Lose/lose: "The Windsor Star"'s coverage of local hospital restructuring (Ontario).

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LOSE/LOSE: THE WINDSOR STAR'S COVERAGE OF LOCAL HOSPITAL RESTRUCTURING

by

Andrea Neufeldt

A Thesis
Submitted to the Faculty of Graduate Studies and Research through the Department of Communication Studies in Partial Fulfilment of the Requirement for the Degree of Master of Arts at the University of Windsor

Windsor, Ontario, Canada

1998
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ABSTRACT

The media have been traditionally championed as the cornerstone to democracy. News is supposed to provide citizens the information required to participate in the formation of social policy. However, political economists of communication have shown that the agenda of the corporate media in a capitalist society severely compromise the public sphere. These theorists contend that the media manufacture consent for neoliberal policies that benefit the corporate world. This thesis attempts to demonstrate how a particular newspaper has aligned itself ideologically with the neoliberal agenda by privileging a certain version of reality.

In particular, this is a case study of The Windsor Star’s coverage of local hospital restructuring. In 1994, the local District Health Council (DHC) released its restructuring plan. The Win/Win model proposed closing two out of four local hospitals and the removal of 540 hospital jobs. To make up for the loss of service and jobs, the community sector was to be enhanced. At the time, the provincial NDP government agreed to the plan and promised funding for its implementation. A year and a half later, the Progressive Conservatives were elected and eventually reneged on the promised funding levels. As a result, the quality of local health care has plummeted.

The Windsor Star has neglected to thoroughly analyze the original Win/Win plan which represented a cut to the services previously available to the community. There was also evidence that local health officials were less than committed to some of the promises contained within the report. Despite this, the newspaper endorsed the plan and omitted
discussion of possible alternatives. Moreover, as the provincial Tories and the federal Liberals have continued to remove more and more money from the system, *The Windsor Star* legitimated these governments’ actions as it has promoted the neoliberal claim that our social programs are not affordable. Voices who oppose these ideas have been marginalized, appearing in the newspaper coverage only sporadically. As a result, our local newspaper has effectively manufactured consent for the quiet erosion of our public health care system in favour of privatization.
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1. Public health care is too costly and ultimately may have to be
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2. Win/Win is the best possible plan for Windsor/Essex County facilitated by the best efforts of our government and health care officials.

3. The "few" jobs that will be lost as a result of restructuring are merely due to the unfortunate "reality" of the times.

4. Opposition to the Win/Win plan represents a terrible threat to our health care system.

5. The Federal government has very little to effect on the local restructuring.

Creating Solutions

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VITA AUCTORIS
CHAPTER 1 - INTRODUCTION

On May 3, 1937 Windsor, Ontario made history. Together with the CAW, a group of local physicians developed a non-profit health insurance plan that would allow residents greater access to health services (Windsor Medical 1965:8 and Walter 16 January, 1998). Windsor Medical Services Inc. was implemented at a time when momentum was gathering toward a welfare state that would protect the public from the harsh economic conditions experienced during the Depression. The insurance plan was the first of its kind in the country and was successful in providing many residents with access to health care. By 1965, the plan was used by 78 percent of local citizens (Windsor Medical, 1965: 8).

In the 1990s, Windsor's health care establishment has found itself in the precedent-setting position once again. However, the initiatives that the area is now undertaking are quite different from those of the 1930s. Instead of developing progressive plans for local health care, the community is leading the way in the undermining of our public health care system. Windsor/Essex County has taken the unusual step of developing its own health care restructuring plan in response to pressure from the provincial and federal governments to cut costs. The health care establishment has tried to sell the restructuring model to the community as one that would mean Windsor is on the cutting-edge of health care modifications for the 1990s. Dr. Paul Ziter, member of the Steering Committee which developed the restructuring plan declared: "if people have will and a little bit of ingenuity they can still pull this off. We're still light
years ahead of other communities" (Ford, 19 October 1995).

And indeed, it seems the community is leading the way. However, the trail it is blazing is headed for disaster. The "restructuring" has meant the removal of tens of millions of dollars and hundreds of hospital employees. As a result the quality of care has been severely compromised. There are reports of patients waiting days for a hospital bed (Pellerito, 8 September 1997; Jarvis, 22 January 1997 and Jarvis, 14 February 1997). Family members are expected to be available to help out in hospitals. If they are unable to do so, they risk the health of their loved ones as fewer and fewer hospital employees are required to take on the care of more and more patients (DeBellis, 16 January 1998). Our local hospitals have resorted to such measures as tying patients to chairs to ensure their safety as there are not enough health care workers to monitor patients at all times (Pellerito, 8 September 1997). Moreover, there have been cases of deaths occurring in local emergency rooms because of overcrowding and under-staffing which have been undocumented (Brennan, 4 July 1997).

Although Windsor/Essex County has become a leader in restructuring, other communities in the province and across the country have experienced similar effects of government cutbacks. The result is what can accurately be described as a crisis in our health care system. As governments claim that they must cut spending or risk financial disaster, our hospitals and other health services have been the victims of severe budget cuts. Polls have revealed that Canadians are in overwhelming support for public health care. There is also evidence that social programs have made little contribution to government debts. Despite this, our medicare system, along with education and welfare,
has been targeted as a means of resolving "excessive" government spending. The local health care system is indicative of the impending collapse of an integral component of the Canadian social safety net.

How did we arrive at this state? How did our health care system become so crippled that reports from even the Ontario Ministry of Health have described Windsor's emergency rooms as "hopelessly inadequate, inefficient and unsafe" (Cross, 12 September, 1997)? While it may seem that this crisis has arisen only very recently, there were many precursors to the situation we are experiencing today. This thesis attempts to shed some light on the current crisis in Windsor/Essex County's health care system and the events that led us here. In particular, this study examines the role that The Windsor Star played in the legitimation of neoliberal initiatives that have contributed to the erosion of our public health care system.

The Win/Win Model

Late in 1994, the Ontario NDP government gave its seal of approval to a hospital reconfiguration plan put forth by the Windsor District Health Council (DHC). The Win/Win model was precedent-setting in that the DHC had formulated its own model for reconfiguration before government cutbacks could dictate the closure of hospitals. No other health care community had taken such a proactive step. Knowing that funding would continue to decline, the DHC recommended the closure of two of its own hospitals and the up-grading of community-based services.

In some respects this initiative may have seemed prescient, but the election victory
of Ontario's Progressive Conservative party in June 1995 meant that it would not be implemented. During the campaign Harris vowed to maintain funding levels for health care saying: "I will not lead a government for which health care is not anything but a priority spending area. That's the No. 1 commitment that we make to health care" (Brennan, 19 October 1995). One should note the double negative in this proclamation. It seems that Harris has really promised that health care will not be a priority. Whether this is a case of poor grammar or an underhanded way to state his true intentions, we will never know. But the Progressive Conservative candidate for Windsor-Sandwich, Joe Durocher, did claim that the Tories were in support of restructuring initiatives: "the PC policy is to support restructuring done by local communities" (Ford, 7 June 1995). This gave some Windsorites the impression that Harris would support the Win/Win model in principle and more importantly, monetarily.

Despite such election promises, Harris would not honour the agreement on the levels of funding negotiated with the NDP government. The former government promised the community over $100 million to rebuild hospitals and said that Windsor could keep the $22 million saved annually from the restructuring. Only five months after the 1995 election, the Harris government made it clear that Windsor would not receive the previously agreed level of funding from the new government. The Tories refused to allow the savings from hospital closures to fund the planned enhancement in the community sector. While the Ministry of Health said that there would be capital funding for hospital restructuring, it was very slow to pledge any specific amount. Eventually, after approximately two and a half years, the Health Services Restructuring Commission,
(HSRC), finally recommended that the community be given $103 million to go toward hospital reconfiguration (Cross, 13 February 1998a). However, upon close inspection of the HSRC's report, it has become clear that the Commission's allocation of funds across the various programs will not resolve the present shortages (Walter, 26 March 1998). This would only intensify the problems that had erupted because of funding cuts implemented by both the provincial and federal governments over the past few years.

It should be noted that the foundations of the Win/Win model were questionable to start. The DHC remained true to the neoliberal prioritization of debt-management. In the report, its authors admit that maintaining social programs as they are is not feasible in light of federal and provincial deficits (SCR, 1994:22). Such notions presume the "necessity" of the current trend in downloading and cuts in transfer payments. This reflects what Linda McQuaig refers to as "deficit pornography" (McQuaig, 1995: 4). By this she means the obscene amount of linkage in the media between debt and deficit levels and social program spending. As we will see in Chapter Six, this line of reasoning has been adopted by The Windsor Star in its coverage of local hospital restructuring through the persistent proclamation that hospital cuts are necessary to avoid the financial ruin of the province.

While Harris may have escalated the erosion of our health care system, the momentum toward this had been building for years. A political economic analysis will reveal the roles neoliberal initiatives have played in the lead up to and in the current disaster. Such factors include the historical development of medicare, the actions of the "Liberals" of the federal government, the deficit hysteria, the victory of the Progressive
Conservatives of Ontario, and the role of the local political and economic and health care establishment.

The Role of *The Windsor Star*

What is most important to this analysis is an examination of how the local media legitimated all of this. Edward S. Herman (1988), Noam Chomsky (1988), James Winter (1992 and 1997) and others have all shown how the mainstream media legitimate and manufacture public consent for policies that suit the interests of the elite minority. If this is true, this should be reflected in *The Windsor Star*’s coverage of local hospital restructuring.

In particular, Winter has developed several "truisms" that are promoted through the mainstream media as common sense. These truisms are the assumptions that inform Media Think - a sort of indoctrination that arises out of a socialization process that begins at birth and leads to the widespread acceptance of neoliberal ideology (Winter, 1997: 114). These "truisms" are presumptions that serve to extend the neoliberal agenda to the realm of public interest. They are repeated so often without mention of alternatives so that they seem to be mere facts. However, they are wholly disputable. In fact, Winter purports that all but one of the fifty-four truisms that he has illustrated are false despite their promotion as the truth (Winter, 1997: 120). The result is that the assumptions of the neoliberal agenda have been accepted in the mainstream as a sort of conventional wisdom (Winter, 1997: 114). Thus, the promotion of these truisms and their subsequent acceptance as common sense are one of the means by which the media manufacture
consent for the pursuit of the interests of the capital class.

This thesis provides an analysis of the discursive strategies used by The Windsor Star in reporting on hospital restructuring. This coverage was compared to interviews done with five social activists who have been involved in the restructuring process. These interviews were integral to my analysis as they provided an alternative perspective to what was printed in the local newspaper. The result was the development and examination of the truisms that have been promoted by The Windsor Star that are specific to this case study. In particular, I have developed and analyzed five truisms that were consistently promoted by the newspaper during the past four years of coverage. The result is a critique of how the neoliberal conversations are translated into representations of public interest. In the virtual absence of alternatives to the "restructuring" efforts applauded by The Windsor Star, this seems to be the only option and thus has legitimated the erosion of our public health care system in the name of reducing deficits which has ultimately resulted in the privileging of privatization.

Purpose

The purpose of this research is to examine the means by which the mainstream media, in particular The Windsor Star, represent the neoliberal agenda as a reflection of public interest. In so doing, the analysis of the promotion of these truisms demonstrates the manufacture of consent which is integral to political economic studies in communication. Thus, this case study attempts to illustrate the means through which the power relations of the structures of capitalism are preserved and extended by the
mainstream media through a promotion of elite interests and a simultaneous marginalization of alternative voices. Specifically, I will attempt to answer the questions that have guided my study: What versions of reality are constructed by the local newspaper concerning the health care restructuring issues in Windsor/Essex County? Specifically, what are the "truths" that have been promoted by The Windsor Star and whose interests do they serve?

In the end, I hope that this study will extend the discussion of local hospital restructuring beyond what has been present in local media coverage. Furthermore, an analysis of this sort is important in developing a critical evaluation of The Windsor Star's role in our community. Beyond this, I hope that it will speak to broader issues regarding the mainstream media's role in the current attack on social programs including education and health care and ultimately democracy itself. Therefore, the case study will be contextualized within a broad political economic perspective on the news media.

Outline

Chapter Two argues for a critical political economic analysis in the place of neoclassical analyses that predominate in the mainstream. Like Adam Smith, neoclassical economics privileges the free market. However, mainstream economics has excluded Smith's commitment to a moral philosophy which led him to a critical analysis of capitalism and the power relations that can develop in a this system (Smith, 1776/1993: 78, 268, 351, 386). In neoclassical economics, Smith's moral philosophy and political economic approach has been displaced by a commitment to objectivity, thereby
effectively insulating the discipline from consideration of the political ramifications of its findings. I argue that a political economic analysis is required so that the power relations that are afforded by the free market system can be properly examined to expose the inequality that is legitimated by the mainstream media who promote this free market system.

Chapter Three provides a political economic analysis of the development of medicare. It reveals how the establishment of a public health care system in the Canadian welfare state was delayed because of the demands of elite groups such as doctors and insurance companies whose interests favoured a private system. The chapter provides a historical context for the current situation, revealing the contemporary developments as extensions of a long-standing debate.

The rise of neoliberalism that has occurred over the past 20 years is examined in Chapter Four. In particular, I have examined how the mainstream acceptance of the neoliberal agenda has affected the health care system across the country. This chapter extends the context developed in the previous one and focuses on the role of the federal government in the current and local situation.

Chapter Five examines the local developments over the last four years. An analysis of the Win/Win model itself and its formulation is provided to reveal the neoliberal interests that seem to have lurked behind the restructuring project. The chapter then brings the restructuring efforts up to date, detailing the lead up to the current disaster.

Through a political economic analysis of The Windsor Star's coverage, Chapter
Six establishes five truisms that speak directly to this case study. The analysis of these truisms reveals the newspaper's role in the erosion of our health care system. Essentially this examination shows how this mainstream medium has worked to close off alternatives to the neoliberal agenda, promoting a narrow ideological view of the world that privileges privatization.

In Chapter Seven, conclusions are formulated about the case study in the political economic context developed in previous chapters. In particular, I provide a commentary on how the truisms speak to the foundations of neoclassical economics and the resulting neglect of a moral philosophical approach in the development and promotion of policy initiatives. I take the opportunity here to provide some rudimentary ideas for solutions and offer direction for further research.
CHAPTER 2 - NEOCLASSICISM VS. POLITICAL ECONOMY

Adam Smith and Neoclassicism

Adam Smith's 1776 work Wealth of Nations has dubbed him the "intellectual father of laissez-faire capitalism" (Henry, 1990: 46). The Wealth of Nations was a comprehensive analysis of the free market society that was developing on the edge of the industrial revolution. The fundamental philosophy of his vision of capitalism was based on the premise that the freedom was a prerequisite for the improvement society. This work provided the framework of assumptions upon which neoclassical (mainstream) economics was built. In particular, three basic assumptions of Smith's work have found their way into the fundamental premises of contemporary neoclassicism. Reification of the market, methodological individualism and harmony were all cornerstones to Smith's version of a capitalist society. These concepts have been adopted by current mainstream economists (Babe, 1995: 53).

Smith argued that the free market was superior due to its character as a natural phenomenon, essentially reifying the construct of the market. Smith went so far as to say that humans themselves were naturally predisposed to the functions of a free market. He described people as having an innate propensity to truck, barter and exchange (Smith, 1776/1993: 22). Not only was the market considered a natural phenomenon in the sense that it grew out of an inherent human characteristic, it was described by Smith as a being unto itself - a sort of naturally occurring organism acting in a balance of cause and effect. If left to its own devices, the free market would naturally carry out economic interactions. Smith, and neoclassical economists following him, have thus come to describe this system
as innately superior. Likewise, the Chicago School, representing a group of economists who have been greatly influential in contemporary, mainstream economics, accepts Smith's thoughts on the natural superiority of the free market system. These economists describe the market as representing the most efficient and equitable means of organization for human activity. In such organization, "optimal allocation of resources and the highest levels of economic welfare" are thought to be the result (Samuels, 1976: 9).

Through this system, Smith promoted the market regulation of wages, profit, prices, employment and rent. According to Smith, justice could not be found in a regulated market. Interference with the natural liberty of the market violated the natural liberty of man and was therefore unjust (Smith, 1776/1993: 330). Thus, the capitalist system would severely limit government regulation. However, there would be specific areas better served by the public sector. Smith argued that the duties of government should be confined to protecting one society from another and citizens against injustice and oppression and establishing certain public works and institutions which would not generate profit for private individuals (Smith, 1776/1993: 392). The Chicago School adopted Adam Smith's reverence for market regulation. For example, Milton Friedman, (probably the most well-known member of the Chicago School), contends that government should be confined to: protecting citizens from the threats of other countries, preserving law, enforcing private contracts and fostering competitive markets (Friedman, 1982: 2). While Smith's vision of capitalism was more interventionist than modern day economists, he did advocate that government intervention be confined to specific areas. The limiting of governmental responsibilities has been adopted by neoclassical
economists. However, neoclassical economics take this to an extreme. These neoclassicists have vehemently promoted the acceptance and maintenance of private enterprise so much so that it can be said that these economists "concentrate their attack almost entirely on government intervention" (Miller, 1962: 65).

Smith also prescribed methodological individualism as a means to national economic success. For Adam Smith, individual wealth represented the route to national prosperity because the economic status of a nation was determined by the summation of the prosperity of individuals (Babe, 1995: 53). Thus, it followed that government regulation that impeded the market freedom of the individual impeded societal wealth:

The natural effort of every individual to better his own condition, when suffered to exert itself with freedom and security, is so powerful a principle, that it is alone and without assistance, not only capable of carrying on the society to wealth and prosperity, but of surmounting a hundred impertinent obstructions with which the folly of human laws too often encumbers its operations...(Smith, 1776/1993: 336).

Like Adam Smith's analysis of capitalism, neoclassical economics embodies the promotion of individual freedom as a prerequisite to prosperity. Utility theory was developed at the turn of the century and is still used as the basis for most mainstream economics (Henry, 1990: 227). This theory demonstrates the neoclassical preoccupation with the individual through its examination of market relations in terms of exchange relations rather than relations of production. Accordingly, the individual's relationship to commodity becomes the essence of theory while social relations between classes become non-existent or of little concern.

Given such a foundation, social relations - those among people or classes - disappear, or, at best, are reduced to a second order of importance and occupy
a peripheral existence in the scheme of things. In fact, this individualist, non-social relationship is held to be essential for a proper understanding of economics altogether (Henry, 1990: 227).

Milton Friedman is perhaps most obviously representative of the neoclassical preoccupation with the individual. His work is premised on the belief that individual freedom is the most important aspiration of any society (Friedman, 1982: 1). The largest threat to this freedom is government intervention because this assumes society is defined as a collective rather than a compilation of individuals. According to Friedman then, the scope of government must be limited to preserve the freedom of individuals (Friedman, 1982: 2).

Harmony was also an essential aspect of Adam Smith's capitalist economy. The combination of the division of labour and individual self-interest resulted in the harmonious relationships of capitalist society (Babe, 1995: 56). The division of labour grew out of the natural human propensity to truck, barter and exchange (Smith, 1776/1993: 20). According to Smith, we cannot depend on the benevolence of others to provide us with our wants and necessities so we must offer something in return (Smith, 1776/1993: 22). Thus, labourers were able to afford necessities and conveniences because they had a great amount of work to dispose of in return for these goods (Smith, 1776/1993: 22). The self-interest of employers to secure more capital resulted in their need for employees who could heighten production. On the other hand, the self-interest of employees to secure the goods they wanted was facilitated by the division of labour that allowed them to exchange their work for these goods (Babe, 1995: 56). The result was an apparent harmony of interests between the two classes.
Utility theory of neoclassical economics assumes similar harmonious relations between members of a capitalist society. As discussed above, this theory is based on exchange relations. 'Exchange' implies a voluntary relationship of common interests. For neoclassicists, such relations are not coercive ones where one party has considerable influence over another. The common interests of the parties result in a harmonious relationship (Henry, 1990: 155). While some neoclassicists acknowledge the possibility for the breakdown of harmony between parties, they purport that such conflicts can be solved by the market (Babe, 1995: 56).

Likewise, neoclassical economist George Stigler of the Chicago School even argues that the market accommodates consumers and that they have effective control over resources. He does not entertain an analysis of exchange relations that critiques the power afforded to the producers in the free market. "...Consumers generally determine what will be produced and producers make profits by discovering more precisely what consumers want and producing it cheaply" (Stigler, 1982: 57). He discounts the potential of advertising in creating a coercive relationship in this exchange when he explains that the fact that he lives in a house instead of a tent is not due to "the comparative advertising outlays of the two industries" (Stigler, 1982: 57).

The Neoclassical Departure from Adam Smith

While neoclassical economists have adopted some of Smith's core premises for a capitalist economy, much of the assumptions that grounded his work are not found in contemporary mainstream theories. Smith's earlier work demonstrates the chasm
between the two visions of capitalism. The *Theory of Moral Sentiments* was a moral
treatise which introduced Smith's contempt for greed that was later echoed throughout the
*Wealth of Nations*. In large part, he focused on the human capacity of sympathy as
integral to human relations. According to Adam Smith, although we are often
preoccupied with our own interests, we should not pursue them at the expense of the
happiness of others:

There can be no proper motive for hurting our neighbour...To disturb his
happiness merely because it stands in the way of our own, to take from
him what is of real use to him merely because it may be of equal or more
use to us, or to indulge, in this manner, at the expense of other people, the
natural preference which every man has for his own happiness above that
of other people, is what no impartial spectator can go along with (Smith, 1890: 26).

According to Smith, self-love was contemptible in so far as it caused the
exploitation of the weaker class. However, self-love was also the characteristic that
allowed one to exploit the market and gain prosperity - something that he argued would
lead to the wealth of nations. For Smith, self-love was paradoxical. On the one hand it
promoted prosperity of individuals and on the other it could lead to the dominance of elite
interests at the expense of the less powerful.

Although Smith realized that there were opportunities for greed in his capitalist
system, he saw the market as a remedy for this. Instead of regarding the free market as a
system which fostered such greed, Smith would argue that for the most part, the market
helps to diffuse it. However, this remedy was not complete without the application of
*moral sentiments* (Babe, 1995: 83). He saw selflessness as the pinnacle of human
behaviour:
And hence it is, that to feel much for others and little for ourselves, that to restrain our selfish and to indulge our benevolent affections, constitutes the perfection of human nature, and can alone produce among mankind that harmony of sentiments and passions in which consist their whole grace and propriety... (Smith, 1890: 29).

In accordance with his commitment to these moral sentiments, Smith was sympathetic to the working class and recognized that the free market provides opportunity for the rich to exploit the poor. He argued that such exploitation should be replaced by the unique balance of self-love on the one hand and moral sentiments on the other. For example, Smith argued that it would not serve upper class interests to oppress the lower class because it was the work of the lower class that sustained the upper class (Smith, 1776/1993: 386). Thus, it was through self-love that the upper class should restrain its oppression of the lower class. Moreover, Smith pursued a vision of relations between these classes that was based on “[t]he establishment of perfect justice, of perfect liberty, and of perfect equality, [which] is the very simple secret which most effectually secures the highest degree of prosperity to all three classes” (Smith, 1776/1993: 386).

For Smith, capitalism had to incorporate the ideals of justice, liberty and equality to quell the free market’s facilitation of greed. Through these ideals, prosperity would be rewarded across classes. On the other hand, neoclassical economists have foregone the values of justice and equality in favour of the isolation and solidification of elite classes:

Far from viewing markets as devices to deconcentrate power and foster equality, neoconservatives put forth [the] Market as neo-Darwinist Mechanism, rewarding the strong, powerful and efficient, and eliminating, never mind the suffering and power concentrations that ensue. Elimination of the weak, to neoconservatives ensures evolutionary progress (Babe, 1995: 74).
Smith's disdain for monopoly capitalism illustrated his concern for the distribution of wealth across classes (Smith, 1776/1993: 351). According to Smith, a monopoly kept the market constantly under-stocked so that demand was high and accordingly, so were prices thereby restricting access to the market to the monied class. On the other hand, the system of competition kept prices at their lowest (Smith, 1776/1993: 60). Thus, free competition did not secure obscene profits for the capital class and simultaneously ensured that the lower class could afford access to the market.

Neoclassical economists outright dismiss the very possibility of monopoly under a free market system. The result is that neoclassical economists carry Smith's optimism for capitalism to a higher level, avoiding a critical examination of class structure.

...it is virtually impossible to eliminate competition from economic life. If a firm buys up all of its rivals, new rivals will appear. If a firm secures a lucrative patent on some desired good, large investments will be made by rivals to find alternative products or processes to share the profits of the first firm. If the state gives away monopoly privileges (such as TV channels), there will emerge a strong competition in the political area for these plums (Stigler, 1988: 164).

When addressing the issue of monopolies, these economists draw from Smith's vision of the harmonious market. Their assertion of harmony through the free market means that they dismiss the class tensions that develop under a capitalist system. Thus, they falsely promote the free market system as a non-power society.

Smith promoted equality between classes at a time when many were openly against it by suggesting the increase of the wages of labourers. The elite class thought that increasing the wages of the poor would raise the workers' expectations about their standard of living. Upon doing so, the elite worried that these labourers would never
again tolerate the meagre levels of subsistence they had known before. In response to this, Smith argued that increased wages should never be considered an inconvenience because the condition of the majority determined the condition of society (Smith, 1776/1993: 78). Such sentiments, when coupled with Smith's optimism for the market revealed a two-sided concern - that for public good and for individual freedom.

Like Adam Smith, neoclassicists are committed to promoting individual freedom. Public good may be touted as a by-product of this but they are very careful to refrain from violating individual freedom in the name of public good. Neoclassicists resist looking at society as a collective. Instead, a society is made up of individuals (Friedman, 1982: 1). Accordingly, Milton Friedman argues that prosperity is a matter of individual will. Those who live in poverty are in that position because they did not have the determination to better their life. Friedman purports that much observed inequality is not really inequality at all. Instead, differences in income reflect differences in occupations chosen by individuals on the basis of their taste for uncertainty. Therefore, those in low-paying jobs simply lack a drive to take the risks required to improve their situations (Friedman, 1982: 162). For Friedman, and other neoclassicists, the possibility that poverty stems from a lack of opportunity available to marginalized groups is not considered. For these economists, poverty is better explained as individual cases of a lack of ambition.

Furthermore, Friedman claims that such individual freedom allowed by the tying of government hands leads to the "variety and diversity of individual action" (Friedman, 1982: 4). Thus, national standards are inferior to individual accomplishments:

At any moment in time, by imposing uniform standards in housing, or nutrition, or clothing, government could undoubtedly improve the level
of living of many individuals; by imposing uniform standards in schooling, road construction, or sanitation, central government could undoubtedly improve the level of performance in many local areas and perhaps even on the average of all communities. But in the process, government would replace progress by stagnation, it would substitute uniform mediocrity for the variety essential for the experimentation which can bring tomorrow's laggards above today's mean (Friedman, 1982: 4).

It becomes clear in this passage that Friedman is willing to forfeit the improvement of living standards for the many in favour of improving the living standards for the few. Friedman's standpoint along with other neoclassicists is elitist its disdain for uniformity found in standards that may improve the life of many.

Smith was clearly optimistic about capitalism and unlike modern neoclassical economists, he celebrated its potential for promoting an equal distribution of resources and a decentralization of power. His use of moral sentiments led him to intermittent meaningful commentaries on social justice and equality which are absent in the work of neoclassical economists. However, in his optimism for the system of private enterprise, he fell short of a comprehensive critique of the class structure that develops in a system of market liberty.

What is absent from both Smith's commentary on capitalism and neoclassical analyses is a broad critical approach. While Smith was critical of the concentration of wealth and power, he saw capitalism as part of a cure for this and neglected a necessary discussion of how capitalism may indeed foster the concentration of wealth and power. Neoclassical economics commits a greater offense in refusing to approach the issue of power at all. While Smith may have provided some of the underlying assumptions to neoclassicism, perhaps a greater influence was its development as a "science" and the
resulting disregard for the role of power.

The Development of Economics in Place of Political Economy

While neoclassical economists have adopted some of Smith's ground-work, they have left behind his moral philosophy as discussed above. In part, this philosophy has been displaced by a commitment to economics as an objective science, thereby effectively insulating the discipline from consideration of the political ramifications of its findings. The tradition of economics, as exemplified by Smith's writings had historically considered polity as influencing economics and vice versa. Mainstream economics today, almost exclusively the domain of neoliberals, has released itself from the examination of the polity of economics in its accepted status as a social science.

The acceptance of the categorization of economics as social science is reflected in many aspects of society. The very organization of society reflects the assumptions upon which it is built. The reorganization plans at the University of Windsor reflect the widespread approval of the absence of polity from the discipline of economics. The decision to join the Math and Economics departments demonstrates the assumptions that have come to underlie the discipline. Economics could make a relevant partnership with other departments such as Sociology but this proposal seems ludicrous if you accept the premises of mainstream economics. Math and mainstream economics are both "objective" disciplines, seeking laws that apply across time. If the Economic department was paired with a department like Sociology, a more subjective study may result that would encourage the critical examination of the politics of economics, a realm no longer
explored in the mainstream.

Alfred Marshall was perhaps the most influential economic thinker contributing to the reform of the discipline of economics. His *Principles of Economics*, published in 1890, began the tradition of economics as social science informed by the assumptions of positivism. The early scholars of this field were "entralled by the rigours of classical physics" (Babe, 1995: 75). While he did not promote economics as a "pure" science, Marshall did commend it as being closer to this than any other social science:

Just as the chemists fine balance has made chemistry more exact than most other physical sciences; so this economists balance, rough and imperfect as it is, has made economics more exact than any other branch of social science (Marshall 1949:12).

Rooted in a commitment to objective study detached from value judgement, economics left behind the political economic methods of the centuries before that assumed the study of economics could not be divorced from other social processes. The process of contextualization was abandoned. Economics was considered a deductive science with laws that applied universally. The emphasis on the dynamic changes of society were abandoned in favour of the search for verities that extended across time. It is evident in the first few pages of Marshall's influential work that he has abandoned the commitment to political considerations:

...progress had done nothing more than anything else to give practical interest to the question whether it is really impossible that all should start in the world with a fair chance of leading a cultured life, free from the pains of poverty and the stagnating influences of excessive mechanical toil... The question cannot be fully answered by economic science. For the answer depends partly on the moral and political capabilities of human nature, and on these matters the economist has no special means of information...(Marshall, 1949: 3).
Marshall continued to exalt economics for its similarities to physical science. He considered it to be superior to other methods of study in its ability to scientifically observe, measure and predict market actions (Marshall, 1949: 12). From examination of these facts and measurements, the economist could eventually generalize their results across various situations. The economist, like physical scientists, began to formulate economic laws that, although subject to conditions, could be applied across time. Eventually, Marshall's economics hardly resembled the economics of Adam Smith and others before him so much so that Marshall explicitly severed his economics from the earlier tradition of political economy:

...it shuns many political issues, which the practical man cannot ignore: and it is therefore a science, pure and applied, rather than a science and an art. And it is better described by the broad term "Economics" than by the narrower term "Political Economy" (Marshall, 1949: 36).

The resulting discipline was one of abstractions. The new field of economics was abstracted from "power and human volition" to ensure that the positivist methods were not compromised by such considerations. Furthermore, Marshall's economics was abstracted from change in its pursuit of laws that extended across time (Babe, 1995: 70). Such abstractions required that political implications of economic actions were no longer considered.

The Influence of the Discourse of Economics

The transformation in the language of economics brought about chiefly by Marshall's work, was influential in defining economic reality and in forming economic
policy (Samuel, Biddle and Patchak-Schuster, 1993: 162). The language of mainstream economics sets the parameters with which we view the world - forming our ideas of what is possible and what is not. For example, the widely accepted neoclassical belief in limiting government intervention precludes any socialist ideas of expanding government and social programs so that any proposals to do so seem ludicrous.

Economics is an artifact which must embody the assumptions of those who define the discipline. Therefore, its claim to objectivity is a myth (Heilbroner, 1990: 102-109 and Babe, 1995: 24). Instead, it is subject to the assumptions and values of the main thinkers in the field. Accordingly, it promotes a certain view of the world and the power structures therein. Robert Heilbroner, writing with regard to the discourse of economics describes the inherently political nature of economics:

Economics from this perspective is thus intrinsically normative in the sense of embodying, whether it will or not, the constitutive beliefs of its parent society. These constitutive beliefs, in turn, are intrinsically political, not merely from the self-justifying intentions of their spokesmen, but because societies themselves ineluctably presuppose structures of subordination and superordination, of cooperation and conflict-resolution, of the instantiation and the utilization of power. All systems of thought that describe or examine societies must contain their political character, knowingly and explicitly, or unknowingly and in disguise. Economics is not, and cannot be, an exception to this generalization, except insofar as it is unaware of the manner in which these order-bestowing ties permeate its own representations of social reality (Heilbroner, 1990: 109).

The literature of "economics of discourse" is dedicated to examining how the predominant thought of neoclassical economics informs our perceptions of reality (Babe, 1995: 24). According to Warren Samuels, this discourse determines the paradigms through which we view the world. In this, mainstream economics does not engage in a value-free discussion, as neoclassicists would purport, but rather does essentially the
opposite and brings to our perceptions a certain set of assumptions:

...it is possible and arguably even necessary to contemplate economics (and other disciplines) as comprising modes of discourse embracing and giving effect to a system(s) of belief, to a particular paradigm(s) with its distinctive set(s) of preconceptions (Samuels 1990: 3).

Through its influence on our belief systems, this widely accepted paradigm influences the values of our society. The work of these economists has come to pervade every aspect of life.

In economics, neoclassical theory is unquestionably the paradigm most often chosen. This is not surprising, for the price-theoretic approach has come not merely to dominate all economic subfields; it is a perspective being applied with increasing frequency 'to every nook and cranny of life' (Miller cited in Whalen, 1987: 259).

Accordingly, societal goals are set within the context of the preconceptions of neoclassical economics (Babe, 1995: 107). For example, political economist Robert Babe explains the impact of the acceptance of the neoclassical paradigm has on the ecological system. The ecological make-up of the world comes to be defined within the bounds of mainstream economic thought. The earth and its inhabitants are not exempt from exchange relations proposed by the free market thereby negating the value of a tree until it becomes a supply of newsprint (Babe 1995: 99). Likewise, if we contemplate the Canadian social safety net in these terms, we have no alternative but to view them as an impediment to the basic goals of society set forth by neoclassical economics. Social programs have no value because their purpose is not to generate profit.

The result is that, Marshall's Economics promoted a certain way of conducting economic affairs that ceased to consider the political values inherent in the free market on
the false premise that it must remain true to its positivist principles of objectivity.

Because of this, it served to legitimate the power afforded to the elite class of the free
market system.

Considered as a social movement, Economics, hitherto Political Economy, which had begun in part as a combined explication of and revolutionary rationale for urban industrial capitalism, was now the vanguard of the defense of the power structure of the new system (Samueis, Biddle and Patchak-Schuster, 1993: 198).

Today, much of Marshall's economics predominates in the mainstream and thus serves to promote certain versions of reality on a sweeping scale. In fact, their work has laid the foundation for many policy recommendations. Neoclassical economics has served to justify neoliberal policy agendas which have become increasingly more popular (Babe, 1995: 2). Milton Friedman illustrates this increased acceptance by commenting on the very different receptions of his 1962 publication of Capitalism and Freedom and his 1980 publication of Free to Choose:

...when this book was first published, its views were so far out of the mainstream that it was not reviewed by any major national publication - not by the New York Times or the Herald Tribune or the Chicago Tribune, or by Time or Newsweek or even the Saturday Review - though it was reviewed by the London Economist and by the major professional journals...How much the intellectual climate has changed in the past quarter century is attested to by the very different reception that greeted my wife's and my book Free to Choose, a direct lineal descendant of Capitalism and Freedom presenting the same basic philosophy and published in 1980. That book was reviewed by every major publication, frequently in a featured, lengthy review (Friedman, 1982: vi-vii).

The popularization of neoclassicism has meant that most of our economic policies are guided without the consideration of power that a critical evaluation of such policies might require. What is required is a reformulation of the way we think about economics.
Instead of accepting its status as an all-knowing, unbiased science we need to challenge its assumptions and use a better-suited vehicle in policy formulation.

Critical Political Economy

Many political economists are critical of the neoclassical approach for numerous reasons. At the forefront of such criticism is the absence of the discussion of the power and class structure that is inherent in a system of market liberty. Thus, political economy is centered on an analysis of the structure of social relations and social power in the capitalist system (Garnham, 1990: 7). The exchange relations of this system are considered by mainstream economists to be harmonious, thereby precluding any analysis of the distribution of power and resources. "Perfect competition is the structure of a non-power society, a world in which everybody is a nobody" (Winch quoted in Staniland, 1985: 21). Political economists see theory as essentially value-laden and argue that neoclassicism gives primacy to the market and in so doing diverts analysis of power:

Viewing economic affairs through the neoclassical prism exaggerates the prevalence and efficacy of Market as Mechanism, and blinds spectators and analysts to problems of human suffering and to the existence, use/misuse of economic power (Babe, 1995: 71).

The neoclassical Market as Mechanism assumes that the distribution of surplus is considered as a given. That is, it is determined by some outside force that will optimize the production and consumption of this surplus. However, political economists problematize the historically unequal distribution of resources and thus, seek to find an
explanation for such distribution. In doing so, they acknowledge that other possible arrangements for production will produce a different distribution of resources and that the existing system is not optimal (Garnham, 1990: 8).

Furthermore, critical political economists see a flaw in the ontological assumption of neoclassical economy. Critical scholars would disagree with the basic assumption that human beings operate as individual atoms. While neoclassical economists would agree that people operate socially, they assume that humans are primarily individuals looking out for their own interests. Critics say we cannot negate the fact that we are social beings and many would argue that we are primarily social rather than individual (Garnham, 1990: 8).

In accomplishing this investigation, critical political economy draws from Adam Smith a commitment to a melding of polity and economy in a critique of the political relations of business and government. It also adopts Smith's efforts toward social change through a commitment to a moral philosophy. "Political economy embedded its historical and institutional analysis in a moral philosophical outlook" (Meehan, Mosco & Wasko, 1993: 108). Moreover, critical political economists seek to put this moral philosophical outlook into practice through efforts "to transcend the distinction between research and social intervention" (Meehan et al, 1993: 108).

While critical political economic theory may draw from some of Smith's assumptions, the content is primarily critical. It rejects Smith's optimism for the free market and extends his critique of power to go beyond an acceptance of moral-tempered greed as a route to prosperity. Critical political economy is committed to a critique of
neoclassicism through a dismissal of objectivity, a melding of economic theory with social processes, and an analysis of power.

Critical Political Economy of Communication

Political economists argue that the media help construct and validate a preferred view of the world which accepts neoclassical economics as the only viable economic model. Political economists call this "indisputably preferred" model into question and assert that there are alternatives to the system of free market capitalism that is legitimized by mainstream media. The fundamental assumptions of political economy challenge the neoclassical commitment to the rigours of objective and timeless laws. Clement and Williams define political economy as a study of:

processes whereby social change is located in the historical interaction of the economic, political, cultural, and ideological moments of social life, with the dynamic rooted in socio-economic conflict (cited in Babe, 1995: 71).

Political economist Robert Babe explains that each key term in the above definition illustrates political economy and neoclassicism's opposing view points:

"Social change," for example, contrasts with the purported timelessness, universality and ahistoricity of neoclassical analysis; "interaction" furthermore is the opposite of neoclassicists' penchant of hiving off the economy from political, cultural and ideological "moments of social life;" and finally "socio-economic conflict" contrasts with the neoclassical presumption of a harmony of interests (Babe, 1995: 71).

Critical political economy of communication draws from above elements to examine the institutionalized factors that influence message production. For these theorists, media products are not considered to be neutral bits of information but rather are "concoctions
fabricated by the established power system to preserve and extend itself" (Babe, 1995: 52). With this as its foundation, political economy of communication is committed to revealing the social injustices perpetuated by the current mainstream media in particular, through their promotion of the neoclassical model and the neoliberal policies they validate.

Critical political economists of communication are dedicated to a critique of mainstream media through their efforts to reveal the power relations implicitly present in the processes of media production in a capitalist system. These power relations make it difficult, if not impossible to ensure the media's role as a public watchdog. The effects of this should be considered disastrous. If the media are not able to create a meaningful and accessible public sphere, the possibility for a working democracy is severely thwarted (Herman and McChesney, 1997: 3).

According to Edward S. Herman and Robert W. McChesney, monopoly media have arisen out of the corporate restructuring and globalizing that occurred in the 1980s. These global media are firmly entrenched in the commercialism of capitalism and serve to promote this system. "...the global media's news and entertainment provide an informational and ideological environment that helps sustain the political, economic, and moral basis for marketing goods and for having a profit-driven social order" (Herman and McChesney, 1997: 10). However, it is not in some innate aspect of the media that they are required to promote capitalist ideology. Instead, it is in the nature of the political economic structure of which the media are a part (Parenti, 1986: 214). Political economy of communication reveals how the viability of democracy is stifled by this structure.
To begin, political economists prioritize the power inherent in communication. "Communication means influence, and a capacity to exert influence over perhaps millions means power" (Babe, 1997: 40). While neoclassicism would confine information to the role of commodity, political economists recognize that this neglects the potential consequences of the interchange of information. Robert Babe refers to the example of Orson Welles' War of the Worlds to demonstrate this:

Albeit unintentionally, Orson Welles drove hundreds, perhaps thousands, from their homes. He affected, however briefly, the thoughts and emotions of six million or more people, many of whom took action based on these mental states. More generally, mass media give editors, writers, programmers, and other content providers, including advertisers, politicians, the military, public relations firms, news agencies, and entertainers, "access to the thoughts and emotions of people in the audience" (Vogel quoted in Babe, 1997: 40).

Because the media convey events which people cannot experience directly, they hold a considerable amount of power (Hackett, 1991: 12). In choosing from the limitless number of possibilities of events to cover and the terms in which to do so, the media relinquish any claims to be mere reflectors of society. In their work on the media's role in socially defining "deviance", Ericson, Baranek and Chan argue that along with a few other elite organizations, the media occupy a position of power in that they are given a monopoly on constructing and disseminating representations of the world.

Given that ownership of, access to, and use of news media are not uniformly and generally distributed, aspects of power are a primary consideration. The news media join with other major cultural institutions in society, including law and science, in constructing an order that is consonant with the needs and interests of dominant groups (Ericson, Baranek and Chan, 1987: 27).

The understanding we can gain of our social world and our subsequent ability to change it
is mediated by the structure of access to and control over the resources needed to communicate on a large-scale as in the case of the mainstream media (Garnham, 1990: 6).

By gaining such access to the means of producing and disseminating images about the world, the media are given the privileged position of informing our very ideas (Golding, 1994: 464). Our fundamental values are influenced by the news which is very often our primary means of retrieving information about our political and social world. "...News helps to construct understandings of what exists, what is important, what is good and valuable, what is bad and threatening, and what is related to what" (Hackett, 1991: 14). Some academics argue that the news in fact "imposes a frame for defining and constructing reality" (Tuchman, 1978: 180). If the media cannot directly dictate opinion, they certainly create the context in which these opinions are formed (Parenti, 1986: 22).

Upon the realization that the media have a hand in constructing our perceptual framework, we need to question the kind of frameworks they systematically promote. Which are the preferred versions of reality repeatedly served up to the public? Herein lies the importance of implicating the political economic position of media organizations and their owners. The assumptions present in mainstream news are based upon this position and serve to inform our knowledge, evaluations, and opinions about the world around us.

Because the corporate community has realized the media business represents a great deal of profit potential, independent news businesses have been swallowed up by multinational organizations resulting in media monopolies (Herman and Chomsky, 1988: 5). Indeed owners of the media are part of the business elite and are thus entrenched in a view of reality that corresponds to the experiences of the capital class (Parenti, 1986: 4).
Studies have confirmed that media elite tend to come from upper class homes and are socially integrated with business culture (Hackett, 1991: 61). The content of mainstream media news products are not unaffected by this. Canadian journalist Linda McQuaig argues that ownership cannot be overlooked as a factor influencing the content of our news products:

We must always remember that virtually all media outlets are owned by rich, powerful members of the elite. To assume that this fact has no influence on the ideas they present would be equivalent to assuming that, should the entire media be owned by say, labour unions, women's groups or social workers, this would have no impact on the editorial content (McQuaig, 1995: 12).

News content tends to be in consonance with the assumptions of capitalism because in their pursuit of the bottom line, it is in the media's interests to promote the very system that ensures these enormous profits. Accordingly, Ben Bagdikian explains that mainstream media content tends to emphasize the shortcomings of public enterprise while being inattentive to the failures of the private sector (Bagdikian, 1992: xxiv). Thus, constructing reality as the media see fit is an ideological practice legitimating capitalism and thereby solidifying the privileged position of the elite. "[The press'] major role, its irreducible responsibility is to continually recreate a view of reality supportive of existing social and economic class power" (Parenti, 1986: 10). In promoting such interests, media organizations negate their self-proclaimed role as public watchdogs. "Far from providing democracy's oxygen, as they claim, the news media today legitimize a fundamentally undemocratic system. Instead of keeping the public informed, they manufacture public consent for policies which favour their owners: the corporate elite" (Winter, 1997: xv).
The nature of monopoly media markets is severely troublesome for democracy. As monopolies grow, fewer and fewer alternative sources of news are available thereby precluding the possibility of an effective public sphere. In the past, anti-trust laws have been put into place to prevent monopolistic control of markets and to ensure some level of diversity in media content. Increasingly, neoliberal initiatives of deregulation are being realized as these laws are either weakened or not enforced (Bagdikian, 1992: 8). Thus, media corporations have been permitted to expand to monopoly size, pushing out many members of competition. It has been argued by political economists that media monopolies are a threat to the public service function of news delivery. While the concentration of wealth inherent in monopolies is troublesome with any type of corporation, James Winter explains that:

news media are a special case. Although they are increasingly in the business of delivering readers to advertisers their "product" is information and ideas. Despite the best efforts of journalists, concentration in ownership means less diversity in the news. This has serious ramifications for our democracy, such as it is (Winter, 1997: xiii).

Ownership's disregard for the unique and important product of media corporations was voiced by Canadian newspaper mogul, Ken Thomson before the Kent Royal Commission on Newspapers when he said "look, we are running a business organization. They happen to be newspapers" (Winter, 1997: 14). However, there is another interest at work here. While Ken Thompson may regard newspapers as a means to profit, other media moguls have found the media industry no only suits their pocketbook, but serves as a political vehicle to promote their interests. For example, Conrad Black has used his monopoly hold on newspapers to influence public policy (Winter 1997: 22).
Warnings against media monopolies put forth by the Davey Committee in the 1970s and reiterated by the Kent Commission in the early 1980s have been ignored by the Canadian government who has conceded to corporate interests. Instead of enforcing anti-trust laws, the government has embraced the doctrine of neoclassical economics and has increasingly divorced itself from the affairs of the market (Winter, 1997: 7). Conrad Black's media holdings exemplify this development within the Canadian corporate world. By the spring of 1996, Black's media giant Hollinger had expanded to include Southam meaning that he was now in control of 60 out of 104 dailies, or 58% of Canada's newspapers (Winter, 1997: 22). Compare these numbers to the United States where the concentration is much thinner and even so, many are concerned over the developing patterns of ownership:

...in the U.S....eleven corporations control about half of the daily newspaper circulation. In Canada, one conglomerate controls 43 percent, two control 55 percent and three control 66 percent (Winter, 1997: xiv).

The effect of governments who are increasingly adopting the prioritization of commercialization has meant that media organizations have been allowed to forego their public service functions (Golding, 1994: 472). The insatiable drive for profit of media monopolies has not left the quality of reporting unaffected. Cutbacks in staffing have lead to higher profits but have cheated the public out of high calibre newspapers (Bagdikian, 1992: 7). Between 1992 and 1998, the decrease in staff at Southam is expected to be 27 percent (Winter, 1997: 31). This drastic cut in staff can only represent a decrease in the quality of these newspapers. Much local reporting has been drastically diminished. There has been an increased reliance on wire coverage which further
decreases diversity across papers. A reporter with the Cambridge Reporter which Thomson sold to Hollinger in the fall of 1995 explained that under the new ownership, the number of stories they are expected to write in a month has doubled. She said "They have people there who are doing nothing but rewriting press releases and [they are] tossing these off as local news" (Winter, 1997: 26).

Furthermore, conglomerate ownership has meant that the instances of conflict of interest are common (Herman and Chomsky, 1988: 12). Newspapers whose owners have other non-media holdings would be reluctant to publish damaging reports about these other companies.

...how could one rely on the four English-language New Brunswick dailies, all owned by the Irving Family, to report fairly on the strike by workers at Irving Oil Ltd. in Saint John N.B., which began in the spring of 1994 and is still going two years later? Or the blacklisting of those strikers which prevents them from being employed part-time elsewhere in the province? Or how could we rely on the Irving media to report on the "Irving Whale," the oil barge containing heavy oil and nine tonnes of polychlorinated biphenyls (PCBs) which sank 60 kilometres off Prince Edward Island in 1970? (Winter, 1997: xiii).

Political ties of media owners also present a conflict of interest (Herman and Chomsky, 1988:13). Many politicians have worked for media owners or go on to do so after their career in politics. Or the ties come from other means as is the case with Prime Minister Jean Chretien and Paul Desmarais, owner of the media giant Power Corp. Chretien's daughter is married to Desmarais' son Andre. Furthermore, Chretien was on the board of directors of Power Corp. One should be skeptical in accepting Chretien's claim of no conflict of interest when his government took the unprecedented step of overturning a CRTC decision that was detrimental to his son-in-law's plans to start a DTH
service through Power Corp. Further media connections to government are exemplified in monetary support as Rogers contributed $100,000 to the Liberal Party of Canada in 1994 - more than any other donation from a firm (Winter, 1997: 8).

While some communication research has down-played the influence of ownership and instead blamed journalists for the lack of diversity in media products, political economy recognizes the limitations placed on journalists through institutionalized news practices that have developed in accordance with political economic structures. Blaming journalists assumes that they are "free agents" who do not have to conform to the expectations of their superiors (Parenti, 1986: 9). This line of reasoning serves to legitimate power relations by placing blame on individual journalists rather than looking to political and economic precursors to institutionalized bias in reporting.

The routines of journalism, set within the economic and political interests of the news organizations, normally and regularly combine to select certain versions of reality over others. Day by day, normal organizational procedures define "the story", identify the protagonists and the issues, and suggest appropriate attitudes toward them" (Gitlin, 1980: 4).

What is served up to us as news is the product of journalistic routines and values. The routines of journalism are particularly troublesome on two accounts. That is, they remove social process and social power from descriptions of the world around us which makes it impossible for news to give a critical account of events (Golding and Elliot 1990: 18). Furthermore, insofar as news can be described as stories, the journalistic routines used in formulating the stories subscribe to the conventions of fictional narratives. The result then, is not some objective truth, but a text that should be treated with the same "freedom and irreverence" applied to fictional texts (Fiske, 1987: 308).
John Fiske describes how the conventions employed in forming news narratives work to close off the polysemic potential of events covered by the news. For example, the subcategories used to define certain stories seemingly by the nature of the events described, limits the meanings that are attached to the stories. Labeling a story as "local" discourages an examination of the larger social structure and limits solutions to the local level (Fiske, 1987: 287).

Todd Gitlin explains that news practices are not a matter of ownership dictating the content and frame of stories. News values such as objectivity suggest a certain way of reporting that lead to a lack of diversity in content and an acceptance of the status quo (Gitlin, 1980: 4). The very concept of objectivity is troublesome because of its reliance on so-called "facts" which are better described as interpretations. Furthermore, in pursuit of finding the "facts" journalists are preoccupied with the value of balance so that what is understood to be fact is said to lie somewhere between two opposing view points. Ultimately, this leads to the avoidance of truth or even the promotion of damaging truths (Ericson et al., 1987: 108). What is problematic is that this view of reality dismisses the possibility of more than two sides of an issue and furthermore, it assumes that truth only inhabits a non-existent realm of the value-free that supposedly hovers between the two extremes.

Objectivity as a journalistic standard is often defended as a cornerstone to the public sphere. In this sense, objectivity is said to enable a diversity of voices and prohibit journalists from developing opinions and "tainting" the issues based on these preferences. The influence of ownership stands in contention with this view of objectivity. At surface
value, this standard may seem to provide integrity to the profession as a defender, promoter and enabler of democracy. However, in part, the imperative of ownership interests precludes the possibility of objectivity (Herman and McChesney, 1997: 192). The practice of pursuing objectivity ensures that reporters rarely issue an overt challenge to the foundations of capitalism from which the owners benefit. If a journalist were to pursue such a challenge it is likely that she would be accused of a socialist or communist bias. However, not issuing a challenge should not be considered a value-free position. If one system, such as capitalism, is rarely questioned while others are often examined critically, this first system is validated. Furthermore, it must be noted that within the profession, many subjective choices are made that often lead to promotion of ownership interests. For example, owners make subjective choices in terms of choosing who will work for them (Herman and McChesney, 1997: 192). Hiring practices are not objective and in fact ensure that certain values are promoted over others. This in turn decreases the diversity of news content. As Winter explains, "Owners hire publishers who reflect their views, and who in turn hire and promote managers, who then hire and promote editors and journalists" (Winter 1997: 86).

Despite the above evidence to the contrary, the public generally believes that the media report to us in an objective manner. We are taught that news reports are based on fact and that any bias is saved for editorial sections. The result is a wide-spread lack of critical consciousness regarding the media and what they report to be the truth. "Authorized knowers" reinforce the media's claim to objectivity. These are people who have been deemed experts such as university professors, and economists and whose
commentary is generated from some special knowledge not available to the lay person (Winter, 1992: xvi). What is not made clear is that these experts subscribe to a certain paradigm, (most often the neoliberal one), and therefore, their statement of "fact" is subject to the assumptions posited in that paradigm. In many cases, more than one position is recognized so that statements of "fact" are indeed subject to debate and two or more experts of "dissenting" opinion may be quoted. But often the degree of separation between their opinions, although presented as extreme, is minimal and merely represent shades of neoliberalism.

In the insatiable drive for profit, the media organizations are increasingly finding ways to cut costs. Sourcing news can be very expensive. To reduce this expense, reporters are no longer sent out to find stories. Instead they are often sent to find news where it is likely to happen. Herman and Chomsky give the examples of the White House and the Pentagon. These bureaucracies are ideal for news media because they produce large amounts of "reliable" information. These sources are deemed "objective" because they come from "authorized knowers" (Herman and Chomsky, 1988: 19).

Other sources of information come from large companies that spend a lot of money lobbying for their own interests. These companies often go to great lengths to make life easy for media organizations by generating prepared statements easily available through news releases and press conferences. Only large, rich companies can afford such lobbying so the result is that their interests are reflected in news pieces while smaller businesses, non-profit and grass-roots organizations, the weak and the disadvantaged receive very little attention. "In effect, the large bureaucracies of the powerful subsidize
the mass media, and gain special access by their contribution to reducing the media's cost of acquiring the raw materials of, and producing, news (Herman and Chomsky, 1988: 22). The result is undemocratic media coverage that legitimates a certain view of the world.

...groups with the loudest, best financed, and most rehearsed voices get their messages across more effectively and more often. The result of journalism's unwillingness to develop a voice for democracy is that the news has become virtually a direct pipeline for propaganda from powerful organizations to people (Bennett, 1988: 13).

Not only do the media ignore the interests of the non-corporate world because of the ease in which information can be obtained through lobbying, but they also feel pressured to portray bureaucracies in a favourable light. The media and the bureaucracies are mutually dependent and to avoid breaking this comfortable relationship, they may feel compelled to be sympathetic to their causes (Hackett, 1991: 83; Herman and Chomsky, 1988: 22; Tuchman, 1978: 87).

In light of all of this, it is not generally the case that reporters answer to direct orders from owners who wish to convey their political sympathies in favourable terms. Instead, they come to learn via experience which stories will be accepted by the editors and publishers. Nicholas Johnson, the former chairman of the Federal Communications Commission in the U.S. elaborates:

The story is told of a reporter who first comes up with an investigative story idea, writes it up and submits it to the editor and is told the story is not going to run. He wonders why, but the next time he is cautious enough to check with the editor first. He is told by the editor that it would be better not to write that story. The third time he thinks of an investigative story idea but doesn't bother the editor with it because he knows it's silly. The fourth time he doesn't even think of the idea anymore (quoted in Winter, 1997: 85).
This account demonstrates the virtual lack of independence held by reporters. "In the final analysis, the news is not what reporters report but what editors and owners decide to print" (Parenti, 1986: 43). Because of this, most journalists practice self-censorship, focusing their efforts on stories that are more likely to be printed rather than pursuing stories that are more obviously not fit to print. Stories that challenge the status quo are most likely to be deemed as such on the grounds that they are not objective pieces. When journalistic work opposes the ideological position of employers, these stories tend to be designated as opinion pieces while those that support the status quo are more often treated as fact and are therefore more likely to be printed (Parenti, 1986: 50).

Journalists are aware of the fact that to offer an alternative outlook will mean an up-hill battle that could result in the loss of their job. David Radler, president of Hollinger International made this clear in a surprisingly candid interview:

I don't audit each newspaper's editorials day by day, but if it should come to a matter of principle, I am ultimately the publisher of all these papers, and if editors disagree with us, they should disagree with us when they're no longer in our employ. The buck stops with the ownership. I am responsible for meeting the payroll; therefore, I will ultimately determine what the papers say and how they're going to be run (Winter, 1997: 86).

All of the above leads to a narrow view of the world filtered largely through a neoliberal lens. Because the public is led to believe that their media report in an objective manner, this neoliberal thought becomes accepted as common sense (Winter, 1992: xvii). Winter also refers to this as Media Think. "It's the means by which the media create particular pictures of the world in our heads, all the while omitting and thereby preventing the formation of alternative, competing pictures. This whole process is so natural, so
much taken for granted, that we generally miss it" (Winter, 1997: 114). Through this, the media have failed to live up to their social responsibility in safe-guarding public interest to ensure the basis of democracy - that is - the informed vote (Winter, 1997: 73). The media help form our consciousness, our basic ideas about ourselves and how we should organize society. Thus there is desperate need for diversity in our media that is all but absent.

Ultimately, most critical political economists agree that the media have become a vehicle for the promotion of corporate interests at the expense of the interests of the greater public. And too often, without many alternatives, the public adopts the neoliberal philosophy, or parts of it as its own. However, upon critical inspection not often carried out by the media, this philosophy stands in direct conflict with public interest. Critical political economy of communication is dedicated to exposing the interests of the mainstream media and to offering an alternative to the worldview offered therein.
CHAPTER 3 - THE DEVELOPMENT OF THE CANADIAN HEALTH CARE SYSTEM

The Contested Journey

W. L. Mackenzie King was perhaps one of the first politicians to seriously introduce the idea of a national health care system in Canada. In his 1918 work *Industry and Humanity* he wrote:

Social insurance, which in reality is health insurance in one form or another, is a means employed in most industrial countries to bring about a wider measure of social justice, without, on the one hand, disturbing the institution of private property and its advantages to the community, or, on the other, imperiling the thrift industry of individuals (Swartz, 1977: 318).

King's work, while demonstrating his class consciousness also shows shades of tokenism that have been present throughout the development of public health insurance. While much of his written work advocated the construction of a welfare state, his actions once in office showed a dedication to the free market (Barlow and Campbell, 1995: 13). It is this tokenism along with slow development of Canada's health system that illustrates the country's reluctance to develop social programs and instead favour the interests of the business community (Tarman, 1990: 21). Often, policy-makers who were active in implementing a public health insurance system, were ideologically aligned with the business community and their demands for a free market economy. The progress towards public health insurance was more often made in efforts to quell the ever-mounting demands from labour for the improvement of social conditions. In the same vein, Donald Swartz warns us to be skeptical of arguments that claim the development of Canada's health care system is the product of a socialist state. He argues that it is more accurately
described as a pacifier for union movements before their ideology could spread and intensify:

...the development of health insurance tends to be seen ...as legislation which has something to do with the state becoming socialist. The actual history and the reality of health insurance are quite different from this image (Swartz, 1977: 316).

Swartz describes the early actions of the government in regards to health care as illustrative of its reluctance to develop a welfare state. In the early 1900s, many employers provided some health insurance for their workers. Employees were unhappy with the ad hoc nature of these insurance arrangements and called on the state to take over. It seems as though government action in compliance with workers' demands was made in efforts to decrease pressure from unions but not due to any firm commitment to socialist policies:

Where workers reject paternalism, where industrial unrest is widespread, and where socialist ideology threatens to take broad root among workers, the need for state reform becomes apparent (Swartz, 1977: 317).

It was more often the threat of a growing socialist movement that spurred politicians to support public health insurance rather than an ideological commitment to the improvement of socio-economic conditions.

By the Depression era of the 1930s, health insurance had become an issue in the forefront of Canadian policy-making. The dire conditions experienced by so many during this time meant that there was widespread support for a public health system. But, as the Canadian government hesitated to make any serious in-roads in this area, private insurance companies grew and upon the realization of this lucrative market, the business
community helped break the broad consensus of support for public health insurance (Tuohy, 1986: 405). However, in British Columbia where the labour movement was strong, and the Co-operative Commonwealth Federation (CCF) was in opposition, (representing 1/3 of the voters), the government passed legislation to establish public health insurance. The medical profession and the business community were opposed to the legislation. Doctors did want to see some form of state health insurance but only for the very poor who could not pay for health care. While the legislation meant that the employed poor would be covered, the unemployed were still basically without access to the medical profession. Furthermore, the business community did not want the province to go into further debt resulting in defaults on its loans or raised taxes thereby diminishing the business market. Thus, the business community did not approve even of the minimal coverage promoted by the medical profession (Swartz, 1977: 319). Due to pressure applied to the Patullo government by the medical profession and the business community, the system would never actually run (Swartz, 1977: 318).

In the early 1940s, W. L. Mackenzie King realized that the working class movement was spreading beyond British Columbia. This was demonstrated by the 1943 election in Ontario where the CCF won 32 per cent of the votes. Under such pressure, King took note of several reports that focused on social reform in Canada (Swartz, 1977: 320). The 1940 *Rowell-Strois Report on Dominion-Provincial Relations* established principles of the Canadian state such as federal responsibility for the economy and welfare, provincial subsidies and standards for education and social services and regional equality (Barlow and Campbell, 1995: 21). *The Report On Social Security for Canada* by
Leonard Marsh recommended the institution of comprehensive health insurance (Barlow and Campbell, 1995: 21). Finally, the *Heagerty Report of the Advisory Committee on Health Insurance* stated that adequate medical care for all Canadians was essential to the maintenance of a democratic state (Barlow and Campbell, 1995: 21). This report called for a more extensive health insurance plan than has ever come to fruition in Canada including recommendations for a preventative program which no province has come close to implementing (Swartz, 1977: 320).

Despite these three reports and some support from King's Liberals, a public health insurance scheme was not implemented at the time. It is speculated that the reasons for the failure to implement the program were a combination of a break-down in provincial-federal relations and the business community's allegations that the government was favouring the labour movement's wishes in excess (Swartz, 1977: 321).

Regardless of the recommendations contained in these reports, the next decade showed little progress towards the implementation of a comprehensive, universal program of public health insurance in Canada. Despite this, there continued to be some strong support for the implementation of a program. Health Minister Paul Martin was firmly committed to the cause. At the provincial level Tommy Douglas as leader of the CCF in Saskatchewan made substantial efforts toward the development of a welfare state. In 1947 a hospital insurance program was implemented in the province (Swartz, 1977: 322). Throughout the 1950s Prime Minister St. Laurent refused to implement a public health system despite Paul Martin's threats to resign if a program was not developed. In 1955, further pressure was applied to the federal government when Leslie Frost, premier of
Ontario announced that the province was in favour of a public hospital insurance program. The premier did not, in principle, agree with the implementation of a program but felt he could not ignore growing demands from the unions (Swartz, 1977: 323). Two years later, the Prime Minister gave in to rising pressure and implemented a national hospital insurance program in 1957 (Swartz 1977: 324).

In 1960, under the leadership of Tommy Douglas, Saskatchewan led the way once again in their implementation of a medical insurance program. This was met with strong resistance from the medical profession which culminated in the doctor's strike of 1962 upon the inception of the program. Further advances were made towards a national program when the Liberal party's federal convention resulted in their support for a public health system. However, the party was divided on the issue. Despite opposition from the business-centred Liberals, the social Liberals were successful in convincing the party to adopt medicare as a platform (Begin, 1987: 52). The increasing pressure for a national program was met with resistance from insurance companies (Taylor, 1986: 5).

Diefenbaker's Progressive Conservative government responded to growing controversy surrounding medicare by forming a Royal Commission headed by Emmett Hall. In 1962, Lester Pearson's Liberals took office while still awaiting conclusions from the Royal Commission started by the Progressive Conservative government. Two years later, the conclusions were in, endorsing a comprehensive range of benefits for health care. This was met by resistance from the medical profession, the insurance industry, chambers of commerce and several provincial governments (Taylor, 1986: 6). Despite this, in 1966, legislation was passed for a national medicare program taking effect on July
1, 1968 with only British Columbia and Saskatchewan qualifying for federal funds. By January 1, 1971 all provinces had joined.

The nature of the Canadian health care system has been influenced by the 1867 British North America Act which established the duties of the different levels of government. The federal government was given responsibility for the roles that were considered most significant and correspondingly given the most lucrative sources of taxation. The provinces were left to oversee the perceivably more minor responsibilities and therefore given minor sources of revenue (Guest cited in Rekart, 1993: 8). Public health care fell into the latter category. Thus, the constitutional act essentially created ten different health care systems stretching across the country (Armstrong and Armstrong, 1996: 157). The Medical Care Act of 1967 was in part an effort to remedy this and create a unified system with national standards. Therefore, to qualify for funding, the provinces had to offer non-profit, comprehensive, universal coverage for health care that was portable from one province to another (Barlow and Campbell, 1995: 28). Under these conditions, the federal government would match provincial contributions.

The New Health Care System

The slow development of hospital insurance and medicare in Canada demonstrates Swartz's hypothesis. Policy makers were generally in favour of corporate interests, only giving way to demands for the development of a public health insurance system when pressure was especially high. In the majority of cases, the government refused to take any serious steps towards the development of a program, much to the satisfaction of doctors,
health insurance companies and the larger corporate community. Only when public
pressure threatened the government's popularity did Prime Minister St. Laurent institute
Canada's hospital insurance system. Similarly, only when many of the federal Liberal
party were begrudgingly convinced to support medicare as an election platform did public
health insurance become reality.

Furthermore, the nature of the program did not fundamentally change the delivery
system. The state did not take over the administration of hospitals meaning that the
boards which governed the hospitals were comprised mainly of doctors who opposed
medicare. Because of this "...state hospital and medical insurance effected no change in
the nature of the health care system. Its control remained firmly in private hands, held by
physicians and the drug and medical supply corporations" (Swartz, 1977: 328-330).
Thus, the new system favoured doctors, medical and drug supply corporations more than
the public (Tarman, 1990: 21).

It has also been argued that delivery of health care has been subject to certain
assumptions present in medicare that limit the kinds of treatment that people receive. Pat
Armstrong and Hugh Armstrong assert that the Medical Care Act has served to preserve
the medical model of health care delivery (Armstrong & Armstrong, 1996: 61). For
Armstrong and Armstrong this model is not the best one for promoting wellness. First, it
assumes that doctors are experts and that patients are not knowledgeable about their own
bodies (Armstrong & Armstrong, 1996: 23). Furthermore, it assumes that the body is
made up of parts to be fixed. This leaves little room to consider interaction between mind
and body (Armstrong & Armstrong, 1996: 20,21). This assumption has also led to the
fee-for-service structure of payment in that payment is made for parts treated or tasks completed rather than on a per patient basis. There is an emphasis on cure through specific and standardized procedures which assume that all patients with the same problem are alike (Armstrong & Armstrong, 1996: 21,22). Other aspects of care which fall outside of these procedures such as psychological support, bathing and feeding are considered non-medical (Armstrong & Armstrong, 1996: 22). The organization of health care institutions is subjected to these assumptions and as a result:

Public funding of health institutions and services has primarily served to support and reinforce provision based on a medical model and private provision. Moreover, when government reports consider care reform, they focus on greater efficiency and effectiveness defined primarily in market terms and based on a medical model. Indeed, it is the medical model which allows the reports to recommend the application of reform strategies taken from the for-profit manufacturing sector (Armstrong & Armstrong, 1996: 51).

Essentially, the Canadian government has created a private system funded by public money. Thus, the health care system in Canada is very conducive to privatization. The structure is in place and those aspects of the system that are most public are being challenged. Increasingly, hospitals and other institutions have been adopting the mannerisms of the private sector by implementing strategies designed for that market. The rise of the neoliberal movement across the country and around the world has meant an increased focus on “efficiency” rather than quality care. Ultimately, this preoccupation with efficiency has meant the simultaneous reduction in public health care services and the promotion of private services.
CHAPTER 4 - THE RISE OF NEOLIBERALISM

Neoliberalism was heavily influenced by economists such as Milton Friedman and Friedrich Hayek at the University of Chicago. These neoclassical theorists experienced surging popularity in the 1970s when they argued that the wavering economy and the oil price shock of the 1970s were in part due to state interference in the market (Weller, 1997: 129). Anti-communist feelings that were fostered by the movement helped demonstrate that market freedom was a precursor to individual freedom. Thus, privatization was justified in the name of public interest when in reality, the shrinking of the public sector proved most beneficial to multinational companies. For them, privatization meant that globalizing and regionalizing could occur without the burden of meeting public interest. Furthermore, reduced spending on the public sector meant reduced taxes for these large companies and more business subsidies (Martin, 1993: 2).

This trend toward leaner governments has been legitimized around the world by defining it as part of a natural course of events. In Canada, the erosion of social programs has been justified in the name of fighting the deficit - something that Canadians are told they must do to be able to compete on the global market. Globalization is portrayed by politicians, the corporate community and the media as a natural force which humans have to comply with unless they are willing to find themselves in a perpetual state of economic ruin.

...Canadians have been the recipients of an endless stream of offerings intended to convince them of the need to obey the dictates of globalization. Right at the beginning of the Mulroney era, there was the Report of the Royal Commission on the Economic Union and Development Prospects for Canada,
a commission chaired by Donald Macdonald, the former Liberal finance minister. The report has been used ever since as a justification for the Free Trade Agreement with the United States. Books and articles by economists such as Richard Lipsey, John Crispo, and Carl Beigie, reports for the C.D. Howe and Fraser Institutes, and policy positions taken by the Business Council on National Issues (BCNI) have advanced the same broad case. The editorial pages of the Globe and Mail and the Financial Post have restated the globalization hypothesis on a daily basis. And Canadians have seen the case boiled down for them in television commercials served up by the Government of Canada and paid for by the taxpayers (Laxer, 1993: 10).

The Canadian health care system has not been immune to the assumptions of globalization - that is, that such programs pose an obstacle to global competition. Geoffrey R. Weller describes the legitimation of opposition to medicare through the use of the concept of globalization:

This is clearly intended to conceal the fact that the concept is being consciously used both to enable and to rationalize the spread of a particular form of organization of economies, the free market capitalist one, around the world. Using the concept in this way the domestic opponents of medicare try to make it seem as if those who support medicare and an active Canadian state are resisting not an opposing set of domestic forces espousing an opposing ideology but an irreversible set of natural forces and, indeed, the very flow of history itself (Weller, 1997: 128).

For neoliberals, the concept of globalizing forces is very useful. It means that attention is diverted from the domestic adversaries of social programs to some abstract energy that is virtually impossible to confront directly. Because of this the economic policies promoted by neoclassical economists that favour the privatization of public sector programs has been legitimized.

The neoliberal movement and its adoption of the neoclassical affinity for market regulation has been epitomized by the Reagan and Thatcher governments of the 1980s.
At the heart of their ideology was hostility to the view that society should organize the provision of public services and structure and regulate the economy. Left to themselves, went the argument, the market and private sector would create wealth, which would 'trickle down' to all. Competition between producers to please customers would define the public interest and ensure it was saved (Martin, 1993: 2).

Rules and regulations of nation states that protected the public sector had to be dismantled to allow the market to operate in such terms. This provided the impetus in the 1980s for trading blocks that would "open up" economies for foreign and private investment. The FTA, NAFTA and the EU are all examples of such trading blocks which were intended to "shrink the influence of nation states" (Weller, 1997: 128).

The result of such growth in the private sector economy has meant increased inequality. Brendan Martin describes such inequality as necessary to the neoliberal agenda.

Inequality is implicitly and even explicitly encouraged by their approach to economic and social policy. The state's role is not to deal with its causes but to police its effects, especially by preventing, by force if necessary, collective action to improve the position of people at a disadvantaged position in the market (Martin, 1993: 47).

The realization of neoliberal policies has meant that massive amounts of money are being exchanged internationally. In the past few decades, world output has tripled and trade has quadrupled. On the world market, $1.3 trillion dollars is exchanged everyday.¹ What is problematic is that this money is being shuffled back and forth between very few hands. Eighty percent of foreign investment and 70 percent of world trade are controlled by 500 corporations that between them own thirty percent of the

¹from an interview with Linda McQuaig that aired April 21, 1998 on TV Ontario.
world's GDP (Martin, 1993: 30). This concentration in wealth continues to grow. In 1996, corporate mergers around the world reached a record total of $1.04 trillion, an increase of twenty-five percent over 1995. Data Corp, a Newark, New Jersey firm that tracks the securities industry expects that mergers in 1997 will exceed those in 1996 (Burton, 27 December 1996).

Amidst this huge amount of wealth has been widespread poverty. Researchers at Simon Fraser University have done a recent study on relative wealth and poverty around the world. They found that if the earth's population was decreased to one hundred people with the relative size of human groups and incomes remaining the same, six people would have half of the world's wealth, fifty would suffer from malnutrition and eighty would have to live in substandard housing (Finn, 1997: 7).

While the corporate community may attribute such inequality to this unstoppable global force and claim that eventually wealth will "trickle down" to all if the market is allowed to operate freely without such obstructions as public health care, reality is very different. Upon examination, it becomes apparent that the actions of the government working in favour of these multinational companies show that national forces, rather than global forces are the predominant influences on medicare (Weller, 1997: 123).

The Neoliberal Influence on the Canadian Health Care System

While Canadian policy-makers had failed to create an effective public health care system that would fundamentally change the socio-economic structure of Canada, the system had fostered some level of equality that had not been present before (Rekart, 1993: 55
19). Access was greatly improved upon the introduction of medicare (Armstrong & Armstrong 1996: 60). The rise of a neoliberal movement in the late 1970s meant that the problems inherent in medicare would be exacerbated. This ideology called for a heightened government alignment with business interests. The resulting assault on social programs was justified by claims that they had taken up too much of the public purse and debts were spiraling out of control.

It was not long after the inception of the program that the creators of medicare took the first major step in undermining its ability to provide for the public. It was within the rising neoliberal context that in 1977 the federal Liberal government introduced a new payment scheme called Established Programs Financing. This meant an end to the cost-shared approach to health care financing and the beginning of block funding. The provinces would receive a cash transfer not based on the dollars they spent but on growth in population and GDP. The federal government was happy with the arrangement because it could now predict how much funding would go to each province. The richer provinces saw it as an opportunity for greater "flexibility" in "determining their health care priorities" (Taylor, 1986: 16; Hastings & Vayda, 1986: 338). In other words, the federal government would have less control over provincial decisions in health care delivery (Taylor, 1986: 16). The weaker provinces were aware that this "flexibility" meant a challenge to national standards and thus could represent the erosion of the program (Bégin, 1987: 57). This new funding arrangement signaled the beginning of fundamental restructuring of Canada's health care system. It would be the first of many policies that would jeopardize the federal government's ability to enforce national
standards.

With the federal government now providing less than half of the funding required to run the national program, the provinces turned to extra billing and user fees to make up the difference (Gainor, 1993: 102). This went largely unchallenged by the federal government due to a change brought about by the new funding formula. Under the EPF, the government reduced the large number of civil servants who had been in charge of auditing the provinces' health care bills to a mere twelve people (Bégin, 1987: 66). With this, the regulations that went with the medicare act were no longer enforced. Monique Bégin, former minister of health explained the effect of this:

Among other things, this meant the end of the practice (prior to 1977) of deducting the amount of user fees a province had charged from federal contributions to that province. In other words, user fees were no longer prohibited - since they were no longer penalized - therefore they were allowed (Bégin, 1987: 66).

The presence of user fees meant that two fundamental principles of medicare, universality and accessibility, were challenged. The undermining of the standards of social programs can be interpreted as a movement toward the legitimation of the neoliberal agenda (Weller, 1997: 125). If the government starves these programs in the name of deficit fighting, it could prove difficult to uphold the programs' principles. Thus, the programs would be rendered ineffective and privatization would be a justifiable option.

By the mid-1970s, the presence of the federal government in social programs had decreased considerably. In 1946, the federal government controlled about 66 per cent of the tax points and the provinces had 33 per cent. Thirty years later, the roles had reversed
and the federal government had 33 per cent and the provinces had the other 66 per cent (Bégin, 1987: 58). With the provinces in charge of health care as set out by the BNA act, it would be difficult for the federal government to enforce national standards with decreasing financial leverage. The reduced funding brought forth by these policies forced the provinces to choose between raising taxes, cutting programs or transferring to the private sector (Tarman, 1990: 22).

The federal election of 1979 meant that neoliberal initiatives would be felt by the public on a widespread scale. The Progressive Conservatives were elected on a platform that endorsed smaller government and the cutting of social programs, increased competition fostered by deregulation, tax cuts and the elimination of the deficit (Bégin, 1987: 29). The growing presence of neoliberalism in Canada was echoed by the medical establishment in its support of user fees, deductibles, and supplemental private insurance (C. David Naylor, 1986: 4). However, there was continued resistance against the neoliberal movement and the resulting erosion of the standards of medicare. The Progressive Conservative government appointed Emmett Hall as head of a public inquiry on the issue of national standards. The inquiry concluded that if extra billing was allowed to continue, a two-tiered system would develop (Taylor, 1986: 19).

Further pressure against neoliberalism came from Monique Bégin as minister of health for the Liberal party in 1980. She headed a campaign against extra billing and user fees. An all-party task force created to examine the perpetually arduous federal-provincial relations concluded that user fees were against the spirit of the national program and resounded Hall's warning that extra-billing would lead to a two-tiered
system. This task force paved the way for the Canada Health Act (Taylor, 1986: 24).

However, the neoliberal influence in the country continued. Bégin had trouble gaining support for her vow to keep health insurance accessible and universal. The source of opposition was not only restricted to the provinces and the Canadian Medical Association (CMA) but many of her own colleagues in her department and cabinet refused to support her cause (Taylor, 1986: 29; Bégin, 1987: 101). In his 1981 budget, Minister of Finance Allan MacEachen announced the abolition of two tax points which had been part of the EPF. Jean Chretien, then president of the Cabinet Committee on Social Development, had been the architect for these major cuts (Bégin, 1986: 83). He would continue to undermine the national health care system as Prime Minister over a decade later. Further neoliberal trends continued at the provincial level. During that same year, the Ontario Ministry of Health introduced a new program entitled Business Oriented New Development or BOND. This program provided incentives for hospitals to become more business-like, in that they were allowed to keep profits from sources such as parking, in-hospital stores, restaurants, and private and semi-private rooms (Tarman, 1990: 23). By the end of 1982, it was clear that the Ontario government was in firm support of the neoliberal initiative of privatization as the administration of Hawkesbury hospital was given over to AMI Canada Ltd., a subsidiary of American Medical International, one of the three largest multi-institutional chains in the U.S. health care business (Tuohy, 1986: 422; Bégin, 1987: 102). Meanwhile, medical organizations continued to voice their support for user fees and other market-based initiatives spurring the National Council on Welfare to describe the CMA as the "harshest critic" of current
health insurance arrangements (C. David Naylor, 1986: 4).

In 1983 the Ontario government responded to mounting pressure against extra billing and user fees. A regulation was passed that made it professional misconduct to charge a patient more than the OHIP fee schedule without warning the patient in advance. The OMA voted overwhelmingly against the regulation. Spokesmen for the association were candid with their ideological position stating that "the law is incompatible with our status as private, independent businessmen" (Taylor, 1986: 31). Clearly, organized medicine supported a free market scenario for health care. In describing themselves as businessmen, physicians refuse their role as civil servants arguably determined by their government-paid compensation, their work setting in buildings funded largely by the state and their labour in achieving public good (Northcott, 1994: 71).

Largely due to Bégin's efforts, in 1984, the Canada Health Act was passed by the Trudeau government with the support of Mulroney in opposition (Gainor, 1993: 102). Through the act, the government could enforce universality by reducing cash transfers to the provinces at a dollar-for-dollar level if extra-billing occurred (Tuohy, 1986: 415). The Act also served to reiterate the five principles of medicare to which each province had to adhere: Universality of coverage obligates the provinces to cover at least 95 percent of their insurable residents under public health insurance; Accessibility ensures that this 95 percent have use of services they need; Comprehensiveness of coverage means that benefits should cover all necessary in-patient services and some out-patient services; Non-profit public administration means that health care is to be administered by the public sector and the provincial government is responsible for it; Portability of
coverage ensures that Canadians are covered for health care in all provinces (Armstrong & Armstrong, 1994: 21). What is important to note is that these principles are only enforceable as long as Ottawa continues to fund provincial health care programs.

Despite the apparent support for the Canadian health care system through their passing of the CHA, upon their election victory in 1984, the Progressive Conservative government continued to undermine the effectiveness of the program through increasing cuts to transfer payments to the provinces. Between the fiscal years of 1984-1985 and 1988-1989 transfers decreased from 27 to 19% of the total EPF (Tarman, 1990: 22). In 1986, the government reduced its contributions to economic growth minus two percent (Armstrong & Armstrong, 1996: 159). Over Mulroney's terms in Ottawa, the federal contributions to health care decreased substantially. Between 1985 and 1994, $22 billion was drained from medicare (Barlow & Campbell, 1993: 4).

Mulroney had to be careful not to take any obvious steps against medicare. They had supported the CHA in order to maintain public support and they did not want to be construed as hypocrites. Thus, they took a series of steps that would ensure the quiet undermining of the system (Weller, 1997: 129). They cut back federal funding in the name of trimming large and inefficient bureaucracies. Furthermore, they promoted voluntarism and philanthropy as a means of rationalizing the withdrawal of federal funds and privatization (Weller, 1997: 130). Also, in 1988 the Tories succeeded in implementing the Free Trade Agreement with the U.S. The agreement represents a back door for neoliberalism in that to ensure a "level playing field" between the two countries, Canada would have to scale down their social programs to U.S. levels (Rekart, 1993: 15).
Thus, the Free Trade Agreement has provided further momentum in the dismantling of Canada's social programs.

After the Tories regained power in the election of 1988, the pace of the cuts to social programs in Canada accelerated (Barlow and Campbell, 1995: 73). In 1989, the government further decreased its contributions to economic growth minus 3 percent (Armstrong & Armstrong 1996: 159). In 1990, the government put a total freeze on contributions and this continued into 1995 (Armstrong & Armstrong, 1996: 159). By now, social programs in Canada had suffered serious blows in the name of deficit cutting. At the provincial level, the effects of decreasing transfer payments were serious. The cuts in Ontario's health care budget slowed average spending growth from 10.1 percent in 1990-1991 to 1.1 percent for 1992-1993 and 0.2 percent in 1993-1994. Before this time, spending growth had never fallen below 8 percent in the province. The effects of such cuts were large. Between 1987 and 1993, 5000 hospital beds were closed in Ontario while the number of people treated grew by over 8 percent. To accommodate these numbers, there was a 23 percent increase in day surgery and an 8 percent increase in number of out-patients (Dzinkowski, 1994: 33).

Prime Minister Jean Chretien's Liberal government has been no less committed to the neoliberal cause. Since they took office in 1993, they have shown their interest in retreating from federal funding of social programs. In the 1993 election they promoted themselves as the defenders of Canada's health care system, accusing the Progressive Conservatives of encouraging a two-tiered system. They stated their intentions to protect medicare in their election campaign:
A top priority for a Liberal government will be preserving and protecting our universal medicare system, maintaining the values that underpin it while we reinvent the means by which health care services are delivered to people (cited in Weller, 1997: 123).

Chretien’s election promise on the topic of medicare was clear: "I don’t want a medical system in Canada where there will be a system for the rich and a system for the poor...We will keep it as it is, and nobody will touch it as long as the Liberal Party is there" (quoted in Barlow & Campbell, 1995: 191). But after only a short time in office, Paul Martin Jr. released the first budget which contained smaller federal transfer payments for the funding of health care.\(^2\) Jean Chretien suggested on CBC’s Morningside that $10 billion needed to be cut from the system. In the interview with CBC, Jean Chretien went on to say that federal funding of medicare had only been put in place to kick start the system. He said that medicare was only supposed to cover catastrophic illnesses and major surgery even though it was instituted to cover all medically necessary procedures (Weller, 1997: 135). This revealed Chretien’s willingness to overlook the Canada Health Act. Covering only these things, medicare would violate two principles of the act, that is accessibility and comprehensiveness of coverage (Barlow & Campbell, 1995: 192).

The federal budget of 1995 is said to have signaled a "fundamental shift" in the federal government's role in Canada's social programs (Pulkingham & Ternowetsky, 1996: 2). This budget merged the EPF with the Canada Assistance Plan into the Canada Health and Social Transfer. This meant that the CAP, which provided cost-shared

\(^2\)Paul Martin Sr. had been integral to the development of medicare as noted in the previous chapter.
funding for social assistance and welfare, would now be block funded under one payment which also included funding for post-secondary education and health. Because these programs were now funded in a lump sum, it would be difficult to determine if, and how much of health care payments had been cut (Weller, 1997: 134). In spite of this, it was clear that the lump sum did not equal previous funding levels. The full payments would be cut by billions each year beginning in 1996-1997. Within six or seven years, payments to the richer provinces would be zero with the others not far behind (Armstrong & Armstrong, 1996: 63). All of the provinces responded with cutbacks of their own. In the 1996 budget, the Liberal government slowed down these cuts and announced that it would freeze funding at $25.1 billion starting in 1997-1998 until the year 2000. Since the inception of the CHST, $6.3 billion has been drained from transfer payments (Canadian Health Coalition, 1997: 1).

Prime Minister Chretien has alluded to these budget cuts as a temporary situation - one where Canadians must swallow some tough medicine in order to continue to benefit from social programs. At the Liberal party convention in October, 1996 he commented on the decreased transfer payments to medicare: "We needed to squeeze it in order to keep it" (Chidley, 1996: 44). However, the effects of these cuts to medicare will probably not be temporary as they will serve to weaken the foundation of the system. While Prime Minister Chretien made promises to uphold the five principles of medicare, the erosion of the federal transfer payments means that the government may not be able to act on preserving them. The only condition given upon the CHST is that whatever portion the provinces use for health care has to ensure the preservation of these principles. In this
sense, the Liberal government can claim that they took steps to uphold national standards. However, with the decreasing financial help of the federal government, provinces may not be able to live up to the five principles. Furthermore, without the leverage of transfer payments, Prime Minister Chretien may not be able to force provinces to adhere to them (Weller, 1997: 134).

The Private Sector in the Public System

Private interests are not shying away from opportunities within health care as more and more of the system is opening up to the free market. Recently, this has become one of the most profitable areas of the market along with media, banking and high technology sectors. The corporate sector in the United States is realizing great profits within the health care industry. In 1995, the U.S. health care market experienced $44 billion worth of mergers (Krieger, 1996: 42). Thus, the private sector views our health care system as "one of the world's largest unopened oysters" which is worth about $72 billion in potential profits (Barlow & Campbell, 1995: 16).

Neoliberal policies favoured by the federal governments which have led to the free trade agreements, cutbacks in social spending and deregulation have made it possible for the business community to access some of these profits. The public portion of dollars spent on health care has been declining. In 1983, it accounted for 76 per cent of spending. By 1993 this had declined to 72 per cent. Furthermore, as a portion of GDP, public spending on health has decline from 6.7 percent in 1991 to 5.8 percent in 1993
(Barlow & Campbell, 1995: 195) All of this has meant that the opportunities for the private sector to pick up the slack are expanding. After the 1995 federal budget was released, a comment from George Ward, head of Alberta Blue Cross reflected this: "We're finding in Alberta with all the [federal] cutbacks, there are lots of opportunities starting to move out of the public health sector into a private environment" (quoted in Barlow & Campbell, 1995: 195).

Various services have been turned over to the private sector that were formerly done on a non-profit basis. The services that have been most vulnerable to this are those that are frequently described as "hotel services". These include, laundry, food preparation and cleaning. Canada's largest hospital, Toronto Hospital, has contracted out its food service, medical labs and several areas of maintenance including laundry and security (Fennell, 1996: 56). In contracting out these services, they are no longer designated as determinants of health. What is overlooked is that these are integral components of wellness and preparing food for the sick, for example, should not follow the same procedures as preparing food for those who are well (Armstrong & Armstrong 1996: 82).

Companies are also realizing great profit by offering top-of-the-line care to those who can afford to use their private institutions. King's Health Centre in Toronto is a privately-owned and operated "luxury" health clinic (Fennell, 1996: 56). The clinic offers publicly-funded health care services along with uninsured medical services. King's Health Centre will greatly benefit from any delisting of services done by the Ontario government. Once these services are no longer covered under OHIP, the clinic is free to offer them to clients for a price (Olunyk, 1997: 19). The centre's founder, Ron Koval,
plans to expand to other cities in Ontario.

In July 1997, Health Resource Group Inc. took over Calgary's Salvation Army Grace Hospital. The private hospital provides acute care and offers various surgeries to patients who can pay for them. Alberta Health Minister Halvar Jonson said he will ensure that the hospital does not charge patients for any medically necessary services (Private Hospital... 6 May 1997). However, this type of hospital represents the private interest in health care and the threat of its expansion into services covered by the public system. As the company hopes to expand to other provinces, private health care will experience a growing presence in Canada. Public hospitals are also contributing to this presence as many are considering renting closed beds to the private sector (Fennell, 1996: 56). For such hospitals and private clinics, delisting of services represents more profit potential. However, the principles of the CHA are compromised as delisting is essentially a form of privatization that has already created a two-tiered system, distinguishing those who can pay for the delisted services and those who cannot.

Insurance companies are more than prepared to profit from privatization. Already, they have begun to cover critical illnesses for which treatment is covered by public health insurance. Cigna Life Insurance Co. of Canada set the precedent for the trend in offering a critical illness insurance package designed specifically for women. It seems the company saw a market where medicare fell short. Women use the health care system much more frequently than men but only five percent of the national health care budget is designated specifically for women's health. The plan and others like it pay lump sums upon a diagnosis of various life-altering diseases and conditions such as cancer of the
uterus, fallopian tubes, ovaries, vulva, vagina, breast or cervix. The plan is designed to cover expenses of daily living that can greatly increase with the onset of such diseases and conditions (Bourette, 27 February 1997). Such expenses had in part led to the institution of medicare as Canadians recognized that illness should not impoverish anyone.

Matthews Posner & Associates Insurance Agency Ltd., a Toronto brokerage has also introduced their own critical illness package. The package is geared towards those who would like to pay extra for "first-class care". This insurance is specifically designed for potential patients of King's Health Centre. Under the coverage, the patient would be diagnosed at King's and then transferred to a place like the Mayo clinic in Rochester, Minnesota (Belford, 29 April 1997). ³ Here the patients are not bound to the Canada Health Act and can pay for medically necessary services. The president of the insurance company, Miles Posner recognizes that these critical illness packages are based on the premise that medicare is deteriorating (Belford, 29 April 1997).

Specialist-referral networks are also becoming popular. These networks take advantage of a loophole in the Canada Health Act. The Act specifies that Workers Compensation, rather than the provincial health plan pays for the treatment of injured workers whose employers pay workers' compensation premiums. Furthermore, if an insurance company requires a medical checkup for one of its clients, that check up is not deemed medically necessary (Stone, 1996: 22). The doctors are paid a certain amount by the network in return for "bumping privileges". That is, clients pay the network to secure

³King's Health Centre is associated with the private, American Mayo clinic.
them "rapid medical attention". When the clients need a medical appointment, the referral network calls one of the member doctors. Because that doctor is paid more by the network than public health insurance, they will usually find room in their schedule in the very near future for that patient. In many cases, this may mean the doctor cancels an appointment requested by a public health insurance patient to make room for the network patient (Stone, 1996: 21). The clients of the network include employers who want to confirm their employee's injuries and speed up their return to work, insurance companies who would like a quick diagnosis for clients' injuries and employers who provide this as a perk to top management (Stone, 1996: 21). Essentially, these networks cater to those who would like to pay doctors in return for privileged health care. Clients pay for access to top specialists and for appointments that "are [often] more leisurely and... comprehensive than those offered to regular medicare patients" (Stone, 1996: 22). A health care industry consultant, Tom Brogan recognizes what these referral networks mean for public health care: "We do have a two-tier system. Anyone who doesn't think so, dream on" (quoted in Stone, 1996: 25).

Privatization means the government is off-loading its responsibility for health care onto individuals. This often means that individuals pay private companies for care. However, it is also the case that privatization means that unqualified individuals provide care rather than expensive companies. For example, many provincial documents have recommended sending people home from institutional care as the best solution in many cases. However, this generally means that there is someone at home who must provide the care for free and usually at some expense in lost wages, equipment, special food,

Furthermore, such care givers are not properly trained to take care of the sick (Armstrong & Armstrong 1996: 140).

As the federal government continues to decrease transfer payments to the health care system, provinces have responded with cuts of their own. The strain on budgets has meant that the various sectors of health care can not provide the level of service that they could previously. Beds have been closed, services have been delisted, out-patient surgery has increased, staffing levels have decreased, waiting lists are excessive and the list goes on. All of this means that the market potential for private providers has increased. There are growing gaps in our public health care system that are increasingly being filled by the private sector. This private sector involvement means that the principles of the Canada Health Act are being overlooked and that the neoliberal agenda is being realized.
CHAPTER 5 - HEALTH CARE RESTRUCTURING IN WINDSOR/ESSEX COUNTY

The Win/Win Report

As indicated earlier, Windsor has been on the cutting edge of health care initiatives. In the 1930s, a progressive plan for non-profit medical insurance was developed for area residents. Now, in the 1990s, the community has found itself in a similar leadership position in health care, however the plans developed by the community are of a different sort. The health care establishment is in the midst of implementing a home-made plan that will heed to the provincial and federal government’s cost-cutting priorities.

In July 1991, a group of obstetricians voiced their concerns to the Windsor/Essex County District Health Council (DHC). In particular, they contested the fragmentation of obstetric services between Grace and Metropolitan hospitals. Neonatal intensive care was located at Grace while Metropolitan offered obstetric services. The result was that infants often had to be transferred from Metropolitan to Grace hospital to be cared for in the neonatal unit there. These doctors argued that the quality of care was compromised by this arrangement because it meant that some of the most fragile patients had to undergo risky transportation between the two institutions. For the first time, the DHC and the hospitals began to discuss the possibility of redesigning Windsor's hospitals (Schnekenburger, 1997: 35).

Hospital CEOs and consulting firms hired by each of the hospitals eventually came up with a discussion paper entitled A Vision for the Future in October of 1991. The paper recommended closing 200 acute care beds through the closure of one or two
Windsor hospitals. The District Health Council agreed that there was a need to re-examine the health care delivery system in the area (Schnekenburger, 1997: 39). To move ahead with a reconfiguration project, the DHC formed a Steering Committee that would make recommendations for local health care restructuring.

To a certain extent, this move allowed some members of the community to decide what kind of restructuring would take place in Windsor. The concerns voiced by obstetricians coupled with the realization that the provincial government was going to decrease funding to the area led to the unusual proactive step of developing the community's own restructuring plan that would accommodate potential budget cuts. The DHC was optimistic about the plan and said that it would put them in a more comfortable working position than other communities which had no such plan.

While most communities will be undergoing significant budget cutbacks over the next two years without a comprehensive plan for the reform and restructuring of their local health care systems, Essex County will benefit from the agreement that our District Health Council has negotiated with the Government of Ontario (Steering Committee on Reconfiguration, SCR 1994: 1).

Subsequent to the Steering Committee's release of a preliminary report in April 1993, the DHC gained the Ministry's support in the form of a conditional pledge of funding. Health Minister Francis Larkin supported the process but instructed the DHC to do more than restructure hospitals.

If you make savings here in Windsor, and if you can show me a plan for their true redirection into targeted community-based health services, I commit to Windsor/Essex retaining those savings for redeployment in your community. The dollars to support a shift to the community-based sector must come from Windsor generated hospital savings. We will not agree to see the bulk of those savings going back into hospital programming. And we will be looking for rationalization plans in the community-based sector as well, expecting that
efficiencies will be planned for in this part of the reconfiguration over the coming months (SCR, 1994: 3).

In February 1994, The Steering Committee's Final Report was released. The recommendations contained in the report were said to be beneficial to consumers, taxpayers, and health care providers. Thus it was called the "Win/Win" model (SCR, 1994: 1). The major recommendations put forth by the committee included closing two out of the four area hospitals, resulting in the loss of 540 jobs in the institutional sector, and the closure of 553 out of the 1430 beds in existence, or a 39 percent overall reduction in capacity. 4

However, to make up for the loss of services, jobs and beds in the institutional sector, the Win/Win model promised new and expanded community services with an annualized increase of about $40 million, $32 million of which would come directly from savings gained from restructuring both the hospital and community sectors (SCR, 1994: 3). Community services in Essex County would be up-graded based on a Community Rationalization and Enhancement study. This would mean the creation of 600 new jobs in the expanded community services and wages were to be equalized so that the rate of pay in the community sector would be brought up to the level of that in the institutional sector (SCR, 1994: 3, 11).

4The report did not include a figure for the beds that would be lost under the reconfiguration. However, it did include the number of beds that would be housed at the two remaining hospitals. I contacted the DHC to inquire about the number of beds that were in the system before the publication of the Win/Win model. I subtracted the beds that were promised in the report from the figure I received from the DHC to obtain the number of beds the Win/Win report recommended closing.
The remaining hospitals were also supposed to be improved so that Windsor would end up with "two modern, well-equipped acute care hospitals" to be up-graded with provincial capital of about $109 million (SCR, 1994: 4). A "Centre of Excellence" for Long Term Care was to be located at Windsor Western with at least 226 beds and perhaps 256 more if Huron Lodge relocated there (SCR, 1994: 5). Further promises in the report included expanded programs for mental health, a new women's health resource centre, a new governance system, an enhanced role for the DHC, a human resource project to aid employees in the coming changes and education programs made available to managers and front-line workers (SCR, 1994: 6, 9, 13).

The Win/Win model also recommended which hospitals should be closed. Before the release of the Win/Win report, it was decided that Grace hospital would close and Metropolitan would remain open. Thus, if there were to be only two hospitals in Windsor, Windsor Western or Hotel Dieu would have to close (Schnekenburger, 1997: 46). Hotel-Dieu and Grace had merged in the mean time and this put pressure on Metropolitan and Windsor Western to do the same. Only a month prior to the release of the Steering Committee's report, the two hospitals announced plans to merge (van Wageningen, 21 January 1994). What was left to decide was what sites the two merged hospitals would occupy. It was already confirmed that the Western/Metropolitan alliance (soon to be called Windsor Regional) would occupy the Metropolitan building. However, the site for Hotel-Dieu Grace was yet to be decided between the Hotel-Dieu and Windsor Western site. In the end, the Win/Win report recommended closing Windsor Western - a decision that would leave the west side of Windsor without a hospital.
Those at Windsor Western were surprised and outraged by the decision. The hospital excelled above the other hospitals in meeting several of the ministry's criteria such as existing property acquisitions and age of building and infrastructure (Schnekenburger, 1997: 46). Furthermore, the Windsor Western site would be less expensive in equipment costs (SCR, 1994: 222). In part, this decision was influenced by the merger between Hotel-Dieu and Grace. The proactive nature of the merger strengthened their case to keep the Hotel Dieu site open. The religious affiliations of both Grace and Hotel Dieu also played a role. Hotel-Dieu Grace would be the only denominational hospital left in Windsor. It would now be very difficult to gain public support for the closure of this hospital (Schnekenburger, 1997: 58). Hume Martin, former CEO of the DHC, described the perception of various hospitals as divided into three categories. Children's hospitals are considered the 'angels', denominational hospitals are the 'saints' and public general hospitals are the 'sinners' (Schnekenburger, 1997: 58). The Steering Committee knew there was a risk of losing the co-operation of the 'saints' if the Hotel-Dieu facility was closed (van Wageningen, 27 January, 1994).

The Labour Advisory Committee

In an effort to keep the interests of various stakeholders at bay, the DHC formed a Steering Committee to oversee the formation of recommendations for area health care. The DHC argued that the process should be undertaken by a disinterested group which would become the Steering Committee. This allowed the DHC to appear impartial and to be working in the 'interest of the public' (Schnekenburger, 1997: 67). Thus, members of
the hospitals, community agencies, doctors and labour were all formally removed from
the process despite the recommendation of the Task Force which had drafted *A Vision for
the Future* that "[p]lanning is a process which requires the ongoing participation and
commitment of both consumers and providers of health care services" (Schnekenburger,

Despite the formal removal of hospitals from the Committee, they had already
been allowed some input in the development of the Win/Win model. It was area hospitals
that drafted the preliminary paper that proposed the closure of two hospitals. Moreover,
they also helped choose the consulting firm that would aid in the decision of which
hospitals to close (Schnekenburger, 1997: 44). Furthermore, the Essex County Medical
Society had a representative on the Steering Committee which allowed physicians to
voice their concerns. Also, Dr. Paul Ziter was a member of that Committee where he was
able to increase the influence of area doctors (Schnekenburger, 1997: 54). Therefore,
both physicians and hospitals had influence over the Steering Committee's
recommendations. Labour representatives had been given no opportunity for such
influence. The Steering Committee did not want labour at the table. They felt that they
were a special interest group and would be difficult to manage (Schnekenburger, 1997:
49). It was only after much protest that labour finally received representation on the
Committee through Gary Parent (Silversides, 1994: 26).

It seemed that the decision to allow a labour representative on the Steering
Committee was a political one rather than being based on a true concern for fair
representation of stakeholder groups. The DHC felt it needed to gain support of the
public and to do so, it would need the support of as many groups as possible (Schnekenburger, 1997: 44). Both the hospitals and labour groups had protested vehemently against their exclusion. Hospitals told the DHC they would not endorse any recommendations made without their consultation (Schnekenburger, 1997: 45). The DHC knew that it could not gain public support for a reconfiguration plan that was not supported by hospitals (Schnekenburger, 1997: 45). So it seems that when the DHC decided to invite hospitals into the process to gain public support, they would also have to invite the other group that had protested its own exclusion. Thus, in early 1992, the Labour Advisory Committee (LAC) to the DHC was formed.

The Labour Advisory Committee was composed of members of all seven unions at the hospitals and was represented on the Steering Committee by Gary Parent (president of Windsor and District Labour Council). The Committee made it clear from the start that while indeed they represented the interests of the many workers who would be affected by the hospital closures, they also represented the interests of "patients and the community as a whole" (LAC, 1992: 1). This dual mandate has meant that the LAC has consistently provided a meaningful and critical voice in the process of the planning and implementation of reconfiguration.

The Neoliberal Win/Win Model

The LAC was reluctant to support the final plan released by the Steering Committee in January 1994. In fact, very early in their official involvement, Karen Morrison, member of the Windsor and District Labour Council and eventually the LAC
noted that the message they seemed to be receiving from the hospitals at the time was about "bed closures, layoffs, concessions and the whole conquer and divide theory" (Morrison, 1992: 2). Gary Parent, the labour representative on the Steering Committee said that labour's decision to participate was indeed a "big gamble" (Silversides, 1994: 26).

Eventually, labour was swayed on side with promises of state of the art facilities, a centre of excellence for long-term care and an investment in community services (Walter, 8 November 1995). They felt that if the plan was implemented as laid out in the report it would be a better health system for the community with enhanced programs, new technology and the staffing to run this. Furthermore, the community sector was to be enhanced allowing for the redeployment of jobs upon the closure of two hospitals. All of this was to be run by a new governing system that would be designed to be accountable (Pierina DeBellis, 16 January 1998).

Labour’s scepticism may very well have been warranted. Armstrong and Armstrong say that community-based care has become a major theme in several recent government proposals for health care restructuring (Armstrong & Armstrong, 1996: 135). However, they warn that rather than being a firm commitment to meaningful reform, shifting care to the community too often meant shifting care to the "lowest cost care provider" (LCCP). Often this means that much of the work is reassigned from the doctor to the RN or RNA. Moreover, increasingly, the favoured LCCP is someone who has little or no training. This kind of LCCP is low cost because they work outside of institutions and therefore have little contact with co-workers, making it difficult to form
unions. But the cheapest community care-givers are the people who provide care to their family at no cost to the system. This work is disproportionately done by women so much so that Armstrong and Armstrong say that community care is really another way of saying care by women (Armstrong & Armstrong, 1996: 136).

Several occurrences lent support to the notion that the DHC and the Steering Committee were at best, casually committed to enhancing the community sector despite their assurances that "everything must be done to protect and enhance the unique caring culture of the community sector" (SCR, 1994: 83). The community agencies were invited to contribute very late in the game and the community enhancement and rationalization study began three years behind schedule. While the Win/Win report came out in February 1994 touting the importance of beefed-up community services, the community study was not even scheduled to begin until later that spring. Before this, there was little effort in bringing the 230 community agencies together to offer input into the process. Ultimately then, the community sector had little input in the final report released by the Steering Committee that stressed the importance of community sector enhancement (Schnekenburger, 1997: 55).

Moreover, the community sector study was given only half the time that the hospital study took to examine five institutions while this would have to look at over 200 agencies (LAC, 1993: 5). The LAC argued that this study should have been done before recommendations for hospital closures were made to ensure that precautions were taken against a budget-minded government and a DHC that might begin hospital cuts before community services were in place (Silversides, 1994: 26; LAC, 1993: 5). Upon the
release of Win/Win, it was clear that the Steering Committee was not committed to this and in fact planned to proceed with community and hospital restructuring at the same time because, they claimed "...with budgets about to be cut across the board, it is clear that we have no choice but to proceed with hospital and community restructuring at the same time" (SCR, 1994: 84). The DHC’s refusal to demand the completion of community sector enhancement before any changes were made in the hospitals led the LAC to fear that the economy was the driving force behind reform, rather than a true commitment to improved health care for the community. (LAC, 1993: 34)

As will be discussed later, hospital restructuring was actually carried out before Windsor/Essex County would see any government funding for community sector enhancement. Already in 1993 as a result of provincial reforms for long term and chronic care patients, many patients would no longer qualify for chronic care. Thus, many chronic care beds were closed and patients were transferred to nursing homes(Walter, 14 October 1993). This was perhaps the precedent-setting contravention to the assurances that the community sector would be enhanced before reductions were made in hospital care. Many such violations of the promises made by the DHC would later become a normal occurrence.

Indeed the language used throughout the report corresponded with a neoliberal worldview which sheds some light on the assumptions made by the Steering Committee in forming their recommendations. The authors of the report borrowed much of the language from the private sector referring to health and social services as "corporate cultures" (SCR, 1994: 51) and consistently labeling the users of the health care system as
"consumers". The Win/Win model also reflected the corporate preoccupation with efficiency, claiming the model gives stakeholders a chance to "help re-engineer a better, higher-quality, more efficient and more consumer friendly system..." (SCR, 1994: 21 emphasis added). Moreover, the authors of the report were resigned to the "realities" of provincial and federal deficits which translates into the inevitability of restructuring:

...it is clear to us that our existing structures cannot survive over the next three years. While our medium and longer-term economic prospects are brighter, the reality is that in the shorter-term, public services will be downloaded and restructured (SCR, 1994: 22).

Meeting fiscal constraints of a cash-strapped society was explicitly laid out in the introduction of the Win/Win model as the motive behind the restructuring. Even the plans for community sector enhancement sounded suspiciously like plans to reduce spending through "rationalization of common services" and "strategies to increase [administrative] efficiencies" (SCR, 1994: 16). And indeed, the DHC planned to reduce the number of community agencies from over 200 to thirty (Cross, 3 February 1994). If the priority of restructuring was based largely on cost savings, one should wonder about the monetary commitments put forth in the Win/Win model. If the money to be saved in hospital restructuring was to be pumped back into the community sector, how would this meet the priorities of budget constraints? How would wage equalization between the two sectors result in the savings deemed necessary? There seemed to be a lot of promises in the model for changes that would invest money instead of withdrawing it. Therefore, one should wonder if indeed these promises would be met or would cost-cutting take priority in the end?

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There was also evidence in the Win/Win report that the Steering Committee was largely committed to the traditional medical model that focuses on curing and treating patients rather than care and prevention - methods most often used in the community sector. This focus on cure leads hospitals to develop acute care centres for treating specific body parts. Indeed, the Win/Win model prescribed an arrangement of services among the hospitals that would avoid "duplication" or in other words, ensured that specific programs would only be offered at one facility (SCR, 1994: 143). These arrangements prescribed by the medical model would allow the hospitals to focus on accomplishing procedures and therefore shortening patient length of stays (Armstrong & Armstrong, 1996: 19). Likewise, the Win/Win model based its selection for the best hospital site in part on the hospitals' "ability to eliminate short, or extended portions of hospital stays in favour of day surgery, ambulatory care procedures, and earlier discharges" (SCR, 1994: 111).

This compliance with the medical model has been linked to the compromising of care and even the privatization of the delivery of services. Under this model, certain tasks are assumed to be non-medical such as bathing, feeding and talking with patients. This legitimates staffing cuts as employees are forced to perform only medical tasks. Jobs such as food preparation and cleaning are considered hotel services rather than health services so that it is acceptable to have less qualified personnel do these jobs (Armstrong & Armstrong, 1996: 22). This has led to the legitimation of the privatization of these services (Armstrong & Armstrong, 1996: 147).

The DHC employed two consultants to aid in the development of the Win/Win
model who made recommendations that could jeopardize our public health care system. Both Price Waterhouse and Health Concepts Consultants recommended Total Quality Management (TQM), a management model developed for the private sector, be used in our reconfigured system (LAC, 1993: 8). The application of private sector tools in our public system is a form of privatization (Armstrong and Armstrong, 1996: 147).

Moreover, both business' own sources such as The Wall Street Journal and the Conference Board of Canada estimate that between 70 and 80 percent of TQM programs fail (LAC, 1993: 8). While the model purports to extend worker autonomy it is a top-down rather than a bottom-up autonomy. The focus on cost-cutting and resulting job reductions means workers are instilled with fear (Armstrong & Armstrong, 1996: 125). The move to "multi-skilling" most often means that more tasks are assigned to already overworked employees (Armstrong & Armstrong, 1996: 128).

The Implementation of the Lose/Lose Model

Despite the above evidence that the Win/Win plan was more committed to cost-cutting measures than the enhancement of care, the model was touted as being a model for the best health care system in the country.

...the people of Essex County will obtain what we think will be the finest system of health and health-related services available anywhere in the province or country. For the stakeholders in the system, we believe that the 'Win/Win' Model...has also lived up to our commitment to ensure that everyone would emerge from total system reconfiguration as "a winner" (SCR, 1994: 2).

While my analysis shows that the restructuring plan developed by the Steering Committee may be more accurately labeled "Lose/Lose", there was at least some reason
for hope. The provincial government made a financial commitment that might have prevented the total preoccupation with budget reductions. The Ministry of Health under the Rae government pledged $66 million for capital funding, (another $33 million would have to be raised locally), and agreed to allow hospital savings of $22 million to be reinvested annually in community care.

In 1995, however, Mike Harris' Progressive Conservatives were elected in Ontario. Joe Durocher, the Progressive Conservative candidate for Windsor-Sandwich, referred specifically to his party's advocacy for local initiatives in health care reconfiguration stating: "the PC policy is to support restructuring done by local communities" (Ford, 7 June 1995). Harris also seemed to have vowed to maintain funding levels for health care saying: "I will not lead a government for which health care is not anything but a priority spending area. That's the No. 1 commitment that we make to health care" (Brennan, 19 October 1995). However, the double negative contained in this promise, whether inadvertent or not, foreshadowed Harris' true intentions. Two months after the election, Premier Harris reneged on these promises. The Conservative government told local hospitals that it would not agree to the capital funding promised by the NDP government (Ford, 31 August 1995).

A few weeks later, a second major assault was made on the Win/Win plan. The Ministry of Health purported that the agreement that had been made with the NDP government on the annual $22 million in funding for community services was "too restrictive" (Brennan, 19 October 1995). The loss of these savings would mean that a major premise behind Win/Win would be undermined (Brennan, 19 October 1995). It
was no longer clear how the community-based system would be able to operate.

Upon the ministry's announcement that they would not honour the agreed upon amount of capital funding, they gave the DHC a mere three weeks to come up with a proposal for some unspecified, lower request for funding (Brown, 8 September 1995). A guest column published in *The Windsor Star* by the two co-chairs to the LAC, Valerie Walter and Pierina DeBellis, pointed out that Health Minister Jim Wilson's stated commitment to reconfiguration should be considered suspect. If he was not going to put the required funding forth essentially the plan would be strangled (Walter & DeBellis, 12 September 1995). Eventually, the government refused the second proposal of $40 million grant and $40 million loan to be paid back over 4 or 5 years (Hospital renovation... 18 October 1995). Thus, the implementation committee was back to the drawing board in a rush to make another offer in just one month's time. Just over a week later, the implementation committee of the DHC came up with the magic number of $72.4 million, with two-thirds of this requested from the government and the rest to be raised locally (Ford, 27 October 1995). This was a thirty percent decrease from the original pledge from the NDP government. Thus, the Win/Win plan would have to be altered to accommodate this cut in funding.

This final proposal to the ministry meant that the Labour Advisory Committee would no longer endorse the reconfiguration project. The LAC saw the DHC folding under the Harris government and thought that hospitals and doctors along with the DHC should have protested rather than giving in to the government's cut-rate approach to funding (Walter, 16 January 1998). Technically, the DHC was supposed to be a local
body ensuring the needs of the community, but as Valerie Walter explained: "...[the DHC] is not a local body. They're appointees of the government who are there to do the government's bidding" (Walter, 16 January 1998). As this became more evident, the LAC decided it could no longer support the council's actions. Members of the LAC decided they would continue to work toward ensuring the community would secure a quality health care system from outside the DHC (Jarvis, 3 November 1995).

The Tory government was only five months into office and the assaults on health care continued. Ernie Eves released his budget at the end of November in 1995. An 18 percent cut over three years would be implemented across the province. This meant that $39 million would be cut out of area hospitals by 1998 to 1999 (Lajoie, 8 December 1995). Eventually, after inflation and the costs of restructuring were added to the 18 percent, this would really represent a 30 percent cutback (Abraham, 7 November 1996). Add this to the lack of community sector funding and the uncertainty over capital funding and it seemed clear now, if it hadn't before, that patient care would indeed be suffering (Ford, 30 November 1995). However, Hume Martin, CEO of the DHC remained optimistic. He noted that health care was the only provincial department expected to maintain its budget. Eves had promised that by the end of their term in office, the Tories would return health care funding to its 1995 level (Ford, 30 November 1995).

Finally in March of 1996, the DHC was told that the government would accept their last proposal of $72.4 million to cover restructuring costs with one third of that being raised locally. The provincial government would give $48.3 million and the hospitals would be responsible for the other $24.2 million (Jarvis, 13 March 1996).
Labour continued to voice their concerns, criticizing the government for giving a reduced capital grant and the lack of commitment to funding for the community sector (Rennie, 13 March 1996). Above and beyond this, $12 million still had to be removed from local hospitals as of April 1st to meet the required 18 percent cutback (Rennie, 13 March 1996). In part, the hospitals turned to job cuts to meet their reduced budgets. By fall of 1996, Hotel Dieu announced it would cut 107 jobs resulting in a total loss of 303 full time equivalent jobs at that hospital in the last two years. Together with Windsor Regional's job cuts, the city lost 557 hospital jobs in the last couple of years with more to come (Cross, 1 October 1996; Cross 5 October 1996; Cross, 12 October 1996). Despite the promises laid out in the Win/Win Model there was no enhanced community sector to replace the jobs and services that had been compromised by the lack of funding. The result of all of this was felt immediately. The staff became rushed, patients were discharged sooner and families were forced to provide care when their loved-ones were sent home early from hospital (Priddle, 4 November 1996).

Windsor's ability to provide its residents with quality health care continued to decline with the announcement in January of 1997 that the emergency room at Windsor Western would be closing On April 18th of that year. This meant a further staffing cut of 40 to 50 workers (Thompson, 10 January 1997). While the Win/Win report was clear in its intentions to do this, many thought that the closure should be delayed because the preparations had not been made at the other two hospitals and moreover, Windsor Western's emergency room continued to be very busy (Thompson, 10 January 1997). The closure would come before Hotel-Dieu Grace would get the $13 million needed to replace
the closed emergency room (Longmoore, 24 June 1997).

It was by now clear that the procedures laid out in Win/Win were gone by the way side. In fact, what was happening now was not "restructuring" or "reconfiguration" but simple cutting of services, beds and staff with no replacement in the community sector. This trend continued. At the end of January of 1997, it was proposed that all psychiatric beds at Metropolitan hospital be closed in spring without the 33 beds that were scheduled to be added to Hotel-Dieu Grace (Jarvis, 1 February 1997). It was of great concern that this proposal was made despite the already over-loaded nature of psychiatric services in Windsor. At the time there were only 10 psychiatrists in Windsor where those in the field say there should be 35 (Jarvis, 31 January 1997b). Furthermore, over 245 people who had serious, chronic mental illnesses were on a waiting list for help from the Canadian Mental Health Association (Jarvis, 31 January 1997b). This was enough evidence to show that the government was not committed to improving mental health even without considering the fact that the community was still waiting for its share of funding promised by the provincial government two years before for mental health services (Jarvis, 31 January 1997b). And only a month after this announcement, the HSRC (Health Services Restructuring Commission) revealed that they planned to close St. Thomas and London psychiatric hospitals by 1999. Forty of the affected patients were from the Windsor area. The HSRC promised Windsor additional funding for beds to accommodate these patients but health care professionals were not convinced. They worried that the closure would take place before the necessary services were in place in Windsor because all the evidence suggested that this had become the accepted procedure with the provincial government.
Meanwhile, hospitals continued efforts to meet the budget cuts required by the province. Hotel-Dieu Grace asked its prized neonatal unit to make cutbacks. Excluding other programs like it that are housed in teaching hospitals, this neonatal unit was considered the most advanced in the province. The medical director of the unit argued that it would no longer be able to provide care to high risk mothers and babies with any further cutbacks. A decreased budget could only be met if high-risk babies and mothers went out city and even the country for care (Jarvis, 4 February 1997).

Windsor Regional was also trying to cope with the cutbacks. The hospital decided that their cardiac education program would be eliminated. This program taught cardiac patients how to care for themselves and prevent heart disease. What was perhaps most perplexing was that this decision was made despite death rates from the disease being 20 percent higher in Windsor than the provincial average (Jarvis, 8 February 1997). Moreover, the decision was in direct contravention to the Win/Win model's "...objective...to make prevention and health promotion an essential part of our health system..." (SCR, 1994: 88). It seemed evident that the changes taking place in Windsor were mere cost-cutting measures.

The state of health care in the area continued to deteriorate. One of the biggest attacks yet to residents of Windsor occurred on April 18th when Windsor Regional closed its emergency room and acute care services. This occurred before funding was made available for the up-grading and expansion of the other two emergency rooms in Windsor. The effects were felt immediately at the two remaining emergency rooms (Thompson, 19
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UMI
Eventually, in March of 1996, the Harris government agreed to $72 million in capital funding for restructuring. The mood conveyed by The Windsor Star was celebratory with articles centred around descriptions of the areas the money would go toward. (Brennan, 12 March 1996; Jarvis 13 March 1996). The newspaper quoted a local health official who explained that this announcement meant there was indeed reason to celebrate:

"That is basically what we asked for in the latest proposal. What you are telling me is good news," Colin Ball, chairman of the Essex County District Health Council, said Monday night. Windsor is the first region in Ontario to receive capital grants from the province to implement restructuring (Brennan, 12 March 1996).

An editorial on the following day continued the optimism: "Last month, the prognosis looked bleak. This week, the diagnosis is excellent - $48.27 million from the provincial government so local hospital restructuring can finally kick into high gear" (Health care: journey...13 March 1996). Perhaps it was easy to rejoice when funding announcements had largely been about cutbacks for quite some time, but one should look more closely at what the government's agreement really entailed. Essentially, this was a disguised cutback. The original amount pledged by the NDP government was upwards of $100 million. Therefore, this was at least a 28 percent cut from what the Win/Win model had deemed necessary. Moreover, in the meantime, the model had undergone other serious assaults. The Tories had reneged on funding for the community sector, ($22 million per year), and had implemented an 18 percent cutback on hospital funding across the province. Nonetheless, the $72 million amount and the resulting changes to the reconfiguration plan was legitimated by Colin Ball, chairman of the DHC: "We would
have liked a deluxe version, but we understand that these aren't times for deluxe hospitals" (Brennan, 12 March 1996).

In a short article that provided some critical insight into the funding announcement, the LAC accurately pointed out that this was not simply a matter of scaling-back on a "deluxe" plan but represented a severe compromise to our health care system (Rennie, 13 March 1996). Moreover, this article provided the only critical mention of this reduction in capital funding in the context of loss of community sector funding: "Windsor & District Labour Council President Gary Parent said the government's failure to commit another $22 million a year once promised community health agencies...was the "bad news" that the health minister didn't talk about" (Rennie, 13 March 1996). While the two other (larger) articles and an editorial that followed the announcement also mentioned the loss of community funding, all justified it in some way. Half way through the first article, the reporter noted that "The former NDP government also promised hospitals could keep any savings realized from restructuring. Wilson has said no to that scheme, saying health-care dollars are too scarce these days to concentrate in one city" (Brennan, 12 March 1996). Thus, the claim that there is an absence of available funding served to justify the loss in capital dollars. Moreover, whatever fears may arise from the loss of this funding were eased by subsequent reports that money for that sector would still be available: "And while the money saved by restructuring health care in Windsor will not automatically be spent on improving community services here, the government will consider requests for money for services" (Jarvis, 13 March 1996). The editorial noted similarly that the Minister of Health has "given every impression
funds will be available as needed" (Health care: journey...13 March 1996).

The Grim Reaper of Ontario's Health Care

Harris formed the Health Services Restructuring Commission (HSRC) out of "one of the most hated and undemocratic pieces of legislation ever to be rammed through any provincial legislature: Bill 26" (OHC, 1997a: 1). Known as the "omnibus" bill and created for the sole purpose of cutting government spending on social programs, it gave ministry of health sweeping powers. The commission was basically granted an absolute bill of right to close hospitals in the name of debt and deficit control (Longmoore, 24 June 1997). There were strong reasons for the community to fear the arrival of the Health Services Restructuring Commission. Across the province, the Commission had recommended the closure of 23 hospitals before it even visited Windsor in 1997 (Jarvis, 13 May 1997).

Despite the track record of the HSRC, The Windsor Star was less than critical in describing their visit to the area. While some of the coverage conveyed a sense of anxiousness about their arrival in Windsor, after their review of the area's hospital the newspaper was largely positive about the HSRC's visit. An editorial described the commission as a group that could determine if we were on the "right track", and if we had "made the best use of our resources, or is there room for improvement in areas we've never considered?" (Hospital Reform: Commission...14 May 1997). When one considers the Ontario Health Coalition's (OHC) description of the HSRC as "a political body [that]
enable[s] the government to pretend an 'arms length' relationship from huge funding, staffing and service cuts, and sweeping privatization", it becomes probable that what the editorial referred to as "improvement" in the use of resources was not about enhanced services or job creation but cost-cutting measures (OHC, 1997a:1).

Unlike *The Windsor Star*, the OHC has provided a critical evaluation of the HSRC. They have noted that the composition of the commission is questionable in terms of its representation of the population of Ontario. Most of the commissioners appear to be relatively wealthy - those who could possibly purchase health care if needed (Benedict, Mussett & Simmons, 1997: 4). At least one commissioner represents a severe conflict of interest to our public health care system. Hartland M. MacDougall is a Deputy Chair of London Life, an insurance company that could profit directly from the erosion of public health care (Benedict, Mussett & Simmons, 1997: 4).

Unfortunately, *The Windsor Star* neglected to expose these important details. Instead, the newspaper cited commissioner Shelly Jamieson who said the HSRC’s goals were to move toward a "genuinely integrated, co-ordinated and sensibly organized system of health care services" (Jarvis, 13 May 1997). While an organized system could certainly benefit the community and others like it around the province, one should be leery of the kind of organization being proposed. The commission has promoted integrated delivery systems which many caution are dangerously close to HMOs in the United States (OHC, 1997b: 1). Furthermore, the OHC noted that virtually no media exposure was given to the HSRC's instruction to all communities across the province to "submit a plan to maximize the efficiency of the delivery of administrative services,
support services and diagnostic services which must address alternative delivery systems, *including services that can be provided by the private sector*" (Benedict, Mussett, & Simmons, 1997: 15 emphasis added).

*The Windsor Star* further legitimated the HSRC by referring to the commission as a long-needed objective yardstick to measure health care delivery across the province (Hospital Reform: Commission...14 May 1997). Thus, the newspaper has adopted the neoclassical regard for "objective" methods of inquiry that date back to the work of Alfred Marshall who championed the removal of the examination of polity from economic study (Marshall, 1949: 36). However, many argue that these objective methods lead to disastrous recommendations. None of the coverage mentioned that the OHC has found the HSRC's yardstick to be severely flawed, noting that "The use of rigid mathematical models that are devoid of any human element is dangerous" (Benedict, Mussett & Simmons, 1997: 1). Furthermore, the HSRC's use of the Planning Decision Support Tool (PDST) is extremely troublesome. This is a method used in determining the appropriate number of hospital beds for a city and includes no "qualitative methods that are essential for the task" (Benedict, Mussett & Simmons, 1997: 6). In fact the PDST manual itself recognized the severe limitations of the method and noted that statistics used in the PDST are intended as a starting point and usually require additional research (Benedict, Mussett & Simmons, 1997: 6). What is more, the HSRC relies on bench marking techniques that seem to be borrowed from Toyota's Continuing Quality Improvement. The use of this private sector tool in our health care system is dangerous. It involves the use of a formula that rates a particular hospital's efficiency level. Hospitals
are aware that if they are given a low-ranking, they will be penalized. This has led to hospitals striving to discharge patients faster and faster (Benedict, Mussett & Simmons, 1997: 6).

**The Little Problem of Big Companies**

The increasingly promoted claim of the extreme costs of public health care served to manufacture consent for a plan that essentially has the hospitals themselves raising tens of millions of dollars. Such heavy reliance on donations means that our health care system is not guaranteed. That is, the plan can only be implemented if private donations add up to the $34 million now determined as required to finish reconfiguration (Cross, 13 February 1998a). While *The Windsor Star* reported on the fund-raising campaigns, the newspaper rarely questioned the practice of having the community raise such a large amount of money. When Ernie Eves delivered his first budget in November 1995, *The Star* noted that as a result, hospitals would be encouraged to raise more of their own money (Ford, 30 November 1995). However, this was not linked to the fact that local hospitals had already begun a massive fund-raising campaign to cover the capital costs of restructuring. In fact *The Windsor Star* celebrated Eves' decision to allow various organizations to create crown foundations which could offer bigger tax breaks to large donors (Brethour, 2 February 1996). The article failed to mention that these tax shelters will largely benefit the rich, those who will be most likely to make such "mega-gifts".

*The Star* gave little reason for concern and even celebrated the "co-operative spirit" of the hospitals which joined together to raise the money for reconfiguration.
(Cross, 30 April 1996). But as Karen Morrison of the LAC pointed out, there was cause for great concern. There were several multi-million campaigns going on in Windsor at the same time including a $37 million one for the University of Windsor. Morrison has experience in fund-raising, working with the United Way on their campaigns. She noted that it was difficult to meet the goals of even this well-known and organized campaign (Morrison, 22 January, 1998). In 1997 the United Way’s goal was just under $8 million (Crawford, 22 November 1997). One should compare this to the $34 million campaign for local hospitals. One article did in fact describe the rising number and size of campaigns and the subsequent possibility that donors may become “tapped out”. The article stated:

There are local campaigns for the university, the cancer centre and our hospitals, as well as buying an MRI, plus the United Way and numerous smaller causes with a cost of more than $80 million. That’s a considerable challenge even for a community that’s prided itself for taking care of its own. “The competition (for donations) is the highest I’ve ever seen says Jim Broderick, manager at the Brentwood Recovery Home for Alcoholics (Cross, 18 November 1997).

The same article briefly noted the government’s role in the rise of these mega-campaigns: “As governments downsize and download, putting pressure on local agencies to do more with less, more groups are trying to find financial answers in fundraising. The average given to charities has gone from $545 in 1990 to $647 in 1995, says Statistics Canada, and charities are wondering how much more people can give” (Cross, 18 November 1997). However, the newspaper failed to examine the essence of social programs in this context. The increasing number of such campaigns should be considered a threat to our health care system. Our social programs are supposed to be paid for with
tax dollars. Instead, we are increasingly having to rely on the private money of large

 corporate donors. For example, Shoppers Drug Mart pledged $250 000 to help pay for a

 birthing centre at Windsor Regional Hospital (Cross, 29 October 1997). The same

 hospital was able to open a new Coronary Care Unit in April of 1997 because of a $500

 000 donation from the president of Tamco Ltd. (Lajoie, 8 December 1997). These

 donations are not guaranteed which means that the survival of our social programs are

 also not guaranteed. Moreover, the escalating reliance on donated money has meant that

 the our social programs are dependent upon the increased involvement of the private

 sector in our public programs. The newspaper did in fact note that necessary

 improvements to our hospitals would be contingent upon the success of the fund-raising

 campaigns, but did so in a manner that did not question or challenge this troubling notion:

 “A successful campaign will mean local jobs and the addition of needed medical

 specialists to cutting-edge facilities...Patients will see big changes at local hospitals if the

 money is raised” (Bailey, 27 December 1997, emphasis added).

 The Windsor Star has neglected to examine alternatives to the slashing of social

 programs on any meaningful level. Instead, The Star has referred to the neoliberal priority

 of cutting funding for public health care as a mere and sometimes unfortunate "reality".

 For example, upon the announcement that the provincial government would not agree to

 the $100 million for capital funding promised by the former NDP government The

 Windsor Star served to justify this, by lamenting the "reality" of the times: "In the fiscal

 climate of the 1990s, well-behaved hospitals can no longer expect to find piles of cash

 under their pillows" (Ford, 2 January 1995). In this, The Star promoted the neoclassical
disdain for the "inefficient" public sector. The assumption here was that the public system at one time doled out "piles of cash" in an irresponsible manner. It is this kind of disdain for the supposed superfluous public sector of the past that serves to justify the private sector's emergence into our health care system.

Moreover, it seems that parts of the public sector are set up for failure to justify privatization. For example, rail travel in Canada, although very popular, has been undermined because it is public (Winter, 1997: 148). The railway transportation of goods has remained in the private sector because it is a very lucrative business. However, public transportation has been transferred to Via Rail - a public service. Thus, the public sector is left to provide the expensive service. Furthermore, Via Rail has been constantly undermined by cutbacks that have meant that routes have been canceled and those that are left are often slow and infrequent. After people stop using Via Rail because of the lack of quality in service, the drop in customers is used to justify further cuts. This ultimately results in a justification for privatization (Winter, 1997: 149). The reasoning behind this is that the "inefficient" public sector cannot be successful in such endeavors. This is better left to the private sector. In the case of health care, the road is similarly paved toward privatization. As the quality of care diminishes because of cutbacks, the private sector is increasingly regarded as a solution to the "inefficiencies" of the public sector.

Bagdikian explains that the mainstream media generally focus on the failures of the public sector while simultaneously ignoring the failures in the free market system (Bagdikian, 1992: xxiv). The result is a privileging of the private sector - an incomplete analysis that results in a sort of endorsement of the free market system. The Windsor Star
gave a similar endorsement in the context of health care not only through inaccurate
descriptions of the failings of the public system as described above, but also through the
adoption of private sector discourse in reporting on public sector domain. The newspaper
adopted language traditionally used to describe the corporate world in reporting on our
health care system. The public was often referred to as consumers of the health care
system while hospitals were described as corporations. The heads of hospitals and the
DHC were given the title of chief executive officer. Accordingly, Lloyd Preston, head of
Windsor Regional Hospital referred to himself as "the CEO of a new corporation" (Cross,
20 January 1995). The use of this discourse while tracking the hospital mergers, meant
that the newspaper conveyed an illustration of our health care system that often seemed to
more closely resemble a discussion of the transactions of Bay Street.

This economic discourse is thus not confined to the traditional economic realm of
the study of the free market. Instead, mainstream economic thought has been applied to
increasing areas of life (Miller cited in Whalen, 1987: 259). Accordingly, this discourse
comes to inform our very ideas about the world. By referring to the public system in
private sector terms, The Windsor Star dismissed the "publicness" that defines our health
care system. The relationship between CEO and consumer does not accurately describe
the relationship between our health care providers and the public. The comparison to the
private sector serves to disempower people and leaves them unattached from the
workings of our health care system. The influence consumers have over the CEO of a
corporation is confined to their buying power. On the other hand, in principle, the public
has very real influences over our policy-makers and how they run our social programs.
The adoption of this discourse is problematical. Tuchman has illustrated that news informs the way we define reality (Tuchman, 1978: 180). The privileging of private sector language means we may come to define our health care system in private sector terms - thus glossing over the important distinctions between the two sectors and favouring the inclusion of our public health care system in the corporate world.

While *The Windsor Star* neglected to thoroughly examine the extent of privatization in the system, there were some references to the involvement of the private sector in our health care system. 4 However, the coverage did not reflect the growing amount of corporate involvement and rather promoted the assumption that while the provincial government had no plans for a widespread privatization of the system, it was perfectly acceptable to privatize some services to increase efficiency. Upon the realization that the Harris government might not provide the capital funding promised by the Rae government, *The Windsor Star* reported that: "Hospitals are looking at everything from private development to treating Americans to make up the shortfall and keep the local health care reconfiguration from falling apart" (Ford, 31 August 1995). The competence of the public sector was called in to question as the private sector was defined as part of a solution to save the revered Win/Win model. This served again to privilege the free market while the dangerous connection between private sector involvement and the erosion of our public health care system was not examined.

Four months into Harris' reign, *The Windsor Star* ran an article that speculated

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4 for an examination of corporate involvement in the Canadian health care system, see Chapter Four.
about the future of community care. The article conveyed a sense of optimism despite the loss of $22 million in annual funding for that sector. The reason for such an outlook? With public services becoming more and more strained, patients would have to turn to the private sector: "[Community-based health care providers] say the closing of hospital beds should logically mean more money for the private and non-profit agencies that provide nursing and homemaking care in homes and smaller institutions" (Rennie, 20 October 1995). Fran Scott, manager of Para-Med Health Services, a private American company, noted that the PC government was looking for agencies that could provide services at the lowest cost - public or not. What was not stated was that public agencies have been starved by government cutbacks and it is not likely that they would be able to under-bid the private companies. Thus, the government would probably buy private services over the VON and other publicly administered organizations (Pierina DeBellis, 16 January 1998).

This is an example of one of the most effective and pervasive myths about the private sector. As shown with the case of Paramed, their involvement in our health care system is justified on the basis that they can save the system money. However, Armstrong and Armstrong note that private sector strategies can actually increase costs (Armstrong & Armstrong, 1996: 9). The private system in the United states provides a telling example. Forty million American do not have health care insurance and their system is fifty percent more expensive than the Canadian one (McQuaig, 1995). Furthermore, spending on social programs as a whole represents only four percent of the GDP (Pellerito, September, 1997).
All of this preoccupation with the deficit and its supposed link to social programs, described by Linda McQuaig as deficit pornography, provides a false representation of what really is occurring. Social programs have been unfairly targeted. There is a massive amount of wealth in this country, however it is concentrated in fewer and fewer hands. Businesses are flourishing. Banks continue to report record profits. Why, then, has unemployment been allowed to reach previously unacceptable levels? And why are we not able to afford our most-loved social program? In fact it is not the case, as *The Windsor Star* and other mainstream media claim, that health care is unaffordable. *The Windsor Star* did not entertain the argument proven by Linda McQuaig's research that refinancing of government deficits and fair tax reform would mean that resources could be more equally distributed and social programs would be easily funded. It is the case, however, that increasing power of neoliberals means that the social programs that had ensured some level of equality are in serious jeopardy.

*The Windsor Star* neglected any challenge to the notion that health care had become much too costly. A guest column by Valerie Walter, co-chair of the LAC, presented the sole challenge to the "reality" of cash-strapped governments when she noted that the savings from health care would largely be eaten up by the promised thirty percent tax relief for the wealthy of the province (Walter, 12 December 1996). The "fact" that social programs had become unaffordable was accepted as conventional wisdom - a truism, promoted throughout the coverage. This truism is so pervasive it has taken on a sort of fundamental truth, and is thus an assumption that underlies the other truisms that have been developed in this case study.
2. Win/Win is the best possible plan for Windsor/Essex County facilitated by the best efforts of our government and health care officials (see Appendix B for example).

Our health is not completely determined by the contents of our medicare system. There are some basic elements to our health that the traditional medical model cannot provide for. These determinants are better facilitated by a focus on prevention, promotion and community health. In the last few years, government reports have asserted the importance of shifting our focus to include these less traditional areas of health. While this may seem like a logical and important step to take, it is often little more than a strategy to off-load health care expenses onto individuals. Unfortunately, these reports focus on cost savings rather than a clear and meaningful plan to shift from treatment to prevention (Armstrong & Armstrong, 1996: 13). Instead, it seems that these reports represent a trend toward government off-loading that is reflective of the neoclassical focus on the individual rather than community-based approaches to social and economic policy (Friedman, 1982: 2). As outlined in the previous chapter, there were many reasons to assume the Win/Win model represented a fixation with the bottom line, coinciding with the neoliberal agenda of the dismantling of social programs. Based on this, it is appropriate to assume that this plan for health system reconfiguration was not unlike other government reports whose main priority was a reduction of costs. However, The Windsor Star failed to examine the indications of a neoliberal preoccupation with budget reductions present in the model but instead promoted it as the best possible plan for Windsor/Essex County.

To begin with, the plans to restructure Windsor's health care system were rarely
brought into question by the newspaper. Health officials claimed that at least one hospital must close to save the system and The Windsor Star accepted this as a logical plan. For example, the newspaper described the Steering Committee's task as "deciding which two Windsor hospitals should remain open" (van Wageningen, 13 January 1994, see Appendix B for full article). The reporter elaborated: "The choice the steering committee had to make was between Windsor Western in the West end and Hotel Dieu hospital, which is downtown" (van Wageningen, 13 January 1994 emphasis added). What was omitted was the possibility of alternatives to the closure of these institutions. Instead, these plans were treated largely as unquestionable and were granted the status of "fact" through the newspaper's refusal to reveal the plans as those favoured by only certain members of the health care community. By doing so, The Windsor Star exonominated the Steering Committee's position. As a result, the elimination of half the city's hospitals seemed merely common-sensical. The virtual absence of alternatives to the Win/Win model was coupled with celebratory descriptions of the Steering Committee's recommendations. A column by Gord Henderson vehemently promoted the model: "There's near unanimity on the need for change. From hospital administration to union officials, you'll look long and hard before finding someone who believes in the status quo - four under equipped and under-used hospitals competing for resources and patients - can or should be maintained" (Henderson, 27 January 1994). Karen Hall reiterated these sentiments two days later in a column stating that "there are all kinds of reasons why Windsor needs two hospitals instead of four" and "it makes perfect sense to merge hospitals and consolidate services" (Hall, 29 January 1994).
The newspaper placed the Win/Win model in such high regard that it seemed practically untouchable. Accordingly, *The Windsor Star* offered practically no criticism of the Steering Committee’s report and described the model without paying any attention to logical questions that should have arisen from a close examination of the recommendations. Instead, the plan was described in very palatable terms:

Hospital consolidation is at the centre of the Evolving Plan for Total Health Care Reconfiguration, released earlier this year. The report calls for the city’s four hospitals to voluntarily merge into two, while using the savings from the consolidation to improve community-based care (Ford, 22 June 1994).

This description was typical of the four years of coverage that I examined. The newspaper offered its approval for the model, making it possible for readers to logically conclude that there was no reason to be skeptical - that indeed, there was no need to examine possible alternatives. However, I wonder what the public’s reaction to the model might have been if it had been described as the following instead:

Closing half of the hospitals in the city is at the centre of the Evolving Plan for Total Health Care Reconfiguration released earlier this year. The report calls for the voluntary closure of 553 out of the current 1430 hospital beds and the loss of 560 jobs. The plan proposes enhancing the community sector to replace lost service and jobs but there is reason to seriously doubt the DHC’s commitment to this.

*Both The Windsor Star* and the Steering Committee’s report downplayed the extensive losses contained in the model. The Win/Win report excluded the number of beds that would be removed from our institutional sector upon the implementation of the model. Likewise, throughout the entire four year period of coverage, the newspaper did not report this figure. A 39 percent difference in capacity at our hospitals was certainly a
substantial reduction and could arguably make the difference between public support and disapproval of the plan. However it seems *The Windsor Star* only showed optimism and took up the challenge of convincing the public: "The greatest challenge ahead for everyone involved in the reconfiguration process is convincing the community that the loss of two hospitals will actually be beneficial" (A long... 25 January 1994). Accordingly the coverage often focused on touting the potential advantages of the plan.

The immediate message that needs to be telegraphed to the community is that this exercise is not one that involves the diminution of services. Windsor isn't losing two hospitals. The stage has been set to create a system that is more efficient, effective and capable of providing new programs and better care (The redesign... 28 January 1994).

Any losses to service that were contained in the plan were glossed over. While *The Star* did note there would be job losses, the public was told that workers would be redeployed to the community sector. Thus, readers were assured that needless bricks and mortar were the only losses contained in the report (The redesign... 28 January 1994; Henderson, 27 January 1994; Hall, 29 January 1994). This suggested that the reconfiguration plan merely promoted the closure of buildings and not the loss of service. This rose-coloured interpretation of the plan dismissed the fact that a significant number of beds were scheduled for removal from the system, many hospital jobs would be lost and at the same time the DHC's commitment to the enhancement of community services was suspect. Members of the LAC had been skeptical throughout the development of the model, fearing that in the end, the money would not be made available (DeBellis, 16 January 1998; Walter 16 January 1998). Despite this, *The Windsor Star* essentially refused to confront the possibility that the plan represented anything less than an
improvement. This one-directional vision was applied so broadly that even the reduction of emergency room hours at Grace hospital, (implemented before the enhancement of other emergency rooms), was described as a positive move for local health care:

"Emergency room hours at Grace Hospital will be scaled back June 1 in a move the hospital says will help consolidate emergency care, reduce costs and improve service" (Ford, 18 May 1995).

The First Blow to Win/Win

An integral section of the Win/Win model was the reconfiguration planned for the community sector. Upon the release of the report, Mary Jean Gallagher, member of the SCR stressed that "This isn't just a report about hospital site closures or mergers. It's not just a report about institutional care" (Ford, 18 May 1994). And indeed, the Win/Win model proposed spending the $22 million saved annually from the hospital closures on enhanced community services (SCR, 1994: 3). The promise of investment in community care was a factor in convincing the LAC to support the plan (DeBellis, 16 January 1998). It was proposed that this would coincide with a greater focus on health prevention and promotion (SCR, 1994: 72).

The traditional medical model focuses on treating ill parts of the body in isolation. Prevention and community health offer an alternative focus on the determinants of health listed by the provincial government as social environments, physical environments, psychological environments, productivity and wealth and health care (Armstrong & Armstrong, 1996: 14). While there is a need for the traditional approach, the community
would certainly benefit from a combined style of health delivery that would focus on both treatment and prevention. Armstrong and Armstrong have found that recent governments have increased their attention on these alternative approaches and unfortunately, rather than representing a true commitment to health, these governments have seemed more interested in cost-cutting. The result too often has meant that community health as promoted by these government reports really means care by the family or friends and most of the time these care-givers are women (Armstrong & Armstrong, 1997: 88). A column written by Tom Bain, chairman of the DHC indeed supports "individuals and communities taking more responsibility for managing their own health" which sounds frighteningly like a justification for the removal of responsibility on behalf of the government (Bain, 20 August 1996). Moreover, this reflects a growing acceptance of a fundamental premise behind neoclassicism which favours the removal of government from most aspects of social life in favour of individual “freedom”.

Upon the release of the Win/Win report, there was practically no indication of the potential dangers of the prioritization of cost-savings. A critique of the proposal would certainly have been warranted based on the existence of other such government reports that while touting the virtues of community and preventative health, essentially focused on cost-cutting measures (Armstrong & Armstrong, 1996: 13). My analysis of the Steering Committee’s recommendations has illustrated that, while claiming to prioritize health promotion and prevention, their report showed little evidence of doing so. While the report asserted the importance of integrating health and social services, they gave little indication as to how this would actually happen (SCR 1994: 51, 52, 72, 89). The lack of
seriousness in the commitment to the community sector was further revealed in the length of time devoted to the community sector study. The study done in the institutional sector examined 5 hospitals. The community study was given only half of the amount of time to examine over 200 agencies (LAC, 1993: 5). The Steering Committee justified the brevity of the study by claiming the pressure of continuing budget cuts would mean the deterioration of these community agencies without quick rationalization (SCR, 1994: 90). However, it is difficult to imagine that this could actually benefit these agencies. Moreover, the LAC voiced concerns that the community sector study should have been completed before the hospital study to ensure that the DHC would not go ahead with hospital closures before the completion of community sector enhancement (LAC, 1993: 5). These concerns were not explored in The Windsor Star.

However, in the second of two columns by Karen Hall printed briefly after the recommendations of the Win/Win model were made public, she revealed the potential disaster that could be lurking in the DHC’s plans. She speculated that community health really was based on the assumption that everybody had somebody at home to care for them (Hall, 5 February 1994). Essentially then, in accordance with neoclassical economic thought, this would mean that individuals would be responsible for the health of their loved ones rather than the community as the term seems to imply. The column did indeed show scepticism warranted by the research done by Armstrong and Armstrong in this area. She asked: "...is community-based care designed to meet the consumers' needs or to foist off work to save the government money?" (Hall, 5 February 1994). An editorial briefly echoed similar concerns when it asked: "Does this mean spouses, children and
grandchildren are expected to become the primary caregivers in years to come?" (Home Care... 15 October 1994). While in this instance Hall provided a critical look at the potentially dangerous results that could be lurking behind the recommendations of the Win/Win model, on other occasions she endorsed the plan. Thus, Hall's criticism is indicative of the sporadic nature of critical coverage. Only one week previous to this critical article, her column showed support for the Win/Win model claiming: "...it makes perfect sense to merge hospitals and consolidate services. Five or six years down the road Windsor will probably end up with two top-notch facilities that daily fill a maximum number of acute-care beds and have sufficient staff to meet the patients' needs" (Hall, 29 January 1994). The occasional critical coverage reflects Winter's claim that the media are not monolithic and that it is in their interest to show some diversity in reporting. He explains:

In order for the illusion of diversity to flourish, it is far more effective if there are occasional stories or columns or even one or two journalists themselves who represent dissenting views. Cracks and openings - fissures - can be created by the inventive journalist and exploited, within limits, by the careful reader or viewer (Winter, 1997: 112).

So while critical moments created by journalists such as Hall provide some level of diversity, the potency of these sporadic queries was diluted by the sea of many congratulatory descriptions of the model and the absence of other articles that reiterated these concerns. Not until two years later, after the Harris government had announced it would not allow the community to keep the $22 million per year earmarked for community sector funding, was there mention of these concerns again. Near the end of an editorial, the case was put forth that "if someone you love needs home care and regular
medical or homemaking assistance, it’s supposed to be there for them. Not because you quit your job to stay home and take care of family members, but because these services are supposed to be readily available in the community” (Health care: waiting...2 March 1996).

In September of 1994, The Windsor Star was given a fitting opportunity to expand on scepticism regarding plans for community sector enhancement. The provincial government announced that Ontario’s ten psychiatric hospitals would be undergoing substantial budget cuts. The Star interviewed Dr. I.A. Rajan who was highly critical and skeptical of the government’s claim that the saved money would be used to enhance local services. Without such investment, he claimed that Windsor/Essex County was certainly not prepared to deal with the increased burden on local services. Rajan called it a cost-cutting measure and Pamela Hines, executive director of the local branch of the Canadian Mental Health Association agreed. She doubted that the money would make it back to the community (Hornberger, 15 September 1994). Even in the face of such commentary on the agenda of the government, there was no reference to a similar suspicious situation in funding for enhanced community services promised by the Win/Win report. If suspicion was warranted for the government’s commitment to community mental health services this should certainly warrant an interrogation of the government and the DHC’s commitment to the investment to be made in our community services after hospital closures.

What seems to be at work here is the news categorization of recency coupled with the pursuit of objectivity has blocked any contextualization of this story. Fiske explains
that one of the criteria of newsworthiness is that the event has to have occurred recently-usually within the last 24 hours (Fiske, 1987: 284). Thus there is little reference to the history of the event. In this case, the budget cuts to occur at the psychiatric hospitals seem to have no connection to the release of the Win/Win report eight months earlier or even the on-going events surrounding its implementation. Furthermore, the pursuit of the news value of objectivity similarly results in the disconnection of related events. While striving for objectivity, news is often reported in a superficial manner that strains out background and interpretation of events (Bagdikian, 1992: 180). Winter explains that the result is "the presentation of news as isolated fragments, a kaleidoscope effect which discourages or even prevents a cohesive view of the world. While the media see the spider, they are seemingly unaware of its web" (Winter, 1992: xvii). In this case, the result of defining these as isolated events is that it avoids an analysis of the provincial government's widespread agenda and the subsequent threat to local hospital restructuring plans.

Unfortunately, with the election of Mike Harris the worst fears for community health were realized. Four months into office, the ministry of health announced that it would not allow the $22 million in annual savings generated by hospital closures to stay in Windsor/Essex County. According to the Win/Win model, this money was to be used to enhance community services. A column written by Steve Lough, senior planner for DHC revealed that the agreement for the funding of community services was disbelieved from the outset (Lough, 4 November 1995). If this was the case it certainly was not portrayed as such by the newspaper. This was the first mention of there being any sort of
collective disbelief on the matter.

Now that a major premise of the Win/Win model had been mixed, one should wonder how the plan could possibly proceed. Without the money for the community sector, hospital closures could only proceed by dangerously depleting services to the city. *The Windsor Star*, however, did not seem to acknowledge the seriousness of the matter, offering critical commentary only very sparsely. A letter from Valerie Walter explained a desperate need for funding for the community sector in the face of the planned closure of two hospitals (Walter, 8 November 1995). Several months later, the editorial staff revisited the issue when it noted the possibility that loved ones would increasingly be asked to provide care in the home because of lack of funding for community sector (Health care: waiting...2 March 1996). However the criticism was short-lived as only a week later, an editorial stated that we are feeling "less anxious" about community funding because Jim Wilson, minister of health had "given every impression funds [would] be available as needed" (Health care: journey...13 March 1996). The editorial staff seemed to have forgotten that by their own admission, they had every reason to doubt the government's promises. Only a few months before they had accused Premier Harris of contradicting his election promise to commit to reconfiguration efforts (Health reform: A troubling...25 October 1995). Moreover, the editorial failed to mention that the minister of health Jim Wilson merely said that "sure, we'll be entertaining (requests) as time goes by" which hardly sounds like a solid promise for funding (Jarvis, 13 March 1996).
The Second Blow to Win/Win

This up-beat editorial (Health care: journey...13 March 1996) appeared one day after the provincial government's announcement that $72 million in capital funding would be available for reconfiguration of local hospitals. The feeling surrounding the announcement in The Windsor Star was one of relief and excitement. Colin Ball, chairman of the DHC called it "good news" (Brennan, 12 March 1996). The Star focused on the proposed addition to Hotel-Dieu Grace along with "rebuilding", "consolidating" and "revamping" to occur throughout the system as a result of the funding (Jarvis, 13 March 1996). But this was not the whole story. Upon closer inspection, what The Windsor Star had referred to as a "slimmed down" construction proposal really represented at least a $28 million cut in what the NDP had promised and what Win/Win said was necessary to provide "two modern, well-equipped acute care hospitals" (Ford, 27 October 1995 and SCR, 1994: 4). Combined with the loss of $22 million in annual funding for the community sector, how could Win/Win possibly proceed as planned? The Windsor Star seemed to think that it could, and with much enthusiasm: "Last month, the prognosis looked bleak. This week, the diagnosis is excellent - $48.27 million from the provincial government so local hospital restructuring can finally kick into high gear" (Health care: journey...13 March 1996).

Consent for the $72 million was partly generated by creative reporting on the amount of funding the NDP had promised for hospital reconfiguration. While trying to "sell" the Win/Win model to the public, The Windsor Star reported that the amount of capital funding approved by the government was between $100 and 109 million. The
government would provide $66 million of this and the community would have to raise the rest. Before the election in 1995, the pledged amount was consistently referred to as at least $100 million. However, after the election, the amount promised by the NDP was almost always reported to be $66 million rather than the usual $100 million thereby making the reneging on the promised dollar amount seem less. This worked in the Harris government's favour, particularly after they agreed to the reduced amount of $72 million for total capital funding. The difference between $100 million and $72 million is $28 million. (If one looks at the figure of $109 often quoted by The Windsor Star, the difference is then $37 million). However, The Star had begun to favour talking in terms of the grant amounts of $66 million reduced to $48 million. Given this new perspective, it now appeared as if there was only an $18 million difference in the levels of funding promised by the two provincial governments.

The Windsor Star dedicated a full page to the long-awaited agreement on the capital funding. The articles highlighted the services and programs that would be offered at each hospital while omitting any mention of what would have to be cut out of the Win Win plan to accommodate the reduction in capital funding. The LAC recognized that Win/Win was now in severe jeopardy and saw no reason to celebrate. Some of their concerns were granted an article in the corner of a broader page that was largely devoted to the celebratory description of the newly reconfigured hospital system to come. The small article noted that the loss in money for reconfiguration was devastating, especially when considered along side the 18 percent budget cut to be implemented in a few months' time and the lack of community funding. Dean Labute, chair of the community sector
reconfiguration study said the government seemed to be committed to privatization of the community sectors (Rennie, 13 March 1996). However, these concerns were not only up against a full page of cheerful coverage, but years of the persistent assertion that Win/Win would save our health care system. Next to the up-beat coverage that surrounds this article and the reported feeling of relief upon the government's long-awaited agreement to some level of funding, the LAC seemed to be looking a gift-horse in the mouth.

Toward the end of 1996 and during 1997, as hospitals struggled to meet the 18 percent provincial budget cutback, The Windsor Star became more consistently critical. Some articles finally identified the raw deal on community health funding, pointing to concerns voiced by health care professionals that patients were being sent home while still sick and family members were forced into becoming care-givers (Cross, 29 October 1996; Priddle, 4 November 1996). Moreover, Frank Bagatto, CEO of Hotel-Dieu Grace noted that $22 million in savings originally earmarked for reinvestment into the community could never have been met. His own research showed that Windsor/Essex County had not been given its fair share of provincial health dollars for years. This would have made it difficult, if not impossible to come up with $22 million in savings in our hospitals (Bagatto, 31 January 1997). Further criticism came from Dr. Paul Ziter who illustrated the importance of putting money into the community sector, arguing that the two hospitals would not be able to provide adequate health care without this investment (Jarvis, 1 February 1997). Sandra Pupatello, Liberal MPP for Windsor-Sandwich noted

\textsuperscript{5} In 1997 through his own research, Bagatto came to the conclusion that Windsor/Essex County had been underfunded by $42 million per year in hospital expenditures alone. Closer examination of his findings will be provided later in the chapter.
that communities that have undergone restructuring were hit especially hard by Tory budget cuts because they had not been able to use any savings for investment in the community sector and were required to use the money to meet provincial budget reductions (Queen's Park Bureau, 12 February 1997). However, like much of the critical coverage, these revelations were reported in The Star long after this could have been incorporated into restructuring plans or proposals to the ministry for funding. It was only after the effects of the repeated cuts implemented by the Tories had become obvious, that concerns started to mount.

Hume Martin even agreed that the community had not seen the Win/Win model implemented as promised and that "reconfiguration was [initially] about much more than" hospital amalgamation (Jarvis, 26 March 1997). However, his critical stance is not whole-hearted as he went on to say that upon his resignation in March of 1997, he felt the largest disappointment so far was a failure to agree on a new managing body. He did not mention the devastating cuts that hospitals had to undergo, while restructuring with inadequate capital funding and the removal of promised resources for community services (Jarvis, 26 March 1997).

Two years after the original capital funding announcement from the ministry of health, the money still had not made it to the community but the HSRC had. Eventually, the commission recommended the community receive $103 million for restructuring. The Windsor Star reported that the funding would go a long way to solving the health care crisis that had developed in the community (Cross, 13 February 1998a). The headline on the front page read "'Everyone is happy' with the $103 million allotment" (Cross, 13
February 1998a). Valerie Walter appeared to be an exception. She noted serious problems with the allocation of money. Funding would be available for new nursing home beds, but none for the already existing beds that are underfunded. Chronic care beds in Windsor would be a third of the provincial average. The commission would fund 68 longer-term mental health beds but it should be noted that this is a reduction from the 106 the Win/Win model deemed as necessary with the enhancement of community services. Moreover, the commission ordered a $9 million cutback to area hospitals which when added to the previous two years of funding cuts represents the draining of $33 million from Windsor/Essex County’s health care system (Walter, 26 March 1998).

Ultimately, over the past four years, the Windsor area has seen promises from two different provincial governments and a lot of disappointments that have caused the deterioration of health services in the area. To summarize the numbers, the NDP endorsed the Win/Win plan that promised $22 million in savings obtained through hospital amalgamations that was to be invested in enhanced community services on a yearly basis. Moreover, the plan promised up to $109 million in capital investments in the two hospitals that would remain. The NDP government would provide $66 million of this amount. After the election of Harris’ Tories in 1995, the provincial government told the community it would not be able to keep the $22 million saved every year from hospital restructuring to invest in community services. Furthermore, in March of 1996, that government also reneged on the $109 promised for capital funding. In place of that, it approved $72 million, with $48 million of that amount to be provided directly by the government. The rest would be raised locally. In the meantime, the hospitals were trying
to meet an 18 percent province-wide cutback to hospitals announced by Tory Finance Minister Ernie Eves in November of 1995. Finally, in early 1998 the Health Services Restructuring Commission recommended that the capital investment to area hospitals should be raised to $103 million from $72 million promised in 1996. While this sounds to be a lot closer to the original amount of $109 million, the allocation of funds recommended by the Commission appears to be problematic, not to mention the history of this government in not following through with a cheque.

**The Saving Graces of Win/Win**

In November of 1995, the provincial Finance Minister Ernie Eves announced an 18 percent cutback in hospital budgets to be implemented over the next three years. For a community in the throws of closing two out of four hospitals, it seems that there might be severe concerns over the health care services our institutions would be able to provide.

But an article speculating on the upcoming budget indicated otherwise:

> Even if the province is preparing for hefty cuts to the health care budget, Windsor's restructuring will leave the region better prepared to cope with it. Hospital consolidation will help cut costs. And even if there isn't local control over the money going to community health care agencies, the planning and research done to determine the gaps in local services will help the area lobby for provincial cash in the future (Ford, 4 December 1995).

An integral part of the Win/Win report was the reinvestment of savings into the community sector. Now it seemed the community was reduced to hoping the provincial government would some day look favourably on injecting hospital savings into that sector. One must remember though, that this government basically said "no" to the
Win/Win model. The Tories substantially reduced the capital funding, they refused to allow the savings in the hospital sector to be reinvested in the community sector, and now had implemented a substantial province-wide cut. It seemed evident that their agenda was not to reinvest in health care but to pull money out of it. So how were we to believe that they would commit to funding the community sector?

Despite the evidence that Premier Harris was not interested in investment in health care, *The Windsor Star* soothed concerns by touting the virtues of the Win/Win model. The coverage asserted that the province-wide cutback would be much more bearable in Windsor than other communities because the hospital restructuring that was underway could provide much of the needed savings (Ford, 30 November 1995; Hornberger, 6 January 1996; Cross, 27 February 1996). But these savings were to be directed into the community sector. In fact it was not the Win/Win model that allowed the community to cope with the budget cut but the compromising of this model. The line of reasoning promoted by the newspaper served to legitimate the Win/Win model by representing it as a sort of safeguard to our hospitals, ensuring that these budget cuts could be met much more easily than in other communities. Moreover, the removal of provincial funds was legitimated by the assertion that there was room for these cuts - that the reconfiguration efforts had made it possible to absorb them. Essentially, *The Windsor Star* was making the illogical claim that earlier cuts had made more cutbacks possible.
Privatization

Despite Canadians’ commitment to public health care, private companies are securing a foothold on our system. The decrease in federal transfer payments and in provincial funding for health care has meant that the extent of services that the public sector can offer is declining. The resulting decrease in the quality of care that our public system is able to provide has meant that people have been encouraged to look elsewhere for help. The OHC has reported cases where family members have been told by hospitals to hire private duty nurses because these institutions are so severely understaffed that they cannot cope with the patient load (Benedict, Mussett & Simmons, 1997: 16). And this is not far removed from the local situation. Pierina DeBellis told of her family being called to a local hospital when her uncle had become disoriented. The staff suggested sending family members to watch him because they did not have enough employees to ensure his safety (DeBellis, 16 January 1998).

The failings of our public system that have resulted from government cuts have promoted private sector access to the system in accordance with the neoclassical preference for the predominance of the free market. However, The Windsor Star failed to examine how our policy-makers were favouring the privatization of the system. The DHC proposed a management model that could further undermine the "publicness" of our system. The integrated delivery system promoted by the DHC seemed to be frighteningly close to HMO-style health care which could, if implemented, put us one step closer to an Americanized, private health care system. Tom Bain, chair to the DHC, described the system as one that would reform primary care:
Primary care reform means that all members of the public will have someone in the health system to serve as their gate-opener. For its part, the public will be required to register with one primary care organization which provides 24 hour service (Bain, 20 August 1996).

What *The Windsor Star* did not explain was that what Bain may be referring to here is a rostering system used by HMOs. ⁶ This could mean that under this management model, individuals would have to sign a contractual agreement for a particular system. If that individual went outside this system for care, she/he may be required to pay the full cost otherwise covered by OHIP. This meant that to avoid paying personally for care, people might have to rely exclusively on the physicians in their particular system for their health care including surgery and second opinions (OHC, 1997b: 2).

It was in the same article that Bain urged individuals and communities to take more responsibility for their health. This sounds like the beginnings of a privatized system. However, the lack of critical coverage meant that this was not given any of the scrutiny it deserved. In fact, *The Windsor Star* merely described the proposed integrated delivery system as one that would ensure that "all aspects of the system are co-ordinated by a central body". *The Star* went on to report that the DHC could ask the HSRC to consider using Windsor/Essex County as a test pilot area for these integrated systems (Cross, 21 August 1996). What was not mentioned is that the province had been promoting this type of governance system and the model had been criticized by the Ontario Health Coalition and other social activist groups as HMO-style health care. But

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⁶The provincial government has approved five pilot projects for rostering to begin in 1998. *The Windsor Star* reported that it would be likely that Windsor/Essex County will be one of the five sites (*The Windsor Star* Staff and News Services, 5 March 1998).
the newspaper continued to promote the idea, exnominating the DHC's position on the matter by "factually" reporting that an integrated delivery system would merely mean better access to the system:

The fact is there is no health system management in Windsor-Essex. It's a fragmented system where decisions are made by Health Ministry bureaucrats in Toronto...What an integrated delivery system means to "Joe Patient" is he should be better able to gain access to needed health services (Cross, 5 September 1996).

This description gave absolutely no reason to be skeptical of the proposed management system. In fact, it promoted integrated delivery systems by presenting the benefits of the system as virtually irrefutable. Without the type of speculation raised by the OHC, who could really argue against fostering more local input and better access to the system?

A warning signal might have gone off with some readers when Steve Lough reportedly said that such systems in the United States have allowed five percent budget reductions. But *The Windsor Star* failed to investigate this warning sign, ignoring the fact that applying the principles of these private, American systems is in itself a form of privatization (Armstrong & Armstrong, 1996: 147). Moreover, private companies have been lobbying for the implementation of this kind of system in hopes that they will get a piece of the action. These companies include such giants as Prudential Insurance Company of America, Johnson & Johnson, and Price Waterhouse 7 who along with other companies and individuals including Mark Rochon, CEO of Harris' HSRC drafted the Langdon Hall Statment. The statement includes an endorsement of these integrated

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7Price Waterhouse played a consulting role in the development of the Win/Win model.
systems and an expanded role for the private sector (OHC, 1997b: 2). Serious momentum was being generated by powerful companies toward the inclusion of the private sector in the proposed integrated system, while *The Windsor Star* endorsed the plan without an investigation of the threat it posed to our public system. Only a single article made brief mention of the possibility of corporate involvement in such integrated systems. The article was mainly focused on an integrated system that was being promoted by local nurses. Only in the second last paragraph did it note the concerns raised byONA vice-president Barb Wahl:

> Wahl said it's vital that an integrated system be implemented before one is forced upon the public that saves money but doesn't improve quality of care. The fear is the government will introduce an integrated system that uses private companies to deliver public health care, she added (Cross, 22 October 1996).

Premier Harris has continued this quiet shifting of health care into the private sector. Recently, he blamed the increasingly apparent problems in the province’s emergency rooms on the slow process of restructuring (The Canadian Press, 4 February 1998). His solution then, was to speed up the plans that were weakening the public health care system. Specifically, he cited the transfer to community based services and the expansion of long-term care as part of the remedy (The Canadian Press, 4 February 1998; Brennan, 3 February 1998). What has not been noted is that these two areas are ones most likely to see increased private sector involvement. Long-term care includes privately funded nursing homes. Community care, as noted previously, often means that loved-ones are increasingly expected to provide care. Moreover, the Community Care Access Centre which oversees home-care in the community has recently selected Olsten
Homecare, a private, American company to provide service to area residents (Mandal, 5 May 1998). The Windsor Star did highlight these concerns in an isolated article that focused on the efforts of local liberals in campaigning against privatization of health care.

Much of the article centred around the efforts of Dwight Duncan:

At the centre of Duncan’s protest is the province’s plan to allow private home-care providers to bid for contracts traditionally filled by organizations such as the Victorian Order of Nurses...Duncan contends private agencies allow profits to override quality of care, lower wages for nurses and hire part-timers with a high turnover rate (Mandal, 5 May 1998).

The provincial government has also begun to open more doors for the private sector in local long-term care facilities. The refusal of the HSRC to designate Windsor’s Malden Park as a chronic care hospital has meant it is likely that it will be privatized because its designation as a long-term care facility will not allow for adequate funding (Walter, 16 January 1998). An article that appeared in December, 1997 noted that the label applied to Malden Park is very important:

What Malden Park is designated is vitally important, because chronic care patients get twice the funding that nursing home patients get. And Malden Park officials are warning that if they don’t get chronic care funding, they may eventually have to close the $40 million showpiece, which was built with $10 million in local contributions (Cross, 11 December 1997).

But this article appeared two months before the final decision came from the HSRC about the fate of the facility. Upon this announcement in February 1998, the newspaper dismissed the importance of the label given to Malden Park. Despite the very real fear of privatization, The Windsor Star has taken the stance that the fuss about Malden Park is merely a case of semantics. Gord Henderson wrote: "Forget all of this yammering over
semantics. Chronic. Continuing. Extended. Who cares what they call it?" (Henderson, 14 February 1998). Similarly, an editorial stated: "The label on the building is meaningless to the people being cared for inside, as long as the proper care is available in the community" (Health care: finally...14 February 1998). These comments were outright dismissals of the funding issue attached to the labeling of the facility, thus precluding any discussion of its potential privatization.

Throughout the four years of coverage, while more and more of our health care system was being privatized, only a handful of articles made reference to the real danger being approached by our governments. A column by Valerie Walter appeared appropriately in December of 1996 amidst all of the promotion of the integrated delivery systems. Her comments provided what was essentially the only discussion of the virtual imminency of privatization:

Huge American insurance corporations are licking their lips, waiting impatiently in the wings to offer coverage to Canadians who have been hit with user fees on everything from drugs and casts for broken limbs to questionable booking fees for procedures (Walter, 12 December 1996).

She asserted that the provincial government was "determin[ed] to privatize our health system" and noted that the Ontario Medical Association was in the process of negotiations with the ministry of health to delist more services from OHIP - which is a form of privatization as patients requiring the delisted services will have to pay out of pocket for them (Walter, 12 December 1996). Moreover, patients are paying for everything from casts to what are essentially illegal booking fees for surgery (Walter, 16 January 1998). This type of description is not otherwise encountered in the coverage.
despite the grave importance of realizing and combating the threat and power of these companies. And certainly none of the coverage accepted the possibility that indeed a two-tiered system was already in place - an assertion that represents reality according to members of LAC (Walter and DeBellis, 16 January 1998).

The Leadership Maxim

One of the strongest and most consistent themes used by The Windsor Star to praise the reconfiguration efforts and reinforce its portrayal as the best plan for Windsor is what I will call the "leadership maxim". Because no other community in the province had taken the initiative in forming their own restructuring plan, Windsor was dubbed a leader in health care reconfiguration. The Windsor Star remained fixated on this unique situation, persistently describing the effort as a noble venture, rather than what might be more accurately described as a kamikaze mission. Health minister Ruth Grier might have instigated the description with her congratulatory comment on the Win/Win model:

Windsor led the province originally on health insurance and they are once again leading the province in showing us how to provide the best possible health care in the 21st century (van Wageningen, 27 January 1994b).

What is referred to here is the formation of Windsor Medical Services Inc. before the formation of OHIP. This was a group insurance plan formed by area doctors to provide health insurance to Windsor workers through the CAW. Once OHIP was put into place, this was dismantled but had provided needed access to medical attention that workers might not have had otherwise (Walter, 16 January 1998). Although several articles refer to the fact that Windsor had a history of "pioneering" behaviour, Windsor Medical
Insurance Inc. is never explained or even mentioned. Moreover, the comparison between the two health care initiatives is not particularly suitable. The initial plan was progressive, ensuring more people had access to health care while Win/Win was part of a movement that would essentially narrow access to the system.

But it seemed that the leadership maxim was too much for The Windsor Star to pass up. Gord Henderson wrote: "Windsor is pioneering here, courageously blazing a provincial trail..." (Henderson, 27 January 1994). Upon the merger agreement between Metropolitan Hospital and Windsor Western, The Windsor Star editorial staff wrote: "Once again Windsor has led the way in designing innovative approaches to meet changing needs. Well done" (Met-West...8 December 1994). Hume Martin stated that the Ontario Hospital Association was looking to Windsor/Essex County as an example in restructuring across the province (Martin H., 27 February 1995). Johnathon Lomas, a university specialist in health economics and policy called Windsor/Essex County the "Mecca of hospital restructuring" (Health expert...28 June 1995). Likewise, the Win/Win model was referred to as "the wave of the future" and even the best model for Canada (Hospital Reform: Hard...16 September 1995; Health care: The national...29 September 1995).

Designating the plan as a leader closes off other potential interpretations of the Win/Win model. The use of the term "leader" assumes the desirability of the plan. Moreover the use of the leadership maxim gives one the sense that Windsor has a responsibility to the rest of the province and even the country to carry out this reconfiguration project - that if Win/Win is not implemented here, the rest of the country
will be without a useful example for future restructuring efforts. Also, the label of leader
assumes the requirement of other such projects in other parts of the province and country.

3. The “few” jobs that will be lost as a result of restructuring are merely due to the
unfortunate “reality” of the times (see Appendix C for example).

While the Win/Win model was being promoted as the best possible health care
plan for Windsor/Essex County, the jobs of many employees hung in the balance. Five
hundred and sixty jobs would be lost in the institutional sector as a result of the plan.
These workers were assured that there would be an alternate plan for their livelihood as
the Win/Win model promised that these jobs and more would be replaced in the
community sector (SCR, 1994: 3). However, I have already established that the promises
contained in the Win/Win report should be viewed with scepticism. Indeed, the plan
seemed to subscribe to a neoliberal agenda, an ideology that most often accepts the
premises of neoclassical economics. Certainly, this should signal a concern for the
workers in the field as neoclassical economists such as Milton Friedman purport that
unemployment rates should not be the concern of economic policy.  

The Minimization of Job Losses

*The Windsor Star* did not examine the possibility that these jobs would be lost
without redeployment to the community sector. In fact, the newspaper was quite jovial
about the matter:

*from an interview with Linda McQuaig that aired April 21, 1998 on TVOntario.*
shifting along with the equipment will be hundreds of employees. They'll set up shop in new or renovated hospitals, or shift gears to go from hospital-based to community-based health care (Ford, 2 January 1995).

Employees were compared to equipment - merely being swapped from one place to another. The use of the metaphor "shifting gears" dismisses the difficulty of changing areas of employment. As Fiske has described, metaphors are often used in the language of news to explain the unfamiliar in terms of the familiar. Because these metaphors are clichéd, they do not draw attention to themselves and are therefore generally accepted as merely objective descriptions of reality. The result is that these metaphors close off potential meanings (Fiske, 1987: 291). In this case, the metaphor limits the effect of redeploymen to a transition as natural as a shift in gears. Other possible scenarios are removed from this description. For example, the potential complications from this mass redeploymen were left unexplored. Adapting to new jobs is very disruptive and while the Win/Win model did promise a human resource plan to aid in the redeployment, it was not in place in time for the release of the Win/Win report. The increased burden that would rest on the decreasing numbers of hospital workers and deteriorating work conditions as the system was down-sized were not addressed upon the release of the Win/Win report. Moreover, wages in the community sector would be increased to the level of those in the institutional sector. But, upon closer examination of the model, it has become clear that cost efficiencies were the driving force behind its creation and therefore one should wonder how realistic this promise was. Unfortunately, we would never find out. The community sector plans have been put on hold for three years now as the Harris government would not commit to funding for these agencies. What was
perhaps most regrettable was that *The Windsor Star* did not allude to the very real possibility that the government lacked commitment to the community sector which eventually resulted in hundreds of workers being forced to leave their jobs with no redeployment plan.

There was evidence that Win/Win could possibly jeopardize many jobs. In February of 1994, shortly after the DHC had disclosed its recommendation for hospital closures, *The Windsor Star* reported that workers at both the Victorian Order of Nurses (VON) and the Canadian Mental Health Association voted to join the Canadian Union of Public Employees (CUPE). *The Star* reported that the decision was propelled by a sense of insecurity about the restructuring (Cross, 3 February 1994). Unfortunately, the analysis of the situation did not delve much deeper than that. There was no examination of the model and the contradiction between its basic premise of cost-cutting and the promises for job and wage increases. Nor was there an examination of previous government reports whose focus on the surface seemed to be a shift to community care but ultimately translated into off-loading care onto loved-ones.

Throughout the coverage of hospital restructuring, readers were assured that job losses would be minimal. Not only were most jobs to be replaced in the community sector, (which could take a full ten years according to the plan), but most job losses, *The Windsor Star* reported, would occur through attrition, early retirement and voluntary departures (van Wageningen, 21 January 1994; Cross, 20 January 1995 see Appendix C for full article). This account of the planned job losses was troublesome not only because of a lack of scepticism about the commitment to job replacement but also because it
assumed that if jobs were eliminated through such "agreeable" measures there was no
basis for opposition to the reduction of employees. However, one needs to ask what of
those currently unemployed health care workers looking for jobs even before the
implementation of Win/Win? Not only did the restructuring plan mean that many of
those currently working would lose their jobs, but it would also increase the chances that
others currently unemployed will remain in that position. This has the effect of merely
adding to the unemployment rate.

The Windsor Star continued to down-play the crisis that could be in store for
hospital workers in the reconfigured system. Lloyd Preston, CEO of Windsor Regional
told the newspaper that layoffs would probably not be necessary upon the amalgamation
of Metropolitan and Windsor Western Hospitals, (Cross, 20 January 1995). It seemed
that job losses would not be as substantial as promised in the Win/Win report. It is
curious then that only four months later Pierina DeBellis wrote in a letter to The Windsor
Star that "we are looking at major job loss" (DeBellis, 26 May 1995). This is the first
mention of the kind of job loss health care workers could be encountering upon the
amalgamation of the four hospitals. If an investigation of the matter by the local paper
was not warranted by the closure of half the area hospitals one wonders when such an
investigation would take place?

Further inaccurate descriptions of job losses continued to be printed by The
Windsor Star. Upon the release of the Progressive Conservative's mini-budget in 1995, it
was reported that 560 jobs in Windsor's hospitals would make up the equivalent of the 18
percent cut implemented by the government (Rennie, 14 December 1995). While it was
reported that hospitals would find other measures to make up the imposed cut, some layoffs would be considered as part of the solution to this "fiscal dilemma" (Rennie, 14 December 1995). Moreover, the newspaper downplayed the job losses that occurred before this budget announcement. It was reported that since the amalgamations, hospitals had been "trimming unneeded staff" and that most of the staff reductions thus far had occurred at the management level (Rennie, 14 December 1995; Cross & Brennan, 29 October 1996).

However, this is an inaccurate way to portray the layoffs that had occurred through the amalgamations. The assertion that job losses had been concentrated largely at the management level was false. Front-line staff had indeed received most of the layoffs (Debellis, 16 January 1998; Walter, 16 1998). Hospitals have a dishonest way of reporting the numbers. For example, they may report that management was cut by 40 percent. While this sounds like a severe number of job losses, they may only include department head and those above as "management level" and exclude sub-management (Walter, 16 January 1998). The result is that the number of management positions lost is exaggerated. What is more is that a number of those who have lost their jobs in management end up back at work. Pierina DeBellis explained some of those in management who have lost their jobs will "come back part time as a consultant...or they’ll have a contract [position]...Next thing you know they’re regular staff and they’re back working" (DeBellis, 16 January 1998). This underestimation of front-line layoffs meant that future layoffs of the front-line staff were legitimated.
The Justification for Job Losses

By early 1996, the coverage did become somewhat critical of the job losses as layoffs were increasing. It was reported that job losses as a result of funding reductions would result in the compromising of patient care (Cross, 27 February 1996; Rennie, 13 March 1996; Cross, 5 October 1996; Cross & Brennan, 29 October 1996). The Windsor Star reported that Hotel-Dieu Grace would have gone from 1634 full-time-equivalent employees to 1331 in two years (Cross, 1 October 1996). However, the scope of the critical coverage was limited. All but one of the above noted articles provided some sort of justification for the job losses. The first noted that the portion of hospital budgets accounted for by wages was 75 to 80 percent (Cross, 27 February 1996). A subsequent article suggested that job losses were a reflection of the changing needs of patients at the Malden Park facility where incoming patients would not be as critically ill as those initially accepted at that site (Cross, 5 October 1996). The last article provided justification for further job cuts to front-line employees when it noted that most positions have been lost in the management level (Cross & Brennan, 29 October 1996). Only one of the above articles provided a critical comment about the link between job losses and level of care without later adding some sort of justification for the layoffs:

Valerie Walter, a co-chairwoman of the labor advisory committee to the health council, said the ministry is cutting local hospital budgets by a total of $12 million annually, starting April 1. That means layoffs for hospital workers and reduced service for the public, she said (Rennie, 13 March 1996).

The reported job losses were often justified by The Star's acceptance of a particular attitude neatly summarized in a quote from a letter to the editor that was printed in June 1994: "It is unfortunate when jobs are lost, but in our changing health care
system it has become a stark reality" (Tutill, 29 June 1994). Frank Bagatto in referring to the amalgamation of Hotel-Dieu and Grace hospitals reiterated this: "In today's world it's very difficult to provide guarantees, but certainly we have a commitment, if it's at all possible to minimize our number of layoffs" (Ford, 11 November 1994). As noted above, neoclassical economists have promoted this acceptance of job losses by claiming that economic policy cannot control unemployment levels. Since Milton Friedman popularized this notion, governments have followed suit by professing their inability to interfere with the market in the name of improving employment levels. ⁹ Instead, we are told that rising unemployment is an unfortunate reality. This was a particularly effective justification because "reality" is difficult to contest. If the staffing cuts were merely a product of changing times, our governments and the DHC were absolved of any blame. What was not explained was that there are other choices - that governments could choose to invest in our public health system rather than facilitating the erosion of it and the subsequent justification for privatization of the system.

*The Windsor Star* continued to manufacture consent for job losses through the designation of hospital workers as expensive burdens on a supposedly over-funded health care system. With an 18 percent provincial cut to hospital budgets, job losses thus became part of a seemingly logical solution. The newspaper reported that Hotel-Dieu Grace would try to target other areas to make up the cutback, but ultimately justified job losses by noting the burden of salaries:

To avoid resorting exclusively to layoffs to reach the imposed fiscal target,
Bagatto said, the hospital has set up three planning committees with input from the union, non-union and management employees. Other ways of cutting costs and increasing revenue will be explored. *The main problem is that salaries are about 80 percent of the hospital’s $115 million operating budget* (Rennie, 14 December 1995 emphasis added).

A subsequent article noted that care would indeed be affected by job losses. The lead paragraph noted: "A $12 million chomp out of local hospital budgets will almost certainly translate into reduced patient care, says the president of the Essex County Medical Society" (Cross, 27 February 1996). However, a third of the way through the article, it was asserted that: "Salaries account for 75 to 80 percent of hospital costs, so it appears inevitable that some of this area’s 2900 hospital workers will be laid off" (Cross, 27 February 1996). This, of course, legitimated layoffs and perhaps even insinuated that it was partly the burden of expensive hospital workers that has contributed to the erosion of care.

*The Windsor Star’s* stance on job creation and protection is hypocritical. At times, the newspaper seems to be in full support of initiatives that will create employment. However, this is usually the case when the newspaper is supporting some sort of government hand-out for business. The newspaper claims that such funding will help create jobs - a self-proclaimed concern for the newspaper. But as this case study has revealed *The Star* is not concerned with job creation. In fact, it has justified the removal of hundreds of employees from the health care system.

**Deskilling the Remaining Jobs**

Along with the legitimation of such widespread job losses, a movement to
"deskill" health professions was promoted. *The Windsor Star* reported that 63 percent of the work done by a physician could be done by a nurse practitioner at 38 percent of the cost (Health care: a will...19 January 1995). When the newspaper reported the staffing cuts to Malden Park in 1996, it noted that there would be more reliance on health care aids and registered practical nurses. While there may be some room in the system to allow nurses to take over some of the responsibilities now looked after by physicians, deskilling should only go so far. For example, the duties of health care aids should be restricted to minimal areas of care. If health care workers with minimal qualifications are asked to take on increasing responsibilities, this means that those who provide more and more of the care will have less education and will be more focused on individual tasks and treatments of health care rather than considering the entire mind and body in the healing process (Armstrong & Armstrong, 1996: 109). Criticism of this trend was confined to only a few articles (Cross, 5 October 1996; Ford, 30 November 1995; Bailey, 29 January 1997). For example, Maggie Hildebrand, Southwestern representative for the Ontario Nurses Association pointed out that staff was being replaced by less qualified workers and as a result, care was suffering (Ford, 30 November 1995). However, only one article really targeted the seriousness of the issue when it cited research that had been noted by Doris Grinspun, executive director of the Registered Nurses Association of Ontario (RNAO):

RNs must fight against their replacement by less qualified - usually cheaper - staff such as registered practical nurses, Grinspun said. RPNs have always played an important role, but extensive research shows an increased staff of registered nurses means reduced patient deaths, hospital stays and readmission (Bailey, 29 January 1997).
The article was quite critical focusing on recent reports of cheaper and less qualified staff being asked to perform tasks usually saved for higher-skilled workers in a health care system that has increasingly focused on "cost-cutting [rather] than quality patient care":

Funding and staff cuts have spawned horror stories across the province as under-qualified health care workers are asked to fill in where more qualified staff have been trimmed (Bailey, 29 January 1997).

Grinspun reported an incident where a hospital administrator requested a member of the institution's kitchen staff who had a Grade 10 education to administer a shot of insulin to a patient after a 40 minute lesson. The worker later called Grinspun to confirm she had done the right thing. While the article did indeed reveal the shocking reliance on unskilled workers in the province it later blamed the workers for not reporting such incidents (Bailey, 29 January 1997). Targeting the workers is unfair when one considers the precarious state of employment in the current system. With the diminishing number of jobs, workers may feel they must comply with management's demands for fear of becoming one of the many who have been laid-off. Moreover, the pertinence of the article was diluted in its last paragraph, as Lucia St. Aubin, president of the RNAO Essex chapter and an RN at Hotel-Dieu reportedly noted that such problems have not occurred at that hospital.

4. Opposition to the Win/Win plan represents a terrible threat to our health care system (see Appendix D for example).

From the beginning of the restructuring process, opposition to the Win/Win model was presented as the enemy of quality health care. In part this was done by presenting the
new model as the best model for health care as described above. The result was that once Win/Win was established as the only means to save our health care system, anyone who opposed it would then appear as a threat to our cherished social program. The very title of the model closes off challenge to the Steering Committee's recommendations. Fiske shows how metaphors are often used in the news to close off the polysemic nature of events. In so doing, the potential for various interpretations is narrowed (Fiske, 1987: 293). Metaphors are often used in the news to help make sense of what is being explained. "A metaphor explains the unfamiliar in terms of the familiar and is thus a conventionalizing agent" (Fiske, 1987: 291). Fiske shows how the metaphor of war was used to describe an industrial dispute and thus cast those involved in certain roles - management as "us" and the unions as "them". This sort of metaphor has what Fiske calls a "clichéd invisibility" that allows it to adopt the status of objective reality. Win/Win used the metaphor of a game to close off opposition to the planned reconfiguration. Games usually have designated winners and losers but the use of "Win/Win" suggested that everyone would win if the plan was implemented. Ultimately, it was implied that veering from the plan would result in a losing situation for everyone. As noted by the Steering Committee in the report: "For the stakeholders in the system, we believe that the 'Win/Win' Model outlined in this report has also lived up to our commitment to ensure that everyone would emerge from total system reconfiguration as "a winner" (SCR, 1994: 2).
Pleas for Public Approval

Despite the Steering Committee's assertion that the Win/Win model was not a final blueprint and that the public would be consulted on the plan, the commitment to this seemed weak (SCR, 1994: 2). Further into the report, the committee made appeals for compliance partially validated through the use of the familiar metaphor of the game noting that without change, nobody would win:

Those who do not want changes to the existing system have every right to argue their case during the public consultation process, but we urge that everyone understands that without agreements on how we are going to change the system, there will be no "wins" (SCR, 1994: 39).

The Windsor Star similarly defined compliance as success: "The massive restructuring that's planned for health services in the Windsor area would be impossible without the co-operation of the affected hospitals" (A long journey...25 January 1994). Only three days later they repeated the need for such co-operation:

And certainly no one should underestimate how critical it's been to have a spirit of co-operation among the hospitals as the recommendation took shape to phase out acute-care services at both Grace and Windsor Western. This unselfish commitment has fueled a very difficult process and must continue (The redesign...28 January 1994).

The editorial staff seemed almost fearful of anything that might challenge the Win/Win plan. Essentially, the writers requested the uninformed consent of the public. Without adequate information to critique the model, public input would be a mere formality, giving the appearance of consultation, but certainly not a meaningful one.

The Windsor Star editorial staff continued its pleas for consent. At the beginning of the following excerpt, The Star seemed to be endorsing negotiation, a process that
could prove beneficial by perhaps resulting in the exposure to various critiques of the plan and an examination of possible alternatives. However, as one reads on, it becomes evident that the editorial is really an endorsement for the Win/Win model:

...there's plenty of room for negotiation and compromise. In fact, the restructuring won't succeed without it, because this is an incredibly complex process, and a smooth transition relies on goodwill and voluntary compliance. It's not just the creation of two "super" hospitals, although that's a massive undertaking in itself. It's dealing with the shift to community-based services and finding a satisfactory way to co-ordinate the more than 200 health-related organizations that currently exist. It's streamlining the system while making sure each agency keeps the identity and autonomy needed to serve its clients (Health services...31 March 1994).

Despite the claim at the outset of this excerpt, promotion of negotiation did not seem to be the true intentions of the writers. Instead, the editorial resumed its focus on "compromise" as a cornerstone to the implementation of the Win/Win model. Rather than presenting a legitimate call for alternative suggestions, this editorial merely called for compliance with a predetermined model, as the editorial assumes the pending closure of two hospitals and the "streamlining" of community agencies.

**News as Negative**

Beyond these requests for compliance, there is another strategy at work. Fiske shows how designing news as negative works to close off the polysemic nature of events. That is, events covered by the news are disruptions from normalcy. The disruption thus comes to be defined as "bad" and normalcy is defined as "good". This is ideological because challenges to the status quo are disruptions to normalcy (Fiske, 1987: 284). Accordingly, whatever posed an obstacle to the Win/Win model was defined as "bad" for
example, when the merger between Windsor Western and Metropolitan hospitals was stalled by a disagreement on who would be the CEO of the new hospital, the resulting rift between the two boards was defined as unfavourable:

While Selkirk played down the ill effects of the public split between the two boards, the dispute has the potential to hold up, if not deadlock, the entire health care reform process (Ford, 22 June 1994).

Because the dispute had potential to "deadlock" the entire process, it was of course, "bad". Conversely, what was not as obvious was the restructuring process was defined as "good" in that the implementation of the Win/Win model was what was threatened by the rift between the boards. Similarly, labour issues were also defined as posing a threat to the reconfiguration effort. If these issues were not resolved, The Star reported that they could "bog down" the "costly business of health care reform" (Ford, 13 October 1994). The article pointed out that there must be a resolution before the province provided any funding for the project. "So if there's no labour deal, there's no influx of cash" (Ford, 13 October 1994). Labour was defined as "bad", prolonging a costly process and even potentially threatening the funding required for the implementation of the revered Win/Win model.

Shortly after the election of the Progressive Conservatives in 1995, tension started to mount when the Tories would not approve of the funding that the NDP had promised. If The Windsor Star consistently defined the Win/Win report as "good", one would assume that the actions of the Harris government, which could cause the dissolution of the plan, would be defined as "bad". But this was not the case. It was curious that the editorial staff that had vehemently promoted Win/Win disapproved of opposition to the
new government that seemed to be threatening restructuring plans. Readers were reminded that "...the Harris government came by their majority fair and square. They've earned the right to govern and promise to do so aggressively" (The legislature...26 September 1995). It seemed that perhaps the editorial staff was more committed to anything with a neoliberal stamp on it. Both the Win/Win model and Harris fit that bill, however, Harris is even more neoliberal than the initiatives outlined in the reconfiguration plan. With Harris representing the epitome of neoliberalism, the editorial staff might compromise its commitment to the Win/Win model in favour of the Tory agenda.

The newspaper described the Harris government's refusal to commit to the required funding as a mere "obstacle" (Health reform: Community...7 November 1995 see Appendix D for full editorial). The withdrawal of funds would be a greater threat than the labour disputes and hospital board splits that The Star said could "deadlock" and "bog down" the process. The Windsor Star refused to accept the idea that Win/Win may not be salvageable and instead prescribed co-operation to save the plan, stating that some involved in the process saw the deadline to come up with a cheaper model as a catalyst for co-operation (Ford, 31 August 1995). The editorial staff defined Harris' actions as merely a "backlash" against the NDP government rather than a real threat to our health care system (Health care: Saving...31 August 1995). Suddenly, the amount of funding required by the Win/Win report was not taken seriously and the editorial staff congratulated the DHC for not pursuing the required amount of funding: "To its credit, the local group isn't going to engage in protracted verbal warfare, and instead will give

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the minister a revised proposal with reduced financial requirements within the next
month" (Health care: Saving...31 August 1995). The article went on to state that without
a co-operative effort, improved health care services would be in jeopardy (Health care:
Saving...31 August 1995). Rather than the lack of funding, opposition to the
government's cut-rate approach to funding was now defined as the threat to health care.

Shortly after, even the revised proposal for capital funding was rejected. However
this was not the end to the assault on Win/Win. The ministry had also announced it
would not allow the community to keep the $22 million in annual savings to fund the
community sector. With capital funding up in the air and community sector enhancement
-- a major premise behind Win/Win now jeopardized -- The Windsor Star still promoted
following the government's plans. The newspaper feared the possibility that the various
stakeholders might withdraw from the now severely compromised plan referring to such
opposition as a "threat" (negativity) (Ford, 19 October 1995) and "dangerous" (Health
reform: A troubling...20 October 1995). The editorial staff even requested complying
with the government despite their acknowledgment that Windsor deserved more than the
government was willing to give:

We sincerely hope all those involved can keep their chins up and go back to
the table to draft a more modest proposal that will meet this new government's
expectations. It won't be what Windsor deserves, but under the circumstances,
it will have to suffice (Health Reform: A troubling...20 October 1995).
Labour's Threat to Health Care

As health care now appeared to be severely threatened, the Labour Advisory Committee decided it would no longer partake in the DHC's "negotiations" with the government. The Windsor Star reported that they "withdrew from the process" (Ford, 4 December 1995).

Charging that the restructuring of health care in Windsor has become simply a slashing service, labour leaders representing hundreds of workers have voted to withdraw from proposals that have been almost four years in the making (Jarvis, 3 November 1995).

The LAC was portrayed as a militant group, making "charges" and walking out on a plan that took four years to develop. Their refusal to continue "negotiationg" with the government for funding was portrayed as an eleventh hour back-out that would jeopardize the implementation of the revered Win/Win model. What was not made explicit was that labour was not walking out on the process but was going to pursue the needs of the community which were being undermined by the DHC's compliance with the government's refusal to provide adequate funding (Walter, 16 January 1998). However, The Star referred to the LAC's decision as "a gut reaction" rather than their effort to secure the best possible plan for the community (Health reform: Community...7 November 1995). The editorial staff belittled labour's efforts which they portrayed as under-cutting the original plans: "[The Premier] is unlikely to reconsider his decision to grab $22 million in local hospital savings and toss it into Ontario's general revenue fund just because labour representatives are angry with his government" (Health reform: Community...7 November 1995). The same editorial said the LAC was "walking away in
a huff" and that this did not serve a useful purpose implying that complying with the Harris government's decision to rob the community of what was promised to them was the smarter plan of action (Health reform: Community...7 November 1995).

A letter to the editor from Valerie Walter showed that labour's decision to work from outside the DHC was not a decision to walk out on health care plans for the community. Walter explained the LAC's position: "let us be perfectly clear - labour has not stepped away from the reconfiguration project" (Walter, 8 November 1995). She cited the ministry's refusal to fund the community sector coupled with fewer patient days as having a "devastating" effect on the quality of our health care system. She noted that labour left the DHC because reducing costs had taken precedence over the quality of services (Walter, 8 November 1995).

However, labour's concerns were not granted consistent coverage. And when an article did centre around their efforts, the often negative portrait drawn of them was arguably just as damaging as the absence of comment on their efforts. The essence of the unfair representation of these social activists can be demonstrated by comparing two articles by the same reporter that appeared in The Windsor Star. Both articles described reaction to the proposed management structure outlined in the Win/Win model - the first described the Health Unit's concerns and the second portrayed the Christian Labour Association of Canada's reaction. Both organizations opposed the proposed structure but their reactions were described very differently. The headlines were telling in themselves. The Health Unit was portrayed as "voicing" its worries about the plan: "Health unit voices concern" (Ford, 20 May 1994). The second headline described a labour group's
reaction in violent terms: "Union slams hospital plans" (Ford, 11 June 1994). The lead paragraphs of the articles were also illustrative:

The Windsor-Essex County Health Unit is lining up with area hospitals and the Essex County Medical Society to assail what they call a money-wasting scheme to increase the local health-care bureaucracy. The board of the health unit overwhelmingly backed a resolution calling for the "existing management and governance structures" to be respected while the rest of the local health-care system undergoes a wide-ranging makeover (Ford, 20 May 1994).

Compare this to:

Calling it a giant power grab, Ontario's fifth largest health-care union has come out swinging against plans to revamp local health care. The effort to consolidate Windsor's four hospitals to two, expand community-based care, and co-ordinate the area's myriad health-care services merely "puts one big bureaucratic system in place", said Ray Pennings of the Christian Labour Association of Canada (Ford, 11 June 1994).

The reaction of the Health Unit and other officials could more easily evoke the readers' support. That is, who would be in favour of a money-wasting scheme that increases bureaucracy to oversee our health care system? But the concerns of the union were described as a violent reaction making it much more difficult for readers to sympathize with the second article. Moreover, the newspaper implied that the union was reacting against the entire health care plan- a plan that had been promoted as the best possible one for the community - rather than more accurately specifying it as a reaction to the proposed management structure.
5. The Federal government has very little effect on the local restructuring (see Appendix E for examples).

Maude Barlow and Bruce Campbell and others have shown how the federal government is ultimately behind the undermining of our public health care system. Consistently decreasing transfer payments to health care has meant that provinces are increasingly unable to meet the principles behind the CHA. While Mike Harris in Ontario and Ralph Klein in Alberta are perhaps the most obvious examples of the neoliberal assault on health care, as the federal government continues to reduce funding for health care, its ability to enforce the CHA has been diluted. It must be remembered that while whatever criticism may be festering towards the PCs in Ontario may be warranted, it is essential to identify the federal government's role in the local situation.

Unfortunately, *The Windsor Star* did not explore the role of the federal government to any degree in the restructuring case of Windsor/Essex County. Winter explains that mainstream news often eliminates context in the name of the pursuit of objectivity. The result is a narrow interpretation of events that omits a discussion of background and relation to other events (Winter, 1992: xvii). Likewise, the national context to the local restructuring story was virtually absent from the four years of coverage examined in this study. There were a mere two articles out of the 285 studied that noted the federal government's responsibility in the financial starvation of the local health care system (Cross, 22 October 1996; Priddle, 4 November 1996 see Appendix E for full articles). And neither explored the issue at any depth. The first article reported on the efforts of local nurses in implementing an integrated delivery system. Midway
through the article, the federal government's role in the current crisis was merely mentioned with no further exploration into the issue: "The Ontario Nurses Association is proposing its own solution to the crisis that's been caused primarily by funding cuts by both federal and provincial governments" (Cross, 22 October 1996). The second article was a fairly critical article, describing a rally against health care cuts. The article noted the deteriorating conditions in local hospitals:

"Things have never been this bad in health care", said Elena Vitella, who has worked in hospitals for 23 years. "There's not enough time to care for patients," said the operating room worker. She said the staff is rushed and patients are discharged too soon after surgery, even when they are elderly and there is not enough home care available for them (Priddle, 4 November 1996).

While the article did explore the ailing state of local health care services there was again, only brief mention of the federal government's role half way through the article:

Sandi Ellis, southwestern representative for the Canadian Labor Congress, said Canadians have awakened to say they have had enough and that lives are being affected. Similar protests are being held across the province to raise awareness. Ellis said that while the province shoulders direct blame, the federal government is responsible for cutting transfer payments used to fund health care (Priddle, 4 November 1996).

Like the previous article, there was no further investigation into the issue. Columns by Valerie Walter and Pierina DeBellis also identified the problem of declining transfer payments(Walter and DeBellis, 12 September 1995; Walter, 26 March 1998). But these were the only articles that alluded to the role of the federal government. As pivotal and integral to the present state of health care as the federal level is, its involvement was rarely mentioned and was never examined in any great detail.

The definition of reconfiguration as a local issue is enforced by the fact that many
of the articles were found in the local section of the news. Fiske notes that this indeed means that the issue is defined as an anomaly rather than a symptom of a widespread problem. "...localizing the definition of problems encourages local 'solutions' and discourages any critical interrogation of the larger social structure" (Fiske, 1987: 287). Not only was the restructuring confined to the local level through its categorization as "local news", but the issues were defined as a local problem by the mere fact that any discussion of the federal role was removed. Likewise, there were few references to similar problems occurring in other communities, thereby dismissing any concern of a widespread crisis created by the neoliberal agenda increasingly present across the country and around the world.

Local Solutions Mean Local Problems

In early 1997, Frank Bagatto, executive director of Hotel-Dieu Grace revealed through his own calculations that Windsor/Essex County had been underfunded for years compared to the rest of the province. Because of this, he suggested holding back on requests for funding until the government changed its methodology (Bagatto, 31 January 1997). While this was crucially important, when the under-funding is considered in the context of an 18 percent budget cut to local hospitals, a significant reduction in capital funding and no commitment for money for the community sector, this really was disastrous. However, instead of launching a campaign against all of the above, the assault was relegated largely to the unfair funding issue. City council, it was reported endorsed a call to the ministry for fair funding (Jarvis and van Wageningen, 4 February 1997).
Liberal MPPs Sandra Pupatello and Dwight Duncan both began to act in starting petitions and other measures. The Windsor and District Labour Council was planning a forum and a door-to-door campaign and the DHC and hospital CEOs were to meet with the minister (Jarvis and van Wageningen, 4 February 1997). This seemed to be the first time the community finally stood up and said "no" to the government.

Much of the coverage now centred on the under-funding issue. This meant that the health care problems were now defined as a local issue rather than being part of a much wider problem. Somehow, this had become the only widely acceptable means of criticizing the local situation. And because this was now designated as a crucial problem, fair funding was also touted as a solution (Rennie, 7 May 1997). But what of the consistently declining transfer payments? What about the Harris government’s refusal to allocate funds for the enhanced community sector promised in the Win/Win report? What about the cuts in capital funding for the rebuilding of the remaining hospitals deemed as necessary by the Steering Committee? Certainly an 18 percent budget cut to Ontario’s hospitals in the midst of the reconfiguration efforts exacerbated the seriously injured state of health care in the area. Fair funding would be a good beginning to reinvestment in our health care program - but it would be just that - a beginning. There are other serious blows that have been administered to our health care system. Ones that have left communities across the province and throughout the entire country struggling with the financial starvation in hospital and community health funding. It is a far-reaching infiltration of the neoliberal agenda that has led us to the current devastation of our beloved health care system.
Another "local" problem was more consistently blamed for the deterioration of our health care system. It seems as though much of the coverage in 1997 focused on just getting that capital funding. The line of reasoning seemed to be that if we could just fix the buildings our health care system could progress. Lloyd Preston reduced the area's health problems to the inability to proceed with the closure of hospitals: "The difficulty is we are faced with having four sites with two hospitals worth of workers" (Thompson, 1 February 1997). He promoted the idea that the 18 percent province-wide cut would be manageable if they could just cut the expense attached to providing acute care at all four sites (Jarvis, 14 May 1997). Hume Martin reiterated this when he said that keeping the four buildings open would compromise care (Jarvis, 9 April 1997). The DHC's hospital task force released a report stating that further cutbacks could not be met until capital funding came in, implying that such cutbacks could be sustained if two hospitals could be closed (Jarvis, 12 February 1997).

Likewise, an article in The Star was jovial in reporting on the blueprints that have been drawn up for Hotel-Dieu Grace: "A display of sketches for a $60 million addition to Hotel-Dieu Grace provided a much-needed dose of good news for staff Wednesday" (Whipp, 28 August 1997). The article noted that the hospital could not close the Grace site until the addition was finished. The article seemed to imply that being able to proceed with the Win/Win plan would solve the crisis in the health care system. Win/Win thus becomes the saviour - a local solution to a local problem.

Without exploring the government's role, one can assume that there is no widespread neoliberal movement, and that the situation in Windsor/Essex County is
somewhat unique rather than it being one instance out of many in a chronic problem that is plaguing our most cherished social program. The result is seen in the analysis above. The solutions are contained at the local level, thereby deflecting attention from a much wider deterioration of the welfare state in favour of a seemingly relentless path towards privatization.

Conclusion

The Windsor Star did offer some critical analysis of the restructuring efforts. In early 1997, it was announced that Windsor Western's emergency room would be closed that April. This came as a shock to many because the emergency room was still busy and the remaining two hospitals had not been expanded yet (Thompson, 10 January 1997). This announcement did spark some critical coverage of the issue on the part of The Windsor Star. There was a series of articles written by Anne Jarvis that took a critical look at the effects of the Harris government's cutbacks to our local health care system. Perhaps after the repeated budget cuts imposed by the Tories, the newspaper could no longer ignore the festering problems that had become open sores in our health care system.

While this coverage added valuable diversity, presenting a strong critical stance on the effects of funding reductions, it was short-lived. Instead, it seemed to fall under the category of token critical coverage that Winter explains is necessary to uphold the illusion of diversity in our mainstream media (Winter, 1997: 112). The result is that the newspaper generally failed to provide meaningful critical analysis of what has come to be
a severely compromised health care system. The initial truism, "public health care is too costly and ultimately the system may have to be privatized", was perhaps the most powerful premise in its widespread application. The supposed exorbitant expenses of our public system served to promote all but the fifth truism that I have developed. It led to the promotion of the second truism: "Win/Win is the best possible plan for Windsor/Essex County facilitated by the best efforts of our government and health care officials". Essentially, this meant the approval of a restructuring plan that would see half of the area hospitals closed and eventually, the erosion of this plan for an even sparser system. Moreover, claims that our public health care system is enormously costly justified the third truism: "The 'few' jobs that will be lost as a result of restructuring are merely due to the unfortunate 'reality' of the times". Jobs were said to devour a large portion of hospital budgets and thus, this meant the acceptance of the loss of many hospital employees. Furthermore, the claim that the public health care system was over-funded meant that any disapproval of plans to restructure and reduce spending were deemed dangerous, thereby promoting the fourth truism: "Opposition to the Win/Win plan represents a terrible threat to our health care system".

The fifth truism, "The Federal government has very little effect on the local restructuring", has served to define the current crisis as a symptom of problems in our local system. The almost complete failure of the newspaper to contextualize the crisis in our health care system on a national level has meant that the neoliberal policies promoted by the above truisms have not been identified as part of a widespread movement to further the interests of the elite. Confining the problems to the local or even the provincial level
presents them as a sort of anomaly rather than an indication of the removal of public interest at all levels of policy-making in favour of the extension of the interest of the elite minority. Ultimately, *The Windsor Star* adopted the assumptions necessary to preserve and extend the capital class. The result was an overall “exnomination” of the neoliberal voice - a formation of a “conventional wisdom” that ultimately privileges the privatization of our health care system.
CHAPTER 7 - CONCLUSIONS

Summary

In 1994, The District Health Council published its Steering Committee’s recommendations for a restructured health care system in Windsor/Essex County. While the authors of the report assured the public that the plan would indeed improve health services in the area, upon close examination of the report, this became questionable. The plan would mean the closure of two out of four local hospitals and the potential loss of many jobs. The loss of services and jobs within the institutional sector was to be compensated for in an improved community sector. However, Armstrong and Armstrong note that many similar reports that have recommended improving community health are really about saving money rather than improving health. The bottom line is that “community health” all too often means care by loved-ones. There were indicators that this plan did indeed fall into that category. The DHC showed a lack of commitment to improving community health when it allowed for only half the amount of time to study over 200 agencies that was designated for the hospital study which looked at only five institutions. Moreover, the DHC refused to heed to the LAC’s demands of completing the community study before the hospital study was done to ensure that hospital restructuring would not go ahead before the community enhancement was complete to make up for loss of service.

The NDP government did show commitment to the plan agreeing to the $109 million in capital funding and had pledged $66 million of that amount. Furthermore, that government agreed to allow the hospital savings to be reinvested in the community sector.
This would mean at least $22 million invested every year in enhanced community agencies. However, in 1995 Mike Harris’ Progressive Conservatives were elected. They have reneged on the agreed levels of funding for this new health care system. The $22 million in savings will not be seen in this community. They have lowered the capital funding amount to $103 and the allocation of these funds that has been recommended by the HSRC will not meet current health care needs in the community (Walter, 26 March 1998). Moreover, the community has yet to see an actual cheque. Also, this government implemented an 18% cutback to hospital budgets. The federal government has contributed greatly to the problem by consistently lowering transfer payments. Since the CHST took effect in 1995, federal funding for medicare, education and other social programs covered under the transfer payment has been cut by $6.3 billion (Canadian Health Coalition, 1997: 1).

The result has been a crisis in our local health care system. It is not uncommon for patients to wait 24 hours for a bed. Local emergency rooms have seen the loss of the directors of trauma and of emergency at Hotel-Dieu Grace who said that frustration with inadequate conditions was the reason for their departure. In fact the government’s own investigation into local emergency rooms resulted in a report that referred to them as “hopelessly inadequate, inefficient and unsafe” (Cross, 12 September 1997). There have also been reports of deaths as a result of overcrowding and under-staffing in Windsor’s emergency rooms (Brennan, 4 July 1997).

Considering the seriousness of this matter, The Windsor Star has not treated the issue adequately. The newspaper essentially endorsed the original Win/Win plan,
omitting any discussion of possible alternatives to closing two hospitals. The newspaper asserted that: "The choice the steering committee had to make was between Windsor Western in the West end and Hotel Dieu hospital, which is downtown" (van Wageningen, 13 January 1994 emphasis added). Columnist Gord Henderson assured readers of the necessity for the recommendations contained within the Win/Win model: "There's near unanimity on the need for change. From hospital administration to union officials, you'll look long and hard before finding someone who believes in the status quo - four under equipped and under-used hospitals competing for resources and patients - can or should be maintained" (Henderson, 27 January 1994).

One might assume that The Windsor Star would have contained critical coverage of the Tories actions in regards to health care as they threatened the survival of the Win/Win plan that the newspaper endorsed. While there has indeed been some critical coverage, it seems to have come more recently when the situation in our health care system has become so desperate that it is hard to ignore. Instead, the newspaper has been very forgiving of the Harris government, endorsing its pledge of $72 million in capital funding in March 1996 without discussion of what would have to be cut out of the plan to accommodate this $28 million dollar cut from the funding initially deemed as necessary by the Win/Win plan. More recently, the latest announcement in February of 1998 has meant that the capital funding amount will be increased to $103 million. The day after this announcement, the coverage was celebratory when it quoted a local doctor in it's headline: ""Everyone is happy' with the $103-million allotment" (Cross, 13 February 1998). It was not until a column by Valerie Walter was printed over a month later that,
in so doing, *The Star* acknowledged that not *everyone* was happy. According to the column, LAC asserted that the distribution plan for the funds recommended by the HSRC would be highly problematical (Walter, 26 March 1998; LAC, 1998).

As argued throughout this thesis, the Win/Win plan was ultimately about saving money and encouraging privatization rather than improving health care. By supporting the recommendations contained within the report, *The Windsor Star* endorsed what was essentially a neoliberal plan for health care restructuring. Furthermore, the newspaper's lack of critical coverage on the Harris and Chretien governments' cutbacks to this area is an even greater assault to our most-cherished social program as these reductions in funding have led to the crisis that we are now experiencing. Without critical analysis of the plan and government initiatives coupled with a lack of even mere mention of possible alternatives, *The Windsor Star* has essentially facilitated what has been a clear and definite path towards privatization of our health care system. Essentially, *The Windsor Star* 's commitment to neoliberalism eclipses any "commitment" to public health care and any possibility for a watchdog role for the press. Thus, this case study has demonstrated that although the media promote themselves as socially responsible public advocates, they really represent corporate interests. The direction toward privatization of health care is part of a larger pattern. There is a connection between seemingly unrelated events that should not be ignored. At both the provincial and federal levels, governments have been clearly aligning themselves with business interests, rather than forming policy to meet the needs of ordinary people. For example, the federal government is endorsing the Multilateral Agreement on Investment that will facilitate trade and investment deals on a
global level and in turn weaken our nation state. But it is all in the name of globalization, a force which we are told we cannot stop nor afford to ignore. Furthermore, recently, the federal government has announced a budget surplus. While we might assume that this will mean the government will return funding to social programs, some recent proposals have revealed that the rich will continue to benefit. The eradication of child poverty has been a popular choice in deciding where new spending will end up. However, it has been proposed that this be done through tax cuts - an initiative that will not be likely to help low income families to any significant degree and will in fact benefit the rich (Tax cuts...1998: 48).

The Ontario government has not confined its attack on the social safety net to health care. Only three weeks after they had assumed office, $1.9 billion had already been cut in government spending (Kitchen, 1998: 13). Over the last three years, Ontarians have seen massive cuts to education and welfare, the deregulation of environmental standards and the elimination of the province’s anti-scab legislation (Clarke, 1998: 11, 12). Perhaps the most obvious message about this government’s decision to get out of the business of providing social programs was the downloading to municipalities. Municipal governments are now responsible for some social programs but have not been given the necessary funding to do so. The result will likely be that local governments will have to turn to charities, the private industry and families to provide these services (The New...1997: 9). Thus health care is but one piece of the same puzzle. Across the province, and indeed throughout the country, neoliberal policies are favoured by our governments so that life has become quite comfortable for corporations
in Canada while the numbers of the poor and the unemployed have increased to levels that would have been previously unacceptable. However, the connection between these seemingly unrelated events has been left unexplored by *The Windsor Star* so that we are not encouraged to draw these parallels that indicate just how widespread the neoliberal agenda has become.

**Critical Political Economy vs. Neoclassical Economics**

Critical political economists of communication base their work on the assumption that communication is a powerful tool (Babe, 1997: 40). In this respect, the news media are granted the privileged position of informing our very ideas about the world around us (Hackett, 1991: 14). Political economists note, however, that ownership and access to the dissemination of information is not afforded to everyone. Capitalist economies have ensured that the mainstream media is owned by the rich and powerful. Knowing that it is largely the corporate elite who have been granted access to the means of interpreting the events that surround us and disseminating this information to the public, we must ask, what are the versions of reality that are consistently promoted by this group? This thesis attempted to shed some light on the answer to this question. In the development and examination of the truisms that were presented by *The Windsor Star* throughout the health care restructuring process, it was illustrated how the local newspaper positions itself within the dominant ideology that has legitimated a neoliberal attack on our social programs in the name of debt reduction.

Political economy of communication is concerned with revealing how the media
create ideological texts. By ideological it is meant that the media create not only an integrated picture of reality, but also, a vision that promotes the interests of the elite class (Golding and Elliot, 1990: 208). The truisms that were offered to the public throughout the four years of coverage on local health care restructuring included both of these ideological elements. These truisms were indeed integrated, creating a web of mutually reinforcing ideas that essentially legitimated the erosion of our public health care system. Together they presented a consistent picture of reality that was consonant with a neoliberal worldview thereby making it difficult for alternative voices to effectively penetrate this integrated picture and challenge the assumptions posited therein. The analysis of these truisms presented in the previous chapter illustrated The Windsor Star's ideological alignment with the dominant class. Not only does this extend the neoliberal agenda which includes the dismantling of the welfare state, but it also serves to promote, in particular, the assumptions of neoclassical economics that serve this agenda.

**Neoclassical Economics and the Truisms**

1. Public health care is too costly and ultimately the system may have to be privatized.

   The rising claims that our social safety net is largely responsible for government debts has legitimated the withdrawal of public funding from our health care system. The message that is conveyed is that we cannot afford our social programs. The Steering Committee adopted and promoted this message as the motive behind the restructuring initiatives:
As the combined impact of shrinking tax revenues, a $45+ billion annual
deficit in Ottawa, a $10 billion deficit at Queen's Park and as the collapse
of major portions of our manufacturing sector continues to wreak havoc on
our country, our province and our community, it is clear to us that our existing
structures cannot survive over the next three years...Over the next two or three
years, as budgets are cut back even further, our system could collapse if we
were to retain our existing structures and organizations. There are widespread
reports that quality-of-care within the system is already beginning to seriously
deteriorate - so there is no time to lose (SCR, 1994: 22).

In the same neoliberal tradition, *The Windsor Star* coverage reiterated these concerns,
noting the "inefficiencies" of the system:

When you get past the politics, the emotions and the misinformation, there are
all kinds of reasons why Windsor needs two hospitals instead of four. There's
the fact that no other Ontario community with a population base this size
has four facilities, each of then operating at almost half their optimum capacity.
There's enormous capital and operating costs associated with supporting four
under-utilized buildings; the expensive duplication of trauma and emergency care
services; the need to constantly pump dollars into infrastructure when that money
should really be used for more nursing and support staff (Hall, 29 January 1994).

Despite assurances from the Steering Committee that budget concerns were not
the main force behind health care restructuring, after examining the Win/Win report and
the newspaper coverage it has become apparent that the neoliberal fixation with
decreasing government spending was indeed the main concern. Accordingly, much of the
newspaper coverage adopted premises similar to the above and promoted the notion that
our public health care system is inefficient and over-funded. The claim that the public
sector is inherently wasteful in turn privileges the private sector, promoting the removal
of "inefficient" government hands in favour of an unregulated free market system. Thus,
the core of neoclassical economics - the removal of most forms of government
intervention, is served (Miller, 1962: 65). However, one of the basic premises upon
which neoclassicists operate has been proven to be false. Their claim that public
spending by "inefficient" governments has led to debts that threaten to cripple our country
has not gone unchallenged. In fact, a statistician at Statistics Canada proved that social
programs are not the cause of the so-called economic woes of the country. In 1991,
Hideo Mimoto studied the debt in relation to government spending and concluded "it was
not explosive growth in social spending that caused the increase in deficits" (quoted in
McQuaig, 1995: 58 emphasis added).

The privileging of the privatization of our health care system responds to the
values that are promoted by mainstream economics. Babe explains, for example, that to
neoclassical economists, a tree is worth nothing until it generates profit by becoming a
supply of newsprint (Babe, 1995: 99). If we apply this value system to our medicare
program, it is naturally without value as it has no profit potential in the private sector. On
the other hand, the privatization of this program would indeed represent the realization of
much profit. Thus, the benefits of the public health care system such as improved health
for the population and an improvement in the level of social equality, have little value to
neoclassical economists.

2. Win/Win is the best possible plan for Windsor/Essex County facilitated by the best
efforts of our government and health care officials.

As explained throughout this thesis, the Win/Win model adopted many neoliberal
assumptions. It seemed that the Steering Committee's report was of a nature of other
similar recent government reports that touted the virtues of investment in community care while at closer examination really promoting cheaper care provided by loved-ones instead of our public institutions and agencies. *The Windsor Star* however, adopted the claims of the Steering Committee and assured readers that the plan was not merely about closing hospitals. The newspaper claimed that the plan would result in a better system:

> The immediate message that needs to be telegraphed to the community is that this exercise is not one that involves the diminution of services. Windsor isn’t losing two hospitals. The stage has been set to create a system that is more efficient, effective and capable of providing new programs and better care (The redesign...28 January 1994).

Armstrong and Armstrong have revealed that other similar government reports that recommend deinstitutionalization are mainly concerned with saving money rather than true investment in community services. In the specific case of Windsor/Essex County, this becomes even more apparent when one considers that over 500 full-time-equivalent jobs have been lost without replacement in the community sector. The result is that the expense of care is off-loaded onto individuals who are left to take care of their friends and family members because there is no room at the hospitals and a lack of community support services. The move toward such a model essentially reinforces the neoclassical premise that society is merely a compilation of individuals. The privileging of an essentially privatized system where individuals are responsible for their own health denies the premise of the collective nature of society upon which our social programs are built. For neoclassical economists, the collective sense of our social safety net is an impediment to the central ingredient for the optimal organization of society - the freedom of the individual.
3. The “few” jobs that would be lost as a result of restructuring are merely due to the unfortunate “reality” of the times.

Before the work of Milton Friedman and his colleagues was accepted by the mainstream around the 1960s, economic initiatives were largely based on the work of John Maynard Keynes. Keynes promoted the idea that we could influence the unemployment rate - that we could indeed create jobs to ensure that unemployment did not rise above a certain level. Friedman’s work, however, essentially rid the study of economics of the concern for unemployment in favour of a preoccupation with inflation rates. He argued that unemployment should not be the concern of economic policies but that controlling inflation was the route to prosperity. ¹⁰ Unfortunately, our governments have followed suit in their adoption of neoclassical economics. Inflation has been the main concern while unemployment has continued to rise to levels that would have previously been unacceptable (McQuaig, 1995). Moreover, the media has adopted this emphasis on inflation and the acceptance of high unemployment rates as a truism itself (Winter, 1997: 116). Accordingly, The Windsor Star showed similar disregard for employment issues as it down-played the potential disruption in workers’ lives and perhaps more importantly, virtually ignored the possibility that the restructuring plan would mean the loss of many jobs:

shifting along with the equipment will be hundreds of employees. They’ll set up shop in new or renovated hospitals, or shift gears to go from hospital-based to community-based health care (Ford, 2 January 1995).

Moreover, as it became apparent that jobs would indeed be removed from the system, The

¹⁰ From an interview with Linda McQuaig that aired April 21, 1998 on TVOntario.
*Windsor Star* justified rising unemployment in the field by noting that hospital budgets were burdened by paying workers: "Salaries account for 75 to 80 percent of hospital costs, so it appears inevitable that some of this area's 2900 hospital workers will be laid off" (Cross, 27 February 1996).

*The Windsor Star*'s promotion of this truism reflects the acceptance of job losses as mere and unfortunate reality - that the government's hands are tied as they must heed to the workings of the market. This dismisses the notion that there is real choice in the pursuit of economic policies and the kind of society that develops around them. What we are not told is that focusing on controlling inflation rates is indeed a *choice* and our governments can choose to focus on increasing the number of jobs without jeopardizing the economic health of our country and in fact improving it by protecting the population from poverty.

4. Opposition to the Win/Win plan represents a terrible threat to our health care system.

Essentially, this truism serves to justify the pursuit of the initiatives outlined in the Win/Win report which I have demonstrated promote the neoclassical prioritization of the market and the individual, rather than a collective, public approach to health care. The report itself emphasizes the importance of complying with the recommendations made by the Steering Committee members despite their assurances that the model was not a final blueprint (SCR, 1994: 2).

Those who do not want changes to the existing system have every right to argue their case during the public consultation process, but we urge that
everyone understands that without agreements on how we are going to change the system, there will be no "wins" (SCR, 1994: 39).

While the Steering Committee has allowed for people to disagree with the recommendations of the report, it seems clear that they are urging for just the opposite by noting that without agreements nobody wins. Likewise, The Windsor Star also emphasized the importance of "co-operation" as the recommendations were implemented, thereby promoting compliance with the Win/Win model:

And certainly no one should underestimate how critical it's been to have a spirit of co-operation among the hospitals as the recommendation took shape to phase out acute-care services at both Grace and Windsor Western. This unselfish commitment has fueled a very difficult process and must continue (The redesign...28 January 1994).

This truism represents an almost obvious plea for compliance with the neoliberal initiatives of the model thus extending the neoliberal agenda to the realm of public interest. Moreover, it demonstrates the absence of critical analysis. In accordance with the premises of neoclassical economics, there is a refusal to critically examine the ramifications that these initiatives will have on society. Neoclassicism ignores such considerations by focusing largely on the depoliticized methods and findings of positivism. The newspaper offered a similarly depoliticized look at the restructuring process by offering very little thorough analysis and criticism of the model. The lack of critical analysis is further facilitated by The Windsor Star's omission of an examination of the possible alternatives to the Win/Win model. By refusing to even acknowledge the possibility of other plans, the one put forth by the Steering Committee has been privileged as the only means of "improving" health care.
5. The federal government has very little effect on the local restructuring efforts.

Neoclassical economics accepts and promotes an absence of social and historical context in the name of pursuing laws that apply to all situations. In this tradition, *The Windsor Star* has echoed this premise and has neglected to analyze the historical role of the federal government in the current and local context. Winter explains that the mainstream media neglect an examination of the background to events and their relation to other issues. The result is a fragmentation of events that inhibits the development of a cohesive view of the world (Winter, 1992:xvii). *The Windsor Star* printed a mere two articles mentioned the impact that the federal government has had on our local system. The first article noted: "The Ontario Nurses Association is proposing its own solution to the crisis that's been caused primarily by funding cuts by both federal and provincial governments" (Cross, 22 October 1996). The second article blamed both the provincial and federal governments for the current crisis:

Sandi Ellis, southwestern representative for the Canadian Labor Congress, said Canadians have awakened to say they have had enough and that lives are being affected. Similar protests are being held across the province to raise awareness. Ellis said that while the province shoulders direct blame, the federal government is responsible for cutting transfer payments used to fund health care (Priddle, 4 November 1996).

These articles merely mentioned the role of the federal government and did not explore the issue any further. The effect of this lack of contextualization within the discipline of economics is that there is an absence of a political analysis of the economic policies that are subsequently developed. Issues of power and class structure are ignored. Similarly, the absence of a discussion of the federal government's role works to depoliticize the
issues. It serves to ignore the widespread nature of the neoliberal ideology and the
nation-wide breakdown of our social safety net.

Creating Solutions

The promotion of these truisms and their support of the foundations of
neoclassical economics and the neoliberal agenda they help formulate has removed the
moral foundation of economics once employed by Adam Smith. In the tradition of Alfred
Marshall, mainstream economics is dedicated to a "scientific" approach, employing
objective, positivist methods that pursue the discovery of laws that apply across time.
The result is that the discipline has freed itself of the political ramifications of its findings,
thereby precluding the possibility of a critical analysis of the power structures inherent in
a capitalist system and the inequality that ensues.

On the other hand, critical political economy is concerned largely with forming
analyses of the class structures of capitalism that develop from the political relationships
between business and government. In particular, political economy of communication
strives to illustrate how media organizations preserve and extend a capitalist society in
which inequality is an integral component while closing off any alternatives to this. In so
doing, political economy also is concerned with transcending the gap between study and
practice so that tangible solutions are offered that work toward a society based on justice
and equality (Meehan, Mosco & Wasko, 1993:108). Accordingly, the next logical
question should be: Based on this moral philosophy, what would the solutions to the
problems uncovered in this case study be? How do we go about forming a public sphere
that offers a diverse range of opinions and in turn facilitates a real democratic process?

Perhaps a logical place to start would be at the level of policy. With the help of anti-trust laws, more diversity can be attained, ensuring that more individuals have access to the means of the distribution of information. However, such policies have been put in place in the past and our governments have failed to enforce them (Bagdikian, 1992: 8). Warnings of both the Davey Committee and the Kent Commission have gone unheeded by recent governments and media companies have been allowed to balloon to unprecedented levels thereby severely decreasing the level of diversity in mainstream media products (Winter, 1997: 7).

What is needed then, is a government that responds to the needs of the public. Winter (1997) purports that the first step should be reforming the “democratic” system in Canada so that its represents and is responsible to the electorate rather than the corporate agenda. This includes limiting the amount of donations a political candidate is allowed to receive for their campaign. This in turn would allow progressive candidates who do not attract large corporate donations to have a fair chance at being elected. Moreover, the system should allow the public to recall those politicians who are not representing their interests. A system of proportional representation is needed to ensure that those who are elected have received a true majority of votes. Cabinet ministers and committee chairs should be elected rather than appointed. This would safe-guard against the Prime Minister’s considerable influence over these members of parliament who may fear the loss of their job if they do not heed to the Prime Minister’s interests. New parties are needed or new party structures which would replace the conventional heirarchies.
In the end, these reforms would help to foster a real democratic system where the public's interest is the main priority of the government rather than that of their financial backers and corporate friends. Under such a system, policies such as anti-trust laws could be enforced as governments might no longer fear the removal of corporate support of media companies affected by these laws. What could result is a system that responds to the needs of the public and protects the public sphere, which in turn facilitates more democratic governance. At base, the changes required are substantial. What is needed is wholesale reform of a corrupt system of governance, which bears little resemblance to anything "democratic" (Winter, 1997).

At present, there are a few Canadian sources that offer alternatives to what is presented in the mainstream. These sources provide a forum for marginalized voices and their promotion of justice and equality but it seems their voices are not loud enough to be heard by the public at large. Against the barrage of mainstream daily newspapers, newscasts and magazines, the public's attention to these sources is severely limited.

What is required is a more direct challenge to the mainstream media, one that can secure a level of public attention that is comparable to that of the mainstream. In part, this may be achieved by developing daily and weekly alternative newspapers so that this source could speak more directly to social issues as they develop and offer an answer to the mainstream media's version of events. Perhaps the best way to formulate an alternative version of reality is to do so on a frequent basis that offers readers a response to what is continually pumped out in the mainstream. This in turn might eventually lead the public to employ tools necessary to think and respond critically to the content of the
mainstream media. I caution here that I do not purport that people lack the intelligence necessary to think critically. However, they do seem to lack resources. That is, I think that many are aware that what the media offer is a narrow version of events, but in the absence of alternatives to the ideas that are continually repeated, the public ends up complying with the neoliberal agenda.

Indeed there are some alternative media that are publishing on a more frequent interval. For example, the alternative media web site *Flipside* publishes new reports on a weekly basis. *The Canadian Forum* and *Canadian Dimension* are excellent magazines that offer socially progressive commentary on a monthly basis. However, there is a greater problem that has to do with a lack of public awareness and exposure to these sources. How could it be possible to extend the plethora of quality alternative media further into the mainstream? These are excellent media but do not have nearly the same numbers of readers as mainstream sources. Because this seems to be a recurring question, a question that has gone largely unanswered, it seems that this is an appropriate and necessary area for further research. As discussed above, the reform of the “democratic” system would certainly be an enormous step toward ensuring diversity in the media. However, further research could also prove valuable in securing a more prominent position for alternative media. Eventually, this research could aid in forming an effective public sphere - one where a socially just society based on the foundation of equality is perceived to be attainable. The marginalized voices who support our social safety net and its programs such as health care would be given equal strength. Ultimately, the formation of an effective public sphere could offer a moral philosophical outlook as a viable and
necessary alternative to the capitalist system that rewards the wealthy few while
impoverishing and disempowering the majority.
BIBLIOGRAPHY


and Mail.


Clarke, Tony. (1997, July/August). Ontario under corporate rule. Canadian


European Journal of Communication, 9, 461-484.


A1, A2.


Bottom line dictated the choices

Ten years ago, it would have been unthinkable. Even five years ago, it might have triggered a vicious community battle.

But in January 1994, dollars-and-cents pragmatism rules supreme, to the point where one of the most important, far-reaching decisions in the history of Windsor and Essex County becomes a sterile, anticlimactic exercise.

It was perhaps appropriate that the fate of Windsor's hospital system was announced with almost clinical detachment in such antiseptic surroundings, a monochromatic Essex District Health Council meeting room, with pale green carpeting and pale green chairs.

It was a setting suitable for the reconstructive surgery that will see the Windsor area emerge by the end of the century with two "super hospitals" and radically streamlined health-care delivery.

Strange how such a historic moment can be so lacking in emotion. The suits sipped coffee, munch doughnuts and chatted politely about a done deal.

They might as well have been discussing hog futures.

It was difficult to make a connection between the euphemisms ("total system reconfiguration") and the blood-and-guts reality of this health-care revolution — the fear, anguish and uncertainty of thousands of workers whose lives are being uprooted by this "win-win" proposition.

Windsor is pioneering here, courageously blazing a provincial trail toward a system that will eliminate costly duplication and provide maximum value for scarce tax dollars.

There's near unanimity on the need for change. From hospital administrators to union officials, you'll look long and hard before finding someone who believes the status quo — four under-equipped and under-used hospitals competing for resources and patients — can or should be maintained.

There's overlap madness in the existing system. Currently 92 per cent of all inpatient procedures are offered at all four hospitals and 58 per cent of doctors and dentists practise in three or more hospitals.

According to Mary Jean Galvin, chairwoman of the committee spearheading this revolution, it's not unusual for patients to be transported to two or three hospitals for tests before treatment can begin.

There might have been a time when we could afford these money-gobbling inefficiencies. But with our provincial and federal government being crushed under mounting debt, we either fix this system or lose it.

Ken Brown, head of Local 210 of the Service Employees International Union, which has 1,400 members at the four city hospitals, has seen the writing on the wall.

"We're between a rock and a hard place," he shrugged. He said it's painful to see members with 30 or 30 years of service facing dramatic workplace changes "but the status quo just isn't available to us."

This community, he said, bad stark choices. It could try to manage change or it could sit back and wait for the paddocks to arrive from Queen's Park. "Sooner or later they would just come in and close the doors."

Nobody faces a more difficult task. In this process than these union leaders trying to explain to their members that the changes are in everyone's long-term best interests.

Lin Murphy, a registered nurse who represents 220 RNs at Windsor Western, has been struggling to contain the fear and anger of union members who learned this week that the hospital's days as an acute-care facility are numbered.

"IT'S BEEN traumatic," said Murphy. "They're scared and upset and unsure of what's happening. There's a lot of anger and frustration."

Windsor Western employees, like those at the other city hospitals, have been through a two-year hell of uncertainty. Would they have jobs? Would their place of employment survive this closed-door exercise? The looming question marks nibbled away at morale and triggered waves of demotivation.

"Nobody wants to change. Nobody likes their job through choice," said Murphy. "But sometimes change is good."

She's been telling her co-workers that bricks and mortar don't matter. What counts is having a job and working in an atmosphere that encourages quality care.

Murphy is excited by the planned shift in focus from hospital treatment to community-based preventive health care, and thinks that's where many of the new nursing jobs will be created.

"PEOPLE STILL see hospitals as the answer to their health problems," said Murphy. "They're not. They only answer illness problems," said Murphy. "If we carry this to its ultimate conclusion, we have to move out of these institutions."

The right choices were made this week. No question about that. But were other factors involved?

Some health-care workers are convinced religious and political considerations played a pivotal role in the selection of Hotel Dieu over Windsor Western as an acute-care facility.

"It's a question of who can I deal with ticking off and who can I not deal with ticking off," explained one veteran of health-care negotiations.

Did the decision-makers want a holy war with the city's religious community, especially the Catholic church? No way. Did they want to run afoul of the city and its noisy downtown business lobby? Not a chance.

Could they head off an outcry from the west Windsor and LaSalle residents? Absolutely. Which made Windsor Western a sitting duck.

Pragmatism, it seems, has more than one dimension.
Hospital closure decision remains under wraps

By Ellen van Wageningen
Star Staff Reporter

The steering committee responsible for deciding which two Windsor hospitals should remain open has made its decision — but it probably won't be made public until the end of the month or early February.

Meanwhile, Windsor Western Hospital started blanketing the city and Essex County this week with a glossy four-page flyer saying it should survive. There is a full-page color advertisement in today's Windsor Star.

"If Windsor Western Hospital closes there will be no acute care services west of Oshawa Avenue in the city and county," the ad says in bold letters on the front page.

"All I can say is we wanted to make the community more aware of our institution," said Doug Cozad, Windsor Western's board president. "There are a lot of people in the community who don't see Windsor Western Hospital or know what it's all about.

"The choice the steering committee had to make was between Windsor Regional in the west end and Hotel Dieu hospital, which is downtown. Metropolitan General Hospital will remain open and Salvation Army Grace Hospital — which is merging with Hotel Dieu — will close.

"The problem is we have to make a choice," said Dr. Paul Ziler, co-chairman of the steering committee.

He declined to say what the steering committee's conclusion was, but said the residents of Windsor and Essex County will have to make a choice. He said they have committed up to $100 million to restructure and rebuild the remaining hospital. The hospitals would have to scrap together $10 million in savings and donations to get the full amount.

People are hearing rumors. There's leaks all over the place it seems," Ziler said.

The committee's recommendation will be the best possible solution. "People are hearing rumors. There's leaks all over the place it seems," Ziler said.

He said it would be necessary to read the committee's entire final report to understand its decision. The report should be ready by the end of the month.

Example of Win-Win, the best possible plan for Windsor/Essex County facilitated by the best efforts of our government and local health care officials.

Ellen van Wageningen, The Windsor Star.

APPENDIX C

Example of truism #3: The “few” jobs that will be lost as a result of restructuring are merely due to the unfortunate “reality” of the times.

Hospital boss moves to allay fears of layoffs

By Brian Cross

Star Staff Reporter

Now that the new Met-Western super hospital has a single boss, the amalgamation of the two former hospital empires can really get going, newly appointed chief executive officer Lloyd Preston said Tuesday.

"Two purchasing departments can be pared down to one, two accounting departments can become one, there'll be one insurance policy instead of two, and toilet paper can be ordered 2,000 rolls at a time instead of 1,000."

"Those are the synergies we'll get," said Preston, who for the last six years has headed Windsor Western.

Last week, after plenty of internal bickering over who should be CEO of a merged Met-Western and three years of hospital staff anxiety over the implications of amalgamation, the newly-formed Met-Western board decided against importing talent from somewhere else and picked Preston. Met CEO John Hastings is retiring, and Preston is moving his office to Met, where employees are nervous about being usurped by their Western counterparts.

THERE WILL BE jobs eliminated, and responsibilities changed under an evolving system at the new hospital, now the largest non-teaching community hospital in the province.

Preston spent the last week meeting with the 2,400 employees, trying to earn their trust. Layoffs shouldn't be necessary, he said, as long as government funding isn't unexpectedly cut by a large amount.

"It's my hope we can do things transitonally," he said, making any necessary staff reductions through attrition.

During a press conference called by the hospital to introduce its new leader, Preston said: "We don't need the trauma of layoffs in this community."

The amalgamation is part of a provincewide plan to streamline the delivery of health care.

The union of Grace and Hotel Dieu hospitals is also in the works. At the end of the day, said Preston, this area will have a more integrated system that casts away needless duplication and centralizes various services at different locations.

The plan was supposed to save $22 million annually.

That amount has already been saved as a result of the social contract legislation that arrived mid-way through the reconfiguration process, he said.

See HOSPITAL, A4

"There's going to be further savings," but it's unknown how much will be saved in total until the entire plan's implemented, said Preston, whose new salary is yet to be determined.

Pushing ahead with the Met-Western merger, a formal name for the new hospital will be announced in a few weeks, picked from a list of staff suggestions. The Windsor Western and Met foundations — which raise money for their hospitals — are merging "as soon as possible."

To offset concerns Preston will bring in his Windsor Western people to run the Met-Western facility, consultations are being brought in to recommend the best candidates for each senior management job.

"The changes start at the top," Preston said. "And so the boards have been changed, the CEO issue has been resolved. Now, the senior executive management level will be dealt with and we'll gradually work down."

Preston is hoping the transition to a single hospital operation can be smooth and gradual, so that any staff reductions can be achieved through the less painful options of retirements and voluntary departures.

"To my mind, there's little advantage in getting the axe out, and later saying, 'Why did we do that? We cut too much, the wrong people left.'"

Preston said his "absolute priority" is to reassure the staff at the hospital:

"I am the CEO of a new corporation, I am not the CEO of Windsor Western. I'll be measured at the end of the day on how fair I am."

He's concerned that workers at the Met facility might feel he's come in and taken over their hospital. With over 20 years experience in hospital administration, he's been through this type of process before, he said. The 46-year-old Toronto native oversaw the transition from a military complex to a teaching and psychiatric facility when he headed Camp Hill Hospital in Halifax. He's also been executive director at Dartmouth General Hospital, administrative assistant for the Canadian Hospital Association, and started out as an administrative resident at North York General Hospital in 1970.

The response from staff at Met to his appointment as their CEO has been fairly positive, Preston said, although he acknowledged there's still plenty of anxiety and apprehension out in the hospital halls. "But my general sense is there's a lot of relief — it's over, let's get on with it. I think everybody's tried. It's been a tough couple of years."
APPENDIX D

Example of truism #4: Opposition to the Win/Win plan represents a terrible threat to our health care system.

OUR OPINION

Health reform

Community needs united voice

The trials and tribulations of hospital reconfiguration in this community are hard to swallow, and nobody likes the twists and turns the process has taken under the new Tory government.

But walking away in a huff won’t have much of an impact on Premier Mike Harris. He’s unlikely to reconsider his decision to grab $22 million in local hospital savings and toss it into Ontario’s general revenue fund just because labor representatives are angry with his government.

With that clearly understood, last week’s labor decision to leave the reconfiguration implementation committee doesn’t seem to serve much of a useful purpose. It won’t preserve the status quo, won’t stop further funding cuts, won’t protect health care workers and won’t humiliate Queen’s Park.

It will, however, hurt each and every citizen of Windsor, because a united front is needed if we’re to achieve even a modest degree of success in getting what this city needs.

And that won’t be easy, because this government will cut funding to health care, will force the reconfiguration team to dramatically alter its plans and will invest our restructuring savings provincewide.

Fair? It certainly doesn’t seem that way, especially after four years of excruciatingly hard work, and particularly since Harris claimed during the election campaign that he wouldn’t slash health care funding.

But he did, and we have to come up with the best plan we can in spite of these new obstacles.

To Windsor and District Labor Council president Gary Parent, that means walking out to show the community’s displeasure: “If we are going to make a statement, then we have to back away from every committee that has to do with reconfiguration. You can’t be half pregnant.”

But that’s not a plan. It’s a gut reaction. We’re much more inclined to agree with Jo-Anne Johnson, former president of CAW Local 498 and co-chair of the implementation committee, who believes workers have to be involved, “for their own sake.”

And so they do. It’s much easier to throw up your hands and cry foul than stay behind to work things out. We urge labor members to come back to the table and help plan a third proposal that will be submitted for Ministry approval.

It’s not about whether Harris is right or wrong. It’s about doing what’s right for this community.

Nurses push integrated health system

By Brian Cross
Star Health Reporter

You want to see waste in the health care system — ask a nurse like Debbie Scholte, who sees the abuse every day in the hospital emergency.

"Sixty-five per cent of the patients we see do not need to be there," the veteran Windsor Regional Hospital nurse reported Monday night at a town hall meeting held by her union to explain a plan to save Ontario's besieged public system by attacking waste and duplication.

"We see things that other people don't see, and we don't have all the answers, but this is a place to start," said Scholte, who noted that during the presentation of problems in the system, there was plenty of head nodding going on in the audience of 200.

Nurses worry funding cuts will kill medicare.

"I don't think our health system will be here for our children, if we don't do anything about it," she said.

This was the reason nurses said they were here, despite criticism from some who attended the meeting, that their plan appears to be a belated attempt to preserve their jobs.

Eighty-five per cent of nurses believe the quality of care is seriously declining, and 81 per cent believe patients are at risk.

The situation has become frightening, said Hotel-Dieu Grace Hospital nurse Liz Matthew.

"When we have patients in the hospital, and we're letting them out quicker than we ever have, and there's no place to send them to, that's when you know it's hurting." The Ontario Nurses Association is proposing its own solution to the crisis that's been caused primarily by funding cuts by both federal and provincial governments.

More cuts — a 30 per cent funding reduction over the next five years — are on the way, said ONA vice-president Barb Wahl.

"So the problem we're facing is a lot more serious than we realized." Labor and social activists stood up at the meeting to call on nurses to join the fight with other groups facing cuts, such as teachers and welfare recipients. But the nurses believe the health system can bear a 30 per cent cut if it is radically changed, Wahl said.

What the nurses are pushing for is an integrated delivery system where an area like Windsor-Essex gets funded based on its population, running one co-ordinated system.

More emphasis would be placed on community health instead of hospitals, on health promotion and prevention instead of treating one health crisis after another, and on measuring health outcomes.

It's a similar plan to the one currently being pushed by the Essex County District Health Council, which wants this area to do a pilot project for an integrated system.

The nurses' plan steps on a few more toes — it proposes paying doctors straight salaries, and setting up one single health employer.

Wahl said it's vital that an integrated system be implemented before one is forced upon the public that saves money but doesn't improve the quality of care. The fear is the government will introduce an integrated system that uses private companies to deliver public healthcare, she said.

"It's the communities that should be driving this, so it's not a made-in-Toronto solution."
Hospital staff, supporters assail cuts to health care

By Alisa Priddle
Windsor Star reporter

It was cold for Saturday's rally, but not as bitter as the effect of the health care cuts being protested.

About 100 people, including hospital staff members, braved the icy wind in front of the Hotel-Dieu campus of Hotel-Dieu Grace Hospital and chanted "hey, ho, ho, Mike Harris must go."

"Things have never been this bad in health care," said Elena Vitelli, who has worked in hospitals for 25 years.

"There's not enough time to care for patients," said the operating room worker.

Staff rushed

She said the staff is rushed and patients are discharged too soon after surgery, even when they are elderly and there is not enough home care available for them.

"It's time to talk about cuts and how they affect people," said Valerie Walker, co-chairwoman of the Health System Labor Advisory Committee, which organized the rally.

"Patients are being admitted more acutely ill and there is less staff to care for them," Walker said.

With staff cuts through attrition and layoffs at both Windsor Regional and Hotel-Dieu Grace "it can't all be done painlessly," Walker said. That means patients are being discharged sicker and relying on families to provide care, she said.

The rally had the support of the hospital's executive director, Frank Sagatto, who was out of town but left remarks which were read by assistant executive director Dave Baker. He said the hospital appreciates the show of concern for patient care in a period of drastic change.

Sandi Ellis, southwestern representative for the Canadian Labor Congress, said Canadians have awakened to say they have had enough and that lives are being affected. Similar protests are being held across the province to raise awareness.

Ellis said that while the province shoulders direct blame, the federal government is responsible for cutting transfer payments used to fund health care.

She said communities should not wait until hospitals have been closed or amalgamated before taking action. Some hospitals are being closed in areas already suffering a shortage of beds, she said.

Tax cuts

Ken Brown, president of Service Employees Union Local 210, said people must make it clear to the government that they are against service cuts to finance tax cuts for the wealthy. "People come before profits."

Brown chastised the Harris government for cutting the health care budget by 18 per cent over two years. He called Harris a "student of new math" if those numbers add up to keeping a promise not to cut health care funding.

And the protests are not over. "There will be more of these," Walker vowed.

VITA AUCTORIS

Andrea Neufeldt was born in 1973 in Windsor, Ontario. She graduated from Belle River District High School in 1992. From there, she went on to Wilfrid Laurier where she completed a General Bachelor of Arts with a major in Communication Studies in 1995. Presently, she is a candidate for a Master of Arts degree in Communication Studies at the University of Windsor and hopes to graduate in fall 1998.