"Social Cohesion and Privatization in Canadian Health Care"

Hugh Armstrong*

Introduction

However critical one might be of the concept of 'social cohesion,' there can be no doubt that health care is a prime site for the construction of cohesion in Canada. In public opinion poll after public opinion poll, Canadians express their strong support for what in English Canada is somewhat ambiguously called 'medicare.' In one poll, 92 per cent of Canadians indicated a preference for the Canadian health care system, while 5 per cent preferred a UK-type system and but 3 per cent preferred a US-type system. In another, which sought to measure degrees of support for the five principles of the *Canada Health Act*, the range was from 93 per cent rating universality as being "very important" to 76 per cent rating public administration as being "very important." Every poll now places health care at the top of the priority list for public spending, over job creation, and public spending on health care is decisively favoured over tax cuts. Indeed, particularly in English Canada, the health care system is considered a "defining national characteristic." According to a poll commissioned by Merck Frostt and the Coalition of National Voluntary Organizations, a quarter of Canadians "cite the health care system as what makes us unique from other countries," more than three times more than cite any other factor, such as multiculturalism, freedom and tolerance.

I argue in this paper that medicare not only promotes social cohesion; it is also a force for the disruption of social cohesion. After a brief discussion of the

term 'social cohesion' itself, I turn to the *Canada Health Act, 1984*, whose five famous principles contribute to social cohesion. I then indicate some of the disruptive realities surrounding medicare. Noting the tension between enduringly high levels of public support for medicare and initiatives designed to transform it radically, I next introduce the concept of 'privatization by stealth.' This discussion entails the identification of several distinct forms of privatization. The case of home care in Ontario is presented in order to reveal some significant problems with privatization. The paper's conclusion is a consideration of lessons for social cohesion drawn from the process of privatizing health care.

In a wide-ranging essay, Jane Jenson observes that ideas about social cohesion come to the fore when social order appears to be particularly threatened. Those who choose to stress the virtues of social cohesion seek to limit the excesses of (market) individualism while masking growing inequalities. Prominent examples she cites are Emile Durkheim and Talcott Parsons. Theirs was the problem of order, not that of equality. In identifying five dimensions of social cohesion -- belonging, inclusiveness, participation, recognition, and legitimacy -- she also draws attention to the term's ambiguity. If it is thus a "contested concept," it is also an emergent one in contemporary political discourse. According to a central policy arm of the Canadian government, it is "the ongoing process of developing a community of shared values, shared challenges and equal opportunity within Canada, based on a sense of trust, hope and reciprocity among all Canadians." With this definition in mind, a conservative definition in that it highlights shared values, and at the same time a liberal definition in its emphases on process and on equal opportunity, I now turn to the

Canada Health Act.

The *Canada Health Act*

At a mere 13 pages (in two languages), the *Canada Health Act* is a simple piece of legislation that establishes the criteria provincial and territorial governments must meet in order to receive federal funding. Passed by Parliament in 1984, it replaced the *Hospital Insurance and Diagnostic Services Act, 1957* and the *Medical Care Act, 1968*, adding explicit prohibitions on direct charges to patients receiving "medically necessary" hospital and physician services. The power of the criteria or principles enshrined in this legislative framework stems both from their simplicity and from the fact that no provincial or territorial government could long resist the lure of substantial transfer payments from the federal government in support of a social program that proved so effective and efficient, as well as popular. The well-known five principles of the *Canada Health Act* have contributed enormously to the high degree of support enjoyed by Canadian health care, and to health care's contribution in turn to a strengthened sense of Canadian identity. In sketching these five principles, let me draw out some of their implications for social cohesion.

First, there is the principle of **universality**, or "Everybody in, nobody out," as Quentin Young, past President of the American Public Health Association frequently puts it in advocating the adoption of this principle in the United States. For "medically necessary" services, there is to be a single tier, with everyone covered under "uniform terms and conditions," states the *Act.* No one is to be able to buy their way to the front of the line, and all are to be treated equally. In

practice of course there are some gaps in coverage, for example with regard to the homeless and undocumented residents. Some of medicare's problems in practice will be addressed below. The point to emphasize here is that universality, the "pooling of risks" by all in society, as Leonard Marsh long ago put it, promotes equal opportunity and reciprocity. These in turn are aspects of social cohesion.

Second, there is the principle of **accessibility**. There are to be no financial or other barriers to accessing the system. It is this provision that has given rise to the largely but not entirely successful efforts to prevent extra billing, administrative fees and other forms of user fee, at least for core hospital and physician services. There can be no risk assessment and no experience rating that would make it easier or cheaper for some than for others to use the health care services that are covered. Just as Canadians are not divided into the eligible and the ineligible, so also they are not divided into the deserving and the undeserving. Rather, medicare is provided on the basis of need, and the development of community and thus social cohesion is served while stigmatizing divisions are avoided.

A third principle is that of **comprehensiveness**. In practice, this is the least well observed of the *Act*'s five principles. At least, however, it creates space for the lively political debates over how best to extend medicare beyond its historical base in hospitals and doctors' offices to various forms of residential long-term care, to home care and to pharmacare. In helping to create a broader space for political discourse, the comprehensiveness principle also helps create the space for public planning that is both rational and participatory, which in turn

can foster the notion of shared challenges and thus social cohesion.

Fourth, there is **portability**. This principle is normally thought of in terms of the payment of services used when travelling to another province or outside the country. Perhaps more important, however, is the portability that comes from not having health care tied to employment. Canadians can move from job to job without worrying about whether they will lose some or all of their medicare coverage. This portability not only contributes to labour market efficiency; it also eliminates a significant source of potential industrial strife. By one estimate, the major issue in three-quarters of US strike actions between 1989 and 1992 was health care benefits. In that country, of course, most health care coverage is employment-linked.

The fifth and final principle in the *Canada Health Act* is **public administration**, with each province having a public, accountable, non-profit agency to administer payments, and with a prohibition on private insurance coverage for the medically necessary services covered under medicare. The messages here are that the public sector, in which all Canadians have a stake, can be efficient and effective, and that Canadians can exercise the freedom to act collectively. Freedom need not, and does not, mean only freedom from constraint. It can, and does, also mean positive acts, a community of shared values and challenges that express and promote social cohesion.

Threats to Social Cohesion

As is well known, the 1990s saw severe cuts in public spending on health care. Particularly hard hit was the hospital sector, but several jurisdictions

experienced absolute cuts to total public spending on health care in one or more years during the mid-1990s. This meant that the cuts in real per capita or percentage of GDP terms were drastic. Public spending on health care dropped from 7.4 per cent of GDP in 1992 to 6.5 per cent in 1996. Private spending during that time rose slightly from 2.6 per cent to 2.7.

A direct result of the cuts was a reduction in public satisfaction with, and confidence in, the health care system. According to the Angus-Reid firm, only one in four Canadians rated the system as "excellent" or "very good" in 2000, down from 61 per cent in 1991. By international standards, Canada no longer stands out as having a high health care satisfaction score. A Harvard University poll reported declines in Canadian satisfaction from 56 per cent in 1988 to 29 per cent in 1994 and 20 per cent in 1998. This placed Canada below the UK (at 25 per cent) and only slightly higher than Australia (18 per cent) and the US (17 per cent), albeit appreciably higher than New Zealand (9 per cent), where the change has arguably been the most marked. By 1998, half the Canadian population thought that health care would worsen in their province during the next ten years, and only a quarter thought it would improve.

With less pride and confidence in the health care system, a force for social cohesion is diminished. Alongside the cuts, however, there is another source of the threat to social cohesion. This source is masked by the concept itself, with its roots in functionalist sociology, and by the public opinion data just presented. Discussion of social cohesion and of public opinion in general conceals the very real divisions among Canadians, and especially between the vast majority on one hand and various elites on the other. For example, 78 per cent of physicians

considered increased private sector participation in health care to be either “very” or “somewhat acceptable” in 1995, while 61 per cent of non-physician respondents considered forcing patients to pay for care to be either “strongly” or “somewhat unacceptable.” This finding was confirmed by focus group results. This division of opinion appears to have prompted the Canadian Medical Association’s Board of Directors to be cautious on the issue of private funding for health care at its March 1996 meeting, and beyond.

A somewhat different split between public and elite opinion has been documented by Frank Graves of Ekos Associates, and appears to have had different strategic results. In 1996, he addressed a self-styled and closed-door “National Health Care Policy Summit,” consisting mostly of business leaders with a few physicians and a sprinkling of health management executives and academics. His message concerned the ranking of values by the general public and by the elites (i.e., top corporate and government decision-makers). Of 22 values, “a healthy population” ranked third for the general public and ninth for the elites. By contrast, “competitiveness” ranked 20th and “minimal government” 22nd (or last) for the general public, while these values ranked first and third, respectively, for the elites. Graves assured his blue-chip audience that “Current public judgements are not based on great understanding of the facts. The public does not really know the facts...about the burning issues of health care.” He found it “disconcerting to think that we [presumably decision-makers rather than pollsters] are going to have to tell the public that this singular success story [i.e., the Canadian health care system] is no longer going to be available to them.”

The “Summit” participants agreed that the Canadian approach to health

care is “a defining value and central to our identity.” They endorsed the five principles of the *Canada Health Act*. They went on however to argue for changes in how these principles are translated into operational assumptions and delivery practices. In their view, years of restraint in health care spending and rapid technological changes are “forcing a reassessment of how health services are organized, financed and delivered.” They went on to call for, among other things, collaboration between the public and private sectors to address major capital requirements, to explore alternative delivery systems, and to direct research funding. In reaching their forced reassessment conclusion, the “Summit” participants nicely echoed the rationale prepared in advance of the event itself, which announced that “a quantum leap in our thinking about the structure, financing and delivery of care is essential.”

Whether “forcing a reassessment” or proposing “a quantum leap,” the “Summit” participants clearly had in mind some far-reaching changes to Canada’s best-loved social program, changes that would introduce much more private sector involvement to it. At the same time, like the leadership of the Canadian Medical Association they acknowledged the popularity of the system and, moreover, recognized that it is “vital to the competitive positioning of the Canadian economy in the global market place.”

"Summit" participants were faced then with two tensions: far-reaching changes to a widely supported social program, and opportunities to privatize a public program that serves at least the export-oriented component of the private sector well. They opted to urge “governments, the private sector, health providers and individual Canadians to rally around innovative solutions.” The

term “rally” suggests that we should all join together, that social cohesion on health care is desirable. Yet “innovative solutions,” ones that place business at the centre, suggest significant changes to the health care system that would be of particular benefit to the private sector. The practical resolution of these tensions embraced by the “Summit” participants and by subsequent reformers of like mind can I think be best understood by utilizing the concept of 'privatization by stealth.'

Privatization by Stealth

The changes are incremental, with a delisting here, a care pathway there, a tightening of eligibility criteria without fanfare next week. The effects are well-known: the declining public share of health care spending, the reduced average length of hospital stays, the restrictions of publicly funded home care, the longer waits for some elective surgery and some cancer and physiotherapy treatments. More significant, perhaps, than incremental reductions, some of which are being reversed under intense public pressure, is the fact that the privatization takes several forms. The privatization of who pays for health care is important, particularly for those who have to start paying out of their own pockets, and for unions and employers faced with difficult collective bargaining as a consequence of the prospect of making up for public cuts through enhanced fringe benefits. An exclusive focus on privatized payment for health care diverts attention, however, from privatization’s other forms.

One of these other forms, of course, concerns who provides the health care service. In one sense, private provision is not new. The vast majority of

physicians have always been in private practice in this country. The “make or buy” choice has long favoured the purchase of health care equipment, supplies and pharmaceuticals from private sources. But a quantitative change is underway that verges on a qualitative change. Hospitals increasingly contract out not only their parking and security services, but also their food, cleaning, laboratory and information services. More fundamentally, as care is moved out of hospitals, which are by and large non-profit and regulated by public hospital acts if not democratically governed, this care is increasingly taken over by for-profit firms. From 1997 on, Canadians have been spending more on drugs than on physicians. As more of the care is shifted from hospitals and nursing homes to other settings -- from institution-based to community-based care, to invoke a fashionable, if false, dichotomy in health reform circles -- more is opened up to private, for-profit provision. The high- profile examples at the moment include MRI (magnetic resonance imaging), eye laser surgery and abortion clinics, but physiotherapy and home care are more significant, at least in financial terms.

A third form of privatization concerns the ways in which health care is organized. One catches a glimpse of these new ways by reflecting on recent shifts in vocabulary, at least in English. Increasingly, we are called customers or consumers, instead of patients or residents or citizens. If as citizens we become active in health care policy, we join long lists of stakeholders, and are enjoined to buy in and take ownership of reform initiatives. Meanwhile, the health care institutions that serve us develop business plans and product lines, and think in business-like, bottom-line and value-added terms about their partnerships and their revenue centres. In short, the language of private property is invoked. One

of the privatization practices involves partnerships, as in the term “public-private partnering,” which appears in the sub-title of the report of the “Summit.” With this device, private sector firms can gain considerable influence over health care delivery while putting up little if any of the capital. The seldom-examined, if frequently repeated, assumption here is that business will introduce cost-effective techniques to an indolent public sector too long insulated by its monopoly position from the discipline of the market place.

Public-private partnerships operate as well at the level of policy development, where they often take the form of industry-dominated advisory committees to government. They also operate at the level of capital fund campaigns, headed by prominent business leaders to line up 'charitable' donations from for-profit firms. In the health sector and elsewhere, the public purse typically provides at least half the funds directly, and then makes a further contribution in the form of tax expenditures. Even with these favorable terms, private sector benefactors cannot always rise to the challenge. In Ontario, for example, the province’s SuperBuild fund provides either 50 per cent or 70 per cent of the approved cost of hospital construction (depending on whether the province ordered the hospital restructuring that occasioned the construction). Faced with huge capital requirements that apparently cannot be met through private donations, even if they are tax-deductible, Ontario hospitals are having to turn to municipal governments for support.

A final privatization practice that merits mention stems from the notion of what is termed a 'purchaser-provider split' and viewed by its advocates as the route to market efficiency and discipline. At one level, the term ignores the reality

that the dominant health care paymasters, provincial governments and regional health authorities using provincial funds, are already split from the vast majority of hospitals, long-term care facilities, physicians and other health providers offering care. This reality is reflected in the titles of the long-available and widely cited books by David Naylor on physicians and Josephine Rekart on social services in general: *Private Practice, Public Payment* and *Public Funds, Private Provision*. What has changed recently however is that the split has been formalized by means of tendering processes and request for proposals or RFP mechanisms designed, in the words of the Ontario government, to "level the playing field," enabling the government to get "the highest quality at the best price."

Before examining competitive bidding practices such as RFPs in more detail, I should identify a fourth form of privatization. The three forms previously listed are based on a specific, if common, way of distinguishing the 'public' from the 'private.' Here the public is centred on the state, broadly conceived, and the private is centred in the market economy. There is however another usage, one in which the public incorporates both the state and the market, and the private is centred in the household. With this latter usage, one encounters initial public offerings or IPOs of corporate stock offered for sale. And one encounters pubs or public houses after a strenuous day at the stock exchange or the seminar room.

With this latter usage, one can also gain insight into the realities of home care. What is benignly termed a shift to community-based care from institution-based care is first and foremost a matter of sending care work home. This is the

most invisible form of privatization, notwithstanding the efforts of feminists to insist that the personal is political. Home care is disproportionately performed by women, usually without pay, and without recognition except from the household members directly affected. It is for this reason that the National Forum on Health wrote of citizens being “conscripted” into home care.

To return to the assertion about privatization by stealth in health care, it is not only occurring incrementally, it is also beset by a confusion over its forms. When critics condemn the privatization represented by the establishment of a for-profit hospital or a for-profit MRI clinic, a Premier Klein or a Premier Bouchard can be counted on to reply that no problem exists, for public payment will remain in place. When more and more is contracted out with the use of tendering processes or RFP mechanisms, the response is that the role of government is to steer the ship of state, not to row it. Finally, it is privatization by stealth because, as hospitals restrict their care to the most acute, and as long-term care facilities fail to grow at a rate that matches the growth in the frail elderly and chronically disabled populations, so much more care is being sent to the private home.

The Case of Home Care in Ontario

When examining privatization by stealth, the case of home care in Ontario is instructive, for several reasons. First, along with rehabilitation care, it is one of the fields most directly affected by hospital efforts to shed all but the most acutely in need of curative health care. The Ontario case is particularly relevant because hospitals in that province have appreciably higher ratios of day surgery to total hospital cases than do hospitals in the other provinces and appreciably shorter

average lengths of hospital stay.

Second, and not surprisingly then, home care is a growing field. The Ontario government now devotes over $1 billion a year to it, and private spending on home care may be half as much. Moreover, the demands for care by formal and informal volunteers are growing rapidly as well, even if they are difficult to measure. The provincial funding is allocated by the 43 Community Care Access Centres (CCACs) set up by the Harris government without benefit of specific legislation soon after it took office in 1995.

Third, although the CCACs themselves employ case managers to assess home care needs (along with placement co-ordinators to determine who gets into long-term care facilities), they are prohibited from directly employing the nurses, therapists and personal support workers who provide the care itself. Instead, the CCACs must use RFPs to allocate the public funds to independent agencies, which then hire those who actually provide the care.

Fourth, there are rigid upper limits on the amounts of home care that can be provided using public funds, and the assessment of need takes into account the availability of household members to do the work. The effect of all this is that household members, and especially women, are "conscripted" into unpaid, unrecognized, privatized home care.

Fifth, home care is usually experienced to be isolating, by providers and recipients alike. The providers seldom have the opportunity to meet with other providers. They are rushed by the caps on service time and budget constraints to get through the bare essentials of medically necessary tasks without taking the time to socialize, despite what is known about the contribution of a rich and

dense social life for the promotion of good health. Recipients meanwhile have the advantage of familiar homes, but also the disadvantage of being cut off from others in like circumstances.

Finally, I am in something of a privileged position with regard to this case. I sit as an elected member of the Board of Directors of the Ottawa CCAC, and chair the Board committee responsible for RFP policy. I am thus a participant observer, and am of course providing here my own perspective and not necessarily that of the Board on which I sit. Everything I cite on this case is from the public record.

Problems with Privatization

From this vantage point, here are some of the problems I see with privatization.

First, it is wasteful, not cost-efficient, even in the narrowest of terms. To take a well-documented, if relatively small, example from Ottawa, the CCAC was forced by the provincial government to "divest" itself in April 2000 of 50-odd occupational therapists, physiotherapists and social workers who had been directly employed to provide a specialized therapy program for adults. In order to protect both continuity of care for those benefitting from this program and the employment security of the health professionals delivering it, the CCAC and the union representing these professionals agreed that the program should be moved in its entirety to its new employer. They also agreed that the professionals and their union should have successor rights, or in other words retain the same pay, benefits, working conditions, collective agreement and

organizational structure in place before the move. As a result, there is the rare opportunity to directly compare the costs of public and private sector employment. The outcome is an extra annual charge of about $513,000, which is over 9 per cent of the total funding for this program. The extra costs of divestment cover “operational requirements” ($223,000), “management/clerical staffing” ($185,000) and “contingency” ($105,047).

These figures may not appear large, but this example is instructive as a sort of natural experiment, holding all the variables constant, except for privatization. If one were to project the extra 9 per cent onto, at a conservative estimate, the two-thirds of CCAC funding that is allocated using RFP mechanisms across the province, the figure is something like $66 million that is wasted each year. Aside from profit, this substantial waste stems largely from what Harry Braverman termed the presumption of dishonesty surrounding firms in the marketplace, with each having to mirror the accounting, legal and other negotiation and monitoring apparatuses of the other.

A second problem with privatization is that the managed competition model on which RFP mechanisms are based assumes the presence of competitors. They are not to be found in areas with low population densities, notwithstanding the relatively low entry costs for firms getting into homemaking and visit nursing. Even in a relatively large urban community like Ottawa, which has a population of about 780,000, the creation of competition may be an artificial exercise. No firm existed to enter the competition for the specialized adult therapy service. Two new firms had to be created, in order that one might win the competition, and both had to learn from the CCAC how to organize the

service. “Best practices” were located in the public sector, and had to be given away to the private sector in order to make managed competition possible. The smaller the community and the more complex the service, the more artificial the managed competition.

Even with less specialized services such as homemaking (assistance with bathing, toileting and feeding, and perhaps also with meal preparation, dressing and some other activities of daily living), competition may be jeopardized in large centres by the tendency of private sector firms to merge with and acquire each other, and to drive each other out of business. One capital always kills many, or at least vigorously attempts to do so. Recent home care examples in Canada include the purchase by Bayshore (formerly Interim Care) of Gentiva (formerly Olsten), the takeover by We Care Health Care (itself owned by We Serve Health Services) of Bradson Home Health Care, and the purchase of Comcare by Medcare, itself owned by Dynacare.

Years ago, Karl Polanyi observed that “*Laissez-faire* was planned; planning was not.” This certainly applies to the home care market in Ontario. With great fanfare, the provincial government announced that the Victorian Order of Nurses (VON) and the other non-profit agencies which had historically provided almost all of the publicly-funded home care would be “protected” when the RFP mechanism was imposed. They would be assured a 90 per cent “market share” in the first year, then 80 per cent and 70 per cent in the succeeding years, after which time they would presumably be tough enough to fight it out in a “fully competitive system” with the for-profit firms. What the government did not publicize but did impose on the CCACs was the requirement

from day one of the RFP system that there be a “mix of service providers” should there be more than one proposal received. In other words, even if the proposal from the traditional sole provider, the VON, say, was far superior to that of Bayshore, say, the VON could not be awarded 100 per cent of the contract. Bayshore would have to be awarded a foothold in a new market.

Third, because the goal of the competitors is to drive out the competition, the system is inherently unstable. In Ontario, this has meant a difficult transition for the non-profit organizations that have traditionally provided the services. In a revealing interview, the Chief Executive Officer of the VON, a century-old charity providing home care, palliative care and related services, recently warned that the VON could go out of operation, at least in Ontario, because it is not prepared to compromise the quality of the care it provides. Such compromises can involve altering staff/patient ratios or simply reducing the time spent with individual patients. For-profit organizations can also use the time-honoured technique of ‘low-balling’ their initial proposals, using profits made elsewhere to drive the non-profit agencies out of an area. The reality of mergers and takeovers within the private sector has already been mentioned. For the CCACs and the patients they indirectly serve, this turmoil can threaten continuity of care, and the employment security of the workers providing the care, which is also to the detriment of quality care.

Name changes and mergers may be responses to fraud, which brings up a fourth problem with privatization. In July 1999, Olsten agreed to pay a $US61 million fine to settle a Medicare fraud investigation in Georgia, New York and Florida, and in November 2000 an Ohio jury awarded further damages and costs

in excess of $US31 million against Olsten, by now the former parent of Gentiva. This firm, which is the largest firm in the US home care industry, is appealing the Ohio verdict but now faces yet another fraud investigation mounted by the Inspector General of the US Department of Health and Human Services. Olsten's legal difficulties in Georgia involved a complicated kickback scheme with HCA - The Healthcare Co., formerly known as Columbia/HCA Healthcare, the largest for-profit hospital chain in the US and the target of several other fraud investigations. A similar pattern emerges with private dialysis clinics south of the border. It appears that fraud is a key component to becoming the largest player in the competitive field.

A fifth problem with privatization is its instability from the perspective of care recipients, even before mergers and acquisitions set in. Contracts are awarded to different firms to provide different services. These firms often pride themselves on employing only casual workers to keep their costs down and their flexibility up. If they lose the contract after two or three years, further turmoil ensues. The effects from the recipient's perspective can be a parade of strangers trooping into the home.

A sixth and final problem with privatization is that in a labour-intensive field like home care competition places considerable downward pressure on the pay, benefits and conditions of the workers involved. In the current Ontario case, this is mitigated by two factors: a shortage of nurses and homemakers, and the fact that the competition is managed through RFPs, rather than through tendering. RFP procedures can and usually do assign priority to quality considerations over price considerations, which form the exclusive focus of tendering procedures.

To review, privatization is problematic for reasons of waste, artificiality, agency instability, fraud, service instability, and threatened pay and conditions for workers. In response, the Ottawa CCAC has undertaken a number of initiatives. Notwithstanding government directives, it has budgeted in each of the past two years for a $513,000 deficit, insisting that the cost of divestment not be borne through diminished services in the community. (The cost does of course have to be borne by Ontario taxpayers generally, if at year's end there is in fact a deficit.) And it has publicized this example of waste. It has established in its RFP for homemaking services a minimum wage rate for the key category of home support workers. It has also started to lengthen by a year the duration of its contracts beyond the former standard of three years with a one-year extension option. It has introduced to its pre-qualification stage a criterion designed to disqualify firms convicted of or having settled out of court any fraud or related matters, or having any such matters pending. This criterion applies as well to the directors and officers of these firms. It has introduced clinics in accessible shopping malls for those who, with transportation assistance if necessary, could travel to have, for example, leg ulcers attended to. This can of course save staff travel time and thus money for the agencies and thus the CCAC, but it can also serve to reduce isolation. Finally, the CCAC actively recruits and mobilizes individual and association members, and ensures that the elections to its Board by these members are contested and are based, at least in part, on policy issues.

The trouble with these and similar responses on the part of individual CCACs is that they just nibble at the edges of the problems with privatization. They encourage public discourse and decision-making, but in a decidedly limited

way. They decrease slightly the degree of service if not agency instability. They make a gesture in the direction of confronting fraud. And they promote some social interaction among those able to attend the clinics they fund. But they fail to strike at the heart of the waste, the lack of competition, the agency instability, the fraud, the service instability, or the downward pressure on worker pay and conditions that characterize privatization in health care.

Conclusion: Lessons for Social Cohesion

The discussion of privatization in health care, and more specifically the case of home care in Ontario, holds several lessons for social cohesion. To start with, public payment for health care places this field of human endeavour on the public agenda. It becomes, at least potentially, a matter of public discourse and thus a vehicle for the development of "a community of shared values." If a principle governing the payment is that of universality, as it is under the *Canada Health Act*, it can also contribute to the equalization of opportunities, another aspect of the Canadian government's perspective on social cohesion. And it can contribute to the sense of inclusiveness, one of the dimensions of social cohesion identified by Jenson.

Although important, public payment is far from sufficient. To the extent that practices drawn from the private sector, such as request for proposals (RFP) mechanisms, are used to allocate public funds, democratic decision-making may be replaced in part if not in whole by market mechanisms. In the end, there can be no sharp distinction made between steering and rowing the boat, to revert to the Osborne and Gaebler metaphor. Meanwhile, citizens may come to the view

that they are powerless to contest the waste, corporate empowerment, instability, and deteriorating conditions of work that accompany this type of contract government. RFP and other market mechanisms promote 'bottom-line' thinking and behaviour, which pull us apart rather than bringing us together.

Another lesson concerning privatization is best seen by examining home care. Here the 'private' is considered the family or the household, not the market. Despite the blurring of this public/private distinction entailed by the growth of home care, the home can be a site for isolation, for the denial of social cohesion. Especially for women, it is not necessarily a haven in a heartless world. This reality is masked by the practice of subsuming home care under the rubric of community-based care, which is then juxtaposed to (bureaucratic, impersonal, inflexible) institution-based care.

'Community-based' care can also be deceptive in suggesting local, democratic, responsive control, and thus the promotion of social cohesion, when the actual control is increasingly centralized through elaborate systems of rules and regulations and/or through program-based rather than core funding. This is clearly the case with Ontario's Community Care Access Centres, which must adhere to contract language, to service limits, to divestment and other policies, and to severe funding constraints imposed by the provincial government. The effect can be cynicism, that enemy of social cohesion.

Finally, the presence of several forms of privatization contributes, as does the practice of making small and incremental cuts throughout the complex but not well integrated health care system, to what is here termed privatization by stealth. Health care is being transformed against the wishes of the vast majority

of Canadians. Again, citizens may be left with feelings of powerlessness and cynicism, and social cohesion may in the process be diminished.

This is not, however, the end of the story. Privatization, by stealth or otherwise, does not have a smooth road ahead of it. Precisely because health care is so important to Canadians, political parties vow to protect its availability and quality. Even the most right-wing of them embrace, at least rhetorically, the five principles of the *Canada Health Act*. Once in office, some of them may undertake to discredit the system by cutting it, but they usually face stiff resistance when doing so. As a result, health care remains a prominent topic for public debate. Governments may seek either to postpone or to promote debate by means of the time-honoured device of appointing study commissions. Indeed, within four years of the final report and five thick volumes of research studies from the National Forum on Health, significant provincial reports had been issued in Québec and Saskatchewan, and two ambitious initiatives were underway at the federal level. On balance, the government commissions appear to promote debate more than to postpone it, perhaps because of what at times are sharp, class-based disagreements that pit the vast majority of Canadians on one side against various elites (corporate, political and medical) on the other. The struggle to protect and enhance a universal, accessible, comprehensive, portable and publicly administered health care system can never be completely and finally won. And it is a struggle that simultaneously promotes and disrupts social cohesion.

Abstract

This paper addresses some of the tensions for social cohesion presented by Canada's medicare system. This system, which constitutes the country's best-loved social program, is broadly governed by the five principles of the *Canada Health Act*. Independently and together, these principles promote social cohesion. Medicare is however also under threat from various elites, who favour elements of its privatization, and whose principal strategy is here termed privatization by stealth. The argument that privatization is disruptive of social cohesion is advanced in general terms and with specific reference to the case of Ontario's Community Care Access Centres, which broker public funds to non-profit and for-profit home care agencies across the province.

Hugh Armstrong

School of Social Work

Carleton University

Ottawa (Ontario)

Canada K1S 5B6

hugh_armstrong@carleton.ca