The Masculinization Effect

Neoliberalism, the Medical Paradigm and Ontario's Health Care Policy

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Drawing from three empirical studies, this article argues that neoliberal policy logic and the medical model have combined in Ontario's health care policy to privilege values, people, professions and most closely associated with the cultural imaginary of elite masculinities. In women's health services decisions, in 9-1-1 emergency medical care developments and in service expansion for those with intellectual disabilities and mental illness, the epistemological biases of these dominant perspectives appear to provide the basis for a masculinization of health care and health care policy.

Se basant sur trois études empiriques, cet article soutient que la logique des politiques néolibérales et le modèle médical se sont associés dans le système de santé de l'Ontario et privilégient les valeurs, la population, les professions et ils sont plus précisément ligués avec l'imaginaire culturel des élites masculinistes. Dans les décisions prises à l'intérieur des services de santé des femmes, dans le développement des services médicaux d'urgence 911 et dans l'expansion des services pour les handicapés mentaux et la maladie mentale, les biais épistémologiques de ces perspectives semblent être à la base de la masculinization des soins et des politiques de santé.

In the spring of 2010, I attended a regional meeting of publicly funded health care and social service providers who serve developmentally delayed and/or mentally ill adults in Ontario, Canada. I was there to report on my analysis of their crisis response and intensive case management service data. The conversation moved rapidly to concerns about justice system involvement in their client's lives. In my quantitative analysis of service data, justice involvement was highly correlated with crisis response service use, and was a factor in 99 percent of the intensive case management cases. Speaking to these findings, providers indicated that many of their clientele—people with developmental delays, mental illness and conditions such as autism and Asperger's syndrome—live without appropriate medical care, income or social supports. Some have been discharged from now-closed residential institutions to families or unsupported independence. These adults are exhausting familial and community care supports, and all too often have ended up in court, on probation, in jail, or in a forensic psychiatric facility. This situation is one more addition to the growing evidence that Ontario's public health care and social services terrain has become increasingly fragmented, with a number of concerning effects. One of these effects is that those with unmet needs for health care and/or social services are increasingly considered to be public safety and security concerns. The result is to criminalize instead of care. This change shifts public funding from the "pink ghettos" of long-term residential care, health care, and social services to the masculinized worlds of policing, jails, probation/payroll systems and forensic psychiatric medicine. This shift is just one example of a masculinizing effect that is embedded in the logics that hold sway in Ontario's social policy formation in the early twenty-first century.

In this article, I argue that the driving logics embedded in contemporary Ontario health care policy are both masculinized and masculinizing. In this article, I will not discuss social services' somewhat different, albeit parallel, policy route, where discourses of activation, responsibilization and individual autonomy from the state have been the (weak) justifications for social services delivery in the face of neoliberal logics. These services have been reshaped and restructured at least as dramatically as health care services with social welfare cuts, particularly in income supports and housing, as part of the masculinization of public policy.

My assertion is that neoliberal logic and medical paradigms are not only

gendered, but share a similar gendered approach, while at the same time both perspectives rely upon an assumption that gender is not a pertinent category for analysis. But, as Janine Brodie (2007a) has pointed out:

> Although contemporary social problems may be framed and analyzed as if gender is no longer relevant, the gendered underpinning of these social problems do not disappear. On the contrary, they tend to intensify. (178)

The conception of gender in this discussion has broad epistemological, ontological and normative dimensions but it does not end there. Drawing upon Leah Vosko's and Pat Armstrong's (1996; 2006) theorizations of feminization in labour markets and inspired by Jamie Peck and Adam Tickell's theorization of neoliberalization as a process, I suggest, like Joan Acker, that gender is also a process, where practices, institutions, organizations, occupations and discourses can be re-gendered, de-gendered or more saturated with gender. In this discussion, I apply the term "masculinization" to denote the ways in which some institutions, organizations, occupations, and practices are constituted as masculinized, deserving, necessary and of high value in relation to other institutions, organizations, occupations and practices—and those who rely upon them—which are constituted as feminized, unnecessary, a drain on the public purse and of lower value. I am proposing a conception of gender that highlights gender's uneven and sometimes contradictory relations and effects, which are contingent on historical and geographic context, and intertwine with relations of class and race in multiple ways. Here, gender is always becoming, and not an end state. Gendering processes are produced and reproduced through institutional and organizational forms, knowledges, and practices, and must be evaluated with a focus on change. In what follows, I will describe how gender processes have operated to produce binary hierarchies, while at the same time, I try to challenge and dismantle those binaries. Describing the essentializing hetero-normative conceptions of gender categories without falling into them is tricky work and this may be apparent in my struggle to articulate an opening for a broader and more complete gender analysis.

In what follows, I provide a brief discussion of gender analysis and social policy, followed by an outline of the gendered nature of the medical paradigm, neoliberal logics and their synergies in health care policies. Next, I draw upon data from three research projects on health care services issues: on women's health services; on firefighter's involvements in emergency medical care; and on crisis and intensive case management responses to people with developmental delays. In each study, the masculinizing trajectory of Ontario health care policy is illustrated.

Gender Analysis and Social Policy

Social policy gender analysis is often restricted to the important—but in my view insufficient—question, "Where are the women?" These analyses are often "body counts" that answer questions about how many women and which women are affected by policy, as well as how these women are affected. They fail to take up the ways gender relations permeate knowledge, practices, institutions, organizations and occupations as well as people in the policy process. Yet, feminist scholars have pointed out repeatedly that when it comes to the issue of state policy, gender is a complex issue. Brown pointed out that "the institutions, practices and discourses of the state are as inextricably, however differently, bound up with the prerogatives of manhood in a male dominated society, as they are with capital and class in a capitalist society and white supremacy in a racist society" (8). Feminists have taken a number of different positions about whether or not states are intrinsically patriarchal or whether they are sites of struggle (Tickell and Peck). My view draws upon Wendy Brown who argued that "[T]he state can be masculinist without intentionality or overtly pursuing the "interests" of men precisely because the multiple dimensions of socially constructed masculinity have historically shaped the multiple modes of power circulating through the domain called the state" (177). To expose these modes of power, gender analysis must dig to expose and uproot the gendered assumptions embedded in epistemologies, institutional and organizational forms, practices and discourses. In making this argument, I inadequately address racialization effects, as understanding the intricate ways that gender, racialization, and class entwine in each case is beyond this article's hold on the gender strand. Neoliberalism, as the reassertion of capital interests, racializes, without question (Goldberg) and in health care policy, erosions of care affect racialized people more severely, due to their predominance as workers in urban care services, and their absence in many public safety and security sectors. I suggest that racialized people in Ontario have never been well served by health care services, or particularly considered by health care policy, and historically as well as currently, health care institutions in general have been marked as "white."

To conduct a gender analysis that exposes Brown's multiple dimensions and their modes of power, gender must be considered not only in terms of bodies and divisions of labour but must take into account the ways in which concepts of masculinities and femininities have developed as clusters of attributes that are, in our particular historical context, associated with a normative understanding of dichotomously sexed bodies. Within these normative clusters, the variation in composition and hierarchical social value shaped by normative conceptions of class, racialization, sexuality, and ability must be taken into account. Further, historical continuities and changes in the nor-

mative constitution of gender forms need attention. Gender analysis must then examine the institutions, organizations, practices and discourses that constitute and are constituted by social policy change, with particular attention to the distributions of costs and benefits. This analysis can identify the gendered nature of the epistemologies and histories that discuss the ways in which neoliberalism *advantages* those institutions, occupations, practices, and subjects who best approximate the masculine norms that are embedded in its logic. Yet, neoliberal policy orientations have a gendering effect on institutions, practices, discourses and subjects, masculinizing those that fit most closely with its logics, and replacing unionized jobs in these sectors with contract, temporary and part-time workers (Vosko; Vosko, MacDonald, and Campbell). Third, services have been restructured in order to provide lower or limited levels of social welfare and increased levels of surveillance and monitoring as strategies to encourage labour market participation and independence

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underpin particular policies as well as exposing the gendered interests that are secured or bolstered as a result.

Neoliberalism and the Medical Paradigm: A Gender Analysis

Phil Hubbard, a geographer, writes, "I highlight a serious lacuna in the literature on neoliberalism: namely, its failure to note the inherent masculinity of neoliberal policy" (667). This "lacuna" is clearly the failure of male-stream academics to consider and engage with their feminist colleagues, for when neoliberalism is subjected to the kind of feminist analysis outlined above, the verdict has been clear: neoliberal governance shapes social inequalities of gender, race and class (Connell 2010; Brodie 2007b). Further, it disadvantages many women, particularly poor women, racialized women, disabled women, and women who care for dependents.

In Canada, neoliberal governance has undermined women's citizenship and marginalized women's concerns and needs (Brodie 1997; Stasiulis and Bakan; Bashevkin; Porter) and rendered work in the "reproductive arena" (Connell 2002) much more fraught (Bezanson). But perhaps because of this focus on women, feminist gender analyses often do not feminizing those that do not.

What do I mean by neoliberalism? Briefly, neoliberalism is a political philosophy that places individual human freedom from particular kinds of servitude and coercion as its highest value: a human freedom that is defined as the right to compete and to choose in markets, in order to pursue self-interest and wealth. It is, in essence, the re-centralization of capital. As a logic of governance, neoliberalism rejects collectivism and elevates markets as impersonal and fair distributors of social goods and "bads." The main task for governments is, therefore, to produce, maintain and protect market or market-like competitiveness throughout all aspects of society (Braedley and Luxton). The gradual blending of this logic into social policy in Ontario, particularly since the mid-1990s, has meant many changes. First, governmental provision of health care and social services is perceived as a limit to fair competition, so policy has endeavoured to expose these services to market competition in a number of ways, including privatization, contracting out and funding mechanisms that pit non-profit providers against for-profit ones (Armstrong, Amaratunga, and Bernier; Baines 2004). Second, labour market competition has been increased by eroding and from state services (Braedley 2006). All these policy directions are both masculinized and have some masculinizing effects.

Neoliberal social policy has been erected ideologically on the basis of neoclassical economics, combined with erratic doses of positivist psychology and sociology, medicine and business management (Mintzberg 1996, 1997). This combination of positivist science, economics, and management has worked at every level to promote the development of "evidence-based policy" (Davies, Nutley,et al.; Dobrow, Goel, and Upshur). At the level of service delivery, there has been a proliferation of "evidence-based" practices, all aimed to justify the use of public funds, to provide some public accountability and, simultaneously, to reorganize the public sector to reflect market norms and priorities. Intrinsic to the understanding of what counts as evidence, and what will create market conditions or market-like conditions, are requirements for standardization and numerically expressed measurement (Kurunmäki). To this end, a wide variety of assessment, measurement and accounting tools have been employed that quantitatively assess particular aspects of service delivery: its effectiveness, generally defined as users reaching a

certain state of independence from services; and its efficiency—generally defined as measuring its costs and its speed. In order to use these tools, significant investments in computer and other technologies have been made and significant work-time is now dedicated to collecting and entering data and maintaining and managing the technocracy in order to feed the voracious policy appetite for quantitative measurement (Baines 2006). Leadership and management in health care and social services, once performed by experienced practitioners, has shifted in many cases to business-style administrators and managers (Coburn).

These shifts are ones that embed norms consistent with the social constructions of elite masculinities into policy and services delivery, while re-shaping gendered hierarchies in ways that privilege those people, occupations, institutions and practices that most closely approximate these norms. Critical studies of elite masculinities and feminist work on economics (Bergeron; Nelson and Ferber) have shown that typically modern masculine norms associated with economics include expertise, objectivity and rationality. The rise of business manager as the figure of neoliberal ascendency has also been elaborated (Hearn and Collinson; Connell and Wood). Contemporary elite masculine norms include independence, self-control, expertise, technological proficiency, objectivity and rational decision-making. They are also associated with notions of prestige, heroic intervention in the face of danger, and a vigilant protective attitude that diminishes and/or punishes those deemed incapable of approaching these norms.

In health care policy specifically, neoliberal social policy epistemologies, approaches, methods, and tools meet those of the medical paradigm, which historically has had a profound influence on the shape of health care. The medical paradigm has also been shown to be gendered (Armstrong and Armstrong 2002a). Andrea Baumann et al. describe this paradigm as one that emphasizes "cure" and takes a bio-medical or technological approach. This paradigm, in its contemporary form, privileges scientific evidence based on reproducible controlled trials and tends to debase or dismiss other forms of knowledge as lacking in scientific rigour. This approach and the practices associated with it are performed by professionals with specialized and expert training (physicians), who employ positivist science approaches. The approach calls for the diagnosis of pathophysiology and reduction of symptomology using a sequential model that employs decision pathways and often highly technical interventions. Measurement of patient outcomes is limited to reduction of symptomology. "In addition, curative activities are often dramatic and carry high prestige…" (Ibid. 1041). While Baumann et al. refrain from a gender analysis, the discursive and material connections between the medical paradigm and constructions of elite masculinities, outlined above, are apparent.

The chart on the next page plots consistencies between the medical paradigm, neoliberal policy logics and related qualities associated constructions of elite masculinities.

This is not to suggest that neoliberal logic and medical paradigms are always in harmony or uniformly converge. Rather, I am suggesting that their historical development has been entwined with the construction of particular masculine normativities, and their combination powerfully constitutes a broad masculinization within health care policy and shapes a deepening of the gendered division within and among services.

The Ontario Case Studies: Setting the Scene

The gendered past of public health care policy in Ontario has always been dominated by elite masculine interests: white "medical men" have shaped this policy right from the start. Yet, struggles for socialized medicine, women's liberation and fair labour conditions had many successes. Although there are significant disparities in access and service provision (Kisely et al.), publicly provided universal health care services have taken an important role in advancing equity (Davies and Hoy) through contributing to better health security for the population, providing an important source of high quality employment for women (Armstrong and Armstrong 2002a; Armstrong et al. 1997; Armstrong and Kits) and taking a share in providing care, relieving unwaged carers in households (who are mostly women) of some care work (Luxton 2006, 2010). Although inequities remained embedded in the health care system, many gains toward equity have been achieved through public health care, which was instituted in Ontario in 1966. Further gains have been the result of subsequent nurses' struggles for more recognition and control over their work.

However, the equity potential of health care services has been substantially eroded since the mid-1990s. Beginning in 1995, Ontario's public sector was dramatically reshaped by the Mike Harris Conservative government, which instituted neoliberal policy through organizational coup, or what is termed "shock therapy" (Connell 2010: 26). The McGuinty Liberal government that followed, first elected in 2003, continued to restructure health care in a more incremental and conciliatory—but no less neoliberal—fashion. Shaken by neoliberal governance's emphatic support for privatization (Armstrong et al. 2001; Armstrong and Armstrong 2002b), stirred by a fervour for medical paradigms that exclude many kinds of evidence (Timmermans and Berg; Upshur) while undermining "social care" (Daly 2007), and poured into an environment where technological innovation and huge labour force change, including a growing emphasis on professionalization and concurrent de-skilling and employment insecurity (Baines 2004; Coburn; Armstrong and Laxer), Ontario's health care system has been radically restructured. It now

	Neoliberal Social Policy Logic	Medical Paradigm	Associated Elite Masculine Norms
Epistemology	Neoclassical Economics, Positivist psychology and sociology Business management	Positivist science	Instrumental Rationality Objectivity
Basis for analysis/ assessment	Measurement	Measurement	Calculation
Subject	Business –oriented manager /Autonomous individual	Physician	One who has control, power over others
Object	Dependent individuals	Acutely ill or diseased bodies and body parts	The feminine
Involvement	Short term, episodic	Short term, episodic	Rescue, Protection from harm
Determination of Effectiveness	Decreased dependency on the state	Decreased symptomology Cure	Independence
Practice Tools	Risk assessments Decision trees Benchmarks Best practice guidelines	Diagnostic assessments Decision trees Technological diagnostics Best practice guidelines	Technological, Rational, Objective

provides less care and more quick-pick-me-up and fix-me-up service. Despite commitments to improving primary care, most public health care services have been reoriented to provide "snatched-from-death" acute care services, emergency responses and short-term care, sending chronic care needs home. It is shedding its (always fraught) potential for improving social equity through logics that shift responsibility, restructuring in inequitable gendered ways.

Analyses from three research studies reveal the masculinizing effects of health care policy on institutions, practices, and discourse, and their material implications for workers and for all of us. My particular interest is to note these effects for various institutions, for workers—particularly paid and unpaid care-givers—and for those with unmet needs. In each of the following research examples, I highlight one particular dimension of the masculinizing process. This does not mean that other effects are not present; in fact, I attempt to illustrate their intertwinement. My point is only that gendering processes do not proceed in a uniform, sequential fashion. Rather they flow from paradigms and embedded logics in many different ways.

Gendering Organizations, Devaluing Care

The Women's Health Services Study[1]

This first case is a study that examined women's health services restructuring, in which the research team analyzed organizational change in gendered terms. Here, we discovered orientations that privileged narrow concepts of efficiency and safety, while justifying a shell game with women's health services. The gendered effects were massive. They included fewer services for women, fewer women as administrators and

providers in the re-structured services, a gendered change in program goals and emphases, and an organizational "feminization" that de-valued one hospital relative to its others with more "masculine" profiles.

The Harris government neoliberal health care restructuring initiative, begun in the mid-1990s, was conducted by the Health Services Restructuring Commission, which not only extended measures such as hospital bed closures begun by the former New Democratic government but instituted a 36 percent reduction in the number of public hospital corporations. Through tight restraints on base funding for hospitals, this government also effectively privatized many health care services by squeezing them out of publicly funded hospitals and into the community. Services like physiotherapy, diagnostic imaging, ultrasound, hearing tests, diabetes counselling, biopsies, and other ambulatory care services were transferred out of hospitals to be provided in private clinics and practices, doctors' offices and community clinics. Since the late 1990s, Ontario hospitals have focused primarily on providing services that are difficult to offer outside of the hospital setting. Thus, hospitals have come to focus on acute care. Health care policy has oriented itself to encourage and facilitate "private" health care provision: either from the market's private sector or from unwaged or informal carers in the private confines of households (Armstrong 2010).

Our study, conducted in 2007–2008, showed the masculinizing influence of this policy direction, perhaps most strikingly by "masculinizing" hospitals through a gendered division of labour amongst health care institutions. There has been a long standing gendered division of labour between doctors and nurses, in which physicians focus on cure and nurses perform care. Emanating from the implicit gender bias embedded in the medical paradigm, cure activities have always held higher value in Ontario's health care system, while care activities have been assumed to be an extension of women's "natural" orientations and therefore less skilled and less valuable. This has been a long-standing point of tension in health care. One of the effects of neoliberal governance, when converging with the medical paradigm already present, was to inscribe this division of labour on institutions. Some Toronto hospitals, perhaps not so coincidentally referred to by a number of the respondents in our study as "the big boys," were expanding their focus on surgical specialties, emergency medicine, high technology treatments and associated research programs, while other hospitals were closed or downgraded to become ambulatory care centres that provided outpatient services only. Money was being invested in high tech, surgically-oriented hospitals where cure results could be easily counted, while budgets were being squeezed in the ambulatory care centre environment (Daly et al.), where care results were more difficult to assess. Highly technical services, such a nuclear medicine, were *not* transferred out of hospitals to an ambulatory care centre, but were being retained and expanded within the hospital setting, even though they were often provided on an outpatient basis.

From the perspectives of neoliberal logic and medical models of health care, these shifts make perfect sense. Neoliberal logic takes a business approach to health care delivery and sensibly looks for measurable returns on investment. Cure activities, and particularly high tech cure activities, are easily counted and costed as, unlike most care activities, they have clear time frames and outcomes. They are easily measurable in positivist research terms and they tend to take a mechanistic view of the body as an assemblage of body parts. This makes them easily comprehensible from a medical perspective.

But at the same time as acute care services were being consolidated in specific sites, services such as mental health treatment, sexual assault services and chronic care programs (ie. arthritis and osteoporosis treatments) were sent out of hospitals to be provided at the ambulatory care level. Treatment for these health conditions do not provide the same clarity or measurability as acute care services do. For example, there is often no predictable end point to service delivery. Spending time with someone to work on coping with pain due to a chronic condition may continue indefinitely and go through periods of improvement followed by deterioration. These circumstances make these treatments difficult to assess through the kind of randomized controlled trial methodology privileged by medical paradigms. They are also difficult to count and cost through the accountancy of neoliberal governance. Thus, these kinds of health care do not translate easily into terms consistent with either neoliberal or medical logics. To a large degree, they have been sent out of hospitals and have also been significantly eroded, as a result.

This gendering of institutions has had material gendered results. In our study, Women's College Hospital, now an ambulatory care centre, had formerly been a research hospital dedicated to training women physicians and providing women's health services. It had fought for its corporate life and saw many of its innovative programs eroded, cancelled, or snatched up by others. Activists were successful in restoring Women's College status as an independent corporation in 2010. They also ensured that the facility was designated a centre for women's health research. However, activism did not touch the roll-out of the neoliberal logic that masculinized other hospitals while undermining many of Women's College Hospital's programmes.

Other masculinizing changes also occurred. Under the guise of gender neutrality, policy masculinization negatively affected women's leadership, employment and health care. Once, Women's College Hospital bragged about its leadership that included at least 50 percent medically-trained women in a woman-friendly work environment. In April 2010,

the list of twelve medical chiefs at this centre included only three women. Further, and perhaps more significantly, only a few of these medical leaders were educated in or committed to a women's health perspective. Women's health care was also eroded through Women's College Hospital's cancelled and transferred programs. These included an innovative inter-disciplinary pelvic pain program that had had significant success in treating what is often a difficult-to-diagnose debilitating and chronic condition. Although another hospital offered a pelvic pain program, our respondents described it as pharmaceutically and medically oriented. It does not include psycho-social support and non-allopathic practitioners, as the program at Women's College Hospital did. It is also no longer explicitly a women's health service for what is clearly a women's health condition.

Under the guise of gender neutrality, policy masculinization negatively affected women's leadership, employment, and health care. Once, Women's College Hospital bragged about its leadership that included at least 50 percent medically trained women. In April 2010, the list of twelve medical chiefs at this centre included only three women.

The masculinist power of intertwining neoliberal and medical paradigms is also illustrated in the reports that recommended the transfer to the Sunnybrook Medical Campus of Women's College Hospital's much lauded perinatal and gynaecological program (Kitts). This report based its recommendations on the results of two reviews: one using clinical criteria, the other one using capital criteria. The clinical review was conducted within a medical paradigm; the capital review deployed the narrow economic logic of neoliberal policy-making.

The clinical review acknowledged that the perinatal/gynaecological program at Women's College Hospital was a provincial leader. It was extremely busy, provided excellent patient care, was highly regarded by patients and was "a research jewel" (Kitts 15). Yet, because other inpatient medical programs had already been relocated, and because the physical plant was antiquated from years of health care budget constraints, the report concluded that high risk births posed too high a safety threat. The medical perspective evident in this review, while excellent on issues like patient safety risks, has some serious lacuna. Through the narrow perspective of medicine, influences such as administrative infrastructure and workplace culture were not taken into account as significant factors in patient outcomes. The bases for patient satisfaction and use were not examined. Care as a quality, rather than a quantity, went unconsidered. The clinical view of these health care services, while useful in many ways, ignored or assumed the smooth social reproduction of patients and health care workers. In other words, a masculinist perspective was embedded in its assumptions.

The capital review added to this picture. It concluded that immediate program transfer was required due to risks to patient safety—even though no safety issues had arisen at the Women's College site. This recommendation for speed was backed by assertions that this move would minimize hospital liability risk plus pique public interest in Sunnybrook's fundraising campaign. Although this review considered the costs associated with the move to the Sunnybrook campus as prohibitive, it provided suggestions to reduce them, but made no suggestions for cost reduction to further the option of retaining these services at the Women's College Hospital site. Taken in its entirety, the report's medical and finance perspectives reveal a failure to consider the perspectives of patients or staff and to examine issues related to care. The effects of this narrow view are clear in recommendations to remove "family space" from the proposed Sunnybrook maternal/newborn unit design and scatter some of the perinatal/gynaecological services around the large multi-building Sunnybrook campus in order to cut costs.

Once again, patients' and staff social reproduction was ignored or taken for granted. Once again, masculinist perspectives worked their way to shape health care. In spite of financial problems at Sunnybrook, concerns that costs would be too high and a statement that Sunnybrook had a poor financial plan for the unit, the review recommended that program transfer proceed (Kitts 79). The underlying logics for decision-making throughout the report, emanating from the medical paradigm and neoliberal takes on financing, favoured building a large complex infrastructure that clustered technology and doctors together over a large campus located away from the urban core and off subway routes. This is not to say that the factors taken into account are not important or worthy of serious consideration. However, the use of medical and neoliberal paradigms without reference to concerns for care, and other aspects of the daily production of factors involved in maintaining workers and patients in the hospital environment, is problematic. Further, these paradigms do not just leave out these considerations: They devalue inquiries into many factors that affect patient comfort, preference, access, excellence in workplace culture, administrative support and worker satisfaction and

retention. How would the decision have been affected if these factors had been taken into account?

After shedding many of its programs, the now Women's College Ambulatory Care Centre's innovative preventative, wellness-based and multi-disciplinary programs continued to run, but operated on shoestring budgets, had long waiting lists and often charged user fees. Thus access to these women's health programs was more limited. Also, the cardiac program charged user fees; the sexual assault program experienced significant erosions in service delivery and community liaisons; the osteoporosis program ran a growing wait list. Our research respondents told us that many experienced and well-qualified staff left to work in less disrupted and more supported environments. Administrative and clinical managers at the Centre agreed that they now "fill gaps" left by the acute care hospitals, while also fighting to regain and retain women's health services.

Health care policy effectively gendered institutions through a hierarchical distinction and managerial separation of cure from care; an approach that in and of itself demonstrates a technocratic and managerial masculinization that focuses on what makes sense to the elite medical personnel and administrators within the system rather than what makes sense for those who are ill, for those who care in households and communities and for those who provide care in the system. This process masculinized some hospitals by concentrating more costly and more prestigious technology and services associated with "cure." It effectively feminized ambulatory care institutions and clinics by concentrating services for those with chronic health care needs. Due to the assessment of masculinized services as both more prestigious and as funding priorities, it provided disincentives and constraints to building strong preventative, women's health and chronic care programs even within feminized institutions. As of 2011, women's health and most chronic care treatment programs[2] are not Ministry of Health priorities and are certainly not hospital-oriented priorities. Consistent with the masculinization of hospitals, wait times for surgical procedures and emergency medicine are priorities.

Re-gendering Practices, Transforming Care

The Fire Services Emergency Medical Care Study[3]

Neoliberal policy direction and the medical paradigm combined in other areas of health care services, with different masculinizing effects. One example is an emphasis on emergency response that has resulted in a circuitous connection between erosions of feminized health care and social services work in long-term residential care, nursing care, and social work and changes to the masculinized work of firefighting. These changes have institutional and discursive aspects, but perhaps most significantly, they are re-gendering practices.

In 2007–2008, I conducted an ethnographic investigation of the rapid and significant increase in fire services' in emergency medical response work at Toronto Fire Services, where emergency medical responses had increased by 42 percent between 1999–2007 to make up 53 percent of annual fire services responses. In 2007, this amounted to 75,117 calls. As a point of comparison, fires accounted for only seven percent of responses in the same year.

Fire services increased involvement in emergency medical care was the unintended consequence of a number of social policy changes, including hospital restructuring. As the provincial government closed and consolidated hospitals in the late 1990s, hospital emergency departments were reduced in number, and the remaining facilities experienced an increase in patient activity that stretched and sometimes broke their capacity to respond. This increase was related not only to the reduction in the number of emergency rooms but to other changes in health care and social services provision. For example, de-institutionalization of those with mental health problems and those with developmental delays to somewhat mythical community services, a sharp drop in social assistance and a cancellation of new public housing initiatives left many people with few supports and at increased risk of health-related difficulties. In the absence of easily accessible primary care or chronic care services, people showed up at emergency rooms in greater numbers (Schull, Slaughter, and Redelmeier; Schull et al.). Further, hospitals' focus on acute care, combined with the introduction of new medical technologies, meant that people were being discharged from hospital "quicker and sicker" (Armstrong 2006). 9-1-1 emergency response became many people's health care contact point. Ambulance services could not respond rapidly to the swiftly growing number of calls without increasing their budgets. Further, due to protocols that require paramedics to stay with patients until a doctor can take responsibility, paramedics were spending more time caring for patients in overcrowded emergency rooms, and therefore were unable to respond to other calls. Firefighters had a lot of down-time at work, fast response times, and were already part of the tiered emergency response system; they took up the slack. Toronto fire service kept no data on who they serve in emergency medical response. However, of the 90 medical responses I recorded at 13 fire halls, firefighters were responding disproportionately to those who were poor, disabled, suffering from chronic conditions such as alcoholism, mental health problems, asthma and diabetes, who lived alone or were homeless, were usually over 65 years old, and were most often men. Firefighters were called for a whole host of reasons. People called because they were unable to move off an electric scooter or get out of bed or had fallen, they wanted reassurance that their breathing was okay, or they were experiencing diabetic shock and other more serious conditions. Not one of the calls I witnessed was due

to the sudden onset of a latent health problem, such as a stroke or heart attack, yet all calls indicated a genuine need for care and assessment. What was most surprising was that every fire station observed in this study had emergency medical response "regulars": people to whom they responded so frequently that their names, addresses, and details were known to the firefighters on all shifts at the particular fire station.

Neoliberal logics of governance shaped this situation in that its focus on reducing costs led to narrowing the mandates of public health care and social services. Without continuous care for chronic conditions delivered in institutional or community settings by health care and social services workers, 9-1-1 is becoming the available alternative for many people, thus shifting and changing the labour involved in meeting those needs to masculinized workers from a public safety service who provide an immediate but minimal response.

The medical paradigm also shaped this situation, by structuring its masculinized form. Firefighters were being trained in health care skills, using a curriculum developed by emergency services doctors. They were not being taught skills to deal with their most common calls related to chronic illness, disability and poverty; skills such as de-escalation, calming, assessment and immediate intervention for cases of mental illness and substance abuse and referral. Instead, they received training in defibrillation, wound treatment, administering oxygen, taking blood pressures and other technical skills. I am not arguing that firefighters should not learn these technical skills but rather that this emphasis on technical skills, emanating from a medical view of health care emergencies as sudden onset life-threatening situations involving diseased or malfunctioning body parts, neglects the very health care needs that firefighters are being called upon to meet and perceives calls for less immediate life-threatening concerns as "inappropriate." When researched by the very medical team that set up firefighter emergency medical training, over 98 percent of calls for 9-1-1 response met by firefighters were considered to be in an inappropriate use of emergency services, because they didn't require the kinds of interventions for which firefighters were trained or for which emergency services have been designed (Craig, Verbeek, and Schwartz).

Emergency medical response practices remain those that firefighters can provide, supplemented by paramedics' more advanced but still medically focused skills. Care skills are unacknowledged and absent for the most part, beyond what these workers bring to their jobs and share in informal ways. A masculinization has taken place through discourses of emergency and a complex re-routing of work to a masculinized workforce—one that is also reluctant to take on care, in most cases (Braedley 2010). While feminized workers—nurses, mental health workers, developmental services workers—experienced layoffs, job erosions and terminations at residential facilities, firefighters continued to experience secure, full-time, relatively well compensated employment, but with a peculiar change of duties. Their health care work remains hidden within municipal budgets and falls under the rubric of public safety and security services: a category in keeping with what neoliberal governments see as the appropriate role of the state. Therefore, not only have services that provided ongoing care been eroded or closed; not only has the work of responding to people been moved to a masculinized labour force and occupational structure; not only have basic needs been pushed into the realm of emergency response; not only have practices changed from longer term supportive services to short-term immediate and inadequate interventions, but this transfer itself has disappeared from health care policy view. A masculinized policy perspective fails to take into account the work of caring, and, through the masculinizing tendencies of health care policy, care, in this case, has become invisible under the rubric of emergency response.

Re-gendering Discourse: Criminalization, not Care

The Developmental Services Network Sub-Study[4]

I now return to the case study with which I began this article. While each of my examples shows the intertwining of institutional, practice and discursive gendering, this case demonstrates the power of discourse more potently. Here, neoliberal logics combine with narrow medical understandings of mental illness, with troubling effects for a highly vulnerable group of people and for the workers who support them.

In 2009–2011, I conducted research on a specialized crisis response and intensive case management service for adults with intellectual disabilities and concurrent mental illness. This service was initiated in some parts of Ontario in 2006, as part of regional "Networks of Specialized Care." Organized through the profoundly neoliberal mechanism of "a network," this service was funded by a group of agencies, which dedicated some of their base-funding to the project, supplemented by a provincial contribution that paid for some administration and "flexible funding" to pay for services to deal with specific "hard to serve" situations. The rationale for this kind of service network is that it breaks down service silos, allows for individualized care plans for hard-to-serve individuals and is efficient. These advantages do proceed from this kind of service mechanism. What remains, however, is another reinterpretation of people's chronic needs as short-term crises or emergencies that can be addressed through short-term involvements.

Although phased out over the last 25 years, people with mental illness and intellectual and developmental disabilities in Ontario had historically been institutionalized in large residential facilities that were designed

as hospitals (Chupik and Wright). These institutions restricted residents' agency and severely limited their lives. The gradual de-institutionalization of those with developmental delays and those with mental illness was supposed to proceed lock-step with the development of a range of smaller, community-based services (Dear and Wolch). Further, neoliberal developments opened the possibility of private sector provision. However, these services failed to materialize in sufficient quantities to meet needs, as private sector investors have not found this service area sufficiently enticing. Many people in residential care returned to the homes of family members, while newer generations of people with these conditions have never been able to leave. Those without family support are often living in substandard conditions or homeless. Despite their often significant needs, however, services for this population are being designed as if their needs were more sporadic and short-term. Further, it appears that when peoples' behaviours escalate due to failures of care, these behaviours are interpreted as intended and controllable, and therefore, criminal.

This interpretation is based upon a quantitative analysis of service statistics collected between 2006 and 2011,[5] ten interviews with key informants and six meetings with senior managers and workers. The quantitative analysis showed that use of crisis response services was highly correlated with involvements with the justice system. The more often that people accessed crisis response, the more likely that the justice system was involved in their lives. More than half of its clients had used the service from two to six times, indicating crisis service "regulars" once again. Further, "regulars" were most likely to be living with their families, while people who lived in group homes or supportive housing seldom used these services.

Interviews and meetings revealed that the individuals served by these services were frequently pushed back and forth between the justice and health care service sectors. In order to address what had become growing tensions associated with this population, a further layer of "networking" was established province-wide by 2004. These 14 regional Human Services and Justice Committees (HSJC) are designed to "to address the needs of people with a serious mental illness, developmental disability, acquired brain injury, drug or alcohol addiction, and/or fetal alcohol syndrome, who are in conflict with the law" through "providing a planning table to bring together service providers to find solutions to the problem of the criminalization of people with the defined unique needs and; developing a model of shared responsibility and accountability in dealing with this group of individuals at points of intersection with the justice system" (Johnson Consulting). An independent review of these committees concluded that:

> [Their] success is limited, however, by the absence of key stakeholders, and the barriers presented by systemic or policy issues that cannot be addressed through collaboration alone. Two other factors also constrain local HSJCs: a lack of involvement on the part of agency decision-makers, and inadequate local services (housing and access to psychiatric assessments, in particular)—without which no amount of goodwill is enough. (Ibid. 34)

In fact, these committees have poor to no participation from the Local Health Integration Networks, which fund health services in Ontario, and, despite efforts from front-line workers who attend the meetings, do little to prevent the criminalization of people with complex needs and conditions. According to my respondents, intellectual disability and mental illness are often misunderstood by physicians, who may skip routine physical examinations of people with these conditions while assuming behaviour is related to their mental illness and intellectual issues. Yet even when those applying a medical paradigm see a psychiatric problem, the concern for cure offers little beside psychiatric assessment and pharmaceuticals. Psychiatric assessment is a scarce and expensive resource, and is offered only to those who can display particular symptomology and, in the words of one respondent, "make good use" of the service. Behavioural concerns and the challenges of dealing with people with intellectual disabilities are not considered the best use of this resource, under the medical gaze. Without needed treatment and lacking care, peoples' behaviour escalates. Criminalization is the effect.

This discursive understanding of behaviour as "an emergency" and/or a "crime" is a shift from the understanding that social services workers perceive as the result of unmet, inappropriately met or inadequately met care needs. It is further evidence of the masculinization effects of health policy. Here, policy has had the material effect of shifting people's problems from longer term social services and health care agencies to short-term problem-solving and public safety and security organizations. Police, courts, jails and forensic psychiatric facilities—all masculinized institutions and workplaces—become involved. Instead of being subjected to practices consistent with supported living, treatment and care, people are charged, go to court, incarcerated or put on probation or payroll.

Once again, masculinization has taken place at multiple levels that have led to this discursive and material changes. It is evident in the managerial practices typical of neoliberal governments which either do not consider care needs as legitimate or consider that care will somehow emerge whenever and whereever it is needed as a private responsibility and activity. Second, masculinization is evident in the decisions to close—rather than to reshape—the feminized care sectors of long-term residential care at psychiatric hospitals and institutions for disabled adults: decisions influenced by both the medical and neoliberal paradigm as well as

activist pressure to improve care. But instead of improvements, this work was downloaded to an immediately overburdened and under-funded community sector, to families and to individuals who instead struggled to be independent and/or find support. This meant that good unionized jobs, filled mostly by women, were lost. Only some of these jobs were replaced by community sector positions, and these tended to be more precarious and lower waged. The burden on unwaged carers—mostly women—in families, communities and households increased as people moved from institutional care to communities. Masculinization is evident in the transfer of work to the justice sector, where secure unionized employment in public facilities is also highly masculinized, regardless of the gender identification of those who perform it. Like firefighters, these workers are prepared to provide particular kinds of services, but they are poorly prepared to provide the kinds of assessment, support and care that can help dual diagnosis and similarly afflicted people to live as well as possible.

It is worth reiterating that justice services, as part of the state's public safety and security complex, are perceived as an appropriate responsibility of the neoliberal state. Expansions in this sector—such as more prisons or police—are palatable to neoliberal thinking in a way that an expanded care sector is not, because they are seen as protecting and maintaining rights to life and property in ways that smooth the operations of markets.

Conclusion

Through reviewing the findings of three research case studies, I have provided support for an argument that Ontario's health care policy—which is not unique among provincial health care policies in either its focus or direction—is both masculinized and masculinizing, due to the congruence between neoliberal logics and medical paradigms that historically have been entwined with elite masculine normativity. While neither medicine nor neoliberal thought considers gender as a useful category for analysis, their gendered nature is evident upon examination of their operations. In health care, we see them operate together with gendered effects.

I make this argument for two reasons. First, I would like to see social policies re-gendered, so that masculinized and feminized labours, institutions and organizations are valued and integrated. Health care is one aspect of the necessary work that supports human survival and thriving; work that, historically, women have performed, unpaid, in households and communities. While medicine has shaped what counts as public health care in Canada, public health care services have dramatically and positively affected the burden of unpaid work borne by women, provided good jobs for women and addressed some women's health care needs. The pendulum in health care policy has been swinging back, however, sending more care to unwaged and poorly waged workers and undermining the conditions of work for feminized workers, as well as subordinating feminized institutions and occupations and leaving those whom they have served with fewer resources. But resources and employment have not disappeared. Rather they have been reconfigured and reassigned to a newly constituted masculinized hospital sector and to other masculinized public services, in ways that interpret social conditions to fit the masculinized nature of these services.

Second, I attempt a gender analysis here that can take into account the *processes* of gender in policy-making. By making a fine-grained analysis of particular cases, neoliberal logic's core failure to accurately take social reproduction into account becomes clear (Braedley and Luxton; Picchio). This failure generates not only the downloading and dumping of care, but has a profoundly masculinizing effect on public service delivery. These kinds of gender analysis offer opportunities for critique, resistance and challenge. In the case of health care policy, the challenge must be to take a wider angle lens so that a more balanced and equitable normative basis can be developed that takes into account both care and cure.

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[2]Diabetes treatment is an exception. See <http://www.health.gov.on.ca/en/public/programs/default.aspx>.

[3]This is the author's dissertation research, which has been published in part in (Braedley 2010; Braedley 2009a; Braedley 2009b).

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[5]I am indebted to Aaron Howes for running the actual data analysis.

References

Acker, J. *Class Questions: Feminist Answers*. Lanham: Rowman & Littlefield Publishers, 2006. Print.

Armstrong, Pat. "The Feminization of the Labour Force: Harmonizing Down in a Global Economy." *Rethinking Restructuring: Gender*

and Change in Canada. Ed. I. Bakker. Toronto: University of Toronto Press, 1996. 29-54. Print.

Armstrong, Pat. "Gender, Health and Care." *Staying Alive: Critical Perspectives on Health, Illness, and Health Care*. Ed. D. Raphael, T. Bryant and M. H. Rioux. Toronto: Canadian Scholars Press, 2006. 287-304. Print.

Armstrong, Pat. "Neloberalism in Action: Canadian Perspectives." *Neoliberalism and Everyday Life*. Eds. S. Braedley and M. Luxton. Montreal: McGill Queen's University Press, 2010 184-201.

Armstrong, Pat, Carol Amaratunga, Jocelyne Bernier, Karen R. Grant, Ann Pederson, and Kay Willson, eds. *Exposing Privatization: Women and Health Reform in Canada*. Toronto: Garamond, 2001. Print.

Armstrong, Pat and Hugh Armstrong. *Planning for Care: Approaches to Health Human Resource Policy and Planning*. Ottawa: Commission on the Future of Health Care in Canada, 2002a. Print.

Armstrong, Pat and Hugh Armstrong. *Wasting Away: The Undermining of Canadian Health Care.* 2nd ed. Oxford: Oxford University Press, 2002b. Print.

Armstrong, Hugh, Pat Armstrong, Jacqueline Choinere, Eric Mykhalovskiy, and Jerry P. White. *Medical Alert: New Work Organizations in Health Care*. Toronto: Garamond Press, 1997. Print.

Armstrong, Pat and Olga Kits. "Caregiving in Historical Perspective." *The Commodity of Care: Home Care Reform in Ontario*. Ed. P. L. Browne. Ottawa: Canadian Centre for Policy Alternatives, 2003. 23-64. Print.

Armstrong, Pat and K. Laxer. "Precarious Work, Privatization, and the Health-Care Industry: The Case of Ancillary Workers." *Precarious Employment: Understanding Labour Market Insecurity in Canada*. Ed. L. F. Vosko. Montreal: McGill-Queen's University Press, 2006. Print.

Baines, Donna. "Pro-Market, Non-Market: The Dual Nature of Organizational Change in Social Services Delivery." *Critical Social Policy* 24.1 (2004): 5-29. Print.

Baines, Donna. "'Whose Needs Are Being Served?' Quantitative Metrics and the Reshaping of Social Services." *Studies in Political Economy* 77 (Spring 2006): 195-209. Print.

Bashevkin, Sylvia. *Women on the Defensive Living through Conservative Times*. Toronto: University of Toronto Press, 1998. Print.

Baumann, Andrea, Raisa B. Deber, Barbara E. Silverman, and Claire M. Mailette. "Who Cares? Who Cures? The Ongoing Debate in the Provision of Health Care." *Journal of Advanced Nursing* 28.5 (1998): 1040-1045. Print.

Bergeron, Suzanne. "The Nation as a Gendered Subject of Macroeconomics." *Rethinking Restructuring: Gender and Change in Canada*. Ed. I. Bakker. Toronto: University of Toronto Press, 1996. 111-125. Print.

Bezanson, K. *Gender, the State, and Social Reproduction: Household Insecurity in Neo-liberal Times*. Toronto: University of Toronto Press, 2006. Print.

Braedley, Susan. "A Ladder Up: Ontario Firefighters in Neoliberal Times." *Just Labour: A Canadian Journal of Work and Society* 14 (2009a): 129-149. Print.

Braedley, Susan. "Accidental Health Care: Gender and Neoliberalism at Work." *Neoliberalism and Everyday Life*. Ed. S. Braedley and M. Luxton. Montreal: McGill Queens, 2010. Print.

Braedley, Susan. "Developing a Theory of Masculinized Care: Embodying Gender and Care Relations in Firefighting." *Deconstructing the Hegemony of Men and Masculinities*. Ed. A. Birbick and J. Hearn. Linkoping, Sweden: Centre for Gender Excellence (GEXcel), 2009b. 51-61. Print.

Braedley, Susan. "Someone to Watch Over You: Gender, Class and Social Reproduction." *Social Reproduction: Feminist Political Economy Takes on Neoliberalism*. Ed. K. Bezanson and M. Luxton. Montreal: McGill Queens University Press, 2006. 215-230. Print.

Braedley, Susan and Meg Luxton. "Competing Philosophies: Neoliberalism and Challenges of Everyday Life." *Exploring Neoliberalism: Power, Social Relations, Contradictions*. Ed. S. Braedley and M. Luxton. Montreal/Kingston: McGill Queens, 2010. 3-21. Print.

Brodie, Janine. "Canada's Three Ds: The rise and decline of gender-based policy capacity." *Remapping Gender in the New Global Order*. Ed. M. G. Cohen and J. Brodie. New York: Routledge, 2007a. 166-184. Print.

Brodie, Janine. "Meso-Discourses, State Forms and the Gendering of Liberal-Democratic Citizenship." *Citizenship Studies* 1.2 (1997): 223-241. Print.

Brodie, Janine. "Reforming Social Justice in Neoliberal Times." *Studies in Social Justice* 1.2 (2007b): 93-107. Print.

Brown, Wendy. "Finding the Man in the State." *States of Injury: Power and Freedom in Late Modernity*. Princeton, NJ: Princeton University Press. 1995. Print.

Chupik, J., and D. Wright. "Treating the 'Idiot' Child in early 20th Century Ontario." *Disability & Society* 21.1 (2006): 77-90. Print.

Coburn, David. "Medical Dominance Then and Now: Critical Reflections." *Health Sociology Review* 15.5 (2006): 432-443. Print.

Connell, R.W. *Gender*. Cambridge, UK: Polity Press, 2002. Print.

Connell, Raewyn. "Understanding Neoliberalism." *Neoliberalism and Everyday Life*. Ed. S. Braedley and M. Luxton. Montreal/Kingston: McGill Queens University Press, 2010. 22-36. Print.

Connell, R.W., and Julian Wood. "Globalization and Business Masculinities." *Men and Masculinities* 7.4 (2005): 347-364. Print.

Craig, A., R. Verbeek, and B. Schwartz. "Improving the Specificity of Urban Firefighter First Response

by Modeling the Probability of Critical Intervention Before EMS Arrival." *Prehospital Emergency Care* 11.1 (2007): 96-97. Print.

Daly, Tamara. "Out of Place: Mediating Health and Social Care in Ontario's Long-Term Care Sector." *Canadian Journal on Aging* 26 (Supplement 1) (2007): 63-76. Print.

Daly, Tamara, Pat Armstrong, Hugh Armstrong, Susan Braedley, Vanessa Oliver, Monnah Green, Sabiha Merchant-Merali, and Kate Rexe. *Contradictions: Women's Health Services in Toronto*. Toronto: Wellesley Institute, 2008. Print.

Davies, J. B. and M. Hoy. "Progressivity Implications of Public Health Insurance Funding in Canada." *Equity* 15 (2007): 133. Print.

Davies, H. T. O., S. M. Nutley, et al., eds. *What Works? Evidence-based Policy and Practice in Public Services.* Bristol, UK: Policy Press, 2000.

Dear, Michael J. and Jennifer R. Wolch. *Landscapes of Despair: From Deinstitutionalization to Homelessness*. Princeton: Princeton University Press, 1987. Print.

Dobrow, M. J., V. Goel, and R. E. G. Upshur. "Evidence-based Health Policy: Context and Utilisation." *Social Science & Medicine* 58.1 (2004): 207-217. Print.

Goldberg, David Theo. *The Threat of Race*. Malden, MA: Wiley-Blackwell, 2009. Print.

Hearn, Jeff, and D. Collinson, eds. *Men and Managers, Managers as Men: Critical Perspectives on Men, Masculinities and Managements*. London: Sage, 1996. Print.

Hubbard, Phil. "Revenge and Injustice in the Neoliberal City: Uncovering Masculinist Agendas." *Antipode* 36.4 (2004): 665-686. Print.

Johnson Consulting. *Review of Ontario's Human Services and Justice Committees Final Report*. Toronto: Ministry of Health and Long Term Care, 2009. Print.

Kisely, S., M. Smith, D. Lawrence, M. Cox, L. A. Campbell, and S. Maaten. "Inequitable Access for Mentally Ill Patients to Some Medically Necessary Procedures." *Canadian Medical Association Journal* 176.6 (2007): 779. Print.

Kitts, Jack. *Sunnybrook and Women's College Health Sciences Perinatology and Gynaecology Program Review Final Report*. Toronto: Ontario Ministry of Health and Long Term Care, 2005. Print.

Kurunmäki, L. "Management Accounting, Economic Reasoning and the Nw Public Management reforms." *Handbooks of Management Accounting Research* 3 (2008): 1371-1383. Print.

Luxton, Meg. "Friends, Neighbours, and Community: A Case Study of the Role of Informal Caregiving in Social Reproduction." *Social Reproduction: Feminist Political Economy Challenges Neo-liberalism*. Ed. K. Bezanson and M. Luxton. Montreal: McGill-Queens University Press, 2006. 263-292. Print.

Luxton, Meg. "Doing Neoliberalism: Perverse Individualism in Everyday Life." *Neoliberalism and Everyday Life*. Ed. S. Braedley and M. Luxton. Montreal: McGill Queens University Press, 2010. 163-183. Print.

Mintzberg, H. "Managing Government, Governing Management." *Harvard Business Review* 74 (1996): 75-85. Print.

Mintzberg, H. "Toward Healthier Hospitals." *Health Care Management Review* 22.4 (1997): 9-18. Print.

Nelson, Julie A., and M. A. Ferber. *Beyond Economic Man*. Chicago: University of Chicago Press, 1993. Print.

Peck, J. and A. Tickell. "Neoliberalizing Space." *Antipode* 34.3 (2002): 380-404. Print.

Picchio, Antonella. *Social Reproduction: The Political Economy of the Labour Market*. Cambridge: Cambridge University Press, 1992. Print.

Porter, A. *Gendered States: Women, Unemployment Insurance, and the Political Economy of the Welfare State in Canada, 1945-1997. Toronto*: University of Toronto Press, 2003. Print.

Schull, M. J., K. Lazier, M. Vermeulen, S. Mawhinney, and L. J. Morrison. "Emergency Department Contributors to Ambulance Diversion: A Quantitative Analysis." *Annals of Emergency Medicine* 41.4 (2003): 467-476. Print.

Schull, M. J., P. M. Slaughter, and D. A. Redelmeier. "Urban Emergency Department Overcrowding: Defining the Problem and Eliminating Misconceptions." *Canadian Journal of Emergency Medicine* 4.2 (2002): 76-83. Print.

Stasiulis, D. K., and A. B. Bakan. *Negotiating Citizenship: Migrant Women in Canada and the Global System*. Toronto: University of Toronto Press, 2005. Print.

Tickell, Adam and Jamie Peck. "The Return of the Manchester Men: Men's Words and Deeds in the Remaking of the Local State." *Transactions of the Institute of British Geographers* 21.4 (1996): 595-616. Print.

Timmermans, S. and M. Berg. *The Gold Standard: The Challenge of Evidence-Based Medicine And Standardization in Health Care*. Philadelphia: Temple University Press, 2003. Print.

Upshur, Ross E. G. "If Not Evidence, Then What? Or Does Medicine Really Need a Base?" *Journal of Evaluation in Clinical Practice* 8.2 (2002): 113-119. Print.

Vosko, L. F. *Precarious Employment: Understanding Labour Market Insecurity in Canada.* Montreal: McGill Queens University Press, 2006. Print.

Vosko, L. F., M. MacDonald, and I. Campbell. *Gender and the Contours of Precarious Employment*. New York: Routledge, 2009. Print.