Attacks on Canada's Health Care System

by Wendy Forrest

Wendy Forrest is a nurse in Canada. Here she explains how Canadian capitalism is attacking that country's national health care system.

As a nurse on the front line, working in a hospital in Canada's largest city Toronto, the issue of health care is very close to my heart. In my view the private health care system in the US is an abomination. Living so close to the US, I know and have spoken to many nurses and other health care workers from the US as well as Canadian nurses who have worked there. I find it very difficult to grasp the reality of US health care. The US system of health care is not only inefficient, costly and wasteful it is in my mind deadly and immoral and reprehensible.

The following is a brief summary of the how the Canadian Health Care system has been undermined and attacked over the decades.

In my experience as a front line worker I have witnessed the stealth" and the sophistication of the neo-liberal agenda to privatize health care and all public services, undermine the power of organized labour in a myriad of ways-all connected), exploit unorganized and marginalized workers (in health care primarily women), and place the responsibility for health and health care on the individual, families and friends (again primarily women.)

1995 Conservative Attack

In 1995 the Tory (Conservative) government launched an unprecedented attack on public health care in Ontario. Recognizing this as a prolonged and multi-step project their initial moves were bold and set the stage for further interventions.

Amassing and implementing a sophisticated public relations campaign they closed or merged many hospitals. Anticipating resistance in communities across Ontario they stopped at nothing to promote the value of Home Care-pulling at heart strings and promoting campaigns that capitalized on a general dislike and fear of hospitalization and prior cutbacks that in some cases had undermined the quality of care in hospitals.

Needless to say this served several purposes. Immense amounts of money would be saved by eliminating actual capital costs of running hospitals. The majority of direct care providers in hospitals were unionized Registered Nurses and Registered Nursing Assistants commanding decent wages, benefits, pensions etc. The same applied to most support staff.

Home Care on the other hand involved no direct capital costs such as buildings etc.

"Home Care"

Home Care would be provided by personal support workers in the community, the majority of who were employed by community agencies and private nursing agencies. Initially Home Care Workers in the

community were not organized in unions. This has changed. More and more community Home Care Workers are now organized in several public sector unions. Wages are low. They enjoy some benefits. Pension plans are rare and there is little workplace regulation partly because of the nature of the work in homes of individual clients. Personal support workers in hospitals were in most cases unionized and enjoyed better wages and benefits.

As the role of personal support workers expanded, especially in Home Care, which gradually replaced much of the care previously provided in hospitals, RNs and RPNs began to take on mainly supervisory roles rather than front line providers of care.

In hospitals as well the role of the personal support role continues to be expanded. Huge numbers of Registered Nursing jobs were cut. This trend continues however the number of Registered staff per patient in hospitals still are many more in number than in the US.

Prior to this most outpatient services were provided in community hospitals and covered by OHIP. This included laboratory and radiology services, diabetes, physical and occupational services etc– the list was long.

All one had to do was check in free at the local hospital and show your health card. As hospitals were closed, despite significant community organizing and protest, these services were contracted out to private clinics or companies yet were still covered by OHIP. So initially more and more services picked up by the private sector were paid from the public pocket. More and more tax payers' money enriched the private sector rather than remaining in the public purse.

At the same time several basic health care services were de-listed from the provincial health care plan and the public was forced to pay out of pocket further enriching the private sector.

Home care up till this time was utilized primarily as an adjunct to hospital care. As hospitals closed and beds were cut, the home gradually became the place where more and more health care was provided. Soon even Home Care hours began to be cut and families and friends were forced to take on the burden of providing health care- free of course. Even supplies such as dressings, diabetic equipment like syringes, incontinent pads, crutches, walkers and canes, to name an important few now had to be paid for by the individual. Early, often premature discharges from hospital became and remain the norm.

For the poor without homes-the provision of care was transferred to hostels and shelters, sometimes delivered by housing workers supervised by RNs and RPNs. In some cases particularly in large men's hostels in cities, care for the terminally ill was provided on site rather than in hospitals and hospices as was previously the case.

Funding Cut

Funding to existing hospitals was and is continually being cut or under threat. More and more workers were laid off and workloads increased. Conditions in emergency rooms soon began to deteriorate and waiting lists for surgery and treatments became longer. Hospital acquired infections began to rise related to cuts in direct care and to support services such as cleaning staff. Meanwhile they kept telling hospital workers that if we just wash our hands more we can get rid of hospital acquired infections. Large amounts of public funds were wasted on hand washing campaigns while the cuts to support services like cleaning workers were rarely spoken about except for the unions.

The federal government began and continues to reduce transfer payments to the provinces, placing the cost more and more on the provinces.

Clearly several objectives were accomplished. The deliberate defunding and underfunding of health care federally and provincially undermined the quality of health care in Ontario-making the private sector appear more attractive and efficient re health care delivery. A previously efficient and high quality public system was purposely underfunded and undermined. Delisting of services provided by OHIP,, outsourcing of services to the private sector and contracting out of labour and services, such as cleaning and dietary staff and service facilitated the gradual encroachment of private sector delivery in almost every area of health care. Tens of millions of dollars were cut from the public health care budgets as less skilled and poorly paid workers replaced well paid Registered staff and the unpaid labour of family members provided much of the care at home.

This project waxed and waned in relation to public protest and trade union protest but has never ceased.

Privatization

The privatization agenda has recently been revitalized and given an injection of energy since the 2008/2009 economic crisis as is the case globally.

While the core of health care remains public and the quality of care remains generally high it has been seriously damaged in a way that may take decades to regain if not longer.

The latest attack on public health care takes the form of competitiveness among hospitals for funding.

This is where it gets really sneaky and where front line workers are coerced into collaborating.

Ideologically and concretely there has been the encroachment of what is called Evidence Based Practice in the delivery of health care. Conceptually it is fascinating but dangerous and has been adopted at all levels of health care. Primarily an ideology to support the American HMO model of "managed care", its raison d'être is cost reduction. Understanding becomes clearer if we think of the US system, where almost every intervention on the part of a health care provider has to be "justified" in precise detail in order for private insurance companies to pay. The quality and quantity of interventions will to a large degree depend on the quality of one's private insurance plan.

This was never the case in Ontario and Canada where standards of care and of intervention were high and everyone regardless of socio-economic status received the same high quality of care.

Currently , embedded in the false ideology of limited state resources for all public services, along with the notion of unsustainablity, Evidence Based Practice to a large degree provides an ideological justification for cost containment and potential for reduction in the number and quality of interventions provided to individuals . It injects and promotes the value and necessity of corporate business practices into all levels of health care provision.

This, supported by the ideology of individual responsibility for one's health and personalized medicine, has forced all practitioners, physicians, nurses, social workers etc to adopt what is essentially a private insurance model to determine and guide what a patient or client receives in the area of health care. It is in fact a blunt instrument in the guise of scientific validity. This primarily affects physicians' practice as they more and more are forced to justify diagnostic tests, visits and medical interventions on "science." It is based on the assumption that there is a tremendous amount of waste in the provision of health care and this must be curtailed.

“Sound Science”

Practitioners must directly or indirectly prove to the funder, in this case the government, that all their interventions must be based in “sound” objective scientific evidence. Indirectly nurses , social workers , physiotherapists etc are also required to justify their interventions and to remove any subjective elements to quantify their care, to account for their time spent and interventions accomplished , in a quantitative way using instruments and tools that take up time better spent on direct patient care . The amount of paper work that nurses and social workers must generate has increased dramatically. Time spent at computers rather than at the bedside has proliferated.

Nurses in Canada used to feel sorry for US nurses who would tell us about the amount of paperwork they had to do in order to account for their interventions and time!

On the surface this whole notion of sound science and objective proof as the basis for providing care sounds good to the patient and to the taxpayer. However as this quantitative approach, based primarily in cost reduction in order to satisfy the funding goals of the insurer, slowly becomes the primary justification for care the previous goal of providing the *best possible* care is undermined.

Human vs. Monetary Costs

When physicians and other care providers are forced to factor in the cost of providing care, and prioritize their interventions accordingly, using cost as a key determinant we are left with what is basically a US model of “managed care.” When cost determines what kind of care and how much care is provided, in the areas of treatment, prevention and the promotion of optimum health in the public and for our clients the entire picture changes.

What we are left with is a situation where the “insurer” determines quality of care rather than those who provide it. Not to mention the increased waste of time and resources, a cardinal aspect of the US managed care model.

Most offensive is that as the state (the federal and provincial governments) gradually reduces their role as insurer/funder of health care as well as the provider of health care they are putting in place many of the structures and tools as well as ideology required by the private sector as they gradually take over.

The measuring instruments and tools we are required to use at the very least are incapable of addressing the qualitative needs of our patients. These instruments cannot capture a patients complex needs. If for instance I determine as a practitioner that my time is best spent for 15 minutes sitting with a patient listening and comforting and from there enhancing the quality of care for my patient, I cannot justify that “objectively.”

Physicians are forced to justify every intervention down to the last test or visit. Social workers are essentially not able to capture the complex social and individual needs of their clients and patients. We have been reduced to what is called ‘ticky-box practice” , checking off boxes on computers .

“Positive Outcomes”

Hospitals are forced to provide “positive outcomes” in order to receive funding and are forced to compete for this gradually dwindling funding. Funding according to outcomes has replaced funding according to the needs of the public and our patients. The notion that patient outcomes may in fact be related to needs as determined by the health care provider and the patient together is not factored in.

Confidentiality

Perhaps most disturbing especially in the field of mental health is the intrusiveness and extent of the data I am required to collect and input. In the best of all possible worlds this would not be a problem. However in the current climate of cost effectiveness and cost reduction, where health and health care is considered to be primarily an individual responsibility rather than a social and political responsibility the implications for "unofficial " denial of care and marginalization from service entitlement are immense.

To top this off the issue of confidentially is compromised. It was once the practice that in order to review or collect information regarding a patient's health and social history, consent from the patient was required each time there was an encounter. We are now asked to obtain a universal consent which means that a patient in a hospital, clinic or physicians office is asked to consent to a release of their entire medical history.

This becomes an issue as third party private insurers gradually replace the state as the primary insurer which is more and more becoming the case. It becomes more complex with more drastic and harmful implications for instance in the UK as companies like ATOS and KPMG are given contracts to implement work assessments designed to force individuals off disability benefits and into menial and low paying jobs that they simply are unable to do. These companies are provided with health histories that previously they would have had to obtain individual consent.

The fact that corporate philanthropy in Ontario/Canada has to a significant degree replaced state funding is a whole other issue worthy in itself of research and exposure of implications to the public.

So this brief and not very well organized sketch of the state of public health care in Canada is not comprehensive and not inclusive of the role of trade union and community fight back past and present. It is not a pretty picture.

U.S. Health Care "System"

Re the US – well the mind boggles.

It is difficult to grasp. Certainly not too hard to understand the ideology that supports private health care in the US but at a very practical level it is hard to understand.

The role of private third party private insurers as well as private providers of health care has been the topic of massive amounts of research internationally.

It has been proven time and time again that it is inefficient and extremely costly to both the state and the taxpayer. Outcomes are worse, infant mortality rates are high, it is ungainly and expensive. The legal costs alone, which are handed off to the consumer, are as is well known, exorbitant. As well innate bureaucratic costs contribute to what is probably one of the worst health care systems in the advanced capitalist countries.

This is not to mention the inhumanity and immorality of it all.

Obamacare

It seems to me that Obama Care, partially because it does not eliminate the third party private sector, will do little except enrich the insurance companies.

Co-pays and deductibles will eat up any financial gain and in fact will more than cover any gains made by denial of insurance and by implication, care due to pre-existing conditions.

What is for sure is that the safeguarding of any current or future publicly funded , publicly administered and universally accessible health care system such as the NHS or Medicare in Canada will not happen without massive community and trade union organization, mobilization and aggressive action sooner rather than later.

I have never known a time where I have had to hand over money to receive health care.