care would further deteriorate when the 1995 budget announced that EPF would be merged with the Canada Assistance Plan (CAP, the fund for social assistance and welfare) into a new block fund, to be called the Canada Health and Social Transfer (CHST).⁵⁰ While the CHST was developed "almost entirely by the Department of Finance without broad consultation either with the public or other departments" it had a serious impact on the fiscal affairs of the provinces.⁵¹ Compared with what they would have received under the former CAP and EPF programs, the CHST

⁴⁷ Stephen McBride, Paradigm Shift, p. 113.

⁴⁸ See: Barbara Cameron, "Social Reproduction and Canadian Federalism," in Kate Bezanson and Meg Luxton, eds., Social Reproduction: Feminist Political Economy Challenges Neo-Liberalism, pp. 66-67; Stephen McBride, Paradigm Shift, p.61; Stephen Clarkson, "The Peripheral State: Globalization and Continentalism," in Uncle Sam and Us, p. 29.

⁴⁹ Stephen McBride, Paradigm Shift, p.107.

⁵⁰ Paul Leduc Browne, Unsafe Practices: Restructuring and Privatization in Ontario Health Care, Canadian Centre for Policy Alternatives: Ottawa, 2000, p. 21.

⁵¹ Roy Vogt, Whose Property? The Deepening Conflict Between Private Property and Democracy in Canada, p. 193.

dramatically reduced transfer payments, with 1996-98 cash transfers to the provinces alone declining by 33% (\$6 billion).⁵²

Meanwhile, as federal spending was slashed, health care costs were mounting. When measured in nominal dollars, between 1980 and 1990 Canada's total health care costs rose by \$40 billion, from \$22.7 billion to \$62.2 billion; with hospital costs contributing to 50 percent of the total increase, physician services and pharmaceuticals to 20 percent, and residential care to 10 percent.⁵³ The result of these cutbacks had predictably the same effects as did the cutbacks to the EPF: a health care system starved of funds posed serious challenges for the provincial administration of quality health care, and an even larger block-funding scheme further diminished the capacity of the federal government to ensure that the five principles of public health care would be maintained across Canada.

The Privatization of Health Care: P3s and Contracting Out

Considerable provincial variation emerged with respect to how the rising costs of health care were dealt with. Given that budget cuts have manufactured a crisis in terms of health care quality and accessibility, many Canadians are left with the perception that Medicare will fall short of meeting their health care needs.⁵⁴ This has created the incentive for 'innovative' change in health provision to deal with rising costs and declining funding. In other words, within provinces with acquiescent governments, there has been a steady rise in the privatization of support services, the use of public-private partnerships (P3s) for health care infrastructure, and the restriction of services covered by public insurance which tacitly permits the increase in user-fees and extra charges imposed by private for-profit clinics. Thus, recent calls for 'reform' and

⁵² Ibid.

⁵³ Ludwig Auer, Douglas E. Angus, J. Eden Cloutier, Janet Comis, Cost Effectiveness of Canadian Health Care, p.82.

⁵⁴ Pat Armstrong, Hugh Armstrong, Colleen Fuller, Health Care Limited, p. 2.

‘restructuring’ with respect to the health care system have been answered with creeping privatization.

However, the rise of privatization within health care is not only the result of the reduction in federal spending, as it is in fact a much wider feature of the systemic attempt to open up new spaces for capital accumulation. While spatio-temporal fixes can be resolved through the build up of productive assets, it also has a predatory tendency which resorts to mechanisms outside of expanded reproduction to enhance profitability. Whereas Luxembourgh and others in the Marxian tradition have relegated accumulation based on predation to an ‘original state’ or one which is ‘outside’ of capitalism, Harvey instead considers that many of the processes associated with original accumulation have always remained present within capitalism.⁵⁵ Termed ‘accumulation by dispossession’, this includes a host of activities which feature prominent in solutions to overaccumulation (including privatization).⁵⁶

Taken together, spatio-temporal fixes for overaccumulation and the use of accumulation by dispossession as a feature of these fixes, goes a long way in explaining not only the waves of privatization through public asset divestiture initiated in the 1980s but also the less obvious forms of privatization that continue today through the contracting out of support services and the implementation of P3s. While different in scale and scope, these processes are nonetheless the same in terms of exposing an ever increasing array of hitherto public goods to the requirements of the private sector: commodifiability, exchange, and most importantly, profitability. While the examples of these tendencies within the Canadian health care system are abundant, a few will be used to illustrate the point that while the P3s and contracting out support services have not

⁵⁵ David Harvey, The New Imperialism, Oxford University Press: Oxford, 2003, p.144.

⁵⁶ For example, the creation of new mechanisms to enclose the commons (e.g. privatization), the creation of new markets (e.g. biopiracy), the commodification of cultural forms (e.g. the music industry), and devaluation through currency speculation. David Harvey, The New Imperialism, pp. 145-148.

qualitatively improved the health care system, but rather have made matters worse, and have served to carve out a profitable niche for the private sector.

Beginning with the use of public-private partnerships, some key features of P3s are the following: there is a legally binding long-term contractual relationship established between the public and private sector, there is a significant amount of funding involved, and the contract model is invariably based on an application of risk allocation theory.⁵⁷ On the final point, the decision to use a P3 to deliver a project is typically based on the neoclassical assumption that the private sector is more efficient than the public sector, resulting in lower costs, shorter completion times, and other such gains. However, while P3 proponents claim that projects come in “on time” and “in budget”, the evidence suggests that many are late and serious cost overruns are frequent.⁵⁸ Furthermore, while the empirical record remains mixed on the amount of efficiency that can be gained through the integration of private decision-making,⁵⁹ P3s continue to be represented as beneficial for both parties despite the fact that P3s close off highly profitable, and significant, public goods from democratic oversight and control.⁶⁰ For public health care this is of particular concern given the propensity for serious conflicts of interest to exist between corporations that seek to maximize profits and public services that seek to meet community needs, as well as the need for strict patient confidentiality.⁶¹ Furthermore, the long-term nature of the contractual commitments inherent in P3s adds a measure of inflexibility in future health care policy planning which may also serve to bind governments to inappropriate long term management strategies given the variable nature of community dynamics.

⁵⁷ Graeme Hodge and Carsten Greve, eds., The Challenge of Public-Private Partnerships: Learning from International Experience, Edward Elgar: UK, 2005, p. 62.

⁵⁸ Natalie Mehra, Flawed, Failed, Abandoned: 100 P3s, Canadian & International Evidence, Ontario Health Coalition, 2005, p. 3.

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*, p. 85.

⁶¹ *Ibid.*, p. 3.

Within the Canadian public health care system P3s have been most commonly used in the financing, design, construction, and maintenance of hospitals and other similar infrastructure, justified on the basis that this is a significant area of rising health care costs. Part of the justification for using private funding via P3s comes from the ideological predisposition to regard public debt as a sign of mismanagement. Thus P3s hospitals are commonly accounted for as operating leases in a provincial budget, rather than capital expenses, leading to the impression that provincial debt is lower when P3s are used.⁶² However, this is merely an accounting technique which misrepresents the fact that P3s have to be paid for whether they are on the books as operating leases or capital expenses.

Furthermore, as mentioned, since cost overruns are frequent with P3s they cannot be considered to be a cost savings for the public. While these increased costs typically relate to the higher interest rates paid by the private sector, cost increases can also be the result of higher than bided construction costs, as well as administrative and legal fees that accompany P3s. For instance, the Abbotsford Regional Hospital and Cancer Centre is an example of a P3 which has experienced serious cost overruns. With this P3 the provincial government has “spent over \$7 million in administrative costs to pursue project savings that were estimated at \$3 million over a 30 year period... construction costs have increased from \$210 million to \$355 million, and the annual operating lease for the private sector has doubled from \$20 million to \$41 million. [In addition] legal and consultant costs are budgeted at \$24.5 million which will be paid by the public”.⁶³ Similarly, with the Royal Ottawa Hospital P3 costs have increased from \$100 million

⁶² Lewis Auerbach, Arthur Donner, Douglas D. Peters, Monica Townson, Armine Yalnizyan, Funding Hospital Infrastructure: Why P3s Don't Work, and What Will, Canadian Centre for Policy Alternatives: Ottawa, November, 2003, p. 5.

⁶³ Ibid, p. 9.

to \$200 million, yet the new hospital will have fewer beds than the hospital it replaces.⁶⁴ Given this propensity to increase the cost of infrastructure, as well as many other social disadvantages that accompany the use of P3s in health care, it is difficult to see how they might solve the underfunding crisis in health care today.

Justified under the rubric of reducing government expenditures, contracting out services is also another salient feature of the privatization of the Canadian health care system. While the Romanow report of 2002 recommended enhanced public spending, the faster delivery and provision of more comprehensive services, as well as less for-profit involvement in health care,⁶⁵ the report distinguishes between direct health care services (medical, diagnostic, surgical care) and ancillary services (food prep, cleaning, maintenance), opening the door for the privatization of these services since they are presented as non-integral to the success of health-care performance.⁶⁶ However, these services are in fact a fundamental aspect of health care provision, as the support staff: “ensure the cleanliness of rooms, furnishings, and equipment that are vital to infection control; they prepare and deliver meals; they dispose of garbage and bio-hazardous material; they do the laundry for patients and staff,” and thus crucial areas of health care are affected such as hygiene, nutrition, infection control, and patient care.⁶⁷

While the privatization of these services benefits multinational corporations such as Aramark, Compass, Sodexo (based in the US, Britain, France respectively), the motivation for

⁶⁴ Ibid, p. 23.

⁶⁵ Sylvia Fuller, Colleen Fuller, Marcy Cohen, Health Care Restructuring in BC, Canadian Centre for Policy Alternatives: BC, January, 2003, p. 3.

⁶⁶ Marjorie Griffin Cohen, Marcy Cohen, Privatization A Strategy for Eliminating Pay Equity in Health Care, in Kate Bezanson and Meg Luxton, eds., Rethinking Social Reproduction: Feminist Political Economy Challenges Neo-Liberalism, McGill-Queen's University Press: Montreal, 2006, pp. 129-130.

⁶⁷ Jane Stinson, Nancy Pollak, and Marcy Cohen, The Pains of Privatization, Canadian Centre for Policy Alternatives: BC, April, 2005, p. 34.

profitability ensures that employees and services suffer.⁶⁸ For instance, when the privatization of these services was initiated in 2003 in BC, the wages of housekeeping aides with Aramark dropped from the usual rate of \$18.32 per hour to the starting wage of \$9.50 per hour, raising to a meager \$11.21 per hour after 6 years, which represents a 79 percent decline in pay.⁶⁹

Furthermore, while work experience and/or credentials were once a feature of hiring policies for support staff in BC, these standards have since been relaxed by the private companies contracted to take on these tasks. While these companies now provide their own training, a recent study published the following statistics: “39 percent of interviewees claimed they perform work they were not trained for, 67 percent said they were expected to train inexperienced co-workers, 54 percent felt they did not receive explanations about their assigned tasks, and 90 percent believed the company’s training was inferior to their previous training. None were impressed by the quality of training offered by their contractors”.⁷⁰ These results suggest that not only are health care support staff undertrained and underpaid when their jobs are sold to the private sector, but also that the integrity of the health care services they provide is dangerously undermined when the need for profitability crowds out the ability to provide adequate service delivery.

Thus, while the introduction of P3s and of contracting out may not be resulting in any improvements in health care provision in Canada, and in fact the quality of service is deteriorating while costs are rising, perhaps the greater danger posed by these policy decisions is that they may one day be irreversible. In the past experimentation with public legislation may have been more easily rescinded once proven problematic or socially unacceptable, yet a salient feature of the current era of neoliberal orthodoxy is that these reforms are virtually locked in

⁶⁸ Jane Stinson, Nancy Pollak, and Marcy Cohen, The Pains of Privatization, p. 10.

⁶⁹ Ibid, p. 11.

⁷⁰ Ibid, p. 35.

through a process of new constitutionalism which serves to impose binding constraints on the policy making decisions of states.⁷¹ Two prime examples of new constitutionalism are the impositions placed on the Canadian government through NAFTA and the WTO's GATS regulations.

While Canada has exempted health care from both of these trade agreements, by “reserving” it as “a social service provided for a public purpose,” the nature of these agreements is such that once private firms are allowed into the for-profit delivery of health care in Canada, the precedent set may make the costs associated with the denial of further privatization prohibitive.⁷² With NAFTA this is of particular concern given that the US Office of the Trade Representative has insisted that “where commercial services exist, that sector no longer constitutes a social service for a public purpose.”⁷³ Similarly, WTO regulations stipulate that in “countries where the hospital sector is a mix of public and private ownership, or where there are user fees or private insurance, [can the government] argue for exemption [of this service from] the GATS agreement”.⁷⁴

Concluding Remarks

⁷¹ Stephen Gill, The Constitution of Global Capitalism, Paper presented at the International Studies Association Annual Convention, 2000. <<http://www.theglobalsite.ac.uk/press/010gill.htm>>

⁷² Pat Armstrong, Hugh Armstrong, Colleen Fuller, Health Care, Limited, Canadian Centre for Policy Alternatives: Ottawa, November 2000, p.36.

⁷³ Ibid.

⁷⁴ Ibid.

With the desperate calls for the establishment of a national system of public health care coverage in mind, it is troubling that what took decades to achieve is being silently undermined by creeping privatization in recent years. While other aspects of the Keynesian welfare state may have fallen by the wayside, one area of public policy and “concern for our fellows” that continues to receive overwhelmingly support remains the universally accessible system of public health care. Unfortunately, as has been demonstrated throughout this paper, many important aspects of social policy, and in particular the right to universal health care coverage, are continually subject to the wider logic of capital accumulation that exists at the time. In a more socially accommodating era of class compromise and large-scale gains for the disenfranchised through a welfare state, the implementation of public health care was something of an inevitability. However, given the current context of neoliberal restructuring, public health care is now increasingly being eroded from the inside out through budget cuts, the establishment of P3s, and the privatization of ancillary services.

By opening up the health care sector to private investment, these strategies of accumulation by dispossession can be thought of as attempts to create a spatio-temporal fix to the overaccumulation crisis in global capitalism within the past twenty five years. This neoliberal restructuring process is occurring around the world in context dependent ways, and this paper sought to demonstrate how reductions in federal spending on health care, along with the privatization of health care infrastructure and support services, are all manifest examples of this process within Canada. When considered in this larger context, in some sense it was only a matter of time before the previously untapped profitability potential of the Canadian health care system was exposed to large-scale capital investment. Interestingly, while it does not seem likely that Canadians would relish the relinquishment of their rights to public health care

insurance, accumulation by dispossession can nonetheless proceed by stealth through the private provision of public property (via P3s) and through transforming the role of the state from that of a provider to a purchaser of services.

Yet while these processes may be a boon for the private sector, quality health care is threatened in the process, as is the potential for reversibility, given the new constitutionalist attempts to lock in neoliberal reform and hence further dispossession. Fortunately, history can serve as a guide to Canadians, should policy continue down this path. The public need not look any further than the not-so-distant historical circumstances which led to the call for public health care in the first place. High incidents of ill health, infant mortality, disease and epidemics, inadequate coverage, and gross inequality in access to health services were all salient features of the residual system of social service provision present only some sixty five years ago in Canada. As a result, anything short of a renewal of the principles of health care and a reversal of the privatization and underfunding campaigns of the past two decades would be retrogressive and could prove disastrous for society. Should we wish to avoid a Polanyian disembedding of the economy from society, attempts to dispossess the commons of what Douglas would call an “inalienable right” must be matched by the double movement needed to rescue such an important area of human need from the whims of the market.

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