# Strengthening Medicare: Embracing equality

Submission by
CUPE Saskatchewan
and the CUPE Health Care Council

to the Commission on the Future of Health Care
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CUPE RESEARCH

# Introduction

We are very pleased to have this opportunity to present our views on strengthening our health care system to the Commission on the Future of Health Care in Canada.

The Canadian Union of Public Employees (CUPE) is the largest union in Canada, with over 500,000 members. In Saskatchewan, CUPE represents approximately 23,000 public sector workers of which 14,000 are front-line health care workers. Our presentation is jointly submitted by CUPE Saskatchewan and the Saskatchewan Health Care Council of CUPE.

As front line workers we have a strong interest in the future direction of our health care system. As you are most certainly aware, our province recently completed a review of our health care system headed by Kenneth Fyke. Our provincial Health Care Council has spoken in favour of the general recommendations of that report primarily because of its emphasis on the development of a primary health care model. That report, however, does not go far enough to expand health services that we believe should be covered by provincial health insurance plan.

Although the provinces have responsibility for delivering health care services, Medicare is a national program that requires national approaches. We are hopeful that this national review of health care will provide Canadians with the opportunity to voice their desire for a strong, public and universal health care system. We believe that the federal government must play a strong role in the financing of a national health care, ensuring adherence to the *Canada Health Act* and in the protection of the system from increasing privatization and fragmentation.

Provincial governments can be innovators, as was the case with Saskatchewan as the architect of Medicare. Similarly, provincial governments can move in dangerous directions that undermine our national health care system, as Alberta has done with the introduction of legislation that encourages private clinics and a report that promotes privatization. The federal government's role as an enforcer of the five principles of *The Canada Health Act* is critical in light of certain provinces' ideological promotion of privatization.

Furthermore, with the recent acceleration of international trade agreements, it is imperative that the federal government excludes our public health care system and protects it from any and all possible threats of trade agreements.

The Commissioner has stated in his Interim Report that the foundation of our renewed health care system must start with the basic values of Canadians. We will outline what we believe these values are and provide our arguments for a health care system that has higher levels of public funding, public, not-for-profit delivery; a health care system that is comprehensive, holistic, equitable and accountable.

# Strengthening Medicare: Our Core Values

The Canadian Union of Public Employees agrees with the Commissioner that we must renovate, not demolish Medicare. Medicare has served Canadians well and will continue to serve us well if governments make the right choices. The foundation of Medicare is sound: its five guiding principles of universality, public administration, comprehensiveness, portability and accessibility ensure that all Canadians have access to health care on the basis of need and not ability to pay.

These principles are rooted in our common values of equality and fairness and our desire for a just and compassionate society. We need to build on these values and strengthen them.

In its *Interim Report*, the Commission on the Future of Health Care in Canada initiates a debate by asking what are the values that Canadians hold for Medicare.

We believe that Canadians strongly hold the values of equality, collective responsibility for one another, fairness and compassion. We believe that we have collective responsibility for the disadvantaged in our society and that we must put measures in place to improve the social and economic status of the most vulnerable. From the perspective of a union, our members fight for these ideals in the workplace and in broader political and social forums.

When we apply these values to Medicare, it becomes clear what kind of a health care system we envision. We want a health care system that is publicly administered and publicly delivered, a not-for-profit health care system, and an accessible health care system that ensures that all Canadians regardless of income receive the quality care they need.

# Reject privatization

Our values require we strengthen Medicare, not dismantle it. That is why our union – and we believe the majority of Canadians – are strongly opposed to any form of privatization or further fragmentation of our health care system.

We want our governments to ensure that all health care services are public and not-for-profit. The move of the Alberta government to encourage private, for-profit health clinics and the Mazankowski report promoting increased privatization causes us great alarm. The vast evidence comparing public and private health care systems conclusively demonstrates that public, not-for-profit health care is more efficient, less costly and more accountable to the public.

In his *Interim Report*, Commissioner Romanow refers to the 70% of health care spending in Canada that is publicly financed and states: "but governments actually deliver very few of these services directly and, in this sense, elements of our delivery system are already, and have always been, 'private.'"[1] We believe it is extremely important that the Commissioner recognize that there is a difference between private, for-profit delivery and private, *not-for-profit* private delivery. The delivery of health services by physicians and not-for-profit private hospitals has been in existence for years. More insidious is the intrusion into our health care system of private, for-profit companies that are only accountable to their shareholders and not to the public.

Research done by our union and other organizations strongly shows that privatization and contracting-out of services is more costly and compromises accountability. In the case of Alberta, a 1998 Consumers' Association study has demonstrated that cataract surgery performed in private clinics is more costly and has longer waiting times than similar surgery performed in the public system. In Calgary, where 100 percent of all cataract surgery is done in private clinics, patients had an average waiting period of 16 to 24 weeks and could expect to pay an additional $250 to $750 fee. In contrast, patients only had an average waiting period

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[1] Commission on the Future of Health Care in Canada, *Shape the Future of Health Care: Interim Report*, February 2002, p.17.

of 5 to 7 weeks in Edmonton where 80 percent of cataract surgery was performed in public facilities[2].

Our union has also conducted many studies showing that private, for-profit companies providing housekeeping, food services, laboratory or home care services are more expensive, less accountable and lower quality than similar services provided publicly.

Doctors Steffie Woolhandler and David Himmelstein from The Center for National Health Program Studies at Harvard Medical School have thoroughly detailed how the Canadian health care system is indisputably less expensive and bureaucratic than the United States' system[3]. They point out that Canada spends about 9% of GNP on health care compared to 14% for the U.S. One of the main reasons for the difference is because of administrative costs: in 1995 the U.S. spent $995 per capita on health care bureaucracy compared to $248 per capita in Canada[4].

The private and extremely fragmented health care system in the United States means that Americans spend so much more of their income on health care than we do in Canada. The percentage of people's income spent on health care increased from 5% in 1959 to 13% in 1995, an increase of 160%. In 1997, the per capita cost of health care in the United States had grown to $3,925.[5]

The private and inequitable health care system in the United States does not represent the Canadian values of collective responsibility, equitable treatment, fairness and compassion. While we guarantee that all Canadians are covered by medicare, in the United States there are 44 million Americans who do not have any health insurance. Infant mortality rates in U.S. inner cities are at about the same level as the impoverished country of Bangladesh[6]. Yet the United States spends more on health care as a percentage of GDP than does Canada.

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[2] Consumers' Association of Canada (Alberta), Access to Cataract Surgery Survey, 1998.
[3] Drs.Steffie Woolhandler and David U. Himmelstein, *For Our Patients, Not for Profits: A Call for Action*, The Center for National Health Program Studies, Harvard Medical School, Cambridge,1998.
[4] *ibid*., pp. 116-118.
[5] Chuck Collins, Felice Yeskel and United for a Fair Economy, *Economic Apartheid in America*, The New Press, New York, 2000, p.17.
[6] *ibid*., p.33.

Private health insurance costs in the U.S. have been increasing dramatically in the last decade making it more expensive to maintain coverage. In fact, the percentage of Americans covered through employer-sponsored health insurance declined from 67.9% in 1990 to 64.6% in 1995.[7] This is not the kind of health care system that Canadians want and we urge the Commissioner to reject any further privatization of our health care system.

## Shifting the costs of health care: public to private

Today all Canadians are guaranteed access to physician or hospital services regardless of their income. Yet this alone does not ensure the attainment of good health for all Canadian citizens. Nor does it take into account the other kinds of health services not covered by Medicare that are essential to good health. Home care, prescription drugs, long-term care, dental and optical care, for example, are not considered part of Medicare.

The decade of health reform in the 1990s and reduced government spending led to a number of measures that shifted more of the costs of health care onto individuals. Governments introduced policies to reduce hospital stays and to delay the transfer of seniors into nursing homes by providing acute and home care services in the home. Health care services previously covered by Medicare were now being picked up fully or partially by people at home. Delisting of services has also resulted in a transfer of costs to individuals or to extended health care plans.

The percentage of health care spending in Canada that is private has increased significantly over the last two decades. Between 1975 and 1998, public sector spending on health care decreased from 75.2% to about 70% of total health spending while private spending on health increased from 24.8% to 29.2%.

In Saskatchewan, individuals are picking up more of the costs of health care either privately or through insurance plans. In 1992 the average Saskatchewan family paid $864 out-of-pocket for health care services. By 1996 that amount had increased by

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[7] *ibid*., p.19.

25.2% to $1,082.[8] This was the four-year period when the majority of provincial government cuts to health care took place, including the major changes to the prescription drug plan.

In 1983, only 17.2% of health expenditures in the province were private but by 1999 private spending made up 25.9% of all health spending[9]. In the same period public spending on health as a percentage of all health spending dropped from 82.8% in 1983 to 74.1% in 1999.

The high proportion of private health spending in Canada is one of the reasons why the World Health Organization ranked Canada's health system in 30th place internationally, behind countries such as France, Italy, Spain, Norway, Greece, United Kingdom and even Morocco.[10] According to the report, 17 percent of Canada's health care costs are paid out-of-pocket by patients at the point of service delivery and private insurers pay another 11 per cent of the bills. In comparison, patients' out-of-pocket patient expenses account for only three per cent of the total bill in the United Kingdom.

# Protect Medicare from Trade Deals

The proliferation of international trade agreements that attempt to reduce the role of governments and increase the mobility and reach of corporations is of considerable concern to our union and the majority of Canadians.

The federal government has on several occasions attempted to placate Canadians by stating that it would never jeopardize our public health care system in an international trade agreement. Several independent legal opinions commissioned by our union, however, have indicated that our public health care system is very much at risk.

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[8] Statistics Canada, *Household Expenditures*, cat. 62-555-XPB.
[9] Canadian Institute for Health Information, *National Health Expenditure Trends,* 1975-1999, p.107.

[10] The World Health Organization, *World Health Report 2000*, Annex Table 1, pp.152-155.

Matthew Sanger has written a comprehensive examination of the implications of the GATS for the Canadian health care system. In his book, *Reckless Abandon*, he points out that important features of our health care system are already exposed to the full force of the GATS rules. Canadian health insurance and services such as data processing are covered under the GATS national treatment and market access rules and hospital support services are likely already subject to GATS national treatment and market access rules. Medical services in hospitals are protected by GATS general rules only if they are provided on a non-commercial basis and not in competition with private health facilities[11].

The threat of international trade deals is another reason why we must prevent any further privatization or creation of private health facilities in Canada. The actions of provinces like Alberta to promote private health clinics could very possibly undermine our health care system and make us vulnerable to actions under trade agreements.

We urge the Commissioner to examine the serious threats to our health care system posed by various trade agreements such as the GATS. We urge you to make recommendations that the federal government insist on a general exception for health care from the GATS and ensure that none of Canada's GATS obligations compromise our ability to maintain a universal, publicly funded and regulated health care system.

# Role of the federal government

The federal government has a crucial role to play in strengthening our public health care system and protecting it from privatization or further commercialization. Through its cash transfers to the provinces, the federal government wields power to enforce compliance with *the Canada Health Act*. On occasion the federal government has used that power to withhold funds, as it did with the province of Alberta in the late 1990s.

We believe that the federal government should have continued to withhold funds from Alberta until that government withdrew the controversial Bill 11 that permits

[11] Matthew Sanger, *Reckless Abandon: Canada, the GATS and the future of Health Care*, Canadian Centre for Policy Alternatives, 2001.

private clinics to keep patients for overnight stays. Bill 11 violates the spirit of the *Canada Health Act*[12] and opens the doors to increasing privatization of our health care system. Our union has grave concerns about the transfer of public funds to private hospitals that are not accountable to the public and we see a clear conflict of interest for physicians who operate in both the public and private systems.

Despite the obvious advantages of a public system, the calls for a two-tiered system and for increased private involvement in health care continue to emerge from various sources. The lack of federal government commitment has opened the door for the privatization pushers who are using the crisis caused by under funding to their advantage. The federal government's financial support to health care has dropped to a scant 13% of total government health spending.

First and foremost, our health care system needs an increase in federal funding to the historical levels of 50/50 cost sharing. As a first step, the federal government should commit federal funding to at least 25% of total health care funding. Without increased federal funding, there is no doubt that various provinces will continue to undermine our public system and continue in efforts to create a fragmented and inequitable health care system that is unrecognizable from province to province.
We also reject individual financing of health care through user fees or the limitation of personal usage of health services through income tax charges, medical savings accounts or increased health insurance charges. Such measures would reduce the equitable features of our health care system and place an unfair burden on the poorest and most vulnerable in our society. Saskatchewan's own experience with user fees in the late 1960s revealed that only the poor and elderly reduced their visits to doctors. The number of visits to doctors by the poor and elderly declined by 18% but the overall costs did not shrink because people with higher incomes increased their visits to their physician.[13]

The federal government must finance health care through general revenues of taxation, which is the fairest way of distributing resources in our society. Although our taxation system could be more equitable, we would like to stress that a

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[12] Former federal Health Minister Monique Begin has stated that the negotiation of the Twelve Provincial Principles Underlying the Alberta Health Care System in 1996 "go completely against the tradition and the spirit of the federal legislation." See *The Future of Medicare: Recovering the Canada Health Act*, Monique Begin, September 1999.
[13] Canadian Health Services Research Foundation, Mythbusters, 2001 at: www.chsrf.ca.

progressive taxation system, based on the concept that people pay taxes according to their ability, is the fairest and most equitable way to finance health care and other social programs.

Unfortunately, all levels of governments have been slashing personal and corporate income tax levels thereby reducing government revenues and ability to finance social programs. Canadians support for tax cuts has waned, however, as they see little change in their take home pay and now face decreased levels of public services, increased user fees and other out-of-pocket expenses for services that used to be publicly provided. Governments must reverse this trend and use taxation revenues to provide more comprehensive, equitable and publicly funded and delivered health services.

## Strengthening Medicare: Expand public services

The Canadian Union of Public Employees believes that we must reverse this shift of health care costs onto individuals and expand what is publicly provided under Medicare.

Because many key health services are not covered under Medicare, Canadians' values of equality and fairness are compromised. Low income Canadians, seniors, disabled persons, and those with chronic conditions do face hardship paying their health bills.

For example, in December of 2001, the *Prince Albert Daily Herald* ran a story about an elderly man in Saskatoon having a heart attack who called a taxi rather than an ambulance because he could not afford the $250 ambulance fee.[14] This is an alarming story that illustrates the impact of a fragmented health care system that increasingly requires individuals to pay greater proportion of necessary medical services. Fortunately, the taxi driver was able to get the man to the hospital in time to save his life – and he didn't charge the cab fare.

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[14] Betty Ann Adam, "Cab ride saves heart attack victim's life: a $250 ambulance ride unaffordable for Saskatoon man," *Prince Albert Daily Herald*, December 24, 2001.

Canadians from all income levels are equally likely to have visited their family doctor in 1999, but only about 40% of low income Canadians saw their dentist in the previous year. In contrast, 80% of high income Canadians visited a dentist[15].

Recipients of home care pay for the services and medications they would have received at no cost if they were in a hospital. It is also important to stress that much of the caregiving responsibilities are shifted onto family often creating a tremendous financial burden and emotional and physical toll on those family members. Women, who represent the majority of unpaid caregivers, are particularly hit hard when expected to care for family members at home. Yet policy makers rarely consider the implications of health care policy for women.

While some provinces do provide some assistance to low income persons who require home care services or prescription drugs for a chronic condition, this is a piece meal approach that does not ensure equitable treatment across the country nor does it reflect the core value that all Canadians should have access to needed medical care regardless of ability to pay.

- **Develop a National Home Care Program**

Home care plays a critical role in our health care delivery system, especially since provincial governments embarked on health care reform that reduced the amount of time that patients spend in acute care facilities or delayed entry into long term care facilities. Providing home care services has saved the health care system tremendous costs that would have otherwise been provided in acute or long term care facilities. The kind and level of services provided under home care differs greatly between provinces.

In 1997 the National Forum on Health Care, after holding major consultations and meetings with Canadians from coast to coast, recommended a national Home Care program. Several years have passed and we are now in the midst of two national reviews (and several provincial reviews) of health care with still no manifestation of a national home care program.

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[15] Canadian Institute for Health Information, *Health Care in Canada: A First Annual Report,* 2000. www.cihi.ca.

We believe that the costs of home care should be fully covered by provincial health insurance plans and that there should be national standards in place that ensure equitable access to services. The federal government needs to support home care by providing expanded funding to the provinces.

We do not support the creation of a separate insurance fund to pay for home care or tax credits to individuals. Such financing measures only partially respond to individual needs and do not address the need to have a comprehensive public home care program that is integrated with the rest of the health care system.

- **Create a National Pharmacare Program**

There is a tremendous financial burden placed on individuals to pay for drugs that are part of their medical treatment. About six million Canadians do not have adequate prescription drug insurance coverage. We believe that this offends our value of equity and that Canadians want a fair and compassionate way of paying for these costs.

Another of the major recommendations of the National Forum on Health Care was the creation of a national Pharmacare program. The cost of prescription drugs is one of the fastest rising costs of all components of the health care system. Between 1985 and 2000 prescription drug costs in Canada increased by 344%.[16] The recent announcement that the provinces and territories will work towards purchasing prescription drugs in bulk as a way of saving costs is a positive step toward reducing prescription drug costs but this will not come close to addressing the problem of inequitable coverage and access.

A national Pharmacare Program is important to ensure equitable access to prescription drugs to all Canadians. Many provinces have high deductibles that make medically-necessary drugs at times cost prohibitive. For example, Saskatchewan has the highest deductible of any province at a threshold of $750 every six months before provincial coverage kicks in. Although the province does

[16] Canadian Health Coalition, *Index on Medicare*. www.healthcoalition.ca.

provide support according to income level, it is clear that Saskatchewan residents are paying more out-of-pocket for health care than a decade earlier.

It is important to point out that Canadians are already paying the high costs for prescription drugs, either out of their pocket, or through private insurance plans. Through a national program we should be able to reduce overall drug costs.

It is also imperative that the federal government repeal Bill C-91 that provides twenty years of patent protection to the pharmaceutical companies so that cheaper generic forms of prescription drugs can be produced for the market in a shorter timeframe.

- **Increase public delivery of long-term care**

Long-term care services are provided by a mix of private, public and non-profit providers. A study of long term care services in British Columbia identified tremendous gaps between long-term care and the public health care system. The report found that inadequate public funding to Community and Continuing Care has led to declining patient health, increased hospitalization, higher injury rates among workers, loss of continuity of care and burnout and low job satisfaction for staff[17].

We are concerned about the high level of private long-term care facilities because we do not believe that companies should be making profit on the backs of seniors. In Saskatchewan, the loss of funding to Levels 1 and 2 nursing homes led to a rapid increase in for-profit private personal care homes. Between 1996 (when funding to nursing homes was cut) and 2000, the number of personal care homes with more than 10 beds increased by 43.8 percent[18]. The lack of public, not for profit options for seniors has left them with few options but to pursue private care. Our main concern is that the private homes are not integrated into our health care system and that it is difficult to implement a primary care model when certain services are outside the public health care system.

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[17] Canadian Centre for Policy Alternatives, British Columbia Government and Service Employees' Union, British Columbia Nurses' Union and Hospital Employees' Union, *Without Foundation: How Medicare is undermined by gaps and privatization in Community and Continuing Care*, November 2000.

[18] CUPE Research, *A Vision for Health Care*, August 2000, page 32.

We urge this Commission to also recommend expanding Medicare to cover long term care.

- **Create innovative, preventive health programs**

Our understanding of what makes us healthy goes beyond the traditional health services. For example, in the 1970s the Saskatchewan government had introduced a school-based dental program that provided preventive dental care to children in the schools. The program provided dental care and education about dental hygiene in the schools, thereby guaranteeing equitable access to dental services and setting the stage for a lifelong approach to healthy dental care. This internationally recognized and acclaimed program was dismantled by the Conservative government of Grant Devine in the 1980s, despite the tremendous success of the program.

We need innovative programs like a publicly-funded, school-based children's dental plan that takes proactive approaches to health care. Midwifery services, health promotion, rehabilitative and mental health services could become essential components of a public health care system that focuses on the whole person, the community and a life-long approach to health care. There is no explanation why ambulance services, which can be a matter of life and death, are not fully covered by Medicare.

## Strengthening Medicare: Primary Care Reform

Health care policy and planning must recognize the various social and economic factors that affect people's health. There is ample evidence that poverty, poor housing, low education levels, working conditions and environmental conditions influence people's health. Michael Rachlis and Carol Kushner argue in their book, *Strong Medicine,* that the increase in life expectancy of Canadians in the first half of the 20$^{th}$ century had more to do with better housing, clean water, sewage treatment and safe food than because of doctors and medicines.[19]

While Health Minister Anne McLellan feels it's important to tell Canadians that being fat is bad for their health (and the future of Medicare), we have noted that she has not told Canadians that being poor, or a single mom, disabled, aboriginal or living near the Cape Breton tar ponds is also bad for their health. It is critical that

[19] Michael Rachlis, M.D. and Carol Kushner, *Strong Medicine*, 1992, pp. 9-11.

this Commission recognize the social and economic determinants of health and develop recommendations that reflect this.

Our union has for many years promoted the creation of a health care delivery model where a broad range of health care providers work in teams and provide a full range of health and social services to Canadians. This model is in existence: in Quebec they are called Centres locales de services communautaire or CLSCs. In other parts of Canada, such as here in Saskatchewan, they are the cooperatively-run community clinics.

The multidisciplinary team approach to health care makes sense if we accept that a range of social and economic factors determines health status. We believe that such a model would be far more effective than the traditional lone-physician clinic. Physicians instead would work in a team with nurses, social workers, physiotherapists, nutritionists and other health care workers to provide the most appropriate care that is needed. We believe that this delivery model would go beyond just the treatment of illness and would focus on health promotion, prevention of disease, and the creation of social support needed for healthy life.

Our union supports the small steps that have been taken toward the creation of a primary health care model in health care. As mentioned in our introduction, the recent Fyke Commission in our province recommended a primary health care model that employs multi-disciplinary teams of health care providers and focuses on population health strategies.

We believe that the following are crucial to primary care reform:

- *Eliminate the fee-for-service remuneration of physicians and place physicians on salary*. Fee-for-service promotes high volume of services and tests that may not be necessary and discourages physicians from working within a team;

- *Support the creation of multi-disciplinary teams of health care providers* that coordinate the provision of appropriate services at the right time. Multi-disciplinary teams are essential to the primary care model;

- *Improve the working conditions of health care providers*. Federal and provincial governments must address high workload and stress in the health

care sector, training and retention issues and the coordination of a human resource strategy);

- *Enhance the role of all health care providers in the health care system.* Many health care providers are not used to their full skills and abilities;

- *Implement economic and social policies that improve health status* (increase social housing, full employment strategies, reduce poverty, invest in water infrastructure, increase environmental protection, and others).

# Creating Healthy Workplaces

As the largest health care union in the province of Saskatchewan, we have major concerns about the working conditions in health care workplaces and the problems of recruiting and retaining qualified health care workers in this province. Other provinces are facing similar problems but the crisis seems more pronounced in a smaller province like ours that cannot compete with the lucrative employment offers of U.S. health employers or other provinces.

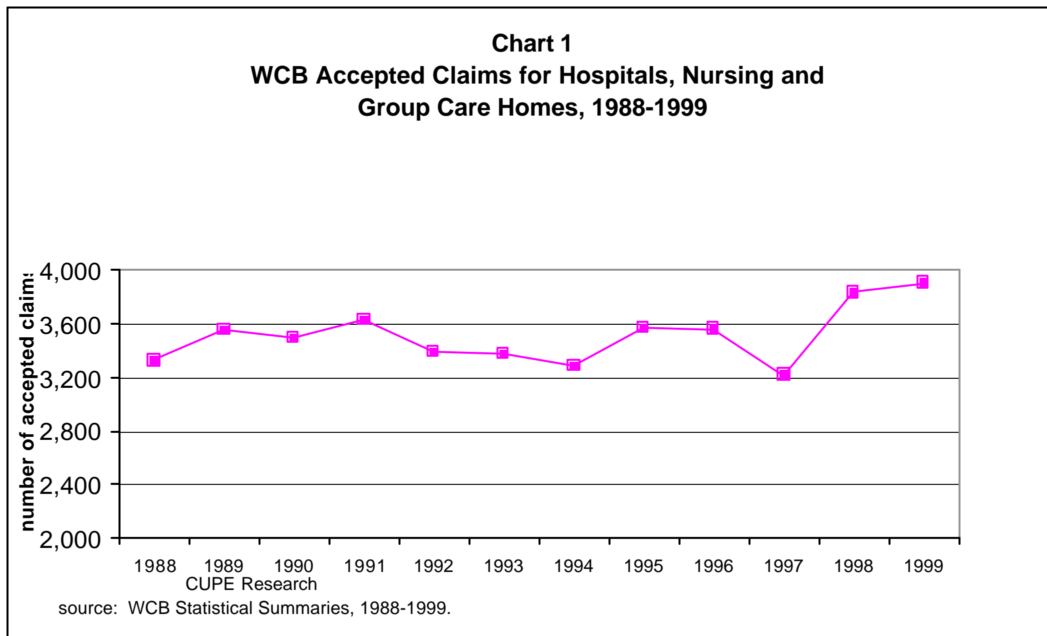
In our view, an important challenge for our health system --that often is overlooked until a crisis is reached – is the creation of healthy workplaces. A healthy workplace is important not only for the health of health care workers but also for patient care because healthy workers provide better quality of care. A healthy workplace is also important for the retention of health care workers – an issue that has reached crisis proportions recently.

## High sick leave rates

Health care workers have the highest sick leave usage of any other group of workers. An average 7.2 per cent of Canadians in full-time health occupations were absent from work each week for health reasons in the year 2000, compared with 4.8 per cent of other workers, according to a study completed by the Canadian Institute for Health Information (CIHI). In Saskatchewan, eight per cent of health care workers

were away from work each week because of illness. This was the third highest absentee rate in Canada.[20]

Health care workers suffer from probably the highest rate of work-related injuries. In Saskatchewan, health care has been the industry with the highest number of workplace injuries in the province since 1993 (with the exception of one year). Health care had a higher number of injury claims than either the Building, Construction and Trades or the Trucking industries. In 1988, health care injury claims represented 9.3% of total claims with WCB but by 1999 had grown to 12.4% of all claims[21]. It is important to note that this data is based on injuries reported to the Workers Compensation Board and does not include injuries for which no claims are made.




## Injuries from violence

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[20] Pamela Cowan, "Hospital employees often sick workers," *The Leader-Post*, November 27, 2001, p.A1.

[21] Saskatchewan WCB, *Statistical Summary: Claims Reported*, 1999 and 1988.

Health care workers also incur a high number of injuries as the result of assaults or violent acts. Nursing Aides and Orderlies – many of whom would be our members – filed 70 claims with the Workers Compensation Board in 1999 for injuries resulting from assaults or violent acts. Guards and watchmen had the second highest number of assaults with 57 claims, followed by Graduate Nurses with 40 such incidents. Policemen and detective filed 25 claims for injuries from violence.

The combined occupations of Nursing Aides, Orderlies, Graduate Nurses, Nursing Assistants and Therapy accounted for close to 30% of all injuries resulting from violence filed with the WCB in 1999. Again it is worth emphasizing that these statistics reflect only those who filed claims with WCB. The incidence of violence in the workplace could indeed be much higher.

It is not surprising that there are high levels of illness in health care workplaces. The combination of understaffing, heavy workloads and physical strain and higher levels of patient acuity is creating a stressful and volatile work environment. It is ironic that the very institutions that are supposed to cure patients are the workplaces that are injuring health care workers.

## New approaches to health human resources

There is probably not a single health care worker in this country that has not been impacted by health care reform. Workplace restructuring has created tremendous stress for workers who may have changed employers, changed union representation, and changed jobs –perhaps more than once – during various stages of health reform.

Workplace restructuring has an impact on health care workers that, in turn, affects patient care. A recent Canadian Policy Research Networks discussion paper entitled, *Creating High-Quality Health Care Workplaces*, points out that:

> The cumulative impact of budget cuts, workforce reductions and current professional shortages have resulted in heavy workloads, longer work hours and intensified demands for nurses (which now includes mandatory overtime) and physicians. Yet few studies have examined these issues among other health care workers or investigated the effect of excessive work hours on

employee well being and patient care. These must be priorities for future research. [22]

The discussion paper also recommends that health care management promote workplace cultures that value employees as assets, providing workers more influence in decisions, greater openness in communication and more investment in training and career development. We agree that these would be important steps in creating higher quality workplaces and helping to retain and recruit health care workers.

The creation of more full-time positions is also a key component to creating healthy workplaces. In Saskatchewan, only 41% of health care workers have full-time jobs whereas 34.5% work part-time and 24.5% work on a casual basis.[23] The casualization of the workforce makes it difficult for part-time and casual workers to balance their family lives around the schedules of their employer or various employers within a health district. Less than full-time work also has a negative impact on the benefits and pensions of health care workers. Employers have difficulty recruiting new employees when all they will offer them is part-time or casual employment.

In Saskatchewan, the provincial government along with unions and health employers has created a provincial Health Human Resources Council that is responsible for coordinating human resource planning on a provincial basis. Instead of letting individual health districts compete for health care workers or develop separate recruitment strategies, the Health Human Resources Council will develop provincial strategies regarding education seats, training and retraining needs and so forth. One idea mentioned by our CUPE representative to the Council is the provision of bursaries to health care workers already in the system to upgrade for positions where there are shortages. This is a model that could be considered by other provinces as they grapple with the same retention, training and recruitment issues.

Health care workplaces would also benefit from the creation of national standards for staffing levels in acute and long-term care facilities. This would not only

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[22] Mieke Koehoorn, Graham Lowe, Kent Rondeau, Grant Schellenberg and Terry Wagar, *Creating High-Quality Health Care Workplaces*, CPRN Discussion Paper, January 2002, p.10.
[23] Saskatchewan Health, 1998 Saskatchewan Health Employer Survey, 1999.

alleviate problems of understaffing and workload but would create higher quality of care for patients and residents.

# Conclusion

We believe that we are at a critical moment in Canadian history. There is a multitude of political pressures and privatization initiatives that, if left unchecked, could lead to the dismantling of our universal, public health care system. Our health care system is viable, but it needs the financial support and bold leadership of federal and provincial governments to make the right choices.

We urge the Commission to see the choices clearly and to stand up for Medicare. Unless we protect the public nature of our health care system and protect it from further erosion by privatization, then we will cease to have a national health care system. Our children will read about Medicare in their history books.

We must embrace the values of equality, justice and compassion that Canadians hold dearly and take Medicare forward so that it is more comprehensive, more equitable and compassionate. This can only happen by embracing a publicly funded and delivered, not-for-profit health care system.

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