



Canadian Health Professionals Secretariat

Meeting Report

Ottawa

May 1-2, 2008

CANADIAN HEALTH PROFESSIONALS SECRETARIAT

Meeting Date: May 1-2, 2008
Location: Ottawa, Ontario

PARTICIPANTS

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Guest Speakers

Larry Brown, NUPGE Secretary-Treasurer
Kurt Davis, Executive Director, Canadian Society for Medical Laboratory Science
Dr. Atul Kapur, Member, Canadian Doctors for Medicare

WELCOME AND INTRODUCTIONS

Co-Chairs Elisabeth Ballermann and Mike Luff welcomed participants to the 11th meeting of the Secretariat and participants introduced themselves and identified their health discipline and position in their union. The report of the previous meeting and the agenda for the current meeting were reviewed and approved.

CHPS COMMUNICATIONS, RESEARCH AND OUTREACH ACTIVITIES

Participants were briefed on the work of the Secretariat since the last meeting. They noted that all of the follow-ups were completed, including:

- a report of the last meeting;
- organizing and mobilizing around the SOS Medicare conference in Regina, SK;
- potential next steps to continue raising profile;
- job descriptions and wage information about anesthesia assistants;
- dental fee increases for 2007;
- information about safe needles campaigns; and
- research on sonographer ergonomics issues.

There was a good discussion about future potential activities to raise the profile of CHPS and the public policy issue of shortages of health professionals. There was a general consensus that CHPs should organize a day of lobbying Members of Parliament around the next CHPS meeting.

Co-Chair Luff provided an overview of communications activities and the issues covered on the CHPS website. He noted the diversity of issues covered by news releases from CHPS and its constituent organizations, including collective bargaining, public policy, advocacy campaigns, public relations and surveys.

Constituents were reminded to send their communications material to Luff for posting on the CHPS website and direct distribution to other constituent organizations. The Co-Chairs offered to assist constituent organizations in ensuring their websites give good exposure to CHPS activities.

It was also suggested that CHPS could organize a conference call for communications and campaigns staff to get to know each other better and to share information and ideas about how each union can raise the profile of the valuable work done by health professionals.

There was also a good discussion about “branding” CHPS with a consistent tag-line for all communications. Participants agreed that the following tag-line best describes the CHPS and should be used on future communications material:

“The CHPS is a national advocacy body that represents 70,000 unionized health professionals who deliver the diagnostic, clinical, rehabilitation and preventative services that are essential to timely and quality health care. Some of the highly trained professionals represented by CHPS include medical laboratory technologists, physiotherapists, social workers, pharmacists, occupational therapists, dietitians and psychologists. These professionals work in hospitals, long-term care facilities, mental health services, laboratories, home care services and public health agencies.”

Participants were also briefed on several new leaflets produced by NUPGE and CHPS. The leaflets are part of a series that outline 10 steps that can be taken to reduce wait times and improve the quality of care. The 10 leaflets in the series are:

1. Recruit, train and retain more health professionals.
2. A national home care program.
3. A national pharmacare program.
4. Better nursing home care for the elderly.
5. More public investment in dental care and oral health promotion.
6. A national mental health strategy.
7. Accurate information and evidence to make better decisions.
8. Primary care reform and expansion.
9. Greater focus on prevention, promotion and public health initiatives.
10. Better chronic disease management.

Participants were encouraged to order and distribute the leaflets to their members in order to raise awareness about the next steps that can and should be taken in the evolution of Canada's successful but unfinished Medicare system.

REVIEW

Recent Meetings with Members of Parliament

Co-Chairs Ballermann and Luff recently met with two Members of Parliament: NDP health critic, Judy Wasylycia-Leis and Liberal health critic Robert Thibault. They had also requested a meeting with the Conservative Health Minister, Tony Clement, but the Minister was not available.

Ballermann and Luff focused their presentation to the MPs on outlining who CHPS represents and the priority issue of labour shortages. They also left a package of materials with the MPs.

Both MPs understood the concern that health human resource strategies must go beyond shortages of physicians and nurses and address the serious shortages of many other health professionals.

There was a frank and open exchange of ideas with both MPs about the role of the federal government in addressing the shortages specifically and health care reform generally. There was also an informative discussion about how CHPS can plug into the development of the party platforms for the next election.

Ballermann and Luff reported that the meetings were a good use of time and that some important progress was made in terms of raising the profile of CHPS with key decision makers and getting the issue of shortages on their radar screen.

DISCUSSION

CHPS Presentation to House of Commons Health Committee

The Co-Chairs provided background information about the First Ministers deal to strengthen health care and the organizing and mobilizing that CHPS did around the meeting when the deal was signed.

For many years, Canadians have been increasingly concerned about wait times for health care. They worry about a lack of access to needed health services and products and they want reforms that ensure the health care system is effective, efficient, safe and equitable.

In response to these concerns, First Ministers in September 2004 reached an historic agreement – the *10-Year Plan* – to renew health care, improve access and enhance accountability to citizens. The plan committed federal, provincial and territorial (F/P/T) governments to move forward on a comprehensive and ambitious set of health care renewal initiatives, through collaboration on solving common problems.

The plan also mandated the federal government (through the House of Commons Standing Committee on Health) to review progress under the plan. The Commons Health Committee initiated a review in May 2008. CHPS was selected as one of the national health groups to make a presentation to the Committee.

Participants discussed the scope and content of the CHPS presentation. It was agreed that the CHPS presentation should focus on the following three messages:

1. Explain who CHPS is and the health professionals we represent. Emphasize that our members are facing serious shortages and that the goals of the 10-year

plan to reduce wait times and improve quality will not be met unless these shortages are addressed.

2. The federal government should work with provinces to develop a strategic national health human resources plan to address the shortages. The federal government can also provide more funding to increase the number of post secondary education seats and clinical training placements for health professionals.

3. Health care reform is urgently required but it can and must be done through innovation within the public system. Privatization will only increase wait times in the public system and result in less and lower care.

PRESENTATION

By Larry Brown, NUPGE Secretary-Treasurer

Brown congratulated the member organizations of CHPS on their recent successes and thanked everyone involved for their strong leadership in ensuring the group continues to work together on common issues.

In particular, he noted the great work that has been done to raise awareness with policy makers about the serious shortages of health professionals across the country. He pointed out that this is an issue that is about to get worse because Canada's work force is dramatically aging and a huge retirement wave is looming. Researchers and groups such as CHPS have been warning for years about potential labour shortages in health care and other sectors of the economy, yet employers and governments in Canada have not responded quickly enough.

Brown noted that there are global shortages of health care workers and while immigration is part of the solution, he emphasized the need for a made in Canada approach. That is, the shortages cannot be solved by Canada poaching health care workers from other countries. This would not be the right thing to do, nor would it be the smart thing to do. It is important to improve the foreign credentials recognition process for health care workers. But most importantly, governments and employers in Canada need to make significant new investments in recruiting, training and retaining Canadian workers to fill the void.

Brown noted that the general state of the Canadian economy has been a growing concern for the National Union over the last year. There is a consensus among economists that the U.S. is in a recession. The sub-prime mortgage crisis in the U.S. has resulted in over 650,000 people receiving foreclosure notices on their homes in the first three months of 2008.

He pointed out that the U.S. economic recession is impacting on Canada's economy, which slowed significantly in the first quarter of 2008. Unemployment

is on the rise in several regions and over 400,000 manufacturing jobs have been lost in recent years. Wages for most workers are stagnant. Canada has a large and growing income gap between the rich and poor. And the true weakness of Canada's economy is being masked by high sales of our primary resources, most notably oil and gas.

Brown argued that the prevailing economic ideology is preventing Canada from doing what is necessary to escape the worst of the falling U.S. economy. Canada has entered into trade deals that prevent us from taking any strong actions to protect ourselves from global economic shocks. Deregulation has become the new religion. We have allowed our major economic forces to become overwhelmingly owned by companies based in other countries. Tax cuts that overwhelmingly benefit the wealthy have reduced government revenues and budget surpluses have evaporated. The role of the government in the economy has been slowly fading away.

Brown urged CHPS members to be prepared because, as history shows, governments will not hesitate to make public employees the scapegoats for financial problems during an economic downturn. Slow economic growth has been used in the past as a bargaining weapon to force wage freezes and roll-backs, job cuts and privatization on the public sector.

Brown also said public sector workers must pay careful attention to the routine manner in which governments override their legal collective bargaining rights and impose wage settlements by law instead of working them out at the bargaining table. A slow economy will accelerate the tendency of governments to abuse their legislative power to get what they want.

In recent years the National Union has been leading the way on a campaign to restore labour rights in Canada. In addition to many other activities, NUPGE is one of four sponsors of an important international symposium called *Labour Rights Are Human Rights* next fall. The featured speaker will be Ed Broadbent, former president of Rights and Democracy and former leader of the federal New Democratic Party in Canada.

Brown noted that the labour rights campaign is critical especially given that Saskatchewan's new government has decided to make a showdown with organized labour one of its first legislative priorities. Saskatchewan Premier Brad Wall introduced a series of pro-business changes to provincial labour laws. Bill 5, the *Essential Services Act*, and Bill 6, amendments to the *Trade Union Act*, strengthen the hand of employers at the expense of workers and our unions. Bill 5 gives enormous powers to employers to designate which of its employees are essential while Bill 6 amends the *Trade Union Act* so that employers can more easily coerce their employees during organizing drives.

Brown noted that the Saskatchewan government is already facing stiff resistance from the labour movement. The Saskatchewan Government and General Employees' Union (SGEU/NUPGE) will hold a May Day rally at the Saskatchewan legislature next Thursday to protest Bills 5 and 6, anti-labour legislation introduced by the anti-worker administration of Premier Brad Wall. And NUPGE will be filing a complaint against the Saskatchewan government with the International Labour Organization (ILO), a specialized agency of the United Nations, on behalf of the SGEU.

Brown also spoke about the civil society opposition to the Trade, Investment and Labour Mobility Agreement (TILMA) signed by the governments of British Columbia and Alberta. Its sweeping provisions impact almost everything our governments do and affect every level of government – provincial, city, municipal, as well as hospitals and school boards. Brown pointed out four fatal flaws with TILMA:

- it fabricates barriers that don't exist;
- it weakens our democracy;
- it diminishes our public policy; and
- it gives businesses a \$5 million hammer to punish governments that don't agree with their position.

Participants were also briefed on the National Union's ongoing campaign to defend and strengthen Canada's Medicare. Brown outlined the campaign's main messages, targets, timelines and actions which are coordinated with various civil society allies across the country. Brown pointed out the need to counter the move in BC to amend its laws to make it mandatory for health care spending to remain "sustainable." Brown warned that this is about moving to a for-profit approach to health care which means fewer and lower quality services.

Brown also updated participants on the work of NUPGE's pensions committee and the multi-union working group of Canadian Blood Services workers. A question and answer session followed.

CONSTITUENT REPORTS

The constituent reports focused on labour relations climate, collective bargaining, strikes, campaigns, staffing, significant grievance decisions and other major developments. Copies of the reports were included in the meeting binders and are available by contacting Co-Chair Luff.

Co-Chair Ballermann facilitated a discussion during which each union reviewed the highlights of their reports and answered questions. The participants were able to share strategies and information on key developments, challenges and concerns across the country. Several organizations are either currently engaged

in or are gearing up for major rounds of collective bargaining. Media and coalition campaigns as a means of raising the profile of health professionals are still very popular amongst the CHPS constituents.

PRESENTATION

By Dr. Atul Kapur, Canadian Doctors for Medicare (CDM)

Dr. Kapur presented some background about Canadian Doctors for Medicare (CDM). CDM stepped into the national health care debate in May 2006 when a group of physicians became concerned about the increased privatization in Canadian health care and the development of a two-tier health care system that would allow the wealthy to buy private insurance for private care at the expense of the vast majority of Canadians.

CDM members include high-profile leaders in clinical medicine, research, policy and education residents, medical students, retired physicians, and "friends" in other health professions and among the Canadian public. CDM believes that Medicare must be reformed but that reform must take place within the public system so that it benefits all Canadians.

According to Dr. Kapur, some of the major challenges confronting Canada's single-payer health care system are:

- an aging population;
- health human resources shortages;
- long wait times for key services;
- rural communities;
- vulnerable populations such as Aboriginal communities;
- soaring pharmaceutical and technological costs; and
- inflation in the health care system.

Dr. Kapur outlined the benefits of public health care funding and exposed the myths and realities of private for-profit health care financing. It was argued that the common argument that countries can't afford to meet growing needs for health care through public financing, and must therefore draw in other sources of finance, makes no economic sense. A country's ability to sustain a given level of expenditure is not increased by moving money through one financing pipe rather than another. And a given level of care actually costs more, not less, if financed through private insurance, because the administrative costs are greater.

He also noted that when it comes to critical health outcomes, such as infant mortality and life expectancy rates, Canada rates better than the private health model in the USA and is among the best in the world. So, in comparison to the American system, Canada spends less and gets more in terms of coverage, quality and outcomes, argued Dr. Kapur.

Dr. Kapur also outlined several examples of how reform within the public health care system has cut months from wait times while reducing lengths of stay in hospital and increasing patient satisfaction.

- The Richmond Hip and Knee Reconstruction Project, for example, introduced system and surgical innovations that slashed median wait times by 75 per cent. By staggering operations between two dedicated surgical rooms focused on hip and knee reconstruction, standardizing practices, and investing in new equipment, the Richmond project has been able to capitalize on the efficiencies that come with specialization (just like the for-profit clinics), but without public dollars being siphoned off to private owners' profits. What's more, operating room efficiency increased by 25 per cent allowing team members to complete 136 per cent more cases. At the same time, average lengths of stay in hospital fell from five days to four for hips and four days to three for knees.
- At North Vancouver's Lion's Gate Hospital, the Joint Replacement Access Clinic – a one stop, centralized booking service for pre-operative and post-operative appointments – cut times for patients waiting for their first surgical consult from over 11 months to just two to four weeks.
- The Alberta Hip and Knee Replacement Project, where simple, common-sense changes in processes of care cut joint replacement wait times from 19 months to 11 weeks.
- Saskatchewan's Surgical Care Network, a comprehensive, pro-active surgical database used by health authorities in cooperation with surgeons to shorten wait times for surgery.
- Ontario's Wait Times Strategy, an ambitious, multi-pronged effort aimed at reducing wait times in five high-demand areas by increasing funding, boosting hospital accountability, investing in information technology and improving quality.

Dr. Kapur argued that governments need to celebrate and embrace these successes and make them the rule, not the exception, rather than promoting private solutions. We need to accelerate the pace of change within Medicare with more innovative projects in collaborative care and queue management. Not only will they make Medicare more cost-effective and help ensure sustainability, they will also ensure that all Canadians can take advantage of new technologies and improved access.

There was a good discussion about how the CHPS and CDM can work together to continue promoting positive reform within the public system and how we can

challenge the Canadian Medical Association's proposal for a competitive market in health care based on recent reforms in the United Kingdom.

A discussion period followed Dr. Kapur's presentation. A copy of Dr. Kapur's presentation is available by contacting CHPS Co-Chair Mike Luff.

DISCUSSION

Market Supplements / Incentives

In response to their need for the appropriate supply and distribution of health professionals, employers and unions are taking steps to bolster recruitment and retention efforts.

There is a growing trend towards providing market supplements as a means to ensure that health care employers can attract and retain the professionals required to provide appropriate health care services. These market supplement programs are often designed to address specific pay-related skill shortages.

Participants discussed the design and application of various market supplement programs across the country, including some of the following characteristics:

- Are market supplements being negotiated at the bargaining table, outside the bargaining process or are they being imposed by the employer?
- How does the employer determine there is a shortage or a recruitment and retention problem? What criteria is used to determine whether a market supplement is necessary?
- Which professions are currently receiving market supplements across the country?
- What role does the union have with regard to determining whether market supplements should be applied?
- Are the market supplements rolled into the salary grid or separate from the grid?
- How often are the market supplements reviewed?
- How have union members responded to the use of market supplements?

There are currently severe shortages in many health professions and there is no sign of relief as independent labour market analysts have predicted these shortages will continue to increase over the next decade. Of course, there are also looming shortages in other health professions.

Given these facts, there was a consensus that the trend of market supplements will continue for many years ahead. CHPS participants agreed it would be useful to continue to share information and exchange ideas about this particular instrument for recruiting and retaining health professionals.

PRESENTATION

By Kurt Davis, Executive Director, Canadian Society for Medical Laboratory Science (CSMLS)

Mr. Davis provided an overview of the vision, mission and values of the CSMLS, which is the national certifying body for medical laboratory technologists and medical laboratory assistants and it represents 14,000 members in Canada and around the world. Membership in CSMLS is voluntary. The only exception applies to medical laboratory technologists (MLTs) who work in New Brunswick. Mr. Davis clarified the difference between the CSMLS and the various provincial regulatory bodies.

He outlined various HHR research and advocacy initiatives conducted by the CSMLS in recent years, such as:

- membership-based research;
- short-term projects targeted to specific needs of the profession;
- graduate employment surveys;
- 1998 and 2001 HR report that provides details for each province;
- reactivation of certification processes for medical laboratory assistants;
- partnered with Health Canada in 2004 and 2006 for studies on clinical education in Canada;
- appeared before Kirby commission;
- appeared before Senate hearings in 2004 on the integration of internationally educated professionals;
- submission to the Romanow commission;
- submission to the Naylor commission on SARS;
- appearance before House of Commons Health Committee in 2008 to review the 10 year Plan to strengthen health care;
- meetings with Members of Parliament in 2007 and 2008; and
- partnerships with other health care organizations

Mr. Davis presented some startling facts about health human resources (HHR) shortages in the sector, such as:

- current shortage of MLTs is global in nature;
- many education programs closed during health reform in the 90s and there is also a shortage of clinical training placements;
- the current Canadian workforce is estimated to be about 20,000 MLT and 20,000 lab assistants;
- it is estimated there are 1000 vacant MLT positions in Canada today;
- the shortage in the USA is about 35,000 and growing rapidly; and
- 50% of the lab workforce in Canada is eligible to retire by 2015.

He offered several explanations of why Canada is facing a serious shortage of medical laboratory professionals:

- lack of HHR planning on a national and provincial level;
- insufficient numbers of post secondary education positions;
- shortage of clinical education seats;
- employment practices, such as over-reliance on part-time employees;
- labs seen as a “cost centre” rather than a “value centre”;
- funding and language challenges with programs for internationally educated health professionals;
- retention problems because of constant reorganization of the health care system, poisoned workplaces as a result of health reform in the 90s, and burned out older workers retiring early;
- increasing demand for patient care;
- growing issues with infectious diseases; and
- new tests.

There was a good discussion about how CHPS and the CSMLS can work together to lobby governments at the provincial and federal level; raise further awareness of the crisis in clinical education; encourage further research into HHR planning for future workplace needs; change the work environment to make health care careers the “place to be”; and address the lack of complete data sets to ensure better HHR planning.

A discussion period followed Mr. Davis’ presentation. A copy of Mr. Davis’ presentation is available by contacting CHPS Co-Chair Mike Luff.

DISCUSSION

Mental Health Commission of Canada

Co-Chair Luff explained that Canada is the only G8 nation without a national strategy or plan to address the prevention and treatment of mental illness. Mental health has often been described as one of the “orphan children” of Canada’s health care system. This has resulted in a mounting prevalence of mental health conditions, rising social and economic costs, and a growing incapacity of our health and social service systems to implement comprehensive initiatives that would benefit people living with mental illness.

Luff noted that the 2007 federal budget committed \$55 million over five years towards establishing a Mental Health Commission of Canada (MHCC) to be chaired by former Senator Michael Kirby. The CMHC was created to develop a national mental health strategy and to provide an ongoing national focus for mental health issues. The 2008 federal budget committed an additional \$110 million to the MHCC for research projects to help Canadians with mental illness who are homeless.

The Commission is now up and running, it has hired staff and established a board of directors, and it is starting to consult with key stakeholders in the mental health sector.

A significant number of CHPS and NUPGE members work in the mental health sector and these frontline workers are clearly key stakeholders and the Commission should hear from them. It was suggested that it would be helpful to send the Commission a submission that reinforces the priority messages of CHPS:

1. As with all sectors of the health care system, mental health services face human resource shortages, including: social workers, psychologists, therapists, counselors, child mental health therapists, community mental health nurses, and crisis intervention workers.
2. Canada's public health care system can provide higher quality services than the private sector. Governments must increase their investments in mental health and mental health services must be brought into the mainstream of the public health care system.

FOLLOW-UPS

Issue	NUPGE / CHPS responsibility	Constituent union responsibility	Task completed
Report of meeting	Complete and circulate		✓
News release or story about meeting	Complete and distribute; post on website	Post on websites or in newsletters, etc	✓
Presentation by CSMLS and Kurt Davis	Circulate		✓

Presentation by CDM and Dr. Kapur	Circulate		✓
Submission to the Mental Health Commission of Canada	Develop and submit	Provide input to Co-Chair Luff	✓
OPSEU Guide to Pandemic Influenza for Healthcare Workers	Collect and circulate		✓
OPSEU report on Sonographer ergonomics study	Collect and circulate		✓
NSGEU grievance arbitration decision on bullying	Collect and circulate		✓
Communications Staff	Organize a Conference Call		