

Canadian Health Care: Privatization and Gendered Labour

Thursday 9 February 2012, by [ARMSTRONG Pat](#), [LEFEBVRE Priscillia](#) (Date first published: 6 February 2012).

Priscillia Lefebvre (PL): A large focus of your research seems to be the ways in which gender and labour intersect from the vantage point of health care delivery. What have been the main influences that have affected the trajectory of your research in terms of a feminist rooted political economy approach? Why is this approach so important in understanding the contradictions that exist regarding the role of women within health care?

Pat Armstrong (PA): It is difficult to identify the main influences on my thinking and research. Growing up in a family where community involvement was not only encouraged but required meant seeking engagement at university. Also, the red Tory approach in our household did not fit so comfortably with the Marx I read as a student in the 1960s or with the growing feminist movement I participated in. As Juliet Mitchell [[1](#)] explained, Marx was not good about women and did not provide a detailed blueprint for analysis, but he did offer a way to make systems transparent and to think about progressive change.

In my reading of Marx, work and the political economy are where the analysis should start because they are so powerful in shaping our lives; however, both productive and reproductive work have to be understood in historically specific ways and in ways that comprehend contradictions as well as interrelations. Indeed, contradictions can provide a basis for creating alternatives. Starting with power and economic forces did not imply ignoring ideas, discourses and cultural practices, but it did put those ideas, often blamed for women's subordination, into a context that allowed us to see the power embedded in them and in their reproduction. Furthermore, starting with the political economy did not mean ignoring gender and other basis for inequities. Rather, as we argued in the 1970s and 1980s, gender had to be theorized at the highest level of abstraction if we are to think through the implications for change in our lives. This relates, in turn, to another influence, which was involvement in student and other politics.

My feminist political economy approach develops in such practices, as well as through engagement with other academics. Canadian Studies at Carleton University in the early 1970s provided fertile ground for the further development of my ideas about political economy with a clearly Canadian twist and so has my continuing policy work. As I became increasingly interested in feminist issues, I abandoned a thesis on the class origins of student activists and focused instead on women's paid and unpaid work. The result was *The Double Ghetto: Canadian Women and their Segregated Work*, [[2](#)] a joint project with my partner Hugh Armstrong, as is much of my research. When our daughter broke her leg and ended up in the hospital for weeks, we realized that health care covered all aspects of women's work. Paid and unpaid work overlapped in obvious and gendered ways, as the staff told me, but not Hugh, where I could get our daughter juice and empty the bed pan. There were unionized and non-union workers, full, part-time and casual jobs, work defined as highly skilled and jobs defined as unskilled, occupations dominated by women classified as managerial, clerical, professional, and service, with many women from racialized and/or immigrant groups. What it took us longer to realize – but what we should have realized as political economists – was that health care provides a unique context and required us to learn about a wider range of forces, policies and

practices in care.

Women are not only the majority of workers, but also the majority of patients and of those who take others for care, creating complicated and often contradictory gender relations. Equally important from our perspective, health care in Canada offers a clear example of how universal programmes can create social solidarity by demonstrating the impact of collective action. What a political economy approach allows us to do is think through the ways work, gender and other inequities intersect, to explore the ways economic and political forces shape not only services and employment, but also ideas, and to bring together the complexity of work relations within this specific historical context. This approach also helps us see the contradictions in, for example, nurses fighting to distance themselves from links with women's caring. [3]

PL: In a previous article published in a 1983 special edition of *Alternate Routes*, [4] you outline the problematic nature of quantitative data analysis as gender-blind. Since then, you have been involved in several working groups, including the National Coordinating Group on Health Care Reform and Women (now Women and Health care Reform), dedicated to researching health care reform policies and their impact on women both as health care providers and recipients. In your experience, what have been the greatest research challenges in gathering information on gender and sex differences within health care in Canada? In your opinion, what needs to be explored further?

PA: In my view, many of the challenges remain the same. There are still problems with the way data are collected and categorized, with the failure to collect some kinds of data and a further problem with the way the data are analyzed and with what gets accepted as good science. In too many cases, quantitative data are still seen as providing the truth and the whole truth, while qualitative data are too often treated as suspect. Especially in health care, there is a hierarchy of evidence in terms of what kinds of data are accepted as legitimate and worthy of attention with the meta-analysis of double-blind randomized clinical trials taken as the gold standard because they are assumed to remove all bias. Yet numbers, and categories, continue to reflect values.

One example from our recent research is the definition of industry. [5] In the past, Statistics Canada defined industry as 'where people work.' Thus, everyone who worked in hospital would be counted as working in the health care industry. Now industry is defined as 'who you work for,' removing from health care all those whose jobs have been contracted out, most of whom are women and many of whom are from racialized groups. A second example comes from data on work-related violence. [6] Our interviews with women employed in long-term residential care indicate that many women fail to report violence, in part because they will be blamed, in part because they won't be believed, and in part because it takes too much time. The result is underestimates of violence in the numbers.

At the same time, research is still published that failed to collect data by sex, and even more frequently, without analyzing the data by sex or gender. Most frequently, the approach to data collection and analysis makes it impossible to do a gender analysis. Women and Health Care Reform has illustrated the problem by looking at wait times for hip and knee surgery, demonstrating that we need to look at the entire patient journey to see the ways gender influences how long women wait and even whether or not women get the surgery they need. [7] A mere comparison of the number of women who get surgery compared to the number of men tells us little about equity. As Women and Health Care Reform struggled to figure out how to ensure gender could be included as a criterion in meta-analysis such as Cochrane reviews, we came to realize that in their attempt to ensure scientific validity such reviews sought to eliminate context. As a result, they eliminated gender and racialization because both are about social relations in context.

In addition, new problems have arisen since we wrote that article. At the time Statistics Canada data

were free and now much of it must be paid for. In the past, we could analyze the data in the way we saw fit. Now for access to much of the original data, you apply for access and then you have to go through a data analysis centre where the analysis must be vetted. Of course, the government has attacked the long-form Census in general and a critical question for feminists in particular, the one that asked about unpaid work. Does gender have an impact, and in what ways, needs to always be part of the question, whatever the research, but this lesson has still not been learned by far too many researchers and policy makers. So, what needs to be explored further is a huge question. In short, we have some more data by sex, but too little analysis by gender and too much faith in numbers.

PL: Much of your work focuses on the privatization of health care and its detrimental effects in terms of access to treatment and quality of care. In *Exposing Privatization* [8] (p. 163), you outline the introduction of privatization measures to health care beginning with the majority Conservative government in Ontario in the mid-90s. Given the current Tory majority at the federal level and provincial inroads to privatization in Ontario, do you see this as a particularly critical time in defending health care as a public good, rather than a competitive market commodity? What are your thoughts regarding Stephen Harper's recent statement that, although the federal Conservatives have no plans to go private, he cannot control the kinds of alternative delivery models used at the provincial level?

PA: The best defence of public health care is popular support and we need to mobilize that support more than ever because we are facing a huge threat. The biggest threat now, in my view, is not costs but further privatization in all its forms. Those pushing for privatization know that medicare is Canada's best loved social programme and so have privatized by stealth, always promising public payment. They have claimed there is a crisis and that health care cannot be sustained; that it must be radically transformed in order to save it. Fear is a powerful force, especially when your health is at stake. Our biggest problem in defending public care is complexity and the difficulty of getting people to understand why it is wrong to have forprofit delivery, even if the money comes from the public purse rather than from private payment, and why health care is as sustainable as we want it to be. I think the Federal government will be very crafty while promoting deep privatization. It will negotiate individually with provinces and territories, allowing them to go their own way and blame the consequences on them. Of course, the Prime Minister can stop that. Monique Begin did when she was Minister of Health and Welfare. But Prime Minister Harper will not intervene, so we need to put pressure at the local level and keep educating people about the perils of profits in care. If we do not stop this erosion soon, it will be too late.

PL: In your opinion, how harmful are agreements such as the Canada-European Union Comprehensive Economic and Trade Agreement (EU-CETA) to Canadian health care and how are women affected in particular?

PA: In many ways, these new agreements have much the same impact as earlier ones and have particularly negative consequences for women as a group and for particular groups of women. [9] The agreements are written to promote profit and limit governments' capacity to shape their own economies and public policies. It is much harder to influence policies if governments are prohibited from acting in the public's interests and are instead forced to act in the interests of global profits. Because more women than men depend on the state for services, financial support, jobs and protections against things like violence at work, agreements that limit or prevent governments from regulating, protecting, and providing have a particularly negative impact on them. The result is likely to be greater inequities among women, as well as greater inequity between women and men.

PL: Labour disputes, in particular organized labour, have received much political attention recently. For example, in an unprecedented move, postal workers were recently legislated

back to work on a lockout. Do you consider the recent use of back to work legislation in both the private and public sectors as threatening to the collective bargaining rights of unions? Also, how do you think these latest negotiations will affect the collective organization and labour struggles of health service workers (for example, nurses and home care workers)?

PA: The attacks on labour are no surprise and it should be clear that attacks on unions in the public sector are attacks on women who make up the majority of unionized workers there. One factor that kept families going during the most recent economic crisis was women's employment in the public sector in general. [10] We are building up to massive cuts in the health sector, where four out of five workers are women and where one in five women works. Those who keep their jobs are likely to see them get worse as privatization is pushed further. Cutbacks in public pensions and benefits will also hurt these women, as well as their families. At the same time however, women employed in health care enjoy tremendous public support. If the unions in the public sector can come together and resist, we may see real limits on attacks from the government. Few doubt these women work hard, few think they are overpaid or pandered to by their employers, so it is much harder to sell the line about being pampered employees or to promote the politics of envy with them, as has been done with other unionized workers.

PL: Finally, in *Critical to Care* [11] (p. 53), you argue that much of the labour performed by women in health services is essential in terms of providing care, yet remains peripheral in terms of social and economic status. Your research indicates that due to this gendered division of labour in health care women are the primary health care providers in Canada, yet women hold very little decision making power when it comes to policy. Also, not only is it highly gendered, it is highly racialized. In your opinion, to what extent has the introduction of state level initiatives, such as the Foreign Live-In Caregiver Program, perpetuated these inequities? Also, even if such initiatives did not exist, how far do you think 'within system' efforts, such as changes to policy, will go in resolving these inequities? Is a shift beyond the present political system also needed?

PA: These are complicated questions and difficult to answer in part because I think there are contradictory policies and practices. Universal health care has undoubtedly helped women, both as care providers and as those with care needs. Women's employment conditions are better in the public sector and they have more power there, in large measure because unions have been strong, but also because there are pressures within and outside government to respond to calls for human rights and to set an example as a model employer. [12] Initiatives such as Pay and Employment Equity have helped make employment in the public sector more equitable than in the private sector. Of course, these gains are precisely why there is pressure on governments to abandon these policies and to attack unions; attacks supported by many within governments.

This is not to claim that health care has been equally accessible or that employment practices in the public sector have resulted in equity but we can demonstrate that women do better in the public sector than they do in the for-profit one. At the same time, the way health care has been organized and policies developed have in many ways reinforced not only women's responsibilities for care, but also the inequities among women. This is happening increasingly with current reforms. Nor is it to argue that we should try to return to some 'good old days.' Those days were not all good and, in any case, they are gone. We are dealing with a new reality and 'old' means of undermining the gains we made. Nevertheless, I think that we should struggle for government policies that promote equity. Universal public daycare combined with more public homecare, for example, could help make the Foreign Live-in Caregiver Programme irrelevant. If workers in these services were unionized and supported by strong anti-racist programmes, it would help address some inequities.

However, it is not sufficient, in my view, to rely on governments alone. We need strategies that address conditions of work and care within the voluntary and for-profit sectors as well, even while we work for public care. We also need strategies to change the power inequities within households. I agree, then, with the implications of your question that we need to shift beyond the system and that we need to connect multiple policies in and outside the state, but I think that it is still important to work to change public policies.

P.S.

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Footnotes

[1] Women's Estate by Juliet Mitchell. Harmondsworth: Penguin, 1971 and "Marxism and Women's Liberation" by Juliet Mitchell. Social Praxis 1(1):23-33.

[2] The Double Ghetto: Canadian Women and Their Segregated Work by Pat Armstrong and Hugh Armstrong. Toronto: McClelland and Stewart, 1978.

[3] "Contradictions at Work: Struggles for Control in Canadian health care" by Pat Armstrong and Hugh Armstrong in Morbid Symptoms Health Under Capitalism, edited by Leo Panitch and Colin Leys. 2009. Pontypool: Merlin Press, Pages 145-183.

[4] "Beyond numbers: Problems with Quantitative Data," by Pat Armstrong and Hugh Armstrong in Alternate Routes: A Critical Review, Vol. 6. Ottawa, Ontario: Carleton University, 1983. Pages: 1-40.

[5] "Doubtful Data: Why Paradigms Matter in Counting the Health-Care Labor Force" by Pat Armstrong, Hugh Armstrong and Kate Laxer in Work in Tumultuous Times: Critical Perspectives, edited by Vivian Shalla and Wallace Clement. Montreal and Kingston: McGill-Queen's University Press, 2007 "Precarious Work, Privatization, and the health care Industry: The Case of Ancillary Workers." Pat Armstrong and Kate Laxer in Precarious Employment. Understanding Labour Market Insecurity in Canada edited by Leah Vosko. Montreal: McGill-Queen's University Press,

2006.

[6] *Critical to Care: The Invisible Women in Health Services*, by Pat Armstrong, Hugh Armstrong, and Krista Scott-Dixon. Toronto, Ontario: University of Toronto Press, 2008.

[7] "Waiting to Wait: Improving Wait Times Evidence through Gender-Based Analysis by Beth Jackson, Ann Pederson and Madeline Boscoe in *Women's Health. Intersections of Policy, Research, and Practice*. Edited by Pat Armstrong and Jennifer Deadman. Toronto: Women's Press, 2009. Pages 35-52.

[8] Bernier, Kay Wilson, Karen R. Grant, and Ann Pederson. Toronto, Ontario: University of Toronto Press, 2001.

[9] "Trade Agreements, Home Care and Women's Health." By Olena Hankivsky, Marina Morrow, Pat Armstrong, Lindsay, Galvin and Holly Grinvalds. Ottawa: Status of Women in Canada, 2004.

[10] "Women Forced to Work Longer, harder, For Less Pay by Pat Armstrong in *Speaking Truth to Power* edited by Trish Hennessey and Ed Finn. Ottawa: CCPA, 2010. Pages 7-14.

[11] *Critical to Care: The Invisible Women in Health Services*, by Pat Armstrong, Hugh Armstrong, and Krista Scott-Dixon. Toronto, Ontario: University of Toronto Press, 2008.

[12] "Precarious Work, Privatization, and the health care Industry: The Case of Ancillary Workers." Pat Armstrong and Kate Laxer in *Precarious Employment. Understanding Labour Market Insecurity in Canada* edited by Leah Vosko. Montreal: McGill-Queen's University Press, 2006.