There When You Need It?

The attack on health care continues
Union is a seasonal publication of the Alberta Federation of Labour (AFL). It is a magazine intended to provide insight and analysis into ongoing social, economic and political issues of concern to union activists, officers and staff. The AFL is Alberta’s largest central labour body representing more than 137,000 Alberta workers and their families.

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Is it just me or does seem that every three years or so Albertans have to beat back another Tory attempt to privatize our health-care system? No, that perception is correct – they have made repeated attempts to privatize, despite Albertans’ insistence that they stop.

We hate to have to report that the Conservatives are up to no good again. And, this latest attack on Medicare may end up being the most difficult to defeat yet. Unlike the last time, they are not putting out a clear plan or package. Instead, they are dribbling it out in pieces — some cutbacks to seniors’ benefits here, some opening of doors to private insurance there — and before you know it, we are on our way to an American-style system.

But we should not get caught in the trap of defending everything about our current health-care system. Medicare is in need of reform, but it needs to be the kind of reform that improves and expands health-care access for Canadians.

We have to talk about the threats to it, but also what else we can do to strengthen it for the 21st century. That is the conversation this issue of Union hopes to start.

Enjoy your reading.

Gil McGowan
President
The Stealth Attack On Health Care In Alberta

David Eggen
The Stelmach Conservative government has been making sweeping changes to Alberta’s public health system, but they’ve been doing their very best to NOT tell anyone about it.

Health and Wellness Minister Ron Liepert has basically admitted as much. He told the Edmonton Journal that the “third way” failed in part because it was unveiled as one entire package, vulnerable to criticism. “People were allowed to pick at certain things they didn’t like, highlight it and then scare government off, and there wasn’t the political will to follow through,” Liepert said.

It is interesting to note that Ron Liepert, a relatively new member of cabinet, before his election as an MLA worked on the Mazankowski report, which was the 2001 plan for privatizing health care and getting people to pay directly for health costs.

Liepert is considered tight lipped and tough talking. However, he has promised to “unveil a new model to ensure delivery of health services is more effective and efficient.”

Up until now, though, the government hasn’t been at all upfront about what the “new model” will look like.

In the midst of the radio silence, changes to health care have been coming hard and fast. Liepert lost little time in clearing the way by firing all the top brass in the province’s nine health regions and putting the whole system all under the new “superboard”, Alberta Health Services. It was revealed shortly after that the Board signed an agreement to do anything and everything the health minister says.

Liepert is always quick to say his plan is NOT health-care privatization, but he has never been quite able to say exactly what it IS. We need to look at some of the steps the government has taken in the past year.

Who’s On Board?

For example, who has Liepert appointed to his new superboard?

Ken Hughes, the chairman, is a former Conservative MP and a private insurance company owner and investor. Liepert picked Charlotte Robb as his first CEO and she came over from one of Alberta’s largest private health corporations, Dynalife, the diagnostic giant.

When Liepert and Hughes announced their hand-picked board members in November, almost all of them were business people with little medical experience. Except of course Tony Franceschini from Stantec, the engineering company that has many contracts with the health regions. Another member, Jim Clifford, is in New Jersey where he has been working for private American health-care companies.
NDP Leader Brian Mason told the Journal that the people picked for the Board were “the clearest signal yet” the government is going to an American-style private health-care system.

**Multinational Companies Provide The Expertise**

Huge multinational consulting corporations Deloitte and McKinsey & Company are clearly the planning brains behind the changes in health care. The government commissioned a report from McKinsey that would be the blueprint for health-care changes.

It’s clear that what he finally revealed – the “Service Optimization Review” – was a carefully sanitized document. There wasn’t any mention of McKinsey or who the authors were. It’s also clear that much more was taken out of the document. Yet what remains is still quite instructive in terms of the government’s plans for health care (see sidebar).

Besides McKinsey, there was also a restructuring plan from Deloitte, who have an interesting approach to health care. At a recent health conference in Toronto, a Deloitte expert offered up their analysis on the topic, “The need for disruptive change in the health-care industry”.

Few Albertans could have imagined bigger disruption than rapidly shutting down all the health regions and setting up the single superboard.

“Disruption also impacts sick Albertans who may be forced to wait more for care,” said Heather Smith, president of the United Nurses of Alberta. “We need a smooth flowing system and we need changes to be smooth too, NOT disruptive.”

**Closing Rural Hospitals**

Deloitte got $2.2 million from Alberta Health for a two-year audit of rural health facilities that created a shock wave with its recommendations to close rural hospitals. After the release of the report last June, Liepert was quoted in the Edmonton Journal saying that some small-town hospitals could be converted to walk-in clinics or seniors care centres.

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**PUTTING THE SQUEEZE ON ALBERTA’S NURSES**

The McKinsey Report (titled: Provincial Service Optimization Review: Final Report) was carefully edited. But one thing it does openly talk about is how to deal with the nursing shortage.

The report says the province is short 1,500 nurses now which could grow to over 6,000 nurses short by 2020. It offers to address this shortage in the following recommendation: “Deepen initiatives and incentives to increase productivity.” The report proposes “increasing the number of work hours required to earn benefits and replacing part-time/overtime incentives with initiatives to promote full-time employment.”

In other words, make nurses work longer to get the benefits they deserve. How will that help attract and retain nurses during serious nursing shortage?

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**HELP PROTECT MEDICARE! JOIN THE FRIENDS OF MEDICARE FIGHT!**

Friends of Medicare is ramping up and preparing to campaign on alerting EVERY Albertan to what the Stelmach government is trying to slide through on health care. There are petitions to be signed, leaflets to be distributed and nearly 70 government MLAs that need to feel the heat. Join in today... see our website friendsofmedicare.ab.ca call: (780) 423-4581 or email: info@friendsofmedicare.org
Higher Drug Bills For Many

For another early Christmas gift, the government announced big changes to drug benefits for the province’s seniors. Seniors with incomes over $21,000 a year will have to pay the full cost of prescriptions up to a limit that is determined as a percentage of their income. For seniors with lower incomes, all costs for prescriptions are covered, but a senior with an income of, for example, $50,000 a year will have to pay for the first $660 of their prescriptions in a year. This attack on universality will affect thousands of seniors who previously paid a minimal co-payment on their prescriptions.

Vision 2020 And “Patient-Focused” Services

Late in December, the government released “Vision 2020,” their outline for health services in the future. “Patient-focused” has been stuck as a major motto on almost every document from the new superboard and it is an important clue in this guessing game. “Patient-focused” sounds great, but as any health practitioner will tell you, care has always been patient-focused.

But, patient-focused has a particular meaning as explained earlier this year by health-care entrepreneur Dr. Brian Day:

“We believe patient-focused funding, where the money follows the patient, will drastically improve the performance and efficiency and accountability of hospitals. ... That introduces an internal market competition between the different hospitals to attract patients, so patients become a value, not a cost. I think you do need to introduce a competitive model and if that means changing the way the (Calgary Health) region is structured so be it -- the reality is any system that is monopolized in nature is not good for the consumer.” (Calgary Sun March 29, 2008)

A key component in “2020” is moving health services out of hospitals into what they call “short-stay, non-hospital facilities

Cutting Benefits For Alberta Seniors

Some of the harshest announcements from Alberta Health came just before Christmas. Liepert announced that NO new full-service nursing-home care beds would be built in the province for several years. This, despite the fact the government estimates it is short 1,100 beds. Instead the government announced it would build more “assisted living facilities” which offer little medical care unless the resident pays extra out of pocket. This is a policy designed to allow the private facility operators to make extra profit by billing for “extras” that are part of basic care in a nursing home.

The report even suggested taking seniors out of nursing homes and, “with support,” putting them back in their houses or with their families, a concept that shocked many.

The government has been also moving towards a long-term care fee system (“variable accommodation fee structure”) where government support or subsidy only applies after a senior’s money is virtually gone. Once the private provider has taken all the senior’s money the government may provide additional support.

Last fall the Parkland Institute released a study by economist Greg Flanagan that shows a steady rise in the number of seniors in Alberta. Flanagan says this means constant growth in the number of seniors requiring long-term care and even full nursing home care. The government’s strategy is going to leave many more frail elderly — and their families — wondering how to cope.

This attack on universality will affect thousands of seniors who previously paid a minimal co-payment on their prescriptions.
and other clinic-type arrangements as an alternative to hospitalization.” While the term “non-hospital facility” is new, it likely means private clinics and private hospitals like HRC in Calgary.

And of course, the government will encourage those who want to pay more for better or faster services to do so through the network of private clinics that will bill both the patient and Medicare for their services. It’s already happening now with the Copeman Clinic in Calgary. Liepert says there is no problem with this.

The Costs Of Health Care

The provincial government is trying to have it both ways. They harp about health-care costs being out of control. Then they say the changes are not really about saving money. They can’t say these changes will save money because in fact they know it will cost both the public purse and all our personal “purses” much more.

The superboard deficit already seems to have mushroomed from of around $100 million to something over $1 billion in just a few months.

And now with the economic downturn, we already see the Conservatives threatening “Klein-era” cuts. They may use their new fiscal difficulties as an excuse to ramp up their health-care reforms, shifting more costs from Medicare to your wallet.

There are better ideas to reform Medicare to make it work more effectively AND more cost efficiently. But the Conservative government has no interest in exploring those ideas. If we are to consider pharmacare or universal homecare, it will have to be Albertans who put it on the agenda.

Who Asked For This?

During the 2008 election, Stelmach reassured Albertans that the “third way” — Klein’s last try at privatization — was “DOA.” That is supposed to mean “Dead On Arrival.” Yet for Stelmach it seems to mean “Do Over Again”. Their actions of the last few months indicate that despite their silence there is a very clear and dangerous agenda afoot. We have only seen glimpses of it so far, but those glimpses point in a very clear direction.

Don’t be fooled by soothing phrases and clusters of seemingly innocuous announcements. Their cumulative impact means a serious and direct threat on our Medicare system.

The good news is that Albertans have stopped health-care privatization three different times in the past 10 years. We can do it again. We need to mobilize and to organize to make sure the government has to backtrack once again.
Few people are content with the current state of our health-care system. There is no question it is under stress and that our almost 50-year old institution is in need of some repair. And like any repair job, finding the right mechanic is one of the most important questions. There is no shortage of suitors for the job of health-care repairman. Yet how are we to separate the whiz kid from huckster? Which ideas could work, and which will only make matters worse for Canadians looking for reliable health care?

There are many ways to tinker with Medicare, but only some of them will get it running again smoothly. Here are a few that may have crossed your path.

**Encourage Boutique Medical Clinics**

Some argue that we need to offer more choice to patients and allow doctors to package services in such a fashion that they can combine traditional acute care with other preventative services. They can cater to executives and other with financial means to free up space in more traditional medical practices, thereby increasing access for all people. These “boutique clinics” offer a solution to Medicare by both increasing patient choice and acting as a pressure valve for the rest of the system.

As an example, last fall, the doors opened on the Copeman Clinic in Calgary. At Copeman, for an initial fee of $3,900 and annual payments of $2,900, patients can get...
guaranteed quick access to a doctor and an array of diagnostic, assessment and diagnosis services from a team of health professionals. The Clinic portrays itself as offering “preventative” health services as a supplement to basic health care. In addition to the patient fees, Copeman bills Medicare for essential services provided.

On the surface, this may seem like it solves two problems at once – offering more choice and reducing pressure on the rest of the system. Unfortunately, it solves neither.

In terms of reducing pressure, a research study released in fall of 2008 found that these clinics contribute significantly to physician shortages in the public system. They draw doctors from public practice and offer them caseloads that are one-third to a quarter of standard practices. Similar problems are found with other health-care professionals. These professionals treat a smaller number and narrower range of patients—patients who are often healthier, due to their economic status, than the population as a whole.

These clinics also play fast and loose with the Canada Health Act. “Many of the boutique physician clinics co-mingle medically-necessary with unnecessary services in an attempt to sidestep the Canada Health Act’s prohibition on two-tiering.”

As for patient choice, these clinics foster the myth that health care is a commodity like any other. Choice is an important concept for buying a car or choosing a brand of cereal, but it does not appropriately apply to health care.

As for patient choice, these clinics foster the myth that health care is a commodity like any other. Choice is an important concept for buying a car or choosing a brand of cereal, but it does not appropriately apply to health care.

A more reasonable direction to increase access to basic health care might be to expand the role of nurse practitioners (RNs with additional training to allow them to perform many physician functions) and other professionals (social workers, physiotherapists, counselors, dieticians, technicians, etc.) in delivering direct medical care.

In many respects doctors are the bottleneck in the health-care system. There are too few of them and their fee-for-service model is restrictive, creating long waits for many procedures and treatments. Many argue care is most effective when a range of professionals work as a team, offering a coordinated compendium of services to patients. Consequently, their idea is to foster interdisciplinary teams to provide more thorough, more timely care.

In Alberta, the Conservative government has turned the nurse practitioner model on its head. It has forbidden them from joining unions and is establishing a doctor-style fee-for-service payment system for them. The government is trying to make nurse practitioners the new health-care entrepreneurs, opening their own private clinics.

However, properly implemented, a team model, led by nurse practitioners, has the potential to greatly increase access to care AND reduce costs at the same time.
One of the innovations of the boutique clinics is to offer wholistic care that focuses on prevention. Why should this good idea be restricted to those who can afford to drop three or four thousand dollars? If we implement a similar model in public facilities, its advantages can be applied to all.

**Allow Private Clinics to Access Public Funds**

If boutique clinics are a concern because they siphon key resources (staff, resources, etc.) from the public system, maybe we can resolve it by allowing private clinics to fully participate in the public system by billing the government rather than the patient for their services.

This is a rapidly growing model for Medicare. Proponents argue this saves money and reduces waiting times, as the government does not have to invest in costly infrastructure, and the private clinic is more likely to stay up to date with technology and techniques. A recent study found that there are 130 private clinics operating in Canada and the vast majority takes both public and private funds.

This proposal neglects the fact that there is a limited number of health professionals in Canada and that the growth of private clinics only draws doctors, nurses and technicians from public facilities – which means waiting times are not reduced, only moved. More importantly when examining the costs of governments paying for-profit operators to deliver healthcare, “researchers found health spending was higher and increased faster in communities served by for-profit hospitals compared to non-profit communities.”

**A SAMPLING OF ALBERTA’S PRIVATE, FOR-PROFIT HEALTH CLINICS**

Alberta has 31 private, for-profit clinics, most of which receive money from Alberta Health. Here is just a sample of them.

**Boutique Clinics:**
- Copeman Healthcare Centre (Calgary)
- Dominion Medical Centres (Edmonton)

**MRI/CT Clinics:**
- Mayfair Diagnostics (Calgary)
- Canadian Diagnostic Centre (Calgary)
- Medical Imaging Consultants (Edmonton)
- Insight Medical Imaging – Meadowlark Wellness Centre (Edmonton)
- Open MRI/MYK Imaging (Calgary)
- Central Alberta Medical Imaging Ltd. (Red Deer)

**Surgical Facilities:**
- Mitchell Eye Centre (Calgary)
- Health Resource Centre (Calgary)
- Sante Surgi-Centre and Vein Clinic (Medicine Hat)
- Alberta Surgical Centre (Edmonton)
- Surgical Centres Inc.(Calgary)
- Gimbel Eye Centre (Calgary & Edmonton)
- Holy Cross Surgical Services (Calgary)
Also, for-profit clinics often offer “upgrades” or “enhancements,” directly billed to clients, that can be hard to restrict. Why get that rusty old government-issue hip when you can get a fancy titanium-alloy, kryptonite-coated hip for only a few hundred dollars more?

In many respects, sending public patients to private clinics serves to only create a captive market for these health-care entrepreneurs that they can upsell other products.

More damning, evidence suggests that private clinics are LESS efficient than public clinics. In the past few years the Manitoba NDP government had a policy of quietly buying up private clinics and returning them to the public fold. Plus it has prohibited private clinics from both billing publicly and privately. Due to its policies, Manitoba has only two for-profit clinics (that have so far refused to sell to the government), compared to Alberta’s 31 (see sidebar).

In 2001, Manitoba bought the Pan-Am private clinic which now operates as a public facility with no extra fees. The number of procedures out of this state-of-the-art clinic has more than doubled since it entered public hands, and the cost per procedure has dropped. Showing that non-profit, public health care can get more done.

The proposal falls down on three fronts. First, it, too, builds upon a marketplace assumption, where free agents make rational choices using best information. It is simply not possible in health care. Information is too hard to gather, and the reasons for accessing health care (i.e., illness) are not times when a consumer is able to make rational, carefully considered choices.

Second, it inappropriately applies an RRSP model to health care. Medicare is like a defined-benefit pension plan – you pay in with your taxes and when you need health care, you are guaranteed a certain level of care. MSAs flip that around, giving you money upfront but making no guarantees of any level of benefit. How do you know that you have enough money in your MSA to pay for that laser eye surgery? Or that physiotherapy? In short, you don’t.

Third, the proposal is designed to create more space in health care for private insurance companies and for-profit clinics. And as we have seen, that leads to greater privatization, higher costs for both government and patients, and unequal access to medically necessary health care.

Ultimately, repairing Medicare might mean finishing the original construction job. The best direction for the future of Medicare may lay in expanding it – as was originally intended.

Noted health-care policy expert, Dr. Michael Rachlis, has recently been suggesting that the time has come to implement what he calls “The Second Stage” of Medicare. As Dr. Rachlis
Ultimately, repairing Medicare might mean finishing the original construction job. The best direction for the future of Medicare may lay in expanding it – as was originally intended.

explains the original vision of Medicare held by Tommy Douglas and his CCF government was of a more comprehensive program, both in what it covered, but also in how it envisioned health and how it delivered health-care. Political realities (the doctors’ strike, opposition from other provinces) forced Douglas to put off the second stage.

Rachlis is arguing we need to restructure health care delivery and our approach to illness and health. He sketches out what the second stage might look like. It includes:

- Expansion to include pharmacare, dental care and universal home care;
- Moving away from physician fee-for-service and toward salaries for doctors;
- More coordinated, community-based care, provided by teams of health-care professionals;
- Focus on wellness rather than sickness;
- More community, democratic control over health care provision; and
- Focus on equity – how to reduce disparities in health outcomes among populations

The model addresses many things simultaneously. It addresses the pressure points currently experienced by Medicare and it effectively eliminates the growing risk of privatized, for-profit medicine.

Plus, it will lower costs while making people healthier. In Tommy Douglas’s own words: “All these programs should be designed to keep people well – because in the long run it’s cheaper to keep people well than to be patching them up after they are sick.” 4 (Douglas, 1984)

REFERENCES

2. Ibid. p. 47.
MAKING SURE THAT SOMEONE CARES

The Fight For Long-Term Care

Union – How did you become an activist for seniors’ care?

LJ - My mother-in-law had been placed into facilities in Barrhead and Edson because there was no long-term care centre in Hinton. When the Mountain View Centre, which had 25 long-term care beds plus 27 supportive living unit facility opened up for residents in Hinton in October 2002, we brought my mother-in-law back home to be close to her family.

During her stay in Mountain View Centre, Mother became ill with Clostridium Difficile. It was during this time that I saw the staff shortages. I lived at the facility full time, caring for her, night and day, until her death. I didn’t want the staff to get sick or pass the infection onto other vulnerable patients.

When my mother-in-law passed away, I vowed to work hard to increase the staffing levels in these facilities.

Union – What did you do first?

LJ - My husband and I started touring Alberta to see if it was the same all over the province, or just our facility. It wasn’t long before we found out, as we traveled from Grande Prairie to Pincher Creek, that there were other issues besides staffing shortages, food issues (including low-quality food, food was being brought in from other towns, served cold, etc.) and we heard stories about systemic abuse and neglect because the staff did not have time for toileting, bathing, or even the time it took to adequately feed the residents. The staff was just so overworked.

What we witnessed was just unreal.

Union – What did you do after you’d witnessed the terrible conditions in nursing homes across the province?

LJ - We took 4,800 petitions to the legislature to ask for increased staffing levels. In January 2003, Premier Klein dismissed what we had witnessed. And then in May, the Auditor General’s report came out and verified what we had seen.

Union – What do you think was the cause of the deteriorating level of care? Aside from the obvious cutbacks and staffing...

LJ – The conversion of long-term care facilities to designated assisted living facilities. These conversions mean that there are inappropriate levels of care for many residents plus inadequate government funding for sufficient skilled staffing and programs to meet the needs of residents. Also, low staff wages have resulted in high-staff turnover.

There are not adequate care standards, funding, inspections and enforcement of facilities.

People are not able to get the care that they need because there is a shortage of palliative care expertise and funding that has caused unnecessary suffering for patients who are dying.

From our experience we’ve seen that many complaints from residents and families are not being investigated.

Union – The long-term care facility in Hinton was converted to a designated assisted-living facility. When did this happen and what impact did it have on your community?

Lynda’s Struggle For Seniors’ Care

TIME LINE

2004

Dec. 21—Attended town council meeting and asked for support in not converting the facility in Hinton to an Assisted Living Facility.

2005

Jan—Received letter from Iris Evans and a statement that she is in favour of assisted living, claiming that the people of Alberta have requested this type of housing.

Aug 9 — Went to sessions for MLA Task Force group in the Barrhead hospital.
LJ - The conversion of the Mountain View Centre happened in 2005 after only two years in operation. Ron and I tried to stop the conversion because it would mean a dramatic drop in the quality of care. In designated assisted-living (DAL) facilities, there is not a registered nurse on duty 24/7 or physician oversight and there are lower staffing levels and programs. At the time there were no government standards for DAL and our low-income residents lost their subsidies.

The conversion has devastated the community. The staff is still trying to provide quality and compassionate care, but the staffing levels are so low that the health, safety and well being of the residents are at risk. The staff must clean rooms, serve food, as well as to take care of 10 or more residents.

Union – How can this be allowed to happen? Are there no inspections of the facilities?

LJ - The community also wondered how this could have ever happened or was allowed to happen. The community raised funds and lobbied this government over 10 years to get a much-needed long-term care (LTC) facility built.

The worst thing is that the government did not monitor to ensure that residents were receiving the appropriate level of care after the conversion. There was no oversight or tracking of residents care. These were the same residents – these were long-term care patients who were all of sudden assisted-living residents over night. Their medical care needs did not change but the quality of care sure did.

It is clear that our elderly will be paying – at the facility in Hinton they already have to pay to furnish their own rooms by supplying their own beds, sheets, towels, toiletries, pay 30% of their medication, purchase their own oxygen, dressing supplies and supplemental diet.

Union – What did you do to draw some attention to the issue?

LJ - I've tried to get action taken on complaints made by the families of residents and the residents themselves. I've seen many ministers - Minister of Health, Minister of Seniors, all of them. I went to see Iris Evans in person when she was Minister; I wrote letters to our MLA, to the Aspen Health Region, to Ministers Dave Hancock, Ron Liepert, Yvonne Fritz, Premier Klein, Premier Stelmach, and to the Ministers Greg Melchin and MaryAnne Jablonski. I had a response from Melchin – his letter stated that the residents are getting the appropriate level of care. Lots of meetings and calls and letters – but the government hasn’t taken action.

Sept. 7 — Met with the Minister responsible for Seniors, Yvonne Fritz, for the release of the Task Force report.

Nov. 8 — Phoned the Health Minister to check if any progress on the new standards had been made.

Nov. 28 — Made a speech on the steps of Legislature in Edmonton; Ray Martin, NDP MLA, presented 400 of our petitions to Legislature Assembly.

Jan. 13 — Talked to Human Rights Commission, they sounded like they were for the government and we did not have a case. Talked to Ombudsman, his hands are tied when it comes to private facilities, they are hoping to get some control in 2006; he gave us a name of a lawyer.

Feb. 23 — Went to vigil on the parliament step to stop the Third Way. Ralph and Iris came out with a reply to the Task Force with 36 million in funds to go to Long-Term Care and designated living facilities.

2006
Union – How do the families feel?

LJ – The families are very upset and frustrated.

Union - Can you tell me about the protest?

LJ - In May 2007, the families of the residents organized a protest on the sidewalk outside the facility. Families were concerned about low staffing levels, food and the cleanliness of the facility and lack of fire drills.

For example, beds hadn’t been changed for three weeks; rooms hadn’t been cleaned for over a month. The quality of the food was inadequate for diabetics and for residents who had trouble swallowing, plus many times food was in short supply.

Union – What happened after the protest?

LJ - Over the summer, the problems got worse and the situation deteriorated even more. So by fall, the families wanted something done. I phoned Aspen Health Region, the Ministry of Seniors, the Health Minister and the Premier’s office, and an investigation was launched.

In December the operator of the Mountain View Centre met with the residents/family members and they apologized and made promises to improve the situation. Temporary staff was brought in from other facilities, but after a few months families started asking me about the investigation. I had to chase up the report from the Minister of Seniors office. We didn’t see anything till March 2008, and then we only got part of the report - they said for reasons of confidentiality we couldn’t have the whole report – we did find out that the facility had lost their licence for a while.

And at the most recent family council meeting in November 2008, we heard same complaints. Alberta’s weak inspection and enforcement system raises serious questions and concerns.

Union - What needs to happen to provide appropriate and quality care?

The government has to stop converting facilities from long-term care to designated-assisted living. It is unsafe for the residents. The quality of care drops dramatically, and even the Auditor General said the government must improve care and be able to prove that residents’ needs are being met, and if not why not.

LJ - Strict regulations and standards need to be enforced to meet the needs of each resident. Standards must be the same for both the public and private facilities. We should have unannounced inspections by an independent body that has the knowledge, expertise, and training required to conduct a proper investigation.

If the facility cannot meet the requirements, it should first temporarily lose its licence to operate. And if things do not improve, the facility should be handed over to the government, another qualified operator or the community should have the option to operate the facility. Also, the resident/family councils should be involved in the oversight of facilities.

We need an Independent Seniors’ Advocate who is an officer of the Legislature. So that when anyone has a complaint it will be addressed, without people having to go through all levels of government. This is what happens now, and still nothing is done.

2007

March 25 — Held a meeting with Iris Evans in the Edmonton; made a presentation on how the third way has affected us with the changeover from long-term care (LTC) to designated assisted living (DAL) by the Regional Health and Good Sam in Hinton. Iris promised to do a needs assessment by the region in Hinton.

May 18 — It is very hot and they said they will not turn on the air conditioner until after the May Long weekend.

Jan. 22 — Wrote a letter to our new Premier Ed Stelmach to get our long-term care back. Copies sent to Ivan Strang, Dave Hancock, Greg Melchin and Aspen Health Region.

April — Started Mountain View Resident Family council.
May 12 — Held a Public Protest Forum on the street in front of the centre (Good Sam); attended by more than 40 people - residents, residents’ families and friends.

Nov. 26 — Held a meeting at Mountain View Centre, things got heated so they requested that Lynda report the living conditions situation to the authorities.

Dec. 28 — Phoned the Ministers for Seniors and Health about the lack of staff, cooks and servers over the Christmas period. This has now been three years since the Auditor General’s report came out and verified what we had seen.

September 18 — Met with MLA Robin Campbell and a town councillor in Hinton and discussed converting Mountain View Centre back to a LTC facility. Campbell stated he would talk Ron Liepert, Health Minister.

Union - What do you think will happen if the government fails to make real improvements to the quality of care provided?

LJ – Our elderly and infirm will be dying from causes that could have been easily prevented. Our hospitals won’t be able to handle all our sick and aging population and there will not be appropriate or sufficient facilities.

We are experiencing this in our community already.

I can see that the government is not planning to make the necessary improvements either, because they are continuing to downgrade long-term care (LTC) beds and residents to designated assisted-living (DAL) residents and beds. And this has to stop. For example, Jasper’s 16 long-term care beds are now gone. The LTC residents were moved over to a new DAL facility in October 2008.

I visited the Jasper facility, the majority of those residents should not have been moved to an assisted-living facility – it is a risk to their health, safety and well being. A few should actually have been placed in a palliative care unit. The cost of their care is now passed onto the residents and their families.

Union – What needs to change?

LJ – Care has to start in the community. There must be the staff available and support services and programs in place to look after our seniors in their own homes. The government must commit to making quality home care available to all Albertans. And the facilities, at all levels of care must be there, when and where they are needed.

We took 4,800 petitions to the legislature to ask for more staffing. In January 2003, Premier Klein dismissed what we had witnessed. And then in May, the Auditor General’s report came out and verified what we had seen.

This could have been very easily done in Hinton by reconverting the Mountain View Centre back to a long-term care facility. Our home-care staff would be able to work in the community where they are needed and the acute care beds in the hospital would be freed up.

Standards need to be in place requiring each DAL and LTC facility to incorporate into its staff mix a nurse practitioner with a specialty in the care of the elderly and disabled, plus the administrator should have training in gerontology.

Union - Do you have any advice for families or communities who are facing the same problems?

LJ - First of all, you should join Public Interest Alberta (http://www.pialberta.org). We have to be a voice for the elderly and infirm in the province. The PIA seniors’ task force is a key opportunity to band together to make a change. The care of our elderly is a health care issue that should be fully covered under medicare, so we need to support Friends of Medicare.

We, especially my generation, the baby boomers, cannot sit by and be complacent. We need to fight for compassionate, dignified and appropriate care for our parents, grandparents, our families, friends, and for all Albertans.

We took 4,800 petitions to the legislature to ask for more staffing. In January 2003, Premier Klein dismissed what we had witnessed. And then in May, the Auditor General’s report came out and verified what we had seen.
W
c
hen people suffer from serious injury or illness, they go to hospitals for treatment. Ironically, however, hospitals and nursing homes are increasingly becoming a source of disease.

Across Canada medical experts are sounding the alarm about hospital-acquired infections (HAIs), which strike over 200,000 Canadians each year, and cause at least 8,000 deaths. Especially troublesome are the so-called “superbugs” – diseases that have developed partial or complete immunity to antibiotics.

The fight against these HAIs is conducted through the infection-control programs in hospitals and other health care facilities. What many people, and most politicians, fail to realize is that the foundation of any effective infection-control program is housekeeping – cleaning and disinfecting equipment, rooms and fixtures.

Last September, the Scottish government ordered health boards across that country to stop the contracting out of housekeeping services in health-care facilities. The health minister, Nicola Sturgeon, announced the move as part of a campaign against HAIs. Speaking to a conference of the Scottish National Party, Sturgeon said:

“On Monday morning, a letter will issue from my department to all health boards advising them that from now on, there will be no further privatization of hospital cleaning and catering services anywhere in Scotland... The public must have confidence in their NHS (National Health Service) and know that they’re going to get the best possible care whenever they need to go into hospital. That’s why tackling the problem of healthcare associated infections (HAI) is a key priority for this government.”

These hospital-acquired infections pose a real and growing threat to patients and health care workers. Elderly Albertans
I. The HAI “Big Three”

MRSA – Methicillin-resistant Staphylococcus aureus. These bacteria live on the skin and on equipment, fixtures and other surfaces in health-care facilities. When they infect the body, the resulting symptoms can include boils, abscesses and, in extreme cases, pneumonia or necrotizing fasciitis (“flesh-eating disease”). Since it was first reported in 1995, MRSA infection rates have increased tenfold. Intensive cleaning procedures are required to kill this “bug.”

C. Difficile – a bacterium spread by contamination from fecal matter. According to Health Canada: “The use of antibiotics increases the chances of developing C. difficile diarrhea because antibiotics alter the normal levels of good bacteria found in the intestines and colon. When there are fewer good bacteria, C. difficile can thrive and produce toxins that can cause an infection. In hospital and long-term-care settings, the combination of a number of people receiving antibiotics and the presence of C. difficile can lead to frequent outbreaks.” Symptoms include diarrhea and potential dehydration which can pose a significant threat to seniors in nursing homes or to hospital patients with weakened immune systems.

VRE – Vancomycin-resistant enterococci. Infections can occur in wounds, the bloodstream or the urinary tract, but it can also exist in a “carrier state” in the bodies of people who exhibit no symptoms. Extremely drug-resistant, VRE poses a threat mainly to those who are already weak or ill.

Living in seniors’ care facilities are especially vulnerable, because they may have weaker immune systems, and because infection-control procedures may be less vigorous than in hospitals, especially in the case of private for-profit nursing homes.

The link between hospital cleanliness and HAI incidence is well established, as is the conclusion that investment in housekeeping is one of the most cost-effective ways to prevent HAIs. A 2001 study concluded “a high standard of hygiene should be an absolute requirement in hospitals. In the long term, cost-cutting on cleaning services is neither cost-effective nor common sense.”

Of course, cost-cutting on cleaning services is exactly what happened to Alberta hospitals in the Ralph Klein era, and the results have been predictable. Jane Sustrik, 2nd Vice President of the United Nurses of Alberta (UNA) says:

“The real problem with hospital-based infections did not start appearing until after the staffing cuts in the 90s. We need to ensure full complements of nurses in order to cut back on cross infections. The same applies for the support staff, who do the cleaning and everything else. Good staffing, not cutting corners, makes for clean and safer facilities.”

There are a number of diseases that are easily spread through health-care facilities in the absence of effective cleaning standards and infection control procedures. The Norwalk virus, for example, causes gastro-enteritis. For most healthy adults this is an unpleasant experience but hardly life-threatening. For patients who are already ill, however, or for elderly residents in a seniors’ care facility, the virus can pose a very serious health risk.

Of greater concern, however, are new strains of drug-resistant diseases. Methicillin-resistant Staphylococcus aureus (MRSA), Clostridium Difficile, and Vancomycin-resistant enterococci (VRE). Because these “superbugs” have developed and continue to develop immunity to antibiotics, they are a serious threat to patients and to health care workers. The UNA’s Jane Sustrik puts it this way:

“HAIs are a real concern to nurses... both for their patients/clients/residents/and for themselves... Cutting corners and reducing staffing levels only increases the risks... We have seen the impact MRSA and VRE can have on a hospital population and health care workers. It’s the 21st century – we should be working to reduce risks and infections.”
The risks associated with “superbugs” aren’t just limited to hospitals and nursing homes – these diseases are capable of escaping into the community. In January of 2007, the Canadian Medical Association Journal warned of the dangers of community-associated MRSA, or CA-MRSA. In February of last year the Calgary Herald reported that the incidence of MRSA in that city had almost doubled in the previous year, and had struck “marginalized populations in the city: homeless people, drug users and prisoners.”

The Herald report went on to say that “The superbug has gained an even stronger foothold in the United States, where the Journal of the American Medical Association estimated last fall that severe infections from the bacteria killed about 19,000 people in 2005, taking more lives than AIDS.”

Source: http://www.canada.com/globaltv/natio...8-aa24063e95f5

One legacy of the Ralph Klein’s war on deficits has been, to put it bluntly, dirtier hospitals.

Over the last 13 years, in hospitals and nursing homes across Alberta, housekeeping budgets have been pared back and, in some regions, housekeeping services have been contracted out. One legacy of the Ralph Klein’s war on deficits has been, to put it bluntly, dirtier hospitals.

The fight against superbugs begins with cleaning and disinfecting our health-care facilities. The government and the owners of nursing homes should make investments in housekeeping a major priority, and the contracting out of housekeeping services should be eliminated.

This argument is especially important in the current economic climate. With the province’s energy revenues dwindling, and the possibility of budget deficits looming on the horizon, Ed Stelmach’s Tories may be tempted to fall back on more cuts to health care. If we’ve learned anything from our experiences since 1993, it’s that such a move would be a terrible mistake.
Alice curiously peered into the Looking-glass House and wondered what it was like there. The Looking-glass House appeared similar to her own but different somehow. When the glass melted away she discovered the Looking-glass House stood in a place where all things were backward. She had to walk away from a thing to come nearer to it. Eventually Alice found herself outside, a pawn in a real life game of chess. As she traveled through the backward place in an effort to become a queen, she was greeted by all manner of nonsense... “

Lewis Carroll, Alice Through the Looking Glass

When dealing with the Alberta Labour Relations Board (LRB), unions might be forgiven if they sometimes think that they, like Alice, have entered some backward Wonderland where the rules of logic have been reversed. At the LRB, it is often the opposite occurs of what one might ably expect.

One such example is how the LRB handles cases regarding “reverse onus.” Onus, or burden, of proof is a crucial legal concept that is to ensure that the correct party has to prove their case to win. It is usually the party alleging wrongdoing that holds the onus.

Reverse onus is when the burden of proof is flipped to the defending party, because the nature of the information cannot possibly be proven by the alleging party.
Burden of proof is an issue in all legal cases. In the criminal matters, the burden of proof is the well-known "beyond a reasonable doubt" which connotes near certainty. In a civil context, the burden of proof is a balance of probabilities so that a party must establish their case is more probable than not. The burden of proof must be met on any given point by the party who holds the onus of proof. Generally, the onus of proof rests on the party who alleges as noted by the oft cited proposition, he who alleges must prove.

The onus of proof is particularly important in civil cases. Where all else is equal, that is both versions are equally probable, the party without the burden of proof will be successful.

There are also instances where a reverse onus of proof arises. Reverse onuses generally exist where the information sought is strictly within the knowledge of the party subject to the complaint and the other party has no reasonable capacity to prove the knowledge.

First Case: Direct Union Evidence Dismissed

This is often the case in unfair labour practice cases. It is contrary to logic to require a union to prove an employer’s intent. Rarely will the union have direct evidence of an employer’s intention. As only the employer possesses knowledge of its intention, it is logical to require the employer to prove that intention.

The Boardwatch project (see sidebar) has uncovered how the LRB handles reverse onus, and how, in its world, up is down.

The Boardwatch Project

Boardwatch is a new database built by the AFL which catalogs all LRB decisions. It was created due to a deepening sense of mistrust of the LRB among Alberta’s labour movement. The searchable database can generate reports based on a number of criteria including subject matter, Code section and Board member so unions can have a better understanding of how the LRB approaches issues. It can also identify key trends in interpretation over time. The AFL will produce database reports for AFL affiliates and other unions. For more information, contact Tom Fuller at the AFL.

On March 9, 2007 the Canadian Union of Public Employees (CUPE) filed an unfair labour practice complaint with the LRB that alleged a revocation application brought by a group of workers of the Town of Didsbury was tainted by an anti-union motive on the part of the employer.

One of the main arguments in support of the anti-union motive was an alleged conversation where a manager made told an employee that his pay would increase if the union was removed. The Board conveniently dismissed the direct evidence of the employee involved in the conversation, suggesting CUPE has misinterpreted it: “It is entirely likely that a new employee like Mr. Johnston, unversed in labour matters, would understand the discussion at its simplest level: without the Union, he would keep more of his paycheque, and this could be equated to a pay increase.”
The Board continued to explain away all of the union’s objections and found the union’s case to be nothing more than suspicion, ordered the revocation ballot counted, where the union’s bargaining rights which lost by a single vote.

On April 20, 2007, by letter to the Board, the employer admitted that the conversation was as Mr. Johnston recounted and that the manager had in fact told the employee that revocation would result in a pay increase. CUPE had been right after all, and they moved to have the revocation reversed. Yet in a Lewis Carroll-like twist, the chose not to overturn the original revocation application – the logical remedy - but instead ordered a second vote, which was also lost by one vote.

This is a prime example of the need for a clear reverse onus consideration. Reverse onus would have protected the integrity of the process. Yet, the LRB is content weights the explanation of a sophisticated employer more heavily than even direct evidence presented by the union. This ignores the logic of the relationship.

In this case, the LRB could have required the employer to prove its motive instead of simply respond with an alternative explanation. Instead, they were quick to dismiss the direct evidence of the employee so that a more unlikely scenario could be elevated.

The Red Queen in Alice’s tale bragged about believing six impossible things before breakfast. This case suggests the LRB may have similar abilities in the realm of logical suspension.

Second Case: Circumstantial Evidence Is Evidently Insufficient

[2007] Alta. LRBR LD-024

On February 16, 2007 the United Steelworkers applied for certification of a unit of 29 employees. The LRB Officer contacted the place of business and spoke to a manager. On February 19, 2007 the employer, apparently unaware of the certification application, terminated 10 employees effective February 16, 2007. The

**SUMMARY OF SECOND CASE**

**THE FACTS**

- The person who initially spoke to the Board Officer left a note for the employer, but the employer argues no knowledge of the certification application previous to the terminations.
- While the employer cited work slowdown as the reason for the terminations in the termination letters, new employees were hired afterward and operations continued as usual.
- The terminations were made on February 20 effective the date of the certification application thereby barring the terminated employees from participating in a representation vote.
- Two employees testify that they saw the employer at work late on the date of the application.

**THE BOARD’S FINDING**

- The Board accepts the employer’s explanation that the note was thrown out as the employer thought it was a call from someone trying to sell something.
- The Board finds the employer wanted to soften the blow and accepts that the employer is planning to shutdown the production area of the terminated employees as soon as practicable.
- The Board finds no issue with the date of termination and accepts the employer explanation for the choice which related to pay periods.
- The Board finds the employees must be confused about the date and time.
employer provided the terminated employees with notices that did not allege cause and cited work slow down as the reason for termination. The employer proceeded to hire new employees and continued the work formerly done by the terminated employees.

The employer alleged no knowledge of the certification application until February 20, 2007 when the Board Officer again contacted the business. However, two employees testified that they saw the employer at work late with a number of office staff on February 16, 2007. The Board preferred the evidence of the employer and found the employees confused and mistaken, accepting, instead, a head-spinning collection of justifications for the employer’s ignorance (See table).

To compound the confusion, the Board did find the employer to have “constructive knowledge” of the application since a manager had been notified by the Board. They did rule the employer had improperly altered the terms and conditions of employment during a certification application. This ruling, however, did little for the fired employees or for the union application.

Suspect terminations should require more than token employer explanations. By incorporating a reverse onus, other jurisdictions require the employer to prove that the terminations were not in whole or in part based on an anti-union motive. Some jurisdictions go further and require the employer to prove that the terminations were for cause.

It’s too late to correct it, when you’ve once said a thing, that fixes it, and you must take the consequences.

– The Red Queen

The Public Service Alliance of Canada (PSAC) alleged the Canadian Corps of Commissionaires (Southern Alberta) discriminated against known union supporters through unfair scheduling practices. To support its claim the union provided the LRB with statistical evidence revealing clear differences between union and non-union employees’ scheduling. While LRB noted the evidence as troublesome, it discounted it as a result of errors in the compiling of data. The Board commented: “Even assuming the numbers were valid and the Employer was unable to raise valid reasons for the differences, the Union has not satisfied us the Employer knew who was or was not a Union member and acted against those members.”

To the LRB cogent evidence of differential treatment along a clearly divided line with union on one side and non-union on the other is not strong enough circumstantial evidence to infer that the employer knew who was a union member and who was not.

The power imbalance between employees and employers is exasperated by the Board’s approach to proof in unfair labour practice complaints. The Board pays lip service to unions while employer reasons are preferred even where improbable to the ears of the ordinary worker.

Other jurisdictions recognize the potential for employer abuse and remedy the problem by establishing a reverse onus. Reverse onuses have been in place in labour legislation since the 1970s. The Alberta Board is behind the times and behind employers. Not only is a reverse onus fair in the context of unfair labour practices, it accords with legal principles. The evidentiary burden should rest on the party with the knowledge.

In Lewis Carroll’s story, Alice eventually found the end of the chess board and became a queen. Unfortunately in Alberta unions are still pawns in the labour-relations landscape.
The American Way Is Not The Only Way

Europe provides more coverage for more people in public health care systems

Samara Jones

When Canadians are asked what distinguishes our country from our southern neighbour, our universal health-care system usually comes up – perhaps after hockey.

As other articles in this issue of Union have demonstrated, Canadians have worked long and hard to develop and protect our medicare system. And often Albertans have had to work the hardest, because the provincial government has repeatedly tried to undercut the principles of universal health care that are the foundation of the Canada Health Act by bringing in more “American style” choice.

But there is another way. Although Canada already has more private involvement in health care than most European countries, Canada could look to emulate the high percentage of services that are publicly covered, including dental and long-term care. Europe also has excellent examples of national pharmaceuticals programs that limit patents and reduce pharmaceutical costs. Europe’s social programs, poverty alleviation and inequality rates are significant contributors to Europe’s good health outcomes and provide excellent models for Canada.

So, where should we look in Europe? Some of the best examples can be found in the northern European countries of Belgium, the Netherlands, Denmark, Finland and Sweden.
Though northern European models of public health care differ slightly, the coverage provided tends to exceed that in our own universal Medicare system. Several countries cover the medical and non-medical costs of long term care; most countries have comprehensive pharmaceutical plans for prescription medications; and while individuals often have to pay for a portion of their medical expenditure (usually under 20 per cent for a visit to the doctor, etc.), the government reimburses the bulk of medical expenses. The “different models” of health insurance in Europe are not generally privatized models. For example, Belgium’s health-care system may look different from Canada’s, because the Belgian government contracts out the administration of the system to health co-ops (mutual societies). However, there are no private, for-profit insurance companies. The Belgian government pays for health care and the reimbursements come from and are regulated as part of the public system.

Primary care and preventive care are priorities in Scandinavia. For example, in Finland multi-disciplinary teams working in publicly owned primary health centres guide patients through the different levels of care. Since the 1980s, Finnish doctors are required to see their patients within three days and their salaries are linked to their workloads; both of these innovations have reduced waiting times and improved access to GPs.

Long-term care is more comprehensively provided and covered in Europe. Belgium and the Netherlands provide good examples of a well-organized, well-funded and well-regulated system. For example, in Flanders, in the northern half of Belgium, the regional government provides long-term care insurance with full or partial coverage for costs relating to non-medical long-term care, including professional care in long-term care homes. In the Netherlands, long-term care is financed by payroll deductions and government funds.

**THE PUBLIC FUNDING BEHIND MUCH OF EUROPE’S “PRIVATE” HEALTH CARE**

Proponents of private health care often hold up some European countries as examples, particularly France and the U.K., both of which have two-tiered systems like Canada. However, this experimentation with mixing more private provision and insurance has produced mixed results.

While the reforms to the U.K.’s public National Health Service usually get bad press, the British government has made a significant impact in tackling the issues of the public system. For example, the British government hired 45,000 health professionals between 2002 and 2006 to work in the public system, which helped to both decrease waiting times and offset the disparities caused by the private component of the U.K.’s health care program.

France is often cited as the model of privatized health that Canada should follow – by proponents of American-style health care, who think that a European example will be more palatable to Canadian tastes. This example is a red herring, however. French doctors are paid, on average, about 40 per cent less than Canadian doctors (equivalent to $70,000 a year). So, because the government pays much lower salaries to its doctors, it can invest much more than Canada does in health infrastructure which is what prevents waiting lists. The privatizers would have us believe that it is the parallel private component of France’s health care system that boosts France’s position in international rankings like those published by the OECD, when in fact it is simply due to sustained public investment in public-health-care infrastructure.

When making comparisons with Europe, the privatizing promoters point to private hospitals. It is true Europe does have private hospitals, but the vast majority are not-for-profit private hospitals run by charitable organizations like Caritas. In the Netherlands, for example, more than 90% of the hospitals are private, not-for-profit facilities.

**SOURCES:**

Private is not the cure – Council of Canadians: http://www.profitisnotthecure.ca/documents/CMA/fs_European_07.pdf

Snapshot of Health Systems – European Observatory on Health and Health Policies:
http://www.euro.who.int/document/e87303.pdf
While there might not be a perfect match – the perfect single model that Canada should look to in Europe – most European public health-care systems should give Canadians and our health-care policy makers something to think about. Though the various health insurance systems and approaches might be complex, Europe clearly offers Canada a strong example of a set of public health-care systems that, even during the “reforms” of the past several decades, continue to provide high-quality publicly funded universal health care. Instead of looking to the south, where health insurance is very often linked to employment, Canada should look to emulate the good examples of Europe, where both more people and more care is covered by the public system.

REFERENCES


GOOD EXAMPLES

PRIMARY CARE AND PUBLIC HEALTH POLICY

Finland
Multi-disciplinary teams working in primary care centres provide primary care, preventive care and public health services. Public health policy has been successful in reducing mortality and risk factors related to cardiovascular diseases.1

LONG-TERM CARE

Denmark
80% - 90% of total placement costs covered by government. It takes an average of two weeks to complete an assessment of a patient’s needs and the waiting period ranges between a few weeks to six months.2

PHARMACEUTICALS

Belgium
Compulsory public health insurance reimburses prescription medications.3

REFERENCES

Canada underwent its own industrial revolution in the last half of the nineteenth century and the early twentieth century. In the rapidly growing industrial centres like Montreal, Hamilton and Toronto and in the resource extraction towns in the west, the burgeoning working class struggled with primitive and brutal living and working conditions.

Early factories, mines and mills were poorly lit, unventilated and unsafe. Work days could stretch to 16 hours a day, six days a week. Working men and women and their families lived in squalid tenement houses – often with two or three families squeezing into a single apartment. With little in the way of sanitation or heating, a subsistence diet and unsanitary public water supplies, outbreaks of diphtheria, cholera and other diseases were rife in working-class neighbourhoods.

Family survival depended upon men, women and children seizing every wage and non-wage opportunity that came their way, from working in factories to doing piece work at home to the youngest children scouring the train tracks for pieces of coal for heating.
In the absence of any dependable social safety net (there were no public unemployment insurance, workers’ compensation, social assistance or health care programs), loss of work time through sickness or injury had devastating consequences for working people and their families. Workers could depend upon their neighbours and kin to provide what support they could, but loss of even a child’s contribution could compromise a family’s ability to survive.

With the construction of the railways, the migration of masses of workers in search of jobs meant that people could not even depend upon kin or neighbours to help since workers could well be working far from family and community.

Even with the advent of the workers’ compensation system, there was little relief, since workplace accidents were a minor cause of workers’ disabilities. There is evidence that up to 91 per cent of all disability was caused by sickness.

Under these conditions, it is easy to understand why access to sickness or disability insurance was a critical benefit for working people. The question was how to get it. Although commercial insurers provided such policies, most workers could not afford the premiums.

The answer, for most workers, was either the early trade union movement, company (employer) societies or fraternal societies like the Independent Orders of Foresters or Odd Fellows.

From a worker’s perspective there were serious drawbacks to the employer (company) societies insurance. If you lost your job for any reason, you were cut off from the coverage. And, at least with the early forms of company insurance, most of the fees came from employee dues anyway.

Although the fraternal societies did provide competitive coverage for members, access to fraternal organizations was an issue. The Odd Fellows, for instance, would not accept Catholics, Jews, women or others outside their narrowly defined membership criteria.

Unions found sickness insurance a powerful draw among workers. In the early days of the Western Federation of Miners, who organized hard-rock miners and smelter workers in B.C. and the western U.S., the union reportedly spent more time and resources on providing direct benefits to members than it did on collective bargaining.

Provision of sick benefits became an increasingly important union benefit over time, so that by the end of the 1920s, for example, 46 of 105 American Federation of Labour unions had a sick benefit. Some unions abandoned the direct union provision of sick benefits in favour of collectively bargained disability insurance. However, the instability of union recognition and the fragility of collective agreements prior to World War II made this a risky endeavour.

Beyond Simple Survival: Looking For Health Outcomes

However, finding ways to cope with the immediate disastrous financial consequences of sickness in working-class families only helped them survive sickness monetarily – it did nothing to allow them access to proper medical treatment or to improve their health outcomes.

There were creative efforts to deal with the problem. In the 1880s, unions and coal mine companies in the Glace Bay area of Nova Scotia arranged to deduct mandatory premiums from workers’ pay (a check-off) which were then allocated on a per-person basis to one of the local hospitals and doctors (at the worker’s choice). The check-off and fees were negotiated between the union, employers and doctors and provided workers and their families with unlimited doctors and hospital visits and procedures.

Similar “check-off” systems became common among mining, lumbering communities and by railway employers. The weakness of the check-off system was that it broke down during industrial conflicts. With workers no longer receiving pay-cheques, the check-offs ended and workers and their families
were left without health care.

Other forms of pre-paid health insurance were also tried. The Medicine Hat General Hospital (1889) in Alberta was the first publicly built hospital in the Northwest Territories (Sask. and Alta.). Any citizen could purchase a “Five-Dollar Ticket” that would guarantee them health services for a year.

Doctors As Public Employees

It is not a huge step from the kind of “voluntary” public health insurance practised by local hospitals like Medicine Hat to the idea of a community actually hiring a doctor under contract.

Saskatchewan’s “municipal doctor system” began in 1910 when a small rural community paid a doctor $2,500 per year to provide medical services to all resident taxpayers. The government then amended the Rural Municipality Act in 1916, legalising the arrangement. Under this system, rural municipalities, villages and towns hired local doctors, financed from local taxation, to provide medical services to their residents.

They could offer a doctor a salary or fee-for-service payments for general medical care, surgery, maternity care, and public health work. During the 1930s, the municipal doctor scheme was adopted across the province and spread to Manitoba and Alberta. (By 1948, 210 local governments had contracts with doctors under the scheme.)

Similarly, the Union Hospital and municipal hospital care plans pioneered in Saskatchewan (later spreading to Alberta and Manitoba) allowed rural municipalities, villages and towns to pool their limited resources to establish and maintain hospitals. Municipal hospital-care plans provided payment for the hospital services from general revenues.

Meanwhile, the public demand for a comprehensive system of health insurance continued to grow. In 1932, a B.C. Royal Commission on Health Insurance reported “an overwhelming desire on the part of the public for the introduction of state health insurance...” The Commission recommended a plan that would cover all doctors’ services, hospitalization and drugs. However, when the province attempted to introduce a watered down version in 1936 (it didn’t include coverage for the unemployed), it was ultimately scuttled by a coalition of business organizations and the medical establishment. Similarly, the UFA government in Alberta drafted a health insurance act that they used as a major platform in the 1935 election. When the UFA lost the election to the Social Credit Party of William Aberhart, the plan was discarded.

Tommy Douglas, The CCF And The Birth Of Medicare

One of the priorities of Premier Tommy Douglas when the Cooperative Commonwealth Federation (CCF – forerunner of the New Democratic Party) came to power for the first time in Saskatchewan in 1944 was public health care.

By 1947, the CCF had developed and implemented the Hospital Insurance Plan which charged individuals $5 per year and families $10 per year for access to free basic hospital services. The government also initiated free mental and cancer care.

By 1947, the CCF had developed and implemented the Hospital Insurance Plan which charged individuals $5 per year and families $10 per year for access to free basic hospital services. The government also initiated free mental and cancer care.

However, Douglas had a far more ambitious program in mind – ultimately he thought to use Saskatchewan’s program to become “the nucleus around which Canada will ultimately build a comprehensive health insurance program which will cover all health services – not just hospital and medical care – but eventually dental care, optometric care, drugs and all other
health services which people require” (Speech to Sask. Legislature, 1961).

Douglas, from the beginning, had been counting upon financial support from the federal Liberals who had been promising a national health care program since 1919. Without federal support, the province could not afford to expand the Hospital Insurance Plan.

However, it was the newly elected Diefenbaker Conservatives who first enacted federal cost-sharing of Saskatchewan’s hospital plan – thus enabling Douglas to announce the introduction of Medicare in 1959. (Curiously, it was also the Conservatives who launched the Royal Commission on Health Services chaired by Emmet Hall whose report mapped out the national Medicare program eventually adopted by the Pearson Liberals.)

When Douglas launched Medicare in Saskatchewan in 1961, just slightly more than half (53%) of all Canadians had any coverage in either a hospital insurance or medical services insurance scheme – equally split between profit and non-profit plans.

The problems with for-profit insurance plans, as the American have found out to their dismay, are legion. First, deductibles actually pass on huge costs to the individual. Insurance companies place arbitrary limits on what procedures are covered, and, unlike governments who do that, the companies are not accountable to the public. Insurers typically penalize or refuse coverage to people who claim too many times (that is, people with serious health issues). Finally, even the most affordable plans are often too expensive for workers unless their employer pays part of the premium costs.

Despite the flaws in the private insurance schemes, business organizations, the private insurance industry, the Canadian and American Medical Associations and the media in Saskatchewan all viscously attacked Medicare, culminating in a 23-day doctors’ strike in July 1962. Despite the furore over Saskatchewan’s social health care, the program was so popular that even when the Liberals won the 1964 election in Saskatchewan, they left the system intact.

**From Saskatchewan To All Of Canada**

And, as Emmet Hall, dubbed by some as the father of Medicare, wrote later to Douglas, “I think your greatest and enduring accomplishment was the introduction and putting into effect Medicare in Saskatchewan. If the scheme had not been successful in Saskatchewan, it wouldn’t have become nation-wide.”

In 1965, at the urging of the federal New Democrats who held the balance of power in Parliament, the minority Liberal government under Lester Pearson passed the *Medical Care Insurance Act* and Canadian workers finally got a national Medicare system.

There is still a long way to go. There is no universal program for optometric care or prescription drug care. Provincial governments continually try to control costs by reducing coverage or providing inadequate facilities and personnel. Many medical services are uncovered. Doctors, paid on a fee-for-service basis rather than on salary and uncontrolled drug costs are huge drains on health care funds.

However, working people no longer have to check their wallets before getting a doctor to check their pulse.

He [Douglas] thought to use Saskatchewan’s program to become “the nucleus around which Canada will ultimately build a comprehensive health insurance program which will cover all health services...”
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