The history of health care is in many ways a history of struggles for control of the work involved. These struggles have typically been highly gendered and racialised as well as class-based, with contradictory and complex consequences for both the care work and different workers. Indeed, some methods of managerial control are derived from reforms that have been fought for by workers, or have been built on their strategies. The nature and results of these struggles have changed over time and with place, shaped by global as well as local pressures. They have also changed with efforts to commodify health services, driven by profit-seeking and ideological motives, alongside management strategies introduced from the commercial sector into the organisation of healthcare work in the non-profit health services that remain. But there are real limits to the application of such strategies in health services, limits set not only by the organised resistance of healthcare workers but also by the nature of the work itself.

Prominent in recent changes has been the introduction of new technologies, especially information technologies. Although they increase precision and reduce waste, these technologies can also serve to restrict the scope for the exercise of independent judgement, and fragment care. Narrow approaches to ‘productivity’ and ‘efficiency’ are invoked by managers seeking to compress work time, whether through traditional Taylorist intensification initiatives or through flexibilisation initiatives introduced in response to the inevitable peaks and troughs in healthcare needs.

These initiatives are often introduced in the name of evidence-based medicine (EBM), with its claim to having the right practitioner do the right thing at the right time and place. Although no one would advocate health care interventions that ignore or flout the available evidence, Timmermans and Berg have persuasively argued that the EBM movement makes uncritical
assumptions about the virtues of standardisation. Feminists meanwhile have revealed how work intensification and flexibilisation are gendered and racialised processes.

As in Western Europe, health care in Canada has, at least until recently, largely escaped many of the forms of managerial control developed in the for-profit industrial sector. In this essay we focus on Canada, not because it is a special case but because it provides a concrete example of processes at work in many countries, and because context matters, with each country demonstrating some unique features.

THE EVOLUTION OF THE DIVISION OF LABOUR IN CANADIAN HEALTH CARE

Health care is about human life. All of us are current or potential users of healthcare services. Yet the risks and consequences of care can be enormous, making claims for skill and scientific certitude particularly appealing. These claims can be used to expand control by healthcare workers as well as undermine it. There are vigorous debates about the extent to which a commitment to saving human life, as opposed to securing a profitable monopoly, motivated doctors to seek control over who could do what in medicine. What is clear is that in Canada as elsewhere doctors gained much of their monopoly power in the mid-nineteenth century, well before there was a firm scientific basis for most aspects of medical practice. Given the belief in scientific progress in ‘the age of reason’ and the continuing guild dominance of crafts, Canadian doctors – who were and remain for the most part self-employed practitioners – established the guild-like Canadian Medical Association that used its class connections to acquire state-supported control over admission to the profession, the acquisition of medical skills and the right to autonomous practice, regulated loosely by other doctors.

Their power as a profession then helped doctors establish methods that were more effective and science-based, and also ensured the dominance of white males over the growing number of other healthcare workers. Although nuns and a range of other women defined as unskilled provided care in hospitals and homes, formally trained nurses did not graduate until the end of the nineteenth century. At the beginning of the twentieth century, there were over 19 doctors for every nurse in Canada, and the doctors were able to determine nurses’ conditions of practice. Basically, nurses were assigned tasks doctors did not want to do and carried them out under doctors’ direction. Unlike doctors, most nurses have always been wage workers, but like doctors they were later to shed some essential tasks to others.

Until the Second World War, the bulk of nursing work was actually done
without pay by female student nurses, who lived in residences where they were carefully supervised by matrons. Because no regulations prevented the firing of women when they married or became pregnant, the relatively small numbers of graduate nurses who stayed in nursing were single women who managed other women. These nurses, not surprisingly, sought to imitate the doctors by forming their own guild-like organisations in an attempt to assert control and gain rewards as well as recognition for their skills. Unlike the doctors’ organisations, however, theirs were not autonomous and, while seeking to establish the regulation of skills, they did so under doctors’ direction. And unlike the doctors, nurses were saddled with the prevailing ideas about women’s natural caring skills and devotion to care work as a motivating force, ideas that were reinforced by their explicit subordination to doctors. But they followed the example of the doctors in seeking to shed some of their tasks as a means of establishing their skills and status, and to do so in a way that allowed them to direct the workers who took over those aspects of their work.

Like many other countries, Canada emerged from the Second World War with a greatly expanded healthcare labour force and a growing demand for healthcare services as well as an expectation that these would be provided through public means. Hospitals were owned primarily by non-profit charitable or religious organisations or by municipalities. Payment for doctors and hospitals came from individuals or insurance companies, and much hospital insurance was run on a non-profit basis. There were very few privately-owned facilities and none with shareholders. There was little effort to introduce methods from the commercial sector, both because most doctors were in solo practices and because there was a strong cultural ethos, supported by them, that health care was about altruism more than financial gain. Indeed, doctors’ incomes were generally quite low, the largely female hospital labour force had low wages and much of the work was still done by unpaid student nurses.

The gradual and uneven introduction of public health insurance – begun in 1947 with the hospital insurance introduced in Saskatchewan by North America’s first social democratic government, and finally realised federally only in the mid-1960s – largely left this system in place, simply making the government the single payer for services that doctors judged to be necessary. Although doctors did not collectively resist public involvement in hospital services, they staged the infamous doctors’ strike when the Saskatchewan government moved in the early 1960s to install a universal medical programme. Claiming that this would make doctors public employees, they appealed to the public on the grounds that government control and the
loss of their autonomy would entail health risks. Although the strike was defeated, the combination of pressures from the doctors and from patients fearing for their lives ensured that the new system would be based on public payment for private practice, and this was reinforced when the Saskatchewan initiative led first to a Royal Commission and then to the federal programme introduced a few years later.3

Under Canada’s federal system, responsibility for health care rests primarily with the provincial (and territorial) governments. The federal role – aside from supporting health research, overseeing food and drug safety, screening immigrants and visitors for health risks, and providing health care to Aboriginal peoples – is to fund a share of the hospital and other medical costs borne by the provinces. By offering, initially, to pay half the costs of ‘medically necessary’ hospital and medical services, in return for the provinces respecting broad principles of universal coverage, equitable access, comprehensiveness (of services within hospitals and doctors’ offices), portability (between provinces) and public administration (of each provincial payment scheme), the federal government made an offer that by 1971 not even the most conservative of provincial governments could refuse.

The new federal system gave rise to an enormous expansion in health services, while also amounting to what the venerable Canadian healthcare historian, Malcolm Taylor, appropriately called a blank cheque to doctors, who continued to be paid on a fee-for-service basis.4 Attempts to control expenditures directly through constraining doctors’ fees have consistently failed, with doctors continuing to use strike threats and public appeals about health risks effectively. As jobs expanded in nursing and women won the right to stay in their jobs after marriage and pregnancy, nurses began demanding decent wages and working conditions. They tried to follow the doctors’ lead to claim power as a profession but were less successful in part because doctors restricted the scope of what nurses could do, in part because of their gender and in part because they were already employees. In 1973 the Supreme Court sided with the Service Employees International Union (SEIU) in deciding that the Saskatchewan Registered Nurses Association could not act as a union negotiating wages because its board of directors included nurses in management positions.5 This decision contributed significantly to the formation of nurses’ unions, although many of these new unions still retained the notions and labels of professional associations, as well as traditional ideas about women’s skills. The unionisation of nurses contributed to rising costs as exploitative wages, or none at all for students, were replaced by relatively decent pay.

At the level of the hospital or other institution, managers embraced the
demands coming from doctors and nurses to shed aspects of their work to less skilled workers as a means of cutting costs and increasing control over some workers by assigning more of the work to those defined as unskilled. Most of these new workers – personal support workers, home care aides, housekeepers, dietary aides, clerical and laundry workers – were women, and many were from racialised and/or immigrant communities, making them particularly vulnerable to exploitation. They also began organising into unions, reducing the impact of the further division of labour on costs and control. In spite of the increasing fragmentation of work and the increasing use of substitute labour, in the foundational years of the Canadian health system the means of institutional control were quite specific. Doctors rather than managers retained much of the power. Health care was primarily delivered as a public good by non-profit organisations and by self-employed doctors working mainly in solo practices, with at most a single employee to assist them. Rather than reduce the power of doctors, the new public investment in health care supported and even increased it as the demand for care rose with access. It also substantially increased their incomes.

Science and technology also tended to enhance, rather than undermine, doctors’ control as they helped them deliver better care and reinforced their claim that their work rested on scientific knowledge and their skill in applying it. Attempts to decrease doctors’ fees largely failed, partly for this reason and partly because they were highly organised. Nurses, although they never enjoyed the same autonomy and control, also managed to carve out particular skill areas as well as improve their conditions of work. The nature of health care assisted both doctors and nurses in their efforts to avoid managerial control, and so did the idea that healthcare work was different from the other sectors of the economy. It was an idea supported by the state through the granting of monopolies over specified areas of medical practice to the various health professions, based on the notion of protecting the public from unskilled care. This degree of professional control was made more acceptable by the non-profit nature of the service, removing it from the pressures that for-profit organisations faced even as the development of universal access increased demand for medical services.

RESTRUCTURING FOR CONTROL

Since the 1970s all this has been consistently challenged. With the end of the post-war boom, rising public debt and growing budget deficits, powerful forces within and outside the state began to talk about a ‘high cost spiral’ and of a general fiscal crisis. The federal government initiated bitter and complex negotiations with the provinces to restructure the cost-sharing
arrangement. From 1977 on, the federal contributions were reduced and made more predictable, while the provinces gained more flexibility in how they were allocated. For their part, the provinces began to adopt managerial control strategies taken from the commercial sector.

Equally important, health services were increasingly seen as an untapped source of profit. Transforming care into profit-making investor-owned services could help solve the crisis in capital accumulation. Multinational corporations began pressuring the provincial governments to open up services, at times finding enthusiastic support within the state. Not only should health care be organised like a business, they argued, wherever possible it should become one. Trade agreements, such as NAFTA in North America and the TRIPS and GATS treaties that became globalised under the World Trade Organization rubric, served to increase the pressure on states to open their public services to foreign investment, transferring elements of care into commodities for market exchange. Health care was held to be ripe for change, with business and business practices leading the way and worker autonomy and the lack of managerial control seen as the problem.

Health care is labour-intensive: in Canada labour costs are estimated to consume between 60 and 80 per cent of health care budgets. As of 2005, registered nurses (RNs) made up 34 per cent of the professional and technical health labour force. Licensed practical nurses (LPNs; in some provinces called registered practical nurses) made up another 9 per cent, as did doctors. The rest were in a vast array of over 30 smaller occupations, ranging from dentists to ambulance attendants, from midwives to medical lab technicians. Missing from this count of healthcare workers are most of those labelled ‘ancillary’, ranging from laundry workers to clerical workers, from personal support workers to food service workers, and well beyond. In total, their numbers in the healthcare sector are broadly equivalent to those in the professional and technical categories. Their numbers are however significantly understated, as many of them doing healthcare work are classified as being in other industries, if their work has been contracted out to for-profit firms. Finally, there are the multitudes who perform unpaid, ‘informal’ work in health care. Although their numbers are yet more difficult to estimate, the Canadian Cancer Society and the Canadian Caregivers Coalition suggest that if those providing homecare were to be switched to paid homecare at the current (low) rates of pay, the annual bill would be $25 billion, or more than Canada spends on doctors.

Not only are healthcare labour costs high, but the autonomy of doctors in particular has given them considerable power to determine what services patients receive, and thus what the state must pay for. For all these reasons
reducing the costs of healthcare labour became a key policy issue from the 1970s onwards. Driven by corporate pressures, neoliberal ideology and rising costs, the provinces gradually introduced many business management strategies, from work reorganisation and time compression to the employment of lower-cost workers and the introduction of labour-saving technologies. But these methods have enjoyed only limited success in reducing costs or increasing managerial control, in part because their proponents have failed to understand that health care is not a business like the rest, and in part because of the considerable power within health care of those who actually do the work. We shall now see how these contradictions play out with respect to doctors, nurses and ancillary workers.

DOCTORS

Doctors remain a self-regulating profession with a mandate from government that supports this independence. It is still the case today that public money pays for private practice through fees negotiated with the provincial medical associations. The doctors’ negotiating strength continues in large part because of their ability to appeal to the public’s concern for their health. Although most Canadian doctors are not employees, they are not owners of profit-making businesses either. They are paid on a fee-for-service basis by the state and in most provinces are required to be either completely in or completely out of the public payment system. They may not charge patients for services that are covered by the public insurance system. Although the provincial regulatory authorities or colleges that are responsible for registration, complaints, education and discipline have come under criticism for failing to protect the public, their only major concession has been to include some non-physicians on their governing boards. Once granted registration by this body, a doctor remains free to bill the provincial government for all medically necessary services, unless either a disciplinary hearing by the college in question removes the licence or the doctor’s annual membership fees go unpaid.

Although the state has gradually reduced the area of practice controlled by doctors alone, allowing some other professions such as ‘nurse practitioners’ to perform tasks previously reserved for doctors, they still have a wide scope and considerable control over the areas (of practice and of location) in which they work. This is in part why efforts to increase control by reducing the number of doctors trained in Canada, and threatening to import more foreign-trained doctors, has had little impact. In an effort to reduce supply and thus costs, the provinces did agree to cut the number of places in medical schools by 10 per cent, starting in 1993, but this turned out to be a largely
futile effort. With doctors controlling so much of the work, very few nurse practitioners were hired and the result was mainly a shortage of doctors. The presence of foreign-trained doctors (just over 20 per cent of the total) has had little impact either, given that the medical profession has a great deal of say over who gets to practice, and given that these foreign-trained doctors, whose education the Canadian state did not have to pay for, are nevertheless paid at the same rates as those trained in Canada.

Indeed, government policy has not proven very effective in either reducing costs or increasing control over doctors’ work. Fees have continued to rise, partly as a result of doctors’ appeal to the public and their threats of work action. Moreover, whenever the real dollar value of fees is reduced, as happened across Canada between 1972 and 1984 and especially in Quebec between 1972 and 1976, doctors increased their billings by equivalent amounts by seeing more patients and providing more complicated services. It is important to note, however, that there is a difference between this speed-up response and one driven by the search for profit by investors. Doctors in Canada who choose to work more slowly will still make a good income. Almost all doctors work for themselves, with no shareholders intent on speeding up the work in order to realise a profit.

Given that most doctors are in private practice, hospitals have not had much direct control over doctors either, although hospitals do decide who has admitting privileges. This partly reflects the dramatic reduction in hospital beds. While acute care bed ratios have been falling across the OECD, Canada had 2.8 acute care hospital beds per 1000 population in 2005, well below the OECD average of 3.9. This trend has had the effect of indirectly controlling doctors. Some hospitals have substituted salaried hospital doctors for family physicians in an effort to fill gaps, promote more integrated care, and increase their control over physicians’ work. The employment of such salaried doctors has been limited, however, both by opposition from family physicians and by the fact that doctors’ fees are paid directly out of the government’s health insurance fund; the global budgets given to hospitals cover all other costs of care, but not doctors’ fees. So if a hospital pays for a doctor it does not get reimbursed unless it has made a special arrangement with the state.

Thus while state funding practices have contributed to doctors’ independence by paying most of them on a fee-for-service basis, government cutbacks and reorganisation have limited doctors’ control, not least by reducing the overall number of hospital beds and forcing doctors to accommodate their practices to the scarce resources. Equally important, the restructuring of hospitals into giant organisations has been combined with an
enhancement of managerial power, increasingly exercised by those trained in the for-profit sector rather than by doctors, as in the past.

The reduction in beds is, in turn, related to other indirect forms of control. Time, timing and tempo have been altered, especially when combined with a move to ‘evidence-based medicine’ (EBM). Evidence-based medicine originated with a group of academics and practising physicians at Ontario’s McMaster University in the early 1990s. It appealed to doctors’ claims to have scientific grounds for their work as well as to their desire to improve care. Although its protagonists were undoubtedly committed to improving patient care, it was promoted within a context of neoliberal cost-cutting and control strategies. The emphasis in EBM is on using the rigorous evaluation of evidence to develop practice guidelines and treatment protocols, as well as performance indicators that would allow doctors to make informed decisions for specific patients. But the notion, encouraged by EBM, of identifying the right person to do the right thing at the right time, fit very well with efforts to control how doctors practise – what they do with each patient and how long they take to do it.

In Canada, it was difficult for governments and managers to use practice guidelines and treatment protocols directly to control doctors. But they have done so indirectly by supporting organisations such as Ontario’s Institute for Clinical Evaluative Sciences to produce reports that could provide the basis for performance indicators, which in turn could be linked to fee payments. Doctors are increasingly required to justify their orders for hospital stays on the basis of standardised protocols. With, for example, evidence suggesting that replacement knee operations require three hospital days, doctors are under pressure to justify any longer stay. However, there are limits to such pressure created by the very real differences in patients’ bodies and by the fact that patients are active, rather than simply passive, in their own care. Some people simply do not recover sufficiently from knee replacements to be discharged in three days, or may not do all the exercises that would make them ready to leave.

Although Canadian hospitals are not under pressure from investors to produce a profit, they are under pressure from provincial governments to control costs and managers tend to have an ideological commitment to market principles. And they do have the ability to appeal to the public, using the EBM approach, arguing that more efficiency is needed to save a system characterised as under threat. The wait times strategy provides a telling example. The public has been bombarded with stories about horrendous wait times for care. There is undoubtedly a problem here, one which concerned doctors and managers have been seeking to address
through a variety of strategies. But the problem has been exaggerated by those seeking to make a profit through the provision of care in investor-owned facilities, and by those seeking to limit doctors’ power. Governments have appealed to the public over the heads of the doctors, using concern about wait times to support strategies for reducing doctors’ control and for moving to for-profit services. Wait times have been used as a justification for taking the management of wait lists for surgeries and tests out of the hands of individual physicians and making them the responsibility of public health authorities. In Saskatchewan, where the doctors’ strike was all about retaining their autonomy, and which they largely managed to secure despite the introduction of the public health insurance system, surgeons today must participate in the provincial registry of patients waiting for surgery in order to book their operations in a hospital.

The wait times issue has also been used to pressure doctors to work in multi-disciplinary pre-surgery centres where their labour is more visible and coordinated with the work of other staff, some of whom are doing work previously done by doctors alone. Based on the argument that valuable time was wasted in preparing surgeries for the preferences of individual surgeons, new protocols have been developed to standardise preparation, speed up the switching of patients among surgeons, and allow ‘swing’ operating rooms that permit no down-time. Not only surgical procedures but also clinical practices have been standardised to eliminate ‘previously idiosyncratic variations’, such as individual surgeons’ preferences among alternative prosthetic devices. Technology has assisted in this approach. New techniques in cataract surgery, for example, lend themselves to production-line efficiencies without loss of quality. In the context of new government wait-time guarantees that require a speed-up in service, and with the stick of evidence-based medicine, hospitals and clinics have been reorganising care in ways that significantly reduce the power of individual doctors.

Most of these strategies have been introduced in the public sector, where profit plays no role. To some extent the strategies are in response to the claim that the commercial sector is more efficient, and they do help to impose a more uniform structure on a historically diversified system, which is one reason these strategies have received support from the public. It may indeed be useful to reduce doctors’ independent control in order to make care more effective and accessible. But the emphasis on wait times not only reduces doctors’ power over these areas, it also fundamentally alters the way care work is approached overall. This is not always in the best interests of patients, and shifts power from doctors to management, just as more care is becoming for-profit by being moved out of the hospital setting to long-term residential care, as well as to clinics of various sorts, and to homecare.
NURSES

The largest single occupational group in the health sector consists of nurses: registered nurses (RNs) and licensed practical nurses (LPNs). Although still hampered by traditional ideas about women and care, their strong unions and professional organisations have been able to protect at least some of their skills and their conditions of work from new managerial control practices. At the same time, however, appeals to nurses’ professionalism and commitment, as well as the constraints on those among them who are also caring for their families, have made nurses complicit in and even promoters of some of these strategies.

As the transfer of some nursing work to lower-paid workers defined as less skilled reached its limits, hospital managers started to look to Taylorist techniques to increase control over nursing work and speed it up. Nursing work was examined to determine the individual tasks required and then to determine how each task could be timed, recorded and reorganised. Many nurses accepted or even embraced this approach, convinced that such an examination would demonstrate that they were overworked and would lead to more staffing as well as more recognition. It quickly became obvious, however, that the purpose was to speed up the work and reduce staff. Even when the figures showed that more staff were needed, nurses found the numbers were simply recalculated to show that what initially took 120 per cent of their time now took only 80 per cent.

These task measurement techniques were combined with computerised patient classification and patient information systems. These systems, like the work measurement ones, were sold as ways of improving patient care. They were not initially resisted by the majority of nurses, who believed these methods would improve patient care by standardising it on a scientific footing. The appeal to science was particularly attractive to nurses seeking to demonstrate the scientific nature of their own work. The appeal to their concern for patient welfare through these classification systems also allowed management to introduce what were in effect indirect forms of control over nursing work.

These measurement systems also reflected and reinforced an increasing emphasis on only the most acute aspects of care being the proper work of hospitals, and even of many public health services. This redefinition of the work of hospitals fits well with government efforts to reduce government involvement in, and payment for, health care, because the federal government’s prohibition against doctors’ charging fees directly to patients is restricted to charges for ‘medically necessary’ doctor and hospital services. Once Canadians leave the doctor’s office or the hospital, they are
no longer guaranteed coverage by universal public health insurance.

The narrower definition of hospital care opens up services to both fees and more for-profit involvement. Many hospitals have been closed, on the grounds that new methods of treatment and of work organisation mean that fewer beds were required. Others have been amalgamated, based on business plans that assumed that this created economies of scale in the private sector and would do the same in the health sector. Governments justified these moves to the public not only as a way to improve efficiency but also as a way to save taxpayers money and so save the public system. For nurses the result was dramatic: in Ontario alone, between 1994 and 1999 more than 5,000 nurses lost their jobs.\(^{26}\)

There was some justification for promoting patient tracking and standard ways of classifying patients as means of improving the quality of care. Similarly, new and less invasive technologies that made it possible to dramatically shorten patient stays and to do more day surgery also improved care for many. However, as Jacqueline Choiniere makes clear in her study of these technologies, when ‘treatment becomes rationalized or objectified in this manner, it is much easier to monitor’, and managers are particularly interested in monitoring the nurse along with the patient.\(^{27}\) Managers acquire greater control over the distribution and pacing of the work and are able to justify staff cutbacks. What had been defined as unproductive time is reduced and staffing levels are adjusted to match with precision what are inherently uneven levels of demand for care. Nurses employed full-time are increasingly ‘floated’ around the hospital, shifted to other areas if the indicators suggest there are too many nurses in one area. So, for example, while in the past fewer babies being born on one afternoon might mean a nurse could provide additional instruction to a new mother or even have a cup of tea, fewer babies now meant fewer nurses, even in the middle of a shift. In addition, more nurses are hired as part-time or casual staff, intended to be at work only during peaks in demand. Meanwhile, new definitions of care and new technologies mean that hospitals serve only the sickest patients. This too intensifies the workload, especially when combined with flexibilisation, and staffing levels dependent on standardised calculations of the time required for care.

At the same time as hospitals were introducing these measurement systems for patient classification and nursing work, by the 1990s many governments and managers were more explicit and open about adopting new work organisation strategies developed in the manufacturing sector. As an advisory body to the Ontario government put it, the ‘health sector can learn a great deal from modern management science – particularly from Japanese and
American experiences in the total quality management of individuals and organizations’ based on the assumption that such practices were ‘equally applicable to manufacturing or service operations’. The manager of one major Canadian hospital even went so far as to claim that these techniques were more applicable to hospitals because the practices of the majority of health care professionals are value-based on concepts of services, care, and compassion for the sick and injured! Here managers were using the specific nature of health services to justify the introduction of new forms of work organisation, appealing to workers’ notions of professionalism and compassion. Total Quality Management (TQM) and similar schemes were promoted as a way to improve quality through focusing on the work processes, on self-managed teams, on training rather than monitoring and on taking pride in the work. Many nurses bought into the schemes because these approaches did seem to support both their autonomy and their ideas about the work. Whatever the motivations of managers and nurses, in the context of a focus on cutbacks and the TQM emphasis on the elimination of variation, which contradicted both the principle of professional autonomy and the promotion of innovation, nurses found themselves multi-tasking rather than multi-skilling in ways that reduced their control over and pride in their work.

During the 1990s many nurses once again sought to improve their power and status by imitating what they saw as the doctors’ methods. They began emphasising the evidence base of their work, supporting the setting up of graduate programmes in nursing across the country that emphasised nursing theory and scientific research. In many jurisdictions, nurses were successful in their efforts to make a university degree, rather than college or hospital-based education, the requirement for entry. These objectives were not without controversy among nurses. A significant number argued that nurses should continue their long tradition of practising hands-on care and should not try to become mini-doctors. At least one jurisdiction, Manitoba, continues to resist the move to making university graduation a mandatory requirement for entry to nursing. Ironically, the shift to higher nursing qualifications as a route to enhanced power and status, following the doctors’ example, has come just as doctors’ power is being somewhat curtailed. Equally important, the nurses failed to recognise that much of the doctors’ power came from their class and gender, the era when they were organised, and their establishment-oriented politics, rather than primarily from science and degrees. What the move to higher qualifications did do, however, was make it harder for working-class women to enter nursing, given that entry required significant tuition fees and longer periods of training without income.
Some nurses have been transformed into wage labourers, employed to produce profits. Although most hospitals are still non-profit organisations – and even those operated as public/private partnerships keep nurses in the public side – they did begin to rely heavily on temporary help agencies to fill gaps in services. Some nurses are willing to work in these agencies for a variety of reasons. Although working for a temporary help agency pays less and offers fewer benefits it does allow nurses to control their time and choose their workplace. Some opt for agency work as a means of managing their unpaid work at home, but many now do so because it has increasingly become the only way to get work, as full-time employment for nurses becomes scarcer. These nurses are ‘just-in-time’ workers, creating profits for private companies that bear few of the responsibilities or risks in the actual management and delivery of health care.³¹

‘Temp agencies’ are not the only for-profit companies that have established a foothold in the provision of health care in Canada. As patients are sent home quicker and sicker, more care work must be provided at home. Much of it is done (or at least is assumed will be done) by women relatives or friends without pay. This shedding of paid labour from the healthcare system is based on the presumption that any woman can do the work involved, which also makes it harder for the women who are paid to do the work to claim it is skilled work. It gives healthcare managers some flexibility in shedding labour when they are denied the resources needed to pay for the service. The public money that is now spent on paying workers to provide care in the home is increasingly channelled to for-profit companies. In Ontario, the government introduced in 1995 a competitive bidding process for the delivery of home care services and actively encouraged private companies to seek contracts. This meant that the nurses, as well as the personal support workers and therapists, became potential sources of profit. It also meant that all employers providing care in people’s own homes were motivated to hire workers on lower salaries, to eliminate job security and benefits, to make employment precarious and to speed up the work. Data from Ontario show that, in the five years after managed competition was introduced, the wages of licensed practical nurses dropped by over two dollars an hour; notably, however, those in the not-for-profit sector were paid more than those in the for-profit sector.³² RNs fared better, in part because the legally-defined scope of their work meant they could not as easily be replaced by other paid workers, but those in the for-profit sector still earned close to three dollars an hour less than those in the not-for-profit sector, and most of the jobs were in the for-profit sector.³³ The Ontario government had a similar programme for the for-profit delivery of long-term residential care. By 2005-06, 62 per
cent of the 88,874 beds in Ontario’s long-term care facilities were owned by for-profit companies.\textsuperscript{34}

Although many nurses initially accepted or even supported attempts to measure their tasks and to standardise the work through the patient classification systems, the sceptics among the nurses increased as the uses to which these methods were put became increasingly obvious. Some left the country to seek jobs elsewhere and many left nursing altogether. Their unions launched research and publicity campaigns, as well as grievance procedures, to limit the increasing managerial control over their work and the privatisation of services. They have also appealed to the public, relying on the high levels of support that nurses continue to enjoy. Their unions and professional organisations were relatively successful in restricting the use of foreign-trained nurses as a reserve army. As of 2006, only about 8 per cent of nurses employed in Canada were foreign-trained. This is comparable to the proportion of foreign-trained nurses in the UK, and about half the proportion found in the US.\textsuperscript{35} A few nurses have also been able to carve out some space from doctors’ areas of work as nurse practitioners. These are advanced practice RNs with additional education in health assessment, diagnosis, and the management of illness and injury. In the last decade or so, they have been permitted to take over some responsibilities of doctors, notably in ordering and interpreting certain tests and in prescribing selected drugs. As yet, however, they account for only 0.5 per cent of the RN workforce.\textsuperscript{36}

At the same time, some forms of standardised practice have given nurses the authority to do some things without seeking instructions from doctors. And they were successful, during the boom years of the early twenty-first century, in restoring some of the lost full-time jobs. But they have been less successful in expanding or even maintaining areas of autonomy for the majority of nurses. Methods of managerial control adopted from the for-profit sector have been eroding nurses’ control over the pacing and order of work, directly via the reduction of nurse:patient ratios, and indirectly as a result of shorter patient stays. New technologies, such as self-administered medications, have taken some work away from nurses, as have efforts by LPNs to increase the scope of their work into areas once reserved for RNs. And RNs are increasingly required to teach women to do nursing work at home without pay, a process that further undermines RNs’ claims to have special skills and threatens their legally defined scope of practice.
ANCILLARY WORKERS

From a managerial perspective, the control strategies taken from the for-profit sector have been most successful in reducing costs for the lowest paid workers, although it should again be noted that those who work in the public health sector earn more than those in similarly-labelled jobs in the private sector.\(^{37}\) The first step involved defining many of these jobs as not being part of health care, even though a wide body of research shows that cleaning, laundry, food and paper work are critical components in health care and that team work is essential to good care.\(^{38}\) Increasingly, from the 1970s on, official documents talked about ‘hotel services’ within hospitals, and the ‘unskilled labour’ involved.\(^{39}\) This redefinition was made easier by the fact that most of the workers were women, dismissively described as doing just what women could do naturally. Many were from racially defined and immigrant populations as well.

On the basis of this redefinition, and of unsubstantiated claims about the greater effectiveness and efficiency of the for-profit sector, hospitals began contracting out the so-called ancillary work to multinational firms providing services to hotels and other businesses. These workers became producers of surplus value, as corporations such as Compass, Sodexho and Aramark recorded huge profits from taking over these services from the public sector. In some cases, companies were contracted to cover just one aspect of work, such as cleaning. In other cases companies took over all the services defined as not being part of ‘clinical’ health care, including the managerial functions related to them. Such major takeovers were often done through public/private partnerships of one kind or another.

In classical capitalist fashion, these companies used technology to reduce their reliance on labour and increase control over workers. Laundry, for example, was centralised in processing centres where machines did much of the work. Food was centrally prepared in capital-intensive plants and delivered over long distances, then reheated in delivery carts with the trays sent back for cleaning.\(^{40}\) Information technologies allowed both the speed-up of clerical work and greater employer control. Cleaning was more difficult to mechanise, especially in patients’ rooms, although it could be centrally controlled through the use of information technology. But managers mainly relied on other means to reduce labour costs and increase control. Cost savings were achieved by using Taylorist techniques to measure the tasks, determining what needed to be done, for how long and how, without much consultation with workers. Tasks were carefully specified and required to be done in shorter time periods, by fewer workers. Managers not only worked remaining employees harder but also paid them less and increased control in
part through making employment precarious.

This neo-Taylorism went to an extreme in British Columbia, resulting in enormous losses of pay, benefits and job security for the overwhelmingly female and often racially-defined workers.\(^4\) In order to privatise the services, in 2002 the government also tore up existing collective agreements, over the strenuous objections of the unions involved. The unions used the Canadian Charter of Rights and Freedoms to successfully challenge, in a case finally heard by the Supreme Court in 2007, the government’s failure to bargain in good faith and to fulfil an existing contract, in the process establishing an important right for all workers.\(^4\) Even apart from this victory, however, it became obvious that cleaning hospitals required not only considerable skills but also attention to the specific nature of the work. The irregular nature (or regular irregularity) of much of the work in health care, the particular skills needed for this, the crucial importance of the specialised cleaning required for germ-free conditions, and the importance of effective teams were all undervalued and underestimated. After cleaning services were privatised in British Columbia in 2003, nursing staff were forced to contact regional call centres to request extra cleaning services whenever spills or other accidents occurred, common incidents in hospitals that were not considered in contracts that specified work assignments suited to regular, measurable tasks. The new division of labour not only took nurses away from their work, reducing efficiency and causing delays, but also undermined the past practices of nurses working cooperatively with other staff when such incidents happened.

Contracting out ancillary work also meant that hospitals no longer took responsibility for the ongoing training of cleaning staff in infection control protocols. Under the terms of at least one commercial contract, the corporation concerned charges up to $57 an hour over and above its contracted price to provide any more intensive cleaning that might be required as a result of a superbug outbreak.\(^4\) Yet research brought together by the Canadian Union of Public Employees shows that well-trained in-house teams, appropriately supported by decent wages and working conditions, are central to preventing such superbugs from taking hold.\(^4\) As the cleaning firms cut back on hours and on training they have been repeatedly cited by the Workers Compensation Board for failure to adequately train workers, and the incidence of superbugs has increased. Between May and October 2008, ‘investigators cited Compass for its failure to provide adequate health and safety training to workers; train workers in the safe use of toxic cleaning agents or in dealing with spills of hazardous substances; keep records of health and safety incident investigations, and have an exposure plan for
workers who are exposed to materials contaminated with blood’. 45

Similar legal, research and collective bargaining strategies have been used across the country to resist and even in some cases reverse the contracting out of ancillary work. 46 Research on rising illness and injury rates, as well as on the declining quality and increasing risks for patients, has been used to muster public support in opposition to these practices. In 1995, there was enormous public support for an illegal strike of healthcare laundry workers in Alberta, prompting the government to back down on planned cuts to health spending. 47 And in 2000 Manitoba unions successfully rallied public support to reverse the contracting out of food services. 48 It is difficult to imagine such support for strikers and unions operating in the private, for-profit sector outside health services, yet another indication of the particular nature of health services.

It would be wrong to exaggerate the extent to which either worker resistance or the nature of health care work has prevented the imposition of control mechanisms, and some forms of control that have been imposed are very difficult to reverse. For example, once hospitals have dismantled their kitchens and laundries, outsourcing the services involved, it is very hard to rebuild them. Some opposition has simply led to new contract controls rather than the reversal of service commodification. Some laws have not been enforced or contracts upheld. Equally important, many healthcare and other public sector employers have adopted business strategies to control labour, and is much harder to rally public support for resisting this form of privatisation.

But it would also be wrong to ignore the extent to which even the most vulnerable workers have resisted control, or to minimise the skilled and particular aspects of these jobs in health care. Indeed, even as unemployment rose with the onset of the global economic crisis in late 2008 employers were finding it difficult to find people to do the work. 49

CONCLUSION: UNPAID LABOUR AND THE STRUGGLE TO CONTROL HEALTH CARE WORK

As hospitals define their mission ever more narrowly, and send their patients home ‘quicker and sicker’, more and more work is being shifted to those who provide unpaid health care. 50 Meanwhile, more individuals survive infancy and childhood with severe chronic conditions, and more individuals live, albeit with varying care needs, well into their 80s or 90s; this is to be celebrated, but it does impose increased homecare obligations. Although it is no simple matter to distinguish social care from health care, the distinction is not particularly important to the caring relationship, especially when the
lessons from the social determinants of health are taken into account. Personal and environmental hygiene, good nutrition, exercise, companionship and so on all contribute to health promotion and disease prevention. Care work is intimately linked to these and other determinants. The unpaid care work that results is critical in simple numerical terms. In Canada, it is estimated that over 70 per cent of all care is provided by unpaid labour, a considerable majority of it performed by women. Unpaid labour is also critical because the threat of shifting even more care work to the home to be undertaken without pay is yet another means of controlling paid care workers.

The ways in which the neo-Taylorist impact on health care is shifting the burden to unpaid labour has potential to create a new basis for solidarity between the general public and healthcare workers. Struggles over labour control take specific forms in health care, shaped not only by its particular characteristics but also by gender, class and race. The nature of health care has allowed workers to appeal to the public’s support for health care and their fear of ill heath as a means of strengthening the workers’ case in these struggles. To be sure, governments have also appealed to the public on the same grounds to justify both neo-Taylorism and privatisation. Equally important, the specific nature of healthcare work, and especially the female-dominated labour force and its association with ‘natural’ female attributes, has allowed governments to shift work from paid employees to unpaid, mainly female workers at home, and to rely on healthcare workers’ altruism within the paid sector. But as with neoliberalism in general, this kind of appeal from governments in the area of health care may be reaching its limits.

Until recently, doctors were mainly white men, largely from middle-class families, who used their privileged position to promote a division of labour that allowed them to shed the less attractive tasks involved in health care. They were able to increase their power as specialists, while retaining their position as the primary decision-makers, and were paid handsomely for the medical work that was determined and controlled by them. But the recent attempts by governments to use indirect forms of control to limit doctors’ autonomy and power, challenging the doctor-determined division of labour by allowing others to do more of the tasks that were previously their exclusive preserve, mean that although doctors may have been the last and least affected, they are nonetheless certainly experiencing a loss of control today. And this loss of control, happening just when the majority of new doctors graduating from medical schools are women, and more are from immigrant communities, has the potential for the first time to ally doctors explicitly with popular struggles in health care.

Similarly the only partial success of the nurses – in good part because
they were women – in emulating doctors’ past strategies, has meant that managers have been even more successful in measuring, timing, compressing and flexibilising nurses’ task. But this provides an even stronger basis for potential alliances than is the case with doctors. And the ancillary workers hired to take up the tasks shed by nurses have been the most privatised and proletarianised, with their work increasingly defined as being outside of health care. The fact that this has been supported by notions of the unskilled tasks associated with female-dominated work as well as racialised and/or immigrant workers, and by the assumptions that the work can be shifted to unpaid, mainly female workers at home, has produced a reaction inside the health sector and out that has already allowed healthcare unions to score some significant victories on their behalf. As we have seen, this has sometimes enjoyed notable public support, and this has been most recently demonstrated by the high public profile of the Ontario Health Coalition’s grass roots mobilisations through town-hall assemblies and popular referenda in communities right across Ontario. As the burden of care in increasingly shunted to the household, while hospital care is increasingly industrialised, the possibilities for combining healthcare workers’ struggles with popular activism to extend and democratise public health care is greater than ever.

NOTES


CONTRADICTIONS AT WORK

Canadian Institute for Health Information (CIHI), *Canada’s Health Care Providers, 2007*, Ottawa: CIHI, 2007, Fig. 3.2.


In Ontario, for example, at least 13, but no more than 15, of the 32 to 34 members must be non-physicians. College of Physicians and Surgeons of Ontario, ‘About Council’ at http://www cpso.on.ca.

The cut had been recommended by M.L. Barer and G.L. Stoddart in *Toward Integrated Medical Resource Policies for Canada*, a 1991 report prepared for the Federal/Provincial/Territorial Deputy Ministers of Health. Their many other recommendations on the reorganisation of healthcare provision were however largely ignored.

In 2007, 22 per cent of Canada’s close to 64,000 practicing doctors were foreign-trained. Their share has been slowly and steadily declining since the mid-1970s.


Investor-owned walk-in clinics, day surgery clinics and diagnostic centres are starting to make their presence felt in some provinces, but numbers remain small.

Just over a third of family physicians in Canada have such privileges, leaving the majority without access to their patients when they are admitted to hospital. College of Family Physicians of Canada, ‘Family physicians caring for hospital inpatients: a discussion paper’, 2003, available from http://www.cfpc.ca.

From 1980 to 1998, for example, the average annual decline was 1.7 per cent, and it has continued to decline in Canada and in all but 5 of the other 27 OECD countries for which there are data between 2000 and 2004 or 2005. OECD, ‘How does Canada compare’, *Health Data 2008*, Paris: OECD, 2008, p. 2; *Health at a Glance, 2001*, Paris: OECD, 2001, p. 26; *Health at a Glance, 2007*, Paris: OECD, 2007, Table A.4.5a.

Galt Wilson, ‘Are inpatients’ needs better served by hospitalists than by their family doctors?’, *Canadian Family Physician*, 54(8), 2008, pp. 1101-03.


Ibid., p. 17.


Ibid.


45 49 Hospital Employees’ Union, ‘WCB issues orders to VIHA’s cleaning contractor’, 7 January 2009 news release. The inspection reports were accessed at http://www.heu.org on 16 January 2009.
46 See, for example, CUPE Local 145 v. William Osler Health Centre [in Brampton, Ontario], March 2006.
48 Canadian Union of Public Employees, ‘Fact Sheet’.