

Submission to the
Standing Committee on Social Policy

Bill 36

Local Health System Integration Act (2005)

OPSEU



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1. OVERVIEW

A. Introduction

The Ontario Public Service Employees Union (OPSEU) is pleased to have this opportunity to provide our amendments to the Standing Committee on Social Policy regarding Bill 36 - Local Health System Integration Act, 2005 (LHSIA).

OPSEU represents about 40,000 workers across Ontario's health care system, including more than 5,000 employees at the Ministry of Health and Long Term Care. The majority of these workers are regulated health professionals. OPSEU health care members work in public hospitals, provincial psychiatric facilities, provincial laboratories, ambulance services, community care access centres, home care agencies, long term care facilities and public health units.

We believe Bill 36 requires substantial amendment. We are currently working in conjunction with other health care unions to present amendments to make Bill 36 democratic, to restore a focus on the effects on patient care and to keep health care publicly delivered. You will see overlap between many of our proposals and those forthcoming from other health care unions.

B. Process

The Minister of Health is correct when he says that Bill 36 represents a "pretty radical change." We believe Ontarians should have a real opportunity to debate this legislation, to ask questions, and to study the implications within a reasonable time frame. Seven days of public hearings in just four Ontario cities, with clause-by-clause amendments required to be tabled the next day, gives a poor example to the LHINs on how public engagement should take place.

Our members have repeatedly expressed their frustration at the nature of the public engagement to date. Many were blunt in calling earlier consultations in 2005 a "waste of time" with their

broad generalizations and lack of detail. With the introduction of draft legislation on November 24, 2005, Ontarians had the first real glimpse of what this new health system might look like, although frustration still continues given so many key issues remain for the regulations. Many of these regulations, such as the nature of public engagement and the criteria for funding health care providers, should be spelled out in the legislation, and not left for regulation.

Given the inevitable public upset this legislation will create, the Minister chose to introduce it just prior to the holiday season, when a Federal election was looming, and when Ontarians were focused anywhere but on the business at Queen's Park. And just as the house returns to examine this Bill, public attention will again be diverted to a major world event -- the winter Olympics in Turin. As such, despite the "radical" nature of these changes to Ontario's health care system, the legislation has so far slipped past public scrutiny in the mainstream media. However, that doesn't mean we aren't paying attention.

We believe this Bill should have a full and complete airing, not slipped through like an inconsequential piece of housekeeping legislation.

OPSEU is doing its best to engage our community of interest in this legislation, along with our partners at the Ontario Nurses' Association, Canadian Union of Public Employees and Service Employees International Union Local 1.0n. Twenty OPSEU members have appeared before this committee, many speaking before a public hearing for the first time in their lives. Contrary to the Minister's negative assertion that this is a campaign of "deliberate misinformation," it is in fact a campaign about remarkable participatory democracy. The web site we share with our labour partners, www.stoplhins.ca, has had more than 122,000 hits in its first month, and that pace is accelerating. We have also distributed in excess of 110,000 leaflets to our members, and the presses continue to turn out more.

These members have also been showing up in record numbers to meetings we have held around the province. More than 5,000 health care workers came out to 17 meetings over two weeks despite winter conditions and very short notice.

In the coming weeks the Ontario Health Coalition will be holding town hall meetings across the province. The government should slow down the process to listen to what is being said at these meetings.

If the speed of this process is any indication, the government is not walking its talk with regards to community engagement.

C. Principles which should guide health care reform

We start with the premise that effective integration of health care services is fundamental to health care reform. Effective integration coordinates access to quality and comprehensive services in order to implement a seamless continuum of health care for patients both in the institutional setting and in the community. This integration should be guided by a set of principles for implementation based on a definition of public interest which reflects our system of publicly funded, publicly administered health care. In reviewing Bill 36 we find ourselves in disagreement with the government over its definition of integration, and its method of implementation.

Although initial government statements concerning Local Health Integration Networks (LHINs) offered promise that patients mattered in health care integration decisions, Bill 36 does not reflect this commitment. Health Minister George Smitherman set out his government's health transformation plan in a speech on September 9, 2004: "our government's plan to transform health care is all about creating a comprehensive system of care that is shaped with the active leadership of communities and driven by the needs of the patient." We can find no reference in Bill 36 that integration decisions made by LHINs will be guided first and foremost by patient access to comprehensive health care services.

"But what matters most to patients," continued Minister Smitherman later in his speech, "is whether care is there for them and their loved ones in times of need. They want better access to the right care, at the right time, in the right place." In a second speech, one year later, Health Minister Smitherman said: "LHINs are going to help us build a system that has patients at its centre that they are prioritized with the needs of local patients and communities front and centre."

When introducing Bill 36 in the legislature, Minister Smitherman indicated a clear direction for LHINs:

Local health integration networks will also have a duty, I dare say an obligation, to consult with communities about the decisions that are before them. This legislation makes it very clear that decisions must be made on the basis of public interest and in the full view of the public.

He also said LHINs will "identify opportunities for greater efficiency," but that "the savings realized by local health integration networks will be reinvested where they are needed most: in patient care."

Something seems to have happened between the making of these statements and the drafting of the legislation because we do not see that a focus on patient care has been incorporated as an overarching factor. Concepts fundamental to genuine integration of health care, such as patient-centred care, open and transparent decisions made in the public interest and based on public priorities, access to high-quality and comprehensive care delivered by the right mix of health professionals, are not "front and centre" in Bill 36.

Instead, integration is defined in section 2 of Bill 36 - without any specific criteria to consider the public interest or to guide decisions on priorities or services to be provided. In the blunt language of restructuring, the reference to transfer, merge, amalgamate, cease, dissolve or wind up services or operations seems to be directed more at cost cutting and reducing government expenditures than it is at a principled approach to health care reform.

The Minister of Health frequently references these changes as being "a model Roy Romanow has been calling for, for years," (January 30, 2006), but the reality is that government policy more strongly resembles the much more controversial recommendations of Senator Michael Kirby. Kirby, a board member of U.S. based Extendicare, has been an advocate on behalf of for-profit delivery of public services.

The LHINs are being presented as the solution to many of the difficulties Ontario is experiencing within its health care system. In fact, Ontario's health system may not be so broken as to require such a massive and costly reorganization of that system. The risks outweigh any potential benefits that we can see reasonably emerging from this restructuring. The McGuinty government often presents the situation in terms of an impending crisis, when in fact, close scrutiny would suggest otherwise.

D. Cost Drivers

The real cost drivers in the system are not addressed by this reorganization. Drugs costs, for example, are the fastest growing expenditure in health care: pharmaceutical costs made up 16.7% of health expenditures in 2004.

Similarly, the shift to privatization has been a consistent cost driver. In home care, where the sector has undergone a massive shift from not-for-profit to for-profit delivery of care, costs have risen dramatically at a time when CCACs having been scaling back scope of service.

When Ontario enacted a one year funding freeze between 2001-2002, the auditor reported an overall decrease in nursing visits by 22 per cent and a decrease in home making hours by 30 per cent. In the same year, the auditor reported of one CCAC complaining it was facing a 48 per cent increase per nursing visit over the three year term of its new contract with private health care provider. The Ottawa CCAC faced an increase of \$800,000 per year after it was forced to divest therapy services to a private contractor.

The large number of P3 hospitals the government has embarked upon also poses a serious threat to the future health care funding. The P3 financing of the William Osler Hospital would have allowed for one and a half hospitals to be built through the public model. Written into the contract is a financing rate that is 2 percentage points above the government ten year rate. Two per cent more on any mortgage is considerable expense. Despite this, the government has announced dozens of P3 projects across Ontario, creating a legacy of debt. We note that although the government claims it wants transparency about decisions in health care, P3 contracts remain shrouded in secrecy and not subject to freedom of information requests. The only way the above information came to light was through a lawsuit.

If the government wants to make health care more sustainable, it could close the present loopholes on the Employer Health Tax, which if applied universally, would bring in an additional \$1.1 billion per year.

E. Efficiency

Ironically, the sector repeatedly targeted by the Minister of Health is the hospital sector. It is ironic because the hospital sector has been the star performer in Ontario's health care system. Ontario hospitals have the shortest stays in Canada (an average of 6.6 days, down from 8 days in the 1990s); they treat more patients on an ambulatory basis than any other hospitals in Canada; and they are the most cost efficient. Ontario also has fewer hospital beds per capita than any other province. While funding to hospitals has exceeded the inflation rate, much of that funding has been targeted to specific initiatives. When core funding is examined separate from specific initiatives, in 2004-05 most hospitals received increases of 1% to 1.8% (source: Ontario Hospital Association).

According to an independent March 2004 report by the Hay Group, Ontario's hospitals are more efficient than those in other provinces in Canada. The Hay Group report shows that Ontario's

hospitals have a lower potential for finding additional savings - a reminder of the efficiency measures already taken by Ontario's hospitals.

F. Health Care Costs

While health care costs make up an increasing share of the provincial budget, publicly funded health care has actually declined as a share of provincial GDP since 1992-93. On average, spending on public health care represents 6.7% of GDP across Canada, down from 6.9% in 1992-93 . As a percentage of GDP, Ontario's health expenditures are the same in 2005-6 as 1992-3 - 6.6%, which is slightly below the national average. Clearly, if health care is taking up a greater share of the provincial budget, it is due to the province's reduced capacity to raise revenues, not from any unreasonable demand from the health care sector. In terms of overall public funding, Canada ranks in the middle of OECD countries for spending per capita on public health care, suggesting the system may not be as broken as advocates for privatization and two-tier health care would suggest.

When we calculate overall health care spending, however, Canada ranks second to the United States due to large parts of the system that are presently being privately delivered. When spending on private health care is calculated (for example, spending on private health insurance health services not covered by OHIP), Canada spends 10.7% of GDP on health, still well below the 16% the U.S. is forecast to spend in 2006. However, this may increase because Bill 36 opens the door to further private for-profit delivery of health care. Given the fastest growing expenditures in health care are actually outside the medicare system, the logical approach to make the system sustainable would be to bring more of it into the publicly delivered system.

OPSEU is of the view that, rather than focusing on cost cutting, effective integration should coordinate services to implement seamless health care in a manner that achieves the goals established by the Government in the preamble to Bill 8:

- Preservation of medicare: our system of publicly funded health services;
- Ongoing commitment to the principles of public administration, comprehensiveness, universality, portability and accessibility as provided in the Canada Health Act;
- Prohibition of two-tier, extra billing and user fees;

- Adoption of a consumer-centred system that ensures access based on assessed need, not on an individual's ability to pay;
- Provision of pharmacare for catastrophic drug costs in recognition that it is important to the future of health care;
- Provision of access to community based health care including primary care, home care based on assessed need and community mental health care in recognition that they are cornerstones of an effective health care system;
- Providing public health services for the promotion of health and the prevention and treatment of disease including mental and physical illness;
- Ensuring public accountability to demonstrate that the health system is governed and managed in a way that reflects the public interest and that promotes efficient delivery of high quality health services to all Ontarians;
- Allowing for collaboration between community, health services providers and government and a common vision of shared responsibility in recognition that a strong health system depends on this collaboration;

2. OPSEU's concerns with Bill 36

Bill 36 falls short of these principles in a number of areas. In this brief, we identify our principal concerns with the legislation; we set out the basis for each of these concerns and identify our proposed solutions.

- The speed at which the government is rushing toward the implementation of change;
- The lack of collaboration with the community and health care workers in the establishment of a provincial strategic plan and integrated health plans;
- The failure to identify the public interest criteria on which funding and integration decisions will be made;
- The failure to protect medicare and the promotion of two-tier medicine, extra billing and user fees by allowing for the transfer of services which are currently being publicly funded to for profit providers;
- The exclusion of primary health care, laboratories, ambulance, public health and other key components from the integration planning thus ensuring that this round of health care reform cannot lead to a co-ordination of services to implement seamless health care;
- The amalgamation and dissolution of CCAC's by the regulation without input from either the LHINs or the community effected by the amalgamation.
- Lack of input from the community and front line health care workers into LHINs integration decisions and funding decisions;
- Failure to provide a meaningful oversight of the integration and funding decisions which will have enormous impact on both patients and health care workers;

- Failure to ensure that there will be adequate funding to maintain publicly funded health care as well as the transition to the new model proposed by the Government;
- Lack of public accountability in the ongoing provision of health care services;
- Contracting out of services critical to patient care and health care workers;
- Failure to address health human resource planning and to adequately protect the rights of health care workers.

A. The speed at which the government is rushing toward the implementation of change and the lack of collaboration with stakeholders

OPSEU is concerned that the government is pushing through changes to the province's health care system without having dealt with two fundamental prerequisites. The first of these is the development of a Provincial Strategic Plan. The second is Health Human Resource Planning. Proceeding with this legislation without a Strategic Plan and without a strategy to deal with Health Human Resource issues will give rise to major disruption and turmoil in the health sector, to the detriment of the legitimate goal of integrated health care and to the certain detriment of patient care.

The Provincial Strategic Plan should be the starting point of any health care restructuring as it forms the reference point for the formulation of the Integrated Health Services Plan by each LHIN and the exercise of all the powers to restructure the health sector contained in the legislation. The Plan should not be developed unilaterally by the Minister of Health. Nor should extensive discretionary powers set out in Bill 36, in OPSEU's view, be put in place before the Provincial Plan is developed.

OPSEU therefore proposes that the Provincial Strategic Plan should be developed with input from all stakeholders, including representatives of patients and front line health care workers, through their unions.

In the preamble to Bill 36, the government set out its belief that:

- (d) "...the health system should be guided by a commitment to equity and respect for diversity in communities in serving the people of Ontario and respect the requirements of the French Language Services Act in serving Ontario's French-speaking community:
- (e) recognize the role of First Nations and Aboriginal peoples in the planning and delivery of health services in their communities."

To give meaning to these commitments, consultation with all equality seeking groups is mandatory.

All aspects of health care including primary care, laboratories, ambulance and public health should be considered in the planning process. The question should be, "How can we improve our health care system", not the more narrow question of, "How can more efficiency be achieved". The development of the Provincial Strategic Plan should be expressly guided by fundamental principles, including those set out in the preamble to Commitment to the Future of Medicare Act, 2004 and the Canada Health Act. The resulting Plan should then be made available to all Ontarians via publication, including on the Internet.

To push through this legislation, with its fundamental shift in the way the system is delivered, without establishing first a strategic plan, is backwards policy-making. It is implementing structural change without first determining that it is needed. We may add, that establishing the LHINs boards and hiring CAOs before enabling legislation is also indicative of the government's disrespect of process. If the consultative process is to have meaning, the government must plan first in consultation with the community, then implement changes.

Amend 14, 15(1), (2)

We are proposing a green paper process for consultation and transparency in the development of the Provincial Strategic plans and also for the development of Integrated Health Services Plans with proper input from the community, including equality seeking groups and stakeholders.

The second issue that must be addressed, in our view, before moving forward with health care reform is the critical issue of Health Human Resource Planning, an area that appears to have been completely ignored in the drafting of Bill 36. The delivery of quality health care for patients of Ontario is dependent on retention and recruitment of an adequate number of educated health care workers, both in the regulated health professions as well as support workers.

Any legislation should have at its core the principle that health care workers not be adversely impacted by restructuring.

The current and projected shortages of certain categories of health care workers, particularly professions, has been well documented. Bill 36 makes no provision for the training of new professions to replace and supplement an aging workforce. In fact we believe the implications of Bill 36 will exacerbate the problem. While the drafters of Bill 36 have downloaded funding decisions as well as extensive powers of restructuring onto the LHINs, they appear not to have thought through the implications of these decisions on existing health care workers. We anticipate that the transfer of services out of hospitals -- where employees enjoy secure employment and benefit from provincially established terms and conditions of employment -- to fragmented employment in the community, will exacerbate issues of retention and recruitment of health care professionals. Later, in our brief we propose that a collective bargaining solution to this problem be worked out between the government and the stakeholders. Until these processes are completed, restructuring should be placed on hold.

Amend s 53(a) Page 13

We propose that Bill 36 not come into force until the provincial strategic plan is in place and an agreement has been reached to address the Collective Bargaining issues arising from this restructuring.

Further, given the magnitude of the changes being instituted through Bill 36 and in order to ensure that the current round of restructuring is effectively achieving its objectives, we propose that the Minister undertake a comprehensive review of the Act two years after it comes into force.

B. The failure to identify the public interest criteria from which funding and integration decisions will be made.

In the Act, as currently drafted, the objectives of the LHINs are to "plan, fund and integrate" the local health system, where "integrate" is defined as: to co-ordinate services; to transfer, merge or amalgamate services, to start or cease to provide a service, or to cease or dissolve an operation. Section 24 mandates LHINs to identify integration opportunities to provide "appropriate, co-ordinated, effective and efficient services".

OPSEU agrees that effective integration of health care is essential to provide proper care to patients (whose needs do not respect institutional boundaries). However, integration and consolidation that is undertaken for its own sake, or in the service of cost-cutting alone, will actively undermine both the accessibility and quality of health care.

OPSEU therefore proposes that the objectives of the LHINs should be amended so the LHINs are required to plan, fund, and integrate the local health system so as to promote the public interest in a patient-centred, publicly funded, and publicly administered health care system. In addition, the legislation should be amended to require that all decisions taken under its authority, whether by LHINs, the Minister or the Cabinet acting through the Lieutenant-Governor, must promote the public interest, so defined.

Such a definition of the public interest is consistent with the principles set out in the Preamble to the *Commitment to the Future of Medicare Act, 2004* and in the Preamble to this Act.

This amendment would also be responsive to the widespread concern that decisions taken under authority of the Act may lead to further privatization of the health care system. At present, the sole provision that directly addresses this concern is the provision that LHIN integration decisions and Minister's Orders may not "permit a transfer of services that results in a requirement for an individual to pay for those services, except as otherwise permitted by law" [ss.25(3), 28(3)]. The government cites this restriction as demonstrating that the Act "does not provide for more privatization or competitive bidding in the health care system", also referring to its commitment to preserving the public health care system in Ontario, as set out in the *Commitment to the Future of Medicare Act, 2004* (or CFMA) (see *Local Health System Integration Act, 2005*, Frequently Asked Questions, Ministry of Health and Long Term Care website).

If the government is indeed committed to preserving the public character of the health care system in Ontario, the Act as currently drafted does not reflect this commitment. OPSEU's proposal to make the LHINs and other decision-makers answerable to a public interest defined in accordance with the commitments contained in the CFMA would assist in correcting this.

It is our proposal that the Provincial Strategic Plan, all Health Services Plans and decisions/approvals made under LHSIA by LHIN's, by the Ministry or the cabinet, including regulation making powers, should be exercised in a manner that is consistent with the following factors:

- The protection of medicare through the maintenance of existing publicly funded health services;**
 - o The prohibition of a two-tier medicare, extra billing and user fees;**
 - o The adherence to the principles of the Canada Health Act ie. public administration, comprehensiveness, universality, portability and accessibility;**
- The achievement of a patient-centred system that ensures access based on assessed need, not on an individual's ability to pay;**
- The provision of access to a full continuum of clinical care as well as community based health care: including primary care, home care based on assessed need, and community mental health care;**
- The protection of the rights of health care workers including the preservation of representational and collective agreement rights as the protection on terms and conditions of employment.**

Amend Section 1 1. (1)

(2)

2. (1)

C. Medicare

The failure to protect medicare and the promotion of two-tier medicine, extra billing and user fees by allowing for the transfer of services currently being publicly funded to for-profit providers.

As currently drafted, Bill 36 fails to protect medicare, our publicly funded system of health care. While we have addressed this general concern with our proposal to establish public interest criteria against which all decisions under the Act must be made, we have particular concerns with the only provision that restricts the transfer of services which are currently funded:

LHINs may not issue integration decisions that "permit a transfer of services that results in a requirement for an individual to pay for those services, except as otherwise permitted by law. This restriction also applies to Minister's Orders s.25(3), s.28(3).

The restriction, as drafted, is very open-ended and can result in a further erosion of currently funded services. The government failed to set an example of its commitment to publicly-funded health services when it decided to delist eye examinations and physiotherapy from OHIP coverage.

By leaving the door open to transfer of services to environments where fees or extra billing can be legally applied, it is anticipated LHINs will take every opportunity to alleviate fiscal pressure by doing so. This will lead to a patchwork system with greater inequities of coverage from one geographic area to another. Such inequities are already a feature of British Columbia's regionalized system.

Private companies are already circumventing Canada's preference for a one-tier health care system through the use of initiation and annual fees, such as those offered by the Copeman clinics in BC. Don Copeman has promised to open three clinic in Ontario in the near future. To date, the Ontario government's response has been limited despite legal opinion that such clinics clear violation of both the CFMA and the CHA.

We are proposing that LHINs can neither force or endorse an integration of services that results in a requirement for an individual to pay for services which were previously publicly funded.

OPSEU is very concerned about the increasing transfer of publicly-funded services from the public sector to the private sector. There are many forms of this. One is the transfer of services to entities run on a for-profit basis. These transfers include such private companies as Dynacare in the laboratory field, Extencicare in the long-term care sector, and Paramed in the home care field. Additionally we are witnessing the increasing transfer of hospital-based services to clinics run by doctors.

The government is actively funding this transfer. Recently it announced it was giving \$20 million in grants to Independent Health Facilities to buy or replace diagnostic imaging equipment. This was part of a \$40 million boost to physician operated diagnostic services that was negotiated by the Ontario government as part of the settlement last year with the doctors. This funding will facilitate the transfer of hospital-based diagnostic imaging services to private-run independent health facilities. This shift was already in high gear before this funding announcement, as part of the "encouragement" by the ministry to hospitals in order to find ways of cutting costs. For example, some hospitals have stopped certain ultrasound testing, because doctors set up clinics in the same community to perform these tests.

This model removes costs from hospital budgets, but there is no evidence that this is any more cost effective. The money simply comes from a different pot, one that is not open to public scrutiny because it is based on a fee schedule negotiated with the doctors. There is no evidence that clinics provide better quality than a hospital-based service. It may even be lower if duties are shifted to lower-paid technicians instead of registered technologists.

OPSEU is very concerned that Bill 36 will encourage a second form of privatization, one where services are downloaded to sectors not protected by the Canada Health Act, encouraging user fees.

The government has put pressure on hospitals over the years to find cost savings. This has intensified with the balanced budget exercise and requirement for hospital accountability agreements instituted through Bill 8. Hospitals have been pressured as a result to focus on core services, increasingly interpreted as in-patient services. If services that a hospital provides on an outpatient basis are available in the community, then the hospital is pressured to eliminate those services. Community is broadly interpreted - it could be the public, not for profit service area, such as a community health centre, where health professionals are on staff, or it could mean the private, for-profit area, such as a clinic, where you can pay \$90.00/visit out of your own pocket for the service. The result of this focus on core services is that out-patient therapeutic and rehabilitative services, such as physiotherapy, have been discontinued at many Ontario hospitals.

Patients who need these services are now left on their own to find them. They are also left on their own to pay for them, because these services are not covered by OHIP. It must be remembered that this government, motivated not by any evidence that physiotherapy was not a medically-necessary service, but simply in its cost-cutting zeal, de-listed physiotherapy services from OHIP. With a few exceptions, such as those in long-term care homes, people who need physiotherapy services must either pay for it themselves or pay for private insurance coverage. If they can't afford to do this, they must do without.

This story also demonstrates how the Ontario government has successfully undermined and eroded coverage under the Canada Health Act. It has forced the elimination of physiotherapy from hospitals and from OHIP, both of which are areas where services are covered by the Canada Health Act. The government may think that it has achieved efficiency with this maneuver, but it certainly can not be called an improvement to health services, or in the public interest.

We are proposing provisions which would prohibit the transfer of any services from a not-for-profit provider to a for-profit provider.

Finally, we are concerned that in Section 28(1) of Bill 36 the Minister is given powers to make a number of orders regarding not for profit health service providers including amalgamation, transfer of services and even winding up of services. These powers however, do not extend to the for profit service providers. We propose that the distinction between for-profit and not-for-profit be deleted in this instance as it is unjustifiable and is inconsistent with the government's own commitment to a publicly administered health care system.

Add s.25(3) amend notes

3.4

s.28 (1)

D. The exclusion of critical components of the health care system from integration planning and the amalgamation of CCAC's by regulation.

The Act's powers to fund and integrate health services apply only to "health service providers," as it defines that term. At present this definition excludes primary health care services, as provided by physicians, optometrists and others. In addition, it excludes independent health facilities (IHF's) (such as free-standing ultrasound and MRI clinics and the recently created cataract surgery clinic, the Kensington Eye Institute), medical laboratories and public health facilities/institutions. One result is that physicians will continue to negotiate directly with the provincial government, even though they represent a large portion of health care services (and budget).

OPSEU can see no principled basis for these exclusions in the context of legislation that is, or should be, directed at providing comprehensive, seamless and improved health care for Ontarians. On the contrary, without inclusion of all major components of the system, the integration mandate given to LHINs will be limited to cost cutting.

OPSEU therefore believes that integration requires funding for physicians and prescription drugs to be included in the budgets of regional entities charged with integration. We also have front-line experience that public health and ambulance are an integral part of the health care system, which should be part of any integrated delivery system (and fully funded by the province). SARS demonstrated the potential dangers associated with the current underfunding and isolation of public health services.

In addition to undermining the promise to patients of fully integrated health care, the omission of the IHFs from the definition of "health service provider" in Bill 36 also creates a structural incentive for the LHINs to move services that are currently publicly delivered into clinics that may be part of the private sector. As others have observed divisions in funding sources create opportunities for cost-shifting, which leads cash-strapped decision makers in the public system to shift costs to entities that draw their funding from elsewhere. The omission of IHFs from the definition of health service provider, combined with the power of LHINs to transfer services to IHFs under this legislation, therefore creates a recipe for the further privatization of the delivery of health care in Ontario.

We are proposing that the Bill be amended to bring all the critical components of Health Care into the planning umbrella of the LHINs.

If the government says they are not ready to do this, then the restructuring should be put on hold until they are. Otherwise this attempt at integration looks more like unprincipled cost cutting and downloading of accountability for unpopular funding decisions than an attempt to rationally integrate a continuum of health care services for the benefit of patients.

ss. 2(2)

Community Care Access Corporations (CCAC's)

OPSEU has particular concerns with the reorganization planned for the CCACs. While Bill 36 includes CCAC's as Health Service Providers that are funded by LHIN's, the restructuring and integration of the CCAC's is largely left to regulatory power and to decisions by the Minister after consultation with the CCAC's. This restructuring, including amalgamation, dissolution and division of the CCACs is done without any consultation with the LHINs in the regions impacted by the reorganization or by the communities served by the current CCAC's.

Through the exercise of these powers the Ministry intends to reduce the number of CCAC's to coincide with the number of LHINs. Consequently there will only be one CCAC to serve the vast and diverse areas covered by each LHIN's region. This constitutes a drastic reduction from the existing 42 CCAC's some of which already service a large area to a possible 14.

CCACs are responsible for the co-ordination and delivery of critical home-care services to residents in local communities. There has already been an appalling cut in these services as a result under funding by the ministry^{viii}. As a result many people who needed these home care services are not able to access them^{ix}. Distancing the decision-making in the CCAC from the users of the service is likely to exacerbate this problem.

Furthermore, since the needs of homecare services vary significantly from patient to patient as well as from community to community we question how a single CCAC operating over an entire LHINs area can effectively respond to the individual needs of residents in local communities. Certainly there can be no reasoned presumption that "bigger is better" or that the amalgamation of CCAC's within a LHIN's region will result in the provision of "appropriate, co-ordinated, effective and efficient care."^x

The amalgamation of CCAC's is another form of integration as anticipated by the Act. In our view there is no reason why the LHIN's, who have been given the mandate to otherwise plan and integrate services within their region should be given no role in the amalgamations of the CCAC's. If the LHINs are to be a "critical part of the evolution of health care in Ontario from a collection of services to a true system that is patient- focused results-driven, integrated and sustainable^{xi}" then they should have a role in all aspects of the re-design of the system including that provided by CCAC's.

For these reasons we are proposing an amendment which would require that the Minister receive a recommendation regarding restructuring from the local health integration networks involved, in addition to a report jointly prepared by the affected community care access corporations prior to the Lieutenant Governor in Council making a regulation or the Minister making an order which restructures CCAC's.

Section 39(18)

OPSEU also has a specific concern with subsection 20(3) of Bill 36. While the Bill makes some general commitment not to restrict patient mobility across the artificial boundaries created by the LHIN's geographic areas there is a specific exception to this commitment in the case of CCACs.

20 (2) *A local health integration network shall not enter into any agreement or other arrangement that restricts or prevents an individual from receiving services based on the geographic area in which the individual resides.*

(3) *Subsection (2) does not apply to any agreement between a local health integration network and a community care access corporation that requires the later corporation to deliver services in the area in which it is approved to provide services.*

The general concern about the restriction on available services to patients created by the arbitrary boundaries applicable to LHIN's also applies to home-care services particularly those provided in schools and clinics. Ontarians should have access to services that are based on their particular needs and in those that are most convenient and should not be restricted by artificial regional boundaries.

It should also be pointed out that CCACs presently make referrals to long term care facilities that are presently outside existing geographic boundaries.

Accordingly, we are proposing that the exception for home care services from the prohibition on patient mobility be deleted from the brief.

Amend 20(3) Delete

E. Lack of Input from the Community and Front Line Health Care Workers Into LHNS Decision Making

1. Boards of Directors

As the Act is currently drafted, it is difficult to avoid the conclusion that the LHINs are simply an additional layer of bureaucracy under the substantive control of the Ministry, since the Ministry controls appointments to the LHIN Boards of Directors, controls LHIN funding and exercises substantive control via accountability agreements, which it may impose unilaterally if no agreement is reached.

If the LHINs are to function as representatives of the community in a manner consistent with the government's stated aims, the Act should be amended to introduce a democratic process for the selection of members to the LHINs' Boards of Directors by the electors who will be affected by their decisions. Further, since the legislation emphasizes the need for public accountability and transparency in decision-making, the situations in which the meetings of LHINs Boards of Directors may be held in camera should be clearly identified in the legislation.

We are proposing amendments requiring the election of a democratic process for the election of the LHIN's boards, as well as amendments to clearly specify the exceptional circumstances in which LHINs Board of Directors meetings may be held in camera.

Amend s. 7(1)

Deletion of proposed 7(2)-(4), s.9(3)

We also have concerns with potential conflicts of interest in the formation of the LHIN's

Boards given the large amounts of public funds which will be entrusted to them for distribution and the large number of service providers who will be vying for a share of the proceeds, especially if a competitive for-profit model is adopted. The unions are aware of some situations already where owners/officers of home care providers are being appointed to the Board of Directors of a LHIN. Since his/her agency stands to benefit from integration and funding decisions such a person should have no part in the LHINs decision-making.

The Gomery Commission has heightened our awareness of the potential for placing private interest ahead of public amongst those involved in public governance and administration. In light of this we strongly believe that there should be provincially consistent legislated requirements to ensure that consistent conflict of interest guidelines are in place for LHINs Boards of Directors with oversight by the Office of the Integrity Commissioner.

We are proposing amendments to achieve consistent conflict of interest rules throughout the province with oversight by the Provincial Ethics Commissioner.

**Amend s. 3 (5)
8 (8)**

2. Community Input

If the legislation is to be consistent with the statements in its preamble, acknowledging that a community's health needs and priorities are best developed by the community, health care providers and the people they serve, the substantive provisions in the Act relating to consultation and community involvement require a substantial overhaul. The Act should be amended to require real consultation at every stage of decision -making by all stakeholders.

Given the fundamental role of community engagement in the Act's objectives, OPSEU believes that it is inappropriate that this matter be dealt with solely via a vague requirement to "engage the community", with details left to regulation.

Meetings need to extend beyond providing a gallery for community members. A process for standing before the boards and committees needs to be put in place.

The legislation must include reasonable advance public notice of meetings, including the

requirement that such meetings be posted on the internet.

**Amend s.5
2 5 (3.51 (6))**

3. Employee input

Bill 36 currently sets out a requirement for the creation of a health professional advisory committee by each LHIN. There is, however, nothing in the legislation setting out the composition of the committee or its role. Accordingly, there is nothing in the Act to guarantee that front-line health care providers will be given a meaningful role in decision-making, despite the recognition in the Preamble of the importance of their perspective. The involvement of front-line employees and unions at an early stage of decision-making will also minimize disruption in the sector when decisions begin to be implemented.

OPSEU proposes that the legislation itself should require the Committee to consist of front line professionals providing care within the jurisdiction of the LHIN, and that they be given a meaningful role in decision making, i.e. notice of meetings, disclosure and the opportunity to be heard.

OPSEU further proposes that there should also be Health Sector Employee Advisory Committee made up of front line employees and their unions who will also be given a meaningful role in the decision making of the LHINs at every stage.

Amend s. 16

4. Integration Plans, Proposals and Decisions

As currently drafted Bill 36 gives neither employees, nor their unions, a role in the decision making process under the Act even though restructuring decision, whether made voluntarily by health care providers or imposed on them by LHINs or the Ministry, will have a huge impact on health care workers both in the way they deliver health care and in their rights and working conditions. At the very least employees and their unions, should be given as much notice as

possible of intended decisions to give them the opportunity for input before decisions are finalized and to make plans to effectively deal with the impact of decisions.

Since many of the decisions will be made by health care providers and other service providers, with the LHINs performing a facilitation or approval role, it is also critical that employees and their unions be notified of intended decisions by these agencies so that they can seek to provide input before decisions are finalized . This could be done through existing union/management structures. Advance notice to affected employees and their union representatives is also a critical component for the orderly exercise of employees' rights, thus minimizing the negative impact of restructuring decisions. Later in the brief we make proposals regarding the promotion of Human Resource Plans which can facilitate a resolution of issues arising from these decisions.

We are proposing that employees and their unions be given notice of decisions by health care providers, LHINs, Ministry or Cabinet, if members are affected, well in advance of the implementation of those decisions.

25 (3.3)

5. Failure to provide for the meaningful oversight of integration and funding decisions

The LHINS have been given extensive powers to make restructuring decisions which have the potential to fundamentally transform the delivery of health care services to the people of Ontario. In spite of this, Bill 36 provides a very limited basis for the review of integration decisions made by LHINs. A reconsideration of integration decisions by the LHINs themselves, upon application by a health service provider and/or judicial review by the courts on a jurisdictional ground, are the only avenues of review available under the Bill. Neither of these forums is likely to result in a meaningful review of the merits of a decision. Presumably it would be particularly difficult for an affected person to convince a LHIN to reconsider its decision, particularly if there are no specified criteria against which a decision could be challenged. Court challenges do not provide affected persons with an effective means of challenging a decision since Applicants would have to establish an excess or denial of jurisdiction. OPSEU is proposing to broaden the rights to have a LHINs decision reconsidered.

Amend s.25-27

F. Failure to ensure that there will be adequate funding to maintain publicly funded health care as well as the transition to the new model proposed by the government.

As discussed in our Overview, Bill 36 seems to be more focussed on financial expediency and cost cutting than on patient focussed care. There is no assurance that the current level of funding or services will be maintained. At the same time the government is undertaking a massive reorganization of the system. As in the past, this reorganization itself will be extremely costly. Furthermore, the government is sanctioning, if not encouraging, further privatization of the system which is bound to be a significant cost driver. It is a fundamental concern of the union that the government will not provide sufficient funding for the maintenance of existing publicly funded services let alone the costs of restructuring and the additional costs to provide the profits for the burgeoning for-profit sector which this legislation encourages. The union is further concerned that attempts will be made to fund this shortfall through cost cutting measures aimed at the front line workers who are the real health providers in the system.

Accordingly we are proposing that the funding decisions made by the Minister and the LHINs be made in accordance with the public interest and that there be a legislative requirement for maintaining the existing funding as well as sufficient additional funding to achieve all the Act's purposes including the restructuring that is being undertaken.

s. 17 (1)

The Ministry allocates to each LHIN its share of provincial funding. In turn, funding decisions made by the LHIN will be critical to the distribution and level of health care services throughout the province and each region. For this reason the funding process should be open and transparent. Funding information should be made available to the public.

We are proposing that the Ministry's website as well as that of each LHIN have posted to it funding allocations.

17(3)

In additional to the union's general concerns regarding the adequacy of health care funding which will be made available to the LHINs the union has a number of specific concerns.

Bill 36 affirms that access to Health services will not be limited to the LHINS area in which the Ontarian lives. In order to give meaning to this promise as well as to recognize the potential for additional travel resulting from the amalgamation of services within the huge geographic areas encompassed by each LHINS the government must ensure that travel allowances be put in place to all Ontarians access to services regardless of where they live in the province.

We therefore propose that the government commit to fund travel costs made necessary by integration decisions.

Savings from Efficiencies

Of particular concern to the Union is the only section that specifically addresses the Minister's discretion regarding funding which is otherwise completely unfettered.

- Section 17. (1) The Minister may provide funding to a local health integration network on the terms and conditions that the Minister considers appropriate.
- (2) When determining the funding to be provided to a local health integration network under subsection (1) for a fiscal year, the Minister shall consider whether to adjust the funding to *take into account a portion of any savings from efficiencies* that the local health system generated in the previous fiscal year and that the *network proposes to spend on patient care* in subsequent fiscal years in accordance with the accountability agreement".
[emphasis added]

The Minister has suggested that the integrated approach to health care under the auspices of the LHIN's will result in efficiency savings which can then be reinvested in patient care. If this is the Minister's commitment then it should be reflected in the legislation without the sanctioned claw back anticipated by Section 17.

We are proposing that all efficiency savings should be reinvested in patient care in the region in which they were realized.

17 (2)

Competitive Bidding

OPSEU continues to have real concerns about the potential for competitive bidding to be extended to the health care sector from the home care sector, the sector in which "managed competition" was first introduced by the former conservative government. In the home care sector, competitive bidding has undermined the rights of our members and has a detrimental impact on their lives, while simultaneously lowering the quality of care and driving up the cost of care provided to the community. While the Minister of Health has repeatedly said that Bill 36 does not specifically address competitive bidding, Ministry officials have described the relationship between the LHINs and the health care providers as a "purchaser/provider split." This is identical to the language that the government uses to describe the relationship between the Community Care Access Centres (CCACs) and home care providers.

While no specific criteria or methodology exist in Bill 36 for choosing where services will be provided and by what entity, as currently drafted, the bill provides no safeguards to prevent LHINs from employing a procurement system based on a competitive bidding model. Moreover, Bill 36 provides no guarantee that the government will not introduce competitive bidding through the regulations to the Act.

Further, during her meetings with labour representatives in her 2005 review of CCACs, Elinor Caplan stated that her work on competitive bidding would be used by the LHINs. The Minister himself has frequently stated that CCACs are models, not just for the rest of the health care system, but for the delivery of other government services (Hansard, November 29, 2005) . Given that CCACs use a competitive bidding process to deliver services, this remains a serious concern not just for health care workers, but for anyone providing public services.

This was recently borne out by the privatization of work done by public service employees who handle applications for the Trillium Drug Plan. The minister is transferring this work to a private for-profit company, placing confidential health records and income tax information in the hands of the lowest bidder. This is after private contractors employed by the provincial

government were found responsible last year for thousands of security breaches, including the loss or theft of 56,000 drivers' licenses, plates and other permits.

OPSEU believes that the privatization of health care delivery through the competitive bidding process would decrease the quality of care and have a negative impact on the practice environment for health care professionals. A body of research literature indicates that the home care sector continues to experience stresses due to poor morale and high staff turnover which is linked to the competitive bidding process. When contracts are lost, workers often face the loss of representational rights, job loss, declining wages, lost benefits, and the loss of pensions. As Elinor Caplan recognized in her report, a satisfied workforce leads to better quality service for patients.

Further, experience in the home care sector suggests that competitive bidding drives up the costs of care. The auditor general has raised several red flags around escalating costs in the home care sector at a time when services were being scaled back, a complaint echoed by some CCACs which were experiencing double digit cost increases from their local providers at the time of contract renewal. The 2004 Annual Report of the Office of the Provincial Auditor of Ontario, for example, noted that a one year freeze in funding between 2001/02 and 2002/03 led to an overall decrease in nursing visits of 22% and a decrease in homemaking hours by 30%.

There are presently nine CCACs that continue to provide direct service - mostly therapy and social work - in the absence of a reasonable private sector alternative. Many more have divested direct care at considerable cost to the taxpayer. Renfrew CCAC hung on to its therapy services after it was learned the lowest bidder would have cost \$1 million more annually than if it maintained in-house service. Ottawa contracted out its therapy services with the knowledge that it would cost the taxpayers \$800,000 more annually to do so.

The competitive bidding environment also discourages the sharing of best practices, which become proprietary information. The secrecy around the operation of home care providers has been an obstacle to improvement within the system.

Finally, while the Health Minister has held up the CCACs as models of local control -- despite reducing their numbers from 42 to 14 in this plan -- the competitive bidding process in the CCACs has resulted in the awarding of contracts contrary to the wishes of local communities.

In 2004, the Victorian Order of Nurses lost a major contract to provide home care in the Niagara Region. Coincidentally, it was their 85 anniversary of service to the community. The VON was well-liked and had an almost flawless record of service. Businesses paid for their automotive leases, volunteers helped with services such as meals on wheels. Two local parks had floral displays celebrating the anniversary. Yet the scoring process of the competitive bidding system did not take into consideration community input, and as the Minister told us, it was a legal process and he could do nothing about the outcome. Despite interventions by representatives from all levels of government, the VON never regained this work in Niagara. In 2004, this same scenario was played out in one community after another, as one private for-profit company after another replaced trusted and valued not-for-profits such as the VON and the Red Cross.

In light of all of the above, the competitive bidding model is hardly a model which should be replicated in other areas of health care. Our first proposal is the addition to the preamble to recognize the concerns of healthcare workers.

Preamble (j)

OPSEU proposes several amendments to Bill 36 that would address its members concerns regarding the extension of competitive bidding to other areas of the health care system. Our first proposal is an addition to the preamble of Bill 36 to recognize the importance of health care workers to the system.

Preamble (j)

Our second proposal is that Bill 36 be amended to prohibit LHINs and the Minister from using a model of cost based competitive bidding for services as a basis on which to allocate funding or make integration decisions.

Insert s. 18(2)(d), 25(3.1) 26(2)(j) 28(3)

Thirdly, Bill 36 must include a provision ensuring that the full successor rights provisions of PSLRTA apply whenever there is a change in service provider through a tendering or re-tendering process.

Section 40(1)

Lastly , given the experience in the home care sector with services moving from provider to provider on each round of tendering, we are proposing a review of collective bargaining in the health sector to ensure, not only successor rights, but also the maintenance of job security, the retention of terms and conditions of employment and the portability of benefits. Not only would this reduce the chances that front line workers will be subject to a race to the bottom regarding working conditions, but it would also provide some measure of continuity of quality care for the patients who are supposed to be the central focus of health care reform.

Section 33

G. Public Accountability in the Ongoing Provision of Health Care Services

Currently Bill 36 provides for accountability agreements between the Minister and each LHIN to be made available to the public at the offices of the Ministry and the LHIN. Accountability agreements presently being established between the Ministry and health service providers have no similar guarantee. Furthermore, once the LHINs take over funding in 2007, there is no requirement for the next round of accountability agreements - between LHINs and health service providers - to be made public.

We believe that all accountability agreements, and the compliance reporting that will establish whether the accountability agreements are being adhered to, should be made readily available to the public with no discretion for the Minister to prevent the disclosure of these agreements. Our view is that disclosure always promotes accountability. Only through complete openness and transparency can trust in the system be established and true accountability to the public be achieved.

We are proposing that all accountability agreements and compliance reports be made available and accessible to the public through Ministry and LHINs' offices and on their website. We are also proposing a number of amendments to increase the openness and transparency in decision making undertaken by the Minister of LHINs.

Proposed Amendment:

[ss. 5 (c) and (c.1), 9(3), 13, 18(5), 20, 25 (3.5) and (6), 37 (1) and (2)

OPSEU is also concerned that not all integrations will be reviewed by LHINs. Section 27 of Bill 36 allows a health service provider to "integrate" its services with those of another person or entity; this would include the transfer of services which are currently publicly funded and administered to a private for profit entity that is not a service provider. The Bill requires notice of such integration to be given to the LHINS only if it relates, at least in part, to services which are funded by the LHINs, unless exempted by regulation. Again, since the regulation is yet to be made public, we do not know the extent of the exemption. In our view, all integrations should be subject to oversight by the LHINs to make a determination of whether the integration is in the public interest. Certainly, in all integrations that involve publicly funded services there should be a full review by the LHIN. Accordingly, we are proposing that the exemption be removed from subsection 27(3) (a).

For the same reasons we are proposing that no Section 27 integration can proceed unless it is approved by the LHINs. As currently drafted Bill 36 requires that, where a Section 27 integration relates, at least in part, to services which are funded by the LHINs, notice must be given to the LHIN. The LHIN then has 60 days in which to issue a decision ordering that the integration not proceed if it is in the public interest not to do. If no order is issued within 60 days the health service provider can proceed to "integrate" its services with those of another person i.e. transfer services which are publicly funded.

Sixty days is a short time frame for the LHINs to consider "the extent to which the integration is not consistent with the network's integrated health service plan " and any other matter, including hopefully the public interest, in order to come to a well reasoned decision. By putting the onus on LHINs to stop integration initiated by service providers and giving it such a short time frame in which to exercise its mandate, Bill 36 is setting up a rubber stamping process which will simply record the further drift of publicly funded services to the for-profit sector. This will be exacerbated if the LHINs themselves are under funded and under resourced. Accordingly, we are proposing amendments that will place these Section 27 integrations on hold until the LHIN makes a decision to permit or reject them.

s. 25 (1) (2), s. 27 (3) (4)

J. Contracting Out Services Critical to patient care and health care workers -- Section 33

Bill 36 allows cabinet to order any public hospital to cease performing any non-clinical services which they chose to prescribe and to transfer it to any other person or entity . OPSEU has real concern that "non-clinical services" are specifically targeted for contracting out. Our concerns are heightened by the lack of a definition of "non-clinical services "which will be determined by regulation at a later date.

It is extremely short sighted to achieve cost savings through the contracting out of services which, while not part of clinical care, are an important adjunct to it and important to the health of patients as well as the occupational health and safety of health care workers. A case in point are the housekeeping and dietary staff of the hospital. In this age of heightened concerns regarding antibiotic-resistant infections and pandemics, the importance of infection control cannot be overstated. The housekeeping and dietary staff of a hospital play a critical role in infection control. Furthermore, as we learned through the experience of our members during the SARS outbreak an important element of infection control is the ability to prevent transmission from institution to institution.

We also have significant concerns regarding the contracting out of labour relations and sick leave administration, a reality which already has been implemented at a number of hospitals where our members are employed. The results are entirely unsatisfactory. When the face to face relationship between the hospital, its employees and their bargaining agent is replaced with a third party, a meaningful employment relationship is unlikely. Experience with third party administration of sick leave plans has led to allegations of harassment and arbitrariness which have resulted in litigation. Thus it is our conclusion that this form of contracting out will further erode employee morale and exacerbate retention and recruitment problems.

OPSEU is proposing that current Section 33 be deleted in its entirety.

I. Failure to Address Health Human Resource Planning and to Adequately Protect the Rights of Health Care Workers

1. Recruitment of Health Care Workers

The delivery of quality health care for patients in Ontario is dependent on retention and recruitment of an adequate number of trained health care workers in all categories in the regulated health professions as well as support workers. It is of fundamental concern, therefore, to OPSEU that Bill 36 completely ignores the issue of health human resource planning that is essential to the delivery of health care within an integrated health system.

The anticipated shortage of trained health professionals is well known. According to a Health Canada Bulletin, Ontario's overall shortage of nurses is expected to reach a shortfall of 78,000 by 2011.

OPSEU commissioned a poll of our members in Nov. 2002 on the effect of shortages on their professions. The survey polled 608 medical laboratory technologists, laboratory technicians, medical radiation technologists, pharmacists, occupational therapists, physiotherapists, respiratory therapists, and other hospital medical professionals. Of these, 78 per cent said staff shortages are hurting patient care.

Because of the training time required to educate new professionals, health human resources planning needs to be done at least ten years in advance to ensure that the specific needs of each community are met.

Therefore, we propose that a provision be added to the preamble to the legislation to confirm a commitment to address shortages of health care professionals. We further propose that the Provincial Strategic Plan and each Integrated Health Services plan be required to project health human resources needs and set out specific plans to address anticipated shortages of health care professionals.

Preamble, 14, 5 (f), 15 (2)

2. Retention of Health Care Workers

Bill 36 sets out extensive powers for the transfer, merger, amalgamation, seizure, dissolution and/or winding up services or operations. This is done apparently without thought to the impact of these decisions on the frontline workers who are providing the health care services to the community. These changes will have a significant disruptive impact on the lives and careers of health care professionals and other employees who have been providing health care services. It is a mistake for the government to ignore the impact on these workers and assume that they can be transferred from place to place along with the furniture and the funding. The fact that the Bill deals with issues of property transfer before the transfer of employees speaks volumes. The consequence of not adequately addressing human resource issues will be that many health care professionals will take early retirement and withdraw from the system thus aggravating and accelerating the pending crisis of a shortage of health care professionals. Transfers between communities present a particular challenge for families which rely on two incomes.

For those employees who currently work in a hospital environment, the prospect of transferring to a smaller setting in the community will necessarily be considered in the context of relative terms and conditions of employment. In the hospital environment, employees have the advantages of compensation parity with their counterparts in hospitals throughout the province: this includes wages as well as participation in HOOPP (the Hospitals of Ontario Pension Plan), standardized disability plans, dental plans, extended health plans, life insurance and other benefits. These benefits are portable from job to job within the hospital system. Additionally, hospital employees have other advantages achieved through collective bargaining including job security protections. Finally they have the advantages of representation by the Union, not only in enforcing their collective bargaining rights, but also in other employment related matters including College proceedings.

Employees faced with the transfer of services in which they are involved will be unlikely to opt to move with those services unless they are assured that the benefits of their current employment will follow. Although the provisions of the Public Sector Labour Relations Transition Act, 1997 will apply on transfer of services from a hospital to a community setting, the realities of collective bargaining in smaller, fragmented workplaces will inevitably lead to an undermining of terms and conditions of employment. Of particular concern is the lack of provision for wage parity through a central collective bargaining system as well as the difficulty of achieving pension and benefits for employees in splintered workplaces. This will be aggravated by the lack of portability of accrued service and seniority from one job to another.

Furthermore, without meaningful and ongoing representation by the Union, professionals employed in small workplaces lose, not only job security, but also representation for the variety of employment related proceedings to which anyone who works as a health care professional is exposed.

OPSEU sees nothing in Bill 36 or in the government rhetoric surrounding the introduction of the legislation which begins to respond to this problem. We have made a proposal on this issue under the heading of collective bargaining.

We are proposing that the government commit to meeting with the representative of health care workers for the purpose of agreeing to a system of province-wide bargaining to extend hospital terms and conditions of employment, including wage rates, benefits and pensions, to all employees regardless of which particular service provider or employer is technically the employer.

3. Impact on Collective Bargaining

Ontario has benefited from stable labour relations in the health sector for a number of years. OPSEU has worked in conjunction with the Ontario Hospital Association to develop a system of central bargaining which has achieved not only the standardization of wages and monetary benefits for our members working throughout the provinces, but labour relations stability for employers, employees and the communities in which they work. It is of significant concern to OPSEU that Bill 36 in no way addresses the potential impact of this round of health care restructuring on these collective bargaining realities. To the extent that the restructuring puts existing bargaining structures at risk, we are very concerned that it will undermine labour relation stability in the Province.

OPSEU is further concerned that the dilution of representation of professionals and other health care workers which has been the grim experience in the home care sector following introduction by the Conservative government of the "managed competition" model will be extended to other areas of the health sector. The undermining of job security and terms and conditions of employment that resulted from the home care model, will severely impede the retention and recruitment of qualified health care professionals and support workers and ultimately, undermine the health care services delivered to the community.

Accordingly, OPSEU is proposing that a system of province-wide bargaining be established to extend the hospital terms and conditions of employment including wage rates, benefits and pensions regardless of which particular health service provider or employer is involved.

This would also allow for portability of pension rights, pension and benefits, as well as seniority to facilitate and encourage health professionals and other health care workers to provide care in a seamless, integrated system which provides a continuum of care to the community. We propose that this system be established in consultation with the stakeholders including the health care unions. As previously pointed out we strongly believe that all integration and other forms of restructuring be placed on hold until an agreed upon solution is identified and implemented.

Amend s.33

4. Impact of Decisions on Collective Agreement Rights

Erosion of Collective Agreement Rights

OPSEU is seeking guarantees that the collective agreement rights of their member will not be eroded by decisions made pursuant to Bill 36. Under s.25(4) of Bill 36, the parties to an integration decision are "the persons or entities that are the subject of the decision". While this may be a broader group than just health service providers, it is assumed that unions and employees are not "parties" nor are they bound by integration decisions. Neither unions nor their members have the right to seek reconsideration of an integration decision as they are not health service providers. Although not parties to integration decisions, nor having the right to ask for reconsideration of these decisions, front line employees will certainly be impacted by these decisions. The rights of employees in these circumstances should be as determined by their relevant collective agreements and the provisions of the Public Sector Labour Relations Act and should not be abridged by integration decisions to which they are not a party. The legislative agenda of the government in implementing changes in the health care system cannot be used to override the rights of employees as determined by bargains that were made at the bargaining table.

Accordingly, we propose that no integration decision or approval made by either a LHINS or the Ministry will alter the terms and conditions of employment of an employee of a health service provider, including a collective agreement, without their/their union's consent (where represented by a union), or except as provided by PSLRTA.

25 (3.2), 28 (4) Page 9

5. Human Resource Adjustment Plans (HRAP)

Section 39(2) of PSLRTA makes Human Resource Plans agreed upon by an employer and a bargaining agent prevail over the act with limited exceptions. During the last round of restructuring in the hospital sector, Human Resource Adjustment Plans were agreed upon between bargaining agents and employers, in some cases of mergers and amalgamations, to smooth the way for the implementation of restructuring decisions. Where they were agreed upon, these agreements decreased the impacts of dislocation on the workers, provided certainty for the employers and removed the need for litigation. OPSEU believes that human resource adjustment plans should be promoted by the legislation in this round of restructuring. Where such an agreement can be reached, it will eliminate litigation and facilitate the resolution of issues for the parties.

Accordingly, we are proposing that notice be given to bargaining agents of any pending integration whether it is voluntary or by order of the LHINS and that before a finalization of any integration that a good faith attempt be made to negotiate, with mediation if necessary, a human resources plan with the bargaining agent(s).

s. 25(3.3) Page 7

6. Public Sector Labour Relations Transition Act, 1997 (PSLRTA)

a) Application

As currently drafted, the legislation defines "health services integration" in such a way as to include only integrations where all successors are either health service providers or an employer whose primary function is, or will be, the provision of services within the health sector.

We are concerned about this limitation on the application of PLSRTA for several reasons:

First, any employees currently working in the health care sector who may be impacted by an integration decision, will have significant concerns regarding the succession of their representation rights and collective agreement rights. These will be the case regardless of the characterization of the successor employer. While PSLRTA does not address the wage and working conditions concerns outlined above, it at least establishes an orderly way of dealing with the issues arising out of a restructuring and should be applied regardless of the nature of the successor's business. The alternative is lengthy litigation under the successor rights provisions of the Ontario Labour Relations Act -- a result which is beneficial to no one. Given that the government is apparently prepared to apply PSLRTA to the contracting out of non-clinical services, presumably to the non-health care sector, we do not understand why PSLRTA should not determine all of the successor issues which fall out of integration decisions.

Second, the qualification on the definition of Health Services Integration will lead to extensive litigation. Some creative lawyer may argue, for example, that if any aspect of restructuring relating to a particular predecessor employer implicates a successor employer who is not primarily involved in the health service sector, then the provisions of Bill 136 will not apply to any integration decision of that employer. This would be of particular concern, for example, should a hospital be involved in a number of "integration" decisions the majority of which will involve health service successors with some minor exceptions. Even if such an interpretation does not apply, we believe the provision will, at the very least, result in a significant amount of litigation.

Accordingly, OPSEU proposes that the PLSRTA should apply to all health service integrations without limitation.

s.40 (1) (a) (b) - Page 11

b) discretion of the OLRB

For similar reasons we assert that the application of the PSLRTA should not be subject to the discretion of the Ontario Labour Relations Board. In the last round of restructuring there was considerable litigation to determine the application of the Board's Section 9 discretion. Given the much expanded number of possible transfers of service and the potential variations in individual circumstances this round of restructuring promises much more extensive Section 9 litigation if Bill 36 is not amended. Regardless of the circumstances, employees who have their employment threatened by restructuring deserve to have their rights dealt with through an orderly mechanism. The PSLRTA provides a mechanism for sorting out some of the consequences of employment dislocations. We believe that the Labour Board should be mandated to determining these cases in accordance with that specified mechanism and hopefully will assist the parties to come to settlements rather than wasting resources on determining whether the provisions of PSLRTA should apply. Otherwise there will be expensive litigation at the Board over whether Bill 136 should apply and extensive resources spent fighting under successor rights provisions of the Labour Relations Act.

We are proposing that the PSLRTA should apply to all health care restructuring unless the Employer and affected unions agree it does not apply. The decision making of the Ontario Labour Relations Board would be limited to determining if an integration had taken place or if a binding agreement had been reached between the parties that PSLRTA did not apply.

s. 40(1) (4), 9 (1) (2) (3) - Page 11-12

c) Retroactive wage adjustments

One consequence of restructuring under PSLRTA is that collective agreements and/or terms and conditions of employment of affected employees are frozen, at least until the bargaining units and bargaining agents with the successor employer are finalized. This often leaves employees working under expired Collective Agreements for many months while their colleagues in agencies unaffected by restructuring bargain improvements in compensation as well as other terms and conditions of employment. To rectify this inequity we are proposing amendments to both PSLRTA and The Hospital Disputes Arbitration Act (HLDA).

Amend Section 40 (13) Section 31

d) Crown Employees:

The PSLRTA contains a number of special provisions that generally apply if the event that triggers the Act involves the Crown as either a predecessor or successor employer. The provisions exempt crown employees from the provisions of the Act which otherwise result in the continuation of bargaining rights and the continuation of collective agreement rights. The impetus for this special treatment of crown employees was the 1995 decision by the Harris government to remove successor rights and related- employer rights for crown employees and their bargaining agents . As a result of these special provisions:

- Crown employees can lose their union representation and collective agreement upon the occurrence of the triggering event;
- Crown employees can be included in a bargaining unit represented by another union upon agreement of the Employer and the other union;
- Crown employees are counted as being non-union for purposes of determining if 40% of the employees in a bargaining unit were previously represented by a bargaining agent, in which case a non-union option must be included on the ballot to determine which, if any, union represents the bargaining unit with the successor employer;
- The rules to determine relative seniority may apply to former crown employees differently than other employees

Although OPSEU does not anticipate that many of the crown employees it represents will be affected by health sector integrations, those that are should fully and equitably be entitled to the rights of other employees subject to PSLRTA. There is no justifiable rationale to continue the distinctions contained in PSLRTA. This government has agreed to restore full successor rights to crown employees and their bargaining agents: now is the time to deliver on that promise.

We are proposing amendments to the PSLRTA to restore successor rights to Crown employees.

s. 40 (14) - Page 13

e) Retrospective Application

Bill 36 is entering an environment where integrations are already in progress. For example, the new central lab of the Eastern Ontario Regional Lab Association is scheduled to be commissioned in April, bringing workers from a number of surrounding hospitals into this new structure. Another example is the recent announcement that laboratory and diagnostic imaging services at London Health Science Centre and St. Joseph's Health Care Centre in London will be combined.

That means that already employment relationships and representation rights are being impacted. For purposes of consistent application the amendments related to PSLRTA should be made retrospective to cover all integrations initiated since November 24, 2005, the first reading of the Bill, including those in which successor rights proceedings have been already been initiated with the Ontario Labour Relations Board, without such a provision there will inequitable treatment of the rights of Health Care workers and potential litigation over whether PSLRTA does apply, and if it does not, how the successor rights provisions of the Act apply.

We are proposing the addition of a provision making the legislation retroactive to cover all restructuring since November 24, 2005 to the time the Bill was introduced.

s. 53(b) - Page 13

J. Conclusion

OPSEU believes that Bill 36 requires substantial amendment in order to effectively implement seamless health care in a manner that respects the public interest, including the interests of workers on the front line of the provision of health care in the province. By adopting the amendments proposed in this brief and set out in the attached Table of Proposed Amendments, the government would better meet the objectives of patient centered care, and open and transparent decision-making that should be at the centre of any health sector reform. Further, adoption of the proposals set out in this brief would ensure that this latest reform to the health care system respects the interests and protects the rights of front line workers who are so very integral to the effective functioning of the health care system.

Citations

- i The Hon. George Smitherman, *Ontario's Health Transformation Plan: Purpose and Progress*, Speaking Notes, September 9, 2004, at 2; http://www.health.gov.on.ca/english/media/speeches/archives/sp_04/sp_090904.html accessed January 20, 2006.
- ii *Ibid.*, at 7.
- iii The Hon. George Smitherman, *Results*, Speaking Notes, October 6, 2005, at 9; http://www.health.on.ca/english/media/speeches/archives/sp_05/sp_100605.html accessed January 20, 2006.
- iv Legislative Assembly of Ontario, *Hansard*, November 24, 2005, at 1410
- v *Ibid* at 1410
- vi Ontario Hospital Association
- vii Canadian Institute for Health Information
- viii Ontario Health Coalition, "OHC Backgrounder: Homecare Privatization - The End of 100 Years of Non-profit Home Nursing?" May 2003
- ix Elinor Caplan, *Realizing the Potential Of Home Care*, 2005
- x *Local Health System Integration Act* Section 24
- xi Ministry of Health and Long Term Care Website - Health Update: *Local Health System Integration Act*, 2005
- xii *Hansard*, November 29, 2005
- xiii *Local Health System Integration Act* Section 27(5)
- xiv *Local Health System Integration Act* Section 33
- xv Health Policy Research Bulletin, Health Canada, Issue 8, May 2004
- xvi T. Hadwen et al. *Ontario Public Service Employment Labour Law*, 2005 *Irwin Law* at 423
- xvii *ibid* at 426-430

Submission to the
Standing Committee on Social Policy

Bill 36

Local Health System

Integration Act

Table of Amendments



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OPSEU TABLE OF PROPOSED AMENDMENTS TO BILL 36

Amend Preamble:

- (l) confirm their continued commitment to medicare and that the health system shall be delivered by the public, not-for-profit sector and in a manner which adheres to the principles identified in the preamble to the *Commitment to the Future of Medicare Act, 2004*;
- (j) confirm their commitment to respect health care professionals and workers as being fundamental to the delivery of quality health care and recognize their right to equitable terms and conditions of employment regardless of where they work in the health system;
- (k) confirm their commitment to addressing the current shortage of health care professionals and workers;
- (l) confirm their commitment to eliminate regional disparities in the availability of health care within Ontario;
- (m) confirm their commitment to fund travel costs for patients necessitated by integration.

Amend s.1

1. (1) The purpose of this Act is to provide, in a manner consistent with the public interest, for an integrated health system to improve the health of Ontarians through better access to health services, co-ordinated health care and effective and efficient management of the health system at the local level by local health integration networks.
- (2) All powers conferred and all decisions made under this Act are required to be exercised in the public interest.

Amend ss.2(1)

“public interest” means

- (a) the protection of medicare through the maintenance and expansion of existing publicly funded health services;

- (b) the prohibition of a two-tier medicare, extra billing and user fees;
- (c) the adherence to the principles of the *Canada Health Act* through the public administration, comprehensiveness, universality, portability and accessibility of health care for all Ontarians;
- (d) the achievement of a patient-centred system that ensures access based on assessed need, not on an individual's ability to pay;
- (e) the provision of access to a full continuum of clinical care as well as community based health care including primary care, public health care, long-term care, home care based on assessed need and community mental health care for each Ontarian;
- (f) the protection of the rights of health care workers including the provision of minimum compensation standards, the preservation of their rights to representation by a trade union, and rights conferred by a collective agreement;
- (g) as is further described in the Preamble to this Act.

Amend ss.2(2)

2 (2) In this Act,

“health service provider” subject to subsection (3), means the following persons and entities

...

- 12. A member of the College of Physicians and Surgeons of Ontario under the *Medicine Act, 1991*.
- 13. A health profession corporation that holds a certificate of authorization issued by the College of Physicians and Surgeons of Ontario under the *Regulated Health Professions Act, 1991* or under Schedule 2 to that Act.
- 14. A family health team;

15. A laboratory or specimen collection centre within the meaning of the Laboratories and Specimen Collection Centre Licensing Act;
16. An independent health facility within the meaning of the Independent Health Facilities Act;
17. An ambulance service within the meaning of the Ambulance Act;
18. A public health unit, within the meaning of the Health Protection and Promotion Act
19. Any person or entity which, as a result on an integration decision, provides services within or to the health sector.

(Consequential amendments to ss.2 (3) to delete references to physicians)

Amend s.3

3. ...

Add

- (5) The Lieutenant Governor in Council shall by regulation prescribe conflict of interest policies that shall consistently apply to all members, officers and employees of local health integration networks, which shall be subject to oversight by the Integrity Commissioner.

Amend s.5

- 5.** The objects of a local health integration network are to plan, fund and integrate the local health system in accordance with the purpose of this Act, including

...

- (c) to engage the community of persons and entities involved with the local health system in the planning and setting

priorities for that system, including establishing formal channels for community input and consultation, including from equality-seeking groups, at all stages of decision-making;

- (c.1) to make copies available to the public of all reports and plans it is required to prepare under this Act, information it is required to disseminate, decisions of the local health integration network, accountability agreements and service accountability agreements in relation to the local health integration network and all related compliance reports, funding allocations to or by the local health integration network, names and contact information of all members, officers and committee members, notices of all meetings of the local health integration network and its committees, including at the network's offices and by publishing these on a website maintained by the local health integration network on the Internet;
- (f) to participate and co-operate in the development by the Minister of the provincial strategic plan, which includes support and guidelines for human resource adjustment planning including projections of health human resource need and specific measures to address anticipated shortages of health care practitioners, and in the development and implementation of provincial planning, system management and provincial health care priorities, programs and services;

Amend s.7(1)

- 7. (1)** Each local health integration network shall consist of no more than nine members elected by electors within the geographic area of the network pursuant to the *Municipal Elections Act, 1996*.

(Consequential amendments as necessary to the *Municipal Elections Act, 1996* and other statutes governing municipalities);

Deletion of proposed ss.7(2)-(4)).

Amend ss.8(8)

8. ...

- (8) The members, officers and employees of a local health integration network shall comply with the conflict of interest policies prescribed by the Lieutenant Governor in Council.

Amend ss. 9(3)

9. ...

- (3) Meetings of the board of directors of a local health integration network and its committees shall be open to the public. Meetings may be held *in camera* only if confidential personnel matters will be discussed.

Amend s. 13

13. ...

- (7) In accordance with ss. 5(c.1), each local health integration network shall make copies of its annual report available to the public by publishing it on its website on the Internet.

Amend s.14

- 14.** The Minister shall develop, in consultation with the public, a provincial strategic plan for the health system that includes a vision, priorities, human resource adjustment planning including projections of health human resource need and specific measures to address anticipated shortages of health care practitioners and strategic direction for the health system consistent with the purpose of this Act and make copies of it available to the public at the offices of the Ministry and shall publish it on the Ministry's website on the Internet.

Amend s.15

- 15. (1)** Each local health integration network shall, within the time and in the form specified by the Minister, develop, in consultation with the

community and entities involved with or served by the local health system, an integrated health service plan for the local health system consistent with the purpose of this Act and make copies of it available to the public at the network's offices and shall publish it on the network's website on the Internet. This is in addition to the requirements of subsection 16(1).

- (2) The integrated health service plan shall include a vision, priorities, human resource adjustment planning including projections of health human resource need and specific measures to address anticipated shortages of health care practitioners and strategic directions for the local health system and shall set out strategies to integrate the local health system in order to achieve the purpose of this Act.

Amend s.16

- 16. (1.1)** Each local health integration network shall establish a health sector employee advisory committee representative of front line health service provider employees who provide health care within the geographic area of the network, and where any of these employees are represented by one or more trade unions as their bargaining agent, these trade unions shall select the representatives on the committee of health sector employees ..
- (2) Each local health integration network shall establish a health professionals advisory committee representative of front line regulated health professionals who provide health care within the geographic area of the network, and where any of these employees are represented by one or more trade unions as their bargaining agent, these trade unions shall select the representative on the committee of regulated health professionals.

Amend s.17

- 17. (1)** The Minister shall provide such funding to a local health integration network as is sufficient to fulfill the purpose of this Act after consulting with the local health integration network and the community of persons and entities involved with the local health

system, on terms and conditions that the Minister considers appropriate.

- (2) When determining the funding to be provided to a local health integration network under subsection (1) for a fiscal year, the Minister shall ensure that all savings from efficiencies that a local health integration network generated in the previous fiscal year shall be allocated to patient care by the local health integration network in subsequent fiscal years in accordance with the accountability agreement.
- (3) A funding allocation described in this section shall be available to the public at the offices of the Ministry and shall be published on the Ministry's website on the Internet.

Amend s. 18

18. ...

- (2) (d) a plan for spending the funding that the network receives under section 17, which plan shall not include cost-based competitive bidding as a basis for decisions for the allocation of funding or determining which service provider will provide services
- (5) The Minister and each local health integration network shall make copies of the accountability agreement of the network available to the public at the offices of the Ministry and the network, respectively, and also publish the accountability agreements on the Ministry's website on the Internet.

Amend s.20

- 20. ...**(1.1) A health service provider that receives funding from a local health integration network under subsection 19(1) shall report to the network each fiscal year on its compliance with its service accountability agreement.
- (3) Delete.

Amend s.25

25. (1) A local health integration network may integrate the local health system by,

...

(d) issuing a decision under section 27 which permits a health service provider to proceed with the integration described in the decision;

(e) issuing a decision under section 27 that orders a health service provider not to proceed with the integration described in the decision.

(2) A local health integration network shall issue an integration decision when the network,

...

(C) by order, permits a health service provider to proceed with an integration under section 27;

(D) orders a health service provider to not proceed with an integration under section 27.

Prohibitions

(3) No integration decision shall permit a transfer of services that results in a requirement for an individual to pay for those services.

(3.1) No local health integration network shall use cost- based competitive bidding as a basis on which to allocate funding or for an integration decision.

(3.2) No integration decision shall alter the terms and conditions of employment or the collective agreement binding on an employer who is a party to such a decision without the agreement of the

affected employees and in the case of employees represented by a trade union without the agreement of the bargaining agent who has bargaining rights in respect of a bargaining unit that is the subject of the decision, except as provided by the *Public Sector Labour Relations Transition Act, 1997*.

(3.3) No integration decision shall be issued before the parties to the decision have met with every bargaining agent that has bargaining rights in respect of a bargaining unit that may be affected by the integration decision and the parties have, in good faith, made every reasonable effort, including consideration of mediation if necessary, to agree to a human resource plan.

(3.4) No integration decision shall permit the transfer of services within the health services sector from a not for service provider to a for profit health service provider.

(3.5) No integration decision or funding allocation shall be issued before the local health integration network has given public notice of the proposed decision in accordance with subsection 5 (c .1) and give an opportunity for representations about it by potentially affected persons and entities.

...

(6) On issuing an integration decision, a local health integration network shall give the decision to the parties to the decision and make it available to the public in accordance with subsection 5 (c. 1).

Amend s 26

26...

(2) (j) the minister shall not use cost-based competitive bidding as a basis on which to make decisions under subsection (1).

Amend s.27

27. ...

- (3) If the integration mentioned in subsection (1) relates to services that are funded, in whole or in part, by a local health integration network, the health service provider shall,
 - (a) give notice of the integration to the network;
 - (b) not proceed with the integration until the network issues a decision permitting it to do so.
- (4) The local health integration network shall, no later than 60 days after the health service provider gives notice under subsection (3), issue a decision,
 - (a) which permits the service provider to either proceed or not proceed with the integration; or
 - (b) ordering the service provider not to proceed with the integration.

Amend ss.28

28(1) After receiving advice from the local health integration network involved and subject to subsections (2) (3) and (4) the minister may order a health service provider to do any of the following on or before the date set out in the order:

- 1.....
- 2.....
- 3.....
- 4.....

- (2)
- (3) An order made by the minister under this subsection (1) shall not use cost-based competitive bidding as a basis on which to make decisions under subsection (1).
- (4) No order made under subsection(1) shall alter the terms and conditions of employment or the collective agreement binding on an employer who is a party to such a decision without the agreement of the affected employees and in the case of employees represented by a trade union without the agreement of the bargaining agent who

has bargaining rights in respect of a bargaining unit that is the subject of the decision, except as provided by the *Public Sector Labour Relations Transition Act, 1997*.

Amend s.25-27 Restructure to permit, in each case, any health service provider or person or entity which may be affected by an integration decision or funding allocation to request that the local health integration network reconsider its decision; no restriction on the number of reconsideration requests the network may consider; to give the network a discretion to reconsider its decisions;

Amend s.32

32. ...

Delete subsection 32(3) and make all consequential amendments (e.g. subsection 32(5)).

- (8) If requested to do so under subsection (7), the Board shall, if satisfied that an agreement described in subsection (4) has been made, by order declare that the *Public Sector Labour Relations Transition, 1997*, other than sections 12 and 36 of that Act, does not, despite subsection (1), apply to the integration in question.

Delete subsection 32 (9).

Amend s.33

Delete all of section 33 and replace with:

- 33. (1)** The Minister shall, within 15 days of this Act receiving Royal Assent, appoint a well respected neutral in the field of labour relations and collective bargaining to review the structure of collective bargaining in the health care sector in Ontario, in consultation with the employers, trade unions and other entities involved in that sector, and propose a province-wide system of collective bargaining to extend hospital terms and conditions of employment, including wage

rates, pension and other benefit entitlements to all employees in the sector, and ensure portability of pension, other benefits and seniority rights for these employees.

- (2) The person appointed by the Minister under subsection (1) shall conduct the review and provide the Minister with his or her report of that review and proposals within 120 days of his or her appointment.
- (3) The report in subsection (2) shall be published by the Minister, including on the Ministry's website on the Internet.

Amend s.37(1)

37. (1) ...

- (a) the Minister has published a Notice of the Proposed Regulation in *The Ontario Gazette* and on the Ministry's website on the internet and given Notice of the Proposed Regulation by all other means that the Minister considers appropriate for the purpose of providing notice to the persons and entities who may be affected by the proposed regulations;

Amend s. 37(2)

Delete s. 37(2)

Amend s. 39(18)

15.1.(1) amend the preamble to read:

Before the Lieutenant Governor in Council makes a regulation under subsection 15(1) or the Minister makes an order under subsection 15(3), the Minister shall obtain a recommendation from the local health integration networks involved and shall require the affected community care access corporations to jointly prepare and submit a report that contains proposals for one or more of the following:

...

Delete 3. and replace with

3. The transfer of employees and the results of negotiations of Human Resource Plans with each trade union who is the bargaining agent for any of these employees

PUBLIC SECTOR LABOUR RELATIONS TRANSITION ACT

Amend s.40

40. (1) ...

“health services integration” means an integration that affects the structure or existence of one or more employers or that affects the provision of programs, services or functions by one or more employers, including but not limited to an integration that involves a dissolution, amalgamation, division, rationalization, consolidation, transfer, tendering, re-tendering, merger, commencement or discontinuance where one or more employer subject to the integration is either,

- (a) a health service provider within the meaning of the *Local Health System Integration Act, 2005*, or
- (b) an employer whose function is or, immediately following the integration, will be the provision of health services within or to the health services sector;

(4) Section 9 of the Act is repealed and the following substituted:

Application of Act to health sector

9. (1) An employer that is or will be subject to a health services integration or a bargaining agent that represents employees of such an employer may request the Board to make an order declaring that this Act applies to the health services integration in question.

Board order

- (2) Subject to subsection 32(4) of the *Local Health System Integration Act, 2005*, where the Board is satisfied that a health services integration has or will occur which will affect a bargaining agent or the employees of an employer described in subsection (1) represented by such a bargaining agent, the Board shall by order declare that this Act applies to a health integration if requested to do so under subsection (1).

Factors to consider

- (3) When deciding if a health services integration has occurred under this section, the Board shall consider the following factors and such other matters as it considers relevant:
1. The scope of agreements under which services, programs or functions are or will be provided by employers subject to the health services integration.
 2. The extent to which employers subject to the health services integration have rationalized or will rationalize the provision of services, programs or functions.
 3. The extent to which programs, services or functions have been or will be transferred among or between employers subject to the health services integration.
 4. delete

(13) Section 31 of the Act is amended by

- (3) notwithstanding any other provision of this act, either party to the negotiation for the new collective agreement can bargain for terms retroactive to the earliest of the expiry dates contained in the collective agreements referred to in Section 15 that was applicable to the employees in the bargaining unit for which notice is being given and where no collective agreement was in existence, then to the earliest date of certification of such employees.

....

Note: a corresponding amendment to Section 10(13) of *The Hospital Labour Disputes Arbitration Act* is required

- (14) Delete the following provisions from *PSLRTA* pertaining to the Crown and Crown employees:

Section 9(7) delete in its entirety

Section 12(3) delete in its entirety

Section 14(2) delete in its entirety

Section 14(3) 1. delete in its entirety

Section 15(5) delete in its entirety

Section 23 (14) delete “or are employees described in subsection (4)”

Section 33(5) delete in its entirety

Amend Section 42

(49) ...

(2) Delete “when required to do so by the Minister or a local health integration network.”

(3) Delete “if the Minister or the network is of the opinion that disclosure would promote accountability.”

Amend s.53

53. Deem that the Act comes into force 120 days after the later of the publication of the plan described in section 14 and the report described in section 33.

Deem that those sections of the Act that relate to an integration which is subject to the *Public Sector Labour Relations Transition Act, 1997*, as amended, are deemed in force November 24, 2005.