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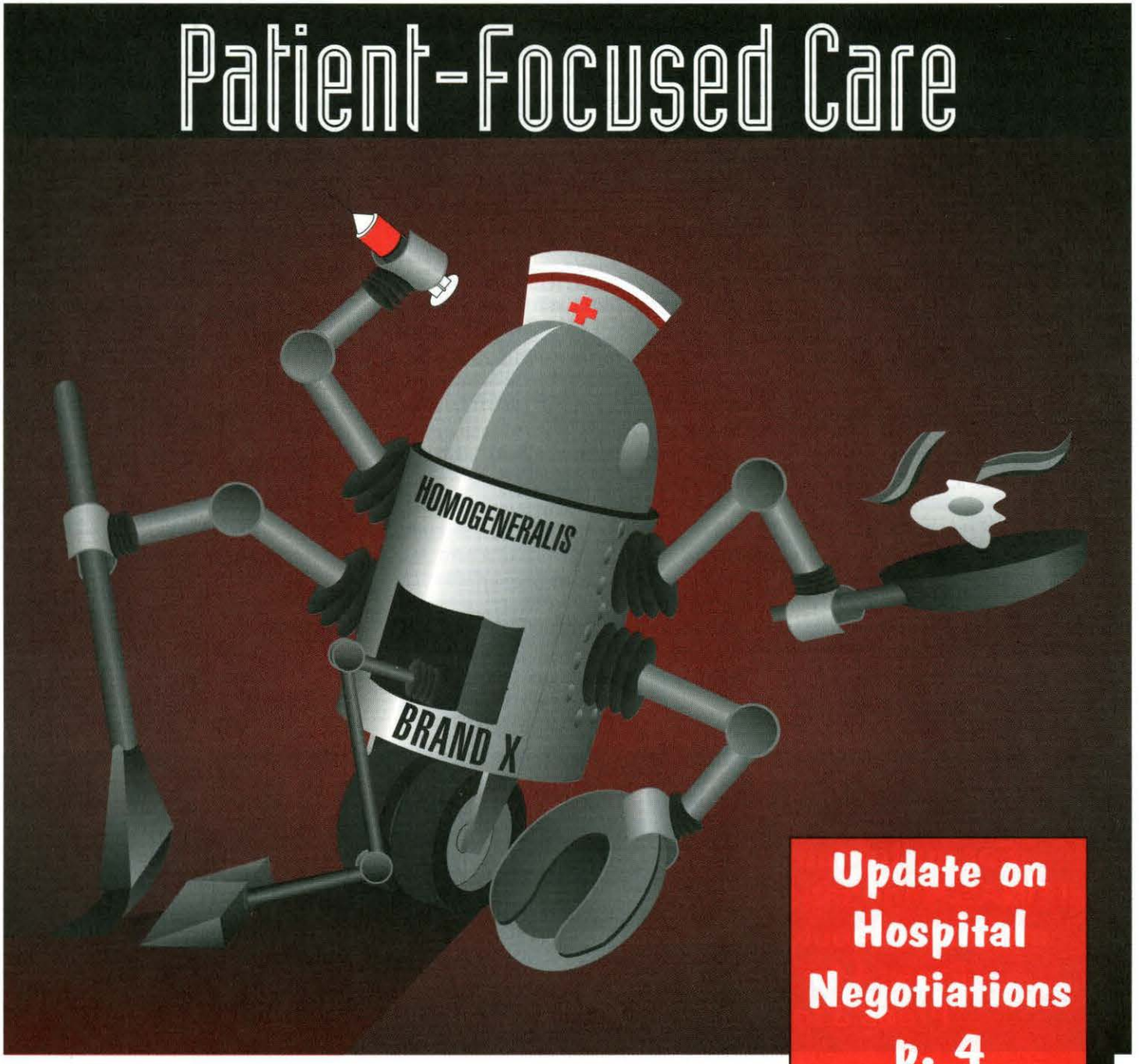
Patient-Focused Care



Update on Hospital Negotiations p. 4

Executive Board and Staff

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RN/RPN PRIDE

If you were a patient clutching your stomach in pain or dealing with the pain of mental illness,

would you want a "patient care hostess" looking after you? Not likely! You would want registered nurses or registered psychiatric nurses using their education and clinical knowledge to take care of you.

Let your patients or clients know that they are in capable hands by wearing a pin that says you are a registered nurse or registered psychiatric nurse. Three thousand plastic RN tags; 4,800 metal RN pins; and 200 metal RPN pins are available for purchase from UNA's Provincial Office. The metal pins cost $3.00 each and each plastic tag costs $2.00. Contact Kim Cook, UNA's Membership Secretary, at 1-800-252-9394 or 425-1025, to order the pins.

NEGOTIATIONS HOTLINE

For up-to-date information on the status of negotiations, call UNA's Negotiations Fact Line at 1-800-667-1379. (Edmonton area members should call 944-1603 to access the same updates.) Press 1 for AHA, Press 2 for Bethany/Capital Care, Press 3 for COTHA and Press 4 for Health Units.

A Ray of Hope

by Heather Smith, UNA President

ON MARCH 29, I was one of nine representatives of health care unions in Alberta who met with Diane Marleau, the federal Minister of Health. We found the Minister to be well-versed in health care issues and understanding of the concerns raised by the unions. Even more importantly, though, she shares our misgivings about Alberta's vision of health care 'reform'. She too perceives private clinics as the 'beginning of the end of a national health care system'. Marleau spoke sincerely of her dedication to the Canada Health Act and to the Act's principles which form the foundation of a society which cares for all citizens regardless of socio-economic standing.

Members want to know why education is receiving public support to fight cuts while the destruction of health care is virtually ignored.

The Minister's visit provided a welcome injection of moral support for all health care unions who for months have struggled against politican and employer denial.

As I met with Locals in recent weeks, I was frequently asked why no one is speaking up about the cuts to health care. Members want to know why education is receiving public support to fight cuts while the destruction of health care is virtually ignored.

When initially asked those questions, I commented on the nature of health care. While the association with education is generally positive, health care invoked memories of illness and loss – experiences that many would rather avoid. Parents look forward to their children receiving an education. Accessing the health care system is a feared eventuality.

But there is a far more basic and sad reality. When cuts to education are announced, principals, teachers and Boards of Trustees openly challenged the cuts as detrimental to the ability to provide quality education. In health care there has been a resounding denial of concern. Administrators and Boards of Trustees have not raised opposition to the government's intention to slash health care funding by twenty per cent. In the absurd situations, as occurred when the Royal Alexandra Hopsitals reduced nursing personnel by close to ten per cent, administrators have suggested that the cuts to staff and services will actually improve the quality of care.

I challenged an administrator who openly admitted to me that the government's goal of 2.4 beds per 1,000 population was unrealistic and would be detrimental to the community. "Why won't you speak up?" I asked him. He reply was simple. "I follow the golden rule – he who holds the gold makes the rules!" he said. Boards of Trustees and administrators are too concerned that their facility will be the one closed or they will not get plum positions in the regionalized boards if they are seen to oppose the government agenda. Although health care workers and unions have spoken out, we have been dismissed as self-serving that we seek only to save our own jobs.

But saving jobs has become a lesser priority than saving our health care system and defending our profession.

A big part of the Alberta health care 'reform' centres around the de-skilling of the workforce. At the hospital bargaining table there have been less than subtle suggestions that the employers can, or will, utilize fewer skilled workers; that registered nurses and registered psychiatric nurses can be replaced with licensed practical nurses or unlicensed, unskilled aides. The employers suggest that nurses are a workforce that can be contracted out. Four years ago, the government and employers were anxious to address the needs of nurses and incentives to attract, recruit and retain nursing staff abounded. The attitude today is in stark contrast to a few years ago. Very few employers have disclosed the extent of job cuts they have made in the last two years. None will admit to their future plans. Suggestions by gov-

A big part of the Alberta health care 'reform' centres around the de-skilling of the workforce

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Hospital Negotiations

Negotiations stalled by employers' refusal to provide information. Labour Relations Board orders hospitals to come clean.

HOSPITAL NEGOTIATIONS are crawling along at a snail's pace as a result of the unwillingness of employers to deal with the union in an open and honest manner. The United Nurses of Alberta's Hospitals Negotiating Committee expressed much frustration over the employers' adamant refusal to provide accurate information about the financial situation of facilities. David Harrigan, UNA's Director of Labour Relations and Chief Negotiator for the UNA's Negotiating Committee noted, "The government has stated that the vast majority of facilities have large surpluses. The facilities claim that they do not. It is time that employers came clean." The employers also rejected the union's request for information related to the plans regarding hospital mergers, transfers, closures and amalgamations.

As a result, UNA filed a complaint with the Labour Relations Board, seeking an order that the information be provided. In a decision handed down last week, the Labour Relations Board agreed with UNA's position and told the employers to deliver the information to the union. "The employers know that it is necessary to deal with finances and future of health care. Now the Labour Relations Board has agreed with UNA and has ordered the employers to provide this information. Why the employers have insisted on wasting so much time is a complete mystery. We have no intention on allowing the employers to gut the scheduling, layoff, working alone and compensation provisions based on vague statements. The frequent allegations that the union has somehow responsible for delay or has been obstructive has now clearly been proven false. We trust that the employers will now be willing to bargain in good faith," said Harrigan.

United Nurses of Alberta is currently at three bargaining tables in the hospitals sector. [Prior to this round of bargaining, there were only two tables—Alberta HealthCare Association (AHA) and Royal Alexandra.] Capital Care and Bethany Care Centre have chosen to bargain together at one table. The large urban hospitals in Edmonton and Calgary (Alberta Children's, Foothills, Glenrose, Calgary District Hospital Group, Royal Alexandra, Calgary General and Caritas) have formed a bargaining table of their own under the guise of the Council of Teaching Hospitals (COTHA). All other employers are bargaining at the Alberta HealthCare Association table. Talks were suspended at both the AHA and COTHA tables when the employers cancelled a number of scheduled bargaining dates due to their decision to change negotiators. [Despite the employers' insistence on having different tables for bargaining, the AHA and COTHA share the same negotiator (Mark Haley) and have tabled nearly identical proposals.]

The United Nurses of Alberta's Hospitals Negotiating Committee has expressed much frustration over the employers' adamant refusal to provide accurate information about the financial situation of facilities.

All employers have proposed massive regressions to almost all areas of the agreement, including the following:

- Reduction of all salaries by $.60 per hour and the creation of a new start rate that is $1.20 below the current start rate.
- Deletion of short term disability
- Reduction of long term disability to 60% (currently 66.6%)
- Employee to pay 100% of long term disability premiums (currently employee pays 25%)
- Employee to pay 100% of Alberta Health Care (currently employee pays 25%)

Heather Smith, Sheila Bailey and Gail Tymens review the employer's proposals

- Employee to pay 50% of dental, life insurance and Blue Cross premiums (currently employee pays 25%)
- No one to be placed in charge if supervisor is away from unit for less than one full shift
- Reduction of shift differential to $1.00/hour (currently $1.50). Shift differential to be applicable only after 2300h (currently 1500 hours)
- Reduction of weekend premium to 50¢/hour (currently $1.10). Weekend premium to be applicable between Saturday at 0001h and Monday at 0001h (currently 1500h Friday to 0700h Monday)
- Reduction of vacation entitlement by one week per employee per year. (In addition, the AHA has proposed that the employer remove one week of vacation that has already earned and is sitting in an employee's vacation bank)
- Deletion of August Civic Day from Named Holiday list.

In addition to rollbacks in compensation, the employers are proposing many more regressions, including the following:

- Deletion of the requirement for the employer to provide inservices.
- Removal of overtime rates paid to part-time employees who are working on their scheduled day of rest.
- Professional Responsibility and Occupational Health and Safety Committtees would no longer be required to meet monthly, and we would no longer have the right to present our concerns to the Board of Trustees
- Employer would have the right to deny a request to work permanent evening or night shifts
- Employees working rotating shifts would only receive one-third day duty (currently two-fifths)
- Posting of shift schedules six weeks in advance of shift worked (currently twelve weeks).
- No payment of overtime penalty if an employer changes an employee's schedule with less than 14 days notice.
- Employer would have the right to assign an employee to work alone on a ward or unit.

The employers are also proposing major changes in the area of layoff and recall. These changes include the following:

- Elimination of bumping rights and deletion of the requirement that layoff be in reverse order of seniority. [NB: this position of the employer is an inappropriate escalation of their ingoing position.]
- Severe restriction of recall rights. All rights to be recalled would cease 12 months from the date of the original layoff.
- The employer would have the right to determine if an employee absent on WCB, illness or LOA would exercise her rights upon return to work or at the time of the layoff.

The Negotiating Committee expects the pace of negotiations to quicken now that the needed information will be forthcoming. More dates are scheduled at all three tables throughout the month of May.

Terry Robertson and David Harrigan discuss UNA proposals.

Employers Kill Tripartite Talks

THE TRIPARTITE PROCESS, begun with the hope that unions, employers and government could work together to solve the problems associated with health care restructuring and cutbacks, died when the employers refused to live up to their earlier agreement to discuss compensation and early retirement/severance packages. David Harrigan, UNA's Director of Labour Relations, said that he believed that the employers did not, and could not, receive a mandate to discuss issues in a tripartite setting. "I believe that this is due to a variety of factors, including their belief that they will have more success in achieving major regressions at individual tables, and the changes that are taking place in industry which make it difficult to determine just who, if anyone, has authority to speak on behalf of employers," said Harrigan. Although the government had previously indicated that it was prepared to force employers to the tripartite table, it rapidly became clear that the government had reconsidered this action.

The joint union caucus has rejected the employers' and government's suggestion that the tripartite process be revived to discuss issues regarding the impact of regionalization on employment regulations. The unions do intend to hold bipartite talks with the government about regionalization. The unions have also agreed to continue working as a common front against the destruction of health care.

While UNA was unable to achieve most of what we had set out to do, we did achieve some gains regarding the workforce adjustment monies. Further information on the plans for workforce adjustment will be included in the next NewsBulletin.

DID YOU KNOW?

- The number of registered nurses working in Alberta decreased by 4.2% between March 1992 and March 1993.
- Cost of programming the City of Los Angeles computer network to catch "welfare cheats" : $2 million. Number of defrauders caught in the first year: 9.
- The richest 5% of Canadians own 46% of the nation's wealth.

UNA Files Another Complaint at LRB

by Kris Farkas, LRO

THE CONTENTS OF a document produced by the Alberta HealthCare Association have resulted in a complaint to the Labour Relations Board by UNA.

On April 5, the AHA issued "AHA/UNA Bargaining" which was widely circulated through the hospitals and posted on public and UNA bulletin boards. It is UNA's position that the document contained several misleading and incorrect statements regarding the status of bargaining between the AHA and UNA.

The document stated that UNA was not willing to negotiate monetary issues. This is not true. UNA has requested financial information, as well as information regarding mergers, closures and downsizing, which the employers have constantly refused to provide. Without this kind of information, it is UNA's position that we are negotiating in the dark. In fact, UNA has now won a previous complaint to the LRB (and to the Public Service Employment Relations Board) on the employers' refusal to share information.

The Bargaining Bulletin also states that the longer UNA delays discussion, "the greater the risk of job losses due to mounting fiscal pressure". It is UNA's position that this is a threat to UNA members because a previous complaint has been filed with the LRB [we are still awaiting that decision].

UNA has also alleged that the AHA bulletin misrepresents and misleads employees as to the actual proposals made by the AHA to UNA.

Patient Focused Care:

Just Another Management Fad?

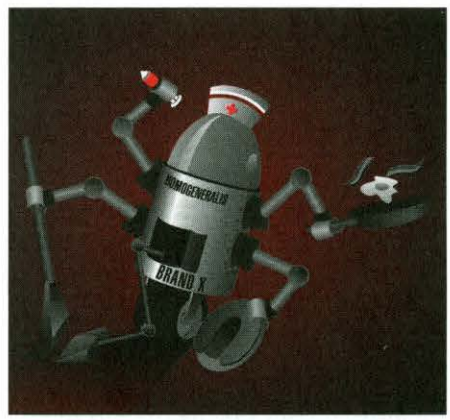
by Trudy Richardson, Education Officer

Has your Nursing Unit Manager been talking about the need to bury the past? Does your employer want its staff to catch the vision and think outside the box? If so, chances are good that patient-focused care (PFC) will be making an appearance in your workplace. In this article, Trudy Richardson explores a management trend newly popular with Alberta's health care employers. According to UNA research, patient-focused care fundamentally restructures the delivery of health care.

IN 1993, UNA presented a series of workshops and produced educational materials on the Total Quality Management programs being developed by consultants and being introduced by employers into Alberta health care worksites. The TQM programs,also know as Japanese-style management programs, had initially been introduced in industrial settings such as car manufacturers and pulp and paper mills. In recent years, many service industries introduced TQM programs in an attempt to reduce production costs. Because the original TQM programs were designed for industries producing goods, the initial applications to service industries were often awkward and ill-fitting. For example, US and Canadian hospitals introduced guest relations programs, shared governance programs and quality care programs and each of these was held out to be the answer for economic instability and worker dissatisfaction. Unfortunately they promised more than they could deliver. One writer described these initial TQM programs as having "the shelf life of cottage cheese."

It was only a matter of time until someone developed TQM programs that seem "services friendly"—shaped around the realities of service production. US consultants are now marketing and setting up trial projects of TQM programs which have been designed specifically for health care worksites. The first of such models was pioneered by Booz-Allen & Hamilton Inc. under the name Patient-Focused Care. It is estimated that the quality initiatives business generates one billion dollars per year for all marketers.

While some people claim that PFC is simply a more sophisticated productivity program than TQM, many analysts say that PFC, with its generic health care workers, technology and its creation of hospitals within hospitals, actually involves a fundamental restructuring of the delivery of health care.



WHY NOW?

The impetus for the development of the patient-focused care model includes general economic conditions as well as some factors specific to the delivery of health care services, and in particular, the delivery of hospital services.

HEALTH CARE COSTS: One critical reason given for the intro-

If any of the following programs are introduced into your worksite, you can be sure that your employer is a patient-focused care convert:

- Care 2001
- Continuum of Care
- Coordinated Care
- Differentiated Nursing Care
- Holistic Care
- Integrated Care
- John Hopkins Professional Practice Contract Model
- New Practice Models
- Organizational Reengineering Partnership
- Patient-Centred Care
- Program Management
- Strategic Process Development
- Worldclass Healthcare

duction of PFC is the dramatic increase in health care costs. While this is a statement that has been given a great deal of media time, the fact is that in Canada our health care spending has remained a constant percentage of our national spending since our health care system was introduced. So if we are spending the same percentage of our income on health care, how is it that we all believe that the costs have sky-rocketed?

One answer is that we have been reading too many American newspapers and magazines and have been watching too many American TV channels. In the US, health care costs have risen as a percentage of spending. And just as the US health care employers have been quick to adopt programs which will reduce rising costs, so, too, Canada's health care employers have followed suit without checking their facts and figures. Real or imagined, the spectre of rising health care costs has driven North American governments and health care employers to adopt money-saving programs such as patient-focused care.

PROSPECTIVE PAYMENT: A second "made in the USA" reason for US health care employers to introduce cost-saving programs, has been the emergence of prospective rather than retrospective methods of payment. In the past, hospitals would itemize all the care given to a particular patient and then would submit a bill to the patient's insurance company. Now insurance companies have decided that they will pre-determine what each procedure is worth and will pay only that amount. It is, therefore, in the best interests of the hospital to drive down the costs of providing care. Although Canada is not faced with the same kind of cost-cutting imperative, we have jumped on the cost restriction bandwagon.

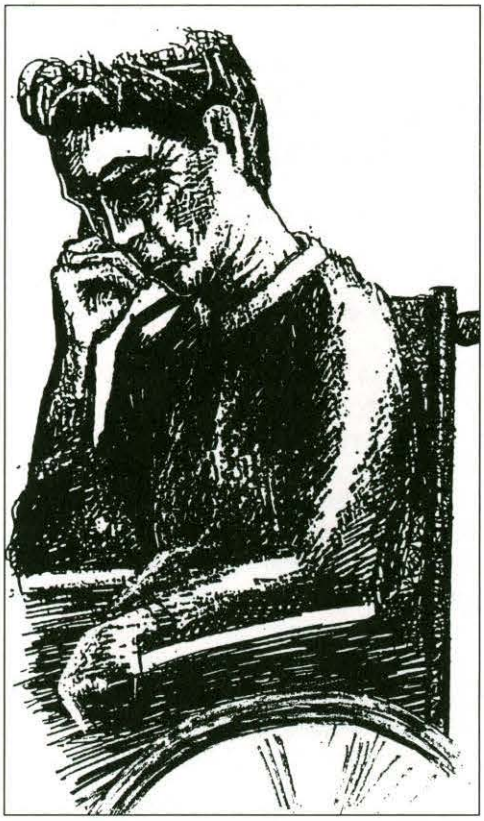
TRANSNATIONALS: When Canada signed the Canada/US Free Trade Agreement and then the North American Free Trade Agreement, the Canadian government promised that we would harmonize our social programs with those of the US and then with those of Mexico. Our social programs no longer stand alone as they are subject to determination on the basis of whether they constitute a an unfair trade subsidy to Canadian business. The transnational corporations now get to lobby trade panels that are deciding whether individual countries can set up and maintain certain social programs.

PRIVATIZATION: The danger of privatization in Alberta grows as a result of the decrease of cash transfer payments from the federal to the provincial governments. At the point where the federal government stops all cash transfers, it loses its ability to force Alberta to abide by the Canada Health Act and the province will be free to introduce user fees, extra-billing and other rationing schemes.

NURSING SHORTAGES: In the late 1980's, there was a shortage of registered nurses. In order to deal with the shortage, employers decided that not all work done by higher-paid workers had to be done by them. Employers have since mounted a drive for the deregulation of health care professionals and the creation of lower-paid and lesser-skilled generic health care workers. Murray Smith, a Calgary MLA, has been mandated to recommend changes to Alberta's Health Disciplines Act. The government is working with colleges to introduce certificate courses for multi-skilled generic health care workers.

It is interesting to note that the accusation that nurses' unions have raised compensation levels beyond the employers' ability to pay, thereby indirectly causing the destruction of the nursing profession is false—Alberta nursing costs, as a percentage of total hospital expenditures, have actually decreased even as nurses' wages and benefits improved.

EMPHASIS ON QUALITY: The provision of quality care has always been a commitment made by nurs-



Patient-Focused Care Glossary

PFC programs have invented a new vocabulary for health care. This vocabulary intimidates the uninitiated and creates the illusion that these programs represent the heights of new thinking, theoretical breakthroughs and management brilliance.

CHARTING BY EXCEPTION: This form of charting is done on the bedside terminals and makes note only of things and conditions which deviate from the care protocol (also known as Chart Thinning).

COMPETITION: Competition is at the heart of PFC. The goal is to become competitive at all levels (including salaries) and to have a competitive advantage over other organizational providers of health care. The costs of running the business must be lower than other health care facilities.

CUSTOMERS: People who are either patients or clients (External Customers) or healthcare providers or management (Internal Customers).

DE-SKILLING: The replacement of highly-skilled workers with lesser-skilled employees. De-skilling is closely linked with the multi-skilling of employees in that as you train other people to do the work of higher-skilled workers, you reduce the number of higher-skilled jobs and deregulate the professions that are based on an exclusive scope of practice.

DECOMPARTMENTALIZATION: This term refers to a central part of the reengineering process. Old structures are said to be compartmentalized, specialized and centralized (these are apparently bad). A reengineered organization would have all processes required by a customer "within reach". For example, reengineered hospitals have placed pharmacy services, diagnostic test services, physiotherapy services, administrative services and operating theatres with each service unit.

DIAGNOSTIC-RELATED GROUPS: A costing technique invented in the US by insurance companies who were losing profits by making large payouts for health care on the basis of fee for service payments. In the old way, a patient was charged by a hospital for all services received. Different hospitals charged different rates. The insurance companies then reimbursed the hospital or the patient. Nowadays, when a patient enters a US hospital, their in-going diagnosis determines what their insurance agencies are prepared to pay for treatment. Thus, in order to make a profit, the hospitals have to find a way to cut their costs. As a result, there has been a move towards replacing higher-paid skilled workers with generic health care workers.

EMPOWERMENT: PFC literature indicates that employees will be empowered by the reengineering process in that they will have decision-making power. What is closer to the truth is that the parameters have already been set—cheaper costs of patient care—and employees are simply asked to work on devising new models of cheaper care.

GENERIC HEALTH CARE WORKER: A type of worker who is partially-skilled in all fields but well-skilled in none (UNA refers to this as homo generalis).

HOSPITAL WITHIN A HOSPITAL: This term refers to the new structure of the hospitals with service units operating independently of one another within the same building.

PROFESSIONAL TERRITORIALISM: The actions of professionals who want to maintain exclusive scopes of practice and the requirement of licensure.

STATISTICS: PFC programs rely heavily upon the use of statistical information. Jobs are analyzed; systems are subjected to minute inspection; and organizational units are scrutinized using computer-generated information. Your employer may advise you that a task analysis, task quantification or statistical process control study is being done.

VARIABILITY: This is the demon in PFC literature. Variability must be hounded and beaten until it no longer exists. Every process should be streamlined and outcomes should be predictable.

VERTICALLY-INTEGRATED REGIONAL DELIVERY SYSTEMS: This term refers to a health care network that is greater than a hospital and includes a consolidated delivery of health care in the community, outpatient departments of a hospital and in the hospital itself. .

es. A program which promises to make the patient the focal point of all activities does not seem strange to nurses. What is strange is the idea that management is only now understanding that all hospital activities should revolve around the patient.

Whether or not "quality" programs have any beneficial impact on the quality of health care is doubtful. Some data indicates that these cost-cutting quality programs have a negative effect on the quality of service.

NEW TECHNOLOGY: New technologies make current practices out-dated. PFC focuses heavily on computers and other technologies which have the effect of reducing long-term staffing costs by eliminating jobs and replacing people with technology.

WHY PFC?

Management theorists contend that the structure, management and performance of North American business originates from a set of principle and assumptions set down in the nineteenth century. As technology, communication, production and marketing changed, the way business took place did not alter. Much has been done to try to "fix" businesses and organizations with automating, downsizing, reorganizing standardizing, centralizing and compartmentalizing, but all such attempts have had the effect of tinkering with the structure without fundamentally changing it. According these management gurus, organizations must reinvent themselves by reengineering. Businesses must bury the past and think outside the box.

Proponents of reengineering frequently present an image of today's worksite as a landscape of functional chimenys built side by side and reaching skyward. There is no lateral or horizontal movement—no one asking "What is it that we are all doing in our chimneys?"

Reengineering is described as a revolution that would change the way work is organized and the way work gets done. Separate tasks would be combined so that an entire work process—the production of a good or a service— would be decided upon, controlled by and performed by the same group of workers in a work environment constructed in response to the needs of that specific work process.

Our health care administrators are being asked which organization they would like to run: a reengineered organization that is flexible, lean, competitive, innovative, nimble, responsive, efficient, customer-focused, quality-centred and profitable or a bloated, clumsy, rigid, sluggish, noncompetititve, uncreative, inefficient, disdainful business that is losing money.

PFC IMPLICATIONS

There are definitely aspects of patient care delivery that are improved under a PFC programs. there are, however also serious implications for nurses and the delivery of safe, high quality patient care.

Research indicates that after an initial outlay of money to renovate current hospital structures to accommodate self-contained, self-sufficient service units, there is a saving of about 10% for the new units. Total hospital space can be reduced by 15-20%. [If our hospitals become privatized, it is anticipated that the taxpayers will bear the burden of renovations before the hospitals are sold to private companies.] The new care teams and flattened management structures require 10% fewer workers, another cost saving. New supply systems and buying patterns account for a 5-10% reduction in operating costs. It is very evident in PFC literature that staff costs in large hospitals can be reduced by millions of dollars after the complete reengineering of facilities and via the use of the 'Homo Generalis' health care worker.

Patients indicate that they experienced less portering and shifting; were not visited by an endless procession of unknown hospital workers and felt they were provided with more continuity of care through the use of assigned care teams.

Employees who are working within a PFC facility report that their job satisfaction had increased, as had overall staff morale. The staff were not asked about their satisfaction with compensation methods; levels of adequate staffing; quality of care when using generic health care workers; absence of licensure and exclusive scopes of practice; and the degree of increased legal liability.

Although PRC programs are touted as producing focused, fast, friendly and flexible patient care, it is hard to believe that a programs which is designed on the basis of substituting lower paid, lesser-skilled personnel for highly-skilled staff can possibly result in better quality of patient care. PFC literature talks about an improvement of quality but doesn't say what the quality was like in the first place.

The introduction of PFC programs has resulted in shorter hospital stays for various illnesses or injuries. [Unfortunately, the insurance companies then decreased the amount of days that they would pay for those diagnoses. This has led to the hospitals having to implement more and more cost-saving practices—a true race to the bottom.] There is no information about the number of readmissions with a complication or the amount of home care that the family has to provide when the patient is discharged. However many of the reduced length of hospital stays is less a result of PFC and more a result of improved equipment and shortened procedures.

Nurses across Alberta should be studying this major initiative of the government and the employers. On a grandiose scale that makes TQM programs look like blips on the computer screen, Patient-Focused Care programs threaten to transform the delivery of health care services to a degree hitherto unheard of. And in doing so, they have as a goal the deregulation and unlicensing of nursing as a profession along with the privatization of Canada's health care system.

For further information about PFC programs and UNA's response to the PFC challenge, please contact your Local Executive, District Representative or Provincial Office.

THE MANITOBA EXPERIENCE

Nicknamed the bounty hunter by members of the Manitoba Nurses' Union, Connie Curran of American Practice Management was hired in Manitoba at a cost of $3.9 million, to save $45 to $65 million by restructuring patient care at Winnipeg's two teaching hospitals. APM, a US consulting firm, is considered to be at the forefront of patient-focused care. The Manitoba Nurses' Union (MNU) has confronted Connie about the health care models she has sold to Manitoba hospital employers. The MNU has talked with nurses from US hospitals where Curran has implemented such programs. These nurses have confirmed that, with the introduction of PFC programs, costs were reduced but always at the expense of patient care, staff morale and job security. Curran advises hospital employers to replace skilled staff with lesser-skilled workers and to reduce the hospital's dependence on highly-skilled professionals through cross-training and multi-skilling. Curran has recently been criticized for failing to reduce the Winnipeg hospitals budgets by the promised amount.

The University of Alberta Hospital recently hired Curran to implement a PFC program at a cost of $2.4 million.

DEFICIT MANIA:
A cure that isn't working

Ed Finn/ CALM

Ed Finn is a research associate with the Canadian Centre for Policy Alternatives.

ARE YOU WORRIED ABOUT government deficits? Do you think they're the result of massive overspending on social programs? Are you convinced that reducing these deficits must now be the nation's No. 1 priority—and that the best way to do that is by cutting back on our "overly generous" and now "unaffordable" public programs and services?

If so, you're the dupe of one of the most effective fear-and-scare propaganda campaigns ever foisted on the people of Canada. You'd have to go back to the early 1930s to find a similar exercise in brainwashing. That was when the same "need" for government restraint was so widely accepted that it prolonged the Great Depression for nearly a decade. Now, in the 1990s, it's deja vu all over again. Already the deficit-cutting obsession, having infected all governments at all levels, has made the first few years of this decade the worst since the 1930s in terms of unemployment and poverty. But there's still no sign that any of our politicians doubt the wisdom of their cost-cutting course. They're stubbornly fixated on tearing apart our social safety net, no matter how much misery they inflict on the victims of their cutbacks.

"This hurts us more than it does you," they glibly tell the hundreds and thousands of men, women and children they're throwing on the economic scrap-heap. And sadly, many of those victims, along with millions of others still clinging to their jobs, actually swallow this excuse. They believe our governments must continue to cut jobs and services, even though such austerity measures are clearly counterproductive.

You'd think we'd have learned a lesson from the nine years of Tory misrule. Between 1984 and 1993, the Tories eliminated family allowances, repeatedly cut UI, and cut billions from medicare and education funding. And yet they ended up with an accumulated federal debt of $500 billion—two-and-a-half times bigger than when they took office!

Let's try an analogy. Let's say you break out in red spots and go to your doctor, and he prescribes pills that he promises will clear your complexion. But a year later, instead of disappearing, the red spots multiply. Your doctor doubles the dosage, but the result is another doubling of red spots. So you go back, and he triples the dosage, and the red spots proliferate yet again.

How long would you rely on that doctor and keep taking his medicine?

Surely there must be a limit to Canadians' gullibility. Surely, after so many years of making the 'deficitis' disease worse, obsessive government spending cuts must be seen as economic quackery, and its peddlers in politics, business, the media and academe as the charlatans they really are.

It's time to change physicians. There are plenty of economists—I can name at least 70 in Canada—who have a much better prescription. It calls for making full employment, not public spending cuts, our top priority.

What these economists contend is that the real deficit we should be addressing is the gap between our potential and actual levels of employment and production. If we tackled that deficit and put people back to work, they argue, we would also get our public debt under control. People with jobs put money into government coffers, instead of taking it out.

Now, if only we had even one government in Canada intelligent enough to toss out that worthless spending-cut nostrum and switch to the elixir of job creation...

User Fees Can Make People Sick

SGEU/CALM

THAT'S WHAT HEALTH economists Glen Beck and John Horne concluded after studying Saskatchewan's experience with user fees.

In 1968, Ross Thatcher's Liberal government imposed a direct charge for a visit to the doctor, claiming it would deter people from making unnecessary trips to the doctor. These "deterrent fees" were removed in 1971 by the NDP government.

User fees caused little change in the total utilization of the Saskatchewan health care system. But Beck and Horne found user fees did change the behaviour of consumers. Their research revealed the elderly and other people on low incomes reduced their visits to the doctor by 18%, while middle and upper-income earners actually increased their visits. Provincial health care costs did not decrease.

Despite this evidence, the Canadian Medical Association, the private insurance companies and some provincial governments continue to call for user fees.

It's no wonder the demand for user fees has been described as zombie-like. No matter how many times the idea is put to death by researchers, it keeps coming back to life.

HEALTH UNIT NEGOTIATIONS

by: Nora Spencer, LRO

GROUP OF SEVEN: Talks with the Group of Seven employers broke off at 1140 hours on April 28 when the employer announced its intention to apply for mediation. Despite the premature nature of this action—the parties had met for only two days—the UNA Negotiating Committee has decided to file a joint application for mediation. Little progress had been made at the bargaining table during the two days of negotiations. The employers remain firm in their demand for a 5% rollback. It was hoped that the mediation process could begin on April 29 (the next scheduled date for bargaining) but no mediator was available. The Group of Seven health units include Leduc-Strathcona, Wetoka, Big Country, Jasper National Park, Minburn-Vermilion, North Eastern Alberta and Vegreville.

ALBERTA WEST CENTRAL: Ingoing proposals have been exchanged at the Alberta West Central Health Unit bargaining table. Bargaining dates have been set for June.

CHINOOK: A 5% rollback is the employer's only ingoing demand at the Chinook bargaining table. May 5 and 6 have been set as further negotiating dates.

LETHBRIDGE: The Health Unit wants a 5% rollback and the elimination of seniority rights in layoff and recall. The parties will meet again on May 9 and 10.

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1-800-667-1379

LETTERS TO THE EDITOR

Dr. L. Douglass
Alberta Association
of Registered Nurses
11620 - 168 Street
Edmonton, Alberta
T5M 4A6

Dear Dr. Douglass,

I am writing to express some concerns I have and to ask some questions you may be able to answer.

I was recently at a meeting in Hanna where the President-elect [AARN] spoke about Direct Access to Services Provided by Registered Nurses. I will not argue that the health care system needs reform and that nurses should be at the forefront of that reform. I also agree that direct access to services may allow nurses their full scope of practice.

However some questions remain.

I was told not to worry about delegation of tasks, that tasks don't define nursing and by delegating them there is no danger to our profession or to our patients. It may not affect nursing practice theoretically but it is certainly affects it realistically. When agencies can, with the cooperation of the AARN, delegate nursing duties to unregulated practitioners, who may be skilled in the performance of the task but are not skilled in the evaluation of its effects on the patient, I worry about the quality of care the client is receiving. In some facilities such as rural health units, these health care workers are delivering care many miles from RN supervision. Does the AARN see any correlation between the development of delegation of tasks and the layoffs of RNs? Since medication and IV courses for LPNs were developed with the help and cooperation of the AARN, do you understand why a large number of nurses question whether the AARN is working to promote the agenda of the provincial government?

The AARN is advocating patient choice in the delivery of care. With the delegation of tasks enabling a reduction in RN positions, will there be true choice if there are no RNs available for the client to choose? Will not cost be the decisive factor? If a client wants an RN for delivery of his/her care but it is determined a lower level of care would be more appropriate, would he still have a choice? The way I read the position statement, the RN would probably bear the brunt of patient choice by being paid less for tasks that could be delegated.

No employer in this day and age will pay you what you are worth just because you ask politely.

Community-based health care sounds great. Who decides what the basic health care services are that each community must provide? Will it be the provincial government? Does the AARN have specific guidelines for basic services? Does each community decide? If so, what happens to comprehensiveness and accessibility?

It seems to me on reading the position statement and in the meeting I attended, that the AARN is moving towards having registered nurses in the function of coordinators of health care, where we will be coordinating and consulting with other professionals in planning and implementing a health care plan for our patients and community. It was presented as what a lot of nurses are doing now and that is true. My concern is with the emphasis of being funded on a contract or a salary basis directly from the provincial government. In the AARN's Position on Increased Direct Access could you explain the sentence on page 59 which states "Most registered nurses are remunerated by salary and it is an appropriate mode of remuneration as long as it is linked to the value of the service." Are you suggesting that some nursing services are worth less than others? Who is to decide what each service is worth? Based on what criteria? Would it be based on the education of the provider or the locale where it is provided, urban vs. rural, ICU vs. medicine, hospital vs. health unit? Would it be based on the skills required? If so, how do you evaluate the worth of the skills required for teaching and supporting breast feeding against those required to work in ICU or a mental health clinic etc.?

The issue of working on a contract basis presents me with some concerns as well. In the questions and answers about the AARN position it is suggested that a nurse or group of nurses offer their services to an employing agency on a contract basis. Will this not lead to nurses competing to put in the lowest bid for a job? Will this not erode the salary levels of nurses? Will this not result in a loss of very hard-won benefits, as they seem to be the first to go?

I was assured that the AARN's position should not be considered "union busting". I am not sure the AARN considers the union at all.

Unfortunately for the solidarity of nurses, I know I am not alone in that opinion. I feel strongly that to say it will be a challenge for the union to protect nurses wherever they are employed while advocating individual contracts shows, at the least, a grave misunderstanding of collective bargaining and the gains brought by collective action. No employer in this day and age will pay you what you are worth just because you ask politely.

Along with restructuring the health care system goes some type of workforce adjustment. If the new emphasis is away from institutions, does the AARN advocate that nurses who are displaced from hospital jobs be given employment in community health care facilities such as health units? What is the AARN doing to limit enrollment in schools of nursing in Alberta? I am concerned that there are recent graduates who have never held a regular nursing position and whose hopes of doing so seem very poor and yet hundreds more are graduating each year.

As you can see, I have a lot of questions. Please don't misconstrue them. I like the concept of direct access to services provided by registered nurses. It would be great to be able to practice the full scope of nursing and I agree that the health of our clients would be better served with multiple points of entry. I do have some very grave concerns for the quality of care due to delegation, for the financial implications to the providers and for the fact that there will probably be fewer registered nurses in the future. The biggest concern is that this is all with the implicit, if not explicit, approval of our professional body.

Sincerely,

Leslie Holm, RN
cc: UNA NewsBulletin

February 21, 1994
Calgary Herald
ATTN: MR. BILL MUSSELWHITE, EDITOR

Dear Sir:

I am writing in response to two letters that appeared in the editorials. One was from Andrea Murphy, RN. re: *"Bumping should be protested"* and the other by David Lawson, M.D. *Nursing care quality sliding* (Feb. 16/94).

As a nurse and as a representative of United Nurses of Alberta, I wish to address both the bumping provisions in our collective agreement and the comment that quality care is sliding. The bumping provisions in UNA's collective agreement with the employers was ratified by the nurses and the employers who are party to it. Bumping occurs to ensure that nurses who have seniority maintain a job and that only the least senior nurses are laid off when there are no jobs. Seniority is a sacred provision that provides security of a kind for nurses who have dedicated time to an employer.

I feel angry when I hear people (including nurses) complain about the bumping provision on the grounds that it causes "incompetent" nurses to take their jobs. For many other reasons I can understand nurses not wanting bumping - but because another nurse who has the same nursing license with all the legal rights to work ANYWHERE as a nurse, as well as with the same basic nursing program as themselves, chooses their job, is NOT a reason to complain.

For some reason some nurses, doctors and the employers feels they must blame the nurse for not knowing the job or not being "job ready" when she enters a new area of work. Interesting how no one complains and blames the nurse when she/he is newly hired into the workplace or when she/he transfers into a new job. The reason they don't is because during those times the nurses who worked on the unit were willing to give of themselves to assist the new nurse and the management provided the proper orientation they are obligated to give. Now, everyone blames and criticizes the nurse because her colleagues are overwhelmed with the increasing acuity and patient workloads; because the doctors no longer have the handmaiden service they once enjoyed; and because the management has chosen to violate the contract and not provide the orientation that they are legally bound to provide.

Let's put the responsibility where it belongs.

Quality care is a universal requirement that requires everyone in the health disciplines to provide. Our patients deserve no less. As a nurse I see the devastating effects of the cutbacks on "quality care". But I most certainly don't blame myself for it. So why does it all come down to blaming the nurse and/or the union? Is it because they are easy scapegoats? In times of great turmoil as we are facing in health care, why must we blame the nurses who are working their hearts out to provide the care they know the patients need? Why must nurses blame each other? I'll tell you why. Blaming each other is far safer and easier than putting the responsibility squarely where it lies – with the politicians and with employers. Come on folks, let's put the responsibility where it belongs!

Yours truly,

Ms.Terry Robertson, RN.
SCD Representative, UNA
cc: UNA NewsBulletin

Pensions Committee Update To Locals

THE PENSIONS Committee is attempting to deal with motions from the 1993 AGM, in particular Motion #99 and Motion #147.

Motion #99 states:

"That United Nurses of Alberta lobby the government for the appropriate legislative changes to the Local Authorities Pension Plan with the intent to allow all employees to enter into or exit out of the Plan at their request."

Motion #147 states:

"The Pensions Committee shall proceed with a supplemental Pension Plan for our members. The Pensions Committee will continue to investigate companies who offer these services, and will recommend one company to provide the services to UNA. This company will make a presentation to the Executive Board at the May 1994 Executive Board Meeting and the Pensions Committee will report to the 1994 Annual General Meeting before a committment is made."

It is felt by the Pensions Committee that Motion # 99 creates somewhat of a dilemma for us at this time. On the one hand, it is an AGM directive for the Pensions Committee; but, on the other hand, the committee feels that it would be risky and dangerous to lobby for legislative changes until there is something in place for those who choose to opt out of the Local Authorities Pension Plan. In the meantime we are continuing with the investigation of a supplemental Pension Plan for the members of U.N.A. and are very close to selecting a company. We will be making a recommendation.at a later date.

It is also important to note that, at present, all employees, do not have an option to opt out of Article #29 in our collective agreement. Article 29 states that the Pension Plan is mandatory for full-time, optional for part-time and not an option at all for casuals. The question of the Pensions Committee to the members is: How do the members feel about this issue; and what further direction from the members can be given to the committee? Would we not be, in essence, "taking away" by now lobbying for changes to something that was successfully negotiated in our collective agreement?

To assist the Pensions Committee, we recommended to the February Executive Board Meeting, that discussion should take place on this issue in each District at the next scheduled District Meeting and the committee be provided with feedback.

If you require further information on this issue, or would like to share your comments please do not hesitate to contact one of the following:

Richard West (L.R.O.) 425-1025

Val Holowach (NCD Rep) 992-0360

Thomas Kinney
(NCD Rep) 458-0316

A RAY OF HOPE

continued from page 2

ernment and employers to alter professional and labour legislation pose significant threats to our union and to our profession.

As this edition of the NewsBulletin goes to print, the new deal for physicians has been announced, the details of which will be provided to Local Presidents. I note that physicians have been assured of funds for early retirement and severance packages. Why won't the government provide the same for nurses?

Community and political action is imperative.

- Wear a registered nurse/registered psychiatric nurse pin, so that your patients/clients/residents and their families know they are receiving care from a skilled provider.
- Post "Stop the DeKlein of Health Care" posters. (Available from Provincial Office on request.)
- Call or write to your MLA with your concerns.
- Call or write to Alberta's Minister of Health, Shirley McClellan, with your concerns.
- Call or write to the federal Minister of Health, Diane Marleau, to indicate support for federal initiatives to preserve medicare.
- Talk to your neighbours, friends, family, church or community groups to make sure that they are aware of what is at stake. Encourage everyone to defend health care in Alberta.

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Everything Old is New Again?

Job Description of Bedside Nursing 1887

In addition to caring for your 50 patients, each bedside nurse will follow these regulations:

1. Daily sweep and mop the floors of your ward. Dust the patient's furniture and window sills.
2. Maintain an even temperature in your ward by bringing in a scuttle of coal for the day's business.
3. Light is important to observe the patient's condition. Therefore, each day fill kerosene lamps, clean chimneys and trim wicks. Wash windows once a week.
4. Each nurse on duty will report every day at 7 a.m. leave at 8 p. m. except on the Sabbath, on which day you will be off from 12 noon to 2 p.m.
5. Graduate nurses in good standing with the director of nurses will be given an evening off each week for courting purposes, or two evenings a week if you go to church regularly.
6. Each nurse who smokes, uses liquor in any form, gets her hair done at a beauty shop or frequents dance halls, will give the director good reason to suspect her worth, intentions and integrity.
7. Each nurse should lay aside from each pay day a goodly sum of her earnings for her benefits during her declining years, so she will not become a burden. For example, if you earn $30.00/month, you should set aside $15.00.
8. The nurse who performs her labors, serves her patients and doctors faithfully and without fault for a period of five years, will be given an increase by the hospital and administrator of five cents a day, providing there are no hospital debts that are outstanding.

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