Brief to the Standing Committee On Social Policy

Legislative Assembly of Ontario

Submitted by
Service Employees International Union Local 1.on

January 30, 2006

I INTRODUCTION:

Good Morning. I am Cathy Carroll, Secretary Treasurer of the Service Employees International Union Local 1.on.

SEIU Local 1.on represents 40,000 health care workers in hospitals, nursing homes, home care, retirement homes and community support services across Ontario.

The Local Health System Integration Act, 2005, Bill 36, in its present form will radically alter the kind of health care services Ontarians receive, how these services will be delivered, who will profit from the services delivered, and who will lose as a result of the integration, amalgamation and devolution of health care services.

Contrary to the Orwellian language of Bill 36, this legislation will remove any local control over health care and place the control of health care services solely within the power of the Minister of Health and Long Term Care and the Ontario Cabinet.

The Minister of Health and Long Term Care professes his commitment to the Canada Health Care Act, but this legislation is an attempt to further circumvent the principles of the Canada Health Act.

At the very least, the Preamble and Section I of the Bill must contain specific commitments to ensuring the principles of the Canada Health Act are maintained.

As this bill now reads every health care service not covered by the Canada Health Act will be subject to privatization.

The government is moving this legislation forward, without a strategic plan for the delivery of health care in Ontario in place.

A provincial strategic plan needs to be in place before the LHINs can even start to develop their plans (Sec. 14 & 15).

SEIU Local 1.on asks the members of this committee to delay third reading until this government has held broad consultations with all stakeholders. The MOHLTC must develop a strategic plan in consultation with the public.

That strategic plan must also include a human resources plan. We will say more about this later.

This legislation is flawed because its premises are based on cost containment of health care services and not on ensuring Ontarians have equal access to quality public health care services.

In effect Bill 36 is nothing more than Ontario Liberal government's cost containment strategy. Privatization schemes that will reduce human resources costs is the route the government has chosen.

The real name of this legislation should be Ontario's Balanced Budget Act for the 2007 Election.

In 2003 little more than a month after the Liberal government was elected, in an economic update, then finance Minister Greg Sorbara alluded to the fact that there must be a way to control the compensation and salary costs of the health care budget.

The following spring the Health Tax was introduced. Health care workers are now subsidizing their own wages up to $900 per year. Every hour a nurse works, fifty cents goes to the Liberal Health Tax.

Apparently, the government believes health care workers can sacrifice even more.

II. LHINS

(a) They are undemocratic.

LHIN Boards are unelected. Each LHIN director appointed by Order – In –Council means they are only accountable to the Minister of Health and Long Term Care.

Section 7 and 8 of Bill 36 must be amended to provide for the election of LHIN Boards of Directors.

The composition of the LHIN boards must specify that all members of the LHINs are residents of the LHIN.

If it is government's purpose to move towards greater local control and to allow communities to determine local priorities (though we fail to see how that is possible given the large geographical expanse of the LHINs and the unequal mix of large metropolitan centres dominating rural areas), it is essential real control resides with local citizens and not those appointed by the Minster of Health and Long Term Care.

That this legislation will give greater control over health services to local authorities is just patently false.

What chance would a small community have to decide what health services it wants, when this community is lumped into a LHIN with larger metropolitan centres?

Section 9 suggests LHIN Board meetings are to be public, but what citizen would travel 200 kilometres and more to attend a Board meeting?

Section 16 states the LHIN is to "engage community." We ask at what level? What community interests are to be taken into account and to what degree? Reconsiderations of LHIN decisions as outlined in Section 26 and 27 do not allow affected parties much time to appeal (30 days). Will unions holding bargaining right have the right to the reconsideration process? The very short time frame for any party to make a submission for reconsideration and to study the impact a LHIN Board decision will have on local health services suggests the government wants to limit the appeal process.

Why does the government draw the line at the health care providers as defined in the Act. Why are Independent Health Facilities, physicians, laboratories and ambulances not included?

Why are independent health facilities outside the scope of this legislation? Is it because ancillary services at these clinics can be charged to patients and services these clinics provide can more easily be de-listed?

The establishment of stand alone specialty clinics belies the government's intention for greater local control over health care services. These independent health facilities could be operated as private clinics, but funded by public health care dollars.

We note also that a LHIN is to establish an advisory committee of health professionals, but physicians are excluded from this legislation. How can doctors act in an advisory role without being part of the entire health system?

Section 14 and 15 of the Act must be amended to allow for community control and input in the planning process.

That the LHINs at this point have no idea of what they are to do is highlighted by these examples:

a) The Chair and CEO of the Central East LHIN speaking to the Campbellford Memorial Hospital's Board of Directors said, "As this is our first plan we expect the fourteen plans to be pretty macro. By the time we get to our third annual plan, it'll settle out on a level of detail that'll be much greater than the first one will be." *(Community Press on Line, January 19th, 2006.)*

b) A *Sarnia Observer* reporter tried to get answers about LHINs from the people who are supposed to know. He spent a day trying to find out why the Ontario government is acting on legislation it hasn't yet passed. He claims he never really got a satisfactory answer.

   The new CEO of the Erie – St Clair LHIN, Gary Switzer, told the reporter to call Toronto. A MOHLTC bureaucrat refused to be quoted. MPP DiCocco was finally reached and commented, "It's a work in progress and not a foregone conclusion that the Bill will pass. It's very complex." (Shawn Jeffords, *Sarnia Observer*, January 6, 2006.

If the bureaucrats and elected members can't tell what is going on with Bill 36 this legislation should not pass until citizens know how it will affect their health care system.

This legislation gives near dictatorial powers to the Ontario Minister of Health and Long Term Care. The Minister of Health will have greater control over the kind, type and amount of health care that is provided in each LHIN in Ontario.

Section 26 of the Act allows a LHIN to:

1. Provide all or part of a service or to cease to provide all or part of a service.
2. To provide a service to a certain level, quantity or extent.
3. To transfer all or part of a service from one location to another.
4. To transfer all or part of a service or receive all or part of service from another person or entity.
5. To carry out another type of integration of services that is prescribed.
6. To do anything or refrain from doing anything necessary for the health service providers to achieve anything under any of the above listed including transfer of property or to receive property from another person or entity.

Section 28 of the Bill allows the Minster of Health to order a health service provider that carries out its operations on a not for profit basis to cease operating, to dissolve or to wind up its operations; amalgamate with one or more health service providers; transfer all or substantially all of its operations to one or more persons or entities; and to take any other action necessary to transfer property.

LHIN powers to order integrations are limited only by the fact they cannot order a health service provider to cease operating, dissolve or wind up.

But what the LHINs lack in power, the Minister of Health can do.

Section 33 will allow the government to order health service providers to cease operating and transfer their property [section 28(1)]. This leaves the door wide open to greater privatization of heath care services.

For example a LHIN could require the transfer of health care services, such as chronic care, from a public hospital to a private for profit nursing home.

(b) LHIN Finances

The Ontario Liberal government promised it would deliver a balanced provincial budget before the next election in October 2007. This legislation will make the promise a reality and the only promise apparently this government intends to keep.

The only way this government can balance its budget is to take a big bite out of the health care budget.

No LHIN will be allowed to have an operating deficit. Each LHIN must make due with the monies allocated to it by the provincial government. A LHIN can not borrow without the approval of the provincial government.

Therefore, this legislation is not about building a better health care system, but rather it is a way to control health care spending.

Even before the LHINs are operational, it is costing Ontario taxpayers millions of dollars in start up costs.

Millions more public health care dollars have been and are being wasted on public private partnership hospitals.

Democratically accountable District Health Councils are to be shut down.

Severance payments for 150 District Health Council administrators will cost $27 million. Many of these same people will in all likelihood be hired by LHINs.

Wind up costs for DHCs will be $ 5.9 million.

The hiring of 550+ new bureaucrats to operate the LHINs will cost $52 million.

Legal fees will add another $14 million.

Almost $200 million will be spent to set up a new LHIN bureaucracy. This will not add a single family doctor, medical specialist, or direct hands on care provider to Ontario's health care system.

Add to this the fact that the government has funded the Hospital Business Services Corporation in the Greater Toronto Area $42 million to eliminate full-time jobs at 16 GTA hospitals. The HBS will devolve "non-clinical services" to for profit providers. It is the exact pro-type the government wants the LHINs to follow.

The HBS is to provide various functions to member hospitals, including payroll, clerical, and materials management services. The HBS will have had the authority to move any non-clinical service from the hospitals to the HBS.

HBS will act as the broker agency to contract out all non-clinical clinical services to the private sector. On January 20th, SEIU Local 1.on heard from the HBS that all materials handling supply chain departments at the 16 GTA hospitals will work under the direction of HBS supervisors. The devolution process has already started.

When we reviewed the HBS model last year, we found no savings, or any return on investment that could be achieved.

If there is no community control over hospital services why should citizens bother to volunteer to raise funds or donate to specific hospital campaigns? If a LHIN has the power to move the service, the community raised funds for, why bother with the effort.

II. HUMAN RESOURCES

Last summer SEIU Local 1.on met with several Liberal MPPs to relay our concerns about the lack of nursing home standards, the quality and continuity of care in the home care sector, and the private financing and construction of Ontario hospitals and our concerns about the Local Health Integration Networks.

In every case the Ontario government broke election promises to the people of Ontario and specific commitments it made to SEIU prior to the last election regarding health care.

Many Liberal MPPs told SEIU members that it was not the intention of this government to achieve health care cost savings on the backs of health care workers.

Were we again misled? Clearly this legislation will affect every health care worker's livelihood.

Hospital service workers continue to see their jobs in dietary and housekeeping contracted out to for profit operators. Direct patient care providers are leaving their jobs because they can no longer cope with the stress. Non-clinical staff is asked to do more and more with less. Hospital cleanliness has been neglected to the extent that infectious diseases are increasing at alarming rates.

Home care workers continue to be subjected to "competitive bidding" that simply removes their jobs from them every three to five years, because this government believes competition is good for home care.

Bill 36 will extend the competitive bidding model to all other health care services.

Everything is for sale including workers' livelihoods.

Shortly after having become Premier, Dalton McGuinty said he believed in public health care. We have not heard him say that recently, particularly now that he is giving a large chunk of our $900 per year Health Tax to the private consortiums building for profit hospitals.

And is this not what this legislation is all about? Transferring public health care assets to private for profit enterprises?

SEIU Local 1.on represents mainly service, clerical and home care workers in Ontario's health care sector.

That's why we are very concerned about Bill 36's terminology "non-clinical services."

Section 33(1) will allow the government to cease performing any prescribed non clinical service and to integrate the service by transferring it to the prescribed person or entity. This section of the Bill gives the government the right to privatize more health services particularly "non-clinical services."

Each LHIN must identify opportunities for integration (Sec. 24).

The broad definition of services and the right of the LHIN to move any non-clinical service means only one thing, the devolution of these services to for profit providers.

A person or entity is defined under the health service provider definition [Section 2 (2)]. This includes "any other person or entity or class of persons or entities that is prescribed [Section (2 (2) (ii)].

Any time a transfer of a service, a person, or entity under an integration order, the transfer of all or substantially all of the operations of a health service provider and the amalgamation of two or more persons or entities under integration decision the, *Public Sector Labour Relations Transition Act*, 1997 will apply.

However, if the successor employer is not a health service provider and the primary function of that entity is not the provision of services within or to the health care sector, then it will not apply. "Non-clinical" service transfers will be subject to the provisions of "successor employer" and "sale of business" provisions under the *Ontario Labour Relations Act* [Sec. 32(3)].

PSLRTA will not apply where the Ontario Labour Relations Board issues an order declaring that it does not apply. In other words, the government wants to remove the protection of current collective agreements from health care workers.

Displaced non-clinical service workers will have no right to transfer their union contracts to the for profit private provider of non-clinical services.

We have said the Ontario government wants to use Bill 36 to control health care costs through the privatization of health care workers' jobs. These workers, I want to remind this committee, are the least costly component of the health care system. They are not the low hanging fruit the Health Minister has labelled them.

Our members' jobs have been under pressure for years. Hospital service and clerical workers wages average $33,000 – $35,000 annually. Nursing home workers average a few thousand dollars less. Most home care workers' annual incomes are below the poverty line.

Many health care workers are immigrants and women.

Does the Ontario government really want to create a class of health care workers toiling for poverty level wages, with no benefits and no pensions?

The proposed legislation offers an exact definition of a "health care provider," but "non-clinical services" have no exact definition. This can mean only one thing. The government wants the ability to privatize more health care services over time.

The term "services" has a broad definition and includes direct services and programs, support services and functions that support the operations of the person or entity that provides a direct or support service or program, (Section 23).

Competition in the home care sector has eroded the continuity and quality of care. Competition in the rest of the health care sector will do the same.

With the transfer, amalgamation and integration of health services, SEIU Local 1.on anticipates a plethora of PSLRTA (Bill 136 votes). Bill 136 will create labour chaos as the integration and amalgamation of services between health care providers begins.

A transfer of three registered technologists from hospital A to hospital B could trigger a Bill 136 vote, if different bargaining agents represent workers at the different hospitals.

If non-clinical services devolve to private corporations, their labour relations will be subject to the Ontario Labour Relations Act. Workers providing these services to hospitals and other health care institutions would, we assume, have the right to strike.

If the government wants to avoid labour chaos, it must not use the Ontario Labour Relations Act to govern "non-clinical services."

It is essential that a human resources plan be developed for the health care sector.

Health care sector workers' rights must be protected.

PLSTRA should apply to all health care restructuring, regardless of whether a successor employer operates mainly in or out of the health care sector.

Nothing in this legislation or any other legislation must override collective agreements or trade union representation rights.

Health care workers must be assured their jobs are protected, their wages and benefits are protected, and their pensions are protected.

No integration decision made by the government or a LHIN must alter the terms and conditions of employment of an employee including collective agreements without their union's consent.

The application of PLSTRA should not be subject to the discretion of the Ontario Labour Relations Board.

Any restructuring of health services including integration, amalgamation, or devolution of services must not be finalized until all affected employees and their unions are notified and a human resource adjustment plan has been agreed to.

It is the only way Ontario citizens will be assured of quality and continuity of care.

IV. CCACs

SEIU Local 1.on is Ontario's largest home care union. The current 42 Community Care Access Centres will be restructured to fit the 14 LHINs. Part VII of Bill 36 will return the

CCACs to a corporate structure similar to a structure that existed prior to 2001. CCACs will have the power to select their own directors and hire their own executive directors.

The integration of 42 CCACs into 14 LHIN will have serious consequences for both home care clients and service providers.

CCACs now contract for home care services though a Request for Proposals process. Both for profit and non profit home care agencies deliver services, Private home care operators have had their market share enlarged.

The RFP process has done nothing to ensure home care clients receive quality service and continuity of care.

The RFP process has subjected home care workers to second class worker status in the province of Ontario. Every time a contract, though the RFP process is tendered, home care workers lose their jobs. They are not entitled to "successor rights" under the Ontario Labour Relations Act, even though the replacement agency has no employees of its own when it bids on the contract. It simply attempts to hire the previous agency's staff.

All that is wrong with the RFP process will be exacerbated when 42 CCACs are integrated into the 14 LHINs and provider agencies must be realigned to fit this new reality.

Continuity of care in home care services must mean there must be an immediate end to the "competitive bidding model" for home care services.

Contrary to Elinor Caplan's observation "that competition is good in the home care sector," all the evidence leads to a contrary conclusion.

The fundamental element of a home care delivery process must be the continuity and quality of care patients receive.

Having home care agencies lose or gain contracts within the 3 to 5 year period of service agreements only leads to disruption in patient care. Home care workers are exiting the home care sector, because they can not put up with the job insecurity and the poverty level wages.

The best way to ensure quality and continuity of home care services is to have the CCAC be the employer. CCACs already set the care plans and decide on the levels of care. Managing the care givers is a logical continuation of the care plan.

A strategic plan for health care in Ontario must include a human resource plan that gives equal employment rights to home care workers that all other Ontario workers enjoy.

At the very least a human resources plan based on the current home care delivery model must:

- Guarantee a new agency to continue to employ the employees of the home care agency they plan to replace.
- Guarantee to recognize and provide the same working conditions, seniority, wages and benefits the employees had with the displaced agency. Wages and benefits must reflect the prevailing union or highest wage rate within the CCAC's geographical jurisdiction.
- Recognize the union representing the employees of the home agency that is being replaced.
- The successful home care agency in the RFP process must be bound to any existing collective agreements with the union that represented the employees with the previous agency.

Only a stable, professional and fairly compensated workforce will ensure Ontarians they will have quality as well as continuity of health care services.

Home care service agencies are not defined as a health care provider in the Act, despite the fact home care services clearly fit the definition of an employer whose primary function is the provision of services within or to the health services sector as defined under the health services integration.

V. CONCLUSION

Bill 36 is a revolution in health care. There will be a lot of carnage left on the battle field if this legislation passes in its present form.

Everyone wants reduced wait times for life saving surgeries and treatments.

Can the government really manage wait times without physician involvement? Wait times speak to the fact that there are not enough family physicians.

A wellness program would have been a better model to reduce wait times than the legislation we have in front of us today.

With 14 LHINs, each setting priorities for their region, what guarantee does a patient have to equal access and equal wait time queues in Kenora, Kapuskasing or Kincardine, compared to a patient in Toronto?

There is nothing seamless about the integrated health system the Minister of Health envisions.

Bill 36 says nothing about the quality of care or services the LHINs will deliver. This Bill is all about the bottom line, how to balance the provincial budget prior to the 2007 election. Ontario's health care consumers and health care workers be dammed.