Privatization and Health Care Reform in Canada

Centres of Excellence for Women's Health Program

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Analytic Glossary

Introduction

The starting point for preparing a glossary of key terms in health care reform in Canada is an understanding that public policy is about language as well as legislation. Policy analysis is commonly conceived of as the application of rational analysis to public policy making and therefore often employs tools like cost benefit analysis, forecasting and evaluation. However, another tradition in policy analysis examines the symbolic dimensions of policy making (e.g., Stone 1988). Within this approach, language is understood to be not a neutral tool for communication but a tool for persuasion and argumentation as well as the means through which problems are framed and understood:

> If political language both excites and mollifies fears, language is an integral facet of the political scene: not simply an instrument for describing events but itself a part of the events, shaping their meaning and helping to shape the political roles officials and the general public play. In this sense, language, events, and self-conceptions are a part of the same transaction, mutually determining one another's meanings (Edelman 1977: 4).

Thus part of the challenge in studying privatization and health care reform is to understand the language in which reform is cast and the problems for which the solutions have been deemed to be those now called health reform. That it is called "health reform" and not health care cost reduction and rationalization, for instance, is neither an accident nor a conspiracy but nevertheless an example of the way in which the phenomenon we are looking at is framed to inspire and comfort (Stone 1988).

With this in mind, we propose that one dimension of health care reform is in fact a shift in the discourse of policy makers, health systems planners, medical and nursing personnel, and researchers. Language is powerful because it shapes the way in which we think about issues and sets the discursive framework for defining both public policy problems and possible solutions. The introduction of new terminology and the use of terms from other fields, particularly business and management, is one element of health reform. Attending to the language of public policy documents, research reports, Royal Commissions, trade agreements, and campaign speeches should help us trace the emergence of and experience with health care reform in Canada. Casting health reform as apart of a larger fiscal crisis has meant that many of the strategies employed are managerial and designed to instil business and administrative values to a field which has formerly operated under different principles.

The purpose of this glossary is therefore not to define terms once and for all but rather to suggest some of the terms that are themselves one manifestation of health care reform, their uses and their variants. The history of Canadian federalism includes a long tradition of provincial experimentation within national standards (Tuohy 1992), so we do not expect a consensus on what terms ought to be used or how they are to be used across the country. Rather, we want to explore in this exercise whether terms are used in the same way in different jurisdictions and who uses which terms in what ways. We are particularly curious about the ways, if any, in which the discourse acknowledges or ignores issues of gender.

One of the lessons learned through an examination of the nature and implications of privatization as an instance of health care reform is that health reform is not only about public policy but also about the actions, policies and priorities of corporations (Armstrong 1999; Fuller 1998). Moreover, health care reform is both an historic and an international phenomenon. Canadian public policy in the health care arena intersects with the policies of other government departments, other nations and international corporations. This means that as we look to understand the language of health care reform that we must include in our examination not only the pronouncements of public officials but also of corporations and even possibly other countries.

This glossary is but a starting point for understanding what health care reform looks like in Canada. We welcome elaboration of the terms we've defined as well as suggestions for words or their uses that are missing.

Glossary

accountability - often captured by the term "report cards," a shorthand term for assessing "what we're getting for our money"; may or may not encompass effectiveness, appropriateness, timeliness but focus only on "efficiency"; a wide range of data are collected and standardized "with a view to influencing policy development and implementation" (Armstrong 1999: 33). Increased attention is being paid to "monitoring" and "surveillance" and the use of "administrative databases" to assess health care utilization, effectiveness, costs etc… Much data previously collected by Statistics Canada, Health Canada and various hospital associations is now collected, stored and monitored by the Canadian Institute for Health Information (CIHI).

AIT - Agreement on Internal Trade - an interprovincial trade agreement intended to liberalize and standardize the movement of goods and services between the provinces [was this only proposed or was it proclaimed?]

alliance - another term for "partnership"

CHST - Canada Health and Social Transfer - Introduced in 1995 to replace the EPF funding arrangements between the federal and provincial governments. Involved significant reductions in the federal contribution to provincially administered programs of health care and education. "The introduction of the CHST meant that it was no longer possible to determine how much the federal government contributed to health care, and

the provinces received much greater leeway in how they spent the transfer dollars" (Armstrong 1999: 26). The effect of the CHST was significant budget cuts throughout the health care system. Most visible were hospital closings, bed closings, reductions in full-time permanent nursing positions (the casualization of nursing work), and reports of longer waiting lists for "elective" surgery, diagnostic services, and other non-emergent care.

Canada Health Act (1984) - Passed in April 1984, the *Canada Health Act* "incorporated and clarified the principles of universal accessibility, comprehensive coverage, public administration, and portability; and, by prescribing the 'dollar for dollar' penalties for user fees and extra-billing, it specified sanctions under the EPF arrangements of violating the principle of universality" (Tuohy 1992: 130). The *Canada Health Act* laid out principles rather than

capitation - A system of payment for services involving a budget based upon the number of persons served on an annual per capita basis.

caregiver - a gender neutral term referring to someone who provides care for others regardless of location; could therefore include paid and unpaid workers, volunteers, family members; minimizes the fact that most care is provided by women, whether as family members or paid workers

co-insurance - Also referred to as 'cost sharing' or the use of 'deductibles'; the combining of public and private insurance schemes or payments by individuals.

community - Community is sometimes invoked to refer to decision making and service delivery being "closer to home," with the idea that such care or decisions will therefore be more appropriate to the local context or immediate patient environment. Community is a "good" thing. Community care generally refers to services delivered in the home and/or to services provided outside of institutions. Community need not mean public provision or public delivery; it can mean public provision, non-profit delivery or it can mean that services have been provided all they way back to home. Another usage entirely of the term "community" arises in discussions of community programs, community research and community development. In such instances, "Community may refer to geographic communities (people who live in the same areas), cultural communities (people who share a common identity), or communities of interest (people who share similar life circumstances or are affected by a particular issue)" (Prairie Women's Centre of Excellence).

communautarisation - when the community sector assumes responsibility (from the State?) for care/service delivery (Bernier & Dallaire 1999: 9)

continuity of care - "seamless" system in which institutional and community care are coordinated; chart may follow patient; may or may not refer to care provided in facilities like community health centres; should run the gamut from acute to palliative care; at core

involves the flow of information with respect to a patient/client; requires assessment of patient experience as well as management

contracting out - see outsourcing

day surgery - Surgery conducted in short-stay facilities which do not involve being admitted to hospital for more than 24 hours. Day surgery is possible because of the introduction of new anaesthetics, procedures and technologies which are less invasive. It is also encouraged by reductions in fully operational hospital beds and reduced hospital budgets and fosters increased reliance on informal (family)or community-based (including private nurses, home care staff) care providers.

de-insure - refers to removal of a procedure or practice from the publicly funded medical insurance scheme; may be "active" such as in the limiting of service coverage or the explicit exclusion of certain populations or "passive" as when services and products previously insured because they were provided in hospital are now privately paid for because the service is ambulatory (Bernier & Dallaire 1999: 25, 26)

delisting - see de-insure

determinants of health - "Factors and conditions which influence the health of individuals and communities. They include: income and social status, social support networks, education, employment and working conditions, social environments, physical environments, personal health practices and coping skills, biology and genetic endowment, healthy child development, health services, gender and culture" (Prairie Women's Health Centre of Excellence). The determinants of health is a phrase that emerged in the 1980s with the release of various government charters on health promotion and research which demonstrated that factors outside the health care system per se had significant association with health status. The most powerful predictors of health status are income and social status. International research consistently demonstrates a gradient in which health status declines as one moves down the income and/or social status ladder. Despite the size of the effect of income on health that has been measured, most health research dollars continue to search for individual genetic, behavioural, or organic factors which account for disease. The language of the determinants of health is declining in favour of a renewed emphasis on genetic and other forms of clinical research as Canada grapples with restructuring its health research infrastructure.

downsizing - reduction of the costs of production (Bernier & Dallaire 1999: 21); Government and corporate downsizing involves reducing full-time permanent staff positions, lay-offs, privatization, and/or contracting out of services and work.

EPF - Established Programs Financing scheme -

equality - sameness

equity - fairness

evidence-based (decision making) - planning or decision making based upon "scientific evidence," typically quantitative derived from population studies and/or clinical epidemiology; not all "evidence" is equal or deemed to be persuasive; what counts as evidence is debated; policy makers and clinicians use and have need of different forms of evidence; in most instances, "hard" quantitative data is presumed to be more valid that "soft" qualitative data which might capture aspects of experience not measured by population level statistics. "In the new paradigm, 'effectiveness means doing the right thing, at the right time and in the right way', based on the assumption that it is possible to determine scientifically precisely that" (Armstrong 1999: 20). Reflects the union of management science and medical science. Armstrong (1999) suggests that two kinds of evidence are privileged in health reform: numerical data (number of beds, number of nurses, patient satisfaction) and clinical (preferably derived from the randomized clinical trial). While there are critiques of the limitations of both of these forms of evidence, they continue to dominate policy and administrative decisions.

extra-billing - a form of user fee; "the practice of billing patients directly for an amount over and above the fee covered by governmental health insurance" (Tuohy 1992: 116). Practices of extra-billing varied among the six provinces in which it was practised. In some instances, extra-billing was clustered among certain specialities among medical practitioners and/or in certain localities with the result that such services became unavailable except to those prepared to pay the surcharge for services. Extra-billing was an important practical and symbolic factor in the passing of the Canada Health Act in 1984 which aimed to further enshrine the principles of medical insurance coverage across Canada: universal accessibility, comprehensive coverage, public administration and portability.

familialisation - where responsiblity for care and services belongs to family members or volunteers (Bernier & Dallaire 1999: 10).

gender-based analysis (GBA) - "Gender-based analysis is a process that assesses how proposed or existing policies, programs, and legislation affect women and men differently. It makes it possible to appreciate and identify gender differences, the nature of relationships between women and men and their different social realities, life expectations and economic circumstances. It is a tool for understanding social processes and for responding with informed and equitable options or program changes. Gender-based analysis challenges the assumption that everyone is affected by policies, programs, and legislation in the same way regardless of gender, a notion often referred to as 'gender-neutral policy'" (Prairie Women's Health Centre of Excellence). With respect to health care reform, a gender-based analysis encourages us to ask about whether the practices and initiatives associated with it differentially affect men and women (e.g., Who is more likely to lose their job as a result of hospital mergers? Who is most affected by hospital bed closures and in what ways? Who is more likely to be able to purchase health care services through private insurance?). Central to gender-based analysis is a critique of objectivity

and an acknowledgement of the gender-specific nature of the scientific/medical gaze which continues to value particular forms of evidence (e.g., numerical and clinical) over others (including, for example, qualitative and subjective).

health - increasingly used in a broad sense as in the Ottawa Charter to refer to states of wellbeing as well as the absence of disease; important to define because it sets the parameters for practice and policy, defines the territory of debate, opens up or closes down discussion about payment, responsibility, practice guidelines; a broad definition of health increases attention to the non-medical determinants of health while risking medicalization of aspects of life that were previously considered beyond the medical gaze

health promotion - According to the Ottawa Charter, health promotion is the process of enabling individuals and communities to increase control over and to improve their health. Health promotion is variously understood as a philosophy and/or a set of practices. Techniques associated with health promotion include social marketing, community development, health education, and "healthy public policy" (public policy explicitly attentive to its potential impact on health, designed to support health outcomes, regardless of the sector in which it occurs). The hey day of health promotion was the decade from the mid-1980s through to the mid-1990s when federal, provincial and local health departments established health promotion programs, departments and staff positions. Today health promotion has been supplanted in many domains by population health, though the underlying activities associated with health promotion continue.

health reform - Current health reform is characterized by a business paradigm in which health is a market good, patients are customers, and market-like mechanisms, managerial principles, and strategies are used. "Health reform includes: recent government statements regarding the goals and principles of health reform changes to the structure of the health system, including the establishment of regional health districts or authorities regionalization) changes in the organization and delivery of health services changes in the amount of staff and money given to various health care and health promotion programs" (Prairie Women's Health Centre of Excellence).

health care system - Sometimes contrasted with a "health system" which would recognize the influence of factors beyond the delivery of services by hospitals and medical personnel as being important in attaining health. Some critics suggest that the health care system is really a "sick care system" and that a "health system" would incorporate activities and initiatives across the spectrum of determinants of health, from housing to social justice. The health care system typically includes the network of acute care hospitals, chronic or long-term care facilities, laboratories, the public health system (which includes inspection services, vaccinations, health education, etc.), pharmaceutical services, research institutes, and rehabilitation facilities, along with their respective personnel. Increasingly, in health reform, hospitals are being encouraged to redefine their "core mission" as the delivery of health services such that activities such as laundry, food services, laboratory and some rehabilitative services are seen as non-essential services which could be offered by other service providers.

home care - formal and informal services provided in the home; typically refers to formal programs; may be coordinated with or separate administratively from other forms of care; may be provided by family members, volunteers, paid workers in non-profit, for-profit, private and/or public enterprises

hospital - today refers to institutions focused upon acute care which in turn has been narrowly defined to include only the most severe and short-term illness or injury (Armstrong 1999: 27); privately run corporations providing publicly insured services. Under provincial legislation, most hospitals – 95 percent – operate on a nonprofit basis and, incompliance with the Canada Health Act, provide publicly insured services at no extra charge to patients. But most of Canada's 850 hospitals are privately owned by private societies or voluntary organizations and run by community boards, voluntary organizations, or municipalities" (Fuller 1998: 226-7). The remaining 5 percent of hospitals are privately owned and operate as for-profit facilities offering non-acute care services such as long-term or extended care or addiction services.

hotel services - a renaming of aspects of hospital activities not directly associated with clinical care; includes such things as laundry, food services, housekeeping, and building maintenance; Pat Armstrong notes that a determinants of health approach would recognize these aspects of hospital care as contributing to health; one of the areas of activity in which considerable outsourcing and/or privatization is occurring, with varying results

information technologies - typically refers to electronic databases and communication devices but could encompass more traditional forms of information collection such as physician handwritten medical records; currently an area of shifting responsibility in Canada with respect to health information; previous data collected by Statistics Canada, Health Canada and various hospital association and is now lodged with the Canadian Institute of Health Information (CIHI); Who owns data? How is privacy protected? Who should have access to data? Who can afford access? For what purposes? Are data set linkages advisable, ethical, responsible, meaningful? In our October workshop we distinguished between clinical information, outcomes information and managerial information. Presumably these represent different goals for information use (e.g., clinical decision making versus program evaluation versus cost-effectiveness) as well as different preferences regarding measurement, availability, access, ownership

integration - likely means various things to various people; for some it might mean one-stop health care facilities, for others it reflects communication between care providers, for managers it may mean coordination, reduction of overlap and duplication of services, ?

integrated health-care delivery - A term used by U.S. corporate sector to "describe a merger of payers and providers, whether those payers are workers' compensation or health insurers, and whether those providers are pharmaceutical or rehabilitation companies. In this scenario, health-care integration is facilitated by the manipulation of

information systems tracking patients' use of prescribed drugs, medical products, and services . . ." (Fuller 1998: 284).
managed care - A term used to describe systems of rationalizing health care utilization such as the use of pharmaceutical formularies and procurement policies.

managed competition - Defined by the OECD as "government regulation of a health care market which uses competition as the means to achieve efficiency objectives within a framework of government intervention to achieve other policy objectives such as equity" (in Armstrong 1999: 17).

medical necessity - A term introduced in the *Canada Health Act* to describe the services which provinces are obliged to insure under their publicly funded insurance scheme. In practice, medical necessity has not been defined and is sufficiently subject to interpretation that it is used to rationalize the de-insuring of various services such as annual eye examinations, annual physical examinations and *in vitro* fertilization, depending upon the jurisdiction. When medicare was initially established, policy makers felt no need to define medical necessity because of the assumption they held about health care, namely, that "all health services were necessary," rendering the question of medical necessity moot (Fuller 1998: 77). The lack of agreement about what constitutes medical necessity creates possibilities for variation in the services available in different jurisdictions (wart removal is no longer paid for in British Columbia unless it is on the foot and therefore causing distress) and among different sectors of society (e.g., different age groups may have different access to services). By incorporating 'medical necessity' into its criteria, the *Canada Health Act* enlarged the space for private insurers to develop a market in providing supplementary health benefits (Fuller 1998).

medicalization - The process by which something comes to be defined as falling within the domain of medicine. Child birth is often cited as one such example. Previously the purview of women and a system of lay midwives, in the western world, prenatal care and child birth came to be regarded as in need of the specialized care of physicians and hospitals. Gradually, home birth was replaced by hospital birth. Debate rages over whether pregnancy and child birth are health problems and should be treated in hospitals by doctors or nurses or "natural" processes which can mostly be handled by experienced but not necessarily medical care providers.

medicare - Canada's national health care program, "under which Canadians receive 'free' hospital care and physicians' services on the basis of financing provided by the provinces, supported by federal funding and legislated standards under the Canada Health Act" (Tindal 1997: 311).

opting out - A term for a practitioner choosing to wholly or partially bill patients directly for services rendered. Some care providers accept co-payments from individuals and the public insurance system. Others bill patients for the entire cost of services. This term does not refer to services which were at one time covered by public insurance but are no

longer (de-insurance or de-listing) but rather to the practitioner's choice of payment system.

outsourcing - Also called "contracting out," "partnerships" or "alliances". These terms cover a variety of arrangements involving the transfer of activities from inside an organization to outside personnel and organizations. "Selective outsourcing is used to farm out specific jobs, for example food preparation or maintenance. Facilities management (a service captured in NAFTA) occurs when a team is hired to oversee all operations at a hospital. Transitional outsourcing brings in an 'outsourcer' for a few years, after which the operations are returned in-house when the hospital has learned how to run them. And finally, full-service outsourcing turns over an entire operation, such as information systems, to outside companies. Contracting out services often displaces hospital employees, reducing the facility's labour costs while providing new opportunities for big corporations" (Fuller 1998: 230).

NAFTA - North American Free Trade Association. Established in 1992, NAFTA links Canada, the United States and Mexico in a trade agreement which has an overall objective to eliminate tariffs and other barriers to free trade over a fifteen year period. While generally regarded as likely to have an effect on a number of economic sectors, including the auto industry, agriculture, fisheries and forestry, textiles and apparel, metals and minerals, machinery and equipment, and services such as transportation, telecommunications, financial services and business and professional services (Tindal 1997), the effects in the health care sector were not necessarily anticipated or widely discussed. Fuller (1998) suggests …

para-public sector - Brooks (1989) describes the para-public sector as including those organizations and services which are funded by public monies but operate without direct government control. This sector includes the major institutions in the education and health sectors such as school boards, university and college administrations, hospitals and other health care-agencies. "These organizations constitute an extension of the state system in terms of their policy goals and their sources of financial support" (Brooks 1989: 160). The federal government role with respect to these organizations revolves around formulating, monitoring and evaluating the conditions of its financial support of provincially administered programs.

partnership - Increasingly refers to public-private collaborations in which public bodies accept private monies to fulfil activities or formerly public activities are transferred to private agencies and corporations; Under a government-wide Program Review, a "partnership test" was understood to involve asking "What activities or programs should or could be transferred in whole or in part to the private or voluntary sector?" (Armstrong 1999: 23).

population health - An "approach which differs from traditional medical and health care thinking in two main ways. (1) Traditional health care focuses on risks and clinical factors related to particular diseases. Population health strategies address the entire range of

factors that determine health. Health is affected by the type of care and services provided, but also by social and economic factors such as social status, income, level of education, child development and social supports, commonly known as 'health determinants'. (2) Health care deals with individuals one at a time – usually individuals who already have a health problem or are at a significant risk of developing one. Population health strategies are designed to affect the entire population" (Health Canada 1999: 36).

public payers - federal, provincial/territorial or municipal governments, workers' compensation boards

public policy - "Public policy is the broad framework of ideas and values within which decisions are taken and action, or inaction, is pursued by governments in relation to some issue or problem" (Brooks 1989: 16). "A commitment to a course or plan of action designed to address a concern, problem or need agreed to by a group of people with the power to carry it out. Sometimes the chosen course of action is no action at all—in this sense, inaction can also be a policy" (Prairie Women's Health Centre of Excellence). In Thomas Dye's (1978) words, public policy is "whatever governments choose to do or not to do".

private payers - individuals, employers or insurance companies

privatization - in the hospital sector, privatization refers to a shift not in who provides the service but in who pays for it; privatization of hospital services means that costs shift from public payers to private insurance plans and individuals; may arise from delisting of services; involves the transfer of public health dollars from non-profit to for-profit sector

providers - institutions, corporations and individuals who organize the finances, supplies and care that patients or clients need to be healthy or to regain health

regionalization - Devolution on from higher level governments to lower levels on a geographic basis. Most provinces in Canada have undertaken to devolve some aspects of health care service organization, administration, funding, delivery or policy making to lower levels structures such as regional health boards, district health councils, or community health centres.

sex/gender - Sex and gender are commonly employed to distinguish between biological or natural characteristics and social or cultural characteristics. For example, Health Canada (1999: 35) defines these terms as follows. "Sex (as in 'sex differences') refers to biological characteristics such as anatomy (e.g., body size and conformation) and physiology (e.g., hormonal activity and the functioning of the reproductive system) . . . . The term 'sex' is also used when referring to the two main groupings of the human species, as in 'clinical trials included both sexes'." "Genders (as in 'gender differences') refers to the array of socially determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. 'Gendered' norms shape the nature of health issues and influence the health system's practices and

priorities. For example, women are more vulnerable to sexual or physical violence, low income, lone parenthood, gender-based causes of health risks and threats (e.g., accidents, STDs, suicide, smoking, substance abuse, prescription drugs, physical inactivity); often the system addresses these issues without taking into account their gendered nature. Measures to address gender inequality and gender bias within and beyond the health system will improve population health." "Biological traits influence gender characteristics and vice versa. For instance, gender roles influence the nature and extent of violence between men and women but sex differences also play a role in that women are generally smaller and less physically strong. Gender and sex are interactive." In sum, "Gendered people do not emerge from physiology or hormones but from the exigencies of the social order, mostly, from the need for a reliable division of the work of food production and the social (not physical) reproduction of new members" (Lorber 1998: 20).

suppliers - corporations that manufacture, prepare or distribute any of a number of products (e.g., computers, food, linens, electricity, laboratory equipment)

two-tier system - A health care system which would involve two parallel systems, one for those who had their costs covered by public insurance, another for those willing to pay directly for their care themselves. Canada has maintained a single-tier system to date in which there is a provider/payer split in which the providers are private, fee-for-service physicians and mostly private, non-profit hospitals. A two-tier system is favoured by those who believe that it would reduce demand on the public system by permitting those people with means to purchase care at their own expense (they would leave the queue for services). A two-tier system is resisted by those who believe that it would lead to inferior care within the public system as a result of the incentives to practice within the private system.

user fees - Fees paid by patients or clients for care. Sometimes these are co-payments, sometimes they are the entire fee. People with private insurance can usually claim reimbursement for their user fees; persons without private insurance must pay the cost themselves. While the *Canada Health Act* outlawed user fees and extra-billing by physicians, it did not stipulate that such fees could not be charged by other care providers. Provinces establish both which services may charge user fees and the rate of those fees.

voluntary work - not a term I came across but presumably a euphemism for "involuntary" work, that is, unpaid caregiving by family members, typically women

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