Stalking Imperial America PAGE 19

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I.O.U. Conrad Black on Margaret Atwood on debt

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Eliminating the Caboose

Technological advances need to override nostalgia and ideology in our healthcare system.

MICHAEL B. DECTER

Who Killed the Queen?
The Story of a Community Hospital and How to Fix Public Health Care
Holly Dressel
McGill-Queen's University Press
479 pages, hardcover
ISBN 9780773533400

Critical to Care:
The Invisible Women in Health Services
Pat Armstrong, Hugh Armstrong and Krista Scott-Dixon
University of Toronto Press
228 pages
ISBN 9780802093332, hardcover
ISBN 9780802096081, softcover

HEALTH CARE IN CANADA IS A MASSIVE enterprise as well as a valued social program. More than $140 billion per annum, or 9.5 percent of our economy, is devoted to health care. More than one million Canadians get out of bed each morning and go to work in the healthcare system to look after the ill and infirm. Health reform has been an ongoing and important process for more than a decade. Yet there is far too little thoughtful analysis beyond the daily press. The relentless cry of health reform leaves many Canadians wondering what exactly is being reformed, why and with what results.

Two quite different books ask what might seem to be unrelated questions: Holly Dressel's *Who Killed the Queen? The Story of a Community Hospital and How to Fix Public Health Care* and *Critical to Care: The Invisible Women in Health Services*, by Pat Armstrong, Hugh Armstrong and Krista Scott-Dixon. Why did this particular Montreal hospital close? Who should we consider to be a healthcare worker? But the answers to these questions have their roots in the same period of reform. These two books examine from quite different vantage points the underpinnings of the great consolidation of health service delivery in the 1990s. Needing to cut government deficits and debts, both the government of Canada and the provincial governments squeezed overall government spending during that decade. These same governments appointed task forces and commissions to examine hospital and health services and to recommend changes to increase efficiency. The result was the closure of hospital beds in the early 1990s and the closure of many smaller hospitals in the mid and late 1990s. There were also significant staff cuts in nursing and other aspects of hospitals.

Two of the ideas that guided 1990s hospital restructuring were the notion of core services and benchmarking of length of stay. These concepts, borrowed from management consulting and industrial process redesign, held that organizations should focus on their core competencies—in the case of hospitals, patient care—and that measurement should drive change. Activities deemed "non-core" should be eliminated, consolidated or outsourced to more efficient, specialized providers. And then everything should be benchmarked or subjected to a comparative measurement of performance. If Hospital A can perform hip replacements with an average length of stay of five days and Hospital B takes eight days, then benchmarking would lead to an effort to reduce Hospital B's length of stay to five days. Shortening lengths of patient stay became the major undertaking of the day. In parallel with these ideas was the powerful reality of minimally invasive surgery and the resultant increase in same-day surgical procedures.

Who Killed the Queen? IS THE WELL-TOLD and compelling tale of the Griffiths, father Alexander and his sons. Their opening of the Montreal Homeopathic Hospital of Montreal in 1894, later renamed the Queen Elizabeth Hospital, was a reaction to the lack of acceptance of homeopathic medicine at the larger, older Montreal hospitals. Many readers will be surprised at the breadth of support for homeopathy in that era. Harold Griffith emerges as a pioneering leader in anesthesiology. His homeopathic training proved a source of insight into the impact of tiny quantities of chemicals on the human body. These insights in turn supported his innovations in the field of anesthesiology.

In a lengthy chapter entitled "Medical Bills," Dressel traces the evolution of hospital funding from the charity of the 1920s through the inception of medicare in the 1950s and '60s. She presents thoughtfully the contrast between the Canadian and American approaches to funding health services, noting the opposition of the leadership of the Queen Elizabeth to universality.

It is in the early 1990s that both the Queen and Holly Dressel go astray. By the early years of that decade the early spirit of creativity at the Queen had been replaced by, in Dressel's own words, "stagnation." She finds evidence for this in failed accreditations and mounting issues of quality. It was a bad time for the Queen to have drifted from its historical tradition of concern for the patient and innovation.

Closing a hospital is the most difficult task facing any government or elected politician. It is not a decision taken lightly or before all other possibilities have been explored and exhausted. Yet in the 1990s elected Canadian leaders of all political stripes—from New Democrat Roy Romanow in medicare's heartland of Saskatchewan to Conservative Mike Harris in Ontario to Liberal Jean Rochon, Quebec's highly knowledgeable health minister—all closed small hospitals. Why?

V.S. Naipaul wrote in his novel *A Bend in the River* that "the world is what it is: men who are nothing, who allow themselves to become nothing, have no place in it." His harsh assessment of life is true of nations and hospitals. By the early 1990s Canada had achieved the dubious distinction of being the most indebted nation in the G8. Our largest government spending program was not medicare but the payment of interest to bond holders. In a changing world, Canada, along with the Queen Elizabeth Hospital, drifted toward the loss of control of its own destiny.

Fortunately, political courage was shown by Finance Minister Paul Martin and fully supported by Prime Minister Jean Chrétien. The federal budget was balanced through expenditure cuts, including reduced transfers to the provinces for health care. The provincial governments took steps to slow the rate of healthcare spending, one of the early consequences being the closure of hospital beds. Later the closure of a number of hospitals also occurred, among them the Queen.

Dressel's explanation for the Queen's and other closures is that misguided politicians and government officials blinded by deficit concerns recklessly set about to dismantle the hospitals of Canada. She then concludes her book by declaring "we should all get tears in our eyes when we think about how a full 20 percent of Canada's hospital system was destroyed in 1995." She substitutes her affection and nostalgia for one hospital for an understanding of the bigger picture. Dressel goes on to invoke "the basic physical laws of this planet." One can only deduce that she believes that the 1994 bed complement of Canadian hospitals, like Avogadro's number or the boiling point of water, is some necessary and natural constant of the universe. Fortunately, the democratically elected leaders of our nation and our provinces allowed the evidence of better care for patients based on less invasive surgery to guide their decisions.

According to the Canadian Institute for Health Information, between 1994/95 and 2005/06 the number of inpatient days—hospitals stays requiring an overnight stay—declined by 13 percent. In the same eleven-year period, the total number of surgeries performed by Canadian hospitals increased by 17 percent. How was this possible? The number of day surgeries increased by 31 percent while the number of inpatient surgeries decreased by 17 percent. The advance of minimally invasive surgery

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has been the central driver of the trend to shorter lengths of stay. These trends are remarkably consistent across many nations, suggesting that technology was the driver of the direction of change, with cutbacks clearly dictating its timing and pace.

The pivotal fact that Dressel pays little attention to is that remarkable technological change transformed healthcare services in the 1990s. It was scientific progress that killed the Queen. In the same way we were able to close sanitariums set up for the isolation and treatment of those with tuberculosis a generation ago; in the same way that polio was transformed from a horrific epidemic to somethig preventable by a vaccination, as much as 80 percent of all surgery in Canada moved in a decade to same-day surgery. Here is the smoking gun: advances in science.

This omission is particularly ironic given the space devoted in Dressel's book to covering advances in laparoscopic surgery pioneered at the Queen and the leadership role of Dr. Harold Griffith and others. It is ironic because the widespread adoption of laparoscopic surgery, also known as minimally invasive surgery, brought about dramatic efficiencies in patient care and the closure of millions of hospital beds worldwide.

To read Holly Dressel's book is to be bombarded by a right–left struggle in which the right triumphs. Given the destructive events catalogued in *Who Killed the Queen?,* one would imagine that public health care in Canada must be a shambles. It would be hard to believe the reality that tens of billions of dollars are being invested over ten years to modernize Canada's hospitals, that the diagnostic infrastructure has been modernized so that Canadians can access much more rapid diagnoses using MRIs and CAT scans, and that wait times are being reduced in every province in Canada through the reinvestment of $41 billion by the federal government through the 2004 First Ministers' Health Accord and through increased investment by provincial governments.

Here is where I agree with Holly Dressel—and these are important agreements. We know too little about the type of teamwork that promotes caring. We need to understand her "teeny bits of excellence" better: bigger in hospitals is not always better. Her chapter on "Social Pathologies" contains a powerful analysis of the tidal wave of drug marketing that affects both patient and provider. And I also admire her energy and hard work in researching and writing a lengthy, well-constructed work.

There are sound health reasons for preferring shorter hospital visits. An array of recent studies, led by the "Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Patients in Canada" by Ross Baker and Peter Norton and their colleagues, has revealed the dangers of hospital stays. Some 9,000 to 23,000 Canadians die prematurely each year because of preventable adverse events in hospitals, many of which are due to hospital-acquired infections. Most recently hospitals have reported hundreds of deaths from *C. difficile*.

Critical to Care is a more daunting read than Dressel's book, with the safety and cleanliness of hospitals a central theme. The book is academic in its construction and relies heavily on statistical work on the health labour force. As I have come to expect from previous works by Hugh and Pat Armstrong, the book is thoroughly and thoughtfully researched. Yet the values and views of its co-authors are clear and forcefully stated. The question of who is a health worker is loaded with significance for the authors. Their book is a lengthy argument for including all ancillary workers—kitchen staff and cleaners primarily—as part of the "health team" and therefore "critical to care." It is also powerful advocacy for considering the importance of *all* health workers to the maintenance of safety and infection control in the hospital setting.

In the 1990s, as a result of examining what is essential, reformers drew a line between clinical services, which were valued and preserved, and support services, which could be eliminated, downsized or outsourced. Medicare was, in a tough time, viewed as medical care, and cleaning, for example, was viewed as an ancillary service and afforded the status of a cost centre to be reduced wherever possible. Clearly hospitals delivering a far greater percentage of services in an ambulatory setting require far fewer patient meals. Significant downsizing was well justified by reduced work in parts of the hospital. However, issues of cleanliness and infection control have proven difficult to manage and they require action and vigilance by all staff, not just clinical staff.

However, as *Critical to Care* powerfully illustrates through detailed interviews, hospitals are complicated labour environments with complex collective agreements that require extremely detailed management. The book's point is that we under-appreciate the frontline managers and staff coping with this complexity. This is a fair and well-supported point about the current organization of hospital work.

But this reviewer wonders whether bargaining to achieve fewer job classifications and much simpler work rules would serve the patient better than accepting the existing situation. Sadly the history of collective bargaining has little tendency toward simpler more manageable agreements or much concern for patient care.

The book is at its most forceful when detailing the failures of various reform efforts. Many reforms are gathered by the authors into the category of privatization and dismissed as failures. Privatization is a label the authors apply to everything from the contracting of health services to the introduction of competition among not-for-profit healthcare providers. This analysis is a little simplistic and unhelpful. Armstrong, Armstrong and Scott-Dixon ignore two decades of British experience with internal markets under both Conservative and Labour prime ministers and a wealth of evidence about improved outcomes. In their enthusiasm for opposing full privatization, their condemnation of all efforts to introduce more responsiveness into bureaucratic command-and-control hierarchies is too sweeping.

The strength of *Critical to Care* is that by casting a wide definition of who is a healthcare worker the authors capture the important reality that all those who work in a hospital can contribute to its safety. The central problem with the hypothesis that all those employed in the health sector are healthcare workers is that it implies much more than inclusion in facility-wide efforts. The authors would like to move to much greater reliance on collective bargaining. There are large and uncalculated costs to such a move. As well there is the considerable downside of rigidity and increased complexity in work organization associated with complete unionization of a sector. Inter-union battles over ownership of work are another potentially negative feature.

Very high levels of unionization in the broader health sector will present greater barriers to the changes needed for sustainability. When the Canadian National Railways led by Paul Tellier moved to end the caboose as a feature of every train in Canada, there was enormous resistance to the shedding of the redundant personnel who staffed the cabooses and their bargaining agents. Yet technology had rendered the caboose an expensive, unnecessary anachronism. Technology has the essential trait of eliminating old work.

In the absence of evidence and performance measurement many arguments advanced in health care, passionately held as they may be, are simply claims.

This is true in health care as in railways. New vaccines did away with wards filled with polio patients. New medications and knowledge closed the sanatoriums for tuberculosis patients. Minimally invasive surgery and better medications closed millions of hospital beds worldwide and allowed resources to flow to prevention and treatment rather than the hotel function of hospitals. Kidney stones that required surgery are now smashed by sound waves in lithotripsy machines. Exploratory surgery has been displaced by better imaging technology. As a society we need to accelerate a process that prevents illness or speeds its treatment rather than waxing nostalgic about the historic institutions of the treatment system or old and bureaucratic forms of labour organization.

In the absence of evidence and performance measurement many arguments advanced in health care, passionately held as they may be, are simply claims. The effort to move the management of healthcare services from an era governed largely by history and politics to one based on evidence and patient outcomes is ongoing.

While not easy reading, both these books are passionately argued by thoughtful and committed authors. Whatever faults found should not dissuade readers from looking at each of these books and making up their own minds. LRC

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