

WORKING PAPER

PRECARIOUS EMPLOYMENT IN THE HEALTH CARE SECTOR

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Health care has become a global industry, one that provides a revealing entry point for understanding precarious employment. Much of care work is unpaid and all of it is highly gendered. Providers and patients increasingly move around the world, creating not only precarious employment but also critical questions about the regulation and definition of care work. At the same time, the health-care sector, which includes unpaid health-care work as well as the paid work of the health-care industry, allows us to link both productive and reproductive labour through a gender lens.

In this chapter, we argue that using the health-care sector as an entry point for studying precarious employment also presents important analytical and comparative challenges. Different definitions of 'health' lead to different approaches to the relationship of health care to other forms of care, both within and among countries. The fact that most care work, including health care, is undertaken by women can result in its being undervalued in research as well as in remuneration. Indeed, it can be ignored. The blurring of public/private distinctions contributes as well to the difficulty in understanding care work and the extent of related precarious employment.

In addition to making comparisons over time and among jurisdictions difficult, we argue that changes in industrial and occupational classifications both reflect and reinforce an emphasis on a medical model of health care, as distinct from a social model. So too do international trade agreements. And both help make more health care work more precarious.

The chapter begins by setting out different definitions of health, definitions that lead to the elaboration of medical and social models of care. We then examine the implications of these models for precarious employment. The next section addresses global forces that are intensifying precarious employment, notwithstanding the important contextual differences that are also at work. This exploration is followed by a discussion of why the health-care sector offers an important entry point for the further study of precarious employment.

THE SOCIAL AND MEDICAL MODELS

Health can be thought of in negative terms as the absence of illness (as perceived by the individual), disease (as diagnosed by a health-care professional), injury, and perhaps disability (although persons with disabilities often dispute the assumption that their conditions are in whole or in part matters of ill-health). Health can also be thought of in more positive terms, even as, in the words of the World Health Organization (WHO), ‘a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity’ (WHO 1985).

These different definitions give rise to different models of health care. The negative definition is associated with the familiar medical model, below. The positive definition is associated with the social model. Although this latter model has some purchase, at least at the level of discourse in countries such as Canada (see for example Crichton *et al.*, 1997), the point of departure in this chapter, it is more frequently identified with several European countries. According to Vaughan-Whitehead (2003: 6) this model implies a commitment to social justice, social dialogue and social inclusion. This in turn means a high level of social protection and the provision of services by the state based on notions of shared risk and responsibility (Vaughan-Whitehead 2003: 4). The emphasis on redistribution and social protection implies collective as well as individual rights and a guarantee of services understood as addressing the general public interest. It implies efforts to eliminate discrimination and to promote equity, along with support for unions. It translates into public services such as health care and child care, based on notions of shared right to care and comprehensive services. It can also mean care is understood as a relationship embedded in social relations often specific to place and may mean that the unpaid care primarily provided by women is recognized in some way.

The Victorian Government in Australia (Victorian Government Health Information 2008: 1) explains that the ‘social model is a framework for thinking about health. Within this framework, improvements in health and well-being are achieved by addressing the social and environmental determinants of health, in tandem with biological and medical factors’. Such determinants of health include, at least according to the Public Health Agency of Canada (2008), health services, income, physical and social environments, employment and

working conditions, social support networks, healthy child development, education and literacy, biology and genetic endowments, gender and culture. From this perspective, health is also socially constructed rather than simply biologically determined or technically produced. Health results primarily from favourable economic, social and physical conditions and relations, as distinct from the effects of most health care interventions undertaken after someone becomes diseased, disabled or injured. This model thus locates biology and health care in a broader context, one that focuses on the root causes of health and ill-health.

This is a model, not a description of reality in Europe, Australia, Canada or anywhere else. Indeed, the reality throughout the high-income world is more closely aligned, albeit to varying degrees, with the medical model. Like the social model, the medical model is embedded in the larger social context and reflects values expressed within that context. It is most commonly associated with North America and especially with the United States, where the emphasis is on the individual, limited state intervention and little shared responsibility.

Within this model, health and social care are more narrowly defined. Based on what is termed the allopathic approach, health services are focused on what are understood as biologically and genetically determined diseases and disabilities, as well as on injuries, all affecting particular body parts (Armstrong and Armstrong 2003: Chapter 2) . Services are focused primarily on chemical or surgical intervention, with a great deal of specialization linked to specific biological issues. Doctors are in authority, with other health professionals

generally playing subservient roles, and with health care workers who are not labelled professional often considered to be outside the health care sector entirely (Armstrong *et al.* 2008), notwithstanding their self-identification with the sector (White 1990). Skills are usually understood as being restricted to those applied by professionals, people with specific, formal training in allopathic approaches to care. With health care defined in terms of body parts, it is easier to see workers as universally interchangeable and as subject to managerial strategies that divide work into specified, measurable tasks. Individuals are held primarily responsible for their own health and care, with some state support for the most vulnerable. Similarly, child health support is essentially about medical services. Child care is largely outside state responsibility and parents are held responsible for their own children. The unpaid work of care is assumed to be a family responsibility and is assumed to be done primarily by women. Rights are primarily about individuals rather than the collective, with markets, at least in theory, critical for distribution. Low wages and what are defined as low skills are often central to health care delivery, especially for those from racialized groups (Vaughan-Whitehead 2003: 23).

Of course, these are ideal types and there are significant differences not only in principles but also in practices both among and within countries. In Canada, for example, in the 1984 *Canada Health Act* (2008: 1) there is an explicit commitment ‘to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers’. There is recognition of collective responsibility and shared financial risks, but this responsibility is narrowly defined in terms of doctors and hospitals without consideration of more

comprehensive care. Equally important, Canada has no legislation related to child care even though Canada recognizes healthy child development as critical to health (see Vosko and Clark, this volume).

In spite of the distance between models and practices and the variations among and within countries, it is necessary to identify the principles at work and how they manifest themselves on the international, national, regional and local scales. This is critical because models shape the nature of the care relationship and the way data on that work are constructed. In the social model, for example, if care is defined as a collective right as well as an individual one — one for which the state has considerable responsibility — and if we understand care as a relationship, the fact that the person needing care has a right to that care can make the relationship both dignified and relatively secure for both the provider and the person with care needs. In the social model, care is broadly defined and thus a broad range of workers could be counted as working in the sector, including child-care and home support workers, housekeepers and cleaners in hospitals. For instance, WHO (2006: 1) ‘defines health workers to be all people engaged in actions whose primary intent is to enhance health’ and acknowledges that this should include unpaid care work done by mothers, even though WHO then fails to do so. The skill involved in the work may also be recognized and the work appropriately rewarded. Equally important, there may be recognition of the unequal division of labour between women and men, the skills involved in the work and the need to protect the wages through unions and other mechanisms.

In contrast, the medical model and its variants encourage a narrow focus on a limited range of services. Collective rights are also more narrowly defined, creating conditions that can make the care relationship more precarious both for those with care needs and for the care providers because neither can count on a stable care process. In our interviews on managed care with nurses and doctors in the United States, for instance, there were frequent references to strategies these providers employed to allow patients to get into and stay in health services. The precarious nature of the individual right to care puts stress on the providers as well as on the patients, creating poor conditions for both.

Under the medical model, only some workers may be counted as part of the health care sector. Galarneau (2003: 16) explains that, for Statistics Canada, 'Health care workers can be divided into three major categories: professionals, technical personnel, and support personnel'. Health professionals are those 'primarily concerned with diagnosing and treating health problems in humans and animals and with providing related services such as pharmacy, nutrition, speech therapy, physiotherapy and occupational therapy' (Galarneau 2003: 17). Both registered nurses and licensed practical nurses are included in this professional group. Technical personnel are 'primarily concerned with providing technical services to professionals' while support personnel are 'primarily concerned with providing technical support to professionals' (Galarneau 2003: 17). This latter group includes assistants and aides, orderlies and patient service associates. These personal care workers are often included when they work in hospitals and excluded when they work in homes as home care workers. Also often missing from the data are those who cook and clean, keep records and do laundry in health organizations. Thus, there can be people whose jobs are

not counted as health care work in the medical model, though they would be in a social determinants of health approach.

Furthermore, under this medical model, child-care workers are excluded altogether and those doing unpaid work are usually ignored or left uncounted. The OECD (2007: 54) defines health care resources even more narrowly, focusing exclusively on doctors and nurses, excluding dental, public health and epidemiology from their count of medical and nursing graduates: its numbers on practicing nurses include only those with post-secondary education in nursing and ‘vocational/associate/auxiliary/practical nurses, with a lower level of nursing skills but also registered or licensed’. There is no talk of the unpaid providers, most of whom are women.

By contrast, the social model of health care, with its emphases on the social determinants of health, on social supports for those with chronic conditions (including those residing outside institutional settings), and on the non-medical aspects of care within institutions, at least opens a door to the inclusion of non-medical, non-professional health care workers. These include the so-called ancillary workers who clean health institution laundry, equipment and facilities; who prepare and serve meals in these institutions; who keep health records; and who provide personal and housekeeping support in both institutions and private homes. They are overwhelmingly female. And to the extent that their vital work is dismissed or ignored, they are more likely to experience precarious conditions of employment, if they are employed at all. Many if not most of these women and men are in

fact unpaid, 'conscripted' in the words of Canada's National Forum on Health (1997: 19) when they provide the care at home for their loved ones, and for their friends and neighbours. When they are paid, as in different parts of Europe under different conditions (Ungerson and Yeandle 2007), there remains the open question of the extent to which their commodification represents the exploitation of workers or the protection of families.

These two primary models shaping health care work highlight the importance of context and the social construction of both labour and the care relationship in this sector. The underlying principles of the models explicitly or implicitly guide the nature and conditions of employment in the sector. So do assumptions about women's paid and unpaid work. We now turn to a discussion of the global forces pushing in the direction of increased precarious employment across the industrialized world.

GLOBAL FORCES

Although countries and even regions and local areas vary significantly in how their systems are organized and in the assumptions on which the systems are based, they face similar global as well as internal forces. Arguably the most important is the pressure to turn health care services into sources for profit. Related to this pressure is the push to transform governments to make them act like profit-making organizations. This push, in turn, is related to the migration of workers and care services around the world as corporations, governments, and individuals seek economic rewards, cost savings and employment. And, finally, there is the pressure that comes from new technologies and related demands as well

as from the increasing longevity in high-income countries. This section considers each of these pressures in turn, linking them to the growth in precarious employment and care.

Health care in all countries has not, until recently, been a major source of profit. Services were primarily provided by non-profit or charitable organizations and by some governments, often at the local level. The many general practitioners and other doctors in private practice were typically self-employed in solo or small group practices, not employed by investor-owned firms. And, outside the United States, most of their income came, and continues to come, from the public purse. At the same time, some aspects of health care, such as pharmaceuticals and technologies, have always been produced in large part on a for-profit basis by investor-owned corporations. Until recently, however, investor-owned companies in health care *services* were virtually unknown. Indeed, there is still a great variety in ownership of health services and in ‘no country is the “for-profit” firm dominant’ (Cookson *et al.* 2005: 123). Health care services thus offer a new frontier for investment by for-profit firms.

The transformation of non-profit and government services into for-profit ones has significant implications for employment in the system and for the principles on which care is based. In his book on the introduction of the profit motive into US health services, Gray (1991: Foreword) explains that ethical and social responsibilities have been replaced by economic concerns:

Today, some hospital administrators are accountable to profit-oriented headquarters rather than local, community-oriented boards; state regulators are no longer monitoring purely local institutions but multi-institutional chains that span many different communities in different states; and third party payers are trying to impose limits and conditions on levels of expenditures based on criteria other than altruism, professionalism, and an orientation towards service on the part of health care providers.

Since the publication of Gray's book, for-profit firms have moved far beyond national borders to become international conglomerates, supported by trade agreements and international organizations of various sorts (Global Health Watch 2005: 13–16).

Speaking of the emerging for-profit health maintenance organizations in the United States, Ellwood and others suggested that they 'could stimulate a course of change in the health industry that would have some of the classical aspects of the industrial revolution – conversion to larger units of production, substitution of capital for labor, vigorous competition, and profitability as the mandatory condition of survival' (quoted in Bodenheimer 1995: 26). To this list, Ellwood could have added the fragmentation of work into discrete, measurable tasks that allow the substitution of lower paid labour for higher paid labour, the contracting out of labour-intensive work, short-term and part-time employment — other common strategies in the for-profit sector. These strategies are closely linked to the medical model of care. Medical caregivers are increasingly narrowly defined as only those who have been successful in being designated professional, with more

tasks given to other workers such as cleaners and with these workers defined out of care in ways that make them eligible for privatization strategies used in other service work. Even among professionals, the body parts approach is combined with an assumption of transferable technical skills in ways that allow easier substitution of one professional provider for another.

With little attention to care as a relationship, it is not surprising that those seeking to reduce costs in order to make a profit looked at work organization, given that health care workers account for a significant proportion of the costs in care. According to a former Director of Health Services Provision with WHO, health human resources consume between 60 per cent and 80 per cent of health care budgets (Conference Board of Canada 2005: 15). In cleaning, for example, one British estimate is that staff costs account for up to 93 per cent of total costs (Davies 2005: 4). And these costs rose with unionization in many countries beginning in the 1970s, as the mainly female labour force resisted existing conditions of work. Not surprisingly then, wages, salaries and benefits have been targets of reforms in health care, although at least in Canada 'Census data show that, on average, employment incomes for full-time workers in health occupations rose at about the rate of inflation between 1995 and 2000. That compares to almost a 6 per cent after-inflation increase for all earners' (CIHI 2005: 17).

Governments across the OECD supported this kind of privatization by signing free trade agreements and by deregulating the for-profit sector. They also set about 'reinventing government' along market lines, based on the assumption that governments should, where

possible, restrict themselves to ‘steering’ and should leave ‘rowing’ the ship of state to others, on the basis of competitively awarded contracts (Osborne and Gaebler 1993). Market principles were extended across the public sector (Exworthy and Halford 1999). Governments were to act like businesses and market rules were to apply. Public–private partnerships mean collaborating with the for-profit sector to build, design, finance and operate facilities. Competitive bidding handed over public services, or parts of them, to the for-profit sector, with taxpayers still footing the bill. Similar labour policies were followed whether or not the work remained directly under government control, with more contract and casual work, more self-employment and more part-time employment.

The privatization process is often complex and difficult to discern, both because health care is itself complex and because governments are wary of the deep-rooted public support for publicly funded, accessible health care whose delivery is not subject to the profit motive. This is most strikingly the case with the New Labour government in Britain (Pollock 2004; Player and Leys 2008), but privatization by stealth is also found in countries as diverse as Sweden (van Otter and Saltman 1991; Burgermeister 2004) and Canada (Armstrong 2001).

The privatization move was based on arguments about the inefficiency of the public sector, especially in health and social services. Governments pointed to rising costs and growing demand in explaining the need for greater efficiency in health and social services. There is no question that health costs in particular have been rising. ‘Health expenditures accounted for about 4 per cent of GDP when the OECD was founded in 1960, but the average across OECD countries is now 9 per cent, and it is close to or above 11 per cent in several large

national economies' (OECD 2007: 1), although not all this spending is public money. But the efficiency of markets and market principles is denied by the evidence. The most rapidly growing expenditures have been in the United States, where the reliance on markets and for-profit corporations is greatest. Within countries such as Canada, the biggest increase in costs has been for the drugs produced in the for-profit sector (CIHI 2008). For-profit financing means higher administrative costs, as a comparison of the US and Canada demonstrates (Himmelstein *et al.* 1996).

If 'efficiency' is linked to quality and not solely to lowered costs, most of the evidence comes from within the United States with its mix of for-profit, private non-profit and public services. And the evidence is clear: for-profit services deliver lower quality, not only in general hospitals but also in nursing homes, dialysis centres, psychiatric hospitals, hospices and health maintenance organizations or HMOs, as the Canadian Health Services Research Foundation (CHSRF 2004) summarized in its report on meta-analyses and systematic reviews. Clearly, for-profit methods do not save money or solve the problem of rising costs, nor do they improve quality. The lack of evidence has however not stopped governments from adopting market approaches in care services.

It was assumed, also without evidence, that market principles could be effectively applied within these services. As Evans (1998: 66) points out, in health care there is no 'private competitive market' of the form described in the economic textbooks anywhere in the world. There has never been, and inherent characteristics of health and health care make it impossible that there ever could be'. Part of the reason is that the need for care is seldom a

matter of choice. It strikes people unevenly and often suddenly. Equally important, care is very difficult to mechanize and necessarily requires labour. Mistakes made by people unfamiliar with the work, the workplaces or those needing care can cause significant injury or even death. Yet governments in many high-income countries have adopted privatization strategies, albeit to varying degrees and with very little success in making care more efficient or effective. What they have succeeded in doing is making both care and care labour more precarious.

Governments in high-income countries such as Canada purposely set out to blur the lines between the public and private sectors in the formal economy, making the public sector much more like the for-profit one. It was less and less the case that working for the state meant relatively secure employment and relatively decent working conditions, as it had previously in many high-income countries (Fine 2007: 6–10; Pollock 2004; Armstrong and Armstrong 2005; Armstrong and Laxer 2006). Although the exact proportions vary, women account for a significant majority of workers in the health care sector and many women have found rewarding employment in this sector. So the reinvention of government has had a disproportionate impact on women. It should be noted that women in this sector have relatively high levels of formal education, a factor which should have put them in a position to benefit from the much touted advantages of the new economy. Instead, they have faced increasingly precarious employment.

The reinvention of government had an additional, and equally important, impact. It blurred the public and private in the sense of shifting the boundaries between households, formal

economies and the state in ways that may have a particularly negative impact on women and their care work. As governments seek to reduce hospital stays, close institutions and cut back on services, more of the care work is sent home, where it is done primarily by women without pay and usually without formal training. At the same time, financial or service support from government often requires government scrutiny of the home and/or services provided in the home, resulting in more government and private organizations paid through public revenues entering the home. Increasingly, governments are offering cash payments to women to provide care for family members, with the result that 'the boundaries of paid and unpaid work have been shifting' (Ungerson and Yeandle 2007: 1). Although this cash for care may mean women providing care in the home have their work recognized and compensated, the low levels of cash payments and the disproportionate division of labour may limit women's employment options at the same time as it has a negative impact on care relationships. In any case, this care work at home is clearly a precarious form of labour.

Directly linked to the privatization of health care services, their global expansion, trade agreements and the reinvention of governments is the development of an international market in care workers and care services (Kingma 2006; Folbre 2006). Worker shortages in high income countries reflect, in part at least, the transformations in paid care work that have made employment more precarious, more intense and less attractive to those born in these countries. At the same time, trade agreements have contributed to deteriorating conditions of employment in low-income countries and thus to the migration of care workers from low- to high-income countries. Indeed, some low- income countries such as

the Philippines have made the export of care workers a major part of their economic strategy. There is, however, a counter trend. Some low-income countries are taking advantage of the highly educated, low-paid workforce to provide medical treatment to those from high-income countries offering elective surgery faster and more cheaply. The Confederation of Indian Industry reportedly estimated that 200,000 foreigners went to India for medical and dental treatments in 2005 (Yelaja 2006: A22). Although medical tourism's economic impact can be expected to remain slight in high-income countries (Milstein and Smith 2007), it is already considerable in countries such as Thailand, Malaysia, Singapore and Costa Rica, as well as in parts of India.

In all these developments, new technologies play a critical role. Technologies have been a significant factor in the rising costs that governments use as a justification for cutbacks and market strategies. Technologies help managers reorganize the work, using scheduling computer programs to move those with care needs and the service providers around the system with ever greater frequency. Technologies assist the division of care into simpler tasks that can be assigned to a range of providers, to workers on call and to part-time or self-employed and agency workers. Technologies also increase demand for care, the new scanning devices and new drugs providing only two examples. Yet there is reason to question the efficacy of these technologies that are so central to rising costs, new work strategies and approaches to care. According to an editorial in the *Journal of the American Medical Association* (Wears and Berg 2005: 1261), 'roughly 75% of all large IT projects in health care fail' and the problems 'are not simply bits of bad programming or poor

implementation'. Similar conclusions have been reached about drug effectiveness (Angell 2004: Chapters 4–6).

There is no question, however, that the demand for care is growing. This is partly due to the push to sell more care as care provision becomes a commodity that generates profit, even if some of the increased care is of questionable benefit. Nevertheless, people are living longer in high-income countries and part of this increased longevity can be attributed to developments in health care. And this increasing longevity undoubtedly heightens the need for care, although not to the alarming extent that many claim. 'Healthcare costs don't go through the roof just because there are more seniors. The real issue is with changes in the number and nature of medical services for elderly patients' (CHSRF 2008; see also Barer *et al.* 1995). The emphasis on tests, drugs and surgery over social support and social care contributes to the rising costs that have been documented. The demographic shift implies a need to develop care models that respond to changing needs and to build a workforce that can respond to those needs through stable employment and thus care relationships. At present, and not just in North America, care work for the elderly is assigned to a primarily female unpaid care workforce, and to (increasingly temporary or undocumented) immigrants and those from racialized communities, most of whom are also women and many of whom work under precarious conditions (Zimmerman *et al.* 2006; Global Health Watch 2005: especially 119–33; Ungerson and Yeandle 2007).

In short, there are powerful forces driving the movement to more for-profit care and to more for-profit methods within non-profit care. The demand for care is rising at the same

time, partly as a result of these forces and partly as a result of new technologies and aging populations. In the process, care work has become more precarious and unpaid care work has increased even as some European governments offer cash payments for care in the home (Ungerson and Yeandle 2007). These developments are based on assumptions about women's innate capacities and their desire to care, while often simultaneously enforcing this labour by the failure to provide alternatives. They are also based on the drive to reduce costs in the public sector by shifting more of the work to the home. With heavier burdens of unpaid or low-paid care work in the home, it is more difficult for women to fully and equally participate in the labour force. These developments are consistent with a medical model of care, with its emphasis on technical, transferable skills and individual rather than collective responsibility.

Yet there are limits on the extent to which care work can be transformed along corporate lines. Some care workers can be replaced by technologies such as those involved in telehealth, where bedside care providers are replaced by machines that monitor those with care needs and connect them to a centralized service (Folbre 2006). Some work can be controlled through technologies such as cell phones and recording devices. Some tasks can be shifted to those defined as less skilled, and thus cheaper and more readily replaced. And some work can be removed from the protection of unions or collective organizations through deregulation and privatization. However, care work necessarily involves time spent with people, often at unsocial hours and beyond the view of any manager. Workers are often called on to make independent judgments, based on their knowledge not only about

care but also about the individuals needing care. At the same time, they must deal with individuals and families who are usually active in the care relationships.

Worker resistance in health care can also place significant constraints on employers, given shortages of workers with particular kinds of skills and the critical nature of their work.

Work stoppages have a particular meaning in care. Because care is so central to our lives, alterations to care work have political consequences as well as health consequences. There is a notion of the right to care or a right of providers to provide as well as the right of those with care needs to receive care, even though entitlement is differently defined in different contexts. All these factors mean care cannot easily be shaped in an industrial mode.

HEALTH CARE AND PRECARIOUS EMPLOYMENT

The discussion of care models highlighted the importance of context to health care. The discussion of the forces encouraging similar developments across national boundaries showed why it is increasingly possible to draw useful international comparisons.

Furthermore, it is clear from these discussions that health care offers an important entry point for studying precarious employment and gender.

First, and perhaps most importantly for these purposes, in the International Industrial Classification of all Economic Activities (ISIC), the health industry is a major employer of women across national boundaries. A 'conservative estimate of the size of the health care workforce globally is just over 59 million workers' (WHO 2006: 4) and this estimates

focuses on doctors and nurses while excluding unpaid caregivers and those entirely outside what is defined as the health industry. Except for the management and physician categories, women are a significant majority of care workers in all countries. Women have long been associated with care work, so much so that they are often labelled natural providers. Yet the variation in their work across nations suggests that there is little that is biologically determined about their care work. For example, in the Americas, more than 90 per cent of nurses are female compared to 80 per cent in the eastern Mediterranean (WHO 2006: Figure 1.1). The health sector, then, offers an excellent place to study women's work.

Second, the health industrial category operates on multiple scales. It is located in the international flow of both capital and labour. Corporations operating in health are among the most profitable and the fastest growing, albeit from a relatively small base outside its pharmaceutical component. Health care service corporations are rapidly moving into countries around the world. International trade agreements and international organizations play a significant role in the structure of ownership and in the nature of the work (Global Health Watch 2005; Koivusalo and Ollila 1997). At the same time, context counts and models of care make a difference in how care is structured and provided. There is significant variation among and within nations, reflecting contexts at the national, regional, municipal, local and household levels. Health care thus offers a way of exploring similarities and differences across boundaries and scales.

Third, health care straddles the public and private divide in the formal economy and the divide between private households and public arenas. It thus may provide the possibility of

exploring differences between employment in the public and private sectors of the formal economy and the ways these are changing under current government strategies. The WHO (2006: 5) report on health workers points out that most 'data on the distribution of health workers between the public and private sectors describe who is the primary employer of the worker rather than where the money to pay the salary or most of the workers' income comes from'. Unfortunately, this blurring of the public and private in high-income countries makes analysis more complicated but it is still possible to examine how shifts from public to private employment influence the development of precarious forms and dimensions. Health also makes it possible to explore the complex and shifting relationship between paid and unpaid work inside and outside the formal economy, and how this is shaped by public or for-profit provision.

Fourth, the health care sector encompasses the entire range of women's work. Virtually every occupational category with significant numbers of women can be found in health. Women work in jobs defined as highly skilled and those defined as unskilled; in management and clerical jobs; in cleaning and teaching, to name only some of the occupational categories.

Fifth, there is a range of forms of work and dimensions of labour market insecurity found in the sector. Every form of employment is there: full-time and part-time, casual and contract, self-employment and agency work. The health sector also includes all the dimensions identified as critical to assessing precariousness. All kinds of work hours can be found in this industry, from shift work to weekend jobs. There are short hours, long hours, call-backs,

paid and unpaid overtime. Health care covers a wide range of physical spaces and locations. It includes small, medium and large workplaces along with many different kinds of employers. Some workers are represented by collective organizations while others are not, accompanied by wide variations in wages, benefits and rights. And of course, there are the many women who provide unpaid care.

Within the health sector it is thus possible to explore variations across jobs and over time in the extent of precariousness. It is also possible to use work in this sector as a way to examine the claims for good work in the new economy, given that the industry includes both those who are defined as highly skilled and those who are not.

Sixth, health care services involve multiple forms of regulation. Health care is a complex field of protected and unprotected work, with some countries such as Canada supporting an extensive division of professional labour based on elaborate rules about licensing and registration. Some regulations reflect efforts by workers to protect themselves while some are intended to protect the public or employers and investors. Recently there has been a push to deregulate even within this industry, giving employers and corporations greater permission to make workers interchangeable and to give them a freer hand in work organization. An exploration of these regulations may help us see how they work in practice, how they influence the flow of labour and services across and within borders, and how they are related to precariousness in employment.

Finally, using health as an entry point allows us to see how classifications shape, and are shaped by, developments in the economy and by dominant ideas. In the ISIC classification, the health industry does not include professional care providers who work in industries such as manufacturing. It includes clerical and trades people, coming closer to a social model, though unpaid providers are not counted. In the North American Industrial Classification System, increasingly those whose work is contracted out, such as hospital cleaners, are excluded from the health industry, reflecting both the medical model and privatization and making it harder to track changes over time.

While the health sector offers considerable opportunities for effective research, it also presents problems. The different models at work in health care often translate into different occupational categories within the industry and the same occupational categories may mean different things.

CONCLUSION

The health care sector is about social reproduction and is profoundly shaped by ideas about women and their work, as well as by ideas about care, health and families (O'Connor *et al.* 1999; Fine 2007). It is shaped as well by ideas about rights and responsibilities, and by the structures and practices of power. Care work links paid and unpaid, private and public in complex and changing ways. Often described as a labour of love, it took a long time and years of collective resistance for many women to achieve decent pay and conditions in these jobs. Many still do not have pay and benefits that reflect the demands and skills

involved and a majority may have no pay at all. The very nature of the work has often meant irregular hours and shift work. Death and discharge disrupt relationships and make the work uneven. Skills are often learned on the job in ways that render them invisible, especially when these are skills long associated with women.

Traditionally, health services have been delivered by voluntary, non-profit and religious organization or by governments. Increasingly, they are influenced by the search for profit, by aging populations, by technology and by international trade agreements. These transformations mean the introduction of new methods of work organization, a blurring of private and public, and a shift in responsibility from the collective to the individual.

Decision-making too has altered, with multinationals making more decisions about care, usually without democratic input or oversight. Health care has become a major industry, albeit one that remains embedded in the local, national and regional in many ways. As the OECD (2007: 1) puts it, the 'health sector of national economies has grown dramatically in importance over time, yet great cross-country variations persist'. On the one hand, health care providers and health services are more narrowly defined along medical lines, denying the contributions made by daily child and elder care, by cleaning, feeding washing, recording and other aspects of work related to the determinants of health. On the other hand, with the search for profit there is pressure to expand what needs to be treated and examined in our bodies and minds so more care can be sold.

Thus, through a comparative examination of the health industry across time and nation, it is possible to explore the extent to which the nature of health care makes work precarious and

the extent to which this reflects strategies to commodify care. It is also possible to raise important theoretical questions about the economy, rights, responsibilities, women, migration, racialization, work, family, the state and care as well as about relationships among them. On a more empirical level, it also helps us see how classifications shape and are shaped by developments in the economy and by models of care.

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