OPINIONS ABOUT PUBLIC HEALTHCARE

FROM WORKING-CLASS LEADERS IN SASKATCHEWAN

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By

SEAN MICHAEL POLREIS

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OR

Dean
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University of Saskatchewan
28 Campus Drive
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Canada

Abstract

The Canadian public healthcare system is consistently rated as highly important by the public. It is a treasured institution, and concern for its future is understandable. However, despite the valuing of the five principles of the Canada Health Act – public administration, comprehensiveness, universality, portability, and accessibility – defense of the public nature of the system seems to be waning; the appetite for a certain amount of privatization appears to be increasing. Saskatchewan, the birthplace of socialist governance in Canada as well as Medicare itself, would seem an unlikely place for this occurrence. However, despite a recent incursion of privatized elements into the healthcare system, there appears to be little in the way of fervent opposition. This lack of resistance is especially interesting among working-class people in Saskatchewan, a demographic group who stand to lose much if Canada's healthcare system would ever transmute into something akin to the healthcare system in the United States. This study was designed to better understand how working-class people in Saskatchewan perceive the healthcare system in Canada, as well as the political, social, and economic factors influencing their beliefs. Over the course of one and a half months in the fall of 2012 I conducted 10 in-depth interviews with labour union representatives and executives. In addition to investigating the beliefs and opinions of my participants, I asked them to approximate how their membership would view similar issues and questions. The results illustrate a public that is being influenced heavily by neoliberal rhetoric, including the ethos of individualism, and mostly one-sided media messages about a so-called 'crisis' in Canada's public healthcare system. It appears as though the public has grown somewhat apathetic about social programs like Medicare. This combination is a perfect storm of conditions that has the potential to fundamentally change the nature of Medicare in Canada. Everyone in Canada - as funders and users of the system - has a

stake in the future of Medicare. Policy changes to Medicare need to be informed by a better understanding of the influences on people's opinions of the system.

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CHAPTER ONE:

INTRODUCTION

1.1 Socialist Saskatchewan?

I was born in what some would describe as the socialist heartland of Canada. Saskatchewan was most certainly home to Canada's first socialist government when the Co-operative Commonwealth Federation (CCF) was elected in 1944. That government's leader was Tommy Douglas, a great Canadian hero as far back as I can recall from my early youth in the 1970s. Douglas had achieved heroic status largely for his involvement in the introduction of a comprehensive publicly funded health insurance system in Saskatchewan in the early 1960s. The CCF implemented a public hospital insurance plan in 1947, and the provincial New Democratic Party (NDP), which evolved out of the CCF in 1960, extended this insurance to cover physician services in 1962. Medicare, Canada's national publicly funded universal health insurance system[1], was implemented in Prime Minister Lester B. Pearson's Medical Care Act of 1966. As recently as 2004, Tommy Douglas finished first in a CBC (Canadian Broadcasting Corporation) poll with a subtitle, "Father of Medicare" ("And the Greatest," 2004). In my youth I do not recall Medicare, as a national institution and socially responsible program, ever being questioned. I saw it as sacred and untouchable, not up for debate. There was never any doubt whether Medicare would always be there for Canadians.

[1] In this paper I will use 'universal healthcare system' and 'universal health insurance system' as synonymous with public healthcare in Canada. While I recognize that our healthcare system is not 'universal' in the sense that not all services are covered (for example drugs and dental), it is 'universal' in that all Canadians do receive basic services – a tenet of the Canada Health Act. Furthermore, it is common parlance in Canada to use these phrases interchangeably.

Fast forward to 2012 and those halcyon days of consensus seem to be fading; according to Milton Terris (1999, p. 157), "The key word today is privatization; the market is king, and profit is the overriding goal." The right-wing Saskatchewan Party obtained 64 percent of the popular vote in the November 7, 2011 provincial election, the highest of any political party ever in Saskatchewan (Atkinson, Berdahl, McGrane, & White, 2012). Federally, 13 of 14 MPs chosen in Saskatchewan in the May 2, 2011 election were Conservative (Liberal Ralph Goodale won the other seat), and a May 8-10, 2012 Ipsos Reid poll (combining Saskatchewan and Manitoba) showed the Tories still in the lead position with 49 percent of support, with the NDP (New Democratic Party) second at 37 percent (Kennedy, 2012b). In a province with such strong social democratic roots, one cannot help but notice that the province's political ideology seems to have shifted to the right. And, if this is the case, what might the implications be for healthcare? This paper will attempt to explore the reasons for this shift, at least in terms of a specific group of people, working-class people in Saskatchewan.

Medicare is more than a venerated and valued program; it is one of the ways many people identify themselves as Canadian. It is an institution that has become somewhat synonymous with national identity, and I feel it is essential that we maintain it. As I will explain, because threats to Medicare are often covert and insidious, it is possible that Canada could lose it, at least in its current manifestation, without much fanfare or backlash. In fact, the lack of public outcry in defense of Medicare is a primary reason for this study. According to Janice MacKinnon, former Saskatchewan NDP finance minister, "private clinics have generated little adverse public reaction in Saskatchewan, the birthplace of Medicare" (MacKinnon, 2013). Only by understanding the beliefs and motivations which drive the voting public can we begin to explore how and why our healthcare system may be in danger. This paper will attempt to begin to

understand and explain why this outcry is so muted, and how this may be detrimental to one of our most valued institutions, Medicare.

Since Medicare's inception in 1966, Canada has had a mix of private and public elements in healthcare - primarily publicly funded and administered with a mix of private and public delivery - but there has been an incursion of private elements recently (Angell, 2008; Camfield, 2008; Howlett, Mickleburgh, Picard, & Moore, 2010; Lewis, Donaldson, Mitton, & Currie, 2001; McIntosh & Ducie, 2009; Picard, 2010; for Alberta see Armstrong, 2000; for British Columbia see Mickleburgh, 2010; for Ontario see Ontario Council of Hospital Unions, 2012; for Quebec see Alphonso, 2010, and Silver, 2010). Although 'necessary' services are publicly funded, 30 percent of all healthcare services are paid through private sources – individuals, employers, and private insurance (Conference Board of Canada, 2013, February; Health Council of Canada, 2011). And while Canada certainly has not seen the hyper-privatization and anti-government intervention rhetoric which is so prevalent in the United States, there seems to be a new, similar if less virulent and more passive, sentiment arising when it comes to government social programs such as Medicare (Manning Centre, 2012). The following comment from the Letters to the Editor in the StarPhoenix (Pearce, 2012, para. 3), Saskatoon Saskatchewan's daily newspaper, is not atypical:

> Considering the amount of tax money that goes to health care, it is unbelievable that this sort of thing can happen. It's time to give the private sector a better shot, since this stuff would never fly there.

This was a response to a news story about a mother and son who apparently did not receive necessary care at a local hospital. Moreover, the option of private delivery of services has also been advocated by Canadian Medical Association president Dr. Jeff Turnbull (Kleiss, 2011).

This is not necessarily a negative development. Vigorous debate should always be promoted regarding any political institution or program – in fact, it is essential for a healthy

democracy. However, my concern has to do with the nature of that debate in regard to Canada's healthcare system. While I welcome a discussion about the current problems of escalating healthcare costs, inadequate and/or overuse of services, and poor health outcomes, this discussion needs to be rational, evidence-based, and socially responsible. The discussion needs to be held among an informed public. Above all, this discussion should not be driven by ideologues ignoring the above requirements in favour of self-interest. And for those of us who have rested comfortably with the belief that Canada will always maintain Medicare as we know it, there is an additional threat from outside – globalization. International bodies like the World Bank, International Monetary Fund, and World Trade Organization are putting tremendous pressure on countries to adopt neoliberal policies - such as corporate tax cuts, industry deregulation, and privatization of the commons - and international trade agreements put additional burdens on governments trying to resist privatization in certain sectors of the economy (Armstrong & Armstrong, 1996; Jasso-Aguilar, Klein, 2007; Leys, 2003; Terris, 1999; Waitzkin, & Landwehr, 2004).

The United States is one of three OECD (Organization for Economic Co-operation and Development) countries (Mexico and Chile are the others) where under 50 percent of health spending is publicly financed (OECD, 2012). Our neighbours to the south offer us an excellent example of a privatized healthcare system, and it appears to be a disaster. The Commonwealth Fund Commission on a High Performance Health System (2013) asserted that United States healthcare spending, as a share of GDP (Gross Domestic Product), has risen from 14 percent in 2000 to 18 percent currently. Furthermore, despite on average spending twice as much per capita on healthcare than other industrialized nations, the United States fairs poorly in health outcomes (Adamson, 2010; Angell, 2008; Brill, 2013; Murray & Frenk, 2010; National Research

Council, 2013; OECD, 2012; Schroeder, 2007; The Commonwealth Fund, 2013). World Health Organization (WHO) data from 2000 indicated that the United States, despite being number one in the world for healthcare spending per capita, ranked 37th in overall health system performance (World Health Organization, 2000). A McKinsey and Company report (2008) showed that nearly a third of what the United States spends on healthcare is above what would be expected in comparison with other OECD countries. This is due to many factors including drugs and administrative costs, and the for-profit motive that comes with private healthcare. The American College of Physicians (2008, p. 72) has recommended learning from other countries and adopting a new approach to healthcare, including "universal and compulsory health insurance coverage," in an effort to cut costs and improve health outcomes. In a comparison of for-profit health institutions versus non-profit ones, Woolhandler and Himmelstein (2007) showed that the former have poorer outcomes and greater expenses. They strongly advise any country looking to reform their healthcare system to avoid looking to America's market-based system for guidance. Brill (2013) showed the exorbitant overcharging, and resultant high costs to the public, in both non-profit and for-profit hospitals in the United States. Over 60 percent of bankruptcies in the United States in 2007 were due to medical costs (and three quarters of them had some health insurance), a rise of nearly 50 percent from 2001 (Himmelstein, Thorne, Warren, & Woolhandler, 2009). This is clearly a system which is costly to Americans, both financially and in terms of their well-being. The current American model is definitely not one to which we should be aspiring or, more importantly, moving toward.

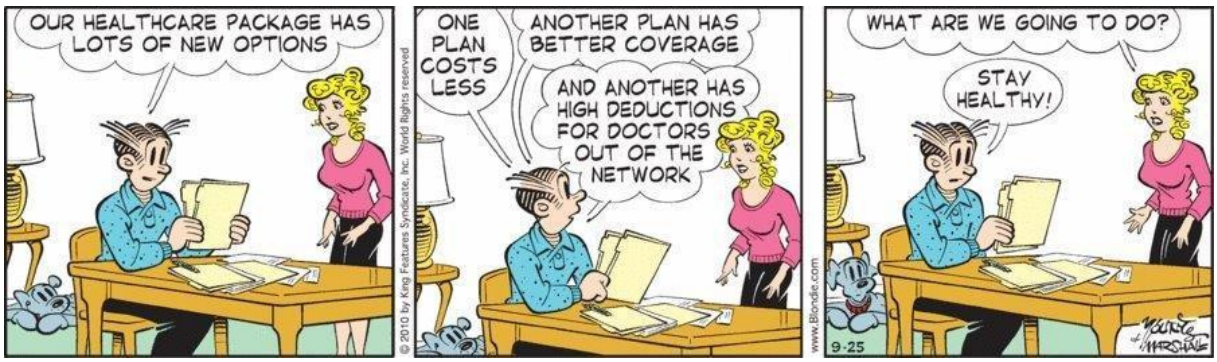


Figure 1.1 Used with permission from blondie.com.

For the record, I am a proponent of public healthcare and believe that to preserve Canada's current system we need to understand public perceptions and attitudes. However, I do recognize that our system is far from perfect and could benefit greatly by studying successful healthcare systems in other countries. According to the Conference Board of Canada (2013, April), Japan, Switzerland, and Italy all rated higher than Canada in terms of health performance. The Commonwealth Fund (2010) ranked Canada sixth out of seven countries in overall healthcare system performance, behind the Netherlands, the United Kingdom, Australia, Germany, and New Zealand. According to Tandon, Murray, Lauer, and Evans (2001), Canada ranked 30th overall for healthcare efficiency compared to other WHO countries. And Snowdon, Schnarr, Hussein, and Alessi (2012) stated that Canada's healthcare system has recently lagged behind other OECD countries in areas of life expectancy and infant mortality. In terms of healthcare spending, Canada's position is also less than stellar. Despite a similar governance structure to the United Kingdom and Australia, Canada's health system costs are much higher than either country, and among OECD countries, the cost of pharmaceuticals is superseded only by the United States (Snowdon et al., 2012). And in 2011, only five out of 28 OECD countries spent more per capita on healthcare than Canada (OECD, 2013).

In a democracy, public opinion has a significant influence on public policy. Governing parties need support to be elected and to carry out social programs. Thus, it is essential that the nature of public dialogue around issues like Medicare be free of bias and false pretenses. I am not sure that this is occurring. If there has been a shift in public opinion about Medicare - if Tommy Douglas has gone from hero to iconoclast in some people's minds - it is important to know the roots of that shift. For example, is there a desire to move toward a more privatized healthcare system or, as some researchers suggest (Dickinson, 2002; Lomas, 1997), are people simply apathetic due to complacency, misinformation, or disengagement? My research will address this apparent shift: What societal factors, forces, and dynamics are involved in people's opinions of the public healthcare system in Canada? Are conclusions being drawn from reasonable concerns and likely consequences? Has an ideological shift clouded the discussion and influenced people in ways whereby they have lost sight of social responsibility or even their own self-interests? The future of Medicare may depend on the answers.

Healthcare consistently ranks at the top of Canadians' concerns (Nanos Research Poll, 2011; Vail, 2001). As well, a vast majority of Canadians highly value our universal public healthcare system and its principles, clearly set out in the Canada Health Act of 1984 – public administration, comprehensiveness, universality, portability, and accessibility (Armstrong & Armstrong, 1996; Marmor, Okma, & Latham, 2002; Maxwell et al., 2002; Mendelsohn, 2002; Romanow, 2002; Snowdon et al., 2012; Vail, 2001). Yet, despite the encroachment of the private sector on the public system, I have not observed a significant reaction in defense of Medicare as we know it. This advance can sometimes be so covert it is basically hidden, as when certain services are cut back or defunded (see Spray, 2013 for an example in publicly funded long-term care facilities). It can also be more overt as in the Saskatchewan government

contracting out surgeries to private companies (Government of Saskatchewan, 2010; Hall, 2012). In any case, it seems that a growing discontent with the public healthcare system often results in an argument of public versus private: Which sector can provide the best care for the cheapest cost? While this is a discussion worth having, some other important questions need to be asked. Why are choices presented in this dichotomous fashion? Why are problems with Medicare so rarely framed without introducing private sector solutions (Armstrong & Armstrong, 1996; Black & MacKinnon, 2011; Dodge & Dion, 2011)? Why are the exorbitant costs of the American system rarely if ever mentioned in news accounts pieces about private healthcare systems? Is the desire for a private solution due to potential economic efficiencies or better health outcomes - or both, or neither? And why are the social and economic determinants of health (income, housing, education, employment, nutrition, social justice, and environment), the primary causes of poor health outcomes, so rarely included in these discussions (Alvarado, Martinez, Vivas-Martinez, Gutiérrez, & Metzger, 2008; Andermann, 2011; Armstrong & Armstrong, 1996; Black & MacKinnon, 2011; Brown, 2010; Canadian Medical Association, 2013; Conference Board of Canada, 2013, February; Haight, 2012; Livingston, 1998; Mackenbach, Meerding, & Kunst, 2007; Marmot, 2004; Meili, 2012; National Research Council, 2013; Public Health Agency of Canada, 1999; Raphael, 2002, 2011; Robertson, 1998; Terris, 1999; "WHO Commission," 2008)? Public discourse in general is heavily influenced by political framing and media representations of issues like healthcare. My research aims to get beyond surface responses to typical questions about peoples' perceptions of healthcare in order to understand deeper motivations and root causes.

To unveil some of these deeper understandings, I conducted 10 in-depth interviews with labour union representatives and executives in Saskatchewan. I relied on these participants to be

sophisticated in their understandings of issues around healthcare and articulate in expressing their views. I also counted on their close proximity to their memberships to gain insight into the large demographic I was most interested in: working-class people in Saskatchewan. It would seem a social program like universal healthcare would be especially important to working-class people, and so I focused on better understanding *their* attitudes and beliefs about healthcare.

Universal public healthcare gained popularity in Saskatchewan as a response to social and economic circumstances after the depression of the 1930s and continued through the post-War period. The social welfare state emerged in response to recognition that markets are unstable and unpredictable, and everyone in society is vulnerable to its vagaries. Because the gains from a market economy are not allocated equitably in society, people counted on governments to provide security and protection against risks for its citizens (Armstrong & Armstrong, 1996; Lipset, 1968; Muntaner, Salazar, Rueda, & Armada, 2006; Saint-Martin, 2007; see Wise, 2012 for a U.S.-based example). A collective sharing consciousness was manifest in the ideal that society should pool its resources to share risks and ensure equality and social justice for all citizens. In this environment, universal healthcare was a natural fit. Since ill health could befall anyone at any time, society as a whole would be best served by a pooling of resources to care for those in need. Medicare was based on this "recognition of shared vulnerability and collective responsibility" (Armstrong & Armstrong, 1996, p. 155).

Neoliberal economic policies swept across Western nations in the early 1980s (significantly assisted by the election of two staunch devotees, Ronald Reagan in the United States and Margaret Thatcher in the United Kingdom, in 1980 and 1979 respectively) and has been a powerful force throughout the world for the past three decades. The effect on governments has been described by some authors as a shift from the welfare state of protection

from economic hardship to a social investment state of protection from big government (Bashevkin, 2002; Harrison, 2008; James, 2007; Leys, 2003; Saint-Martin, 2007). Neoliberalism adheres to a belief that markets are best suited to solve social and economic problems and government, as opposed to being a mediator on behalf of its people, should stay out of the way (Graefe, 2007; Jasso-Aguilar et al., 2004; Laforest & Phillips, 2007; Orlowski, 2011; Saint-Martin, 2007; Szreter, 2003; Tobin, 2011; Yates, 2008; see Muntaner et al., 2008 for an illustration of how this played out in Venezuela). Universal publicly funded and administered healthcare seems incompatible with neoliberal philosophy, and its influence in politics and mainstream media may be a reason why public opinion appears to be shifting as well (Robertson, 1998). In fact, Robertson (1998) argues that neoliberalism's economic trickle-down has been applied to social programs like healthcare; i.e. the perception that by increasing the wealth of the country, you will improve its citizens' health (see also Szreter, 2003). This argument gains traction when it is put alongside the 'crisis' in healthcare spending and the austerity budgets of current governments in Canada and other Western nations.

This supposed healthcare crisis is something that all too often is unquestioningly promoted in the mainstream media (Evans, 2007). As Orlowski (2011) explains, corporate media acts as a hegemonic machine, even in democracies like Canada. In fact, in democracies, this can become even more insidious because the public is often unaware that misrepresentation of information (or at least bias) occurs. The high frequency of words like 'crisis,' 'wait lists,' and 'unsustainable' in the discourse can be extremely persuasive, and there is likely a very straightforward reason for their regularity (links between media, governments, and corporate interests – the neoliberal agenda - will be explored further in Chapter Two). Many people assume that the information they receive is unbiased and agenda-free. However, corporate

control of the media results in promotion of corporate concerns (Fillmore, 2009; Gutstein, 2011; McChesney, 2001; McKie, 2011; Orlowski, 2011), and privatization of healthcare is something many large business interests would like to see. Combine this with governments that support neoliberal economic agendas and you have a very dangerous and powerful hegemonic voice influencing society. For Saskatchewan (and Canada) to have a healthy discussion around issues as important as healthcare, it is essential that citizens are well informed and fully aware of the implications of any and all policy decisions. Hegemonic forces may be distorting the information people are receiving and, as a consequence, the public discussion around healthcare. This study attempts to uncover if such distortions exist and what the implications may be for the Canadian healthcare system.

1.2 Audience and Definitions

There is a virtually limitless audience for this research. Physicians are front line educators on the healthcare system (in addition to other health issues) for their patients and are also expected to advocate on their behalf. For effective communication physicians should be well equipped with knowledge of how the public thinks about issues involving the healthcare system. Medical students and residents should be similarly well versed and thus there is a role for medical education to include public attitudes about the Canadian healthcare system. More broadly, everyone in society has a stake in our universal healthcare system – as users and funders. As indicated earlier, it is essential to have evidence-based informed discussions about future directions. A better understanding of how and why people think the way they do about healthcare can only help such discussions. At a deeper level, my study has the potential for consciousness raising, providing insight and awareness for people to better understand how they come to form opinions and beliefs. Kvale (1996, p. 11) described this as providing insight into people's "own conceptions of their lived world" in order to "enhance the human condition." In

essence this is an in depth study into how social, economic, and political influences shape personal attitudes and beliefs. Ultimately the result could possibly be social action and policy change.

There are many complex binaries in terms of the structure of healthcare in Canada such as - federal versus provincial influence, federal versus provincial financial commitments, and for-profit versus not-for-profit delivery. These administrative arrangements have evolved over the years since universal healthcare's emergence in the 1960s. Furthermore, despite Canada having a 'universal' healthcare system, we have some aspects of healthcare which could be described as two-tier (a system whereby those who are financially able can purchase better quality and/or faster service and care than what is provided in the basic publicly-funded system), and many aspects of healthcare that have moved in and out of 'publicly funded' status or have been 'de-insured' (Madore, 2005). An obvious complication for my study is that the phrase 'private healthcare' likely has different meanings to different people. For the purposes of my study I will define Canada's public healthcare system as publicly funded and administered with a mix of private and public delivery. "Public" refers to government agencies at various levels (national, provincial, regional); examples of private delivery of healthcare services are primary physicians, laundry services, and diagnostic services in most provinces (Madore & Tiedemann, 2005 – see table below).

However, it is important to keep in mind that, although our system has always had components of private delivery (physicians are primarily in private practice), adding more private delivery may affect the public system. As an example, Saskatchewan's current experiment with contracting out surgeries to private clinics has the potential to affect the number of physicians and staff available in the public system and jeopardize funding of other vital health

services (Dutt & Meili, 2011). I provided the above definition at the beginning of each interview but it is still quite plausible that people will not all share the same conception of private healthcare and consequences for the public system.

Table 1.1 Public- and Private-Sector Involvement in Health Care

		Delivery		
		Public	Private Not-for-Profit	Private For-Profit
Financing	Public	(1) Public Health Provincial psychiatric institutions Home care in some provinces	(2) Most hospitals Addiction treatment	(3) Primary health care physicians Ancillary services in hospitals (laundry services, meal preparation and maintenance) Laboratories and diagnostic services in most provinces Some hospitals
	Private	(4) Enhanced non-medical (e.g., private room) and medical (e.g., fibreglass cast) goods and services in a publicly owned hospital	(5) Some home care and nursing homes in some provinces	6) Cosmetic surgery Long-term care Extended health care benefits such as prescription drugs, dental care and eye care in some provinces Some MRI and CT scan clinics Some surgery clinics

Source: Madore & Tiedemann, Private health care funding and delivery under the Canada Health Act, *Library of Parliament, Parliamentary Information and Research Services*, December 28, 2005.

I am using Camfield's (2008, p. 61) definition of working class: "People who sell their ability to work to employers in exchange for a wage and who do not exercise significant managerial authority." I am using the definition of social democratic ideology from Atkinson, et

al. (2012, p. 2); “social democratic ideology encompasses the belief in the need for wealth redistribution coupled with a positive feeling towards government intervention in the economy to achieve a greater degree of fairness than the market can be expected to deliver.” Orlowski (2011) makes an important distinction between economic and social when discussing political opinions on the left-right continuum. For example, someone could be economically conservative – right wing - but socially progressive – left wing (or vice versa). For the purposes of this paper, these political positioning terms will refer to economic beliefs and attitudes. Thus, left wing refers to a belief in a strong social welfare state, pro-union, pro-government regulation of corporations, and, likely, pro-publicly funded healthcare while right wing refers to a belief in small government, pro-business (anti-regulations), and, possibly, privatization in healthcare. A typical Saskatchewan example would involve Crown Corporations: Left wingers are primarily opposed to privatizing them while right wingers often promote privatization (one must be careful to use qualifiers like “primarily” and “often” to avoid over simplifying issues that are often grey, not strictly black and white, in people’s minds).

CHAPTER TWO:

LITERATURE REVIEW

Medicare has been a venerated Canadian institution for more than 50 years now. It is one of the important ways many Canadians distinguish ourselves from our close neighbours to the south. However, there appears to be a mismatch between Canadians' passion for public healthcare as part of their identity and something they value greatly, and the lack of opposition to privatization elements that have been making their way into the system. There has been little, if any, analysis into how and why people form their opinions and beliefs on Medicare. It is my view that this is the only way to understand the apparent lack of opposition to threats to the existing healthcare system. Ultimately, public opinion will be a large determinant of the shape of Medicare for the next 50 years; therefore this question needs immediate and thorough consideration.

There is a dearth of qualitative research into people's attitudes and values regarding Medicare. Furthermore, I have not discovered any such study that focuses on working-class people in Saskatchewan. Therefore, this chapter will be less a review of previous work in this area and more an analysis of some of the phenomena which may better help to understand some of the many factors involved in people's beliefs. This chapter also highlights background research which helped guide my interview question construction. I will begin by looking at the current state of Medicare in Canada. Is it truly in a state of crisis, and is a fundamental change needed? I will then look at two fundamentally different ways of viewing services like healthcare: public good or private enterprise? How people answer this question may go a long way in determining their outlook on more privatization entering the healthcare system. For the

same reason, I will briefly look at determinants of health. While it has been largely proven that social and economic determinants of health are the primary factors in determining individual health, this message may not be making it through to the general public. This will include the first of several references to the media's influence on public opinion (acting as a hegemonic device). Next I will look at the role governments play in shaping public policy around healthcare, as well as their direct and indirect influence on public opinion. This will be followed by an analysis of neoliberal influences in government, media, and society in the past 30 years or so. Finally, I will explain how the above conditions can all play a part in creating a false political consciousness in the public and how this may potentially play a significant role in shaping perceptions and beliefs regarding public healthcare in Canada.

2.1 State of Medicare – Crisis or no Crisis?

Healthcare costs are rising at an alarming and potentially unsustainable rate (Conference Board of Canada, 2013, February). Certainly some, like Michael Rachlis and Diana Gibson (Tremonti, 2011), contend this (also J. Oulton, public lecture, Cracks in the foundation: Canada's right to health, December 1, 2010; Boychuk, 2002; Romanow, 2002). Furthermore, Evans (2007) made a strong case that it is private not public healthcare costs which are escalating out of control. Still the numbers are hard to ignore. For example, Saskatchewan's 2012 budget allocated $4.68 billion toward healthcare which accounts for approximately 42 percent of its total budget. This was significantly more than the budget for Education, Advanced Education, Employment, and Immigration, and Social Services combined (Government of Saskatchewan Finance, 2012). An important caveat here is that any statistics which measure healthcare spending as a percentage of Gross Domestic Product or total budget need to be considered carefully. For example, GDP may decrease for any number of factors causing the percentage of healthcare spending to increase without a correlating increase in actual, or absolute, costs. This

is especially true of government budgets that rely on global commodity prices, which is the case for Saskatchewan with its dependence on potash and oil revenue. Moreover, budgets may decrease as a result of tax cuts and present an 'illusion' of escalating costs in any social spending program like healthcare (since social spending becomes a larger percentage of the budget).

Nevertheless, in the past 10 years, healthcare costs in Saskatchewan have more than doubled and there appears to be no end to the increase in this healthcare spending frenzy (Lemstra, 2011). The consensus of public opinion is also that escalating costs simply cannot keep pace with the needs of public healthcare (Brown, 2010; Health Council of Canada, 2010; Jackson, Zagon, Jenkins, & Peters, 2002, Lewis et al., 2001). Exacerbating the problem of escalating healthcare costs is the fact that health outcomes have not seen an improvement; in fact, it seems the more we spend, the poorer our results (Cherian, 2011; Health Council of Canada, 2009; The Conference Board of Canada, 2004; see Drummond, Giroux, Pigott, & Stephenson, 2012 for an Ontario example). This may not be too surprising when one realizes that an extremely small portion of health outcomes are influenced by healthcare; only 10 percent of premature deaths are related to healthcare according to a study in the New England Journal of Medicine (Schroeder, 2007; see also Meili, 2012). Furthermore, the corporate media is quick to draw attention to discontent around poor service, long wait lists, and inefficiencies whether in administration or healthcare delivery (Picard, 2010; see Leys, 2003, for a United Kingdom example). And, as Hayes et al. (2007) pointed out, even when the media presents health stories through a socioeconomic lens, the broad determinants of health – poverty, employment, education, housing, etc. – which involve fundamental aspects of social policy and the welfare state, are rarely discussed. In this way, the mainstream media act as a hegemonic force,

portraying one side of an issue as accepted truth or even natural while another side is ignored or treated as irrelevant or unimportant (Orlowski, 2011).

Recent opinion polls have suggested that public faith in the Canadian healthcare system has been in decline (Bakvis & Skogstad, 2002). Lewis et al. (2001, p. 928) stated that "the real battle is for the hearts and minds of those sympathetic to Medicare's principles but less convinced than ever of its viability." While disenchantment with Medicare is understandable given concern about rising costs and timely access to services, what is harder to reconcile is that solutions are so often presented as needing to come from *outside* of the public system. Although costs are soaring and inefficiencies need to be addressed, why are solutions so rarely discussed as coming from *within* the public system? The highest costs in healthcare are surgeries, diagnostics, and specialist services, while capital and drugs are the fastest growing expenses (Constant, Petersen, Mallory, & Major, 2011; Evans, 2007; see Morgan & Cunningham, 2011 for a discussion regarding British Columbia). Some of these expenses, like pharmaceuticals, are not even public sector costs, and furthermore, it is difficult to imagine how these costs will be reduced through greater privatization.[1] The raison d'etre of private companies is to increase revenues and return profit to shareholders; a fundamental principle which is at odds with keeping costs down for the general public (Angell, 2008; Woolhandler & Himmelstein, 2007).

In addition to a wide variety of problems with privatized healthcare, many authors have analyzed its cost efficiencies and found them to be specious (Angell, 2008; Armstrong, 2000; Armstrong & Armstrong, 1996; Boffey, 2012; Deber, 2002; Dutt & Meili, 2011; Evans, 2007; Flood & Lewis, 2005; Howlett et al., 2010; Hurley, Vaithianathana, Crossley, & Cobb-Clark, 2002; Leys, 2003; Martin & Dhalla, 2010; Nelson, 2010; Romanow, 2002; Simard, 2012; Terris,

[1] Ironically perhaps, this is one area where Saskatchewan Premier Brad Wall has advocated for more healthcare cost savings through government bulk-buying (Couture, 2013).

1999; Tuohy, Flood, & Stabile, 2004; Woolhandler & Himmelstein, 1991; see Donnelly & Ball, 2009 for an example from Great Britain; see Siemiatycki & Farooqi, 2012; Vining & Boardman, 2012 for examples specific to public private partnerships). Saskatchewan's current premier, Brad Wall, has stated lofty goals for healthcare: elimination of wait times for emergency rooms, reduction of wait times for surgery and diagnostics, and increasing access to specialists (Canadian Press, 2012; Fitzpatrick, 2012; Government of Saskatchewan, 2010, 2012; Saskatchewan Party, 2011). The problem is that none of these measures has *better health outcomes* as its focus. They are all *process* goals which may (but more than likely will not) increase the health of Saskatchewan citizens (Cherian, 2011).

2.2 Healthcare: Private Commodity or Public Good?

At a deeper, philosophical level, the debate about public versus private healthcare involves the very nature of what kind of a service heath care should be. Is it a typical market commodity to be provided by the private sector at rates and costs that consumers will endure? Or is it a public good to be provided to all citizens, regardless of ability to pay. Is it a restriction against freedom of choice or a fundamental human right? In a very practical sense, healthcare cannot be a typical market commodity. Sick patients are not typical consumers in position to shop for the most economic and high-quality supplier, health outcomes (the 'product') are difficult to measure, and ill people increase profits, thus there is no incentive for 'sellers' to improve anyone's health (Woolhandler & Himmelstein, 2007). In healthcare, 'Roemer's law' is at work, flipping capitalist market principles on their head: supply dictates demand (Armstrong, 2000). As Brill (2013) described, the marketplace for healthcare is a "crapshoot" (The Way Out Of the Sinkhole, para. 15); people are "powerless buyers" (1. Routine Care, Unforgettable Bills, para. 20) with all advantages in sellers' hands.

So, although healthcare does not seem to be a good candidate for typical privatized markets, this is one of the areas where Canadian values can conflict - the socially responsible idea of caring for those in need versus the right for individuals to use their own money as they see fit (Mendelsohn, 2002; Vail, 2001). In fact, as Orlowski (2011) described, since modernity there has been a tension between individual freedoms and the social good. Armstrong & Armstrong (1996) argued that private sector solutions are promoted, not only as a way of increasing efficiency and reducing costs, but also as a way of giving consumers more choice and control in their healthcare decisions (this is consistent with neoliberal discourse which will be discussed below). Regina Saskatchewan's Leader-Post financial editor Bruce Johnstone (2012) recently made the point that, given Prime Minister Harper's penchant for advocating economic rights and freedoms wherever possible, there is nothing to stop the federal government from viewing healthcare in a similar fashion; i.e. that Canadians should have the right to choose how and where to get their healthcare insurance.

In an example of how these conflicting values have recently played out in legal circles, in 2005 the Supreme Court of Canada struck down Quebec laws prohibiting the sale of private health insurance on the basis that they violate the Quebec Charter of Human Rights and Freedoms (Judgments of the Supreme Court of Canada, 2005). Three dissenters on the Supreme Court found no violation of the Quebec Charter (or the Canadian Charter of Rights and Freedoms) showing just how much these matters can be contentious and up for interpretation. This is indeed no small matter as the constitutionality of laws protecting the public healthcare system may be seen by some, including a majority on the Supreme Court in the Chaoulli decision, as contravening basic human rights guaranteed by the Canadian Charter (Flood & Lewis, 2005). In other words, some would argue that the Canada Health Act has the potential to

violate the Canadian Charter of Rights and Freedoms. This is a legal opening that the private sector can possibly use to gain entry into the healthcare system.

Should economic profit be part of our health system and, if so, who should benefit? Neoliberal proponents support this idea as markets are believed to be the optimal way of reconciling costs and efficiencies with the desires of the population. In fact some authors (Alvarado et al., 2008; Armstrong & Armstrong, 1996; Leys, 2003; Livingston & Capps, 2010; Muntaner et al., 2006) have claimed the transformation of healthcare from a social right to a market commodity has already occurred in some countries. This philosophy also strongly suggests that individuals are responsible for their actions and should be accountable for insuring their own protection from ill health, in addition to following behaviours that ensure optimal health (Orsini, 2007; Taylor-Gooby, 1994). This is where a specific area of healthcare – health insurance – unfolds very differently depending on one's viewpoint. Neoliberal philosophy aligns with the idea of *private* insurance whereby individuals, responsible for their own health, assume the risks and protect themselves appropriately. Conversely, a progressive or social democratic ideology frames healthcare in a much different light: It is seen as a social good and, therefore, not something which should be subject to private business models (Orlowski, 2011). Healthcare is something government must provide for all its citizens – i.e. *public* insurance, for their individual health as well as the overall health of society. Although there may be personal behavioural factors involved in ill health, disease and illness are largely unplanned events in a person's life. So, unlike many market commodities, healthcare service consumption can be necessary, and extremely expensive. Furthermore, ill health is not distributed equally, or one might argue, fairly, throughout society. With this progressive model it makes sense to pool resources and share the risks involved in ill health.

When people decide whether healthcare should be treated as a typical market commodity or a public service good, two more factors may play an important role: What is the ultimate cause of ill health? And how responsible should people be for these causes? While behavioral factors like smoking, physical inactivity, obesity, poor diet, and excessive alcohol consumption are the main causes of poor health, the primary predictors of these behaviours are socioeconomic, especially low income (Canadian Medical Association, 2013; Haight, 2012; Health Disparities Task Group, 2004; Lemstra & Neudorf, 2008; Manuel, et al., 2012, Meili, 2012). The Conference Board of Canada (2013, February, p. 4) recognized that "many of the socio-economic factors that shape health outcomes are beyond direct, individual control." It seems obvious that if we want to improve health outcomes, our first priority should be to address poverty. However, a progressive view of poverty is very different from a neoliberal view. If we take as our starting point that poverty is the number one cause of ill health, a progressive outlook would see government as having a role in helping those who fall between the cracks of a typical capitalist market (Arts & Gelissen, 2001). Due to overt (but in many cases covert and systemic) discrimination, equal opportunities for everyone do not exist in the real world, and poverty can result without personal fault (Wise, 2012). Conversely, neoliberalism promotes the idea that equal opportunities do exist and it is, therefore, the individual's responsibility to utilize those opportunities (James, 2007; Saint-Martin, 2007). If any intervention on behalf of the government is required, it is simply to ensure everyone has equal access into the market system (whatever limited sense that might mean to proponents). Again, the difference is a progressive policy of protecting people *from* the market compared to a neoliberal one of integrating them *into* the market (Saint-Martin, 2007). Neoliberals may acknowledge that there are legitimate and acceptable reasons why someone cannot participate in the market economy – for example a

physical limitation with a genetic component - but for the most part, poverty is thought to be self-induced (Zucker & Weiner, 1993). How people frame the ultimate causes of poverty is crucial in their formation of attitudes about healthcare.

2.3 Determinants of Health

While much evidence exists regarding the significance of socioeconomic factors responsible for poor health outcomes - recognized by the Ottawa Charter for Health Promotion (World Health Organization, 1986) and the Public Health Agency of Canada (1999) - it is very revealing that mainstream media and governments do not express much interest in discussing this fact (Brown, 2010; Canadian Institute for Health Information, 2005; Grabb, 2007; Hayes et al., 2007; Raphael, 2011). One does not have to be a conspiracy theorist to question this seemingly intentional omission – as Orlowski (2011) explained, media can be just as significant a hegemonic force by what it neglects covering. While there has been much discussion about the 'crisis' in Canadian healthcare, the solutions presented rarely aim at addressing socioeconomic determinants of health. On the contrary, since the 1970s there has been a definite focus on personal lifestyle and behavioural causes of ill health (Armstrong & Armstrong, 1996; Brown, 2010; Raphael, 2002, 2011; Robertson, 1998). This focus on lifestyle and personal responsibility, to the exclusion of socioeconomic factors like unequal wealth distribution, poor housing, and malnourishment, conveniently coincides with the strong neoliberal undercurrent which has dominated such discussions since the 1980s. This diversionary tactic shifts the focus away from where it should be – addressing the fundamental, structural social and economic factors which underlie the majority of poor health outcomes (Raphael, 2002). Michael Orsini (2008, p. 340) used an example from the Asthma Society of Canada to illustrate how "hyper individuality" is used to shift health discourse from societal factors to personal responsibility, under the pretext of patient "empowerment." While the media and governments focus on long

wait lists (Angell, 2008) and inadequate service delivery, a conversation about the ultimate problems associated with ill health, at least at the fundamental level, are not being discussed. As a result, the population has a false sense of the true causes of ill health, as well as the solutions to problems with the healthcare system (Hayes et al., 2007; Raphael, 2011). If ill health is a result of personal behaviour, the solution lies with the individual taking responsibility and changing her behaviour. If ill health is the result of socioeconomic conditions, the solution lies in reducing economic and social inequality (Brown, 2010).

2.4 Government Influence

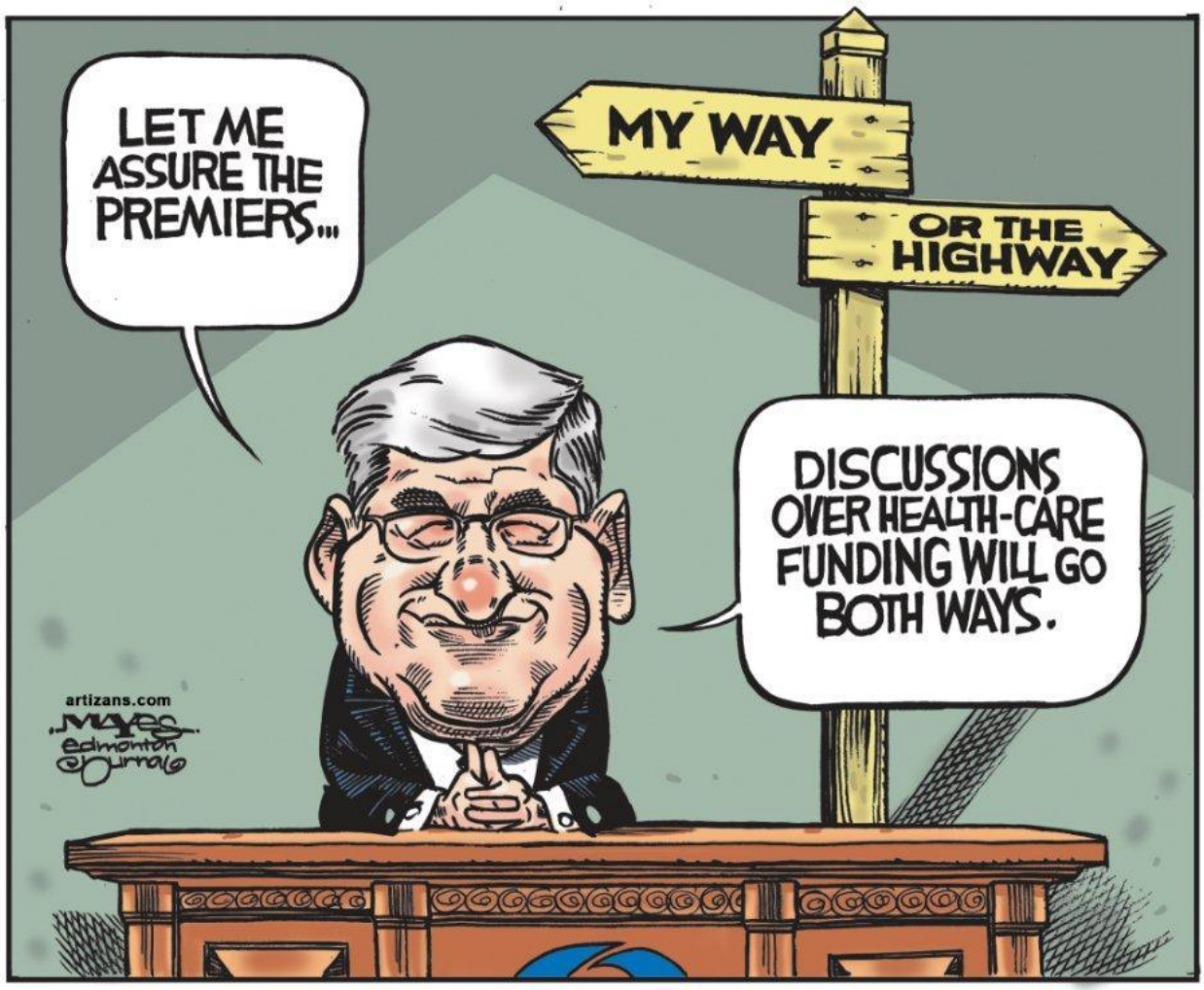
Governments can have considerable influence over public healthcare discourse through their actions and words. One of the primary reasons for my research is that it is vital to understand the connection between public perception of healthcare and the nature of the dialogue in the public sphere. As Brown (2010, p. 219) states:

> The recognition of justice as highly sensitive to context suggests public perceptions of justice may be intentionally or inadvertently manipulated by the way social issues are framed in government announcements and in media messages.

Berdahl & McGrane (2013) illustrated this effect in discussing labour unions in Saskatchewan. How unions are portrayed and represented in the media can have a large impact on how the public views them: "The more unions are framed as being self-interested and a 'special interest group,' the more unsympathetic the public may be to their cause" (Berdahl & McGrane, 2013, para. 14). Before he became Canada's Prime Minister, Stephen Harper described his general policy approach as "open federalism" in 2004. He espoused "respect for the division of powers between the federal and provincial governments … fully respecting the *exclusive jurisdiction of the provinces* [emphasis mine] (Harper, 2004, para. 3). Harmes (2007) argued that this policy of

open federalism is very business-friendly and part of the neoliberal agenda. In any event, it certainly is not something defenders of Medicare want to hear.

A practical example of the strategy described above is in the recent federal Conservative government's no-strings-attached policy regarding the proposed 2014 Health Accord (The Council of Canadians, 2011). The Harper government has been very clear that it wants to provide a limited amount of funding (increases of six per cent annually until the 2016-17 fiscal year followed by annual increases tied to the nominal GDP, with a minimum of three percent) while leaving healthcare decisions, which may or may not involve adding private sector components, up to the provinces (Bakvis & Skogstad, 2002; Canadian Doctors for Medicare, 2011; Kennedy, 2012a; Picard, 2011; Silver, 2010; Simpson, 2011). While this may seem a welcomed change for some, it most certainly deviates from federal governments of the past who have intervened based on their role as protector of the Canada Health Act, especially under the 'equal access' provision (Alphonso, 2010; Bakvis & Skogstad, 2002). Another manifestation of this kind of passive privatization occurs when services formerly covered by the public system are discontinued and, therefore, must be paid for privately.



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Providing a 'cash-crunch' argument with a 'service inadequacy' problem gives an opening to neoliberal solutions and can also significantly influence policies related to healthcare. Since the early 1990s Canadian governments have focused on deficit and debt reduction and/or elimination (Armstrong, 2000). As a result, there has been a recent flurry of 'austerity' budgets, including the Canadian federal and Saskatchewan provincial budgets in 2012. Austerity measures, however, seem to have their greatest impact on the working and middle classes while the wealthy remain virtually untouched; Spain and Greece offer good examples of this in Europe;

Wisconsin, United States closer to home (Carter, 2012; Tremlett, 2013). Some have argued that governments create artificial crises in order to build a case for, and implement, neoliberal policies like privatization of the commons (Harrison, 2008; Ontario Health Coalition, 2011; Stanford, 2012; see Jasso-Aguilar et al., 2004 for an example in Mexico; see Klein, 2007 for the use of crisis to privatize war; see Orlowski, 2011, chapter 9, for an example in the Canadian education system). And Livingston (1998) pointed to subtle ways governments can move toward privatization, like decentralization of powers – Saskatchewan's local and district health boards for instance (see Armstrong, 2000 for an Alberta example). Another example is through the strategies of deinstitutionalization and dehospitalization – shifting home care costs to individuals and families (Armstrong & Armstrong, 1996; Spray, 2013; Terris, 1999).

For a more direct illustration of government policy leading to privatization solutions, the neoliberal Brad Wall-led Saskatchewan government has focused the discussion about improving healthcare toward surgical waiting lists and access to specialist care. The Saskatchewan government has offloaded excess surgical procedures to private companies with the goal toward reducing wait times (Government of Saskatchewan, 2010). Our western neighbour Alberta used a similar rationale for shifting cataract surgery to the private sector (Armstrong, 2000). The federal non-interventionist approach combined with Wall's focus on service delivery highlight the importance of the private versus public debate around healthcare. If provinces are on their own to make healthcare service decisions, there is little, outside of public opinion, to prevent them from introducing more and more private market elements into the healthcare system (likely something the Harper government would welcome). Provinces can already determine this simply by deciding which services are covered publicly and which are not.

Former Saskatchewan NDP finance minister Janice MacKinnon has been sending similar messages to the public when discussing healthcare. While claiming she is advocating for the preservation of the public nature of the system, many of MacKinnon's ideas are more consistent with a move away from the tenets of the Canada Health Act. She has claimed that her conceptualization of user fees circumvents problems typically associated with them (MacKinnon, 2013). However, her idea of collecting fees on income tax as opposed to at the time of service is a semantic difference; people still pay more for healthcare based on their use of the system (granted Mackinnon does advocate for those who can afford to pay more, doing so) (MacKinnon, 2013). MacKinnon discussed the "fiscal squeeze" (MacKinnon, 2013, p. 2) approaching due to an aging baby boomer generation. This is another aspect of the 'crisis' of Medicare promoted by governments and media. However, many analysts argue that an aging population adds very little to additional healthcare costs (Evans, McGrail, Morgan, Barer, & Hertzman, 2001; Reinhardt, 2003; Skrapek, 2013). This is yet another misleading argument for the need for privatization. Finally, MacKinnon has advocated in favour of private health clinics for certain procedures due to affordability and effectiveness (MacKinnon, 2013). Individuals paying proportionally for their use of the healthcare system and the promotion of private health clinics from a former NDP finance minister? A shift in political ideology certainly seems evident in the party that first implemented universal public healthcare.

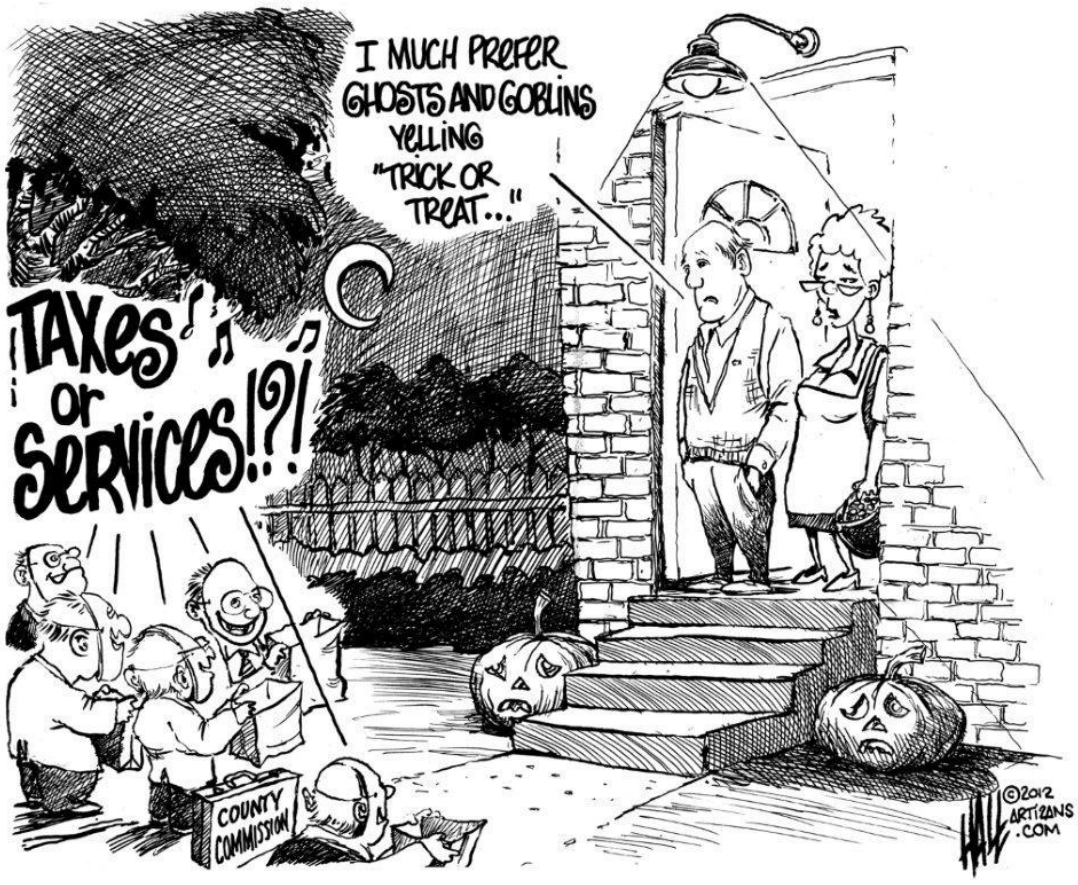
Of course there are a number of ways to address the current 'crisis' in healthcare in Canada. The problem is not with the discussion about privatization, it is a lack of other equally legitimate options. For instance, we could look to places like Cuba and Venezuela as examples of equal or better health outcomes at much lower cost (Alvarado et al., 2008; Brouwer, 2011; Cooper, Kennelly, & Orduñez-Garcia, 2006; World Health Organization, 2009). Their solutions

focus on prevention, health promotion, socioeconomic factors, and community models of healthcare. Venezuela's health reforms of the early 21st century were the result of a backlash against neoliberal privatization of healthcare in the late 1980s and 1990s (Alvarado et al., 2008; Muntaner, Salazar, Rueda, & Armada, 2006). Venezuelan President Hugo Chávez's constitutional reform of 1999 guaranteed many social rights to Venezuelans, including healthcare. Much like the principles of the Canada Health Act, the state became the guarantor of healthcare for the people.

We could also ask more nuanced and challenging questions. Is healthcare delivery service addressing health issues in an optimal way? Should current healthcare dollars be reassigned to address deficiencies in other healthcare-determinant areas like education, employment, housing, and food security? Are solutions available while continuing to maintain a fully publicly funded and administered system and, if so, what are those solutions? More and more the public is presented with an oversimplified option: We have a publicly funded healthcare system which is becoming too expensive; so is the private sector able to provide equal or better services than we currently have? What if these services have little to do with better health outcomes? The dialogue's limited focus not only ignores addressing more fundamental problems with the current system, but presents a dichotomy which has a natural and inevitable conclusion.

Governments must balance the demand for social program spending with limited resources. However, neoliberal discourse frames this dilemma in a particularly narrow way; the strategy is to present the public with the option of government reducing its expenditures or increasing taxes (Taylor-Gooby, 1994; Dodge & Dion, 2011). This strategy allows governments to indirectly move the solutions it wants to the forefront without rational, informed public

debates. Even the focus on individual responsibility for health has an economic component in that neoliberal governments can use it, combined with austerity policies, to cut costs and help solve the problem of escalating expenditures (Pederson, O'Neill, & Rootman, 1994, as cited in Brown, 2010). Occasionally, the neoliberal solution to problems of public policy do not even consider increasing taxes at all; there is but one option and that is an austerity budget with heavy cuts to social program spending. A recent example of this was seen in Ontario Liberal Premiere Dalton McGuinty's instructions to the Drummond Commission (McQuaig, 2012; Weir, 2012) that was tasked with finding solutions for Ontario's large deficit (Foster, 2012). The option was not whether or not to cut spending but only *where* to cut it.



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Some have argued that the extensive tax cuts we have seen in recent years have created the 'crisis' which apparently needs private sector solutions; reduction in government revenues (from the cuts) lead to reduction in social program spending (like healthcare) which lead to poor performance and a critique that the current system is not working (Armstrong & Armstrong, 1996; Bakvis & Skogstad, 2002; Livingston, 1998; Muntaner et al., 2006; Orlowski, 2011; Terris, 1999; see Leys, 2003, for a United Kingdom example). In terms of healthcare, an inadequately performing system is then framed as a problem with *publicly funded* care so the solution is to introduce privatization to correct for inadequacies and inefficiencies. Thus governments can intentionally or inadvertently direct a problem like healthcare funding toward a specific solution like privatization. It can also be argued that issues like long waiting lists are manufactured, or at least overblown, by governments and mainstream media as an avenue for privatization and, furthermore, that private clinics do not alleviate these problems in the public system anyway (Armstrong, 2000). In any case, public opinion may not be fully aware of other possible solutions, and neoliberal governments (and the corporations they support) benefit since they rely on consensus of their beliefs and policies for their existence in power.

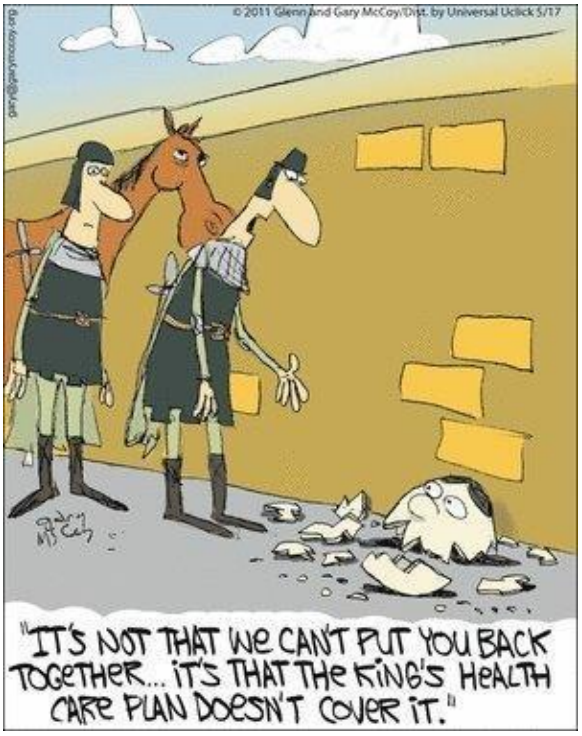
2.5 Neoliberalism's Influence

Over the past three decades or so neoliberalism has become a hegemonic philosophy in much of the Western world (Leys, 2003; Orlowski, 2011), including Canada (Flood & Lewis, 2005). It would be hard to imagine this not influencing how Canadians think about issues like healthcare. Ideals central to neoliberalism – unquestioned supremacy (and goodness) of free markets, individual responsibility, efficiency and effectiveness of private enterprise, small government, deregulation, privatization of the commons, and open global markets – are not compatible with universal healthcare and the principles of the Canada Health Act (Mickleburgh, 2010; Orlowski, 2011). The exact meaning of the five principles – public administration,

comprehensiveness, universality, portability, and accessibility – depends on a certain amount of interpretation (see Brad Wall's comments in Fitzpatrick, 2012). For example, it is up to the provinces to decide which services qualify as "insured health services" ("Department of Justice," 1985), and phrases like "reasonable access" ("Health Canada," 2012) are somewhat ambiguous. Nevertheless, the very notion of a publicly funded and administered healthcare system does not fit well with neoliberalism, which frames problems of social policy as having private market solutions. These solutions are often accompanied by promises of less government 'interference' in the economy and lower taxes – notions which have great appeal to masses that see plenty of government waste and abuse of their 'hard earned money.' However, again, this solution comes about from a false dichotomy of higher taxes *or* cuts to social services spending, when issues like healthcare are much more complex (Armstrong & Armstrong, 1996). And, of course, eliminating large tax breaks to corporations or the wealthy are not as readily offered up as alternatives. It should also be noted that societies which have smaller gaps between the wealthy and the poor have better health outcomes than those which do not (the neoliberal policies of Canada have been moving it toward the latter) (Black & MacKinnon, 2011; Canadian Medical Association, 2013; Kawachi & Kennedy, 1999; Meili, 2012; Wilkinson, 1994). A recent poll by the Broadbent Institute (2012) showed that over two thirds of Canadians were concerned that the widening income gap could lead to the erosion of public healthcare (see also Brown, 2010).

People's opinions about healthcare are heavily shaped by notions of responsibility. Arts & Gelissen (2001) argued that the governmental regime people live under can significantly influence peoples' notions of solidarity and justice principles. As I alluded to earlier, neoliberalism promotes the idea that society provides equal opportunities and choices for its citizens and it is their responsibility to ensure their own success (or, in terms of our discussion,

health). In contrast, a socially progressive ideology understands that there are myriad reasons why some succeed while others do not and it is up to governments (in other words society as a whole) to help out those who fare poorly (encounter poor health outcomes). Not only do structural barriers, overt and covert, exist to prevent everyone from having equal opportunities in society, these obstacles are often supported by government policies (Wise, 2012). For example, dental care, despite its importance in people's health, is not deemed 'medically necessary' according to the Canada Health Act (Madore, 2005). Thus, those without alternate private healthcare plans must find ways to cover these costs themselves. Another marginalized group facing institutional obstacles is refugees. In June, 2012 the Federal government announced significant changes to the Interim Federal Health (IFH) program which significantly limited and restricted access to medical coverage for Canadian refugees (Jones, 2013). Therefore, it behooves governments in power to recognize inequity of opportunities and provide assistance for those unsuccessful in the not-always-fair game of life.



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If people are framing healthcare issues as more of a personal responsibility matter than they may have during the Depression for example, is this part of a neoliberal trend in the social psyche? Taylor-Gooby (1994, p. 81) maintained that "arguments which stress ideas of individual responsibility and obligation may serve to legitimate the withdrawal of state responsibility." Just how deep does this emphasis on personal responsibility go? How much control do individuals have over health outcomes? Put another way, how much blame should they shoulder? Blaming the victim discourse is compatible, and useful, within the neoliberal paradigm.

Research has shown that people attribute more anger and less sympathy toward victims of ill health if they see their condition as a result of factors they are perceived to be in control of, and thus responsible for (Brown, 2010; Seacat, Hirschman, & Mickelson, 2007). This is no doubt supported and exacerbated by the myth of meritocracy so prevalent in the colonial North

American narrative (Orlowski, 2011; Wise, 2012). This narrative provides fertile soil for the weeds of blame discourse, which feeds the neoliberal agenda. Simply put, if everyone has equal opportunity and ability, it must be the individuals' fault, via behavioural choices, for their own ill health (at least for the most part – I believe most economic conservative thinkers would still ascribe very little blame to those who are ill via heredity or getting cancer from asbestos for example). As Wise (2009, p. 107) explains:

> If we are taught - and we are, most all of us, irrespective of race or economic status – that anyone can make it if they try hard enough, then isn't it to be expected that those who haven't 'made it' will come to be viewed as especially damaged, and as the source or their own sorry station in life?

This has direct implications for perceptions about healthcare as people who attributed more blame to the victim had fewer propensities to want to help them out (Brown, 2010). Brown (2010) studied how people's subjective assessment of deservingness influenced their preference for allocation of healthcare assistance. She concluded that as perception of controllability of illness increases, so does attributed responsibility and blame. This, in turn, causes sympathy to decrease, anger to increase, and deservingness for public help to decrease, along with the amount of public funding allocated to the claimant. Furthermore, social attitudes and biases significantly influence blame judgments: Social conservatives are more likely to attribute blame to people for their predicament and, therefore, are less likely to advocate providing assistance than social progressives (Brown, 2010; Lakoff, 2004; Mantler, Schellenberg, & Page, 2003; Skitka & Tetlock, 1993; Zucker & Weiner, 1993).

Applying Salter's (2007) model for describing problems and solutions in terms of targets versus sources, do people think of health in terms of the target - the ill individual who is responsible for their condition which requires a biomedical intervention. Or do people instead think of health in terms of the source - the fundamental cause of ill health as being

socioeconomic with solutions found in economic and social policy and government intervention (Brown, 2010)? Furthermore, should healthcare service emphasis be on an equity-based system of entitlement for particular individuals or on universal social equality? The answers to these questions will shed light on how people resolve who should be covered by our healthcare system and how such services should be delivered. Ideology is closely tied to people's perceptions of justice, which is subsequently tied to their feelings about social policies like healthcare. It is very important to understand whether people's opinions are formed by rational, evidence-based information or an ideological bent that promotes a certain type of social policy over others.

An additional consideration is the issue of legitimacy of dependence on government-provided healthcare. Some may argue that a system like Medicare fosters a sense of entitlement and overuse (see Brown, 2010). Combined with notions of responsibility, this creates some very important questions around healthcare. For example, do people believe healthcare should be provided based on the degree of medical need? Or, should decisions be contingent on level of personal responsibility (Brown, 2010; Picard, 2008)? Also, if we believe in Medicare, just what services should be included as necessary in our healthcare system? As Taylor-Gooby (1994, p. 81) illustrated, neoliberalism's stress on individualism and responsibility results in a discussion about what is "legitimate and illegitimate dependency." This leads to a need for criteria to determine who deserves help and who does not (James, 2007; Orsini, 2007). According to Lakoff (2004), conservatives believe that the poor do not deserve help as they are seen as responsible for their predicament due to lack of discipline and diligence. A recent Salvation Army report (2011) revealed that about one quarter of Canadians believed people are poor due to laziness and lower than average moral values. What often seems to be missing in these discussions is the unequal playing field of the free market – something that was ever-present in

the progressive sensibilities arising out of the Depression.[2] In regard to healthcare, this emphasis may also influence how people feel about which services are offered, who should pay for them, and who should receive them. My research attempted to unearth some answers to these questions, at least in the minds of a select group of people – working-class people in Saskatchewan.

While some authors like Wright (2008) and Johnston (1987) stated that social class remains a significant and powerful aspect of peoples' lives, the strong economic class identity and solidarity which was evident from the Depression through the post-War period seems to have waned in recent decades, with new patterns of organization - gender, ethnicity, religion, and region - emerging (Escudero, 2009; Frank, 2004a; Fraser, 1998; James, 2007; Saint-Martin, 2007; Taylor-Gooby, 1994). Miriam Smith (2008) described this as pluralism, whereby individuals have many different interests and form groups depending on context and importance at the time. While there may be many reasons for this, it is likely that the emergence of neoliberalism as a dominant force exacerbated the waning of economic class consciousness.[3] Organized, collective group action based on economic class is anathema to individualism, consumerism, and unfettered markets, and neoliberal governments' sympathies lie with the markets (Camfield, 2008; Orlowski, 2011; Weis, 2008). While some groups have made gains, socially and economically, in recent decades – women and lesbian, gay, bisexual, and transgendered to name a few – these groups are not disruptive and challenging to the dominant economic market system in the same way that organized labour unions have been.

[2] In fact, at least in terms of the United States, Wise (2012) pointed out that history is full of this recognition, and the subsequent support for government interventions which helped even out the playing field.
[3] It is important to note that some (Walker, 2002) have described a waning class consciousness post World War II when working classes began to receive decent wages and see themselves more as middle-class consumers.

Fraser (1998) described two different types of justice: political-economic and cultural-social. Neoliberalism benefits when the focus is on cultural-social injustice. Correcting for this may simply be a matter of recognition of the suffering group (as an example, legalized gay marriage), which may be considered symbolic (this can create the seemingly paradoxical person who is socially progressive yet economically conservative, referred to in Chapter One). Conversely, when the focus is on political-economic injustice, the solution needs to be redistribution and quite possibly a restructuring of the economic system (Fraser, 1998). The decreased enthusiasm for a unified class consciousness has been accompanied by decreased public support for organized labour and interventionist government (Taylor-Gooby, 1994; Frank, 2004a). Robertson (1998) agreed that neoliberalism has heavily influenced public discourse and provided the rationale for the rapid retreat of the welfare state (see also Jasso-Aguilar et al., 2004; Orsini, 2007). A shift from larger class identities to smaller group allegiances, as well as neoliberalism's emphasis on individualism, may have a significant impact on how people view the healthcare system. I will investigate whether these undercurrents are at work in how people perceive the Canadian healthcare system.

2.6 False Political Consciousness and Healthcare

If the class consciousness of the past has been supplanted, what is the nature of the rationale that has led to this shift? Thomas Frank (2004a, 2004b) and others (Gramsci, 1971; Orlowski, 2011; Smith, 2008; Wise, 2012) have described a false political consciousness within the working class (Frank and Wise discussed the situation in the United States but parallels in Canada are easy enough to see). Politicians, with the assistance of the media, have sold the working class a false package of hopes in two ways. First, they have brought hot button social issues to the forefront to distract from the economic injustices that have been created – "cultural anger is marshaled to achieve economic ends" (Frank, 2004b, p. 5). In fact, this is a way of

binding social conservatism to economic neoliberal policy (Orlowski, 2011) that has given birth to the extremism of the Tea Party movement in the United States. This is how economic class solidarity can be broken down by cultural distractions that serve to create alternative allegiances and obfuscate issues. Second, despite an ever growing gap between the wealthiest and poorest, many with less have been led to believe that they have a realistic shot at ascending into the top one percent. Many believe this to such an extent that they will endorse tax cuts for the wealthy while getting no such relief themselves (Frank, 2004b, 2012; Wise, 2012). The free market's status has become so sacrosanct that to suggest alternatives usually results in a scornful rebuke (Frank, 2012).

Just as false political consciousness does not allow one to clearly see alternative economic options, it can cloud social issues as well - healthcare is quite complex as it has significant economic and social components. Evans (2007, p. 30) described the neoliberal agenda and mainstream media complicity as "a political wolf dressed in phony economic clothing to deceive the sheep." Lakoff (2004) contended that politicians use linguistic framing to influence the public. One of his examples is the conservative use of the phrase tax *relief* implying that taxes are a foul burden as opposed to an investment in people's futures (Lakoff, 2004). The same could be said of language commonly used to describe healthcare in Canada: *waiting* lists, *crisis*, fiscally *unsustainable*, and *unaffordable*. In other words, by bombarding the public with claims that Medicare is economically unsustainable, the neoliberal policy of privatizing the commons gets little resistance from the very people who say they highly value public healthcare and even benefit from the current system. Furthermore, an unawareness of alternative views may be responsible for the pervading tendency to focus on the behavioural or lifestyle aspects of health (Brown, 2010). This is precisely what is accomplished by the

simplistic, dualistic arguments around private versus public healthcare (Flood & Lewis, 2005). Foster (2012) described how this looks in terms of Ontario:

> But the overall framing of the issue [how to solve problems in the healthcare system], especially as it's trickled out through the mainstream media, serves those who can afford the increasing individualization of once-collectivized expenses, and who are free to rake in the rewards of historically low taxes while the rest of us have our backs turned to ponder the merit and value of a litany of public services. (Who Benefits?, para. 4).

Mainstream media bombards the public with discourse promoting the necessity of corporate tax cuts while demonizing unions and governmental social programs. Citizens who hear this message frequently may very well internalize it and champion economic policy that is detrimental to their personal welfare.

Recent voting patterns in Saskatchewan may also reveal that false political consciousness is at work in the province. As previously mentioned, the 2011 provincial election saw a whopping 64 percent of voters choose the right-wing Saskatchewan Party. However, a recent study from the Johnson-Shoyama Graduate School of Public Policy (Atkinson et al., 2012) showed that the majority of Saskatchewan residents valued social democratic principles that are more in line with the parties more to the left ideologically – specifically on issues pertaining to Crown Corporation privatization and wealth distribution. Especially intriguing is the fact that out of voters who voted for the Saskatchewan Party, 47.2 percent disagreed with any Crown privatization, over half (55.4 percent) believed more should be done to reduce the gap between rich and poor, nearly a third (28.6 percent) oppose opening private hospitals, and a quarter (25.1 percent) actually believed in *more* government intervention in the economy. While there are many reasons why people vote for certain parties, it does seem paradoxical that the representation of right-wing ideology in Saskatchewan government does not match well with voter beliefs on such fundamental issues. Again, the role of the corporate media may be a factor.

People's lives are embedded in social relations but the groups with which they identify are fluid, context-dependent, and shift with time; ethnicity, gender, economic class, region, religion, and occupation may all play varying roles. Furthermore, people's identities and social realities can be significantly influenced by government policy as well as discourses promoted by governments and media (Salter, 2007). How healthcare is framed, discussed, and defined is influential, if not essential. If the dialogue is focused on a simplistic dichotomy of private versus public, other options will not see the light of day. As Salter (2007, p. 315) so succinctly stated, "Particular constructions of problems both enable and necessitate specific solutions." Therefore, false political consciousness can lead people into identifying and aligning with groups and policies which do not necessarily best serve their, and society's, interests (Hopkins, Kahani-Hopkins, & Reicher, 2006; Orlowski, 2011). By helping to create 'false' social relationships and groupings, neoliberal discourse can promote policy that is supported by the masses, even though it benefits a select and lucky few, changing social class from a matter of "material interest" to "cultural authenticity" (Frank, 2004b, p. 259). An example of this is when tax breaks for the wealthy garner support from the working classes who will never see benefits in their own lives. They may align with wealthy Canadians as sharing similar values – for example meritocracy and liberty – while ignoring the very real economic disparities that undermine those very principles.

2.7 Summary

Working-class people have a lot to lose if our healthcare system would ever devolve into a structure similar to what exists in the United States. The idea of equal access for all based on need seems to be in their best interests. Privatizing more of the healthcare system would offer the wealthy in Canada more services and options for less relative cost while those with lower incomes would have to pay relatively more for poorer care (Evans, 2007). Furthermore, working-class people are typically more supportive of government intervention and social

support measures like healthcare than upper classes and corporate interests (Wise, 2012). Two fundamental questions are: Are members of the working class aware of the limits in the current discussions on healthcare? Are they aware that there are a variety of other options for correcting the problems of the healthcare system without resorting to privatization? Despite much evidence that social and economic determinants of health are more important than lifestyle behaviours, or at least that the behaviours responsible for ill health are largely predicted by social and economic determinants of health, a majority of Canadians seem unaware of this fact (Canadian Institute for Health Information, 2005; Ipsos Reid Public Affairs 2012; see Eyles et al., 2001 for an example from Prince Edward Island). Several sources studied by the Canadian Institute for Health Information (2005) indicated that the majority of the public believe individual-level contributors to health are more significant than socioeconomic determinants like income, education, and social support. Whether this delusion is the result of intentional or unintentional misinformation, it contributes to a type of false consciousness in that solutions that seem natural (for example, people should stop smoking) supersede others (for example, reducing poverty) as a priority for healthcare reform. Blame may also be misattributed to individual decisions as opposed to larger social policies and institutions. Individual responsibility for health outcomes fits nicely with the neoliberal agenda. As such, attribution of blame may have very important implications for how people perceive the role of Medicare for Canada's future.

Does the idea of a free market system for healthcare hold some appeal as being in peoples' best interests (i.e. more choices and more freedom)? How are people framing their interests and identities? Politicians in Saskatchewan and Canada need to maintain public support for policies to remain in power. Current governments have given vocal support for Medicare (Health Canada, 2012, May 21; The Saskatchewan Party, 2011), and indeed they must as it still

ranks highly with a vast majority of Canadians on opinion polls (Jedwab, 2012; Marmor, Okma, & Latham, 2002; Nanos Research Poll, 2011). This could change rather abruptly if public sentiment shifts to a desire for more privatization; in fact it could be argued that this is currently happening. Civic commentator Gerry Klein, in discussing the shift of Canadians to conservatism, lamented, "Canadians, like our American cousins, have become preoccupied with taxes and public debt. It is a preoccupation driven by rhetoric and ignorance of context" (Klein, 2011, para. 15). It is crucial that we have a well-informed public, rationally thinking through all options and cognizant of the possible dangers involved in adding more private components to the healthcare system.

The future of healthcare in Canada is one of the most important social and economic issues Canadians face. It is vital that we search for a better understanding of the many social, economic, and political factors which shape how the public view this valuable institution. An important step toward this better understanding is through dialogue with those closely connected to the working-class people of Saskatchewan. In Chapter Three I will discuss in detail the rationale for interviewing labour union representatives and executives, as well as the methodological approach for my study.

CHAPTER THREE:

RESEARCH DESIGN AND METHODOLOGY

I am attempting to better understand the types of influences that shape attitudes and perceptions about the healthcare system in Canada. More specifically, I am interested in working-class people in Saskatchewan and their opinions about universal healthcare, including public versus private components. Since people act on their beliefs, it is pertinent to understand how opinions are formed and what influences and factors are involved. What are the reasons behind the apparent paradox of a public in love with Medicare and highly in favour of the principles of the Canada Health Act while also showing little resistance and protest against the increase of private elements in the system? Does the public believe Medicare is in crisis and, if so, what information do people use in formulating their opinions on how to improve the system? What is ultimately behind people's rationale for deciding who should pay, who should benefit, what services should be covered, and myriad other questions central to our healthcare system?

3.1 Qualitative Approach

To attempt an understanding of these fundamental questions, a qualitative approach is appropriate. Most opinion polls and surveys only scratch the surface of public beliefs in terms of healthcare, and they certainly do not reveal the reasons and rationale underlying those beliefs. Because of this, results can be somewhat superficial or at least tell only a small portion of the story. While it is valuable to get a general feel for the public pulse on important issues like healthcare, these quantitative approaches are insufficient if we desire to uncover core beliefs, values, and motivations. A qualitative inductive and abductive data analysis approach is optimal for illuminating this depth of information – allowing a "privileged access to our basic

experiences of the lived world" (Kvale, 1996, p. 54). Essentially my goal is to make explicit many of the underlying rationales for people's belief systems.

There are certain characteristics of qualitative research particularly germane to my question. Context sensitivity involves understanding how situations and environment influence people (McMillan & Schumacher, 2010). Not only is this of vital concern in understanding my participants' point of view, but these situations and environments may very well help elucidate answers to my research questions. I needed as much detail as possible to fully understand the perspectives of my participants, and a rich narrative description helped to provide that. I believe human action and behavior are highly complex and the only way to study them in their entirety is through a detailed description of peoples' lives and experiences. Only a qualitative research method is capable of providing this detailed description.

This research is descriptive explanatory with a grounded theory approach. I looked for themes and patterns to emerge – those which would help to explain the reasons underlying people's beliefs and values. My interview analysis involved a theoretical interpretation of meanings (i.e. beyond mere description) (Kvale, 1996; McMillan & Schumacher, 2010). I used recent historical events, political movements, and ideological shifts, indicated throughout the literature review, to help ground my study. While this grounding in the past is integral, it is important to note that I was open minded and aware of the fact that new theories may result from a grounded and emergent analysis. This is a constructivist version of grounded theory whereby my experiences and perspectives directed my initial research questions but they did not determine the theoretic results (Charmaz, 2008; McMillan & Schumacher, 2010), nor did they create a hypothesis in need of testing (Glaser & Strauss, 1967). As is consistent with Glaser & Strauss (1967), theories and explanations were derived from the data and then tested through

more analysis of the participant interviews (see also Corbin & Strauss, 1990). My goal is to shed light on the connections of large, complex social phenomena to individual (my 10 participants and, potentially, their membership) working-class Saskatchewan people's beliefs about universal healthcare. Furthermore, in light of the potential contradictions between people's beliefs and actions, as outlined earlier, I used dialectic situating in the interview analysis to discern whether or not this was apparent (Kvale, 1996).

3.2 Participants and Interviews

As the birthplace of socialist governance and Medicare in Canada, Saskatchewan offers an interesting demographic to study in terms of universal healthcare. The Canada Health Act pertains to the entire country, and all provinces and territories receive federal money for healthcare. However, the provinces and territories are largely on their own for how they implement healthcare delivery and interpret the Act. Saskatchewan people share many values with others across Canada, but their regional history is certainly unique. (The same is true of other provinces and territories, as well as regions within those provinces and territories). While my research involves looking for theories to explain why people think the way they do about healthcare, it is important to keep in mind that social values and beliefs can be very grounded by the context in which they live, and therefore they can shift significantly in a relatively short time. A recent Association for Canadian Studies (2012) survey showed that people in Atlantic Canada are more likely than those on the Prairies to empathize with unemployed people and welfare recipients. Jack Jedwab, executive director of the association, surmised that this may be due to the fact that in recent years Saskatchewan has had one of the strongest economies in the country, and therefore are less able to relate to those struggling with unemployment (Abma, 2012). If this is true, given the fragility of economic good times, even in Western industrialized nations, it is illustrative of how populations can have sharp swings in feelings around issues of social

justice, like empathy. Recent voting patterns have also indicated that Saskatchewan is in a unique period of its history making it even more intriguing to study this population.

As mentioned earlier, working-class people likely have the most to lose with a shift from public to private healthcare. This is quite apparent if we look to our southern neighbours where many working-class people simply cannot afford private healthcare insurance (Auerbach & Kellermann, 2011). Even for those who can afford it, exorbitant costs from services not covered can be financially devastating (Brill, 2013; Himmelstein, Thorne, Warren, & Woolhandler, 2009). As such, it is interesting to examine whether working-class Saskatchewan people's beliefs about universal healthcare reflect this reality and, if not, what underlying reasons might exist for the discrepancy. Ultimately, grounded theory participants are chosen based on their ability to contribute to theory development (McMillan & Schumacher, 2010). This is why my sample group consisted of union executives and representatives in Saskatchewan. This is potentially a politically astute group of people, able to articulate opinions of their membership. Thus, this group enhanced my data collection and analysis and was able to speak to my research questions. Because of their position, union executives and representatives were able to not only discuss their own values and beliefs but also, to some extent, those of their members. In addition, they are in a position of potential influence with their members and, as a result, their opinions carry extra significance. Of course a possible weakness of this study is that union representatives and executives might not be completely in touch with attitudes and beliefs of their membership so I have taken a cautious approach when making any generalizations from my interviews. As well, they may not be able to articulate what the working classes in general, such as those not belonging to unions, think about public healthcare.

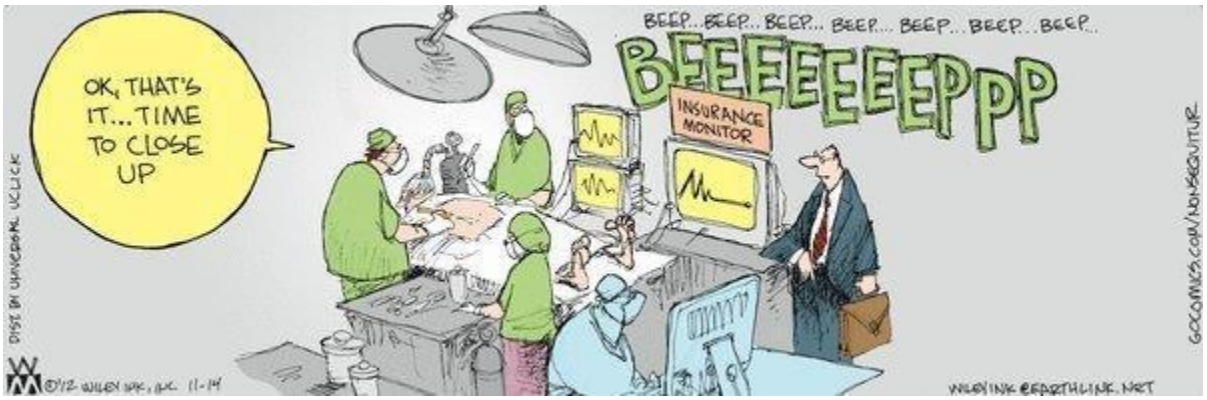

Figure 3.1. Permission from Universal Uclick.

Since there may be a difference between union and non-union members in terms of social democratic attitudes – union members tend to be more left wing on economic issues (Atkinson et al., 2012) - my sample allowed me to better analyze the beliefs of a very specific socioeconomic group. (At the same time I need to be careful with generalizations to all working-class people in Saskatchewan since results from non-union sources may differ). I also chose this sample group as they were likely to be easier to access for requesting interviews. As paradoxical as it sounds, my sampling may be described as a typical, yet unique case type (McMillan & Schumacher, 2010). While my sample group is certainly typical in some respects – working class and Canadian – in other ways, it may offer a unique perspective due to their union status, in addition to Saskatchewan's unique political history and geographic location. My goal was to interview 10 executives and/or representatives in Saskatchewan unions, and this I was able to achieve. The size of the participant group was chosen because it is a large enough sample to try to find connections and common themes yet small enough to be able to go in-depth in an area which often only receives superficial treatment in quantitative studies.

3.3 Interview Question Construction

I used the information in the literature review to ground my survey questions and provide some structure around certain topics and themes while allowing for much flexibility – probing - in case new ideas or concepts developed during the interviews. I began by creating a document of primary themes and concepts that emerged from my literature review – essentially eighteen topics with a description of sub-themes and questions that pertained to each. This helped me to create a logical progression of themes, as well as a systematic approach for addressing my thesis questions. From this I narrowed the topics down to five central themes of questions to answer, with more specific questions under these categories. Finally, I used this document to derive a draft of possible questions to use in my interviews. The five central themes provided the rationale behind the creation of the questions I believed were most important to ask my participants. With this systematic approach I ensured my interview questions would speak directly to my research questions. And to that end, several questions involved asking not only the opinions of the interviewee but also their estimation of how their membership might respond to the same question.

For internal validity, I submitted my thesis themes, questions to answer, and interview questions to the members on my thesis supervision team – Dr. Paul Orlowski and Dr. Janet McVittie – to vet. I revised my interview questions, including prompts, based on their feedback and suggestions. In addition to the goal of ensuring my interview questions directly addressed my thesis research questions, I wanted to create questions that were open ended and non-leading, which are essential features of an emergent research design. To further enhance internal validity, I did a pilot test of my interview questions with two experienced unionized social workers. This proved to be extremely helpful, especially in identifying ambiguities and leading questions. I did

a final revision of my research questions based on the pilot test and feedback from my pilot interviewees (Appendix A).

I would describe my interview questions as primarily "standardized open-ended" with an "informal conversation" component (McMillan & Schumacher, 2010). I agree with Conrad & Schober (2008) who showed that response accuracy is improved by allowing the interviewer to clarify meanings to provide a more consistent interpretation of responses (although their research involved fact-based surveys while mine involved opinion). Assuming that participants automatically have the same interpretation of words and concepts, or not accounting for the fact that they often do not, would certainly discredit the validity of grounded theory results. Thus I used an emergent method relying on adaptability to inductively build on participant responses (Charmaz, 2008; McMillan & Schumacher, 2010). This semi-structured open approach is the best way to fully understand the dynamism of participants' experiences and perspectives (Kvale, 1996).

3.4 Recruitment

Once my research was approved by the Behavioural Research Ethics Board at the University of Saskatchewan, I began the process of recruiting participants. Through several internet searches I compiled a list of slightly over one hundred labour unions and locals in Saskatchewan. From this list, I chose 28 for initial contact. I eliminated any labour unions exclusively pertaining to healthcare (although there were healthcare workers involved in some labour unions involved in the study). My concern related to possible conflict of interest with the public healthcare system in Canada. While I believe healthcare workers have valuable insight and opinions on public healthcare, to increase the validity of my research, I wanted to avoid as much as possible viewpoints which could be shaped by people's reliance on the system for their own livelihood. I selected unions located in Saskatoon and Regina for ease of arranging

interviews (I live in Saskatoon) – 21 in Saskatoon, seven in Regina. While I attempted to focus on Chief Shop Stewards and Staff Representatives because of their close proximity to union members, in many cases contact information was not provided for these positions and so I needed to select the best available contact person. All people in this first group were sent an email as well as a similar letter via regular land mail (Canada Post). The invitation letter (Appendix B) included a brief explanation of my research project, rationale for requesting their participation, and a description of the interview process. In some cases, with no contact person listed, letters and emails were sent to a generic address with 'Dear Sir or Madam' in the greeting/salutation. Other contact individuals included President, Director, Office Manager, Regional Representative, Administrative Assistant, Business Manager, and Chief Operating Officer.

From this initial mail-out I was able to secure five participants for interviews. While arranging for times and locations (which were at the request of the interviewees), I sent out email invitation letters to another 39 potential participants, approximately three weeks after the initial communications. For this pool, I primarily chose additional people from unions that did not respond to the initial mail-out. As a result, I added three more participants, so I did a third email invitation to an additional eight union executives and representatives one week later. From this final invitation I was able to secure two more interviews which gave me my target of 10 participants. I recognize that there was a degree of self-selection bias in this process. Those who responded to say they were willing to be interviewed for my research were likely very passionate about public healthcare. At first, this may seem like a limitation but it actually enhanced my data collection. Since I was interested in general membership views of public healthcare, having participants who were politically motivated and interested in Medicare themselves could provide

richer description and detail than if they had less interest in my topic. All but two (one of which did not indicate previous history) of my participants had been in an executive or staff position of some form or another for at least 10 years. I was able to achieve a gender balance with five women and five men as well as representation from a variety of labour unions; two from the public sector, four from the private, and four from a mix of public and private (see table 3.1). I have used pseudonyms to protect my participants' anonymity.

Table 3.1. Interview Participants.

Participant (Pseudonym)	Gender	Title	Years in Current Position	Public or Private Union
Alice	F	Regional Director	1	Public
Janick	M	Former President	Retired	Mix of both
Ronnie	F	Representative	8	Public
Linda	F	Representative	6	Private
Bons	F	President	9	Mix of both
Lee	M	Business Manager	3	Private
Geddy	M	Labour Relations Officer	5	Mix of both
Rick	M	Representative	4	Private
Simon	M	Staff Representative	18	Private
Carley	F	Representative	5	Mix of both

This research involved no anticipated risk to participants. The consent form (Appendix C) outlined steps taken to protect participant identification and ensure confidentiality. A guarantee was provided that any identifiable information from direct quotations of participants' comments would be removed. Consent forms are being stored separately from the data. An identification number was assigned to each participant in order to link interview results. Due to the number of executives and representatives within my participants' labour unions, there is minimal risk to confidentiality due to context. However, I decided not to identify specific labour

unions at all in my study to further ensure the confidentiality of my participants. In the table I have only identified their gender, title, years in their current position, and whether the labour union represents public, private, or a combination of sectors. I believe this creates an appropriate balance between transparencies to my audience while maintaining the confidentiality of my participants. There is a very small potential limit to confidentiality due to the selection process. In my invitation letter, I requested that, if the receiver was not interested in participating, I would appreciate it if they would pass on the request to another person whom they thought might be more inclined. Nine of the participants, however, were contacted directly, eliminating that possibility. The other participant responded to one of the generic requests ('Sir or Madam'). Participants were given the right to withdraw from the study at any time prior to data analysis. In my interview preamble (Appendix D), which I verbally expressed to each participant before the interviews, I also mentioned the assured confidentiality, lack of foreseeable risk involved in the study, and right to withdraw from the study at any time prior to data analysis.

3.5 Interviews

All 10 interviews were conducted over a period of seven weeks. To increase reliability I performed all interviews personally, using the same interview question set. All but one interview took place in the participant's office (or a nearby room in the same building); the other one was conducted in a public dining establishment, which was the choice of the participant. All interviews took place at a mutually agreed upon date and time. Eight interviews were conducted in Saskatoon, two in Regina. Before each interview, participants were given a copy of the consent form to read and sign. The form explained the purpose of the study, procedure, risks and benefits, confidentiality guarantees, the right to withdraw, and contact information. The consent form also encouraged participants to ask about questions or concerns at any time. To ensure further transparency, before the interview I read a preamble statement to each participant which

emphasized the purpose of the study, nature of the questions, confidentiality guarantees, risks, and procedure, including the right to decline answering any questions. Participants were also informed that, in addition to taking notes, I planned to record the interview for clarity and accuracy. All participants agreed to this condition. Participants were notified via the initial mail-out as well as the consent form that the interviews would be approximately one hour. The actual duration for the interviews ranged from 40 to 105 minutes. Some participants were more succinct with their responses while some took more advantage of the open-ended format to elaborate at length. At the conclusion of the interviews participants were given the option of receiving a transcript to review and edit as they saw fit. Two participants requested this option and did some minor edits before returning their transcripts with a signed transcript release form (Appendix E). Participants were also given the option of receiving the completed Master's thesis and all 10 did request this.

All recordings were then transcribed by a professional transcriptionist. After receiving the interview transcription, I read through them along with my personal notes from the interview. This was a way of ensuring that as few subtleties or nuances as possible, which emerged during the interviews, were missed in the wording of the transcripts. Furthermore, I listened to the recorded interviews and made any necessary edits in the transcripts where errors existed or where the transcriber had difficulty understanding the audio. In addition to ensuring better accuracy of the documents, this process allowed me to immerse myself with the data and become familiar with it prior to coding and identifying patterns and themes.

3.6 Data Analysis

In terms of analysis, I used a "dining room table" approach (McMillan & Schumacher, 2010), searching for themes and patterns in responses. I began by reading through the transcripts, pulling out any substantive comments (words and phrases which captured important

aspects of the data), placing them on large sheets of Bristol board paper. As I did this, I organized them by specific category – for example, 'comments about public-private partnerships,' 'comments about corporate influence in the media,' and 'membership views of tax cuts.' These categories emerged from the participant responses, and were therefore flexible, in accordance with a grounded theory approach (Glaser & Strauss, 1967). I used numbers one through 10 to identify the participant and also used colour-coding to differentiate between private, public, and mix of public and private labour unions. I also used colour-coding to identify more general categories; for example, 'membership views,' 'positives of the healthcare system,' and 'healthcare priorities.' Once I was finished reading through the transcripts, I studied the large sheets and grouped common categories into themes; for example, 'government involvement in healthcare,' 'concerns with privatization,' and 'reasons for lack of political involvement.' Although some themes were predictable based on the questions asked (for example, people's personal experience with the healthcare system), others emerged from the open-ended nature of the questions (for example, the view that membership is more individualistic now than in the past). Next, I created data summary sheets indicating the frequency of participant comments for the various themes, and specifying, by their identification number, which participants' remarks applied to each theme. I then proceeded to put the general themes into a systematic order and drew conclusions based on the final analysis.

In line with the emergent approach used for the interviews, my analysis was open ended and iterative, looking for the best theoretical explanations for the empirical results. However, due to my literature review, I did have an idea of some of the themes that might emerge. Nonetheless, I allowed the results to speak to me and I incorporated new themes into my analysis. I followed Charmaz' (2008) strategies for data analysis, using comparison and

interactivity at each stage of the process (see also the description of grounded theory in McMillan & Schumacher, 2010).

3.7 Summary

My goal was to study how working-class people in Saskatchewan view public healthcare in Canada. To better understand how people formulate their opinions and beliefs about healthcare, I used in-depth interviews with open-ended questions. With this method I was able to discover a variety of economic, social, and political factors that operate together to influence public opinion. I tried to ensure my interview questions were as reliable and valid as possible, through vetting, pilot testing, and revision. I was able to interview 10 union representatives and/or executives who were able to provide their unique perspectives on public healthcare, as well as some insight into their membership's likely views. My goal was to uncover some of the reasons behind the seeming contradiction of a public that highly values Medicare and the principles of the Canada Health Act while also showing little resistance and protest against the increase of private elements in the system. I discovered that a perfect storm of factors, including neoliberal discourse, right-wing governments, and business-influenced media, are combining to threaten a cherished public institution.

CHAPTER FOUR:

ANALYSIS AND RESULTS

My primary research question emerged from a perception that there exists a dissonance between the passion Canadians feel for public healthcare and the seeming lack of fervent response to policies and various changes which have the potential to considerably alter this cherished institution. My overarching question is what societal influences and undercurrents are involved in shaping how Canadians perceive the public healthcare system? For reasons outlined in Chapter Three, I decided to focus specifically on working-class people in Saskatchewan. In order to address this large question, my interviews were structured to understand some of the many components that might shape people's opinions. Is the public convinced of a crisis in healthcare and, if so, what solutions do they advocate? How are potential solutions presented to the public by the mainstream media and governments? What are people's views on the role of social and economic determinants of health? How much blame do people ascribe to those who are ill, and should this influence the amount and type of publicly supported healthcare they receive? Do people value social responsibility and community well-being over individualization and self-interest? Does universal, publicly funded healthcare constitute a fundamental right for all or does it infringe on individual choice? If there is a desire for more privatization, or at least a lukewarm resistance to it at best, what are the reasons for this? At a more fundamental level, do people see healthcare as a commodity or social good: Who should pay and who should benefit? Should healthcare be provided based on need, or some other criteria?

In this chapter I will attempt to use my participant interviews to answer these questions in the hopes of creating a better understanding of how and why working-class people think the way

they do about public healthcare in Canada. Consistent with a grounded theory approach, the characteristic examples from my interviews described in this chapter provided the structure for my analysis (Glaser & Strauss, 1967). While some of my interview questions were directed at answering some of the specific questions outlined above, there was not necessarily a one-to-one correlation between any particular interview question and the answer to any of my research questions above. Furthermore, in many cases, answers to my research questions derived from a combination of participant responses to a variety of interview questions. This was especially true for my primary research question which involved synthesizing responses from all participants and all interview questions. Therefore, the best organization for this chapter will be thematic, using a similar structure to the one established in Chapter Two. I will begin by describing my participants politically, as well as situating them in terms of their general views about healthcare, including their perception of the current state of Medicare in Canada. I will then look at their views on the determinants of health, the role of government, neoliberalism's influence, and political consciousness. In addition to these, there are two other prominent themes - privatization and media - that are not discussed separately because they frequently appear within many of the other categories. Where applicable, I will give the perceived views of union membership based on the perceptions of my participants. It should be noted that when my participants gave an assessment of their membership, they obviously did not mean for it to apply to every single member, but a significant portion at least. I will conclude by focusing exclusively on union membership perspectives, as surmised by my participants.

4.1 Socialist Saskatchewan?

My participants were all labour union executives or representatives in Saskatchewan. To varying degrees, they are all in touch with their memberships. There were no significant differences noted in terms of whether the participant was from a private, public, or combined

sector union (it was part of my analysis to look for any trends of this kind). Given the occupations of my participants, and their position on their union executive, I certainly expected to have a group situated to the left on a political spectrum.[1] Indeed, seven participants grew up in families who were supportive of public healthcare when it was first introduced in Saskatchewan (the other three did not know). Given a scale of one to seven with one being extreme left and seven extreme right, all participants chose numbers between two and three and a half (most gave a range). It should be noted that participants were not given any distinction between social versus economic in the phrasing of this question (as was discussed in Chapter One). However, given the nature of their responses, as well as the general discussion during the interviews, I believe it is safe to say that their positioning on the political continuum was primarily due to economic considerations (the question asking participants to situate themselves on a left-right political continuum was asked at the end of the interviews). This range was particularly small, in fact only Bons chose three and a half (and she chose three to three and a half). However, I found it interesting to note how careful some of them were to avoid locating themselves too far to the left: "I am not a radical union …" (Linda), "I am not a rabid lefty" (Bons), and "I am not an extreme lefty" (Lee). Geddy took exception with my linear model and preferred a circular one to account for the extremes on both the right and left eventually meeting. I found it similarly interesting that all nine of the participants who responded to a question to situate their membership placed them to the right of themselves on the same political scale. Six of those chose numbers of three and a half or more which would place their membership right of center. And while Tommy Douglas was highly regarded by all participants, four of them lamented that at least a portion of their membership would not know who he was. The possible reasons for the

[1] Palmer (1992) found that only 24% of union members vote NDP federally.

differences between my participants and their membership will be discussed within the themes below.

4.2 State of Medicare and Government Role

Given much media hype of a 'crisis' in Medicare over the past few years, it might seem surprising that there was near-consensus – eight participants - of satisfaction with the Canadian public healthcare system. Of the two who did not speak favourably about the healthcare system, one participant's response was ambiguous and the other, Lee, expressed dissatisfaction, but this displeasure was focused on the current government's dismantling of it (which will be discussed further under the government themes below). When asked to compare Canada's healthcare system to other countries, my participants also spoke favourably about their home country. Eight specifically mentioned that Canada's system was superior to the United States' (the other two had no opinion). The language was often quite strong in describing this discrepancy: "We are light years [ahead]" (Simon), "vastly superior" (Alice), and "far superior" (Ronnie). Six participants did indicate that other countries have, or likely have, equal or better systems to ours. The countries mentioned were Cuba and some in northern Europe; those that are more socialist or more social democratic than Canada. It should be noted that all of the participants also expressed positive personal experiences with the healthcare system which certainly would influence their response to this question (and perhaps others). Many of the participants had theories pertaining to the reasons for the current discourse around healthcare and these will be described in the sections below.

My follow-up question to the query about satisfaction with the healthcare system regarded which particular aspects they were either pleased or displeased with. Dissatisfaction responses will be discussed in the context of some of the themes below. In terms of characteristics they highly valued, the most frequent response – from eight participants - was

related to universality. Lee stated: "I think everybody deserves healthcare." Rick's first response to the query about which aspects of healthcare are most important was: "The fact that it is accessible by everyone." Linda was equally explicit: "I believe we have to maintain that fundamental universality of healthcare." Six participants spoke about the high quality of healthcare in Canada: delivery, types of care, and accessibility. As Ronnie explained:

> When we go to the hospital or visit a doctor that these are highly trained individuals, their level of education is superior, their level of commitment is superior and you know … just the general care that is provided to us as residents is superior.

Another aspect of the Canadian healthcare system that was highly valued was the fact that cost is not a barrier to care. Four participants mentioned this facet including Geddy:

> I love the fact that it is free, I love the fact that we have access to doctors, hospitals without going through red tape third party insurance companies or pulling money out of my pocket to do so to get the service.

My participants were very aware of the importance of universality, which is one of the five principles of the Canada Health Act.

It should be noted that all of my participants were supportive of the basic principle of a publicly funded and governed healthcare system. All of them advocated for a large and/or significant role for government in providing healthcare for its citizens. In some instances, this was explicitly stated as a responsibility or obligation due to inherent rights and needs of citizens. Linda said that governments "are responsible for maintaining the welfare of their citizens." Lee similarly stated, "I believe it should be a basic right that Canadians have," and Ronnie said, "I think that it's a responsibility of government to ensure that citizens have healthcare, have good healthcare." Three participants noted that governments have the capacity and ability to not only control and govern healthcare, but to use its power to achieve cost savings. For example, Carley stated that the "government has a pivotal role in providing that service to the citizens of the

country [because it] is a central body that can collect the money and administer the program." Janick noted that in terms of insuring healthcare, "[governments] are the only ones right now with the overall capacity to do it" and that "they can borrow money cheaper than you or I can." Janick also described how unions have the power to fight for healthcare for their members but much of the population must rely on government: "At least half the people in the province don't have a union providing it [healthcare] and it is very necessary." Similarly, three participants noted that government involvement is necessary to ensure and protect the integrity of the healthcare system by providing consistency and guidelines for safety. Bons believed that "the role of government is to ensure standardization and regulation … to fund it [healthcare] properly, to support some pretty innovative changes." My participants were quite clear on the importance of government to manage and operate Canada's healthcare system.

When asked "If you could be Premier of Saskatchewan, what would be your top priorities for spending tax dollars?," nine participants specifically stated that healthcare would be first or near the top of the list. Nine also mentioned a variety of socioeconomic determinants of health: education, housing, food, water, poverty, social services, welfare, and child protection. While jobs and infrastructure were listed by five participants, they usually were minor priorities behind those mentioned above. For example Rick said: "Education, healthcare, and then down from there … obviously you do have to look after your infrastructure." Interestingly, when responding to the question about thoughts on how their membership would answer the same question, a few participants noted that the answers might be weighted somewhat differently. Three thought that infrastructure would rate higher for their membership than they would place it and three others mentioned that tax cuts would be a priority:

> [Some of my membership would] probably [be] very similar to the Sask. Party. They would probably be talking about tax cuts and you know, business and

> economic booms and making sure that the resources are well spent and, or that business comes in to access our resources. The typical, 'let's make everyone happy and rich' type rhetoric. (Linda)

This slight discrepancy between the views of my participants and the perceived views of their membership reflects the fact that all of my participants rated their membership as being to the right of them politically. Reasons given for the discrepancy were government actions and rhetoric, messages from the corporate media, influence of big business, and lack of political engagement which will all be explored in the themes below.

Not only did my participants see a prominent role for governments in providing and protecting healthcare, but seven of them specifically noted that coverage should be expanded (however, one – Bons – believed that coverage should decrease and four others mentioned that elective services – those that are considered not necessary for improved health - should not be covered). Some of the ideas for areas of expansion of services included nutrition, mental health, dental, and pharmaceuticals. Rick said: "If it is a situation where you need the medication or you need the operation for your quality of life, then that should be covered in the public healthcare system." Lee believed that "everything to do with health should be covered." Alice explained:

> I think that the basket [of conditions/situations/services covered] should be as big as possible, because as I said earlier healthcare to me is not just, you know, going to emergency if you have a broken leg or going to get your flu shot; it is all of the elements that make a human being a healthy person. So it is sort of psychological, nutritional, physical … I think healthcare should be as broadly defined as possible.

It is quite clear that my participants believe strongly in the Canadian healthcare system and the tenets of the Canada Health Act; they shared many of the same concerns that provided the impetus for this study. Furthermore, their responses about the healthcare system showed no indication that they believed we have a current crisis in Canadian healthcare. One difficulty, of course, is the idea of expanding Medicare coverage in an era of tax cuts. Alice explained that her

membership would likely share her sentiments in terms of coverage but that they would not want it to cost them any additional money. This is a common refrain we hear from neoliberal governments and the corporate media: Increase in social services comes with a higher individual tax bill. On the one hand, better social services may indeed result in a higher individual tax burden (even though the payoff may be a healthier population and decreased taxes in the long run). However, adding money to social services does not necessarily need to hit individuals in this manner as there are alternative ways of accomplishing this, like redistributing budget money (for example from defense spending to poverty reduction) or increasing corporate taxes. It seems that this rhetoric is having a more significant impact on union membership, at least in the thoughts of my participants, than on the executives and representatives who often see through this misleading statement.

4.3 Current Governments and Healthcare

As previously stated, my participants all believed that governments should have a significant and essential role in ensuring Canadians receive quality healthcare. Therefore, it is unsurprising that many of their concerns regarding the healthcare system involved government policies and discourse. Although the provincial Saskatchewan Party and Premier Brad Wall, and the federal Conservatives and Prime Minister Stephen Harper, were mentioned specifically in many instances, sometimes 'government' was used in a general sense. Due to the context of the interviews and the fact that Wall and the Saskatchewan Party have been in power since 2007 and the federal Conservatives under Harper since 2006, the vast majority of references to 'government' were directed at one or both of these right-wing governments. If a comment was ambiguous, or if the term really was meant as a broad generalization of 'government,' I will indicate so below.

All 10 participants, when asked about their opinion on tax cuts versus social services, expressed concern regarding policies of our current provincial and federal governments. All had an understanding that tax cuts do not come without reduction of services:

> Some people unfortunately have a belief that you can have tax cuts and maintain everything you still have. So if I said to somebody that I am going to cut your taxes by 5 percent they would probably all go 'yahoo' until I told them oh but we are going to shut your hospital down because we don't have the money … (Simon)

> … Why are you cutting my taxes? Is there a good justification for cutting taxes and what effect is that going to have on my social services you provide? (Linda)

> People just have to understand that social programs cost money … I like them, I believe in them. (Lee)

In fact, many participants explicitly stated that they see taxes as a social necessity:

> In the unionized work environment taxes are not viewed as a bad thing. They are viewed as a good thing because they allow you to have good roads, good education, good social services, good healthcare and they allow better access to everybody. (Ronnie)

> I have no idea who said this but I live by this, 'taxes are the price we pay to live in a civilized society.' (Bons)

I have already noted above that some of my participants believed that their membership would value tax cuts as a more important priority for governments than they themselves did. This sentiment was repeated by several of my participants when they were asked to consider their membership's likely views of tax cuts versus social spending:

> Taxes are money out of their pockets so they don't necessarily always think of 'okay what is going to be cut in order to make that happen?' They don't necessarily recognize the good that they are getting for that money. (Carley)

> The most disposable income they have in their pockets, the better. But when you tell them they have to pay $60 a year for some services then suddenly it's upsetting … but people don't necessarily think that far ahead. (Linda)

Tax cuts and the resultant reduction in social spending can be seen as either a precursor to more privatization of formerly publicly operated institutions or simply part and parcel of an overt

agenda or plan. In either case, a crucial aspect of my analysis involved understanding how people view privatization and its implications for healthcare. My participants were keenly aware of the implications of the tax cut agenda of the current neoliberal governments. They frequently articulated the need for taxes to support social programs like Medicare. It was also apparent that they felt that this connection was either not as clear to their membership or that they were not willing to sacrifice their own finances for better social programs.

4.4 Privatization

To understand the feelings my participants have toward privatization, I asked what I consider an underpinning question: Do they see healthcare as a social good with publicly provided services or a business with commodities and individuals purchasing services? I knew that the answer to this question might have a significant influence on their thoughts about privatization. Not surprisingly, most - eight of 10 - said healthcare is a social good, not a commodity. Of the two who did not state this as explicitly, Lee indicated that it *should* be considered a social good but "it's [unfortunately] about commodities and lobbying and everything else." And Simon explained that some aspects of healthcare are social goods and others are commodities, while lamenting that much that is currently supplied privately "should have never gone outside the realm of mainstream healthcare" and that, unfortunately, the "genie is kind of out of the bottle." The consensus was that union membership would see the answer to this question similar to my participants. Rick said: "The thoughts by the union membership are definitely behind that [healthcare should be a social good, not a business]." And Linda expressed: "I think most union members would consider it [healthcare] a social good." This was one of the few areas of clear accord between my participants' views and the perceived views of their membership.

Participants frequently discussed privatization when responding to the question about what they saw as potential problems in healthcare. In fact, it was by far the most frequent concern expressed. When asked specifically whether or not there should be more, less, or about the same amount of private sector involvement in healthcare in Saskatchewan, all 10 participants thought there should be less than there currently is. Interestingly, four participants thought that their membership would be more accepting of increased private participation in healthcare. The reasons for this varied from lack of education on such matters to a (mis)perception of better service in the form of reduced wait times for surgeries to the discourse from governments and the media (this will be further explored in the sections below). In terms of the concerns my participants had about privatization, they can be broken down into sub-categories: the incursion of the private sector into formerly public areas, government - Saskatchewan Party and Brad Wall and the Federal Conservatives and Stephen Harper – policy and rhetoric, mainstream media, corporate interests, and reasons why privatization is detrimental for healthcare.

4.4.1 Privatization's Incursion

All participants expressed concern with what they see as private sector involvement into areas that had previously been public. The Saskatchewan Party's new agreements with private surgery clinics and privatization of long-term care were areas specifically and frequently addressed:

> I have some serious problems with the increasing privatization of surgery in Saskatchewan in particular. And so the push to do that work not in the public, rather than focusing on building capacity in the public system, so of just shooting it off into the private. (Alice)

> The introduction of more private opportunities, business or for-profits pardon me. Business driven opportunity to provide long-term care. Long-term care facilities … are very expensive … and they cost old people a lot of money. (Geddy)

Public- private partnerships (P3s) were mentioned by seven participants:

> Even if we go to P3-type of system and there has been a lot of talk about that. I don't know that that is serving the public interest. That is serving the private interests that certain companies or you know certain individuals may end up making money but I don't know that it really serves the public as a whole the way I would like to see it happen. (Carley)

A common undercurrent with many of these descriptions of increasing privatization in healthcare was the insidious nature of these moves. In some cases this was directly related to healthcare while in others it was seen as a general trend regarding public sector institutions. Participants often saw private surgery clinics and P3 partnerships as ways of beginning the process of a wider, more encompassing attempt to make healthcare less and less a public institution. Linda used two analogies to articulate this situation; one of a lobster that does not scream due to boiling water if they are put into cold water that is slowly heated, and the following tree metaphor:

> You have a tree in the back yard and that neighbour is complaining because the branches are coming into their back yard. Your neighbour wants to get rid of your tree but instead of getting rid of the tree they, say, just cut this branch. So then they slowly cut each branch one at a time and eventually the tree dies. So your neighbour gets what they want because you are going to have to get rid of the tree anyway, but because they have done it branch by branch you don't realize that you have actually cut it out … and we see them doing that with SCN [Saskatchewan Communications Network] with SaskTel [Saskatchewan Telecommunications Holding Corporation] and … SGI [Saskatchewan Government Insurance].

My participants clearly saw a changing landscape in terms of the amount of public versus private ownership and administration of businesses and institutions. It was also not too ambiguous as to where they placed the majority of the blame.

4.4.2 Participant Views on Government Actions

When discussing concerns with Medicare, all participants but one (Geddy) mentioned Brad Wall and the Saskatchewan Party as well as Stephen Harper and his Conservative government, either specifically or using the terms 'federal' or 'provincial' government. Some of the discussion involved fairly generic pejorative comments about the government being right-

wing and pushing for privatization. When asked for an opinion on the future of healthcare in Canada, Alice remarked:

> I am really concerned … the privatization initiative will continue and expand and certainly this provincial government. The Feds too but the provincial government specifically … and now identified, 'next on the block' [referring to services to be cut]?

And from Lee: "Lately in Saskatchewan and federally we have two governments that are trying to dismantle it [healthcare] … The Sask. Party … are extreme right-wing." Carley asserted that "there isn't the will of the government [federal and provincial] to keep [public] healthcare and possibly make it stronger." Participants were expressing a fear, or at least a sense of unease, with the implications of having these two right-wing governments in charge of affairs.

Some of the comments were more specific in terms of government policy. It should be noted that, when discussing government policy and directives, topics occasionally veered away from healthcare, but the implications for the public healthcare system were never far away. Linda discussed recent non-progressive labour legislation: "There is very clear degradation of the labour laws in Saskatchewan specifically." Lee similarly stated: "Provincially the Sask Party has just decimated the labour laws." Janick lamented: "Wall currently is talking about setting up private-public partnership to do things …." While not directed specifically at healthcare, the theme of anti-labour (or pro-business) certainly has implications for the public nature of healthcare in Saskatchewan. Governments with neoliberal economic policies favour business interests over those of public or social good. In such a climate, fears of privatization of healthcare are very real. Public-private partnerships are a very tangible effect of this climate and acceptance of more private involvement in formerly public institutions is potentially alarming to those who treasure the public nature of healthcare.

In some cases, participants were not shy to accuse governments of intentionally creating an environment where privatization was needed to save a crumbling system. This is produced by degrading the public system via de-funding to such an extent that it looks like it just would not work without private involvement. Because of the federal government's historical role as protector of Medicare and provider of at least most of the funding for healthcare, it is perhaps unsurprising that half of the participants singled out transfer payments to the provinces as a specific area of concern. Using the public school system, for which he was more familiar, as an analogy, Janick said that it was "underfunded for a purpose." His point was that governments could influence the direction of an institution or industry simply by providing less funding for it. Simon was even more blunt. When asked about the decrease in federal funding (which he had alluded to previously in the interview), Simon said that this policy was "intentional with its design being forcing cost to a point where your only option is to go into private … public/private or private healthcare." In light of the recent Conservative government's deal with the provinces for healthcare funding, the accusation certainly has some merit. Harper's proposed 2014 Health Accord provides a limited amount of funding to the provinces. If this is not adequate to maintain, or improve, the current state of healthcare, provinces will need to adapt. They will either need to find additional funding sources or decrease services currently provided. A typical neoliberal response to a lack of funding for public institutions is to allow private business to provide the funds and/or services. This is currently happening in Saskatchewan with private surgery clinics and P3 hospital proposals.

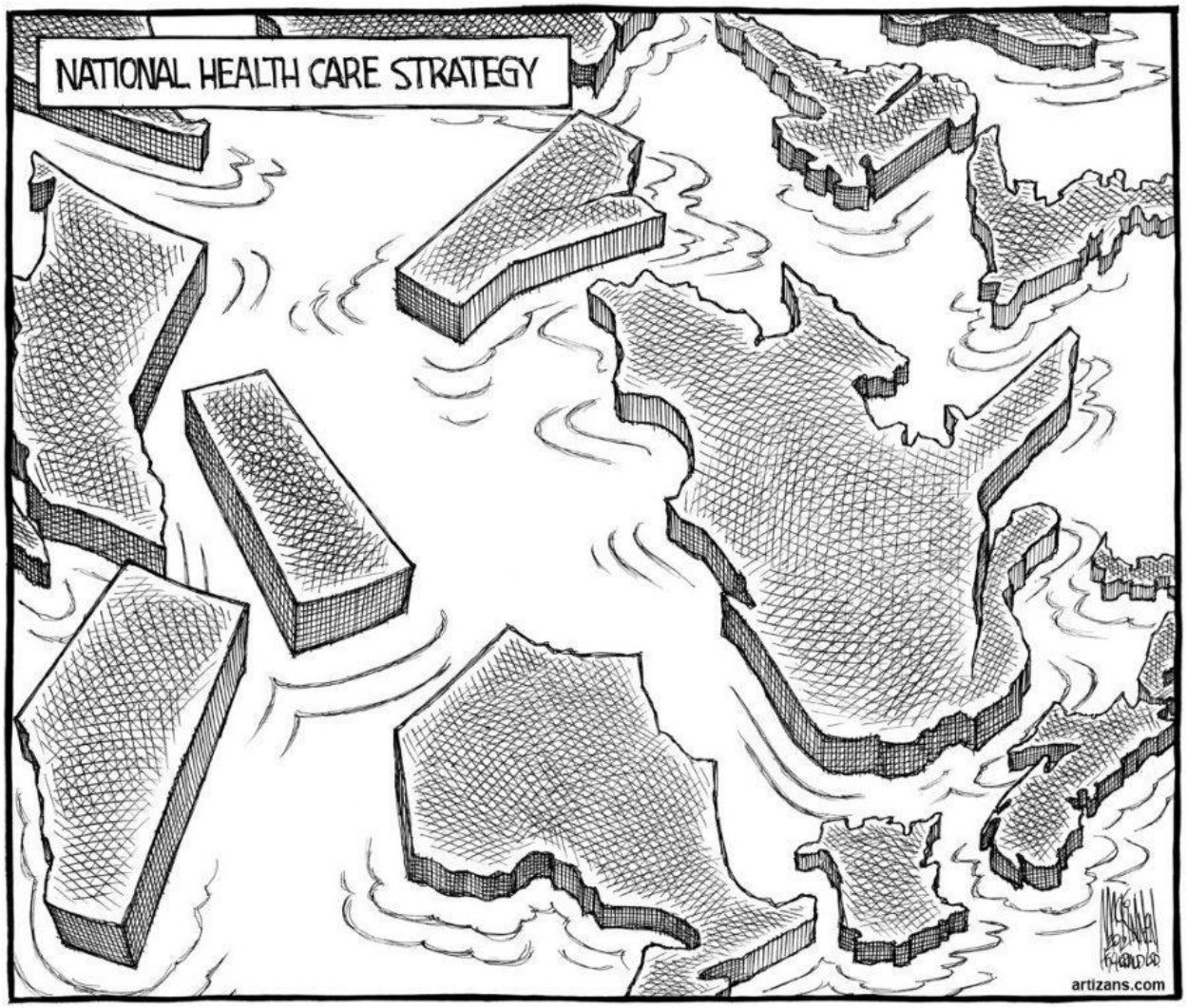

Figure 4-1. Permission from Bruce MacKinnon / artizans.com.

4.4.3 Government Rhetoric

Both governments were also taken to task for distorting the messages the public received about healthcare. Seven participants singled out the message that healthcare costs are out of control: "There is continual talk about how we can't afford the healthcare in this country" (Janick). One corollary is that, since governments can no longer cover the costs, the private sector is essential if we want to maintain the same services we have now. Another corollary is that private business can somehow offer the same services for less cost. Alice said: "That part of

the discourse is very troubling, you know private is cheaper, private is cheaper." Half of the participants noted that governments claimed privatization was needed to relieve the backlog of patients on waiting lists:

> Because there are waiting lists and such I think that people think that our healthcare isn't as good as it is. You tend to hear the negative and then it kind of gets blown out of proportion that you don't recognize … this is a superior system quite honestly. It is a superior system to private insurers. (Carley)

The primary message is that governments tend to use convenient issues, and in some cases misinformation on issues like waiting lists and escalating costs, to push an agenda of privatization. This is in keeping with the neoliberal agenda of privatizing the commons (Orlowski, 2011).

In some cases the language used by participants was very strong in terms of government culpability for misinformation. Participants often moved beyond simply claiming that governments showed bias due to their political ideologies but that they actually distorted information. Occasionally, governments were called out for intentionally lying to the public in order to push forward an agenda of privatization in healthcare:

> The Brad Wall government has bombarded people … with some very biased information about certain problems such as waiting lists … this government has said it enough times that it has started to really resonate with people. Waiting lists have actually not expanded or become longer. The government has basically just thwarted the whole Canada Health Act and sort of by stealth allowed some of these private clinics to operate. (Ronnie)

> Nobody is calling bullshit on the lies … nobody is saying, 'you know what Brad Wall you are wrong about this. And this is why you are wrong.' And I don't know why that is not happening … Brad Wall or whoever, Stephen Harper, saying the system is crumbling, we are in crisis. (Bons)

These comments not only speak to the dishonesty of governments but also to the affect it has on the public. There is clearly frustration that the public does not seem aware of the dishonesty or that they have heard it so frequently they believe it.

When discussing the government rhetoric regarding the public discourses about the unsustainably high costs of healthcare, Carley claimed that "we have had governments over the last while, particularly at the federal level, that aren't particularly progressive, and that has kind of influenced how healthcare is reported on and therefore what people [hear]." And from Simon: "From the government [federal and provincial] end, to be blunt, there is a very prevalent lack of honesty." The mistrust was summed up nicely by Alice when she said: "I don't want Brad Wall setting my healthcare policy, or Stephen Harper for that matter." Democratic governments have a responsibility to be open and honest with their citizens. This is necessary if we are to have a rational dialogue about healthcare. This cannot occur if governments are intentionally withholding information, or worse, misrepresenting all of the facts. The result is a citizenry increasingly cynical and suspicious of government policy and motives, which was indicated by my participants' responses. Alternatively, it may create a citizenry ignorant of many pertinent issues, and with a false sense of implications for them as well as others in society. According to my participants, this may be occurring with many of the union membership. Suspicion of governments was echoed in comments about the mainstream media.

4.4.4 The Media's Message

Since many of the complaints and accusations directed at the government were similar to, or conflated with, comments about the media, I need to now examine how my participants viewed discussions of Medicare by the mainstream media in Canada. When asked where they get most of their information on the healthcare system, six participants said from their own or other union's research and six said from family/friends/union members (two participants mentioned both). However, all but two said that the media is a prominent source of their information. While my participants appear to be very critical appraisers of information they

receive from media sources (as indicated by their nuanced and detailed responses to my interview questions), they do not seem to believe, at least generally, that their membership is as discerning. Thus, the discussion to follow foreshadows the false political consciousness analysis that will be presented in Chapter Five. I am using the phrase 'false political consciousness' as an analytic category to explain the phenomenon of a discordance between what people think and do and what is in their best interests, not to denote persuasion. Thus policies that benefit a select few may be willingly supported by the masses who may not benefit at all (Frank, 2012; Gramsci, 1971).

There was a common theme that the media's coverage of healthcare was at best uneven and one-sided and, at worst, dishonest (similar to the discourse promoted by governments). Four participants said the media was inaccurately framing the issue of healthcare by focusing on negative aspects that are causing the so-called 'crisis':

> There is a belief out there that the healthcare costs are too high as it is, and it is a false belief. There has been a push … partially the media and it is partially the government … that you hear the negative, you hear the costs of the healthcare system and the inefficiencies of the healthcare system so then people start falling into that belief that, oh yeah it isn't a good system, whereas in fact if you start looking around at other countries and their systems, like ours is pretty damn good actually. (Carley)

> I think that is designed … I think the spin doctors can spin most things … in the media I think that there has been a distinct slant towards promoting and highlighting the negative aspects of our healthcare system rather than promoting or highlighting the benefits or the success stories. (Linda)

Similar to the messages from governments, the media is providing an inaccurate, or at best incomplete, picture of healthcare and the public is not questioning this bias. Three participants spoke about how governments work with and use media to promote their privatization agenda. According to Geddy:

> We are seeing a lot more debate about public healthcare and private healthcare system. We are seeing a lot more politicians ramp up their agendas on private

> healthcare system and they are using as many reasons or rationales or excuses to find and publicize within the media to work with them for their agenda on privatizing.

According to Carley" "Sometimes I don't feel that they [mainstream media and governments] are telling the whole story but they have an agenda." Carley was very balanced in her assessment, however, noting that unions too have agendas that they promote and that people have to figure out for themselves what is true. Two participants were quite critical of the way labour unions are portrayed in the media compared to a favourable view of business. Carley mentioned: "What a lot of people see of unions [in the news] is negative … it is not accurate at all." Janick added:

> One of the messages that comes out quite often and not just local media is that unions are too big, and too powerful, they have outlived the union usefulness. Union bosses are too big and powerful and rich; that is a message that is repeated quite often.

For Rick: "If you have a different way of thinking … anything that is left of center … either you are ignored by the media or you are singled out and you are crazy." We will revisit the idea of an attack on unions (and the left wing) in the discussion on false political consciousness. For now, suffice to say that it is a part of the media's message which seems to be quite consistent with the rhetoric we hear from neoliberal governments: Healthcare is in crisis mode and private business is a way of alleviating pressures on our treasured, but beleaguered public institution. My participants believed that the corporate media is promoting a neoliberal agenda, and that their general membership has bought this view. My participants' experience and position in the union may require a more sophisticated level of political engagement. Or, perhaps, those who have an interest in being politically aware are more inclined to end up in executive positions. In either case, according to my participants, the membership do not seem to be as discerning when

it comes to analyzing media messages and motives (reasons for this will be explored in the section below on Working-Class People in Saskatchewan).

4.4.5 Business Interests

By definition, right-wing governments are pro-business and profit-oriented in the private sector. Therefore, one should expect labour union executives and representatives to be suspicious of their policies and motives. Ultimately, I did want to find out what my participants thought was at the heart of the drive to privatize at least some aspects of healthcare. Furthermore, I wanted to know their thoughts on why the mainstream media would be marching in lock step with the federal and provincial governments in this respect. It turns out the answer to both questions revolved around business influence and control in both media outlets and governments.

All participants, except Bons, mentioned the influence of business on either government or mainstream media. Some of the comments were quite general, indicating a link between business, governments, and media:

> Government, media, you can spin anything anyway you want when you've got control of the papers and control of radio. Where is the money coming from to support the government that's in power right now? It is coming from business. It is definitely not coming from the working class. (Rick)

> I think that they [the Saskatchewan Party] very clearly have interest groups being mainly business that fund them. [These businesses] make sure that their interests are being served and their interests are obviously to privatize not just healthcare but other services as well. (Linda)

> This government's [Saskatchewan Party] entire agenda seems to be economic and that is the message. Even when you look at the trend in the media … economics is one of the primary messages that the media bombards us with … economic growth, we must grow, grow, grow, grow. (Ronnie)

> The real question is why is there an interest of governments to privatize? And the second, why is there an interest of the private sector to become involved? And

> the simple common denominator is money; one is profit and one is cost cutting. (Simon)

The drive behind the promotion of neoliberal policies like privatization of the commons is big business. Corporate interests are in control of most messages received by the public. Corporations hire the workers and pay for commercials, advertisements, and product placements. And many corporations stand to benefit from privatization. Thus, the messages received by the public are heavily slanted in favour of privatization while highlighting any deficiencies in public institutions (whether real or manufactured).

Lobbyists were also mentioned by two participants. Linda actually exonerated political parties and blamed "the people that lobby political parties" for the misinformation the public receives about healthcare. Cynically, but not necessarily erroneously, she asserted that "it is actually businesses that run everything in North America." Geddy expressed worry that special interests may be lobbying governments to push their own agendas. After claiming he was "against money influencing decisions," I asked him if he thought that was happening. His response was, "Absolutely."

Some participants targeted specific businesses as influencing governments and media outlets. Pharmaceutical companies were mentioned by three participants. Ronnie unequivocally stated: "Absolutely I think that government[s] are being influenced by the pharmaceutical industry, by you know like the multinational healthcare companies." Geddy said that the "pharmaceutical companies are major players in pushing their agenda forward." Janick explicitly indicted governments for policies favourable to the pharmaceutical industry:

> Federal pharmacy rules were set up, the laws, patent laws are set up … those rules or regulations could have been set up so that the industry was controlled. Instead, they are given money in addition to their own research funds to develop medicine; medicine that pharmacy company has patents on and runs the profits on. Anytime you give federal money and federal regulations to promote one industry over the benefit of the masses is not right.

This statement shows how government policy can favour businesses like pharmaceutical companies – through direct or indirect funding, regulations (or lack thereof), and patent policies. Carley believed "insurance companies … have a certain amount of influence on the government," and that they "could stand to make more money from private health." Ronnie named "multinational healthcare corporations" and "pharmaceutical companies" as influencing media and government: "They have a vested interest in privatizing the system." Alice blamed the government for getting "locked into a contract with Omni" [Omni Surgery Centre, a private surgical facility in Regina], and for not acting on a glaring conflict of interest: "orthopedic surgeons from the public system who were shareholders in Omni." The idea that business influences have a direct impact on government policy and media reporting, in one way or another, certainly was pervasive with my participants.

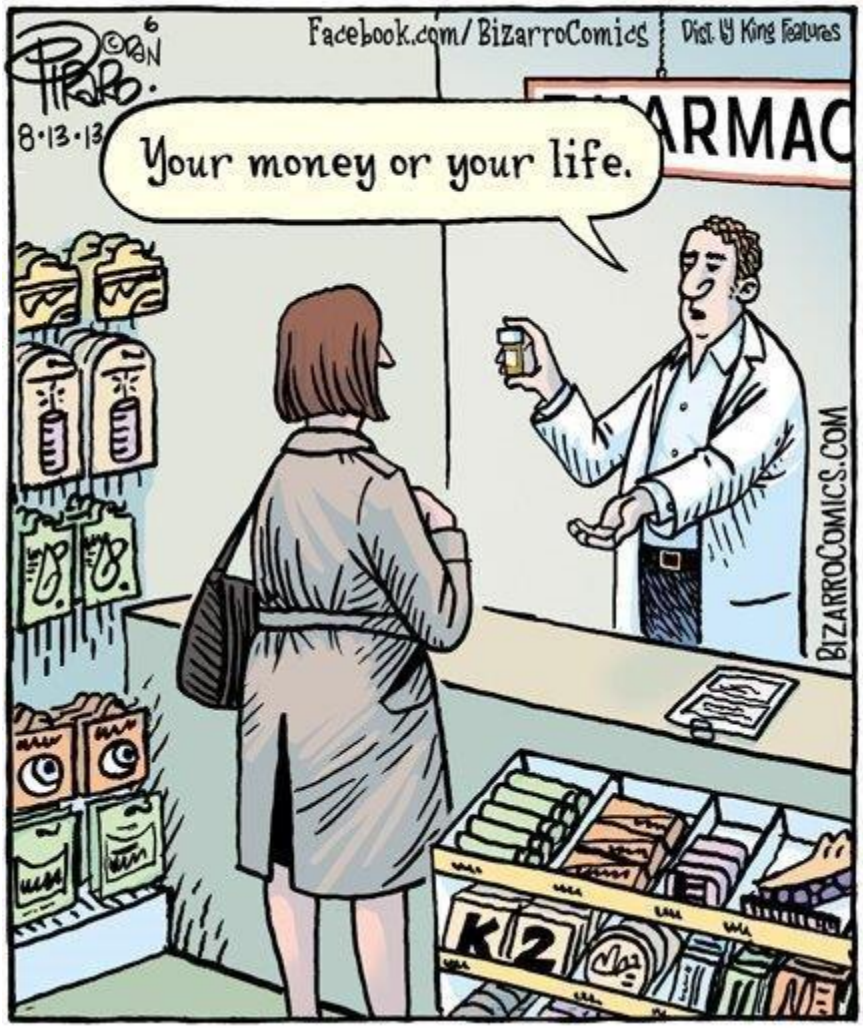

Figure 4-2. Permission from Dan Piraro.

Finally, two participants noted a general trend in monopolization of media outlets as an important factor in limiting Canadian's exposure to multiple viewpoints. They claimed that the simple fact that media is concentrated in fewer hands than it was in the past, would prevent diverse opinions and narrow their focus:

> There are alternative medias out there but mainstream media … are huge conglomerates … you don't have individual owners that might report something. It used to be like somebody owned the Leader Post and somebody else owned the StarPhoenix and somebody else owned the Winnipeg Press … you had three different views on a story. There is one thought put out there in the media and it's closing more and more all the time … there are no alternative ideas out there. (Carley)

> There used to be a limit to how much one newspaper or one news media could control and that is virtually eliminated. We have the newspaper in Saskatoon that is the same as the one in Regina and that is the same as the one in … We have got essentially two radio stations in the city and they're all part of a big chain. (Janick)

As you might expect, the tone of these two statements, as well as many of those above, was one of frustration and disappointment. My participants were upset with the control that big business seems to have over government policy and public dialogue. In terms of healthcare, the fear is that these influences may alter the public nature of Medicare and bring in more privatization. So what is the big problem with that anyway?

4.4.6 What's the Problem with Privatization?

It should be clear from the question asking my participants to situate themselves on a left-right continuum that they do not see themselves as 'extreme' left wingers (one even admitted to being a pro-Mulroney Conservative earlier in her life). My participants often commented on how they were not against business and fully accepted the necessary role of businesses in the economy. All of them had worked in a non-union environment at some point in their life. In other words, they were not against privatization on ideological grounds only. For example, Lee stated: "I understand that businesses have to be businesses that have to make profits … I am good with that." And Bons commented that to socialize everything would not be "fair to people who want to build a business and make some profit." Yet, they unanimously agreed that there should be less privatization in healthcare than there is currently.

Three of the participants did see some benefits for private business involved in healthcare. This was quite limited however, as all three mentioned the benefits of quicker access to services when going through the Workers' Compensation Board's process (i.e. getting people back to work faster). Simon also mentioned: "The only benefit I can see to the private sector is

the delivery time in service." Since all of my participants were essentially against privatization in healthcare, and at the same time did not seem to be taking this position on principle alone, I needed to know their rationale for taking such a stance. Responses can be broken down into three themes: unequal care, quality, and cost.

4.4.6.1 Unequal Care. The most frequently cited problem with privatization, expressed by eight participants, was the unequal distribution of healthcare services. There was a fear that with more privatization, a two-tiered system would result with wealthier people being able to access better and faster care while poorer people would be left with inadequate, or certainly inferior, quality healthcare.[2] A few participants spoke directly to the idea of wealthy people having an advantage with privatization and two-tiered healthcare. When asked if she could see any benefits to more, or current levels, of privatization, Alice said no with the tongue-in-cheek caveat: "If I were hugely wealthy I would say that if there is more private care I can buy my needs." Similarly, Geddy said: "The only thing that disturbs me is the growing trend that if you have money you can supersede any lines for surgical needs or for treatment." In elaborating on his fear of privatization, Simon worried about "queue jumping" since "as long as you have finances" you would have "access to a better quality of healthcare." Janick took a slightly different tack by comparing provincial systems: "The option of waiting here for three or four months for a particular procedure or if you go to say Edmonton to receive it within the next two or three weeks … if you are able to pay, makes a big difference." Carley discussed the benefit wealthy people would have in purchasing private health insurance should it prove to be advantageous in terms of accessing healthcare services. These comments reflect an underlying principle of fairness and equal treatment for everyone regardless of ability to pay. It is a

[2] For some health services this situation already exists in Canada. For example, those with resources can purchase additional insurance for drugs and dental.

sentiment consistent with my participants' feelings regarding healthcare being a publicly provided social service and not a private commodity for private purchase.

The flip side of a wealthy advantage with privatized healthcare (which some people might see as just and fair), is the disadvantage poor people could experience. Linda also expressed worry of a "two-tiered system where one group gets better services than another." Linda went on to say that she would even be "willing to sacrifice some services or some perceived service of like wait times and stuff like that in favour of providing real universal healthcare." Ronnie said: "Private systems will often exclude people who need healthcare the most which is the lower income users, because they can't afford the user fees for the system." Rick worried that an eventual development could be user pay: "Basically if it is a user pay … the rich will be looked after and the working class won't." Carley stated: "If it [healthcare] isn't publicly delivered, the costs are so high that it limits people's access to it," and "everyone deserves the same healthcare." Carley also shared a poignant personal story about her late mother who lived with many health issues, which speaks to the very real impact she is referring to:

> If we wouldn't have had public health, I don't believe she [my mother] would have had the ability to get a healthcare carrier, so that ends up impacting the entire family … we [my siblings and I] would have ended up having to assist with the healthcare and then it adds a burden to the entire family and, in fact, I don't know if my mother would have lived as long as she had without the healthcare that was provided.

Carley recognized how significant our public healthcare system was for her family's situation. Her personal experience highlighted the various costs involved (financial and emotional) when a parent gets older. In addition to the poor and elderly, half of my participants expressed concern for immigrants in need of healthcare services, likely a response generated from new federal regulations which could deprive new immigrants of healthcare equal to current Canadians:

> New Canadians, immigrants and refugees – I think that they should have healthcare … to marginalize them or ghettoize them … it is not who we should be. It is not who I want us to be. I find that abhorrent that people in my world, you know people that I live [with] in the same province, think that that is okay. (Bons)

Here, the idea of fairness applies to everyone, including new and future Canadians. Bons invoked the idea that Medicare is directly related to Canadian values and who we are: In this case 'universal' healthcare truly means 'universal.' The quotations in this section speak loudly to protecting two particular pillars of the Canada Health Act: universality and accessibility. My participants expressed genuine concern that everyone in society should have equal access to the same quality of healthcare services, and privatization threatens this principle.

4.4.6.2 Quality. Almost as frequently as the unequal care described above, seven participants expressed concern with the quality of healthcare for *everyone* in a privatized system. The most common manifestation of this was a loss of control over regulations and standards. As has already been discussed above, some of the participants valued the government's involvement in healthcare because it could ensure quality standards without having to worry about making a profit. Janick described the potential problems with private business being in control of regulations in healthcare:

> Any time you have an industry [like healthcare] that is so important to such a huge population, and to allow it to be controlled by some outside force whose only objective is one thing, to make themselves and their shareholders a profit…

Janick used the meat industry and a recent calamity that occurred in Canada to help illustrate his point: "The federal government cut back on inspectors that regulate the food industry and it became self-regulating and we had … one of many, I will call it, catastrophes." According to Linda:

> My concern is anytime I see privatization I think that we end up losing some governmental control over it and goodness knows that when they cut back money and funding usually the regulatory bodies are the first ones to go.

Janick's concern about government funding cuts often resulting in a deregulatory environment is well founded. Deregulation of private industry is one of the main tenets of neoliberalism (Orlowski, 2011). A privatized healthcare system would be an industry ripe for deregulation. Janick was not the only participant who had this concern.

Bons felt that the private sectors are "not held to the same standard" as the current public system is. Ronnie gave a detailed description of what she thinks a potential privatized system might look like:

> The things that will stem out of increased privatization are … decrease in the quality of the care provided. When you have a system that is for-profit rather than not-for-profit there is inevitable cutting of corners; facility closures, cutting of staff … there is the whole issue of basically germs in hospital so when you say, for example, when you have a private company come in to clean a hospital rather than the trained staff that are publicly funded staff right now, they may not have access to or may not use the same level of hygiene as what is used now, which can increase potential for all of the super viruses and the diseases in the hospital which can actually compound the effects on patients. I would be quite concerned to go into a hospital that I knew contracted out their cleaning or was a private hospital.

Government regulation and control is needed to prevent businesses from 'cutting corners' in order to increase profits. My participants recognized this inherent problem with having private business involved in healthcare: If profit is the primary motivation, there is a danger that safety will suffer.

Another aspect of quality deterioration which was expressed by several participants was that resources could shift from the public to the private system, thereby decreasing quality in the public sector. Bons bluntly stated: "They [the private sector] are stealing valuable resources from the public system." Similarly, Rick fears "we would lose our doctors, or at least some of our doctors, obviously to the private sector, [and] nurses." With a limited amount of resources, it is reasonable to think that private sector involvement would negatively affect resources in the public system. Another concern is regarding the amount of public money paid for private service

delivery. If costs increase – as they invariably do when profit is necessary for survival – more money must come out of public healthcare funds, and therefore there is less to go into the system as a whole. My participants shared very real concerns about the implications of losing public control, as well as precious resources, to the private sector, for something as important as the Canadian healthcare system.

4.4.6.3 Cost. Finally, my participants strongly felt that the rationale behind the move to privatize is considerably flawed. While the comments above speak to contravening the principles of the Canada Health Act, my participants also challenged whether privatization even makes sense economically (which is a proposition assumed by neoliberal philosophy and one which much of the public seems to take as a given). Seven participants commented that privatization does not lead to cost savings; in fact, inherently, a shift away from pubic control and finance will end up being more expensive. Carley stated: "The costs that are incurred for the healthcare system under a public provider are no higher than in a private [system], it is just who gets the services that is the difference." Simon has "a big concern with for profit health." And this was the point of other participants as well: Businesses need to make profits for shareholders, so privatization would naturally, and by necessity, be more costly. According to Geddy:

> The concern I have is when you get business or specific industry involved in the healthcare system, they are really putting their agenda forward for the sake of their shareholders, their stakeholders, that have investment in the company, not necessarily the good or the welfare of the society in general.

Geddy's concern was not only the extra cost but that private business interests are not interests of the public good. In discussing a specific company, Alice said: "It is a private company; I mean they are doing what they do to make money." And Rick commented: "They [businesses] are offering the [surgical] operations where money can be made." Janick gave a very straightforward description of this basic economic principle:

> Wall currently is talking about setting up private-public partnership … whether it is a school, a hospital, or any publicly used facility … in the long run … it costs substantially more to the government and the people using it, which stands to reason. If I own a building like this, I want to make a little bit of money on it. So if you have a clinic that is doing MRIs … or laser surgery on eyes … can the government do it cheaper? In my view, most definitely yes. If an individual has money involved he is going to want a return on that investment above what operating expenses are. If the government has it, all it wants in return is to be able to get the operating costs, which, no matter who runs it, is the same. Publicly owned is cheaper.

My participants were quite adamant that the arguments for increased privatization in order to save money for the healthcare system are specious. Private businesses need to make profit to stay in business so an increase in costs is inherent and inevitable.

Instead of focusing on businesses and their need to make profits, some participants discussed how governments can provide services cheaper than the private sector since it is one large collector, payer, and provider (this was discussed briefly in the section *State of Medicare and Government Role* above). This was the angle Ronnie took: "Just look at economies of scale. I mean if more people are paying into the system …" My participants were certainly not buying into the mantra that private businesses can help alleviate economic pressures on the healthcare system through efficiencies which the public system is unable to attain. If privatization leads to poorer quality healthcare, unequal health services, and higher costs, why on earth would there be an agenda to change the nature of our publicly funded healthcare system in this direction? This may be a good time to have a look at the elephant in the data: neoliberalism.

4.5 Neoliberalism

It is interesting, especially in light of the discussion thus far in this chapter, that the words 'neoliberalism' and 'neoliberal' did not come up once in all 10 of my interviews (this may be due to the fact that the terms are primarily used in academic settings and not used frequently in mainstream discourse or in the media). Privatizing the commons, deregulating industry,

corporate tax cuts, and dismantling the power of unions are primary tenets of neoliberalism (Orlowski, 2011); all concepts frequently discussed by my participants.

Many aspects of the neoliberal paradigm have already been elucidated, even if it has not showed up specifically by name. As mentioned above, the government focus on tax cuts and the rhetoric, by governments and mainstream media, of the benefits around such policies, is a staple of the neoliberal agenda. The idea that the private sector can best solve economic problems and governments should stay out of the way as much as possible was also frequently alluded to: too much privatization in healthcare, policies favouring business over labour (and the media coverage of these issues), and reduced funding for healthcare. Discourse of the 'crisis' in healthcare and the 'crumbling' healthcare system, by both media and governments, also feeds into this idea that private enterprise is much more efficient and effective, and could help save the public system.

Another tenet of neoliberalism, which has not been addressed yet, is individualism. Neoliberal philosophy gives great credence to individualism over social or group concerns. While most of my participants indicated a strong support for individual rights, all of them believed the rights of collective society supersede those of the individual. When asked how their membership would respond to the same choice, half of my participants unequivocally said they would feel the same way. However, there were two who used qualifiers - "for the most part" (Rick) and opinion "would be split" (Linda) - and one who thought the membership would side with the individual (Carley). Three participants blamed the media for its emphasis on promoting individualism over the collective. Alice referred to "rhetoric around the rights of the individual" and Ronnie elaborated:

> The generation X and generation Y … the 'me' generation … it is very self-centered and you know egocentric thinking. And I blame the media a lot for that

> because, when you look at [it], they are bombarded with images of me, me, me like from the time they are children, that they really don't develop any sort of sense of group action or group thinking.

The idea that current union members may think differently about issues around individual versus collective was also apparent in discussions about group solidarity.

In order to address feelings of class consciousness, I asked my participants how strong group solidarity was among their workers, followed by a question about any changes they have witnessed over the years (if they needed a prompt, I gave them the example of the amount of consensus on job action votes). Four participants said group solidarity was strong, four said it was weak, and two did not directly respond. However, eight participants believed group solidarity is decreasing among members, including two of those above who thought it was still currently strong. Of the two who did not say group solidarity is decreasing, one did not have an opinion and another thought it was increasing recently after a previous waning period. Carley said: "Group solidarity is not strong and it has lessened over the years." Similarly, Linda stated: "It is bad … it has definitely gotten a lot worse." Janick generalized to all unions saying that they are "weaker now than they were years ago; there is less solidarity." Lee used the strongest language saying group solidarity is "pitiful" and "terrible." Many of the reasons for this decreasing solidarity have been discussed above in terms of government and media discourse. This topic will be revisited in the discussion on *Working-class people in Saskatchewan* below.

The individualism coin has (at least) two sides: rights and responsibilities. The responsibility aspect of individualism was addressed with participant responses to the interview question regarding the causes of ill health. Participants were asked, "From most to least important, what factors do you think are involved in determining the health of individuals?," with a follow up asking how much control individuals have over these factors or, in other words, how much personal responsibility (blame) they should have. The most frequent responses, from

seven participants, were related to lifestyle and individual behaviour and choices. Six of them mentioned individual choices either as the first or second most important factor. The next most frequent responses were related to the social and economic determinants of health. In fact, income/poverty was the first item mentioned by four participants; others cited were environment (primarily work-related), housing, family support systems, employment, education, and clean water/good nutrition. Two participants mentioned hereditary factors and two stated access to the healthcare system. Of those who listed individual choices and behaviour, only three did not mention some aspect of social and economic determinants as well. Most participants did not venture into much conjecture about how their membership would respond to this same question. However, for those who did, five stated that they thought their membership would be more inclined to mention individual or lifestyle choices and not see the social and economic determinants of health as being as influential. According to Linda: "I think a lot of the membership … are not as aware of limits and barriers to people accessing health … individual responsibility rather than, yes, circumstances." Participants seemed to think that their members would be a bit more likely to attribute ill health to lifestyle choices than some of the social and economic determinants which might influence those choices. This might not be surprising given previous comments about how participants believed government and corporate media rhetoric was significantly influencing their membership. However, it was surprising that so many participants also quickly invoked the individual responsibility discourse. I believe this speaks to the pervasiveness of individualistic thinking in our culture, as well as the dearth of discussions in the media and from governments about the true underlying causes of ill-health.

There were varied responses to my question about the amount of blame individuals should shoulder for their ill health. Two participants said that essentially *all* factors are under an

individual's control and so they bear full responsibility. However, the majority of responses were quite nuanced, articulating conditions on whether an individual would be blameworthy or not. This was especially true for those who mentioned social and economic determinants of health as being significant factors. As Janick stated: "We are all somewhat responsible for what we do but there are so many things beyond our control." Other contributing factors according to Janick are poverty, heredity, and working environment. Alice did a quick question and answer for this one: "I mean how much individual responsibility can someone bear for being poor? Maybe sometimes it is choice…I don't believe that it is very often." In general, most participants had an understanding that personal behaviour could be influenced by factors beyond their control.

It is important to note that, even though there was some ambivalence in responding to the question about personal blame, nine participants unequivocally said that health coverage should be universal for everyone without exception for conditions, including those for which people may be personally responsible (the one exception still believed in universality, but with some caution). Of the five who offered up opinions on their membership, two thought they would agree with their position on universal coverage without conditions, but three thought that at least a portion of their membership would not. This may be somewhat consistent with the breakdown on personal responsibility and blame for ill health discussed above. In either case there appears to be a bit of a difference in how my participants viewed issues like personal responsibility, blame, and universal coverage compared with how they perceived their membership would view them. For my participants, while individual responsibility was mentioned as an important contributing factor in people's health, they often also stated that social determinants of health influence personal choice. This seems to be a condition some thought their membership would

not be so quick to grant individuals. And some participants believed their membership might be more inclined to put restrictions on some people's access to free healthcare based on the fact that their ill-health could be considered self-induced.

4.6 Working-class People in Saskatchewan

I chose to interview labour union executives and representatives in order to get sophisticated answers to my research questions as well as to gain valuable insight into a large group of people – working-class people in Saskatchewan. While it must be noted that my participants may be incorrect in their assumptions, they certainly are in a favourable position to offer valid opinions. It should also be noted that my participants were free to decline answering any questions and many did, especially when they were unsure of the way their membership would respond, or view a particular issue. I have already outlined many of the divergences between my participant's views and those they expected of their membership. Unanimously, each participant placed their membership further to the right than they placed themselves on a political continuum.

My participants believed that union members place higher value on infrastructure and tax cuts in terms of government spending priorities than they themselves would. They also thought some of their members see tax cuts as important, or at least more so than social program spending. While members were thought to think similarly to my participants that healthcare is a social good not a business, they were perceived to be more accepting of increased privatization. Some members were thought to be more in favour of individual rights over collective rights. In terms of ill health, members were assumed to be more inclined to think of individual or lifestyle choices as causes, were less inclined to consider social and economic determinants of health, and more inclined to attribute blame, or at least personal responsibility. Some were even thought to be more likely to desire limitations to universal healthcare without conditions.

Since a primary purpose of my research was to understand motivations and deep reasons for beliefs and opinions of healthcare, an important part of my research was to determine why? If the above statements are true, why is the labour union membership thinking differently from my participants on many issues involving healthcare? Why do my participants think their membership is more politically disengaged and less likely to think communally? To uncover possible answers, my questions needed to expand beyond the public healthcare system to issues of group solidarity and class consciousness, political engagement, and other cultural and individual factors which may be involved. Part of the answer has been addressed above in terms of public discourse driven by neoliberal governments, mainstream media outlets, and powerful business interests. A few more themes emerged which may help to illuminate this phenomenon.

4.6.1 Apathy

Half of the participants explicitly bemoaned the lack of engagement and interest their members had in political issues like healthcare (and all did so implicitly as will be indicated by the discussion below). When discussing the decrease in worker solidarity, many participants attributed it to contentment and lack of interest. Janick said: "Some of that is because they are not interested." Lee described her memberships' feelings about healthcare with the term "complacency." Rick used the word "apathy" and described people today as "complacent. As long as things are perceived to be going well or just well enough, they don't want to make things better." Linda said, "People aren't radical nowadays. People are very apathetic, people are very docile." Simon was a bit more diplomatic when he discussed why the general public is not involved in public discussions about healthcare: "I think many [people] have a less than adequate amount of concern." Simon is the one participant who would not even garner a guess as to where his membership would fall on the seven-point political continuum from extreme left to

extreme right. Beside the fact that "they would be all over the map," he contended that there would be "a huge part that don't care. Until something affected them … then all of a sudden [they may become interested]." (Naively, I had not even entertained the thought that someone might not even *be* a number on a political continuum). If workers today are apathetic to political issues, including healthcare, the next important question to explore is, why?

4.6.2 Lack of Purpose for Unions

The idea that unions are under attack was previously discussed in terms of neoliberal government rhetoric and mainstream media coverage of labour issues (both of them being influenced by the corporate agenda). Eight participants expressed concern at the negative portrayal of unions and how it was influencing their membership (it should be noted that two participants put significant blame on unions themselves for doing a poor job of educating and informing their members on important issues). Lee stated: "Union has gotten to be a bad word … because those that are on the extreme right spend a lot of time trying to make that happen." Linda lamented the "blatant attack, even federally, on unions and people who work within the labour movement." She continued: "The public always is inundated with negative perceptions of the union … there has been a much more concerted effort to make unions look redundant and impossible." Geddy similarly noted: "We are seeing more businesses and politicians push for the agenda of reducing unions and the influence that unions have on government." Geddy sees this influence stretching into "our education system where they have really taken out things to do with workers, workers' rights … and influenced them more with a business agenda." Similarly, Rick said: "Even in school it is pounded, 'unions are bad.'" Participants were bemoaning a concerted and deliberate attack on unions. And this bombardment of negativity seems to be influencing even working-class people in unions. The constant neoliberal refrain they hear is

that unions are too powerful, stifle legitimate business interests, and cause inflated salaries and lower efficiencies. In addition to internalizing this refrain, working-class union members may buy into the 'unions are bad' discourse because they do not see the value or use of their own unions.

According to my participants, there appears to be a feeling among union membership that unions are not as relevant to worker's lives as they were in the past. This may be due to the distance in time from when labour unions were seen as more vital and essential. All 10 participants communicated this view in one way or another. The primary expression had to do with a lack of hardship for today's workers, added to a lack of appreciation for, or at least a sense of, the historic struggles of labour movements in the past. While discussing strikes and collective bargaining battles in his career, Simon stated that today's workers "have never had those fights." According to Janick:

> Once people have actually suffered – suffered isn't the right word – experienced some of these downfalls, some of these lows, there would be more interest in helping … the people coming up into the 60s and 70s and 80s did not experience that, they had no idea what it is, they are not interested. If you grew up on social assistance or in poverty or in a household that had a major medical need or faced some major medical whatever, your perspective on it changes and you become more interested.

Referring specifically to public healthcare, Rick used a common expression when he described how easily people forget of the battles that were fought and won before them: "It was a long hard fight to get public healthcare and once you have something, you don't realize that it's gone until it is gone." Geddy echoed this sentiment when he discussed Medicare:

> As far as healthcare systems go, people generally forget historically what got them here today … the rise of resistance will be there I believe when that individual has been denied access, when groups have been denied access. I think that is when you will see the rise up happen … but I don't think you will see a rise or resistance until it is actually taken out of your hands.

Bons said: "We are so many decades removed from how Medicare was first introduced that … how things used to be is not as immediate to people." The historic distance from more tumultuous times seems to be an important influence on how today's workers perceive the status and necessity of unions and their objectives.

There were a few other explanations given for why many current workers do not see unions as being as important and necessary as in the past. In Linda's union, there are many new immigrant workers who "don't have any allegiance or any sort of, not loyalty, but affiliation … they know they are part of a labour union but what does that mean? It usually means nothing to them until they need us." And she noted that the level of transience of her membership also contributes to the decrease in solidarity. In describing one particular company Linda explained:

> They [this company] proposed buy outs for their senior employees … so that they created a vacant vacuum up top and then filled it up with the new hires. The new hires don't have any allegiance … the perception is "what is the purpose of having a union, and for me as a new hire, I don't see that larger bang for my buck until I am there for four years, so if I can go to Tim Horton's now and get $13 an hour instead of $11, I am gone. And I think you get that with the general public too … there is no allegiance to workplaces.

Lee believed his membership's feelings on unions are directly related to the current booming economy in Saskatchewan: "That goes with good times … the struggle of the labour movement is far stronger when they are down beaten and trodden." Finally, according to Alice, unions have become a victim of their own success:

> It seems to me that because unions have over time … over their history done a pretty good job of advancing workers' rights and solidifying worker's rights and in obtaining wage increases, so it is sort of like, what is there left for a union to do then?

It is likely that the decrease in feelings of solidarity among labour union membership and the lack of interest in traditional union goals is due to myriad of factors – one of which is that workers see very little purpose for unions in Saskatchewan in the 21st Century. Exacerbating this

is the continuous neoliberal rhetoric promoting individualism and the goodness of free markets. Despite the many gains made for all Saskatchewan workers by union actions, these factors seem to have combined to create a false political consciousness in the working-classes, who now sometimes see the collective power of their own unions as a negative, or at least unnecessary, for not only society but for themselves.

4.6.3 Feelings of Entitlement

Related to some of the ideas expressed above – seemingly good economic times and lack of hardship – seven participants described their members as feeling privileged and/or having high expectations of benefits and services. There was often an age component in these comments, comparing the younger generation to older workers. According to Rick: "Younger people … especially in the labour movement, [have] a sense of entitlement." He went on to say this sense of entitlement transfers to feeling about healthcare: "'I have healthcare because that is what the government *gave* me. [Emphasis mine]'" Similarly, Linda said: "A lot of young members … take it [healthcare] for granted that this is free and I get this service for free." Referring to the time that has lapsed since the introduction of Medicare, Carley said that, even though Canadians "recognize that it [healthcare] is a very important service for the government to provide … healthcare is something that we have had around long enough that most people kind of take it for granted." Twice in my interview with Simon he highlighted this point, and without any specification for age:

> Canadians overall see our healthcare system as not a privilege but as an entitlement … A lot of that [healthcare services] I think they very much take for granted because they have had it … and they haven't contemplated what that means to lose that … I know there is a strong sense of entitlement, right, as opposed to actually being privileged.

Simon is describing an attitude that the public today has towards public healthcare that others who know what it was like without it would not have had. In other words, people today think of healthcare as an 'entitlement' – something owed to them and that they deserve – as opposed to a 'privilege' – something we should appreciate and consider ourselves fortunate to have. Ronnie discussed how people "expect to be serviced" by their union because of the dues they pay. She went on to say: "That pay for service expectation runs through the healthcare system too." This sense of prerogative speaks to a distinct difference (at least a perceived difference) between Canadian workers today and those of previous generations.

4.6.4 Individualism

Another generational difference that came up in my interviews was the idea that people are more individualistic today than in the past. This was discussed above under the theme of neoliberalism and the discourse that goes along with it. Seven participants lamented what Ronnie called the "me generation" and Rick called the "right now generation." In most cases, this was apparent in an attitude of "what can my union do for me?" (Alice). This individualism runs parallel to the idea of entitlement discussed above. Alice went on to say: "The whole individualistic tendency … manifests itself in the union movement. 'If they [the union] don't do everything I want them to do, well they are bad.'" When asked to describe her membership's feelings on individual rights versus collective society rights, Alice said: "There might be an emphasis on how I am doing, how this is affecting me personally." Carley also believed that "there is a push towards the individual and a push away from the group." Janick's description of individualism was a bit more abrupt: "A lot of working people … have this philosophy that I am good at what I am doing; I am going to do it for my benefit and my benefit only, the heck with everybody else." According to Linda: "People in general don't pay a lot of attention to it

[healthcare] until it is something that affects them personally." Individualism, as described above, goes counter to public social policies like Medicare, and could be seen as another factor contributing to apathy.

4.6.5 Membership and Political Awareness

In some cases, participants simply said that their membership was under-informed on political issues of importance. In fact, eight of them mentioned this as a reason for their political disengagement. In many cases, there was little blame placed on people themselves for this deficiency. Ronnie, in discussing research that showed that the private surgery clinics do not markedly decrease waiting time for surgeries, said: "The general membership may not have the same access [to the research]." Bons ascribed a large degree of blame on labour unions themselves:

> I think on the whole, people are not as politically aware as they used to be, or as we think they used to be. We are so many decades removed from how Medicare was first introduced … fight for this Medicare system is not as engrained in our current generation. I think unions in the healthcare system have done a shitty job of reminding people to keep them informed, of giving them all the facts.

If unions are inadequately countering the discourse of individualism and privatization, I believe Bons may be on to something with the above comment. Labour unions may be assuming too much when it comes to their membership. Perhaps the lack of concerted effort on their behalf is based in the false belief that their membership will automatically see the union as an important force for good in their lives. The politically savvy and astute executive may believe that the counter arguments are so logical and intuitive that their membership will easily see through the rhetoric they hear in the media. With the apparent false political consciousness described in this paper, this miscalculation could turn out disastrous when it comes to defense of social programs like Medicare.

According to Geddy, the education system is lacking in teaching our youth about labour (this was described in the section above - *Lack of Purpose for Unions*), and the government is not giving information to the public that they need to make informed decisions. Orlowski (2011) discussed the failure of the public education system to teach students about labour history issues, including collective bargaining and strike action. Thus, many working-class union members do not have a background in the importance of the labour union movement from a historical perspective. Lack of this grounding contributes to the fact that many may not see the purpose of their labour unions.

In discussing the 'crisis' in healthcare, Geddy stated: "How it [public healthcare] got broken … will never be explained to them [the public] how it is broken; they will just be notified that it is broken and needs to be repaired." In some cases logistics prevents public awareness. According to Rick, with both parents working, discussions about labour history, simply do not take place as they should. And Linda mentioned language as a barrier to educating their membership:

> We don't speak the languages of most of our members anymore. It is not English as a second language anymore; it is English as an additional language because everybody speaks different languages so it is hard for us as a union to educate people on all different kinds of issues, let alone their own collective agreements, but keep them up to date on privatization and issues that should affect workers.

Clearly there are societal and institutional barriers that are preventing the public from being as informed as they need to be about political issues that affect their lives.

Three participants put more of the onus on the membership (and, by extension, the public in general) for not being as politically aware and astute as they should be. In complaining about their lack of education, Lee said that his "membership is totally blind to what is going on politically with things that will affect their lives every day." Carley pointed to the lack of critical thinking in questioning and analyzing what her membership hears from the media. She said that

if people are not seeking out "alternative media" sources, "you are watching the 6 o'clock news, you are reading the paper that is easily accessed, and there is still a belief out there that if it is in the news it must be true." When discussing privatization, Simon complained that many members "have not taken the time to concern themselves or educate themselves." And tying the lack of education with current government policies, Simon said: "The right wing agenda counts on, absolutely counts on, people not educating themselves and not being involved." Similarly, Linda stated:

> It is easier to live your day to day life in a sort of state of blissful ignorance, and I think that the government that we have in place right now – and all governments rely on that – I think all governments rely on a good portion of their electorate to remain blissfully ignorant and not to rally and oppose things that are coming up.

Whether the fault of individuals, institutions, or logistics, my participants were very adamant about the perceived lack of knowledge and political engagement of their membership. And it appears labour unions themselves are dropping the ball when it comes to educating their membership on issues such as the importance of public healthcare, the value of the collective good, and the dangers of privatization of the commons.

4.6.6 Busy Lives

One final theme, related to the apathy so prevalent in many of my participant's comments, was quite simply economic realities and busy lives. This was mentioned by five interviewees, and there was often a generational undercurrent to these comments as well (or at least reference to young workers). Janick articulated this sentiment:

> When you are young your interests are different, your goals are different. If we are talking about a union member who is twenty years old, his first priority is making enough money to buy a car. After that he needs money to buy his house which right now is almost impossible. Whether you are a little older and you have got three kids in school and trying to put money away for their further education. That becomes your priority, not looking after a neighbour.

Those familiar with de Tocqueville's (1956) 19th-century critique of American democracy will recognize a similarity in Janick's comments. Tocqueville (1956) believed that people in a democracy would be too consumed with the day-to-day demands of trying to survive that they would not have time to stay politically aware of what is in their best interests. Janick believes this is exactly what is occurring with many working-class people today. In this case, political ignorance is simply an unavoidable consequence of having to deal with other more practical realities in one's life.

In her response to a question about universality of healthcare services, Alice said that her membership "have hard jobs … [so] they don't have the luxury maybe of thinking of stuff like this as much as I do." According to Geddy: "As far as healthcare systems go … for a lot of the majority of the people and their families are, 'what is going to happen today?'" Linda also discussed how young, and transitory, workers often do not have health as an issue at the top of their minds: "A lot of young members, also a lot of turnover, so I think that sometimes health is not necessarily a consideration for them." She elaborated later in our interview that "people are living in very isolated, busy lives." The practicality of being busy with work, not garnering a large wage, and being concerned with things of immediate economic importance were seen as barriers to political engagement by several of my participants. While lamenting the lack of political awareness of their membership, my participants showed considerable empathy by identifying these barriers. Given this understanding, it is apparent unions must do more when it comes to educating their membership and helping them to become more politically aware. They must address the fact that their membership consists of people consumed with practical day-to-day economic and social struggles. They are absorbed in a culture of individualism that seems to have forgotten the value of the collective good. And they are a more transient group than

workers several decades ago, living in a time five decades divorced from the original struggles of the introduction of Medicare.

4.7 Summary

My participants located themselves slightly to the left of center politically, some being careful not to label themselves as 'extremely' left wing. In general, they expressed high satisfaction with the quality of the Canadian healthcare system, especially when comparing it to healthcare in the United States. My participants placed high value on most of the tenets of the Canada Health Act: universality, accessibility, public administration (and funding), and comprehensiveness. There was a significant level of disappointment with the policies and public discourse of both the provincial Saskatchewan Party and Premier Brad Wall, as well as the federal Conservatives and Prime Minister Stephen Harper. Participants believed healthcare should be a public service, and expressed concern at the amount of privatization creeping into the healthcare system: private surgery clinics, privatized long-term care, and public-private partnerships. This concern was quite nuanced and not based on blind obedience to left-wing ideology. Participants articulated many practical reasons to oppose any loss of public control over healthcare: unequal care, quality, and cost. Occasionally government motives were questioned and some participants accused them of intentionally creating an environment conducive to privatization. In other instances governments were taken to task for not being honest with the public on issues involving healthcare (among other things). A similar sentiment toward the media was also quite common. Influenced (and even controlled) by big business, mainstream media and the government were both thought to be promoting an agenda of neoliberalism (despite the omission of that specific term in my interviews), especially concerning privatization and individualism. Despite this prevailing rhetoric, most of my participants were well aware of the importance of social and economic determinants of health as being the most

important factors in an individual's health status. There was near consensus that group solidarity among labour union membership had decreased in recent years, largely due to the factors listed above.

My participants located their membership as center or slightly right of center politically, while unanimously placing them further to the right than they themselves were. While it was thought that union members would highly value Medicare, there was some concern expressed that they may not rank it quite as high in terms of government priority, giving more significant importance to things like tax cuts and infrastructure. While it was believed that the union membership, like my participants, would think of healthcare as primarily a social service, it was thought that they would likely be more open to increased privatization in healthcare. It seems that a steady diet of neoliberal rhetoric from governments and the corporate media may have convinced much of the working class that public healthcare is not sustainable without the infusion of private businesses. This neoliberal discourse, including the ethos of individualism, seems to have created a false political consciousness whereby the working-classes are not standing up for social institutions that they benefit from, and that they have fought mightily for. In terms of ill health, participants thought their membership would attribute more responsibility for individuals and the choices they make, and less on the social and economic determinants of health. It was common among my participants to describe their membership as disengaged with politics and disinterested with political issues like healthcare. This was attributed to a wide variety of factors: demographics, lack of purpose for unions today, sense of entitlement, individualism, lack of education and information, economic realities, and being preoccupied with typical concerns of daily life. My concern is that the ship of Canadian public healthcare, as

sturdy as she has been for 50 years, is vulnerable to a perfect storm of factors, described by my participants, which may be occurring in Saskatchewan today.

CHAPTER FIVE:

DISCUSSION

Social trends are difficult to capture and understand since they involve complex individuals with diverse motivations and desires. They can be fluid and ever-changing because people do not necessarily base their beliefs and actions on any specific set list of contributing factors. Thus, studies of human behaviour and societal movements are almost inevitably limited to gleaning partial insight and not the full picture: certain layers of the onion skin without the entire onion being revealed. The purpose of this study was to uncover some of the layers involved in how the public forms opinions and attitudes about healthcare in Canada. Because of recent trends toward privatization and the lack of a passionate and sustained opposition to it, I chose a group of people who would likely be strong supporters of a publicly funded and administered healthcare system. Working-class Saskatchewan people seem to be an apt demographic due to their geographic location in what was once the heartland of socialism in Canada, and because their socioeconomic status would put them in a position to benefit from a system like Medicare. I relied on labour union representatives and executives in order to get insight into the attitudes and beliefs of a broad group of workers. By doing in-depth interviews I was able to delve into the thoughts of my participants as well as the predicted thoughts of their membership. What became apparent as I studied the interview discussions was that a potential perfect storm of factors – social, economic, and political – seem to be at play in creating a very dangerous climate for Medicare as Canadians have come to know it. These factors consistently fell into two major categories: neoliberalism and political apathy. False political consciousness plays a role in each of these themes.

5.1 Neoliberalism

Although 'neoliberalism' was never mentioned specifically by name, many of the factors participants discussed as being influential were, indirectly if not directly, linked to the philosophy of neoliberalism. The most direct link occurred when participants discussed current government policies and rhetoric. While most of my participants exhibited a very skeptical, and at times critical, view of the federal Conservatives under Stephen Harper and the provincial Saskatchewan Party under Brad Wall, they expressed concern that their membership was not so discerning. Apprehension was articulated over the government's creeping privatization agenda and a working class that was not paying much attention to the phenomenon. One of the primary reasons for this perceived lack of public concern is the nature of the dialogue around healthcare, initiated by governments, and echoed by a biased mainstream media.

The messages being promoted by current governments and mainstream media are consistently in harmony with neoliberal philosophy: Medicare is in a crisis situation and the only way out is through more privatization. It is not the purpose of this paper to prove or disprove that assertion. As Chapter Two attests, there is a great deal of literature that fundamentally disagrees with this contention. More important to my research is that my participants *believed* that governments are intentionally manipulating the truth to push forward an agenda of privatization that threatens Medicare. Furthermore, they believed that their membership is being influenced by mainstream public discourse to the point where they are buying much of what governments are selling: Privatization can alleviate pressures on the healthcare system, lower taxes are paramount, and small government is better for society. Corporate influence with both governments and media outlets is seen as a primary driving force behind the neoliberal agenda.

Participants frequently discussed the lack of fairness in the current public dialogues on healthcare in Canada. Government is heavily influenced by big business and the corporate

media. Thus, the business agenda is promoted heavily to the exclusion of, and detriment to, the public good. A typical example of this is the heavy focus on process goals like surgical wait times while ignoring things which would improve health outcomes, like the socioeconomic determinants of health, the primary causes of ill health for individuals. Thus it may not be too surprising that my participants thought that their membership would be more likely than themselves to see ill health as a result of lifestyle choices instead of other environmental influences (many of which would be out of people's control). Furthermore, incremental changes to healthcare – like user fees and private surgery clinics - are often unnoticed, insidious ways to slowly erode Medicare in its current form. Given these factors, it would be unsurprising if the labour union membership were swayed by the privatization-of-healthcare discourse.

Hence, it is likely that we have the creation and nurturing of a false political consciousness among many working-class people in Saskatchewan. Despite being a demographic group that would normally be staunch supporters of public healthcare, my interviews revealed that the union representatives and executives believed that many in this group have likely bought into the neoliberal agenda. The repeated discourses of crisis in public healthcare and wasted tax dollars on a failing system are very influential and powerful. Government and media rhetoric espouses the efficiencies and effectiveness of private enterprise compared to a public system of waste and bloated costs. Lower taxes *sound* like a good deal for everyone, including the working-classes. However, by accepting these premises without question, and without challenge, much of the public can end up bearing the burden for the wealthy corporate elites while missing out on benefits that they deserve. Such is the paradoxical harm involved with false political consciousness. A cultural undercurrent which exacerbates this phenomenon is the discourse of individualism.

It is not clear whether individualism is consciously promoted by neoliberal adherents as a means to support much of their philosophy or if it is a cultural trend which happily (for neoliberal proponents) coincides with this agenda to defend and justify it. In either case, individualism is seen as a dangerous ideal from my participants' perspectives. Individualism supports personal freedom and responsibility over public good and communal responsibility. In terms of healthcare, individualism is not compatible with a publicly funded and administered system where everyone is treated the same, without concern for how much they have contributed or how much blame they might have for their condition. While my participants certainly did not think that their membership had turned into cold-hearted libertarians, the concern over changes in communal spirit and solidarity was palpable.

5.2 Apathy

Another overarching theme emerged when my participants discussed the decrease in worker solidarity in recent years: a lack of interest in, and concern with, issues of potential political importance among their membership. While some of the blame for this apathy may be the result of the policies of government, influence of big business, and rhetoric from government and media, other factors were also described. Given the historical distance from more extreme times of labour versus business strife, it is easy to see how workers would have less sense of the importance of the united powers of resistance that labour unions offer. Labour unions have made significant gains for their workers since the Depression and today's working-classes may be taking for granted many of the hard-fought rights won in the past. Many of the province's workers are benefitting from economic prosperity in Saskatchewan, which is likely causing a detachment from the causes of decades past. In some cases participants viewed this apathy to be a result of institutional barriers, like an educational system which is ignoring teaching young people about labour history and the importance of gains won. (This is yet another reason to

question the extent of neoliberalism policy's reach and influence.) Labour unions themselves are also guilty of ignoring the importance of educating their membership. In other instances, a more pragmatic reason surfaced: Working-class people are simply too busy with everyday economic and social needs to be overly concerned with political matters.

It appears what is happening is a not-coincidental false political consciousness (Frank, 2004b) among working-class people in Saskatchewan. This appears to be having a very deleterious impact on how they are thinking about issues like public healthcare. It is not clear whether political apathy is a cause or a result of false political consciousness – likely a bit of both. It is not that the labour union membership are promoting an overt dismantling of public healthcare in Canada but more that they seem to be generally accepting of measures taking place which could have this effect. The pervasive discourse of tax cuts, small government, and the Medicare 'crisis' seems to have convinced many working-class Saskatchewan people, at least according to my participants, that privatization is a good thing and quite possibly necessary to save healthcare. This is despite the fact that they are very likely to be the group which would lose the most with a move towards privatized healthcare. All of this fits with neoliberalism.

5.3 Recommendations

Democratic countries rely on open and honest discussions of policies and motivations in order to make rational and fair decisions that benefit all citizens. My fear is that an agenda of neoliberalism, combined with misinformation, is creating a false political consciousness in much of the public – at least in working-class people in Saskatchewan. If this is the case, open and honest discussions about healthcare are not occurring; in fact they cannot possibly occur. A typical Saskatchewan worker's view of public healthcare in Canada is being created through a lens obfuscated by misinformation and one-sided rhetoric. I believe it is imperative that every

Canadian should be aware of the potential distortion that can be created and seek ways to ameliorate the forces which are at the root cause.

5.3.1 Government

We currently live in a political climate of hyper-partisanship. Given this reality, it is difficult to imagine much change coming from the upper echelons of government. However, we do live in a democracy and, therefore, we can demand changes to the way things are currently done. Dissenting voices need to be given an opportunity to challenge existing ideologies and philosophies. Current neoliberal governments in Saskatchewan provincially, and especially in Canada federally, have been controlling the dialogue around political issues to the detriment of healthy, open debate. Bons mentioned that the prevailing way of referring to progressives these days is "crazy left wingers." And, tongue –in-cheek she referred to her own beliefs as a "goofy left-wing perspective." This has created a climate where arguments for increased taxes to pay for social services are dismissed out of hand. The social and economic determinants of health, the most important factors in ill health, are mentioned infrequently while personal responsibility as the exclusive reason is accepted without question. And any discussion of reforming healthcare from within the public system is denigrated as hopeless and unrealistic. Opposition parties must continue to hold current government's feet to the fire and make the case that governing parties do not hold exclusive rights to the truth. They must remind the public of this and make cogent arguments to counter what has become accepted knowledge. They must continue to provide the public with additional views of reality in order to continually push public dialogues so that they become more informed and substantial.

A larger, and likely more difficult, problem to tackle is the influence business has with governments and the mainstream media. It is beyond the scope of this paper to detail all of the

ways business has influence in governmental decisions – well-paid lobbying, contributing to capital construction projects, and campaign donations to name a few. However, a clear connection can be made: The more influence business has with governments, the more likely governments will opt for policies favouring those businesses. And privatized healthcare provides lucrative opportunities for entrepreneurs to make significant amounts of profit, especially compared with a publicly funded and administered system. One does not have to make much of a leap to see how governments, influenced by the corporate agenda, may be interested in promoting privatization in healthcare; especially governments espousing a neoliberal philosophy. Every effort must therefore be made to eliminate, or reduce as much as possible, the potential conflict of interest (to put it euphemistically) that exists in our current political system. Perhaps the education system is a place where positive change with the greatest impact can occur.

5.3.2 Curriculum

I believe it is necessary that children in the K-12 school system be educated on social justice issues including labour history and the history of Medicare in Canada. Orlowski (2011) discussed topics which need to be taught in Canadian schools – populist history, the creation of the social welfare state, labour contributions to society, public versus private ownership, what taxes are used for, and critical media literacy to name a few – along with methods to accomplish this. A focus on critical pedagogy is obviously essential. I currently work in a faculty development teaching support unit for medical education in the College of Medicine at the University of Saskatchewan. Because of this, I would like to briefly focus on the role of undergraduate, post-graduate, and continuing professional education in Medicine.

It is important that physicians are knowledgeable of all issues pertaining to Canada's healthcare system, including public perceptions. The Royal College of Physicians and Surgeons of Canada, and more recently the College of Family Physicians of Canada, has adopted a list of competencies for their physician members – under the seven CanMEDS roles. These competencies help shape the content of medical education for undergraduate students as well as post-graduate residents. Two of these roles - communicator and health advocate - are related to my research:

> The competencies of this [communicator] role are essential for establishing rapport and trust, formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care (Frank, 2005, p. 12).

As such, physicians with a better understanding of patients' views of public healthcare in Canada will be better equipped for these communication tasks and, therefore, more effective in providing care. In terms of health advocacy: "Individual patients need physicians to assist them in navigating the healthcare system and accessing the appropriate health resources in a timely manner" (Frank, 2005, p. 19). In addition, "health advocacy involves efforts to change specific practices or policies on behalf of those served" (Frank, 2005, p. 19). Since my research deals directly with public perceptions and attitudes regarding the Canadian healthcare system, it has implications for medical education's advocacy role as well. And future physicians need to discuss these issues early on in their training. According to Alston et al. (2011, p. 195):

> It is essential that students in health professional programs be equipped with the necessary knowledge to actively participate in shaping the healthcare system and to advocate for optimal care and population health outcomes.

There is some evidence that current medical education may not be preparing future physicians adequately in this regard (Alston et al., 2011). And, as mentioned earlier, the mainstream media and political discourse may not be sufficiently (or even accurately) educating the public on issues pertaining to the healthcare system.

Physicians are front line educators of the public on issues of health and healthcare systems. They are also advocates of public health policies – promotion of health equity in society (Andermann, 2011) - and intermediaries in dialogue between the public and administrators in terms of future directions of healthcare. Public involvement in healthcare decisions is vital since they are essentially the owners and users of the system (Dickinson, 2002; Maxwell, Rosell, & Forest, 2003; Romanow, 2002). Local and provincial governments are consulting the public for input on healthcare reform (Armstrong & Armstrong, 1996; Chafe, Levinson, & Hébert, 2011; Jackson et al., 2002; Laforest & Phillips, 2007) and, thus, their attitudes and perceptions are of utmost importance.

Physicians have the ability, through the advocator and communicator roles, to encourage citizens to be involved in their healthcare system, help educate them on issues like privatization of healthcare services and delivery (i.e. help people develop informed opinions), and act as liaisons between administrators and the public in this ongoing healthcare dialogue. Medical education curriculum needs to provide the knowledge and tools for physicians to take on these multiple roles. The significance of these factors is evident in the Medical Council of Canada's (responsible for licensure examinations) objectives for medical students, which include knowledge of the healthcare system, educating others, working to improve healthcare, and advocating on patients' behalf (Medical Council of Canada, 2012). This importance, combined with the dangers of false political consciousness, highlights the necessity for physicians, current and future, to understand the factors which lie at the root of people's opinions of healthcare in Canada.

5.3.3 General Public

Finally, I think some onus needs to be placed on the general public. They need to be aware that the social programs within our society did not magically appear, and they certainly could disappear or deteriorate without much (or any) notice. Political engagement may not be everyone's cup of tea but living in a well-functioning democracy requires it. Without it, the 'well-functioning' aspect suffers and degenerates. The first step to engagement is political awareness. People need to become familiar with the history of Medicare and the reasons why so many people struggled mightily against many of the powers that be to implement a public healthcare system. They need to be fully aware of what healthcare was like before Medicare and what healthcare might be like after further changes. They need to be aware of the implications for themselves, their families, and their fellow citizens. They need to challenge what is being reported by governments and media outlets and demand evidence for significant claims and policy decisions. They need to demand alternative explanations and make informed decisions on what is the best course of action. If all of this is accomplished, and the decision to go down the road of more privatization is still accepted, then those of us who espouse Medicare in its purest public form must accept that decision. However, if the political, cultural, and economic climate lulls the public into a false political consciousness, only with knowledge, reason, and determination can they possibly overcome this obstacle. In my opinion, it is the only antidote.

5.4 Reflections

This study was conducted with an emergent grounded theory approach. I have made it clear that my primary research question was derived from a concern with Medicare and the lack of public opposition to perceived changes in the system. I was born and raised in Saskatchewan which likely increased my intrigue in this phenomenon happening in my own backyard; a backyard with deep social democratic roots. Aside from the motivation described above, I

attempted to allow the results of the interview analysis describe people's opinions about healthcare with as neutral a filter as possible. I expected that my participants would provide valuable insight into the minds of working-class people in Saskatchewan, and I believe they did. I cannot say I was surprised by most of the results of the interview analysis. I was looking for plausible reasons why a group of people who would be expected to be staunch defenders of a program like Medicare did not seem hell bent on protecting it in light of potential transformations. While I was not necessarily expecting to uncover a false political consciousness, it certainly helps to explain the phenomenon which prompted my research.

Given recent voting patterns in Saskatchewan, both provincially and federally, I was not too surprised at many of the characteristics and attributes ascribed to labour union membership: individualistic, pro-tax cuts, and being politically apathetic. (Granted, these characteristics are the conclusion of my participants, and their analysis of their membership may not be entirely accurate.) For the same reason, I was expecting the membership to be located more to the center or right on a political spectrum compared with my participants. I was, however, surprised at the degree of difference ascribed to these two groups by my participants. Granted, union membership would be extremely demographically diverse. However, there were so many comments that had a generational tone that lamented the difference in workers today compared with those a couple decades ago. It was clear that, for the most part, my participants believed that in terms of worker solidarity, social collectivity, and importance of fairness, their membership certainly held different viewpoints than members in the past.

A few things surprised me about my participants themselves. In terms of politically positioning themselves on the one to seven scale, I certainly expected a few to place themselves as a one, or an extreme left winger. I was not prepared for numbers so close to the center.

Perhaps this is due to different impressions of what it means to be an 'extreme' left winger. A contributing factor in this perception is the political climate of the day as well as one's past experiences. For example, in today's neoliberal environment (one which began with Mulroney in the 1980s) in which Canada is quite far to the right, lefties may consider themselves to be centrist in comparison – a shifting of the entire spectrum, one end of the continuum pulling the other along with it. Alternatively, one who might have considered themselves centrist in the past may feel very left wing now due to the distance between themselves and neoliberalism. This really highlights the complexity and subjectivity of such descriptors. Furthermore, when asked this question, my participants may have been thinking of economic *and* social issues, some of which may fall on either side of the middle of the political spectrum.

Further, although I expected my participants to be pro public healthcare, I was surprised at the degree of commitment to our current system as well as the level of articulate arguments for maintaining it without private business involvement. I expected a bit more wavering when discussing universality, but nine participants staunchly stated that this condition should remain with no exceptions (except for elective-type procedures). In other words, they believed that although some people might be partly responsible for their ill health, that fact should not matter in terms of accessing equal healthcare benefits. (Perhaps this is an example that I interpret such a position as far left while my participants may see it as somewhat to the left.) Further, seven of them advocated for expanding the basket of goods that are currently covered by the system.

I expected many of my participants to be aware of the social and economic determinants of health but, given the lack of public dialogue about these factors, I again was surprised by the degree to which they brought them up as important. When commenting on governmental spending priorities, when healthcare was mentioned, usually socioeconomic determinants of

health were considered as part of that priority. And socioeconomic determinants of health were also significantly mentioned by some of the participants when discussing the reasons for individual ill health. Finally, my participants gave well-thought out, nuanced reasons for rejecting privatization; i.e. not simply ideological talking points. It was not just a matter of being anti-business and pro-labour. The arguments given by participants analyzed many repercussions to the healthcare system in terms of equity, costs, resources, responsibility, safety, and many other aspects.

5.5 Limitations

Qualitative research sometimes needs to sacrifice breadth for increased depth. I attempted to ameliorate this by interviewing a select group that could shed light on a larger population. This did, however, sacrifice hearing first hand from many workers who were the primary focus of my research question. Thus, the most obvious limitation is that the opinions of my participants may not completely match the sentiments of their workers. Due to their position within the labour union, it is likely that my participants would be able to at least somewhat accurately reflect their membership's beliefs and opinions, but this is not certain. After all, I am unsure to what extent each union executive polls its membership about societal issues such as public healthcare. My participants' discussions about the beliefs of their membership could be biased by personal experience, position within the labour union, or political leaning, among other things. Furthermore, my participants all expressed personal satisfaction with the healthcare system. Interviewing people who would have had negative experiences with the system may have altered the results as well.

Another limitation is related to my interpretation of motivations and deeper reasons for the way these union executives and representatives described how working-class Saskatchewan people think about Medicare. An analysis of this kind has the potential to suffer from

misinterpretation. I personally did all the interviewing and data analysis and, thus, a certain degree of subjectivity is unavoidable. (I find it ironic that reliability can have the effect of sacrificing objectivity.) It is possible that the idea of false political consciousness is a red herring and that working-class people have looked closely at the issues involved, reasoned through the debates, and have come to the conclusion that privatization is necessary in order to save our public healthcare system. It may be the case that government neoliberal rhetoric and biased media reporting are not fooling anyone. Perhaps the public sees it for what it is but has still concluded that Medicare needs a fundamental change. This certainly does not appear to be how my participants view what is happening. My attempt in this paper was to find the most logical explanation for the results of my research interviews and the "best fit" theory to explain the data (Glaser & Strauss, 1967; Corbin & Strauss, 1990).

A further limitation arises from the particular sample participants – labour union executives and representatives - chosen for this study. Using this specific group makes generalizing to wider areas and populations somewhat precarious. I was able to interview an equal number from each gender and a sample from private, public, and mixed labour unions. However, the way non-unionized workers see similar issues such as healthcare was not addressed. I do think it is fair to believe that many of the factors influencing the working class referred to in my study would be influencing the public in general. However, it is difficult to determine how these factors might manifest in other socioeconomic groups that might have very different interests and motivations. My sample also may be unique in that all participants were from Saskatchewan labour unions and, thus, not necessarily representative of other geographic areas of Canada. I believe my research likely speaks to wider-spread cultural trends in Canada but this would need to be studied in other geographical areas. Finally, my interviews took place

over a period of three months late in 2012. My participants addressed current social attitudes as well as trends over time but it is possible that their responses were shaped by current events and may not represent how they might respond at another time (or place of course).

5.6 Suggestions for Further Research

The limitations described above lend themselves to suggested ideas for further research in this area. First and foremost, interviews with labour union workers in Saskatchewan would help corroborate whether the picture painted in this study is an accurate one or not. Using the insights gained in this study, quantitative instruments could be created to sample a wide range of workers that would potentially lend credence to the conclusions drawn here. It would also be useful to do a similar study with non-unionized workers to see if they differ in substantial ways. That would give a more complete picture of working-class people in Saskatchewan. To check my own biases, it would be interesting if another researcher did in-depth interviews with a similar group of participants to see what conclusions she might come up with.

Comparable qualitative interviews could be done with similar participant groups in other provinces to compare Canada's working class geographically. As mentioned earlier in this paper, Saskatchewan offers a unique perspective because of its social democratic roots as well as a very particular historical, economic, and political path that make it very different from other places in Canada. It would be interesting to see whether the conclusions in this paper are general phenomena occurring in Canada or localized and unique. Given the political and social climate in recent decades – and the fact we have shared the same neoliberal federal governments - my money would be on finding more similarities than differences throughout Canada.

It would also be interesting to compare my specific socioeconomic group with others in Saskatchewan (and Canada) to see if the same sorts of factors are influencing their perceptions of healthcare and other political issues; for example, rural compared to urban or women compared

to men. How would false political consciousness manifest in other groups, if at all? How would the middle class respond to the same questions? How would the upper classes or those on welfare or the working poor respond? Comparisons of various socioeconomic groups would give a more complete picture of the Canadian voting public. There may be other significant demographics to look at as well – gender, race, and religion – but socioeconomic status is an important starting point.

Finally, as mentioned in Chapter Three, I avoided interviewing members of labour unions that were exclusively connected to the field of healthcare. I wanted my research to reflect a broad spectrum of working-class people's opinions about healthcare and avoid what might be considered a conflict of interest. Interviewing labour union representatives and executives strictly in the area of healthcare would offer a very interesting comparison with those outside the system.

5.7 Summary and Conclusions

This study aimed to achieve a better understanding of how working-class people in Saskatchewan view the Canadian healthcare system, as well as some of the factors underlying those beliefs. Although human behaviour is messy and complex, some recurring themes may illuminate why there is not a stronger backlash against private incursions into the public system. The public is being bombarded with one-sided messages from governments and mainstream media outlets who are promoting a specific agenda. After a while, it is not surprising that the masses start to believe what they are hearing and dismiss dissenting voices. The lessons learned here are to be ever vigilant and politically aware, promote this awareness throughout society, and never take what you have for granted. My hope is that this paper is never referred to prophetically by a future Canadian society without Medicare. My wish is to never need to utter the phrase 'I told you so' regarding this issue in Canada.

> If we allow ourselves to become indifferent to the suffering of some, because we view them as responsible for their plight or as bad people, then the programs and efforts we might have otherwise supported (and once did) for those in need will cease to exist as effective measures. Then, having allowed our biases to cloud our judgment and influence our public policy decisions, we will find ourselves-as we are now-without those very safety nets needed for our own support: their pain and our pain become one (Wise, 2012, p. 139).

While Wise was discussing white privilege specifically, and social programs generally, this statement could easily apply to the current discussions Canada is having about public healthcare. It reflects the sentiment that forms the basis for the reason I originally undertook this study. It is a warning of the potential dangers and repercussions of neoliberal discourse and false political consciousness among the public. In fact, Wise's quote speaks directly to the responsibility (read blame) discourse so essential to neoliberal thinking. In terms of healthcare decisions about allocating resources, there are two fundamental questions we can ask ourselves when forming policy: How much responsibility and blame do people have for ill health and should it even matter? I fear that given the current public discussions, we often do not even get around to the second question (which in my mind precludes the first). Even if we buy into the ethos that people are for the most part responsible for their own health, we can still challenge whether or not that has anything to do with how and where we allocate resources. In a caring and compassionate society many of us have come to the conclusion that healthcare is a fundamental right which should be given universally to everyone regardless of things like background, wealth, personal habits, occupation, and citizenship.

None of this is to say that people should take no responsibility for their own health. We should do all we can to promote healthy lifestyle choices, even to the point of economically supporting them. I believe subsidizing healthy foods such as organic produce and taxing junk food are laudable measures. However we need to be careful not to penalize those already economically marginalized. For those without easy access to the above mentioned 'healthy

foods' this would be more than slightly unjust. What we need to do is address many of the social and economic determinants of health that lie at the root of so much ill health in society. If these are the primary causes of ill health, should not a majority of our 'healthcare' funding go towards solving these problems? Charles Darwin (1997, "19th of August," para. 2) said, "If the misery of our poor be caused not by the laws of nature, but by our institutions, great is our sin." Government policy and funding can just as easily support programs to alleviate poverty as increasing surgery centers – which one would give more bang for the buck? Are we using evidence to make these types of decisions, or ideology and political expediency? In light of these questions, I cannot help but see the plea for privatization to save the public healthcare system as a disingenuous, and in some cases an ethically questionable, red herring.

Ultimately the debate about public versus private healthcare is a moral one (Reinhardt, 2001). As Ryan Meili (Hamilton, 2012) succinctly put it, "it's [Medicare is] just." While healthcare costs continue to rise, decisions on the mechanisms for funding and delivery are political decisions as much as economic ones. If we value equal healthcare for everyone without any deterrent caused by low income, with every tax payer contributing to this universal insurance, we will find ways of funding it; whether this means attending to inefficiencies in the system, reigning in high-cost pharmaceuticals, or, god forbid, raising taxes. If we believe people who cannot afford high quality healthcare should not be receiving it, and that people who can afford it should not have to support them, privatized healthcare is the appropriate model. Do we espouse an egalitarian model or an individualistic one? Is healthcare a social good or a market commodity?

Another way of looking at this is how different ideologies view what it means to be a good citizen. According to Orlowski (2011), for social conservatives and neoliberals (aka,

economic right wingers) a good citizen is someone who has the freedom to make personal choices and takes responsibility for their actions and behaviours; for social democrats and progressives (left wingers) a good citizen is someone who recognizes that inequities in society create an imbalance in terms of opportunities and, in any event, it is everyone's responsibility to work together for the public good, even if it means forgoing a liberty or two (one could also easily argue that a more equal society provides *more* freedom and liberties – for example, personal safety and health would likely increase overall in society). In terms of healthcare, the implications could not be more important. The latter worldview is completely consistent and harmonious with universal public healthcare; the former is more in line with at least a large dose of private, corporate interests allowed into that sphere.

According to recent voter turnout rates in federal and provincial elections in Canada, voter apathy has been increasing for several decades. While people living in a democracy should certainly all decry this situation (despite the fact that neoliberal adherents benefit from this lack of engagement), it is particularly disheartening when considering the possible repercussions of such disengagement. I believe Canada has a treasured institution in Medicare and that the principles of the Canada Health Act are honourable and should be venerated and protected. If the majority of Canadians agree with that view (which poll after poll seems to indicate), it would seem a tragedy if, for some reason or other, we deviated from protecting it.

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APPENDIX A

INTERVIEW QUESTIONS

Questions; "Working-class Attitudes about Healthcare in Saskatchewan"

1. Please tell me about your position in the union and in relation to the union workers. How long have you been in this position? Involved in unions in general? Have you worked in non-union environments?

2. Are you satisfied with the healthcare system in Canada? If so, what aspects are you satisfied with – if not what problems exist?
Do you have any thoughts on how the union membership views this issue?

3. What is your outlook for the future of healthcare in Canada?

4. Describe your experiences with the Canadian healthcare system, either personally or with family members or friends. Have these experiences shaped how you view the healthcare system in Canada?

5. What aspects of healthcare are most important to you?
Do you have any thoughts on how the union membership views this issue?

6. Do you see healthcare more as a business with commodities and individuals purchasing services? Or more as a social good with publicly provided services? Explain.
Do you have any thoughts on how the union membership views this issue?

7. What, if any, is the role of government in providing healthcare to citizens?
Do you have any thoughts on how the union membership views this issue?

8. What types of conditions/situations/services should be covered with public healthcare? What factors should be considered in making these decisions?
Do you have any thoughts on how the union membership views this issue?

9. From most to least important, what factors do you think are involved in determining the health of individuals? How much control do individuals have over these factors?
Do you have any thoughts on how the union membership views this issue?

10. Are there any factors involved in whether or not someone should NOT receive free healthcare? If so, what situations or circumstances would be involved?
Do you have any thoughts on how the union membership views this issue?

11. Describe your thoughts on whether there should be more, less, or about the same amount of private sector involvement in healthcare in Saskatchewan. What role should the private sector play? Do you see benefits and/or drawbacks to more privatization in healthcare?
Do you have any thoughts on how the union membership views this issue?

12. Where do you get most of your information on the healthcare system? What are your thoughts about the public conversations involving healthcare - from government/politicians, from media, from educators?

13. How strong would you say group solidarity is among your workers? Have you seen any changes over the years? For example, is there usually near consensus on job action votes?

14. When deciding on a party to vote for, how important are issues like tax cuts compared to social services?
Do you have any thoughts on how the union membership views this issue?

15. Which is more important to you; the rights of individuals or the rights of the collective society? Explain.
Do you have any thoughts on how the union membership views this issue?

16. If you could be Premiere of Saskatchewan, what would be your top priorities for spending tax dollars? Do you have any thoughts on how the union membership would view this question?

17. How do you see former Saskatchewan Premier Tommy Douglas, considered to be the father of Medicare, as an historical figure? Do you have any thoughts on how the union membership views Tommy Douglas?

18. Was your family in Saskatchewan in 1962 when healthcare became public? Do you know if your family was supportive of the publicly funded and administered healthcare system? Do you have any thoughts on Canada's healthcare system compared to other countries?

19. How would you describe yourself politically from a scale of 1 to 7, 1 being extreme left and 7 being extreme right? Explain.
How would you rate the general political positioning of the union membership?

20. Is there anything else you would like to add about healthcare in Canada/Saskatchewan?

APPENDIX B

INVITATION LETTER

Receiver's address (specific individual if possible)

August 1, 2012

Dear _____ :

I hope this letter finds you well. I am working on my Master's thesis in Curriculum Studies at the University of Saskatchewan. I also work at the university as the Assistant Coordinator for Clinical Teaching Development in the College of Medicine.

As you likely know, 2012 marks the 50th Anniversary of the public healthcare system in Saskatchewan. *I hope to learn more about the attitudes of working people regarding our healthcare system.* I would greatly appreciate your participation in this study. I am contacting you because you will be able to communicate your own views and perhaps the attitudes of the membership toward our healthcare system.

It has often been said that Canadians feel pride in our public healthcare system. I hope that through this study, our knowledge about how Saskatchewan citizens feel about our public system today will be updated and therefore more accurate. (After all, Saskatchewan is the birthplace of Canadian public healthcare.) I believe that understanding how members of the public develop attitudes about our public healthcare system is of the utmost importance in terms of its future.

The interview will take about an hour, and will consist of open-ended questions regarding attitudes toward public healthcare in Canada. If you are interested, I would be happy to meet at *a time and location of your convenience*. You may contact me by either replying to this e-mail or by phone, 966-1311. (If you would like further information, you may contact my thesis supervisor, Dr. Paul Orlowski, at 966-6907 or at paul.orlowski@usask.ca.)

I would greatly appreciate the opportunity to interview you for this study. If you are not interested in participating, however, I would be grateful if you would pass along this invitation to other colleagues whom you think may be interested in participating in this research. The plan is for me to interview 10 members of various union executives in Saskatchewan. I will also be sending you a paper hard copy of this letter via regular mail. Thank you very much for considering this request.

Sincerely,
Sean Polreis

APPENDIX C

CONSENT FORM

"Working-class Attitudes about Healthcare in Saskatchewan"

UNIVERSITY OF SASKATCHEWAN

Introduction: You are invited to participate in a study entitled "Working-class Attitudes about Healthcare in Saskatchewan". Please read this form carefully and feel free to ask any questions you might have. Your participation is greatly appreciated.

Union executives are being interviewed since they will likely be very articulate in regard to political and economic issues which will aid data collection. Furthermore, union executives are in a position of influence with their members and will be able to communicate, to some degree, the attitudes members hold around issues like healthcare.

Researcher Sean Polreis
Graduate Student, Curriculum Studies, College of Education, U of S
Tel: (306) 966-1311; Email: sean.polreis@usask.ca

Supervisor Paul Orlowski –
Curriculum Studies, College of Education, U of S
Tel: (306) 966-6907; Email: paul.orlowski@usask.ca

Purpose: The purpose of this study is to analyze the factors and influences which play a role in shaping working-class peoples' perceptions of healthcare in Canada.

Procedures: My goal is to achieve a deeper understanding of the economic, political, and social factors than typical opinion polls and surveys can show. Thus, I will be conducting in depth interviews with approximately 10 people. I will be taking notes as well as recording the interviews for accuracy. The audio recording can be turned off at your request. These interviews are to take place at a location and time which is convenient for the participants. It is expected that each interview will take approximately 60 minutes.

Funding: There is no outside funding provided.

Potential Risks: There are no known or anticipated risks to you by participating in this research.

Potential Benefits: Physicians as well as medical educators will potentially benefit from this study. Physicians have a number of roles when it comes to patients and the public - including educator, advocate, and intermediary with administrators. A better understanding of how people form opinions about healthcare will aid them in all of these roles. It is also possible that public policy makers will benefit from this same knowledge. More broadly, it is beneficial for society to have a deep understanding of how and why people think the way they do about important topics like healthcare. This study hopes to contribute to making the dialogue around healthcare in Canada more open and informed.

Confidentiality: Participants will be assigned an identification number to link to the interview results. For reporting, the researcher will remove any identifiable information from direct quotations of participants' comments in the interviews. Data will not be used for any other purpose outside of this research study. Participants will be provided with the option to view a transcript of the interview as well as the Master's thesis. The likelihood of any quotations identifying individual participants is extremely low.

Storage of Data: All data, including transcripts, will be stored at the University of Saskatchewan, College of Education, Curriculum Studies for a minimum of five years. If the researcher chooses to destroy the data after five years, it will be destroyed beyond recovery. In order to protect the identity of the participants, consent forms will be stored separately from the data. This data will not be used for any other purpose.

Right to Withdraw: Your right to withdraw data from the study will apply until data has been pooled. After this, it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data. Data will be deleted from the research project and destroyed, if desired. To do so, please contact Sean Polreis at sean.polreis@usask.ca or 306-966-1311 or Paul Orlowski at paul.orlowski@usask.ca or 966-6907. You may also refuse to answer individual questions.

Compensation: Participants will not be compensated for their time.

Follow Up: You may contact me at the above email address or phone number to obtain a transcript of this interview and/or a copy of the completed Master's thesis.

Questions or Concerns: If you have any questions concerning the study, please feel free to ask at any point. Please let me know if you would like a copy of the consent form. You are also free to contact the researcher at the number or email address provided above if you have questions at a later time. This study has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on September 28, 2012. Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office ethics.office@usask.ca (306) 966-2975. Out of town participants may call toll free (888) 966-2975.

Consent to Participate: I have read and understood the description provided above. I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above and understand that I may withdraw this consent at any time. A copy of this consent form has been offered to me for my records.

Name of Participant	Date
Signature of Participant	
Signature of Researcher	Date

APPENDIX D

INTERVIEW PREAMBLE

For my master's thesis I am researching public perceptions of public healthcare in Canada. Specifically, I am exploring what sorts of influences and factors shape people's opinions on healthcare. I am looking at a specific socioeconomic demographic – working class union members in Saskatchewan.

I ensure complete confidentiality with the results of my research. No identifying information will be reported along with the data. There are no foreseeable harms involved and you may withdraw from this study at any time. There are more details of the study on the consent form.

I will be asking you for your own opinions on various issues as well as how you feel your membership views these issues. I know you cannot speak specifically for individual members but if you believe you can broadly represent how the majority feel, I invite you to share those thoughts. The Canadian healthcare system is complex. For the purposes of this study, "public healthcare" will be defined as publicly funded (single payer) and administered with a mix of public and private delivery.

In addition to specific questions about our healthcare system, I will be asking some questions about politics, economics, and society in general. For the most part my questions are open ended. In order to insure clarity and accuracy, I encourage you to elaborate as much as you feel necessary with your responses. Also for accuracy, I will be recording the interview as well as making notes. You are free to decline answering any questions. Thank you in advance.

APPENDIX E

TRANSCRIPT RELEASE FORM

I,_____, have reviewed the complete transcript of my personal interview in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with Sean Polreis. I hereby authorize the release of this transcript to Sean Polreis to be used in the manner described in the Consent Form. I have received a copy of this Data/Transcript Release Form for my own records.

_____ _____

Name of Participant Date

_____ _____

Signature of Participant Signature of research