

Rebuilding Health Care

Executive Summary

Since our founding Convention in March 1957, the Ontario Federation of Labour (OFL) has consistently advocated for our vision of a universally accessible health care system for all Ontarians.

Our last comprehensive Convention policy paper on health care was: "*Your Health, Your Future, Your Life - Our Vision for Health Care in Ontario*" which was endorsed by delegates at our 1999 Convention. Health care was also a component of the 2003 Convention Policy Paper "*Organize! For Stronger Unions, for Stronger Human Rights, for Stronger Communities*".

Our vision for health care draws on the experiences of:

- Dedicated health care workers who provide needed services, and who are profoundly troubled by the misdirection of public policy and the failures of the institutions which employ them; and
- Workers and their families who in the past used or continue to use the services of Ontario's health care system.

The health care system itself must be based on the principles expressed in Justice Emmet Hall's 1964 Royal Commission on Health Services, which were reaffirmed and defined in the 1984 *Canada Health Act*. To quote from our 2003 Convention document, these principles are:

Public Administration

The administration of the health care insurance plan of a province or territory must be carried out on a non-profit basis by a public authority.

Comprehensiveness

All medically necessary services provided by hospitals and doctors must be insured.

Universality

All insured persons in a province or territory must be entitled to public health insurance coverage on uniform terms and conditions.

Portability

Coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country.

Accessibility

Reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers.

The advances in our public health care system have been the result of long and hard struggles over many years. In these struggles, the OFL has always worked with our affiliated unions and our community partners.

We should never forget that there is always present a well-organized political ideology with adherents both in government and in the wider community who oppose public health care as part of their particular world view.

Like the "zombies" of Hollywood cinema, this group of "ideologically undead" keeps coming back with the same core message, which they attempt to disguise with talk of "consumer choice" and "greater efficiencies". Make no mistake, what they want is an American style of health care, which will cater to consumers with financial resources to pay for needed services.

We are at a crossroads. If we allow our public health care system to be further eroded or destroyed rather than expanded and strengthened, we will get the "zombie model". We need look no further than the ongoing struggles of our American brothers and sisters in the political and collective bargaining arenas to build and maintain even minimum

levels of health care for themselves and their families.

As a labour movement we stand with other like-minded Ontarians and say that in our public health care system we want:

- fair treatment for all health care workers
- no privatization in our health care system
- improvements to the capacity and resources of our public system in order to deal with such issues as low staff levels, workloads and wait times
- to recognize and positively address the broad determinants of health
- to improve our capacity to evolve the public system to address issues not currently part of the system such as home care, pharmacare, chiropractic, physiotherapy, dental and vision care programs.

To accomplish this, we need to understand and defeat the policies of the Liberal government which are leading to more layoffs of health care staff and setting up more delivery of health care by profiteers.

We have the expertise of our members in health care which is essential to this cause. Working closely together and, with like-minded Ontarians and their organizations, we will build and sustain broad public support for

public health care across our province.

Since their election in 2003, the Liberal government has had little apparent difficulty in supporting and accepting Tory policies, which they had spoken against while in opposition. The most obvious example is the public/private partnerships (P3) form of privatization. Other examples are continuing to delist services in the Ontario Health Insurance Plan (OHIP) and continuing the competitive bidding process in home care.

The Liberals have drawn attention to the poor state of Ontario's finances inherited from the Conservatives after October 2003. The reality is that Ontario has more money available for health care than what has been spent.

Liberal policy vision has been inspired by the actions of the British government under Prime Minister Tony Blair. Ontarians need to be educated about the dangers of the McGuinty government's Local Health Integration Networks (LHINs).

The "health" of our health care system in Ontario is affected by developments at the federal level. Unfortunately, unlike other Ontario Premiers in the past, McGuinty has chosen not to show leadership on health care issues.

Health care workers continue to be strong advocates for the kind of health care system we want in our province.

In May and June 2005, the OFL, working with affiliates and their health care members, embarked on the first phase of a campaign with an emphasis on addressing the systematic and serious issues flowing from the persistent understaffing in all health care sectors. Workers came together to share their stories and to learn from each other. A report entitled *Understaffed and Under Pressure - A reality check by Ontario health care workers* was written and distributed by the OFL.

In October and November 2005, the OFL and affiliates returned to the same communities with the report to share the findings with health care workers and the wider community. Health care workers and labour councils are using the report in their lobbying of MPPs. The campaign is demanding that the McGuinty government use the \$1.136 billion which has been allocated to health care but not used, to address the issue of understaffing by implementing:

- An immediate moratorium of layoffs in hospitals.
- In nursing homes and homes for the aged, establish a required minimum standard of 3.5 hours per day for nursing and personal care for residents.

- In 1996, the Conservative government had repealed an earlier standard of 2.25 hours.
- Establish required minimum standards for staffing with appropriate complement of full-time workers in all health care sectors by the end of 2006.

ACTION PLAN

As noted in this paper, the struggle for public health care in our province and country has been a long and difficult struggle. As a labour movement, we have worked through collective bargaining and the public political process to push for needed improvements. We have worked together with our friends and allies in community organizations.

We are at a crossroads. There are those who would turn the clock back to an American style of health care and impose that model on Ontarians. There are those of us who believe that our public health care system is a vital part of our society that has served us well and will continue to do so as it evolves and expands to better serve the people of Ontario.

Through education, working together, and supporting our brothers and sisters and their unions in the health care sector, we will keep our public health care system.

The Convention Policy Paper dealing with the P3 model outlines the strategy we will follow to end the use of that model in Ontario.

Our strategy calls for a commitment to publicly financed, owned and operated facilities whose purpose is to serve the best interests of Ontarians and not to make profits for a select few. To accomplish these goals we will:

1. Continue and expand the activities which have begun with the Understaffing Campaign. In particular:
 - (i) Continue the lobby of MPPs in their ridings by health care workers to build support for the demands of the campaign.
 - (ii) Continue to pressure local MPPs in the pre-budget period (early 2006) to ensure that the McGuinty government acts now to deal with understaffing in health care.
 - (iii) Continue our efforts to build understanding and support for positive action to deal with the implications of understaffing in health care on the lives of all Ontarians. We must develop media strategies to get the information to Ontarians.

We will outreach to community agencies and organizations in the wider community to ensure that they understand and support the need for positive action to deal with understaffing.

- (iv) We will work with seniors' organizations to ensure that human dignity and respect is central to how our health care system works in Ontario. This situation is inadequately addressed because of understaffing in all sectors of health care.
- 2. We will work to develop our charter for home care which is based on the successful public sector models used in Manitoba and Saskatchewan. The McGuinty government must be forced to abandon the Tory competitive bidding process which has brought only chaos to this important sector.
- 3. We will continue to work with affiliates and community organizations to educate Ontarians on the dangers of the McGuinty government's Local Health Integration Networks (LHINs).
- 4. We will continue to be active in and supportive of the important work of the Ontario Health Coalition which brings together labour and the community to work on issues of common concern.
- 5. Make privatization of health care an issue in the next Federal election.

Rebuilding Health Care

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Our last comprehensive Convention Policy Paper on health care was: *“Your Health, Your Future, Your Life - Our Vision for Health Care in Ontario”* which was endorsed by delegates at our November 1999 Convention.

Health care was also a component of the 2003 Convention Policy Paper *“Organize! For Stronger Unions, for Stronger Human Rights, for Stronger Communities”*. This was the outcome of two years of work endorsed by the 2001 Convention to bring progressive forces together to meet, discuss, debate and decide on a priority agenda for rebuilding Ontario which was known as *“A People’s Charter”*.

We have a comprehensive understanding of what the building blocks of our health care system must be. To quote from our 2003 Convention Policy Paper:

“Full health care should encourage the prevention of illness. Important determinants of good health are a safe and secure job, a decent income, good housing, quality education, and a healthy environment. We need a full employment strategy and a strong social safety net. If we ignore these, we risk creating more illness and suffering, with resulting higher health care costs.”

Our vision for health care draws on the experiences of:

- Dedicated health care workers who provide needed services, and who are profoundly troubled by the misdirection of public policy and the failures of the institutions which employ them; and
- Workers and their families who in the past used or continue to use the services of Ontario’s health care system.

The health care system itself must be based on the principles expressed in Justice Emmet Hall's 1964 *Royal Commission on Health Services*, which were reaffirmed and defined in the 1984 *Canada Health Act*. Again, quoting from the 2003 document, these principles are:

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Accessibility - Reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers.

The advances in our public health care system have been the result of long and hard struggles over many years. In these struggles, the OFL has always worked with our affiliated unions and their members and with like-minded community organizations and our community partners.

With the release in November 2002 of Roy Romanow's *Report on the Future of Health Care in Canada*, there was a feeling that, as a society, we were looking to the future. Unfortunately, the lack of action on the Romano Report by federal, provincial and territorial governments, and the recent Chaoulli Decision by the Supreme Court of Canada, show that we should take nothing for granted in our health care system. Nor should we forget that there is always present a well organized political ideology with adherents both in government and in the wider community who oppose public health care as part of their particular world view.

Like the "zombies" of Hollywood cinema, this group of "ideologically undead" keeps coming back with the same core message, which they attempt to disguise with talk of "consumer choice" and "greater efficiencies". Make no mistake, what they want is an American style of health care which will cater to consumers with financial resources to pay for needed services.

To accomplish this goal, the existing system must be forced to increase the presence and influence of the for-profit sector to allow for seemingly “greater efficiencies”.

If new services are needed, they will be provided whenever possible by the for-profit sector. Public resources are disposed of or diverted in order to pay for the legacy of tax cuts.

Decisions are based on a governance philosophy of talking to their friends, making decisions behind closed doors with a minimum level of meaningful consultations with the users and providers of programs and services and the wider community. Their “zombie” belief is that, in time, this will lead to a lower quality of service, fewer workers to provide the service and a heightened level of public frustration with the service.

The next stage is then set for an ideologically motivated government to fundamentally change health care since the existing system is “not working” and to replace it with one that “does work”.

We are at a crossroads. If we allow our public health care system to be further eroded or destroyed rather than expanded and strengthened, we will get the “zombie model”.

We need look no further than the ongoing struggles of our American brothers and sisters in the political and collective bargaining arenas to build and maintain even minimum

levels of health care for themselves and their families.

In June 2005, an article in the *Washington Post* quoted the Center for Studying Health System Change that for the eighth straight year the growth in medical costs far outpaced the growth of wages - by nearly four times in 2004. This is not the future that Ontarians want to be part of in their province.

A counter to this bleak vision is the forward thinking of Tommy Douglas, the acknowledged father of Medicare. His vision saw a comprehensive public health care system, which had the capacity to address the needs of the population. A system which would take time to build and which would be done one step at a time. A system firmly rooted in democratic principles where the decision-making process is open and transparent and fully involves communities, patients and health care workers.

As a labour movement we must stand with other like-minded Ontarians and say that in our health care system we want:

- fair treatment for health care workers;
- no privatization of our health care system;
- improvements to the capacity and resources of our public system in order to deal with such issues as low staff levels, workloads and wait times;

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To accomplish this, we need to understand and defeat the policies of the Liberal government which are leading to more layoffs of health care staff and setting up more delivery of health care by profiteers. We have the expertise of our members in health care which is essential to this cause. Working closely together and, with like-minded Ontarians and their organizations, we will build and sustain broad public support for public health care in our province.

THE McGUINTY GOVERNMENT'S VISION FOR HEALTH CARE

In the 2003 Ontario provincial election, the Liberal Party, under the leadership of Dalton McGuinty ran under the slogan "Choose Change". The people of Ontario responded and the Liberals won a majority government.

It soon became apparent that the Liberals' concept of "change" is at odds with many Ontarians. In health care, Liberal "change" was influenced by several factors.

1. Support/acceptance of discredited policies of the previous Conservative government

The Liberal government has had little apparent difficulty in supporting and accepting Tory policies implemented during their period in office (1995-2003), policies which the Liberals had spoken against while in opposition.

The most obvious example of this is the public-private-partnerships (P3) form of privatization, which the previous government had begun to implement for hospitals in Brampton and Ottawa. To quote Dalton McGuinty on September 26, 2003: "I'm calling on Mr. Eves to halt any contract signings when it comes to P3s. I stand against the Americanization of our hospitals." A month after the October 2003 election, the Liberal government signed P3 hospital deals in Brampton and Ottawa. Studies show that the Brampton hospital will cost an extra \$175 million, proving that the P3 approach drives up costs.

Rather than abandon the P3 model, the Liberals embraced the idea and gave it a new name. Their Minister of Public Infrastructure Renewal, David Caplan, calls it "alternative finance and procurement methods".

In May 2005, he released *ReNew Ontario 2005-2010* - the Liberal five year privatization plan for the public sector which includes, at least 23 new hospitals to be financed and built using this model. After this

announcement, it is not surprising the Conservatives congratulated the Liberal government for continuing their (Tory) agenda of privatization of the public sector.

The Liberals continued the Tory policy of privatization in a number of ways. Firstly, more OHIP (Ontario Health Insurance Plan) services had been delisted. The Liberals, in their first budget, delisted some physiotherapy, optometry and chiropractic services. Ontarians needing these services could purchase them from the private sector or do without. This was a deliberate shrinking of the scope of public health care.

The Liberals continued Tory policies in other areas. For example, the continuing chaos in home care is a direct consequence of the Tory policy of the competitive bidding model. Rather than abandon this model, the Liberals instead appointed Elinor Caplan in the fall of 2004 to conduct a *Review of Home Care Competitive Bidding Process*.

Her mandate was to fine-tune the process, not reject it. Another example in a related field was their continuing the Tory policy of funding for long-term care facilities without proper accountability.

2. **The perceived financial constraints forced on the Liberal government by the “unexpected” poor state of the Ontario government’s finances inherited from the Tories after October 2003**

The issue of the state of Ontario government’s finances has been challenged. The Ontario Alternative Budget 2004 notes:

... McGuinty’s most damaging failure of leadership is his failure to challenge the assumption that health care costs are rising out of control and beyond our ability to pay. While this assumption is commonly accepted by critics of our public health insurance system and is used as a point of departure for advocates of privatization, it is not supported by the facts.

The Ontario Alternative Budget 2005 notes:

“Provincial program spending on health care has fluctuated in a narrow range of between five and six percent of GDP over the last ten years. At the same time, health spending accounts for an increasing share of total programs spending...It reflects the Conservative government’s policy of reducing taxes and cutting back on public services. Over the term of the previous government, the province’s annual revenue base was reduced by \$13.3

billion. This means that tax revenues available were 27 percent lower than they would have been without the tax cuts.” (Emphasis added)

Also, Ontario has more money available for health care than what has been spent. During 2004-05, the Ontario government received increases of almost \$3 billion in increased federal funding for health. Federal monies without strings are a problem. Over the same period, they collected \$1.5 billion in new taxes from the Ontario Health Premium. Even after the May 2005 provincial budget, there remains \$1.136 billion in revenues dedicated to health care but not yet allocated in the province up to March 31, 2008. The issue facing the Liberals is one of credibility. As already noted, this government did not spend all monies it had available for health care on health care.

The labour movement and our allies through such venues as the Alternative Budget process have outlined a doable process of building and sustaining the kind of health care system we want in our province.

Financial considerations are an important component for policy development and implementation. However, it must be remembered that both a policy vision and adequate finances are needed to build the kind of health care system needed and wanted by Ontarians.

3. Liberal Policy Vision

The “reforms” undertaken by the British government under Prime Minister Tony Blair have an appeal for Ontario’s Liberal government with their (Liberal) talk of “transformative change” or “government, which steers but does not row”. The British government’s agenda has created both widespread public skepticism and strong opposition from labour and community groups across Britain.

In health care, the “reforms” reduce the national government to the role of funder of the National Health System. Safeguards to ensure equal care is available to all are inadequate when local structures known as Foundation Trusts approach patients, treatments and services on the basis of financial risk rather than the health care needs of people. In Britain’s P3 hospitals, 26 percent of hospital beds have been cut in P3 hospitals and the staff has been reduced on average 30 percent. The reduced majority won by the Blair Government in the British election in May 2005 may have an impact on further implementation of their “reforms”.

Greater awareness of the nature of the British “reforms” by Ontarians is a necessary first step to counter the Liberal government’s desire to implement such “reforms” in our province.

In March 2005, the Ontario Federation of Labour, Canadian Labour Congress, the Ontario Health Coalition and the Canadian Federation of Students, brought together labour and community groups from Ontario and representatives from Britain to discuss these “reforms” in health, education and government.

In the summer of 2004, the Liberal Cabinet quietly approved a plan to implement fourteen “Local Health Integration Networks (LHINs)” across Ontario. However, this whole LHINs initiative was marked by a lack of meaningful public input into their mandate, mission and structure.

The government proceeded without a legislative framework for the LHINs. The process of choosing the local LHINs Chairs and Board of Directors was both flawed and anti-democratic and does not reflect the diversity of Ontarians. The purpose of the LHINs model, according to the government, is to plan, coordinate and fund the delivery of health services in a particular region.

By 2007, LHINs are supposed to take over key responsibility for funding hospitals, nursing homes and community care. The LHINs will enter into contracts with organizations wishing to provide services and who will bid on them in a competitive basis.

The most likely scenario is that the LHINs structure will insulate the provincial government from the political fallout from Ontarians, as they realize the changes to their

local health care system. Local support and clinical services and the local jobs providing these services will be threatened by this centralization / integration implemented by the local LHINs.

Simply put, there is a very real threat that the LHINs model will threaten the access for Ontarians to health care services in their community. The local community will have limited say in the operation of the local LHINs since the provincial government appoints them.

The LHINs are not local, nor based on communities or even communities of shared interest. Based on past experiences with regionalization, the existing boundaries of the current LHINs will most likely change. The LHINs structure erodes even further, any idea of community control over health care.

The LHINs structures require a split between the purchaser and provider of services. This model can already be seen in home care, which is hardly a model which should inspire confidence. In this sector, workers have seen their wages and benefits deteriorate and have no opportunity for successor rights if their employer loses a contract. It has kept both users and providers of services in a state of flux and has facilitated the rise to prominence of large for-profit operators. This is the model, which could be the norm in other sectors of health care if the Liberal government is allowed to implement their plans.

By not involving health care workers in a meaningful way, the government has turned its back on this opportunity to improve the health care system.

The labour movement must work together and with community allies to ensure that the provincial government is held responsible for the quality and availability of needed health care provided by our members in communities across Ontario. We must work closely with like-minded individuals and organizations to ensure that the broader community has both an understanding and real control over the actions of the LHINs between now and the next provincial election in 2007, at which time it can be replaced by structures more reflective of the needs of local communities.

There is no shortage of areas where the Liberal government could show leadership, such as, in needed improvements in primary health care or community health centres. They could show leadership by identifying what are the real drivers for increases in health care costs - drivers such as the cost of drugs. They could then become strong advocates for a pharmacare program to address this serious issue. The Liberal government could show leadership in this province and on the national scene but, as yet, they have not.

4. Developments at the Federal Level

The “health” of our health care system in Ontario is affected by developments at the federal level. An effective *Canada Health Act* is central to our vision of a public health care system which serves the needs of all Ontarians and Canadians. Unfortunately, the Federal Liberal government cannot be counted on to stand up for public health care.

In 2002, the Federal Auditor General noted that Health Canada is unable to tell Parliament the extent to which health care delivery in each province and territory complies with the criteria and conditions of the *Canada Health Act*. Three years later, the Canadian Health Coalition was raising similar concerns.

Roy Romanow’s *Report on the Future of Health Care* was given to the Federal government in November 2002. The content of the report disappeared from the political stage and was superseded by two meetings of federal, provincial and territorial governments in 2003 and 2004, which resulted in two health accords.

The first of these accords was arrived at after two days of closed-door negotiations in February 2003. More federal dollars were dedicated to Medicare but without a collective and clear stand against the role of private for-profit corporations in providing health care services.

The federal government did not seek to roll back the efforts of some governments to increase the involvement of the private sector.

The second of these accords was signed in September 2004. The process began as an open meeting which was adjourned the second day and the meeting carried on behind closed doors. Money was a major item and the agreement centered on a \$41 billion transfer from the federal government over the next twenty years. There was little surprise from labour and community organizations that policy discussion and development on such issues as the role of private for-profit providers was sidestepped. An interesting aside was that Gary Doer, Premier of Manitoba, addressed these issues but Dalton McGuinty, Premier of Ontario, did not - although he had spoken about them before his election as Premier in October 2003.

Another disturbing development on the federal scene was the June 2005 Chaoulli case ruling by the Supreme Court of Canada. Their ruling (4-3) found that Quebec's ban on private insurance for insured health services violated the Quebec Charter of Human Rights and Freedoms, but on the question of the Canadian Charter, the Court split 3-3. This decision will be used by the "zombies" as the latest weapon in their attack on public health care. Immediately, the OFL called on Premier McGuinty to make an immediate public commitment to a universal, accessible health care

system. His statements were not inspiring.

Unfortunately, unlike other Ontario Premiers in the past, McGuinty chose not to show leadership on important issues on the federal scene, which have an impact on Ontario. This complements his lack of leadership on the provincial scene.

WE DELIVER THE CARE IN HEALTH CARE

Health care workers continue to be strong advocates for the kind of health care system we want in our province. In May and June 2005, the OFL, working with affiliates and their health care members, embarked on the first phase of a campaign with an emphasis on addressing the systematic and serious issues flowing from the persistence of understaffing in all health care sectors. A total of 17 meetings were held across Ontario, bringing together health care workers from all sectors and from all affiliated unions.

This first ever experience brought workers together to share their stories and learn from each other. A report of their stories was developed and distributed by the OFL. In conjunction with the meetings, post cards were distributed to health care workers across Ontario who were invited to sign them and get them back through their union to the OFL. Members of the wider labour movement were also encouraged to sign. The OFL

presented these to the McGuinty government.

Workers came to mutual conclusions that all sectors and workplaces have been hard hit by understaffing. The problems associated with understaffing, and its consequences, are systematic and serious. Workers feel that they are not listened to by government when they call for increased resources to do the tasks they know should be done. These tasks become less and less doable in the time and resources allotted. The quality and level of needed service deteriorates for Ontarians in need. The quality of the working environment deteriorates as workers face increasing levels of injury and unsafe conditions as they strive to do their job. This is an unacceptable situation for all Ontarians.

A report entitled *Understaffed and Under Pressure - A reality check by Ontario health care workers*, was written and distributed by the OFL. In October and November 2005, the OFL and affiliates returned to the same communities with the finished report to share their findings with health care workers and the local media. Health care workers are using the report in their lobbying of MPPs. The campaign is demanding that the McGuinty government use the \$1.136 billion which has been allocated to health care but not used, to address the issue of understaffing by implementing:

- an immediate moratorium of layoffs in hospitals;

- in nursing homes and homes for the aged, a required minimum standard of 3.5 hours per day of nursing and personal care for residents. In 1996, the Conservative government had repealed an earlier standard of 2.25 hours;
- a required minimum standard for staffing with appropriate complement of full-time workers in all health care sectors by the end of 2006.

Implementing these particular recommendations would show that the McGuinty government is serious about addressing the challenges facing our health care system. There is a need for action on measures which are needed across health care while there are other measures that are more sector specific.

General measures would include:

- Parity of wages and benefits and job security for workers across health care since they are collectively providing a continuum of needed services. This is needed to attract and retain workers in every sector of health care.
- Staffing levels across health care must reflect not only the numbers of staff but also the appropriate classifications and qualifications of staff to ensure that Ontarians receive the care that is appropriate to their needs.

- Successor rights for all workers in health care to ensure that they retain their right to be members of their unions and to receive and keep the improvements won through collective bargaining.
- Improvements in health and safety protection for health care workers including positive changes to legislation, improved training, procedures and equipment.

There are serious issues in all sectors of health care. This is not a new development. Many of these issues were noted in the 1999 OFL Convention Policy Paper.

The task for the labour movement is to identify the problems and be strong advocates for positive solutions which build and sustain the kind of public health care system we want in our province.

HOME CARE AND COMMUNITY CARE

The crisis we are now experiencing in home care is the direct consequence of the ideological policy preferences of Conservative governments during the period 1995-2003 and the Liberal government's refusal to change these policies. The Tories first imposed the competitive bidding process in home care in 1996. The system forces providers to bid low in order to win the contract from the Community Care Access Centre (CCAC).

The instability in the workforce and the continuum of care for patients is a direct consequence of the competitive bidding process. When contracts are lost, workers are laid off and are offered the opportunity to start over at lower wages and benefits, most often without their union. Workers in home care need successor rights. Home care workers are health care workers and should be treated as such. There must be a relationship between wages and benefits in this sector and other related sectors such as long-term care facilities and hospitals. Unlike hospital care, home care is not covered by the *Canada Health Act*

This process has increased privatization in home care. For example, the for-profit market share has increased from 18 percent in 1995 to over 50 percent today as a result of long established not-for-profit agencies losing the contract to provide these needed services in the community. There is a need to increase funding. The Tory funding freeze in May 2001 resulted in the reduction of 115,000 clients served between April 1, 2001-2003 and a service cut of six million hours (a 30 percent drop).

Among the questions asked in a 2003 questionnaire addressed to the three major political parties in Ontario, the OFL asked: "Will your party stop the move to for-profit home care?" Dalton McGuinty, Leader of the Ontario Liberal Party answered, as follows:

*“Our commitment to home care centres on ensuring that our frail and elderly have access to the services they need to keep them independent and healthy. **The current system is not working and we need to change it.** We will work to create a system that is patient-centered and flexible.”*
(Emphasis added)

A year later, as Premier, he appointed Elinor Caplan with a mandate to conduct a *Review of Home Care Competitive Bidding Process*. The OFL and its affiliates with a direct involvement in home care, used this review as yet another opportunity to discuss both the crisis in home care and viable solutions. They met together and individually with Caplan on numerous occasions.

When she reported back in June 2005, the OFL and its affiliated unions saw her report as simply tinkering with a flawed system because she did not/could not call for the elimination of competitive bidding.

There are specific actions which the McGuinty government could begin to implement immediately:

- Stop the competitive bidding process in home care. A process which has created massive and regular disruption of job security and working conditions for workers and in the continuity of services for Ontarians in need.

- Move to establish a public system of home care drawing on the successful working models found in Manitoba and Saskatchewan.
- In such a system a continuum of care is provided on a universal and equitable basis, without the presumption of unpaid care giving by family, and based on enforceable standards; and a system that ensures that services reflecting the diversity of our province are accessible to Ontarians where and when they are needed.

LONG-TERM CARE FACILITIES

Nursing Homes and Homes for the Aged

Our 1999 Convention Policy Paper noted that like home care, the *Canada Health Act* does not cover long-term care [and] is a growing industry predominantly owned and operated by for-profit multinationals. In 1998, the then Conservative government announced 20,000 new long-term beds over the next eight years. Two-thirds of these beds were awarded to for-profit corporations. The Conservatives also said that monies should be set aside for capital funding.

Earlier, in 1996, the same government eliminated the 2.25 hours of minimum nursing and personal care per patient per day, as well as removed the requirement that facilities must staff a registered nurse on site 24 hours a day. This has been reinstated by the Liberals, but funding for minimum staffing standards remains the issue.

In 2001, a PriceWaterhouseCoopers study ranked Ontario's long-term care facilities at the bottom of the heap for any jurisdiction studied. It found that in the previous year, Ontario had the lowest levels of care coupled with the sickest and oldest residents.

In the above mentioned 2003 survey of party leaders, the OFL asked: "Will your party stop awarding long-term care beds to private, for-profit companies?" Dalton McGuinty answered:

"We have a comprehensive plan to improve the quality of life for residents of long-term care facilities. Our plan includes restoring standards and providing the necessary funding to increase the level of nursing care that long-term care residents receive. We are also committed to ensuring proper inspections of our nursing homes on a regular basis. Inspectors will be required to audit the staff to resident ratios ... inspections will not be scheduled in advance so that a real

inspection of day-to-day activities can be evaluated."

In May 2004, the Liberal government released *Commitment to Care: A Plan for Long-Term Care in Ontario* which had been prepared by Monique Smith, the Parliamentary Secretary to the Minister of Health and Long-Term Care. A shortcoming of this report is what is overlooked - the need for minimum staffing standards. This need is addressed in policy work by affiliates in this sector such as CUPE's 2004 survey: "*There are not enough hands - Conditions in Ontario's Long-Term Care Facilities.*"

It is also addressed in the April 2005 recommendations related to the *Inquest Touching the Death of Ezz-El-Dine El-Roubi and Pedro Lopez* in 2001 at the Casa Verde Nursing Home in Toronto. The Chief Coroner's Office highlighted the inadequacy of the status quo and called on the Ministry of Health and Long-Term Care to revise its whole approach to addressing and funding the needs of elderly patients in long-term care facilities.

The Coroner's Jury Recommendations, arising out of the inquest, support the need for a staffing ratio based on evidence arising from a multi-stakeholder study, not one arbitrarily determined by bureaucrats or the industry. In the interim, the jury called for an immediate staffing increase to 3.06 hours of care per day inclusive of .59 hours of care by a registered nurse.

Funding of \$400 - \$500 million, which was a central part of the Liberal campaign promises, has not materialized. In part, this money is earmarked for 2,000 new staff, including 600 RNs and RPNs. Meanwhile, residents care needs have increased. The number of multiple medical diagnoses has increased. Physician-ordered therapeutic interventions have increased, and so has the number of medications that a resident must take daily.

All of these indicators point to a resident population which is sicker and more in need of assistance. Given this need and the past record of for-profit owners diverting government monies, there must be a mandatory reporting and monitoring of staff levels instead of the "voluntary compliance" approach used by the Liberals.

This will ensure that government monies are used for the purpose intended - a higher level of care for residents and not to increase the level of profit for the corporate owners. The Liberal government has not broken with the policies of their Conservative predecessors. To do so there are specific actions which the McGuinty government could begin to implement immediately:

- A required minimum standard of 3.5 hours per day of nursing and personal care for residents.
- Staffing levels that reflect not only the numbers of staff but also the appropriate classifications and qualifications

of staff to ensure that residents receive the care that is appropriate to their needs.

- Soliciting ongoing input into long-term care policies by workers through their union, residents and their families.
- Increase capacity of workers to have a say in what is happening in their facilities by instituting regular, unannounced inspections and mandate inspectors to speak with residents, family and workers about conditions. Implement whistleblower protection for workers who complain about conditions and for the protection of residents.
- Mandatory reporting and monitoring of staff levels instead of the Liberal "voluntary compliance". This will ensure that there is the proper use of government monies.

Retirement Homes

The retirement home sector in Ontario is a run-for-profit industry that is controlled by a small number of large corporations. These corporations operate in a legislative and regulatory framework consisting of the *Ontario Building Code* and the *Tenant Protection Act*.

The original intent of retirement homes was to provide a minimum level of support for Ontarians who could and wished to continue to live independently but who needed some light housekeeping, meals and low

levels of personal care. Many retirement homes have mutated from their original intent and have become more and more like nursing homes. In these “nursing homes”, the staff are expected to take care of residents who are now less independent and more in need of a higher level and complexity of care.

Staff is expected to deal with such important aspects of care as personal hygiene, physical and social activity and medication, often without the needed levels of training or resources. To supplement this basic service, more “personalized” services (e.g. contract nursing) are available for an additional fee from the corporate owners. However, these new “nursing homes” operate outside the existing legislative and regulatory framework applicable to the nursing home sector. Our members who work in this sector are both concerned and frustrated by what is going on.

Inaction is not acceptable. A growing number of retirement homes are operating in a manner which should bring them within the definition of nursing homes under the *Nursing Home Act*, but they are operating without the appropriate license in violation of that *Act*. The Ministry is abdicating its responsibility by failing to enforce the current law.

Our 1999 Convention Policy Paper noted the need for the provincial government to develop meaningful standards for retirement homes. In 2004, the OFL brought affiliates together from this sector to use the opportunity of a consultation

organized by the Ministry of Municipal Affairs and Housing concerning the *Tenant Protection Act* to address our concerns about retirement homes.

Our recommendations, ignored at the time, called for actions which the McGuinty government could begin to implement immediately:

- A Retirement Homes Act, which would establish the appropriate legislative and regulatory framework for the operation of retirement homes in Ontario. This would be similar to the situation found in other kinds of residential care facilities.
- Regular inspections of retirement homes.
- Develop a clearly understood and simple process for residents and/or their families to complain about the operations of retirement homes.

MENTAL HEALTH

Our 1999 Convention Policy Paper noted that the Tory government policy was to close and divest public psychiatric hospitals across Ontario and to set the stage for the privatization of these public services. This resulted in the disappearance of almost 20 percent of the psychiatric beds (more than 500 beds).

In their 2002 report *Reality: Ontario's Mental Health Care System Isn't Working*, OPSEU gives a snapshot of the state of the sector:

"The current hodgepodge of funding arrangements and governance arrangements, and divestment, and re-investment, and bed closings, and bed transfers, and program closures, and program start-ups, and proposed hospital closings and proposed hospital building, all of this has put treatment, care and services for people with mental illness in chaos."

The election of the Liberal government in the fall of 2003 had little impact on the policy direction implemented by their predecessor. The Liberals have continued the policy of divesting by having mental health services from psychiatric hospitals become part of the services offered at existing hospitals in select communities. The concern with this approach is that mental health services become a lower priority. For example, in London there was a reallocation of \$8.1 million in mental health funding from the London Psychiatric Hospital to the general hospital revenues at St. Joseph's Healthcare. A similar concern should be noted regarding how mental health services would fare under the Liberal government's Local Health Integration Networks (LHINs) initiative and their fondness for P3 funding for health facilities. People desperate for psychiatric and mental health support are also straining the

abilities of the justice and corrections systems, community agencies and even nursing and retirement homes.

That is what made the Liberal government's re-announcement in January 2005 of \$27.5 million such an act of hostility. The money, to be divvied up by more than 130 agencies, won't create even one new assessment bed.

There are specific actions which the McGuinty government could begin to implement immediately:

- Putting a stop to further divestment and bed closures until full assessment of provincial needs is completed.
- Undertake a full assessment of needs in order to develop policies and allocate resources to offer a continuum of needed services to Ontarians. This must be done with those affiliates in mental health services and users of these services in the broader community.
- Provide these needed services in the not-for-profit public sector across Ontario.

HOSPITALS

Our 1999 Convention Policy Paper noted that the omnibus *Savings and Restructuring Act, 1996 (Bill 26)* which was rammed through the legislature in 1996, created the Health Services Restructuring Commission (HSRC). The HSRC

was given the task of cutting health care costs and closing hospitals. By 1999 it had recommended the closure of some 44 hospital sites by 2003. The purpose of this exercise was to implement the Conservative policy of privatization. The legacy of the dangerous and irrational cuts made during the Conservative years (1995-2003), have left our province with fewer acute beds and shorter length of stays than any other province and fewer staff per capita.

After their election in October 2003, the Liberals, as part of their "Choose Change" agenda, continued the Tory attitude and policy towards hospitals.

A key component of this Tory/Liberal policy is the Public-Private-Partnership the so-called P3s.

The flawed nature of this policy is evident in the experiences of Brampton and Ottawa, which are well documented. In both communities, this policy has faced continuing opposition from labour and community activists.

The Liberals could have rejected the P3 model as flawed and inappropriate to serve Ontario's needs. Instead, the Liberals embraced the Tory policy as their own and gave it a new name.

In May 2005, David Caplan, Ontario Minister of Public Infrastructure Renewal, released *ReNew Ontario 2005-2010* which discussed "alternative financing and procurement methods" to finance and

build projects over the next five years. For hospitals, the plan calls for 66 projects of which 30-35 percent (approximately 23) are "large and complex". This is the Liberal government committing itself to at least 23 P3s, not public hospitals, over the next five years. The Liberal vision for hospitals went beyond how new facilities should be financed.

After the provincial election in October 2003, part of the Liberal's "transformative change" was slower growth in financial transfers to hospitals. In July 2004, the Minister of Health announced that hospitals would be limited to a 4.3 percent increase in operating funds for fiscal year 2004-05. This was less than half of the rate of increase for hospital funding in the previous two years. In January 2005, the Ontario Hospital Association (OHA) estimated that hospital expenditures would rise by 7.9 percent in 2004-05.

On January 17, 2005, the Health Minister announced a further \$200 million in one-time transitional funding, of which, \$91 million would be used for severance payments and other costs associated with hospital cutbacks, approved by the Minister that would be the equivalent of 1,145 full-time positions. Because of the high level of part-time work, even more workers will be affected in these cutbacks.

Under *The Commitment to the Future of Medicare Act (Bill 8)* the Liberal government requires hospitals to balance their budgets by 2005-2006. Earlier this year, the Ontario Hospital Association (OHA) said that

hospital deficits would total \$760 million in the 2005-06 fiscal year. To eliminate this deficit the OHA said that 8,700 hospital jobs would be cut. This situation makes a mockery of Liberal election promises such as 8,000 new full-time nursing jobs by the end of their mandate, which became the Health Minister acknowledging that 757 nurses would lose their jobs in the 2004-05 fiscal year. Hospitals and health care workers will face another round of cuts in the next budget.

Research reveals the obvious link between the number of staff needed and the quantity and quality of services they are expected to provide. Understaffing, as noted in the "We Deliver the **Care** in Health Care" campaign is a major concern for our members across the health care system. Individual affiliates, drawing on the experiences of their members, also undertake political education and action campaigns which focus on understaffing and the impact it has on Ontarians who need to use the system and those Ontarians who are providing needed services.

Examples of such campaigns include: the Hospital Professionals Division of the Ontario Public Service Employees' Union (OPSEU) *Workload Alert* campaign, the Service Employees' International Union Local 1 campaign - *Summer of Solidarity Tour*, the Ontario Nurses' Association (ONA) campaign "*Still Not Enough Nurses: Act Now! Patients Can't Wait*", and the recent 2005 campaign by the Canadian Union of Public Employees (CUPE)

to demonstrate, through the use of a mobile hospital room, the importance of cleaners in the control of hospital infection rates.

Another aspect of this issue is the increased workload as a result of the push for shorter lengths of stay. Workers, such as nurses, have to hasten both treatment and education of patients in the shorter time available. The push for shorter stays is counter-productive in terms of higher re-admission rates and complications. The system is failing to live up to its obligations to patients when they are discharged from hospital before they are fully recovered and/or have appropriate home care arrangements in place in terms of hours, appropriate provider and duration.

One aspect of *The Commitment to the Future of Medicare Act (Bill 8)* is "accountability agreements" which require the hospitals to meet certain goals. The British "reforms" mentioned earlier inspire such agreements. Under these agreements, hospitals will be expected to provide certain services. Others may be cut or not offered as the hospital must also balance its budget. Services, which are needed but no longer available at the public hospital, may be/will be available from private providers in the community.

The desire to privatize hospital services is often disguised with discussion about the need for "greater efficiencies". One approach is for hospitals to come together to create a new (not-for-profit)

corporation to provide a range of services. The services may be specific, such as Booth Centennial Healthcare Linen Services, which is a not-for-profit organization jointly, owned by 26 Ontario hospitals.

Another example is the Hospital Business Services Corporation (HBS). Work by SEIU Local 1 notes that this non-profit corporation has been established by 16 hospitals in the Greater Toronto Area (GTA) with the assistance of the Ministry of Health and Long-Term Care. It will amalgamate finance, human resources, and information technologies and materials management functions. This model, as a broker for services, will provide “greater efficiencies” by reducing the number and cost of staff. Once services are integrated, the labour force is reduced; the stage is set for hospitals to rid themselves of these services, which then will be privatized.

The understaffing and the stresses in the hospital sector are detrimental to our members who work in this system and to Ontarians who rely on this system in their time of need. There are specific actions which the McGuinty government could begin to implement immediately:

- Abandon the Tory P3 model in Brampton and Ottawa and commit to work with these communities to ensure that they have publicly-financed and publicly-operated hospitals to serve their needs.

- Abandon the Liberal P3 model introduced in May 2005 in their policy document “*ReNew Ontario 2005-2010*” and commit to work with communities to ensure that they have publicly-financed and publicly-operated hospitals to serve their needs.
- Abandon the pro-privatization policies directed at hospital clinical and support services.
- Return privatized services to the public sector.
- Establish staff-patient ratios that will ensure safe and effective patient care.
- Commit resources to ensure that hospital services provided by appropriate levels of qualified staff continue to be available to Ontarians.

LABS AND THERAPY

Our 1999 Convention Policy Paper noted that services offered in hospitals were under pressure from the private sector that said that they could run them more efficiently. The Conservative government of the day did not challenge this claim and, in fact, established a number of private MRI clinics.

The election of the Liberal government in 2003 did little to address these issues. Their decision in 2004 to “buy-back” private MRI clinics was more a public relations exercise rather than a substantive change in the policies brought in by

the Conservatives. The government paid \$75,000 to have four CT and MRI clinics converted from for-profit to non-profit. Over a year after the Liberals announced that they would cancel all nine contracts with for-profit clinics, there are still five CT and MRI clinics operating in Ontario.

In a recent health and safety survey conducted by OPSEU, it was found that among hospital professionals such as physiotherapists, MRI and lab technologists, the top issue was stress and workload.

Another indication of this was an OPSEU survey which showed that between 1999 and 2004 the overtime costs for their members in 40 hospitals increased 152 percent to nearly \$4 million. These workers were expected to do more and more with less and less. In another OPSEU survey of their members in outpatient rehabilitation services in Ontario hospitals, the survey found that hospitals are laying off or eliminating positions for such services as physiotherapists, speech language pathologists, occupational therapists and social workers. Ontarians who need these services are now forced to find them and pay for them from the for-profit sector.

There are specific actions which the McGuinty government could begin to implement immediately:

- Establish a timeline for the return of all of the CT and MRI clinics to the public sector.

- Return privatized therapy services to the public sector and ensure that there are sufficient resources to provide these needed services to Ontarians.

The labour movement must play a full role with government in developing effective strategies to solve the serious and persistent issues of understaffing and workload and how to retain and recruit sufficient numbers of skilled professionals in order to offer a range of needed services across Ontario as part of our public health system.

EMERGENCY SERVICES

Our 1999 Convention Policy Paper noted that the then Tory government had little understanding of the vital role played by workers in emergency services. They saw workers and their unions as obstacles to their tax cutting and privatization agenda. The concerted efforts of ambulance workers and their unions (CUPE, OPSEU and SEIU) have ensured that this service continues to be publicly run and that the workers are fairly compensated for their important work.

In 1998, when the Tories downloaded land ambulance services to specified municipalities, they agreed to fund 50 percent of costs. Even then, provincial funding was not enough. Ambulance services were struggling to maintain standards in the face of growing demand.

Now with more than 1.4 million requests per year, it is the professionalism and dedication of paramedics and dispatchers who compensate for the serious lack of resources.

The Liberals have done little to break with the Tory policies. Currently, ambulance services are organized on what is known as an Ambulance Off-Loading Delay. What this means is that when an ambulance comes to a hospital, the paramedics may be told that a patient cannot be admitted because of backlog. They are required to stay with the patient at the facility until admitted. This prevents them from being available for other calls.

This situation reflects the strains and lack of resources in our hospital sector.

A commission mandated by the Ministry of Health and Long-Term Care to review this issue has not reported. Lack of resources creates circumstances where paramedics must violate the *Ambulance Act* (which calls for every ambulance to be staffed with two qualified attendants) in order to deal with the immediate needs of their charges. Lack of resources often results in paramedics denying themselves adequate breaks for food and rest. Lack of resources result in ongoing challenges to control infections which may threaten patients, paramedics and the wider community.

A legacy of the Tory years is the use by hospitals of private ambulance companies for routine movement of patients. These companies operate in

an unregulated environment; they are less regulated than taxis. Ontarians using an ambulance should rightly expect professionals, not fly-by-night operators.

The ambulance industry through their voluntary organization, the Ontario Paramedic Association, advocates for the establishment of a College of Paramedics. Our members oppose this suggestion because it adds nothing to the level of service currently available to Ontarians and, if implemented, would likely result in the loss of paramedics to the existing system.

Another Liberal initiative is the creation of a new non-profit organization to co-ordinate all aspects of Ontario's air ambulance system. This service responds to 17,000 calls per year and is responsible for all air ambulances dispatched across Ontario, from flights between hospitals for surgery to accident response. They are also responsible for organ transplant retrieval across Canada and into parts of the United States. The concern with this development is that it could be setting the stage for the privatization of this service at some future date.

There are specific actions which the McGuinty government could begin to implement immediately:

- The labour movement must play a full role with government in developing effective strategies to solve the serious and persistent issues of understaffing and workload and how to retain and

recruit sufficient numbers of trained workers into this sector of health care. Government must be committed to these strategies and ensure that sufficient resources are available to deliver necessary services to Ontarians.

- The labour movement must play a full role with government to develop effective strategies to effectively address working conditions and health and safety issues such as infection control, measures which are of concern to workers, their patients and the wider community.
- Demand enforcement of the *Ambulance Act of Ontario*, which calls for every ambulance to be staffed with two qualified attendants.
- Commitment not to go forward with the idea of a College of Paramedics. This is viewed by paramedics as unnecessary and is seen as a disincentive for trained workers to enter or stay in this sector.
- Ban the use of unregulated private ambulance companies and direct these services back to the public sector where they were provided before the Tory legislative change in 1998.

PUBLIC HEALTH

Millions of Ontarians got their first glimpse at the inner workings of Public Health when the SARS epidemic hit. Years of negligent

government policies, lack of funding, inadequate capacity, mismanagement, bad politics and other serious problems were played out in the public arena in 2003. Health care workers, members of our affiliated unions accounted for over 40 percent of SARS infections. During SARS, approximately 30,000 Ontarians including health care workers were put into quarantine. Some of those who died from SARS were members of our affiliated unions.

Infectious disease control is one of the critical important aspects of Public Health work. But there are many more: chronic disease prevention, water safety, rabies control, food safety, early detection of cancer, sexual health, reproductive health, substance abuse prevention, children's health, tuberculosis, vaccine preventable diseases, pre-natal and post-natal care and intervention.

In 1997 the Harris government announced that it was downloading responsibility for 100 percent of public health funding to municipalities, workers were vocal in their fear for the public. As a partial fix to the catastrophe they created, the Tories announced that effective in January 1999, the province would reassume 50 percent of the approved cost of public health services. They did not restore funding to the former provincial contribution of 75 percent. In response to Walkerton, the SARS epidemic, the interim reports of the Campbell Commission (the independent commission which is

examining the SARS epidemic) and public scrutiny, the McGuinty government has pledged to restore the 75 percent funding level by 2007.

The Walkerton Inquiry noted that the province has increased the responsibility of Boards of Health without increasing the funding required to fulfill those responsibilities. The interim Campbell reports described a “grossly underfunded public health care system” with “no elasticity” as a key problem. Ontario is the only province with extensive cost-share public health programs with municipalities. This produces the bizarre situation of crucial health programs and services in competition with dozens of other municipal services. Public health programs are often the first to be sacrificed.

There are specific actions which the McGuinty government could begin to implement immediately:

Acknowledge that the province is responsible for establishing minimum requirements for public health programs and services through the *Mandatory Health Programs and Services Guidelines*. The Guidelines note the importance of the social determinants of health, including economic and educational factors, and workplace environments.

Commit to rebuilding public health based on the principles recommended in public health inquiries in recent years, such as the Walkerton and Campbell

Commission. A rebuilding which includes the meaningful involvement of the labour movement, in particular, those affiliates involved in this sector and the broader community.

A commitment to adequate and stable funding to ensure the appropriate level of resources including staffing to provide public health programs and services to all Ontarians.

A commitment to ensure that local Boards of Health will continue and will operate based on democratic principles where the decision-making and accountability process is open and transparent and fully involves and addresses the needs of communities, residents and health care workers.

In his 2004 interim report, *SARS and Public Health in Ontario*, Justice Archie Campbell noted the dedication and commitment of frontline workers during the SARS crisis and the important role that public health workers and their unions play in providing services and protecting the people of Ontario.

He also recommended the importance of properly funding public services. His recommendations reflect the views put forward by health care unions before, during and after the SARS crisis. It remains unclear if the Liberal government has taken to heart Campbell's recommendations or any other lessons from the SARS crisis.

LABOUR'S VISION FOR OUR HEALTH CARE SYSTEM

There are broad themes which are the underpinning of our vision for our health care system. The OFL and its affiliates and community allies will continue to work together, build popular support for our vision of health care and to challenge the McGuinty government to ensure:

1. Fair Treatment for Health Care Workers

Parity of wages and benefits and job security for workers across health care since they are collectively providing a continuum of needed services. This is needed to attract and retain workers in every sector of health care.

Staffing levels across health care determined with the full involvement of the labour movement must reflect not only the numbers of staff but also the appropriate classifications and qualifications of staff to ensure that Ontarians receive the care that is appropriate to their needs.

Successor rights for all workers in health care to ensure that they retain their rights to be members of their union and to receive and keep the improvements won through collective bargaining.

Improvements in health and safety protection for health care workers including positive changes to legislation, improved training, procedures and equipment.

2. No Privatization in our Public Health System

Abandon the Tory P3 model for hospitals in Brampton and Ottawa and commit to work with these communities to ensure that they have a publicly-financed and publicly-operated hospital to serve their needs.

Abandon the Liberal P3 model introduced in May 2005 in their policy document "*ReNew Ontario 2005-2010*" and commit to work with communities to ensure that they have publicly-financed and publicly-operated hospitals to serve their needs.

Abandon pro-privatization policies directed at hospital clinical and support services.

Return privatized services to the public sector.

End the destructive competitive bidding process in the home care sector and call on the McGuinty government not to expand this model into any other sector of health care.

Ban the use of unregulated private ambulance companies and direct their services back to the public sector where they were provided before the Tory legislative change in 1998.

3. Local Health Integration Networks (LHINs)

Recognize the dangers of the Local Health Integration Networks (LHINs) model and ensure that labour and community organizations play a full role with the government in the development and implementation of any alternative structures.

4. Improvement of the Capacity and Resources of our Public Health Care System to Deal with Such Issues as Staff Levels, Workloads and Wait Times

With full labour involvement multi-stakeholder studies determine appropriate minimum staff levels (such as 3.5 hours per resident in nursing homes and homes for the aged). Staff levels should reflect not only the numbers of staff but appropriate classifications and qualifications of staff to ensure that patients receive the care that is appropriate to their needs.

With full labour involvement the government develop strategies to recruit and retain sufficient numbers of needed workers in every sector of health care.

The McGuinty government must commit itself to establishing required minimum staff levels by the end of the year for all health care sectors. They must also commit to providing the necessary resources to attain and retain these agreed upon staff levels.

Based on the situation in long term care facilities, there must be mandatory reporting and monitoring of staff levels rather than a “voluntary compliance” model to ensure the proper use of government monies. We also need public accountability by institutions to their residents/patients and to the wider community. Also missing and needed are effective whistle blower rights and protections for workers seeking to challenge inappropriate actions by their employer.

5. To Recognize and Positively Address the Broad Determinates of Health

Our public health care system must be seen as a valuable social asset that is an integral part of our society. The links must be made between the importance of broad determinants of health such as safe and secure employment, a decent income, good housing and a social safety net as preventive measures whose presence has a positive impact on our individual health now and in the future. Our public health care system must have both the ability and the sensitivity to work with Ontarians with particular needs.

6. To Improve the Capacity to Evolve Our Public Health Care System To Address Issues Not Currently Part of the System Such as Home Care, Pharmacare, Chiropractic, Physiotherapy, Dental And Vision Care Programs

The McGuinty government shows political leadership on the national scene to protect and enhance the *Canada Health Act*

The McGuinty government acknowledges the true drivers of health care costs such as the cost of drugs and become a strong advocate for effective pharmacare programs at the federal and provincial levels.

Abandon the competitive bidding model in home care and establish a public home care system based on the model found in Manitoba and Saskatchewan.

Enact a *Retirement Homes Act* to serve and protect Ontarians who use these institutions.

Build a health care system firmly rooted in democratic principles where the decision-making process is open and transparent and fully involves and addresses the needs of communities, patients/residents and health care workers.

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