NEOLIBERALISM AND THE CREATION OF 'OBEDIENT BODIES' IN HEALTHCARE: CURRENT POLITICAL CREEDS AND THEIR IMPACT UPON THE ACUTE CARE SECTOR IN CANADA

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Abstract

Neoliberalism, described as a current hegemonic ideology and mode of governance that embraces individualism, market fundamentalism and subservient governments as its core tenets, has generated an increasingly fragmented society - with a deriving Darwinian culture where everybody tends to self, and only the strong and capable will survive. Constantly attacking the 'commonplace' and everything related to the idea of shared responsibility, while refusing to admit our ever-present interdependencies, neoliberalism has created a world-wide asphyxiation of care. This crisis of caring spreads into every sphere of society, from the *polis* to our natural resources, depleted more and more by neoliberal greed. Policies and measures designed to protect communities and populations are constantly removed or weakened, superseded by the worship of capital and the struggle to generate profit at any cost.

Canada, like many of the Western capital-oriented nations, has, unfortunately, embraced the neoliberal agenda, too, since the late 1970s and early 1980s. Consequently, social protection strategies and publicly owned assets are relentlessly - and sometimes surreptitiously - assaulted. Common resources and their governing processes are under constant surveyance in the name of efficiency. Often, the result is tragic: what once belonged to *all* is now the possession of just *a few*. The Canadian healthcare system is, too, beneath the neoliberal talon. Yes, although under permanent criticism and tireless invigilation, our public healthcare system still stands, despite sabotaging discourses that claim unsustainability. For how long, though? Affected by partial removal of government coverages, fractional privatization, and relinquishment of certain services to the marketplace, our public capacities to care are weakened day after day. Efficiency is consistently dethroning quality, with numerous consequences that equally hurt receivers and

providers of care. A downwards spiral is thus created, whilst privatization of healthcare services is presented as the only viable solution, a cure for all lesions and a remedy for all deficits.

As one of the epitomes of *care*, as those who are ever-present at the patient's bedside, regardless of resources, strategies, support, pandemic measures, or lack of thereof, this paper will argue that *nurses* are affected the most by this healthcare crisis. The existential encounters that the *caring profession* is so proud of, and so gratified with, become scarce. The very idea of *quality of care* needs to be restrained to a few fortunate moments or limited circumstances. After prolonged and unsupported compensatory efforts, a multitude of nurses - burnt out and disheartened - might consider alternate ways of regaining professional and living satisfaction, and leave the profession: a current post-pandemic, still unresolved, unfortunate reality.

The proposed way forward that concludes my study is the constant resistance against neoliberalism, this present *zeitgeist*: defiance through contrasting ideology and counter-discourse, and confrontation by counteraction, from the smallest act occurring at the individual level, to the larger acts, initiated by communities and nation-states. The suggested alternative is the idea of common good, while promoting the restoration of a culture of care. Instead of promoting self-sufficiency, we need to point toward the incessant human need for one another. Instead of relentlessly competing with each other in a fragmented and disoriented world, we could allow others to win as well.

Keywords: Canadian, care, crisis, healthcare, neoliberalism, nurses

Introduction

One of the most efficient forms of ideological dominance is when also the dominated groups accept dominant ideology as natural or commonsense.
- Teun A. van Dijk, 2006

Since the birth of Medicare in Saskatchewan in 1962, our publicly funded healthcare system has been one of the most beloved social programs, a Canadian staple feature and a "sacred trust" (Armstrong & Armstrong, 2003, p. 1), as almost 90% of Canada's population supports it without hesitation. Nevertheless, a rhetoric widely promoted over the last few decades has succeeded in convincing Canadians that what is offered freely is also improperly managed, and what is publicly owned (in essence, everybody's and nobody's property) will necessarily be inefficient and wasteful (Armstrong & Armstrong, 2003; Choiniere, 2011; Teghtsoonian, 2009). In the context of healthcare, the concepts of escalating costs, reduction of expenditures, sustainability and austerity measures have become widespread in socio-political discourse, being easily assimilated by the public as common-sense knowledge. Because of a generally accepted premise that the private, for-profit sector is more efficiently managed than the public sector, sadly, Canadian healthcare has suffered a surreptitious and steady shift toward neoliberal market principles: mainly the individualization of responsibility and risk, as well as a strong emphasis on private initiative to the detriment of governmental involvement.

Globally, the rendition of neoliberal practices in a healthcare context has created ample room for policies that reduce governmental responsibility for the health of populations, emphasizing individual choice and behavioural changes (Navarro, 2009). While the government retreats as the main provider of health-related services, the marketplace promoters, fierce advocates of privately-owned assets, of profit, and of deregulation of labour and capital, consistently gain ground. Canada is no exception. Although our publicly funded healthcare

system still stands like an oasis in the middle of the socially hostile neoliberal landscape, (considered rather a vestige of older times which valued human life above capital and profit), a stealth campaign of undermining its core values is current and constant, with the neoliberal ideology - regretfully - gaining augmented popularity.

After an initial description of neoliberalism and its generally accepted tenets, placed in the wider context of contemporary models of social organization, this paper will argue that the neoliberal ideology and structures continue to fail the populations they ought to serve, ultimately creating a divided society where everybody provides for self. In neoliberalism as a mode of governance, the value of human beings is exclusively ascribed based on their knowledge, skills, health, and eventually productivity, while the workplace - especially in healthcare - becomes nothing other than a 'machine' used to create 'obedient bodies' (Foucault, as cited in St-Pierre & Holmes, 2008).

Applying a political economy lens, this research paper will further thematically analyze the aforementioned reform direction as applied to the Canadian acute care area, showing that, as the methods employed by the private sector decision-makers have the idea of profit as their core belief, a culture of *care* has been replaced by rigid and impersonal molds, 'standardized pathways', and effectiveness being measured in purely economic terms. A neoliberal agenda will necessarily lead to strategies applied in the name of *efficiency*, such as decreasing the number of hospital beds, admissions and length of stay; eliminating jobs; contracting out services; as well as standardizing and fragmenting providers' work (Armstrong & Armstrong, 2003; Choiniere, 2011). Consequences could be summed up and placed under the same umbrella: a continuous decline in the quality of care provided. Contrary to the generally unchallenged assumptions, research shows that the principles promoted by the marketplace will eventually lead to a

decrease of quality of services in our acute care sector, with both providers and receivers of care being affected in numerous negative ways. Patients will be dismissed from hospitals "quicker and sicker" (Armstrong & Armstrong, 2003, p. 208), while healthcare workers will suffer high rates of stress, moral distress and eventually burn-out. Employing a critical social theory approach, the impact upon the providers of care, as well as the receivers of care, will be described and analyzed.

The solutions proposed in the final part of the paper could be identified as a return to the value of *common good* (Varcoe & Rodney, 2009), as opposed to the "decline to greed and brutality" (Hart, 2004, p. 252) that neoliberal principles and practices fundamentally sustain and promote. As health is a thoroughly political issue - since its socio-economic determinants are provided (or not) by political ideology and action (Bambra et al., 2005) - solutions aimed to redress the current health-related problems need to target the political roots and foundations of societal organization. Band-aid-type initiatives cannot represent a long-term remedy. Above all, as the answers do not rest primarily upon a society's *ability* to intervene, but upon its *willingness* to tackle core issues, we ultimately need to re-create a ***culture of care*** (Alexander, 2001; Armstrong & Armstrong, 2003; Fraser, 2022; Hursh & Henderson, 2011; The Care Collective, 2020).

Methodological and Theoretical Considerations

The overarching research paradigm employed in the process of topic exploration, analysis of writings and themes, as well as presentation of findings is *critical social theory*. This approach has been chosen as it focuses on *contexts*, believing that "facts can never be isolated from the domain of values or removed from some form of ideological inscription" (Kincheloe & McLaren, 2005, p. 304). Additional reasons to consider this paradigm most appropriate: critical social theory aims to empower the oppressed categories by confronting injustice and by not accepting the status quo, while the awaited result is fundamental societal change, and not simply knowledge development (Guba, Lincoln, & Lynham, 2013; Kincheloe & McLaren, 2005). Consistent with the chosen research paradigm, the theoretical approaches used are *feminist political economy* and *critical emancipatory theory*. Using a political economy lens, feminists aim to add innovative dimensions to it, such as alternatives to approaches that focus exclusively on quantitative analysis and rationalization, in the quest to prove that lived experiences and sentiments could represent evidence, too (Armstrong, 2001).

One of the aims of this paper is to focus on the nursing profession within the larger milieu of Canadian political economy measures that profoundly affect it. In relation to the nursing world, *feminist political economy* places nurses in the *context* of neoliberal, market-based and profit-oriented reforms in healthcare, namely the supremacy of cost-effectiveness, efficiency, standardized models and measurable outcomes, greatly harming the quality of provided care (Choiniere, 2011). Another essential *context* brought forth by *feminist political economy* is the ancient underrating of women's work, or the devaluing of *social reproduction* activities, ultimately described as *care* (Fraser, 2022, The Care Collective, 2020). According to Adams and Nelson (2009), this attitude could be explained by a Cartesian philosophy of life: a

world divided into “mind versus body, reason versus emotion, separation versus connection, self-interest versus altruism, and public (marketplace and government) versus private (home)” (p. 7). The first element in each duo will be associated with a masculine structure and therefore greatly valued, while the second constituent will not be received with much interest, being linked with feminine, ‘less desirable’ qualities. This school of thought could partially explain why nursing work has always been undervalued, whilst regarded as nothing more than a natural expression of the feminine quintessence, unworthy of compensation (Adams & Nelson, 2009; Choiniere, 2011). “[T]hey have enveloped reproductive activities in a cloud of sentiment, as if this work should be its own reward” (Fraser, 2022, p. 56). Nothing else than the echo of a still-lingering patriarchal worldview, this philosophical construct is contested by feminist political economists.

Other theoretical and methodological tools used in this study will be: *thematic analysis* - attempting to discover common themes in the explored discourses; *policy analysis* - employing concepts and models pertaining to political economy and revealing hegemonic narratives; as well as *critical discourse analysis* - aiming to demonstrate the correlation between discourse and society, with discourse having the consolidation of those in power as the intended ultimate result (Fairclough, 1995). This research paper will be constituted as a *narrative review*, since it provides “interpretation and critique”, while its strategic contribution is “deepening understanding” (Greenhalgh et al., 2018, p. 1).

Socio-Political Context

The unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics.
- World Health Organization, 2008

Welfare state retrenchment in Anglo-Saxon countries (Canada included) - translated as minimal intervention of governments in public life and a shift toward privatization and individual responsibility - is often justified in discourse by new economic standards, globalization, and a worldwide financial crisis (Saint-Arnaud & Bernard, 2003). Nevertheless, some researchers disagree that we live in conditions of economic collapse, declaring austerity as "an empirically and ethically unjustified policy" (Labonte & Stuckler, 2016, p. 312). "[W]e do not have a fiscal crisis. We have a crisis of inadequate taxation. We are not living in conditions of economic scarcity. We are living in conditions of extreme inequality" (Labonte & Stuckler, 2016, p. 316).

Navarro (2009) supports the idea that rather than a lack of resources, the actual distribution (and redistribution) of resources is the core issue of our modern society. It is not mainly about the *capability* of decision-makers to tackle the issue of poverty - and necessarily poor health as its consequence - but rather about *values* and the immanent *interests*. Ultimately, the socio-political *values* embraced and promoted by national governments - also known as *political economy* - determine the array of outcomes recognized as welfare, prosperity or health of a population as defined by the World Health Organization (WHO): "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2003, para. 1).

Experts agree that these socio-political values adopted by governments will divide the nations of the world into a minimum of four basic typologies, or welfare states: liberal (or

*neo*liberal), conservative, social-democratic and Latin. (Some researchers add a number of sub-types, or hybrids where possible, recognizing though the preeminence of the aforementioned primary categories.) Needless to say, Canada has always been included in the stream of liberal states, regardless of origin of studies (Bambra, 2005; Bryant et al., 2011; Coburn, 2010; Eikemo & Bambra, 2008; Navarro & Shi, 2001; Raphael, 2010; Raphael & Bryant, 2015; Saint-Arnaud & Bernard, 2003).

Typologies of Welfare Regimes

Although there is no current standard definition of the concept of *welfare state*, the term generally refers to the state's role in provision of main *public services*, including healthcare, and *social transfers*, closely related to redistribution of income and correction of inequalities (Eikemo & Bambra, 2008). According to the same authors, "the welfare state actively (re)organizes social relations through the way in which it deliberately modifies market forces by guaranteeing citizens and families a minimum income […] and by reducing the welfare responsibilities of the family" (pp. 3-4). Esping-Andersen (1990) classifies welfare states on the basis of *social stratification*, *decommodification* - "the extent to which individuals and families can maintain a normal and socially acceptable standard of living regardless of their market performance" (Esping-Andersen, as cited in Eikemo & Bambra, 2008, p. 4) - and *public-private* involvement in providing basic services.

Building on Esping-Andersen's work, more recent studies propose the divergent approaches to societal organization - or the differing types of welfare states - as emerging from various combinations of the current main trade systems: the *state*, the *market* and the *civil society* (including *family*) on the one hand, and three basic principles of social interaction (also identified

by the French Revolution): *solidarity*, *equity* and *liberty* on the other hand (Eikemo & Bambra, 2008; Navarro & Shi, 2001; Saint-Arnaud & Bernard, 2003). Emphasis on any particular element of this scheme will generate a cascade of very specific consequences. For example, societies that focus on *liberty* will eventually promote unlimited economic freedom, resulting in a shortfall in *equality* due to the increasing gap between rich and poor, and to a deficit in *solidarity* due to community dissipation and division of society: "Indeed, no genuine cohesion is possible except where each and every citizen enjoys access to a minimum of resources, and where relative equality prevails among them" (Saint-Arnaud & Bernard, 2003, p. 502). Societies that focus on *solidarity* are vulnerable to various types of indoctrination and to potential domination of elites (with deficits in *freedom* and *equality*), while those promoting *equality*, in extreme cases, could move towards totalitarianism (with consequent lack of *freedom* and *solidarity*) (Saint-Arnaud & Bernard, 2003).

[Note: Appendix A, Figure 1, presents the ideological foundation of the main types of welfare state, as agreed by numerous researchers, while Appendix B, Figure 2, shows the possible interfaces of the three fundamental principles of social citizenship mentioned above (Saint-Arnaud & Bernard, 2003).]

The Social-Democratic Welfare Regime

Emphasizing *equality* and a considerable role played by the *state*, social-democratic countries (such as Sweden, Norway, Finland and Denmark) are advocates of full employment, *universalism* (services created for the entire population, regardless of socio-economic circumstances) and sharing of burdens and collective responsibilities; they endeavour to minimize their populations' dependence on marketplace through income safeguarding and strong

social protection; and they aim to level hierarchies and to control social stratification through fair taxation laws and equitable social transfers (Eikemo & Bambra, 2008; Navarro & Shi, 2001; Saint-Arnaud & Bernard, 2003). Due to a diligent focus on socio-economic determinants of health and illness, inequalities in health are markedly reduced (Eikemo & Bambra, 2008). Infant mortality rate, a measure generally accepted as a litmus test for the general welfare of a country, is invariably lower in social-democratic regimes (Bryant & Raphael, 2020). Equality seems to also influence the sphere of gender-related issues: the social-democratic welfare states aim to embrace a much more feministic approach, compared to other state structures (Saint-Arnaud & Bernard, 2003).

The Conservative and 'Southern' State Structures

Solidarity, the core value of conservative nations such as Germany, France, Switzerland, Belgium and the Netherlands (Saint-Arnaud & Bernard, 2003) is shown by the *state* through provision of social transfer programs - mainly pensions - that aim to minimize socio-economic risks (Raphael, 2011a). The *family's* role is very important though, and families are relied upon to sustain the vulnerable or the less able to sustain paid work in a consistent manner, as conservative states seem to have, generally speaking, underdeveloped social services (Navarro & Shi, 2001). Thereby, *defamilisation*, defined as the degree of independence of family relationships, is shallow (Eikemo & Bambra, 2008).

Both *conservative* and *Latin* welfare states (such as Italy, Portugal, Spain and Greece) - with the latter also named *Southern*, or *ex-fascist* according so some classifications (Navarro & Shi, 2001) - are fairly hierarchical from a socio-economic, cultural and political perspective, and thus inclined to support tradition, ruling class dominance with preservation of status, trust in

political authority, and gender gap (Raphael, 2011a). *Latin* regimes are even more family-oriented than conservative states, as their economy is less developed, and therefore their dependence on *family* as ultimate socio-economic protection mechanism is increased (Raphael, 2011a). Women's participation in the marketplace is lower in Latin regimes, due to their traditionally perceived role in society; nevertheless, these same women offer a significant amount of unpaid, and - sadly - partially unrecognized, hours of housework (Saint-Arnaud & Bernard, 2003). Latin states seem to have the most significant wealth gap in European Union, with closely related high infant mortality rates, and a subsequent increased rate of poverty among children (OECD, 2023a; 2023b).

The Liberal Welfare State

Liberal regimes (primarily found in Anglo-Saxon countries: Canada, the United States of America, Australia, New Zealand, the United Kingdom, and Ireland), with their core principle of *liberty* and their strong reliance on the marketplace, endorse minimal interventions of the state (Bambra, 2005; Navarro & Shi, 2001; Raphael, 2010; Raphael, 2011a; Saint-Arnaud & Bernard, 2003). Only when the market fails to satisfy the population's most basic needs, the state provides modest benefits to the most vulnerable recipients through means tested plans (based on proven financial difficulties) (Navarro & Shi, 2001; Raphael, 2010; Raphael, 2011a; Saint-Arnaud & Bernard, 2003). The wages are lower, and the social protection is nominal (Navarro & Shi, 2001; Raphael & Bryant, 2015). Since liberal welfare states represent the interests of institutions affiliated with the marketplace, predictably, they "have the greatest degree of wealth and income inequality, the weakest safety nets, and poorest performance on indicators of population health such as infant mortality and life expectancy" (Raphael, 2010, p. 148).

The core idea of *liberty* is closely connected to freedom of opportunity and thus with *formal* equality: all individuals are treated 'equally', regardless of context (rather than *substantive* equality, which addresses structural inequalities, socio-economic factors, as well as issues of access and power) (Burns, 2009; Saint-Arnaud & Bernard, 2003). Liberal countries also believe that government initiatives will only hinder this freedom of individuals, limiting and controlling them; consequently, the phrase 'small government' is so typical and so widespread. At the same time, liberals embrace the idea that the *marketplace* is the solution to all things, while its central tenet, *profit*, becomes the god of the 'global village'.

Liberal practices seem to dominate contemporary society, not only since they are mainly promoted by nations regarded as world-leaders, but also due to the deceiving nature of liberal ideology. Catch phrases and words such as 'hard work', 'perseverance', 'freedom of opportunity', 'limitless possibilities', and even the well-known, sacredly regarded motto promoting the human rights to 'life, freedom and pursuit of happiness', can be thoroughly misleading. Common sense and history show that definitions of human rights, justice and social justice are always dependent on the socio-political context of the societies that promote them (Pauly, MacKinnon & Varcoe, 2009). This is the reason why deceiving discourses, easily sold to the public by making use of such catch phrases, should be challenged.

The *libertarian* concept of justice, promoted in different degrees by Anglo-Saxon countries, seems to be mainly related to *market* justice; inequalities created by lacks and deficits of a socio-economic nature become thus not unfair, but rather a result of unavoidable marketplace forces (Pauly et al., 2009), triggered by individual lack of action, lesser work, or own inability to 'see' the opportunity. Consequently, "rather than a matter of justice or unfairness, it is a matter of charity to provide the poor with what they need by evoking a

humanitarian response to provide aid" (p. 121). The focus thus becomes the 'commendable' act of giving, with the subsequent unavoidable power imbalance, rather than the tackling of structural causes of such inequalities (Pauly et al., 2009). Even worse, the poor are demonized, being presented as 'lazy', 'unproductive', 'unwilling to seize the opportunity', exploiting the group of 'good', 'decent', 'hard-working people' through their 'shameless dependence' on them.

It may be informative to mention at this point the recognized contradiction in the human rights world, more precisely the acceptance and ratification of treaties that promote *negative*, or defensive rights, while documents which focus on *positive* rights do not have the same popularity with some nations. Negative rights would be the ones focusing on political and civil liberties (protecting against state intrusion and unjust punishment, among others), while positive rights place socio-economic freedoms at the same essential level, believing in the state's responsibility to provide adequate socio-economic prerequisites for the general welfare of its entire population (Burns, 2009). In this context, it is interesting to note that the same promoters of a relentless right to pursuit personal happiness through many unscrupulous means, fail abysmally when it comes to pursuing the happiness of 'the other'. The USA, for example, has - up to this date - declined to ratify the United Nations' *International Covenant on Economic, Social and Cultural Rights,* operating in full starting 1976, as such treaties legally bind the signatory states and make them accountable before various committees for providing *everyone*, including their *less able* to 'see an opportunity' or to 'work hard', with the needed prerequisites for a humanly decent living. In agreement with the saying that advises us to judge a tree according to its fruit, one could thus assuredly declare that the main promoter of core liberal and neoliberal values is not the best example to follow.

What is Neoliberalism?...

…neoliberalism, that exceptionally predatory, financialized form of capitalism that has held sway across the globe for the last forty years. Having poisoned the atmosphere, mocked every pretense of democratic rule, stretched our social capacities to their breaking point, and worsened living condition generally for the vast majority, this iteration of capitalism has raised the stakes for every social struggle, transforming sober efforts to win modest reforms into pitched battles for survival.
- Cinzia Arruzza et al., 2019

Concepts and Facets

According to Armstrong (2013), although many researchers accept three primary interpretations and manifestations of neoliberalism, namely: *ideology*, *policy*, and *mode of governance*, the term 'neoliberalism' is associated with a plethora of perceptions - some overlapping, others found in inherent contradiction with each other:

> It is variously seen as a political philosophy, a system of economic thought, a system of values, a system of accumulation, a project, an agenda, a logic of governance, a rationality, a doctrine, a faith, a program, a practice, a strategy, an ethos, an ethical ideal and/or a set of completed or established institutions. (p. 188)

Garrett (2019) uses a stronger terminology (or terms of higher valence, according to Raphael et al., 2021) when presenting his interpretation of neoliberalism. He introduces six overlapping dimensions that characterize this "dystopian zeitgeist" (Garrett, 2019, p. 188): the displacement of once well-established, Keynesian, liberalism; the use of state in the service of market-related interests (although always misleadingly claiming that states need to be small, neutral, and uninvolved); the redistribution of resources from the poor to the rich; the reign of

precariousness, insecurity and poverty; the upsurge of mass imprisonment; and, ultimately, its strategic and opportunistic pragmatism.

A detailed history of neoliberalism's ascension is beyond the scope of this study; nevertheless, a brief sequential explanation of the overturning of once 'embedded liberalism' is necessary at this point. According to Gill (2021), Keynesian liberalism - the precursor of neoliberalism - established during the post-World War II period, was born as a response to high rates of unemployment and precariousness, and was seen as a compromise between the interests of the wealthy and the interests of the working class. Unlike neoliberalism, Keynesianism embraced the idea that state involvement is necessary for economic growth and social protection (Gill, 2021), thus limiting and containing financial markets through a strong set of socio-political boundaries (Garrett, 2019). Abhorring the confinement of markets promoted by the Keynesian social orientation, neoliberalism is perceived as a revolution against welfare capitalism, proposing instead an ideology and policies that glorify radical capitalism and unlimited capital accumulation, at any cost to society (Garrett, 2019).

Regardless of choosing a linear, enumerative description of neoliberalism's tenets (as above), or choosing a cascade-like, cause and effect view, researchers agree to a few incontestable main characteristics of this hegemonic ideology and mode of governance. Although in very close connection with each other, overlapping at times, for the sake of clarity and discourse esthetics, this study will categorize the creeds of neoliberalism as *pursuits*, *rhetoric*, and *consequences*.

Pursuits and Interests

Market fundamentalism - or the supremacy of financial markets - appears to be the underlying principle and pursuit of neoliberalism. Claiming that unrestricted entrepreneurial freedom needs to be the quest of any society, neoliberal ideology promotes the philosophies of free markets, free trade and privatization of public assets. Not only public institutions and communal establishments, as well as culture and history, will be acquired by private entities, but a commodification of nature itself takes place; nature in all its forms - earth, forest, water, and air (Harvey, 2007). At the same time, the reduction of any type of collective property rights (childcare, education, healthcare, or pensions) becomes the norm (Harvey, 2007). As stated by Labonte (2020), the social contract between state and civil society is eventually replaced by a financial contract between state and the market. Nevertheless, according to Fraser (2022), this newly created alliance leads to a crisis of democracy, or to *social totality*. "Devolving vast aspects of social life to the rule of 'the market' (in reality, to large corporations), it declares them off limits to democratic decision-making, collective action, and public control" (Fraser, 2022, p. 122).

According to some schools of thought, the idea of 'free markets' is very disputable. "'Free' from whom?" is a rhetorical question raised by various scholars (The Care Collective, 2020, p. 72). Claiming that "the archetypal free market has never existed" (p. 72), The Care Collective (2020) underlines the fact that markets are subdued by very influential financial entities, while at the same time completely reliant on governmental decisions "for the creation of further 'free' markets" (p. 10) - conundrum which brings us to a second disputable concept: 'small governments'.

The neoliberal duplicity loves to depict the statal authority as potentially dictatorial, and governmental institutions as sluggish consumers of capital and resources, implying that the society's interests need to be protected against such entities. The expression 'small governments' communicate nothing less than the following picture: the government is the enemy, while the market forces, being on the *populus'* side, are the avengers that keep such a colossus in control. The irony, though, consists in the fact that there is no third party anymore, in a figurative sense. The governments have become one with neoliberal forces, acting in tandem against the civil society. 'There is no such thing' as a *small government*, but rather a *docile*, or *assimilated government*. In accomplished neoliberalism, the state will *become* "a neoliberal set of institutions" (Harvey, 2007, p. 38). Or, in other researchers' views, "democratic governments are now outgunned, if not wholly captured, by oligopolistic corporations with a global reach, lately liberated from public control" (Crouch, as cited in Fraser, 2022, p. 116). Garrett (2019) supports this approach in his section named *Putting the state to work for capital*, affirming that a government's aureole of neutrality is an illusion; there is no 'rolling back' of the state, but rather a 'remaking' of it: "despite the anti-big government rhetoric often associated with neoliberalism, there has been little diminution in the actual size of many governments in the West" (p. 191).

Once assimilated, the state itself "becomes a prime agent of redistributive policies, reversing the flow from upper to lower classes that had been implemented during the preceding social democratic era" (Harvey, 2007, p. 38). The results: insufficiency and precariousness, as well as loss of control, power and ownership for the numerous, in the favour of those very few who make sure their assets are intangible. Ultimately, what takes place is an attack on *democracy* in the real sense of the word - the governing of *demos*: "democracy's decline in Global North coincides with a coordinated tax revolt of corporate capital and the installation of global financial

markets as the new sovereigns that elected governments must obey" (Streeck, as cited in Fraser, 2022, p. 116).

But how could a *demos* be coerced - day in and day out - to act against itself, sustaining in fact the interests of its oppressors?... Perhaps by introducing the concept of *competition* between individuals as a positive feature of a merit-based system; possibly by depriving groups, communities and nations of many of their collective assets; or by declaring war to any potential *demo*-cratic establishment that would withstand or challenge neoliberal ways - anything to weaken social cohesion and solidarity. The cornerstone of this villainous plan, I would argue, is neoliberal propaganda.

Rhetoric and Internalized Values

The era of neoliberalism is characterized by an emphasis on everything that encompasses the individual sphere, while the idea of collective interests or goods is approached with distrust (Dobson, 2015). Self-reliance, hard work, self-sufficiency, and private affairs are the slogan embraced by this ideology, in detriment of solidarity, social cohesion and the common good. The deception of absolute freedom of opportunity promoted by the neoliberal agenda might have some appeal at a first sight. Nevertheless, a more in-depth analysis of neoliberal discourses cannot be followed by a neutral stance. Statements that "there is no such thing as society" and that the "government is the problem, not the solution" (Giroux, 2011, p. 589), made in the late 1970s and early 1980s by politicians such as Ronald Reagan and Margaret Thatcher, have definitely established the beginning of a global dark age (Giroux, 2011; Hursh & Henderson, 2011; Syed, 2016).

Although neoliberalism has been perceived as being generally concerned with short-term goals, one of its long-term strategies is launching messages that have as target the *internalization* of its ideology (Peacock et al., 2014) and, ultimately, according to some scholars, the *transformation of human being* (Dobson, 2015; Giroux, 2011). In media - the shaper of public opinion - messages about individual responsibility abound, personal agency is regarded as a given, and resilience is always applauded. Unfortunately, such messages are digested by the public, and, consequently, the neoliberal discourse gives birth to a "no legitimate dependency" attitude (Peacock et al., 2014, p. 173) that works in tandem with the concept of personal failure. Because of labels and stigma, because of the belief that there is no other way, and ultimately as a form of self-flagellation, "all forms of dependency … [are] disavowed and disproportionate amounts of personal responsibility … [are] assumed for aspects of life that we would argue are not reducible to the personal agency of individual" (Peacock et al., 2014, p. 174).

One of the ultimate targets of neoliberal ideology, some would argue, is the transformation of human nature itself through assimilation and internalization of the neoliberal discourse (Dobson, 2015; Giroux, 2011). Mills (1959/2000) points towards similar processes by stating that humans and their aspirations are always exposed to the danger of being undesirably molded and potentially dulled by outside, uncontrollable forces originating from the society they are part of. The notions of *resignation, dullness, lack of agency,* or *apathy of the oppressed* are not new. In line with these concepts, Dobson (2015) introduces the idea of "anthropological transformation" (p. 258) resulting in *docility* and *subordination* as an additional aim of neoliberal ideology.

Two other concepts of interest could be brought to attention in the context of perceived value of humans in a neoliberal era: *biopolitics* (Dobson, 2015; Wiebe, 2009) and *biopower* (El-

Lahib, 2016). Both concepts point toward a potentially higher value of certain human beings, based on their knowledge, skills, health, and eventually productivity. Some argue that such an approach could be rather labeled as modern-day slavery (Forcier & Dofour, 2016; Syed, 2016). Consequently, some lives will be more grievable than others, and some humans not human enough (Dobson, 2015). Dehumanization becomes a potential useful tool in the context of justifying exclusion: "…the people huddled under the mantle of the faltering Westphalian state system are lost except insofar as they generate profits. Their bodies are reduced - as many from Marx onward have noted - to machines designed to reproduce capital" (Dobson, 2015, p. 262).

Consequences and Impact

Since neoliberalism demonizes the intervention of government - the only potential rescuer! - in the public sphere, keeping it at a minimum (Bambra, 2005; Navarro & Shi, 2001; Raphael, 2011a; Saint-Arnaud & Bernard, 2003), consequences are multiple and devastating. Some of them (such as privatization of public assets - a great loss for any society) have been already mentioned, as they represent *quests* and *consequences* at the same time. Others will be described in the next section.

In the economic arena, protection is minimal, and commonly replaced by private sector initiatives (Navarro & Shi, 2001). Since the newly *assimilated* government has abandoned the role of safeguarding its citizens, neoliberal protocols claim that mostly the non-governmental, non-for-profit organizations need to play the role of buffers and contend for the vulnerable and disadvantaged (Nakhaie et al., 2007). Consequently, the idea of social capital emerges as an alternative to governmental protection, and thus as a solution to structural inequalities. "Within neoliberalism, social capital theory aims to explain and solve social problems through

development of non-state relations such as community, family, networks, and other social relations" (Nakhaie et al., 2007, p. 562).

However, the importance of social capital, although promoted in discourse, is ultimately sabotaged by the core beliefs of neoliberal ideology. Researchers have rightly concluded that neoliberalism creates an atomized society where everybody provides for self (Dobson, 2015), a Darwinian approach regarding inter-human relationships, and a survival-of-the-strongest philosophy (Nakhaie et al., 2007). Its discourses of shame and guilt accuse any type of dependency (Peacock, Bissell, & Owen, 2014), blame the victims (Bambra, 2005), and ultimately dehumanize the vulnerable. Neoliberalism has effectively managed to implement the old Roman strategy *Divide et Impera* - instructing to 'divide and rule'. Thus, collective responsibility is shifted towards identifying threats to the common welfare, a strategy which demonstrates replacement of the welfare state with a *policing state* and a *punishing state* (Giroux, 2011). In addition, these distractive techniques transfer the emphasis to lateral rather than vertical relations (Peacock et al., 2014). "Fairness is no longer about redistribution or equality - the eye is drawn down and sideways and fairness becomes about what you deserve in relation to others in the same social position" (Peacock et al., 2014, p. 178). According to Garrett 2019, the *policing state* will also become manifest in relation with its dependent populations (such as social assistance recipients), with stern case management and rigorous record-keeping, while implementing a very strict regime of monitoring and surveillance.

Regardless of claims related to a chief pursuit of individual liberty and capital-related freedoms, the clandestine core purpose of neoliberal efforts was - and is - to ultimately re-establish the class power of the wealthiest (Harvey, 2007). There is no doubt that neoliberalism has failed to fuel global growth and to achieve high economic domestic performance, but it has

unfortunately succeeded in this covert concluding endeavour: concentration of power and capital in the hands of ruling elites, either already established or newly formed - "the main effect of neoliberalism has been redistributive rather than generative" (Harvey, 2007, p. 34), or, in other words, "accumulation by dispossession" (p. 34):

> We can, therefore, examine the history of neoliberalism either as an utopian project providing a theoretical template for the reorganization of international capitalism or as a political scheme aimed at reestablishing the conditions for capital accumulation and restoration of class power. […] I shall argue that the last of these objectives has dominated. Neoliberalism has not proven effective at revitalizing global capital accumulation, but it has succeeded in restoring class power. (Harvey, 2007, pp. 28-29)

This crucial argument, then - *restauration of upper-class power* as the Alpha and Omega of neoliberalism's pursuits - suddenly shines a different light on every claim, every discourse, every apparently harmless and well-intended objective promoted by neoliberal strata. Consequently, *this* is the light we need to employ when we behold our newly created, neoliberalism-compliant world.

Neoliberalism and Care

The creation of this neoliberal system has entailed much destruction, not only of prior institutional frameworks and powers (such as the supposed prior state sovereignty over political-economic affairs) but also of division of labor, social relations, welfare provisions, technological mixes, ways of life, attachments to the land, habits of the heart, ways of thought, and the like.
- David Harvey, 2007

According to Fraser (2022), the multiple crises that neoliberalism has created (economic, financial, socio-political, democratic, and ecological), could be placed under a common canopy: a *crisis of care* - care for the common good; care for a less fortunate 'other'; care for the earth and its resources; and, eventually, care for the future generations. Described as a "corporate bingeing" (p. xvi), this self-devouring type of governance - or rather a type of *society*, in Fraser's view - seems to be "congenitally oblivious to qualitative metrics of social wealth and human wellbeing" (p. 5):

> Serving that wealth on a platter to the corporate classes, this society invites them to make a meal of our creative capacities and of the earth that sustains us - with no obligation to replenish what they consume or repair what they damage. (p. xv)

In deviation from *care*, which promotes solidarity, cohesion, commonality and reciprocated responsibilities, recognizing our continual interdependencies, *neoliberalism* is concerned only with (certain types of) growth, accumulation and surplus, with (a certain type of) efficiency, and with individual choice and competition - leading to societal fragmentation and crumbling (Fraser, 2022; Monbiot, 2016; The Care Collective, 2020). Social relations are treated as if they were economic, and carework is declared 'unproductive' (Fraser, 2022). Social capacities are stretched out "to their breaking point" (Arruzza et al., 2019, p. 3).

An artificially created schism between *production* and *social reproduction* takes place, with the subordination of the latter, defined - pejoratively at times?... - in various ways: "subjectivation", "affective labor", or, simply, "care", and generally associated with women and with unpaid, subservient work (Fraser, 2022, p. 9). Neoliberalism willfully ignores the fact that, in any society, commodity production would not exist without social reproduction, since the latter forms the very essence of its anthropoid subjects and their "socio-ethical substance" (Fraser, 2022, p. 9). Ultimately, activities of social reproduction define, form, constitute, build, nourish, sustain and consolidate individuals, communities, states, and any form or expression of human touch and quintessence (Fraser, 2022).

A more appropriate, then, description of social reproduction is consequently uncovered as "the forms of provisioning, caregiving, and interaction that produce and sustain human beings and social bonds" (Fraser, 2022, p. 9). Remunerated labour would obviously not occur without housekeeping work, child care, sick care or elderly care; nevertheless, social reproduction continues to be devalued, subordinated, "unpaid or underpaid, naturalized or sentimentalized" (Fraser, 2022, p. 147). As commodity production is usually associated with men, while social reproduction with women, this partition points toward a gendered-based, biased approach embraced by neoliberal beliefs, promoting male domination (Arruzza et al., 2019; Fraser, 2022; The Care Collective, 2020).

Another shortcoming of this unnatural dichotomy (that is, commodity production versus social reproduction) is a self-destructive, self-destabilizing feature (Fraser, 2022; The Care Collective, 2020). Neoliberalism, with its worship of production, capital and profit, derails and ingests all the societal energies that would have otherwise been invested in care. The result: not only "social exhaustion and time poverty" (Fraser, 2022, p. 147), but also, unfortunately, a

"progressive destruction of our collective capacities for public action" (p. xvi) - always a very convenient result for the oppressive class. Resources that would have nourished, would have replenished and would have consolidated society are simply consumed by greed - somewhat irrationally, with high depletion of human vitality, and with focus on a robotized and compliant running on profit-driven hamster wheels.

Another interesting point, proposed by The Care Collective (2020), is the connection between neoliberalism and caring only for "people like us" (p. 4). If neoliberal agenda ever mentions *care*, it is singularly for 'self' and for 'your own', while caring for a *different* 'other' is portrayed either as an impossibility, or as a possible error of judgment. Regrettably, residing in a present-day society with decreased capacity and worn-out will to *provide* care, the likelihood to *receive* care diminishes as well for all of us (The Care Collective, 2020); an indisputable "organized loneliness" (p. 45) will follow.

Monbiot (2014) eloquently speaks about the "age of loneliness" as well (para. 1), a time when humanity has already internalized the neoliberal discourse to the point of acceptance that 'there is no such thing as society' - a desolating result of our astonishing compliance:

> Yes, factories have closed, people travel by car instead of buses, use YouTube rather than the cinema. But these shifts alone fail to explain the speed of our social collapse. These structural changes have been accompanied by a life-denying ideology, which enforces and celebrates our social isolation. The war of every man against every man - competition and individualism, in other words - is the religion of our time, justified by a mythology of lone rangers, sole traders, self-starters, self-made men and women, going it alone. For the most social of creatures, who cannot prosper without love, there is no such thing as

society, only heroic individualism. What counts is to win. The rest is collateral damage. (para. 5)

Neoliberalism and Healthcare

But what if policymakers are not allies but rather barriers to progress in reducing health inequalities […]?
- Dennis Raphael et al., 2021

According to Navarro (2009), implementation of neoliberal practices in healthcare translates into a *self-care* industry emphasizing choice, individual responsibility, and biomedical science. Governmental responsibility for population wellbeing is gradually reduced to a minimum, whilst its withdrawal from public health as the main provider of health-related services creates ample opportunities for the market fundamentalists to portion the healthcare system, to appropriate parts of it, and to openly transform it into a source of personal profit. Healthcare becomes thus a commodity, "a matter for the market to resolve" (Pauly et al., 2009, p. 121), while freedom and opportunity - in neoliberal terms - mean no other than increase of services available for those able to pay.

Hart (2004) shares the same beliefs: in nations embracing market fundamentalism, health becomes a commodity acquired through capital, rather than a human right. The race for financial gains trumps every other consideration, patients are regarded as consumers, while care is evaluated in term of end results and savings rather than processes and quality. Providing health services thus becomes a production system (Hart, 2004).

Whether neoliberalism is understood as a mode of governance, an ideology or a cluster of policies, two important outcomes seem to be always present post neoliberal tainting: the shifting of power and resources from the 'many' to the top of the social pyramid, and the 'governing from the distance' mechanisms gradually installed (Armstrong et al., 2016). In the healthcare world, governing from a distance implies a need for standardized measuring tools, rigid concepts and inflexible patterns that do not allow the voice of *context* to be heard, cannot accommodate

variation, do not tolerate deviations from 'the norm', and leave no room for values. Worshiping 'evidence-based' practices that reject the human touch and fiercely promote the reign of quantitative analysis, such tools will eventually exclude both the patient's and the provider's voice from what should actually be the ultimate target of all endeavours, namely the *healing process*.

At this point, the question of what constitutes *evidence* should be asked. Is *evidence* only a row of numbers waiting to be plotted in a graph? Or could it be also potentially represented by individual human experiences and emotions (Armstrong, 2001) that, even if not entirely generalizable or transferable according to quantitative molds, shine light upon the repeated, consistent, and therefore hard to ignore results of particular actions? "For evidence to be useful, it must be varied and have varied resources. It must also be transparent in terms of the sources and construction of categories" (p. 139).

Although *efficiency* represents one of the pillars of neoliberal ideology superimposed over the healthcare sphere, interestingly, research results do not support the idea of real efficiency of these much-acclaimed standardized processes of care: "…there is still no solid evidence that managed care has in fact reduced costs or raised quality" (Terris, as cited in Hart, 2004, p. 247). For example, various studies show that for-profit hospitals in the United States have worse outcomes compared to non-for-profit hospitals: worse health indicators, a higher risk of death, and - surprisingly?... - higher costs (Hart, 2004).

The Acute Care Sector in Canada: Neoliberal Influences

On golden chairs
Sitting at ease, you paid for the songs which we chanted
To those less lucky. You paid us for drying their tears
And for comforting all those whom you had wounded.
- Bertolt Brecht, 1934

Unfortunately, the Canadian health services have fallen, too, under the spell of market fundamentalism. Although our publicly funded healthcare system still stands - a haven in the middle of the socially arid neoliberal landscape, a current covert campaign of undermining its core values is relentlessly gaining popularity. The presented alternative: nothing other than capital-oriented philosophies and marketplace-based strategies applied in the same name of *efficiency*, such as a decreased number of hospital beds, admissions and length of stay; eliminating jobs; contracting out services; as well as standardization and fragmentation of providers' work (Armstrong & Armstrong, 2003; Choiniere, 2011).

Consequences could be summed up and placed under the same canopy: a continuous decline in the quality of care provided. Patients are dismissed from hospitals "quicker and sicker" (Armstrong & Armstrong, 2003, p. 208), while healthcare workers suffer high rates of stress, moral distress and eventually burn-out, as the burden of care placed upon their shoulders is almost impossible to bear on a daily basis. Unfortunately, this situation serves very well the promoters of privatization of public services. They unscrupulously use these current painful realities, targeting blame on the only entity that could actually redress the situation: the government, with its compensatory mechanisms.

Neoliberalism in Canada: Socio-Economic Implications

Neoliberal ideology started to gain momentum in Canada during the late 1970s and early 1980s, eventually translating into a departure from Keynesian welfare state - more socio-democratically oriented - towards a plethora of policies that promoted the interests of corporate elites, while the needs of the working class and the more vulnerable categories of population were "systematically ignored" (Gill, 2021, p. 6). "The shift away from Keynesianism was an intentional and political one, and served to dismantle the social safety-net in order to fiscally support the wealthy and powerful corporatist agenda" (p. 4). Federally, the neoliberal programme began its Canadian expansion starting 1984, once Brian Mulroney, representing the Progressive Conservative Party, was elected as Prime Minister (Gill, 2021). In Ontario, the neoliberal havoc had its beginnings undoubtedly marked by the Liberal party gaining power in 1985, and culminated with Conservative Mike Harris's devastating anti-societal policies (1995-2002). The same corrosive agenda undeniably continues - as we speak - with the latter's incendiary torch passed forward in time and relentlessly carried by today's Ontario Premier, Doug Ford.

While trying to gain the support of *the many* by using catchphrases such as 'reduction of federal deficit', 'increase of international competitiveness', 'support of the private sector through deregulation', 'ladder of opportunity', 'social responsibility', 'fiscal responsibility', 'prudent management', 'accountability', 'fiscal flexibility', or 'individual achievement' (Gill, 2021), the neoliberal measures continued to covertly promote the interests of *the very few*. The justification: economic crisis, or world-wide recession. The high-ranking principle: austerity.

According to Gill (2021), the implications of neoliberal policies for the Canadian socio-economic milieu in the past few decades are multiple: weakening or complete elimination of

national social safety programs that provide a certain measure of socio-economic security (such as pension plans, disability benefits, unemployment insurance, family and child allowances, access to various social services, universally accessible healthcare); massive cuts in healthcare and education, including closure of hospitals and deinstitutionalization of the mentally ill (leading to nothing other than homelessness for this exposed segment of population); workplace precariousness; increase in unemployment rates; and, overall, deepening poverty. Our publicly funded Canadian healthcare, or Medicare, established after decades of effort and political struggle, has been - also for decades - the target of neoliberal policies as well. In line with the federal legislative measures of financial cuts in healthcare and consequent diminished transfer to the provinces, Ontarian Mike Harris of the Progressive Conservative Party (1995-2002), launched a ruthless attack upon the acute care (i.e. hospitals) and its workers (mainly nurses), with great and irreparable losses for the province and its healthcare system.

Years later, Ontario's Liberal Premier, Dalton McGuinty (2003-2013), continued to weaken public healthcare by delisting - thus privatizing - services previously covered by the Ontario provincial plan (OHIP), such as dental care, physiotherapy and chiropractic services, eye exams and optometry services, while an annual health premium for all residents became mandatory in the province, varying between $60 and $900 (Gill, 2021).

This "current internal erosion" of Medicare (Whiteside, 2009, p. 79) is neither a random event, nor an undesired consequence of some careless policies, as certain private actors would like to disseminate. Top researchers have agreed that it is an intentional process, initiated by unscrupulous players. "The induction of neoliberalism into Canada was driven by particular interests; a calculated move on behalf of the corporate elite to reassert control over the elements of political and economic life that was lost" (Harvey; Raphael, as cited in Gill, 2021, p. 4). In the

view of such experts, “[p]overty was a conscious and deliberate part of a structure of accumulation associated with industrial capitalism (Sell & Williams, 2020, p. 3), while inequalities in health are also “deliberate” (Schrecker, as cited in Sell & Williams, 2020, p. 6), with “individual human health and the body identified as new sites of capital accumulation” (Sell & Williams, 2020, pp. 1-2).

> There is longstanding policy pressure to market-*ize* and liberalize health and to treat it as a private and tradable commodity. […] These dynamics are readily discernible across multiple and expanding regimes and spaces of global governance. Private actors working with policymakers in trade and investment regimes have substantially reconfigured health as a transnationally tradable commodity with strong claims of private ownership and investor rights that can be enforced globally. (Sell & Williams, 2020, p. 13)

According to Whiteside (2009), commodification of healthcare in Canada is less related to the exceedingly vocalized issues of *efficiency*, but rather to “capitalism’s propensity for crises of overaccumulation” (p. 80), which leads to compulsory expansions in new spatiotemporal scenes. The imperative need of a shift to a “new plane” of wealth accumulation seems to be solved by the creation of new markets and “the penetration of capital into new spheres of activity (by reorganizing pre-existing forms of activity along capitalist lines)”, as well as the construction of new social needs, combined with geographic expansion into new territories and long-term investment in social and physical infrastructures (Harvey, as cited in Whiteside, 2009, p. 83). Nonetheless, this expansion happens primarily - as previously noted - by *dispossession* of assets

and rights, and not by "a strict reliance on expanded reproduction to absorb surplus capital" (Whiteside, 2009, p. 80).

> [D]ispossession remains continually important as it devalues assets and/or strips away rights so as to create an outside that can then be incorporated into the circuits of capital accumulation at low, or no, cost. In this fashion, new spaces for capital accumulation are opened up, and overaccumulated capital can be valorized - an effective way to resolve accumulation problems. (Whiteside, 2009, p. 83)

One major example of *accumulation by dispossession* is the transformation of public assets into private property. Nonetheless, besides full-scale privatization, where *dispossession* occurs in a necessarily unconcealed manner, more subtle forms of privatization will, unfortunately, occur (Whiteside, 2000; 2009). Unquestionably, "the public health care system offers enormous untapped potential for profitability and is thus subject to ever-proliferating varieties of privatization" (Whiteside, 2000, p. 9). Two of these forms of stealth privatization in Canadian healthcare, namely joint ventures, or public-private partnerships (P3s), and contracting out of hospital support services will be discussed in more detail in the next section. Other forms of asset transfer in healthcare and, consequently, public wealth erosion, will be also further described and analysed.

'Accumulation by Dispossession' in Canadian Medicare

"The necessity of health care services makes them an ideal target for dispossession, but this simultaneously helps to preserve strong public support for one of the few robust elements of

the tattered welfare state" (Whiteside, 2000, p. 9) is a partially optimistic statement. Nevertheless, as previously mentioned, *dispossession* is not always obvious, while Canadians are not always aware of the many dissimilar practices of privatization in healthcare. Consequently, the public does not always know exactly what to defend or support. The general population tends to associate the idea of acute care - or hospitals - with governmental funding, and thus inclines to believe that all matters hospital-related, from medical teams' earnings to dietary and maintenance service costs are under governmental responsibility and control. Some of these beliefs are, certainly, valid, while others could not be further from the truth. Although the government is, indeed, responsible for much of the funding, the same government has, sadly, renounced much of the preceding control.

On the other hand, certain segments of population, despite having enough valid information regarding behind-the-scenes processes in management of healthcare, could nonetheless fall prey to the distorted neoliberal logic (i.e. privatization of everything possible), as "business leadership *does reach* into civil society and into state institutions, recruiting support for a world view within which the interest of capital in profitable accumulation becomes universalized as the general interest of society, or even humanity" (Carroll, 2016, pp. 14-15). A less optimistic perspective, potentially conducing to major losses of shared wealth. Nevertheless, regarding the vastly targeted Canadian public healthcare, the battle is not yet considered lost.

Public-Private Partnerships and Contracting out Hospital Services

One of the less understood forementioned forms of covert privatization is the creation of **public-private partnerships**, or P3s (Armstrong & Armstrong, 2003; Feldberg et al., 2010; Whiteside, 2000; Whiteside, 2009). This model has been used for a few decades, mainly related

to infrastructure provision and delivery, such as hospital buildings, highways, roads, schools or water and sewage amenities (Whiteside, 2000). Although the government retains ownership of the involved public asset, these decades-long partnerships offer private investors - multinational companies most of the time - not only significant profits by drainage of the public purse, but also a place at the decision-making table (Armstrong & Armstrong, 2003; Whiteside, 2000; Whiteside, 2009).

The most common types of P3s are DBFO (design - build - finance - operate), BOOT (build - own - operate - transfer), and DBO (design - build - operate), models based on the extent of control and decision-making that private entities have over the involved public assets (Whiteside, 2000). The main incentive of a P3 for the participatory governmental institution is shared 'risk allocation', mainly interpreted as short term public 'savings' due to investment of private funds (Armstrong & Armstrong, 2003; Whiteside, 2000; Whiteside, 2009).

> Yet greater profit-making for the private partners and contractors does not necessarily translate into lower costs for taxpayers, especially when hospital infrastructure is privately financed. P3s are often used by government to avoid upfront capital expenses and as a way to shift costs and risks away from the public sector; however, higher interest rates, hidden fees, inadequate or misleading risk transfer, and higher private-partner overhead costs all add up, producing more expensive infrastructure and services over the long run. (Whiteside, 2000, p. 12)

According to Whiteside (2009), starting with the early 2000s, in Ontario and British Columbia all new hospital developments costing over $50 million have been established by use

of the P3 model - with only one exception: the Peterborough Regional Health Centre, Ontario. “Meaning that private actors are now partners with exclusive ownership rights and revenue streams linked to most new hospital projects’ physical infrastructure and support services in BC and Ontario” (p. 6).

Another form of private involvement in Canadian hospitals’ affairs is transferring, or **contracting out support services**, such as housekeeping, food preparation, or maintenance, a measure justified - again - by the need of reducing public expenditures (Armstrong & Armstrong, 2003; Whiteside, 2009; Zuberi & Ptashnick, 2011). “The clear beneficiaries of this process are the multinational corporations who take over the once-public contracts, companies such as Aramark (United States), Compass (Britain), and Sodexho (France)” (Whiteside, 2009, p. 94). Presented as non-essential to the process of care, these services continue to be abandoned to the ruthless processes of such private entities, exclusively interested in one objective: *profit*. One of the multiple results: unsurprisingly, significant cuts to wages, such as in British Columbia, in 2003, when Aramark reduced the earnings of its housekeepers from $18.32 per hour to $9.50 hourly (Whiteside, 2009). This is, obviously, in line with the recognized neoliberal approach of devaluing labour and exploiting the labourers (Garrett, 2019).

Other undesired consequences of privatization of ancillary services have been described by workers as being the felt lack of training (predominantly in infection control practices), increased workloads due to understaffing, emotional distress and social isolation, high turnover, as well as high rates of workplace injuries; in summary - deterioration of work conditions and decrease in the quality of work provided (Whiteside, 2009; Zuberi & Ptashnick, 2011). According to an investigation made by British Columbia Centre for Disease Control into a hospital-acquired infection outbreak at a Vancouver Island hospital, the report states that, due to

insufficient housekeeping staffing levels and inadequate training, cleaning protocols and standards of cleanliness were breached, with this negligence resulting in multiple patients' deaths (Zuberi & Ptashnick, 2011).

> Among the most serious mistakes, cleaners over-diluted the bleach disinfectant used for cleaning, mixing it with nearly 1000 times more water than recommended in order to kill the Clostridium difficile bacterium, rendering the disinfectant solution useless against this killer bug. As a result, 64 patients became infected and 8 died. (Zuberi & Ptashnick, 2011, p. 910)

Current Medicare Crises and the Neoliberal 'Resolutions'

The long-standing blemish on our Canadian publicly funded healthcare system, primarily *wait times* for various types of care, has been exacerbated by the recent COVID-19 pandemic crisis. During and post pandemic, potential patients have encountered generally the same issues: walk-in clinics that do not receive 'walk-ins', but rather require appointments; family physicians (still) unable or (unwilling?...) to see their flock; consequently, over-crowding of Emergency Departments - partially due to an influx of unexpected patients, partially due to lack of nursing and medical staff, and partially due to changes in typical hospital flow processes, such as admissions and discharges (and this - again! - predominantly due to lack of nursing staff); temporarily closed ERs in small community hospitals; postponed surgeries; delayed diagnostic testing or cancelled minor interventions. Systemic causes for these deficiencies are multiple and of various origins, and this paper could not (and does not intend to) possibly address them all. Nevertheless, rather than focusing on *causes*, this section will aim to address policy *approaches*

and the so-called *resolutions* proposed - and legislated in some cases - by our democratically elected political leaders; not without starting with a significant quotation, in support of the suggested line of thought:

> Corporations see the potential of enormous profits in the provision of care. Powerful interests in Canada - in business, politics, and the media - want to create enough crisis in public health care that private care becomes attractive. Alternatively, conservative governments claim to want to "save" Medicare by introducing policies (beginning with alternative private services) that will actually undermine it. (Coburn, 2010, p. 84)

The Ongoing Nursing Crisis in Canada

As previously mentioned, the COVID-19 calamity exposed and enlarged the unattended cracks in our healthcare system. Despite the previous SARS outbreak of 2003, Canada was not prepared for a new tragedy of this kind. During the first days and weeks of the COVID-19 pandemic - as an Emergency Department Registered Nurse in Ontario, I recall - personal protective equipment (PPE) was insufficient and inadequate, infection control rules were changing from one day to another, risk and exposure ran very high, and the uncertainty was deep. While media was presenting the disasters in Italy and USA, with hundreds of deaths and dozens of coffins aligned in improvised spaces, we, nurses, were preparing for the worst. We were discussing last wishes with our loved ones. In the ERs, we were offered free food, free flowers and free wills. (Oh, we still tapped into that dark and quirky nursing humour, joking with each other that the public already perceives us as dead…) There was a new war happening, and **we** were, suddenly, the soldiers.

It is not simple to express the many emotions that ran through us, nurses, during those days. Not much was understood about COVID-19, and we knew that there was no cure. People simply died. So, for many months, every time we entered that room where airborne precautions were initiated - just in case! - initially with no N95 protective masks, we were prepared to 'take a bullet'. Yes, we **did** fear for our lives. Also, despite our fears, like all soldiers, we protected each other. On numerous occasions I witnessed exchanges such as: "It's ok, let **me** go into that room. I came in contact with the patient at triage anyway. You don't need to be exposed as well…" And… Like in all wars, a so much deeper sense of solidarity has been created between us, the newly improvised soldiers.

Why do I evoke these deep emotions, as an Ontario ER nurse and a COVID-19 frontline worker? So that the readers may understand an untold story: the exodus of nurses during and post pandemic is due to a deep sense of betrayal, above all. After we offered all that was humanly possible, we were so easily discarded by our politicians. We were shown once again that we do not matter; we are just numbers. A reservoir of *disposable workers* who remain "accessible, socialised, disciplined and of the requisite qualities (i.e. flexible, docile, manipulable and skilled when necessary)" (Harvey, as cited in Garrett, 2019, p. 193). Applauded as heroes one day, then sabotaged and betrayed through Bill 124 only weeks later. Ontario Premier Doug Ford fought for Bill 124 with all his might. And, after more than 3 years, he seems to have lost this one battle. Has he, though? The chronic nursing understaffing and the havoc thus created in patient care, with major ramifications in all possible healthcare spheres and niches, render this battle still in progress. By now a well-recognized neoliberal strategy is to first create a crisis, then 'solve' it… Isn't this, maybe, what is happening now on distinct battlefields?...

One of the paradoxes of the nursing crisis is that, in stark contrast to Bill 124 (intended to restrict nurses' wages to an increase of 1% yearly for 3 years), we find now newly emerged, **privately-owned, for-profit** nursing agencies, available to fill nursing shortages and thus somewhat ease the ache we are experiencing in healthcare. Nevertheless, the costs on the public healthcare system are huge, and this 'solution' is unsustainable. Agencies pay their nurses more than double (and up to three times) the unionized wages paid directly by the public sector, and this, of course, does not include the bare profit of the agency.

"In 2020, the first year of the pandemic, 31 hospitals purchased 450,000 hours from agencies. Last year, 77 hospitals purchased 1.2 million hours. Costs to the public purse more than quadrupled, to $174 million from $38 million" (Yalnizyan, 2023, para. 2). My emphasis: *cost to the public purse*; a one-way road leading to private receptacles. Isn't it peculiar that Ontario politicians seem to have no remorse ultimately paying a 200% - 300% increase (or more!) to the private sector for nurses' work, while trying so hard to cap to 1% the wages earned by nurses in the public sector?...

Privatized Healthcare Hubs in Ontario

The same Ontario Premier, Doug Ford, announced early this year the enactment of Bill 60, allowing privately owned clinics to perform various types of surgeries (cataract, minimally invasive gynecological procedures, and, eventually, hip and knee replacements) and to conduct diagnostic testing (CT scans and MRIs), while getting paid by public funds (DeClerq, 2023). The claimed motive: increased wait times and significant backlog of surgeries. Nevertheless, according to Ontario Health Coalition (2023), numerous hospitals throughout Ontario have operating rooms that, for years, have stayed closed for weeks or months due to staffing crises and

underfunding. “Instead of using existing public capacity and supporting public hospitals, the Ford government underspent on health care by almost $1 billion last year […] and has done nothing to open public hospital operating rooms to capacity” (para. 5).

Numerous researchers, organizations and field experts point towards manifold issues embedded in Bill 60. First, as human resources in healthcare are limited, this tactic will further deplete the public system of the medical, nursing and other supporting staff involved (Casey, 2023; Klostermann, 2022; Ontario Health Coalition, 2023; Salutin, 2023; Thompson, 2023). Second, based on documented accounts, for-profit clinics have a less-desired reputation of extra-billing, up-selling and up-coding (Casey, 2023; DeClerq, 2023; Klostermann, 2022; Ontario Health Coalition, 2023; Salutin, 2023; Thompson, 2023). This will potentially cost both the public system and the uninformed patient additional amounts ranging from hundreds to thousands of dollars per case (Ontario Health Coalition, 2023; Thompson, 2023). Third, an issue of access is being raised: private, for-profit clinics are usually selective and discriminatory (Akadinma, 2023; Klostermann, 2022; Ontario Health Coalition, 2023; Thompson, 2023). Uncomplicated cases are constantly cherry-picked and prioritized, and the potential for greater financial gains always plays a significant role in these choices.

> While it may seem at first glance that we need private care to fill these care gaps, […] private care actually creates more care gaps. This sets up a vicious cycle where austerity leads to privatization, which further degrades care. This only justifies more austerity for a “failing” public system and an increased role for more “efficient” private options. (Klostermann, 2023, para. 5)

Despite clear evidence and common sense, there are many lessons regarding the irreconcilability between **profit** and **care** that Canadian politicians simply refuse to learn. A very recent - appalling - example is the unfolding of events in Ontario's long-term care (LTC) facilities during the COVID-19 crisis, province where the majority of these homes are privately owned and operated.

> COVID-19 deaths in these homes were nearly double the average in not-for-profit homes and almost five times higher than those in homes owned by municipalities. […] [A]mong the 15 long-term care homes with the highest number of resident deaths, 13 were operated by for-profit entities. […] Profit has no place in the delivery of publicly funded and necessary health care services. (Armstrong et al., 2021, p. 6)

Nevertheless, forgetting history and ignoring Commissions, reports and incontestable data, Premier Ford has recently awarded new 30-year licenses to privately-owned LTC entities, which means that an additional 18,000 Canadians in need of long-term care will soon have to hope for the best (Salutin, 2023).

Impact Upon Receivers of Care

There seems to be an artificially maintained dichotomy between *provision* and *prevention* of healthcare services in Canada (Armstrong & Armstrong, 2010). Much has been spoken lately about prevention, about tackling roots of disease, and about upstream approaches; there is almost a trend that insiders know too well and rigorously need to embrace in order to show themselves 'up-to-date'. A formidable paradigm, at a first sight. Commendable targets, solidarity-oriented

approaches, and noble efforts, at least in theory. In practice though, things might appear a bit different. There are a minimum of two related issues regarding this aforementioned dichotomy: first, funds are being redirected from acute care to 'somewhere out there' - nobody really knows where and how - in the name of *prevention*. Second, these so-desired 'prevention' mechanisms are predominantly behavioural, targeting mainly individual lifestyles, promoting self-care approaches, and lauding self-sufficiency. Rarely, and in the best of cases, these initiatives seem to target communities, but nothing further. Deeper societal measures such as addressing the socio-political determinants of health through changes of nation-wide policies remain at the stage of pure rhetoric.

Armstrong and Armstrong (2010) repeatedly describe this trend as a switch '*from cuts and chemicals to carrots and condoms*'. They rhetorically ask *why can't we have both*: real and significant *prevention* which goes beyond neoliberalism-infused initiatives that target merely individual lifestyles, **and** a properly funded *acute care* sector?… People will get sick sooner or later, despite real or imaginary efforts of prevention, and they will need care of an adequate quality. There is no justification in cutting funds for the acute care sector in the name of prevention.

Nevertheless, decision-makers do not seem too concerned with justifying their actions. As previously mentioned, *austerity measures* are the easy slogan to sell to an unsuspecting, gullible audience. The dominance of a business paradigm and a relentless capitalism is by now infiltrated in our acute care, too, with the assimilation of *cost*, *management* and *evidence* as prime concepts (Armstrong, 2001).

Hospital patients are the first to suffer: initially, due to the very definition of 'acute care' currently in use, which includes only the severely ill who can receive immediate treatment

(Armstrong, 2001). As a side-effect, this implies, among others, that those deemed not ill enough will fall in the care of - possibly - communities and - surely - families: the unpaid, taken for granted work of care provided at home is thus increased (Armstrong, 2001; Fraser, 2022; The Care Collective, 2020). Meanwhile, those eligible for acute care services are only at the beginning of a trip that seems to have accumulated more and more flaws as the time has gone by.

In the name of cost-effectiveness - translated as less time and resources spent by patients in acute care facilities - many Canadian hospitals have reduced beds and length of stay (LOS) and have employed standardized pathways that force patients into molds, irrespective of acuity and progress of healing (Armstrong & Armstrong, 2010; Choiniere, 2011; Rankin, 2015). Care providers - primarily nurses - are thus pressured to ignore realities, dismiss expertise, silence their inner voice, and follow a rigid, impersonal, context-free 'care pathway'. The outer voice of patients is often dismissed as well, despite current claims of patient-centred care and modern, democratized approaches, as opposed to old-school, paternalistic provision of healthcare services (Norlyk et al., 2017). "Efficiency is equated with the numbers of procedures done and parts fixed or at least treated. Outcomes are recorded by length of stay, not state of health in the longer term" (Armstrong & Armstrong, 2010, p. 65).

The quality of care suffers through 'contracting out' of hospital services, as well; the believed need for more available capital has also given birth to multiple public-private partnerships (Armstrong & Armstrong, 2010). Food provision, laundry and cleaning services are often sold to third parties, which results in an obvious shift from intended quality care to profit. Food becomes less expensive and therefore less nutritious, while the rooms and other facilities might not be as clean and they should be, since housekeepers abruptly have a significantly increased workload to manage (Armstrong & Armstrong, 2010).

Impact Upon Providers of Care

"With workloads that are too heavy, employees worry about providing inadequate service and this, too, adds to the stress" (Armstrong & Armstrong, 2010, p. 116). Physiotherapists concerned about premature discharge of patients who cannot survive on their own, but are expected to; dietary workers worried about the low quality of served food; clerks fearing improper transcription of documents; housekeepers ashamed of the facilities' lack of cleanliness: "Worker after worker […] found it more difficult to take pride in their work or to feel they are helping people because there is no time to put care into the work or to provide the minimum service" (p. 116). Through a political economy lens, due to persistent devaluing of carework found in neoliberalism-driven societies, "[t]he capacities of those employed to provide care are severely diminished through ongoing exploitation, understaffing, poor pay, time constraints, inadequate or non-existent job security and a lack of training and support" (Skeggs, as cited in The Care Collective, 2020, p. 15).

Nurses, widely recognized as the linchpin of healthcare, might be affected the most, since their work in proximity of the patient is constant. The known - yet insufficiently addressed - impact of marketplace-oriented strategies upon nurses working in acute care takes various forms: from unmanageable workloads due to inadequate staffing - leading to burn-out and potentially nurse attrition - to tight managerial control, horizontal violence and alarmingly increased rates of workplace aggression (Armstrong & Armstrong, 2010; Choiniere, 2011; Choiniere et al., 2014).

In addition, nurses are robbed of what many consider the most satisfactory aspect of nursing: the therapeutic relationship nurse-patient. Deprived of *time* as their most important resource (Varcoe & Rodney, 2009), the consequence in not only their exhaustion, but also removal of the very element that would make their labour most rewarding: the "existential

encounter" between the patient and the nurse (Norlyk et al., 2017, p. 4), the "human-to-human relationship" (p. 3) that most nurses seek above all.

Regarding nurses' relationship with managerial staff, Choiniere (2011) points to the fact that accountability seems to have become a one-way road: nurses are expected to embrace the cult of efficiency and be accountable to hospital management through their consistent revision of practice, based upon neoliberal values. Nevertheless, there is no indication of any accountability of the management team toward the group of nurses (Choiniere, 2011). Such an attitude is congruent with Foucault's concept of *disciplinary power* (St-Pierre & Holmes, 2008): the workplace is converted into an oppressive entity, nothing less than a *machine* used to create *obedient bodies* (Foucault, as cited in St-Pierre & Holmes, 2008). This topic will be further developed in the next section.

A Nursing Perspective

What didn't you do to bury me,
but you forgot that I was a seed.
- Dinos Christianopoulos, 1978

Existential Encounters and the Philosophical Concept of Care

In a neoliberalism-driven age where the concepts of *care* and *caring* are constantly devalued, whereas aspiration to any type of care may be regarded as a potential sign of weakness, insufficient self-reliance and lack of adaptation to current canons, nurses **remain** and ardently **pride themselves** in being the *embodiment of care*. Nurses describe themselves as the *caring* profession, immerse themselves in the '*caring* science', aspire to the '*caring* moment' (Watson, 2005), while embracing nursing theories such as 'human *caring'* (Watson, 1997) and 'critical *caring'* (Falk-Rafael, 2005a). Their identity, their daily life, their constant efforts, and their very inner being - they are all related to *care* and *caring*. To viciously try to eradicate the concept and meaning of *care* from the current societal structures and interactions means to strip nurses from their very identity, their professional role and their place in society. Thus, adding to the well-known slogan stating that 'the personal is political', we could argue that 'the political becomes personal', too, for this particular group.

There are many other ways in which nurses are rather the opposite of neoliberal quintessence. A profession dominated by women - while neoliberalism's archetypal agent is the Alpha male; a group that has devoted itself to the less able, less privileged, less triumphant, to the destitute and marginalized; a group that serves people during their lowest times, and not during peaks of success or fame. A group that serves the loss and the less… No wonder that divergences between the nursing profession and current neoliberal establishment occur.

The “social order that entwines women’s subordination with the gendered organization of work and the dynamics of capital accumulation” (Arruzza, 2019) doesn’t seem to hold nurses dear, or perhaps what is actually unpopular is the nurses’ latent power residing in their unionized numbers, and maybe also their recognized socio-political inclinations and bluntness. Identifying themselves with the labour force, and not the leading classes, with the masses, and not the elites, nurses are very much aware of their protective role for those in need for care, their safeguarding function against mechanized approaches and heartless methods. When neoliberal agenda aims towards minimum time invested in care and minimum human resources available, despite exhaustion and lack of support, nurses still find - somehow - deep in themselves something added to give. For how long, though?...

Scholars have examined the philosophical concept of *care* as deriving from the Old English *caru*, decoded as anxiety, concern, grief, sorrow, trouble, caring. “This reflects a reality where attending fully to the needs and vulnerabilities of any living thing, and thus confronting frailty, can be both challenging and exhausting” (The Care Collective, 2020, p. 27). Hands-on caring involves being allowed into personal spaces, being permitted into a world that is deeply personal, and therefore rather frail because of its very exclusive nature. Such endeavours trigger a multitude of emotions, negative and positive alike, equally on the sides of caregivers and care receivers - emotional reactions that will ultimately influence the caring capacities and the practices of caring (The Care Collective, 2020). “The challenges of care, and in particular anxieties over whether it is given well or even adequately, not to mention its devaluation, can easily fuel resentment or aggression in caring relationships, even in those often mythologised as exemplary” (p. 28). These complex, difficult to control and contradictory emotions have been termed by the aforementioned scholars as representing the *ambivalence of care*.

Because of the overwhelming challenges of hands-on care and because of its ambivalent complexity, abundant resources - including *time*, as well as the appropriate societal infrastructure are necessary to properly provide it and sustain it:

> Ample resources and time in turn create the conditions that make a caring disposition towards the other, however distant, even more possible. Only by ensuring this infrastructure can we work through at least some of the negative emotions that are inevitably tied up with care, whether in giving or receiving it. Far from public spending creating the pathologies of dependency, the reverse is true. Only with adequate and secure resources can anyone, however fragile and in need of specific assistance, develop and maintain whatever capabilities they have to enable some sense of autonomy, and escape from the pathologies of being rendered completely helpless and passive. (The Care Collective, 2020, p. 29)

Unfortunately, in our present-day healthcare circles, the opposite is true. Nurses do certainly not have ample time and resources; to the contrary. The current nursing staff crisis results in day-to-day increased workloads for the available employees, and previously unheard-of nurse/patient ratios. The replacement of missing personnel with less qualified workforces, novices, or recruits with a reduced scope of practice leads to progressively more difficult assignments for the more competent nurses. The workplace becomes an increasingly daunting place, while nurses are heard less and less. To save themselves from grief and exhaustion, many find no better solution than hopeless relinquishment of their profession.

Nonetheless, what else could nurses do? Understanding that neoliberalism is a political oppressive tool for everyone, providers and receivers of care alike, nurses could constantly search for, and relentlessly promote alternatives: values and societal measures related to the 'common good' (Varcoe & Rodney, 2009), as well as societal structures that would preserve that common good. Falk-Rafael (2005b) challenges all nurses to view *political* involvement and advocacy as one of our expressions of caring; such cause would represent no less than continuing Nightingale's legacy of political action as part of our nursing responsibilities.

A Way Forward

Can we figure out how to dismantle the social system that is driving us into the jaws of obliteration? Can we come together to address the entire crisis complex that system has spawned - not "just" the heating of the earth, nor "only" the progressive destruction of our collective capacities for public action, nor "merely" the wholesale assault on our ability to care for one another and sustain social ties, nor "simply" the disproportionate dumping of the ensuing fallout on poor, working class, and racialized populations, but the general crisis in which these various harms are intertwined?
Nancy Fraser, 2022

Ideological Concepts and Counter-Discourse

Despite major damages inflicted by neoliberal practices upon contemporary society, socio-political measures based upon this ideology remain dominant and quite reticently challenged. As maintenance of the status quo is incontestably benefiting power elites, there is keen interest in preserving current discourses that exalt market fundamentalism (Harvey, 2007; Hursh & Henderson, 2011). Consequently, the first antidote proposed is a *counter-discourse*. Built upon critical thinking and careful analysis of current societal rhetoric and trends, this counter-discourse needs to challenge in an eloquent way the very bases of neoliberal propaganda: the concepts of choice, surplus and accumulation, the idea of individualism, competition and meritocracy, as well as the survival of the strongest attitude, merged with the heartless discard of those less able to perform.

A few ideological concepts in particular, such as *choice* and *resilience*, need to be addressed and confronted. One major error - or perhaps deception - of the neoliberal ideology is the implied idea of human boundless *resilience*. In disagreement with this flawed rhetoric, we need to argue that the human being does not have infinite capabilities of re-creation (Wilson, 1983). The lethargic acceptance of irremediable loss and unchangeable condition is possible, too, as the ill-fated alternative to continuous perseverance and stubborn determination. Downfall is

the state of many, and shattering of the human spirit is an unfortunate reality, causing unidentified amounts of lost human potential. Accordingly, the subsequent philosophical concept of *choice*, promoted so extensively by neoliberal discourses, needs to be placed in a much larger context of prerequisites, interactions and constraints. Choice is obviously not always 'free'. Choice finds itself limited by inner and outer resources, reality that firmly leads to the idea of potentially indispensable compensatory intervention from elsewhere.

Other neoliberal concepts that need to be challenged are *accumulation*, *surplus* and *growth*. *Accumulation* should never be through exploitation, dispossession or redistribution (Fraser, 2022; Harvey, 2007; The Care Collective, 2020). *Growth* and *surplus* should never be achieved at the expense of depletion of human and natural resources. A fair, care-oriented and clearheaded society will always "replenish, repair, or replace" all the means used up in commodity production or social reproduction (Fraser, 2022, p. 153). Also, a healthy society would "democratize control over social surplus" and "deinstitutionalize the growth imperative hardwired into capitalist society" (Fraser, 2022, p. 154). The question of *growth* would thus become a political question and would be decided upon in a democratic manner: how much growth, what type of growth, where and how (Fraser, 2022). In a fair-minded society, *surplus* - perceived as a collective fund of additional social capacities and energies, assessed after replenishment - will not necessarily be measured in *capital* (Fraser, 2022). "Surplus can also be thought of as time: time left over after the necessary work of meeting our needs and replenishing what we've used up; hence, time that could be free time" (p. 154):

> How a society uses its surplus capacities is absolutely central, raising fundamental questions about how people want to live - where they choose to invest their collective

> energies, how they propose to balance "productive work" vis-à-vis family life, leisure, and other activities - as well as how they aspire to related to nonhuman nature and what they aim to leave to future generations. (Fraser, 2022, p. 5)

Remaining in the sphere of discourse, counter-discourse and rhetoric, it is meaningful mentioning at this point a new thought-provoking study that proposes a change of *tone* and *intensity of speech* amongst the scholars who advocate for a democratic and equalitarian society, and, consequently, oppose neoliberal ideology and politics (Raphael et al., 2021). In spite of unwritten - and written - rules that recommend researchers to maintain a neutral, reserved and well-mannered tone in their academic endeavours, a group of Canadian scholars investigates whether or not the use of high valence negative concepts and messages, such as "social murder", "structural violence", or "social death" might be more effective in ultimately contributing to the hoped societal changes (Raphael et al., 2021, p. 137). The assumption that policymakers need exclusively sustained research in order to implement socio-political changes has been proven wrong by the experience of the few last decades; in reality, political will is determined by personal - and not societal - interests, despite clear and incontestable data (Raphael, 2011a; Raphael et al., 2021). Consequently, written research might need to be addressed primarily to the masses, rather than to those in power (Raphael et al., 2021):

> But what if policymakers are not allies but rather barriers to progress in reducing health inequalities […] since reducing health inequalities involves redistributing income and wealth and reining in the power and influence of those who benefit from the living and working conditions that create health inequalities (i.e. the corporate and business sector)?

> In this case, the aim is not to influence policymakers but rather to mobilize the victims of problematic public policy and their advocates to confront these same policymakers. And if this is so, then use of negative valence terms of high intensity is to be preferred. (Raphael et al., 2021, p. 136)

In line with the call for a change of valence in scholarly research, due to the same reasons - namely the policymakers' obvious disregard of research data, as well as their clear subservience to narrow private interests - leading Canadian researchers in the sphere of equity, social justice and socio-political determinants of health propose new research *topics* as well (Raphael & Bryant, 2022b). In the quest against agents who embrace the claim that 'there is no such thing as society', a more clarity of thought and less restraint in discourse is suggested, with emerging themes and methods. Among these: a political economy of health approach, unveiling that corporate and market interests dominate "the superstructure of capitalist society" (the media, the law, education and numerous other institutions), and will therefore make the achievement of various health-promoting public policies very improbable (Raphael & Bryant, 2022b, p. 429). Other proposed themes: the study of social movements, unionization and collective agreements; the exposure of structural causes of disease and food insecurity, merged with demands for raise of wages and for progressive taxation; the impact of neoliberalism on the structure and provision of health and social services; as well as the irreconcilability of capitalism with environmental preservation (Raphael & Bryant, 2022b).

Socio-Political Action and New Societal Measures

Globalization and the new economic standards are often used by the *assimilated* governments trying to justify their lack of intervention, reductions in public investments, and, ultimately, major inequality (Saint-Arnaud & Bernard, 2003). Nevertheless, since "economies are embedded within social contexts" (Coburn, 2010, p. 60), such approaches cannot dominate for much longer, as they undermine the very fabric of society and its solidity: "Indeed, no genuine cohesion is possible except where each and every citizen enjoys access to a minimum of resources, and where relative equality prevails among them" (Saint-Arnaud & Bernard, 2003, p. 502). Despite neoliberal chants, studies have concluded that inequalities are not a prerequisite of growth, but rather that reduction of social injustice has marked new starting points for economic development (Navarro & Shi, 2001). "Government spending in health and social protection not only improves health equity and contributes to social stability but also boosts economic growth" (Labonte & Stuckler, 2016, p. 316).

The need for societal change is imperative. Considering current research, while acknowledging the idleness of policymakers, this study proposes various paths and approaches aiming to give birth to socio-political action, as well as alternatives to the current status quo. These could be classified either as ethical, social and political (Raphael & Bryant, 2022a), or as individual, local and global (Alexander, 2001; Fraser, 2022; Garrett, 2019; Harvey, 2007; The Care Collective, 2020).

At the ***individual*** level, we need to build awareness and a critical filter informed by historical events and genuine evidence (Alexander, 2001). As diverse practitioners and educators, we have the mandate to "critique policy, not simply deliver it", both within our workplaces and as part of various emerging social movements (Garrett, 2019, p. 198). Resisting neoliberalism-

infused institutional practices is viewed by some scholars as *ethical* resistance, while joining various grassroots movements such as the labour movement, various human rights organizations or social movements such as *Black Lives Matter* is perceived as *social* resistance - expressing disapproval of current prejudiced models of thought and action (Raphael & Bryant, 2022a). According to Choiniere (2011), this approach could be summarized as "challenging dominant ways" (p. 333).

Taking a step forward towards the ***community*** level, The Care Collective (2020) highlights the phenomenon of dispossession of local communities of their once publicly owned spaces, as a result of corporate greed and massive privatization. "The decimation of public spaces renders a sense of communal life increasingly difficult" (p. 16). "Fewer community resources, a culture that places profit over people, and a social and political landscape that incites us to focus on our individual selves has meant that cultivating community ties, which enhance democracy, has become even harder" (p. 16). We need to reclaim these shared spaces as hubs that cultivate a spirit of community and the appreciation of joint resources, as opposed to the individualism, loneliness and isolation proposed and created by neoliberal dominance.

Subsequently, The Care Collective (2020) introduces the concept of *caring communities*, built on the recognition of our interdependencies and unapologetic need for one another. A caring community, in their view, has four central features: public space, communal resources, reciprocated support and local democracy. "Expanding our common public space means reversing the neoliberal compulsion to privatize everything" (p. 46). The shared resources could be both material (such as tools, libraries, art, architecture and environmental infrastructures), or immaterial (time and information). Also, regarding local democracy, the above-mentioned scholars point towards the idea of governing through co-operatives and radical municipalism (or

'the new municipalism', or 'remunicipalism'), as well as towards the need of rebuilding the public sector through developing and 'insourcing' its welfare and care-oriented activities, rather than "the outsourcing that accompanies privatization" (The Care Collective, 2020, p. 46):

> Municipalism is the practice of self-government by an area, town, or city. While there are political complexities to these forms, the key feature of the new municipalism is that it breaks with the neoliberal system of siphoning off public money to feed remote multinational corporations. The new municipalism mobilizes local 'community wealth-building' to counteract the exploitation of global capitalism commodity chains. (The Care Collective, 2020, p. 55)

Harvey (2007) speaks, too, about the "reclaiming of the commons" and the partial or total dissociation "from the overwhelming powers of neoliberalism and neoconservatism" (p. 41), in its various potential forms, when he proposes alternatives to the current state of affairs. Other researchers categorize such broader action as *political* resistance - challenging inequity, globalization and capitalism itself (Raphael & Bryant, 2022a).

Resisting market fundamentalism principles at the ***national*** level, starts, once again, with awareness that political economy of a state is what actually determines the health and welfare of a population (Bryant et al., 2010; Coburn, 2010; Raphael, 2011a). Countless studies demonstrate that more *equality*-oriented systems have always had the highest degree of population wellness and an upraised standard of living. Nevertheless, as previously mentioned, incontestable research data does not seem to suffice, as Canadian politicians have in mind not the societal wellbeing, but rather the preservation of upper-class interests and pursuits (Raphael, 2011a; Raphael et al.,

2021). (In such circumstances, a potential solution would be evidently their replacement with those who are genuinely committed to the 'common good'.)

Research in the field has shown various ways in which inequalities can be addressed through implementation of new social policies: from identifying those in need of governmental services (*targeted* interventions), to reshaping socio-economic and political structures (Raphael, 2011b). Mantoura and Morrison (2016) propose potential policy interventions aiming to reduce health inequalities, ranging from approaches directed towards individuals and communities to macrosocial policies and political economy (Appendix C, Figure 3). Aware that, unfortunately, current policies are mostly concerned with promoting healthy behaviours in lives of individuals, researchers point towards the need to focus on structural determinants of health and macropolitical causes of inequalities (Bambra et al., 2005; Mantoura & Morrison, 2016). Policies such as increasing minimum wage, adopting progressive taxation, raising the amount of social assistance payments, presenting a pertinent plan that would secure affordable housing for all, providing free early childhood education and a national Pharmacare, to mention only a few possible macrosocial policies, have a particularly high value because of their *universalism* (Bryant et al., 2010; Coburn, 2010). Such universal policies prevent community collapse and weakening of social capital due to shortage of solidarity (Saint-Arnaud & Bernard, 2003).

Remaining in the sphere of national and statal interventions, according to The Care Collective (2020), a *caring state* "must resource all the structures that facilitate the well-being and foster the capabilities or sustainability of all human and non-human life within its domains" (p. 60). The caring state will place societal care-taking activities above profit-making, safeguarding accessible quality care that is accessible to everyone throughout all ages, and warranting that major sectors of economy such as education and health remain untouched by

markets (The Care Collective, 2020). The markets themselves will need to be, as much as possible, localized and reconfigured into "more democratic, socialized and egalitarian modes of ownership" (p. 84).

Fraser (2022) proposes a similar economic model when stating "no markets at the top, no markets at the bottom, but possibly some markets in the in-between" (p. 156). Translating *the top* as social surplus - hence collective wealth - allocation, Fraser claims that market mechanisms and private property must have no rule in the matter, but only democratic, collective decision making and planning must occur. The same applies to *the bottom*, interpreted as the stratum of basic needs, such as "shelter, clothing, food, education, health care, transportation, communication, energy, leisure, clean water, and breathable air […] provided as a matter of right, and not on the basis of ability to pay" (p. 156).

From a ***global*** perspective, we need to revisit the idea that accumulation or growth of any kind simply cannot happen through dispossession of others, expropriation of others, or depletion of natural resources (Fraser, 2022; Harvey, 2007; The Care Collective, 2020). In the spirit of respect among nations, "we need to foster transnational institutions, global network and alliances based on the principles of interdependency and sharing resources, while embracing a democratic cosmopolitanism" (The Care Collective, 2020, p. 86). Among the suggested measures, certain researchers propose the restructuring of international financial institutions, with consequent redistribution of global wealth through progressive and all-inclusive taxation, and with national debt cancellations (The Care Collective, 2020). Unfortunately, the 'shadow economies' and deregulated financial markets "are little understood, let alone made accountable" (The Care Collective, 2020, p. 82); as a consequence, the 'shadow banking' - or the activity of the offshore financial entities - amounts to $183 trillion dollars, approximately three times the world's GDP

(Pettifor, as cited by The Care Collective, 2020). Main researchers agree that, ultimately, neoliberalism embodies a "social totality" (Fraser, 2022, p. 116), or an overwhelming *crisis of democracy* (Fraser, 2022; The Care Collective, 2020):

> But is the profoundly antidemocratic nature of neoliberalism that should surely be the main focus of political struggle. Institutions with enormous leverage, like the Federal Reserve, are outside any democratic control. Internationally, the lack of elementary accountability let alone democratic control over institutions such as IMF, the WTO, and the World Bank, to say nothing of the great private power of financial institutions, makes a mockery of any credible concern about democratization. (Harvey, 2007, p. 42)

Conclusion

This study aimed to present some generally accepted - and to unveil some less obvious - features of neoliberal expansion in every sphere of life, having tragic results such as deep individualism, fierce competition, division and shattering of society to the point of remodelling of human quintessence, transfer of wealth in the wrong direction, depletion of human and natural resources, and, eventually, world-wide devastation. The promises of global economic growth and welfare trickling downwards have proven to be empty, while concealed purposes, such as restoration of class power, were, regrettably, achieved (Harvey, 2007). “In reality, the differences, within and between countries, in income levels, opportunities, and health status are greater now than at any time in recent history. Something has gone terribly wrong” (Chan, 2009, p. 2). Seen by many as social Darwinism, with an imperialistic mentality that applies combat tactics such as *Divide et Impera*, neoliberalism has proven to be concerned only with the very few, while the masses are abandoned to providence - with no help, no mercy, and no protection against loss. “What counts is to win. The rest is collateral damage” (Monbiot, 2014, para. 5).

The neoliberal syllabus includes ingestion of healthcare as well, after assessing the potential for tremendous financial gains. In Canada, this assimilation is happening as we speak. While covered by ‘well-intended’ purposes of sustainability and efficiency, neoliberal agents attack the little is left of our common goods, public wealth, and joint resources. Nevertheless, research and common sense argue that, when private interests interfere, capital, accumulation and profit always become the main pursuits, and not human wellbeing or quality of care. Accordingly, both receivers and providers of healthcare services will suffer multiple uncalled-for consequences.

In the last part of this research, ways of resisting the neoliberal expansion have been proposed and detailed. It has been suggested that, in the present-day careless circles, the answer could be the restoration of a culture of care. Finding ourselves equally affected by the current profound democratic crisis, our forces need to be joint in the quest against world-wide human and ecological exploitation, depletion and, eventually, destruction:

> The more clearly oppositional movements recognize that their central objective must be to confront the class power that has been so effectively restored under neoliberalization, the more they will be likely to cohere. Tearing aside the neoliberal mask and exposing its seductive rhetoric, used so aptly to justify and legitimate the restoration of that power, has a significant role to play in contemporary struggles. It took neoliberals many years to set up and accomplish their march through the institutions of contemporary capitalism. We can expect no less of a struggle when pushing in the opposite direction." (Harvey, 2007, p. 43.)

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Appendix A

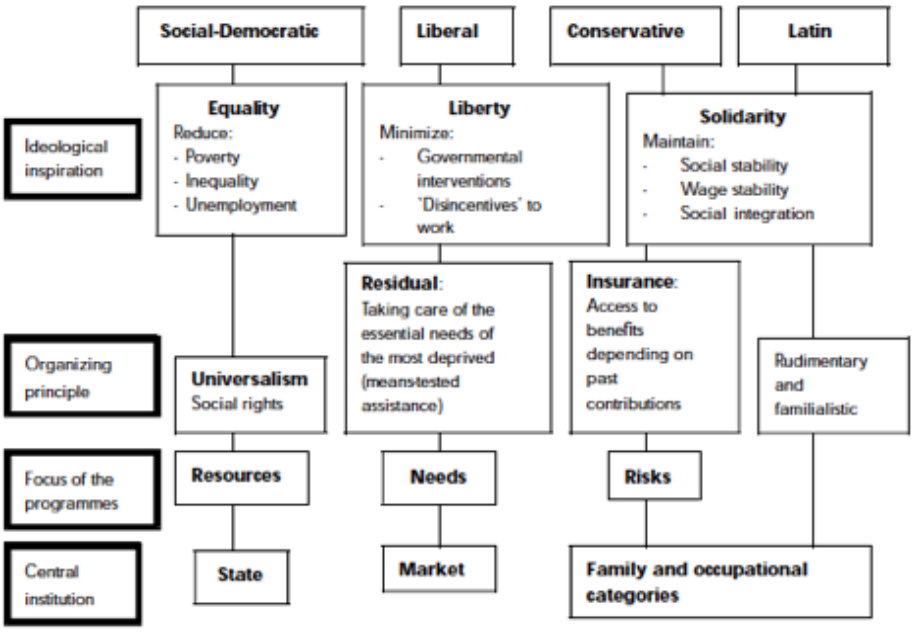

Figure 1. Types of political ideologies and their basic philosophy of social citizenship. (Source: Saint-Arnaud and Bernard, 2003, Figure 2, p. 503).

Appendix B

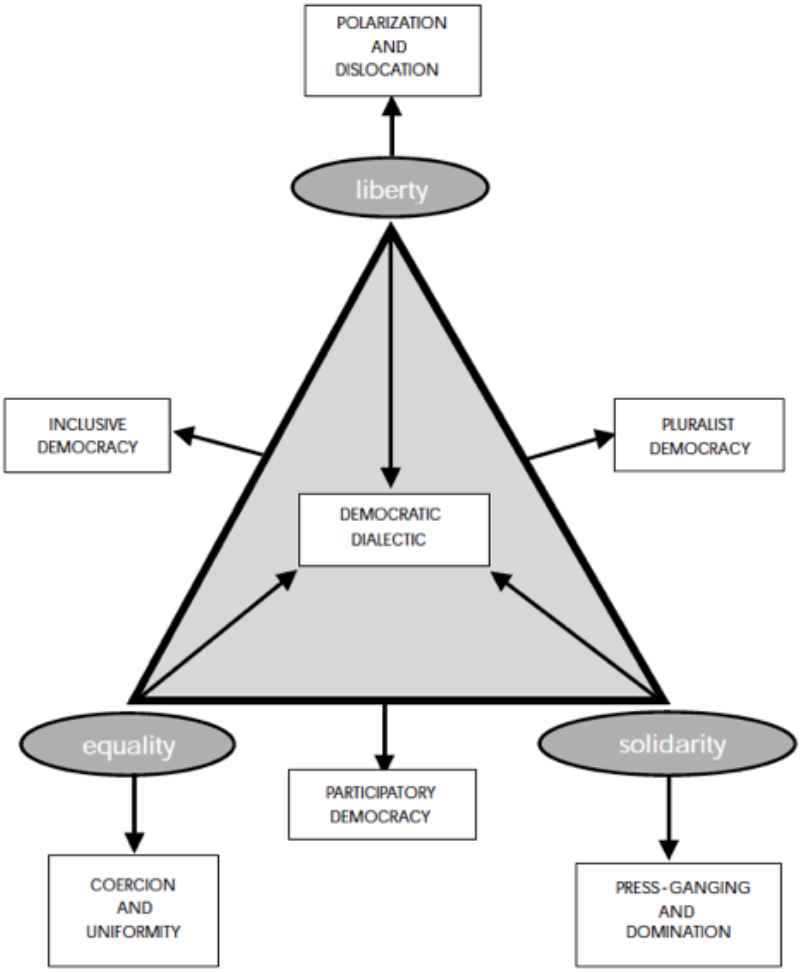

Figure 2. Essential principles of social citizenship and their interaction. (Source: Saint-Arnaud and Bernard, 2003, Figure 1, p. 501).

Appendix C

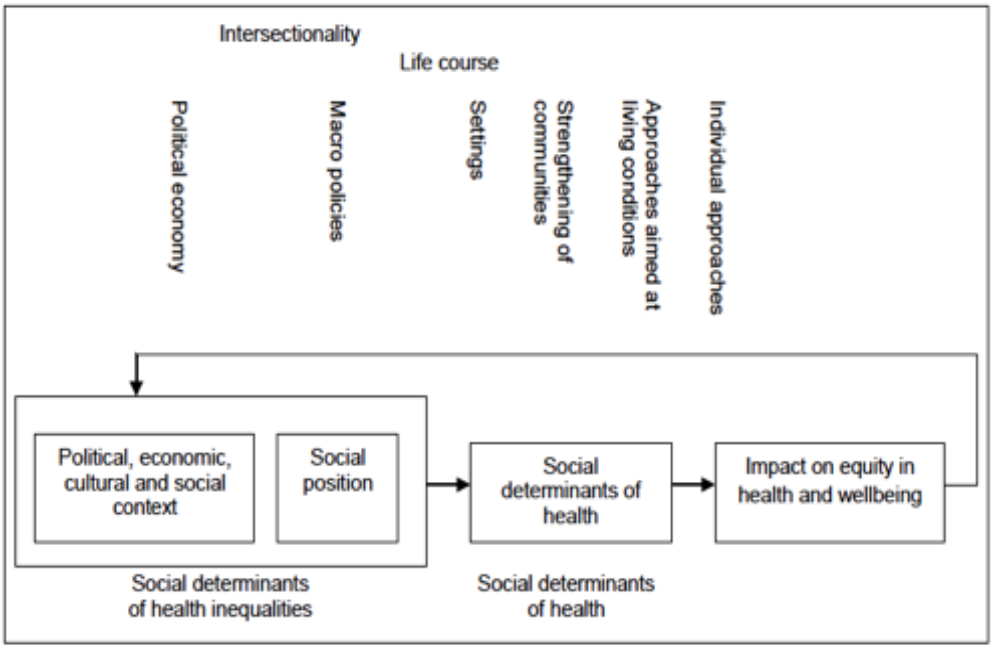

Figure 3. Entry points of different policy approaches. (Source: Mantoura & Morrison, 2016, Figure 2, p. 5)