CANADA’S HEALTH CARE “CRISIS”: ACCUMULATION BY DISPOSESSION AND THE NEOLIBERAL FIX

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Public health care in Canada (“medicare”) is based on five principles, and its realization balances precariously on the method by which this public service is provided. At one end of the delivery spectrum, medicare could be a fully decommodified public service similar to the public education system; at the other end, public health care insurance could exist alongside the private, for-profit delivery of services and infrastructure. However, these varied delivery options are not interchangeable equivalents, since the increased commodification of health care serves to erode the five principles, a process that has been steadily underway since the 1980s. Thus, while medicare may remain formally tied to its core commitments, the Canadian landscape is now dotted with public-private partnerships, privatized support services, and newly sprouting private clinics, and it has been subject to chronic underfunding.

Addressing the various stages through which medicare has passed — the struggle over its formation, its eventual implementation and brief stabilization, and its current internal erosion — is a complex issue that may be approached in a variety of ways, ranging from the synchronic to the diachronic. While much can be gained from a slice-in-time approach, a policy that aims to provide free and universal public health care to all citizens is not one that operates in a vacuum, as it is intimately bound up with the prevailing social relations of power and thus with developments occurring within capitalism itself. In this regard, the growing exposure of medicare to the logic of capitalist profitability underscores the need to explore the relationship between crises, fixes, and the framing of public policy bound-
aries. This leads to the conclusion that commodification has less to do with
the often-lamented efficiency problems of medicare than it does with a crisis
of accumulation. Furthermore, it is a reminder that Canada is not alone in
its reforms, given that crises are global in their reach, and thus restructuring
is a national phenomenon only in a limited sense.

At issue here is the way in which policy restructuring is linked to
capitalism’s propensity for crises of overaccumulation, or “condition[s] of
surplus capital,” represented by a “glut of commodities on the market, idle
productive capacity, and/or surpluses of money capital lacking outlets for
productive and profitable investment.”⁴ The use of the term “fix,” therefore,
is “a metaphor for solutions to capitalist crises,” which extends beyond
merely economic restructuring to include social, political, and institutional
support mechanisms.⁵ From roughly the mid-1930s through to 2008,
Canada has had two distinct fixes, one associated with the Keynesian welfare
state (KWS), and the other with the more recent emergence of neoliberal-
ism.⁶ Both arose out of a crisis of overaccumulation.

The KWS was designed to support a Fordist-style regime of mass produc-
tion and consumption through policy measures such as countercyclical
demand management, public ownership of enterprises in areas key to the
production process (e.g., utilities), and expenditures on public works.⁷
During the height of the postwar KWS, calls for the creation of a public
health care insurance system were able to take root. Neoliberalism would later
emerge as an antithesis to such policies through its familiar expressions of
privatization, trade liberalization, de-/re-regulation, and monetarism. This
neoliberal policy turn, with its characteristic emphasis on individualism and
market-led economic and social restructuring,⁸ has not proven favourable
for the Canadian public health care system, given its need for strong public
oversight and funding, as well as its collectivist approach to care that delinks
ability to pay from the receipt of services.

The dispossession of rights and assets, rather than a strict reliance on
expanded reproduction to absorb surplus capital, is a prime expression of
the neoliberal fix. In this vein, Harvey has coined the term “accumulation
by dispossession” to refer to a host of processes aimed at breaking down
barriers to realization, many of which were described by Marx as original
accumulation, yet remain important to realization today. Examples include the orchestrated devaluation of assets through financial markets, the creation of new markets, and the conversion of public property into private property. This article will discuss the latter — privatization as a feature of the neoliberal era. Although privatization takes many distinct forms (including asset divestiture, public-private partnerships, and contracting out), each manifestation contributes to a transformation in the social relations of power through an expansion of private property rights, and each exposes an ever-increasing array of hitherto public goods to the requirements of the private sector — commodifiability, exchange, and, most importantly, profitability.

Neoliberalism poses serious challenges to any social service more suited to the KWS, and medicare is especially vulnerable. This makes Harvey’s theoretical insights of particular relevance for understanding the current problems of maintaining a vibrant public health care system in Canada. As will be discussed, the adoption of neoliberalism has resulted in a two-front assault on its processes and principles. First, deep funding cuts and freezes on future increases during the 1980s and 1990s dramatically challenged its functioning. Second, the more recent adoption of public-private partnerships (P3s) and the privatization of support services increasingly commodify its future development, undermining its core tenets. From this perspective, we see that the gradual privatization of the public health care system cannot be understood as simply the end result of a lack of funds, or their improper allocation. The argument here is that partnerships with the corporate sector and privatization via contracting out are themselves aimed at resolving overaccumulation through dispossession. Thus, medicare in Canada has proven a useful contributor to the neoliberal fix. How this has manifested itself will be addressed directly in the latter half of the paper. First, we turn to an examination of the underlying structural transition at work: crises, fixes, and accumulation by dispossession.

**Crisis, Fixes, and Accumulation by Dispossession** 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.”

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However, by the mid-1970s growing problems with the postwar fix 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 global capitalism had entered into an economic downturn.\textsuperscript{10} For example, between 1965 and 1973 the rate of profit in the United States fell by 40.9 percent in the manufacturing sector and by 29.3 percent in the private business sector.\textsuperscript{11} This downturn in profitability in the United States was of special concern for Canada given its branch-plant status.\textsuperscript{12} By 1975, overaccumulation in Canada's manufacturing sector had clearly set in, taking the form of "high unemployment of labor and capacity, slow growth of output and limited accumulation of capital."\textsuperscript{13} Thus began a restructuring campaign promoting the belief that the Keynesian class compromise embodied in the KWS was now a fetter on profitability, ultimately leading to the initiation of several significant policy changes in the early 1980s.

The adoption of monetarism early on in the neoliberal era 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 in Canada when real interest rates were increased from their negative or low levels in the 1970s to 6 percent in the 1980s, peaked at 9 percent in 1990, and remained around 4 to 6 percent in the 1990s.\textsuperscript{14} While creditors benefit from high interest rates, debtors, including large government debtors, can quickly find themselves strapped for cash when interest rates are increased so dramatically. In Canada, this translated into an increase in gross public debt as a percentage of budgetary revenues — from 12.7 percent in 1970–71 to 34.1 percent by 1989–90 — putting an enormous strain on the ability to pay for the KWS at a time when regressive taxation policies were increasingly adopted.\textsuperscript{15}

Thus, monetarism worsened the burgeoning recession and created the very conditions needed to justify the widespread introduction of neoliberalism. Although it has become commonplace to suggest that neoliberal policies were a solution to the faltering KWS, in practice these policy changes have served to undermine the ability of the welfare state to function properly. Rather than accepting the standard description of neoliberalism as the
solution to the problems of Keynesian economic policy, we may instead suggest that neoliberal tactics had the result of exacerbating the economic slump and eliminating viable options for repair of the KWS.

These two periods of crisis within global capitalism, roughly 1929 to 1945 and 1970 to 1984, are not unique, but rather are expressions of the internal contradictions within capitalism itself. Thus, the periodic crises referred to here do not signify a collapse of the system, but instead represent moments in which social reaction operates to resolve the problematic features of one mode by replacing them with a shift to what Harvey calls a “new plane” of accumulation, which structures new, more successful domestic arrangements. Typically, this new plane will 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. In addition to geographic expansion and spatial reorganization, Harvey adds the concept of temporal displacement to account for long-term investments in physical and social infrastructure, which he then terms “spatio-temporal fixes.” 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.”

One way of attempting to restore profitability is through the use of accumulation by dispossession. Whereas Marx’s *Capital* focused on valorization through expanded reproduction, Harvey insists that the processes of “original accumulation” identified by Marx are ongoing features of the system, and not relics of a precapitalist or protocapitalist period. For Harvey, dispossession remains continually important as it devalues assets and/or strips away rights so as to create an outside that can then be incorporated into the circuits of capital accumulation at low, or no, cost. In this fashion, new spaces for capital accumulation are opened up and overaccumulated capital can be valorized — an effective way to resolve accumulation problems.

Although dispossession is by no means unique to the current era, it is
especially prevalent with neoliberalism. This includes the creation of new mechanisms to enclose the commons (such as privatization), the creation of new markets (such as trading in carbon credits), and devaluation through currency speculation. Considered together, neoliberalism and its propensity for dispossession are meaningful ways to explain not only the waves of public asset divestiture in the 1980s, but also the less obvious forms of privatization that continue today through contracting out and the use of P3s.

With full-scale privatization, dispossession occurs in the most overt of ways. The divestiture of public assets (in Crown Corporations, for example) converts public property into private property directly, through the sale of ownership rights. In Canada, this process has included some of the most potentially profitable assets in the country, as well as areas of policy significance for the KWS. For example, federal sales have included the Canadian National Railway (1995), Air Canada (1988), and portions of Petro Canada (1991). Provincially, this has included Alberta Government Telephones (1990), Nova Scotia Power Corporation (1992), and the Potash Corporation of Saskatchewan (1989). Once transferred, these assets then become sources of private accumulation. It is also common for these assets to be devalued and sold off well below their anticipated exchange value. For instance, in 1994 the cable network portion of Manitoba Telephone Service (MTS), a then 61-year-old Crown Corporation, was sold for $11.5 million, which translated to only 18 percent of its $63 million valuation according to an internal MTS assessment.

However, dispossession is not an unambiguous, or unidirectional, process of ever-increasing plunder. In the Keynesian era, publicly owned enterprises were commonly encouraged by the private sector as a way of providing cheaper infrastructure, utilities, and services, and to ensure that natural monopolies did not fall into the hands of rival firms. This meant that, in some cases, establishing public corporations and utilities involved converting private property into state property. Take the example of MTS mentioned above. Manitoba’s telephone network was first established by the private sector (the Northwest Telegraph Company in 1878, taken over by Bell Telephone Company of Canada in 1880), and it would be three decades before the province purchased these private assets (which later became the
property of MTS, incorporated in 1933). This means that some of the
now-privatized assets under the neoliberal fix ought to be more accurately
described as having been recommodified — first transformed from private
capital to state capital, and then back into private capital. Thus, solutions
to overaccumulation involve complex, and potentially contradictory, processes
of dispossession/repossession and de-/re-commodification occurring over
time, with a different rationale appropriate during different fixes.

Similar to full-scale privatization, P3s are best understood as forms of
spatiotemporal fixes using accumulation by dispossession. Whereas traditional
public works projects (physical and social infrastructure) are wholly owned
and controlled by the public sector, with contracts awarded to a private
company for a limited and specified role (such as the construction portion),
P3s establish binding long-term contracts that incorporate the logic of the
private sector into the provision of public goods. This is reflected in Cohn’s
definition of P3s as “instruments for meeting the obligations of the state that
are transformed so as to involve private property ownership as a key element
in the operation of that instrument.” Therefore, although public assets are
not divested directly, P3 contracts nonetheless carve out avenues for profitable
private sector investment by contractually guaranteeing future revenue
streams in areas that would otherwise prove potentially unprofitable, or too
politically sensitive to privatize.

P3s in Canada typically occur in the area of public infrastructure provi-
sion (including hospital buildings, water and sewage facilities, and roads).
These projects involve the private sector in a variety of ways. The most
common forms of P3 are build-own-operate-transfer (BOOT), design-build-
finance-operate (DBFO), and design-build-operate (DBO). This means
that, while partnerships between government and the private sector have,
to one extent or another, been present for centuries, the novel feature of
contemporary P3s (i.e., DBFO, BOOT, and DBO) is the amount of
decisionmaking and control that the private sector has over all stages of the
formulation and implementation of public policy.

In contrast, contracting out public services, which occurs with public
service delivery of all sorts (such as hospital maintenance and dietary services),
involves far less decisionmaking on the part of the private contractor. As
opposed to asset divestiture or partnering with the private sector, with this form of privatization “the government entity retains ownership and overall control but employs the private vendor to actually render the service.” Nonetheless, all of these forms of privatization are equally part of a neoliberal spatiotemporal fix using dispossession for two reasons. First, they all provide for spatial displacement by enhancing the breadth and depth of profitable private accumulation. Second, temporal displacement is achieved by opening up investment in long-term capital projects and social services to surplus private capital, rather than the previous pattern of crowding out private investment in these areas.

Overaccumulation does not simply resolve itself, and thus the transformation of a crisis into a new plane of accumulation is crucially dependent on the state. Since capitalist society is class divided, and these divisions contribute directly to crises, “a separate structure to specifically maintain, monitor, and restore equilibrium” is a necessary feature of successful long-term accumulation. The state takes up this task and must therefore retain a relatively autonomous position from civil society in order to fulfill the role of “ensur[ing] the reproduction and the political cohesion of capitalist societies.” How this manifests itself concretely varies from state to state in each historical era.

The emergence of a neoliberalism worldwide illustrates this variation. Under the umbrella of neoliberalism, state action has not been uniform, and Jessop argues that these differences can be classified as neoliberal regime shifts, policy adjustments, and radical systemic transformation. Whereas we have been discussing the emergence of a new fix in Canada, or what Jessop calls a regime shift, in the Scandinavian countries the introduction of neoliberalism more accurately took the form of policy adjustments; and in Eastern and Central Europe, systemic transformation would be a more apt description of what occurred after the fall of the Soviet Union. These varied applications of neoliberalism also correspond to the different forms of state that emerged postcrisis. Jessop classifies his ideal types as neoliberalism, neostatism, neocorporatism, and neocommunitarianism. The neoliberal form is identified through the adoption of policies mentioned earlier: liberalization, privatization, a new juridi-
copolitical framework supportive of market solutions (such as flexibilization of the labour market), and free trade. This most closely characterizes the Canadian experience.

Before turning to a more in-depth discussion of medicare, it is worth emphasizing that the concept of a relatively autonomous capitalist state provides space for the balance of class forces to have an impact over time. Thus, as public policy, neoliberalism is not an agentless fait accompli implemented through blind economic necessity; its privileged position requires constant maintenance and renewal by the capitalist class and its organic intellectuals. Similarly, the Keynesian fix set the tone for how to revive a morbid economy, but the establishment of medicare itself was never predestined — it took strong public demand for it to bloom.

The Creation of Public Health Care in Canada The public health care system in Canada is the outcome of many years of negotiation and compromise, making medicare a perpetual work in progress with few moments of stasis in its relatively short existence. Public concern over Canadian health policy was jump-started in the late nineteenth century as the result of a series of serious epidemics, including influenza and tuberculosis, yet the situation would turn grave once the economic and health impacts of the Great Depression were felt. Conditions at that time had become so severe as to call into question the entire residual system of social security that existed prior to 1940, which relied on the family and the private sector (including the charitable sector) as a “first line of defense.” Although this residual system of social security had always proven inadequate for the most marginalized, the massive amount of unemployment and destitution that accompanied the 1929 stock market crash 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. 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. 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.”

Despite the desires of the public, and some in the private sector (recognizing that socializing health care costs would prove beneficial not just for the working class, but for capital as well), it would take some two decades for these demands to be fully met. Keynesian policy began in Canada with the 1935 introduction of legislation to cushion the blow of the Depression, namely with the passage of the Employment and Social Insurance Act, the Minimum Wages Act, and the Limitations of Hours of Work Act. Further interventions included the creation of Crown Corporations in order to provide necessary goods and services not offered by the private sector. The inauguration of medicare was much slower-going due to the constitutional stipulation that “provinces were to establish, maintain, and manage hospitals, asylums, charities and eleemosynary [charitable] institutions.” Thus, a national health care program would have to arise within the restrictive context of the British North America Act, resulting in much interprovincial division on the issue. In addition, the interests of powerful private, for-profit insurance companies, coupled with doctor-led resistance through bodies such as the Canadian Medical Association, created firm resistance to the initiation of a comprehensive national health care plan. Ultimately, through a series of legislative steps beginning in the 1950s, opposition to medicare was overshadowed by unwavering public pressure and the support of a fix biased towards government intervention.

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. Next, in 1966 the Medical Care Act was instituted to insure doctors’ services, with all costs met by general tax revenue. Finally, on 1 July 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. 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 administered on a nonprofit basis without the involvement of the private sector). 49 By 1971, just before the transition to neoliberalism, all provinces had universal health care.

**Paving the Way for Privatization: The Financial Erosion of Medicare**

The federal-provincial cost sharing that was a key feature of the viability of medicare would last only until 1977, when the federal government implemented the Federal-Provincial Fiscal Arrangements and Established Programs Act (EPF). The EPF replaced the 50-50 cost split between the provinces and the federal government in the area of health and postsecondary education. The Act also rolled federal transfers for health and education into a new block-funding formula whereby contributions would be partly cash and partly tax points transferred to the provinces. 50

The effects of this policy were twofold. First, the block-funding policy served to decentralize funds and therefore devolve political power to the provinces. 51 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. 52 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 of the federal government to enforce national standards, since the provinces were given more power over the allocation of funds.

With the federal capacity for oversight reduced and health care transfers declining, from 1977 onwards a significant amount of provincial variation emerged, with some provinces beginning to permit extra billing and the imposition of user fees by both doctors and hospitals. 53 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.” 54 The federal government responded to these
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and other similar findings with the 1984 Canada Health Act. The Act restated the five principles of health insurance and allowed the federal government to withhold transfers to a province, should extra billing or user fees be permitted. 55

The promise of the Act would be short lived, however. One year later, in 1985, the release of the Macdonald Commission report symbolized the onset of a shift towards neoliberalism in Canada. Although not all recommendations were implemented, some pertinent areas include 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, trade liberalization, and a rejection of Canada’s historical commitment to an interventionist state in favour of more entrepreneurial forms of governance. 56

Adopting 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, and 1991–92, and a freeze on health care expenditures from 1992 to 1995. 57 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). 58 The CHST was developed “almost entirely by the Department of Finance without broad consultation either with the public or other departments,” and it had a serious impact on the fiscal affairs of the provinces. 59 Compared with what they would have received under the former CAP and EPF programs, the CHST dramatically reduced transfer payments, with 1996–98 cash transfers to the provinces alone declining by 33 percent ($6 billion). 60

Meanwhile, as federal spending was being brought in line with neoliberal dictates, 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. 61 Predictably, spending cutbacks during a time of rising costs bore results
similar to those of the EPF: a health care system starved of funds compromised quality health care, and an even larger block-funding scheme further diminished the federal government’s capacity to ensure that the five principles of public health care were being maintained across Canada.

However, growing public concern over long waiting lists and understaffed/overcrowded facilities, and some within the capitalist class taking issue with the erosion of the “competitive advantage” of Canada, would urge a rise in health care spending once again. Thus, by 2001 spending had increased to almost $60 billion, well above its 1992 level of $52 billion. Yet despite this increase, expenditures on hospitals remained well below their 1992 level, and jobs eliminated (primarily nursing staff) were not restored. Many analysts were beginning to recognize that health care funding was not the only issue, as poor management and organization were also to blame. This theme was emphasized in the Romanow and Kirby reports of 2002, both suggesting that innovation in service delivery would be needed to resolve the problems of medicare.

Despite medicare requiring strong stewardship, the exact nature of this innovation has been left largely up to the provinces. In many cases, “alternative service delivery” has proven to be a euphemism for dispossession — P3s and contracting out — rather than searching for alternatives that match the spirit of the Canada Health Act. Provincial autonomy was further enhanced only in 2004, when the federal government committed to transfer an additional $41 billion over 10 years to the provinces without any conditions attached. Thus, whereas fiscal austerity manufactured a health care crisis in the 1990s, the recent spending increases concurrent with dispossession illustrate that privatization cannot be blamed on a lack of funds.

The Privatization of Health Care: P3s and Contracting Out The provinces have dealt with the rising costs of health care in a variety of ways. Where neoliberalism is favoured, there has been a steady rise in the privatization of support services, the use of P3s to provide health care infrastructure, and the restriction of services covered by public insurance. Thus, recent calls for reform have been answered with creeping privatization.
Public-Private Partnerships (P3s)  P3s dovetail with many New Public Management (NPM) prescriptions. One of the central aims of NPM is to transform the government and its agencies into the procurer of services rather than the provider. This relies on the assumption that partnering will avoid the problems associated with (inefficient) public administration. By this reasoning, P3s are presented as a net gain for the taxpayer — they deliver value for money through lower costs over the lifetime of the project by transferring risk to the private partner who, it is argued, will operate in a more innovative, efficient, and financially prudent fashion.

As a result, risk allocation is often touted as the central advantage of the P3 model. The most common risks associated with public projects include site (e.g., tenure, access, suitability), design and construction (e.g., delays, weather, cost overruns), operation and maintenance (e.g., cost overruns), and financial risks (e.g., interest rates, inflation). However, in order for the public partner to offload some or all of these risks, compensation for the acceptance of risk must be offered. This compensation translates into the anticipated profit margin for the private partner. Unless the private partner is inexperienced with P3s, this risk will be reflected in the price of the bids submitted to a request for proposals. Therefore, justifying the use of a P3 on the basis of risk transfer is untenable, since qualified private partners will either avoid bidding on contracts that offload too much risk, or this risk will be monetized in the form of higher-cost bids in line with the anticipated profit margin sought by investors. Thus the monetization of risk through the bidding process cancels out risk transfer as “risk becomes just one component of the project’s cost structure and is therefore passed completely onto the state in the consortium’s bid.” Furthermore, should the private partner not live up to its risk-bearing obligations, it is difficult to imagine how important projects, such as hospital facilities, would be allowed to fail.

Notwithstanding their largely ideological appeal, P3s continue to be represented as beneficial for both parties despite the fact that they close off highly profitable, and significant, public goods from democratic oversight and control. For medicare, 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.
The long-term nature of the contractual commitments inherent with P3s adds a degree of inflexibility in health care policy planning, which may serve to bind governments to inappropriate long-term management strategies.

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 P3 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. However, this is merely an accounting technique that misrepresents the fact that P3s have to be paid for whether they are on the books as operating leases or capital expenses (although new P3 accounting rules may eliminate this budgetary sleight of hand altogether).

In addition, P3s are often more expensive than traditional projects. While proponents claim that projects come in on time and “in budget,” the empirical record in Canada suggests that many are late and serious cost overruns are frequent. Increased costs typically relate to the higher interest rates paid by the private sector, but they can also result from higher-than-bidded construction costs, as well as administrative and legal fees that accompany P3s. For instance, with the Abbotsford Regional Hospital and Cancer Centre, the British Columbia 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.

Similarly, with the Royal Ottawa Hospital P3 costs have increased from $100 million to $200 million, and the new hospital will have fewer beds than the hospital it replaces. In the case of the Brampton Civic Hospital P3, not only did the province pay $33.9 million to advisors subsequent to the selec-
tion of the preferred bidder, but the Ontario Auditor General also found that the decision to go with the P3 model was skewed — the province overestimated the costs of the traditional procurement model by $289 million, which made the P3 option seem cheaper.\(^80\) Once adjusted, going with the traditional model would have saved taxpayers $200 million.\(^81\) 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 create solutions to the problems with medicare today.

**Contracting Out Support Services** Justified under the rationale of reducing government expenditures, contracting out is another common form of NPM-style innovation in the public health care system. While the 2002 Romanow Report recommended enhanced public spending, the faster delivery and provision of more comprehensive services, as well as less for-profit involvement in health care,\(^82\) the report distinguishes between direct health care services (i.e., medical, diagnostic, surgical care) and ancillary services (i.e., food preparation, cleaning, maintenance), opening the door for the privatization of these services, since they are presented as nonintegral to the success of health care performance.\(^83\) In fact, these services are 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.\(^84\)

The clear beneficiaries of this process are the multinational corporations who take over the once-public contracts, companies such as Aramark (United States), Compass (Britain), and Sodexho (France); meanwhile, the motivation for profitability ensures that employees and services suffer.\(^85\) For instance, when support staff services were privatized in British Columbia in 2003, 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, increasing to a meager $11.21 per hour after six years.\(^86\) Furthermore, the standards of prior work experience and/or credentials that were once a feature of hiring
policies for support staff in British Columbia have since been relaxed by the private contractors. Although these companies now provide their own training, a recent study reports that “39 percent of interviewees claimed they perform work they were not trained for, 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.” These results suggest that not only are health care support staff undertrained and underpaid when their jobs are contracted out, but also that the integrity of the health care services they provide is dangerously undermined when the need for profitability trumps the provision of adequate services.

Concluding Remarks

With the desperate calls for a system of universal health care coverage in mind, it is troubling that what took decades to achieve is being silently undermined by creeping privatization. While other aspects of the KWS may have long since fallen by the wayside, one area of public policy that continues to receive overwhelming support remains the universally accessible system of public health care. However, it will take much more than passive support to reverse the tide. As has been discussed here, social policy is coloured by the wider logic of capital accumulation that exists at the time. Within the context of neoliberal restructuring, this has meant that the public health care system offers enormous untapped potential for profitability and is thus subject to ever-proliferating varieties of privatization.

By opening up the delivery of health care infrastructure and support services to (multinational) private for-profit investment, these strategies of dispossession act as a fix to accumulation problems within global capitalism. Thus, while neoliberal restructuring is occurring around the world in context-dependent ways, the newly emergent varieties of health care privatization discussed here are all manifest examples of how this process is occurring in Canada. Moreover, dispossession now proceeds by stealth because P3s and contracting out do not require the formal sale of public assets.

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. Hence, further dispossession is likely should contracting out and P3s remain largely unchallenged by the public. The implications of this scenario are already well known, since the historical record clearly indicates the results of a residual system of health care. High incidence of ill health, infant mortality, disease and epidemics, inadequate coverage, and gross inequality in access to health services were all characteristic features of the Canadian landscape as little as 65 years ago.

There are many solutions to the serious problems faced by medicare that do not involve turning to the private sector. In one trial, changes such as better management and planning of surgeries, standardizing practices, and investing in new equipment reduced hip and knee waiting times by 75 percent; in another, a collaborative care approach yielded reductions in wait times by 90 percent. Other solutions that have proven successful include strengthening preventative community-based care and primary care. Many more solutions abound. However, in order to ensure that an improved health care system remains public, anything short of a strict enforcement of the five principles of health care, along with a reversal of privatization and a renewal of predictable funding, would be regressive and could prove disastrous. Fundamentally, this means that attempts to dispossess the commons of what Tommy Douglas would call an “inalienable right of being a citizen” must be matched by the significant public effort needed to rescue such an important area of human need from the whims of the market.

Notes

I would like to thank Carlos Novas of the SPE Editorial Board, reviewers Hugh Armstrong and José Julián López, as well as Stephen McBride for all of their helpful comments.

1. These five principles are universality, accessibility, portability, public administration, and comprehensiveness.
2. Pat Armstrong, Hugh Armstrong, and Colleen Fuller, Health Care, Limited (Ottawa: Canadian Centre for Policy Alternatives, 2000); Lewis Auerbach, Arthur Donner, Douglas D. Peters, Monica Townsend, and Armine Yalnizyan, Funding Hospital Infrastructure: Why P3s Don’t Work, and What Will (Ottawa: Canadian Centre for Policy Alternatives, 2003); Paul Leduc Browne, Unsafe Practices: Restructuring and Privatization in Ontario Health Care (Ottawa: Canadian Centre for Policy Alternatives, 2000); Sylvia Fuller, Colleen Fuller, and Marcy Cohen, Health Care Restructuring in BC (Vancouver: Canadian Centre for Policy Alternatives, 2003); Colleen Fuller, Caring for Profit (Ottawa: Canadian Centre for Policy Alternatives,


6. Since there is significant economic turmoil at the moment, it is difficult to accurately predict the exact magnitude and future implications of the ongoing problems. Thus, the neoliberal fix has been dated to at least 2008.


16. Harvey describes three central contradictions within the capitalist mode of production that produce these periodic crises: those that arise within the capitalist class as individual capitalists act in a competitive profit-seeking manner, leading to a condition of surplus capital and thus overaccumulation; antagonisms that exist between labour and capital create class struggle over the wage/profit split; and contradictions arise due to the potential for strife to occur between the capitalist production system and non- or pre-capitalist sectors. David Harvey, *Spaces of Capital: Towards a Critical Geography* (New York: Routledge, 2001), pp.79–80.


33. BOO T projects refer to arrangements in which the private partner is responsible for the design, construction, finance, and operation of an asset; and feature long-term contracts (typically 25 to 30 years). The DBFO model is similar to BOO T projects, except that at the end of the contract, ownership reverts back to the public sector for a fee. DBO does not involve private financing, but instead integrates design, construction, and maintenance into one contract that the public partner purchases once the commission period is over. Hodge and Greve, The Challenge of Public-Private Partnerships, p. 64.
40. Fuller, Caring for Profit, p. 20.
41. Fuller, Caring for Profit, p. 27.
42. Fuller, Caring for Profit, p. 28.
44. Stephen Clarkson, Uncle Sam and Us (Toronto: University of Toronto Press, 2002), p. 20.
45. Fuller, Caring for Profit, p. 13.
46. For example, the 1945 Dominion-Provincial Conference was the first national conference to discuss the implementation of a national health care system, and talks collapsed 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 (Fuller, Caring for Profit, p. 30).
48. Auer et al., Cost Effectiveness, p. 6.
51. Ibid.
52. Ibid.
54. Ibid.
55. Auer et al., Cost Effectiveness, p. 9.
60. Ibid.
61. Auer et al., Cost Effectiveness, p. 82.
62. Medicare in Canada has meant the reduction of costs for companies such as the Big Three automakers in the United States (Ford, GM, and Chrysler). In 2006, they were spending more than $10 billion on health care benefits in the United States that they did not need to
pay in Canada. See Guy Caron, Best Kept Secret: Canada's Health Care Competitive Advantage (Ottawa: The Council of Canadians, 2008), p. 9. This, and similar examples from other industries, has led many commentators in the private sector (including Richard Nesbitt, CEO Toronto Stock Exchange Group, and A. Charles Baillie, former Chairman and CEO, TD Bank, and honorary chair of the Canadian Council of Chief Executives) to advocate maintaining a system of public health care in Canada.


64. Rachlis et al., Revitalizing Medicare.


66. See Roy J. Romanow, Building On Values: The Future of Health Care in Canada (Saskatoon, SK: Privy Council, Commission on the Future of Health Care in Canada, 2002); Michael J.L. Kirby, Study on the State of the Health Care System in Canada (Ottawa: The Standing Senate Committee on Social Affairs, 2002).


72. Ibid.

73. The recent financial crisis has proven illustrative. In British Columbia, for example, some ongoing P3 projects that rely on private financing (typical of BOOT and DBFO models) are now in serious trouble given the credit crunch. This includes the Royal Jubilee Hospital Patient Care Centre Project, whose private financiers Depfa Bank (Ireland) and Dexia (Belgium/France) received substantial bailouts from their respective governments, and the Surrey Outpatient Hospital, which was also being funded in part by Depfa Bank. If they have not received bailouts, or should the credit markets worsen, it seems likely that these hospital projects would be rescued at local taxpayer expense. See Jonathan Fowlie and Lori Culbert, “BC’s P3 Projects Not Immune to World Financial Meltdown,” Vancouver Sun (24 January 2009), p. A1.

74. Mehra, Flawed, Failed, Abandoned, p. 3.

75. Auerbach et al., Funding Hospital Infrastructure, p. 5.

76. Ibid.

77. Mehra, Flawed, Failed, Abandoned, p. 3.

78. Auerbach, et al., Funding Hospital Infrastructure, p. 9.

79. Ibid., p. 23.


81. Ibid., p. 117.

82. Fuller et al., Health Care Restructuring in BC, p. 3.


86. Ibid., p. 11.

87. Ibid., p. 35.


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92. Fuller, *Caring for Profit*, p. 38.