NEWS BULLETIN

9th floor, Park Plaza, 10611 - 98 Avenue, Edmonton, Alberta T5K 2P7

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Canada Post Corporation / Société canadienne des postes
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Edmonton

VOLUME 21 NUMBER 9 UNITED NURSES OF ALBERTA NOVEMBER/DECEMBER 1997

In this Edition ...

Health Care—
The Canadian Advantage

Who knew? (Well other than 25 million Canadians!) Our public health care system is not only great for Canadians, it's also great for business. Officials from Japan say that one of the top reasons for relocating a Honda plant to Canada, instead of simply expanding an Ohio plant, was our cheaper health care benefits. In 1994, the president of Ford Canada said that Canada's lower health care costs were taken into consideration when Ford decided to expand a plant in Windsor. Perhaps someone could tell Alberta's Cabinet about the newsflash! They seem to be out of the knowledge loop.

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UNA members will be receiving 9 NewsBulletins each year. Any article, letter or comments for the NewsBulletins must be received by the Provincial Office no later than the 3rd of each month. Please include your name, Local number and phone number with the text. UNA reserves the right to edit any copy received and to make all final decisions on material published by the Union.

Melanie Chapman, Editor
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Standing Up for Health Care

UNA President Heather Smith recently spoke to the Government of Canada's Standing Committee on Finance during their pre-budget consultation stop in Edmonton. Smith urged the federal government to provide additional resources for national home care and pharmacare programs and to establish a Royal Commission on Privatization in Health Care. She said that the Commission should investigate and make recommendations regarding the division of public/private financing, public/private funding and public/private partnerships in the health care industry. Smith also asked that the government provide all Canadians with a thorough analysis of the impact of the Multilateral Agreement on Investment on health care. The federal budget is expected to be revealed early next year.

UNA 1998 Nurses' Planner

It's Here!!

The UNA Nurses Planner for 1998 was distributed to all Locals in late November. Every UNA members should have received her own copy of the Planner. If you haven't seen yours yet, call your Local Executive.

"When I give food to the poor, they call me a saint. When I ask why the poor have no food, they call me a communist."

—Dom Helder Camara, CUPW, Regina Local

1997 Annual General Meeting President's Speech

by Heather Smith, President

Welcome to UNA's 1997 Annual General Meeting — the twentieth Annual General Meeting of United Nurses of Alberta.

How fast twelve months fly by. It has been another year of non-stop activity at every level of UNA and I don't see an end in sight.

Although the vast majority of bargaining is completed, several of our Locals remain in negotiations. But in addition to bargaining, we must launch series of activities and initiatives in 1998—not the least of which is what I hope will be the biggest response to assaults on Medicare since its inception.

I looked back over my record of events; the first—the saddest—was the death of Dale Fior, UNA's Secretary/Treasurer. I know Dale's spirit is amongst us today. Not only would she have revelled in the celebration of UNA's 20th anniversary, she would have been absolutely thrilled by the joining of UNA and SNAA.

My calendar has been full of bargaining dates, Local proposal preparation, meetings (including a meeting with Ralph Klein) with a sudden flurry of activities in late February and early March. That work is ongoing as even this Saturday, the Health Unit Negotiating Committee will be meeting again with the employer.

1997's calendar is a record of media interviews covering a multitude of topics including the budget, another budget surplus, bargaining, the 1000 "nurses" to be hired, the provincial election, the economic summit, LPN regulations, access issues, HRG and now HCoA. UNA has been called to comment on professional, provincial and national issues. In fact, we have been so visible that more than one reporter has referred to us as Alberta's official opposition.

1997 has been a year of winding down the Workforce Adjustment initiative. There is a sense that the worst is now behind us. Perhaps that is true.

I attended several Local meetings in 1997, almost all because of issues surrounding bargaining, staffing or certificate changes, but I enjoyed every one. However, I really would like to visit Fort McMurray sometime other than January. But the weather is always a factor in Alberta—it adds emphasis to the memories. As many of you know all too well.

Several meetings and ultimately mediation resulted from the Capital Health Authority's application to consolidate certificates in Edmonton. My involvement paled next to the Local and staff commitment but I am hopeful that the final agreement will serve to deter other employers and regional health authorities from formulating grand designs to move nurses willy and nilly across institutions.

The greatest event of this year—I have said of two decades—is the unification of the UNA and SNAA memberships. Although our year may have started sadly, it has ended with tremendous happiness and optimism.

Unfortunately, the bigger picture of what is happening in health care is not good news. Last week, the Executive Officers and several UNA staff members spent a day with Wendy Armstrong of the Alberta Consumers Association. The Consumers Association is focusing on health care since it is a commodity with which most Albertans (and Canadians) can identify. The CAC believes the national and international forces that are reshaping business and industries can be demystified by understanding the implications for health care. They also see the threats to health care as cataclysmic with repercussions that will alter our fundamental premise of a caring society.

The impetus for the meeting was a lengthy conversation I had with health care economist Richard Plain who called to ask what UNA was doing to oppose WCB signing a contract with HRG (Health Resources Group). Richard views HRG and HCoA (Health Care of Australia) as a most blatant attack on our public health care system and on unionized jobs. "A union has to take the lead," he said. There is no mystery as to why he called UNA—nurses lead other groups when it comes to public confidence in health care. We met with Wendy because we know HRG and HCoA are just parts of the puzzle. We wanted to identify all or as many pieces as possible. The picture revealed is that of a deadly concoction.

The threats we believed we had averted by forcing health care exemptions under the NAFTA agreement appear to simply have taken a more circuitous course to achieve the same destructive end. In a few minutes I cannot explain each of the pieces; what I want to do is to raise the issues so that you support initiatives we must undertake in the coming months.

This is not about a conspiracy theory. It is the linking of activities many of which are quite public in nature and then considering the motivation for the activities.

We have said for many years that Canada holds a plum—our single payer Medicare system. In other countries, such as the United States, the pro

vision of health services is the source of immense wealth and profits for a few Americans. Although governments in Canada may espouse public support for Medicare, we have all witnessed efforts by the provincial and federal government to "divest" themselves of financial responsibility for health care and shift responsibility to individuals.

We have heard politicians at both the provincial and federal levels denigrate a "cradle-to-grave" mentality as passé as they promote the ability of the private sector to provide services. But if you ask individual Albertans (as we have) or individual Canadians, the response is clear: they want to maintain a public health care system. Since it is not politically wise to overtly go against the public will, so much of what is done to undermine the system is done quietly and with great subterfuge. At the same time, governments around the world are losing control of their economic—and therefore social—destiny as globalization erodes the nation-state. We are seeing a more oblique approach to transferring health care responsibilities from government to individuals:

Since it is not politically wise to overtly go against the public will, so much of what is done to undermine the system is done quietly and with great subterfuge.

Core services

In the recently unreleased consultant report that everyone has, the following appears:

"The main purpose of defining and describing core health services is to identify the range of services to which Albertans can expect access, regardless of where they live in the province. Identification and description of core services is the foundation for determining which parts of the publicly funded health system are responsible for ensuring access to which services ... The cost of core health services may be entirely covered by public funding, or individual may be expected to contribute to some costs." In other words, fewer services and more user fees.

Third Party Liability

Bills 15 and 46 are 'point the finger' legislation. In the past the government recovered hospital expenses related to MVAs only if the victim sued but this is no longer the case. Alberta can now sue without the agreement of the victim. And health professionals are now responsible for letting the government know who should be sued. In one year Alberta went from collecting $9 million to $43.5 million. Much of this will be translated into higher insurance premiums and is a quiet form of user fees and increased taxation.

Public/Private Contracts

As Wendy Armstrong says, "Too many doctors want to be businessmen and too many businessmen want to be doctors." These contracts will allow private enterprises to skim high volume, low intensity (and low risk) cases from the public system.

Take, for example, cataracts—public services are now being funded in private clinics. And a new way has been found to "profit"—by the offering 'enhanced services' like foldable lenses and superior surgical solutions.

The glorious future of health care: "I have a coupon" and "Sale on foldable lenses today only".

In the public system we see money-making activities such as fiberglass casts, IVP dyes with less potential for side effects, buy the better lens from the ophthalmologist to be implanted in the public hospital and buy the better titanium hip. In a BC hospital, there is a kiosk to purchase the better lens with a portion of the money going to the Ophthalmology Research department. The glorious future of health care: "I have a coupon" and "Sale on foldable lenses today only".

The private sector is being given access to public assets at fire sale prices—K-Bro, for example, will do Calgary's laundry in the RHA's laundry facilities. This is a betrayal and a misuse of public funds.

Clinical Practice Guidelines

It is our understanding that the provincial government is trying to pressure the AMA to move from a decision-tree model, which recognizes that decisions about health care (who gets what services) are not black-and-white, to a system which more closely resembles the US HMO model where decisions are made by funding managers.

HRG has stated that they will make decisions about who they accept on the basis of predicted outcomes—rejecting higher risk clients. HRG would do low risk cases and leave the high risk procedures to the public system.

Health Information System

Millions of public dollars are being put into this system which links back to third party liability as data retrieval mechanisms are needed to bill the right people. The HIS will facilitate a multi-payer system. One of the significant provisions is that we will be required to disclose personal financial information to the government and health care providers. Why would a health care provider need to know their client's personal financial information? In order to know who can be charged for their care.

MAI - Multilateral Agreement on Investment

The MAI will be the new Constitution for Canada. Unlike NAFTA, if there is **any** mix of public and private funding, it will **all** be considered private domain and the MAI will apply. That means that corporations can sue governments for trying to impose or bring in any kind of health, labour or environmental legislation. In fact, there are suggestions that the MAI will prohibit nurses from trying to require staff mix ratios in our collective agreements. Certainly the MAI will prevent any legislation or provincial government regulations for minimum staff levels but there may also be some challenge that we couldn't even put it into collective agreements because that might be seen as an agreement with the government.

There's yet another international activity, the APEC (Asia Pacific Economic Cooperation Forum), to facilitate globalization. It's a global trade block but the difference is that it's not just countries that are involved in this, it's economies. So you have Canada, IBM, Coca Cola, there—all eligible for equal standing. There is a big conference that's going to be happening in Vancouver and there's quite a growing opposition to this whole APEC agenda. So we've got to get more information on that as well. In the end we're not just talking about blending a public and private health care system; I think we're talking about pureeing our public system.

UNA is already moving on activities to fight these privatization and de-regulation activities of the government and business. Through Karen Craik's participation in the WCB Workers' Coalition, unions have indicated their opposition to HRG and other private initiatives receiving WCB contracts. I gave that same message of opposition to the new Deputy Minister of Labour last Friday. On your behalf, in our submission to the federal government's Standing House Committee on Finance, we called for a full disclosure of the MAI agreement and its implications for health care. We also called for a federal Royal Commission with the scope, detail and analysis of the Emmett Hall Commission, to investigate and put forward recommendations regarding the delivery, the division of public/private financing, public/private service delivery, and public/private partnerships in the health care system.

I believe we should also support the Consumers' Association call for a provincial referendum on the issue of private health care in Alberta. Our greatest fear is that by ignorance and tacit agreement we will be harmonized into a three-tier American health care system. In the States, there is one system for the poor and the elderly, there's the private tier and then there's the third tier—about 50,000,000 Americans who have no coverage at all.

In the end we're not just talking about blending a public and private health care system; I think we're talking about pureeing our public system.

Last week I attended a breakfast where Maude Barlow, a very dear friend of UNA, spoke about the implications of MAI and APEC. She ended with a story of hope, of how a single woman in India has organized workers to go from village to village collecting and cataloguing seeds to protect the seeds against patenting under intellectual property rights. She wanted to save the seeds for the people. The workers are called the Seed-Keepers, and in her speech, Maude Barlow referred to UNA as a Seed-Keeper because we fight to preserve the seeds of our culture, Canadian values of caring for one another, and our health care system.

We are now a bigger, stronger membership. As of yesterday, UNA had 16,610 members. We have combined our resources and created the potential to support and achieve in ways that it was not possible for either of our organizations to do separately. What I am talking about in terms of taking on this much bigger agenda, is an immense job. To move our membership, to move Alberta, and the federal government to act. But I have never seen the enormity of a challenge hold us back in the past. Our grandparents and our parents, lived through depressions and wars. They built a country based on caring and mutual support. That country is being torn apart. We are Seed-Keepers. It is our job to rebuild and strengthen. Our legacy is to move what seems immovable. For our country, our families, out jobs, our health care, and ourselves. We must not only try, we must succeed. Thank you.

Are You Aware of Protection for Persons in Care?

Have you been informed about your responsibilities under a new piece of legislation called "The Protection for Persons in Care Act"? Under the terms of the Act, employers must ensure their employees know about the Act, which is likely to come into effect at the beginning of January 1998.

Some people call the new legislation an attempt to provide consumer protection in health care; others call it merely a public relations exercise by the Alberta government. According to the legislation, the Protection for Persons in Care Act is intended to provide comprehensive protection for the health, safety and well-being of adults being cared for in the public care system along with some protection for those who file complaints about abuse of patients/clients. However, others point to the fact that the new law applies only to regulated employers, such as approved hospitals and nursing homes, but not to unregulated facilities as evidence that the provincial government is playing a cynical game to impress the public that they care after years of slashing health care budgets. The legislation has also been criticized for ignoring individuals receiving care in their own home—where they are the most vulnerable to abuse.

Background of the Act

Legislation to protect people in care was the topic of a 1991 paper prepared for the Premier's Counsel on the Status of Persons with Disabilities. Statistics from other jurisdictions quoted in the paper included

- abuse by paid caregivers is 45% more likely to go unreported than abuse by other persons
- abuse in institutions is 52% more likely to go unreported than abuse in other settings
- at least 2/3 of known sexual abuse in institutions is unreported.

In 1992, Stockwell Day introduced the *Vulnerable Persons Protection Act* but the Bill died on the Order Paper at the end of the Legislature Sitting. The Act was revived by Don Tannas in 1995 as a private member's bill and received Royal Assent on October 26, 1995.

Although the Act was passed in 1995, serious concerns about the content of the Act were raised and the Act was never proclaimed as law. [For example, the Act, when first passed, contained no definition of "abuse".] Earlier this year, when the Legislature had one of its all too rare sittings, an amendment to the Protection for Persons in Care Act was passed which attempted to correct some of the more blatant flaws in the legislation. Unfortunately, the result is still a seriously deficient piece of law-making.

Overview of the Act

- *Employer responsibilities*

Employers must advise their employees of the new legislation and make the provisions of the Act available to all service providers. Every successful applicant will have to pay for a criminal records check in order to be employed in approved hospitals, nursing homes, lodges or group homes (generally those of more than 4 people). Employers are not prohibited from hiring or continuing to employ people who have criminal records.

- *Individual responsibilities*

Under the legislation, every individual who has reasonable and probable grounds to believe and believes that there is or has been abuse against a client must report the abuse to the Department of Community Development. A 1-888 hotline will be set-up by the government and will be operational during office hours only. Abuse means:

- intentionally causing bodily harm
- intentionally causing emotional harm, including threatening, intimidating, humiliating, harassing, coercing or restricting form appropriate social contact
- intentionally administering or prescribing medication for an appropriate purpose
- subjecting to non-consensual sexual contact, activity or behaviour
- intentionally misappropriating or improperly or illegally converting money or other valuable possessions
- intentionally failing to provide adequate nutrition, adequate medical attention or other necessity of life without a valid consent.

Questions surround the definition of abuse and in particular the issue of how one knows whether the incident was intentional e.g. Will people report suspected abuse simply because there is a remote possibility that the service provider intended harm when a patient fell out of bed because the bed rails were not raised as they should have been? This is a serious concern given that those who do not report abuse are liable for a fine of up to $2,000 or up to 6 months in jail (in addition to discipline from their professional body and their employer).

- *Investigation and penalties*

The process of investigation is also unclear under the legislation—there is no mention of the use of natural justice (a legal term which means that you are entitled to know who the complainant is, what the complete complaint says and what evidence there is against you). Up to four

(continued on p. 10)

United Nurses of Alberta

November 28, 1997

Dear Prime Minister Chretien:

The United Nurses of Alberta represents 16,600 registered nurses and registered psychiatric nurses working throughout the Province of Alberta. Over the last few years, nurses have become increasingly disturbed about the direction health care is heading in our own province and across the entire country.

We are very concerned that the Multilateral Agreement on Investment has the potential to substantially alter the health care system enjoyed by Canadians from coast-to-coast. We request that the federal government provide UNA with a full analysis of the implications that an MAI agreement will have for health and other social programs in Canada . We further request that all Canadians be provided full disclosure of the ramifications of the MAI. Specifically, will the federal government be forced to abandon home care and pharmacare initiatives as a result of the MAI? Currently, private health services are provided in a virtually unregulated environment, particularly in Alberta. Will the MAI pre-empt government regulation of private health care activities and corporations?

The federal government has a responsibility to Canadians to pursue exemptions for health care at all levels of government (e.g. federal, provincial and municipal) in any agreements reached with other 'economies'. Canada must also take the position that, should our health care system not be exempted, an agreement that does not protect health care will not be signed and ratified by our government.

UNA also has deepening reservations about the extent of privatization in health care. We trust you are aware of the private hospitals under development in Alberta—Health Resources Group (Calgary) and Health Care of Australia (Canmore). The federal government has thus far maintained a very low profile in these recent privatization events.

Albertans, and indeed all Canadians, look to the federal government to provide clear leadership in the enforcement of the Canada Health Act and the philosophy behind its five principles. We are appealing to you to initiate a Royal Commission on Health Care Privatization which would reflect the scope/breadth/depth of the Emmett Hall Commission of the early 1980s. The Royal Commission would be charged with examining public/private financing, public/private funding and private/public partnerships in the health care system.

Since these issues are of great concern, we need a specific response from you so that our membership and other health care advocates in Alberatcan plan appropriate action. We know that Albertans want our health care system preserved and enhanced. Our health care system is a shared value which crosses all boundaries—cultural, racial, religious and linguistic.

There seems little merit to debating national unity if, by neglect or intent, we allow the true unifying agent of our country to disintegrate.

Sincerely,

Heather Smith

Heather Smith
President of the United Nurses of Alberta

1997 Annual General Meeting

October 22 & 23, 1997

More than 500 people crowded into a ballroom in Edmonton's Convention Inn South for UNA's Annual General Meeting. The two-day meeting in late October celebrated UNA's 20th Anniversary and welcomed UNA's newest Locals—from the Staff Nurses Associations of Alberta—to their first AGM.

Day 1

Loud cheers and applause greeted UNA's new members during the annual roll-call of Locals. Former SNAA members quickly became active members of UNA by participating in debates and drafting motions for the assembly.

After the President's Address (see page 3), the delegates launched into a lengthy but lively debate about the structure of "composite locals." [The Composite Local Appendix was passed and is contained in the 1997-98 UNA Constitution. Watch for your copy of the Constitution in the mail.] The business meeting closed with speeches from the candidates for the position of Secretary/Treasurer.

Later that evening, hundreds of UNA members—past and present—gathered to celebrate the rich 20-year history of the union at the 20th Anniversary Banquet. Laughter and tears accompanied the sharing of memories of UNA activities and members from over the years.

Day 2

Day two began with a short executive session for UNA members only to ask confidential questions of the Executive Board. Throughout the day, many constitutional amendments and policy resolutions were discussed and debated. Issues included: funding for Local Executives, the frequency of Board meetings, terms of office, quorums for Local meetings, monies distributed for strike-related activities, rules for membership in UNA and leaves of absence for members of Local Executives and the Executive Board.

The 1997/98 budget was approved as presented by the delegates after a page-by-page review of the contents. The work done by the delegates was extensive and in an unusual move, delegates agreed to extend the meeting by 30 minutes to complete elections and to hear Board Committee Reports.

Elections

- **Executive Officers**: Bev Dick was acclaimed for a 2-year term as Vice-President of the United Nurses. Karen Craik, whom the Board had appointed as Secretary/Treasurer following the death of Dale Fior late last year, was elected to complete the last year of Dale's two-year term.
- **District Representatives**: Darlene Wallace was acclaimed as a North District Representative for a 2-year term. Beryl Scott, Dorothy Ferguson, Alan Besecker and Betty-Ann Emery agreed to take on the District Rep responsibilities for North Central District. Nancy Walker from Central District will make her first appearance on the Executive Board as will Donita Yorgason from South District. Beverly Krabsen will replace Karen Craik as a South Central District Representative for the final year of Karen's 2-year term. Newcomer Blanche Hitchcow will join long-time UNA activists Donnie Lacey and Denise Palmer for 2-year terms on the Board as South Central District reps.
- **Trial Committee**: Each year, UNA establishes a Trial Committee to hear any charges against UNA members arising from the UNA Constitution. Five members are elected at the AGM—one from each of UNA's Districts. Rachel Donohoe (North), Rose Pederson (North Central), Ingrid Ponto (Central), Pennie Bucilla (South Central) and Donita **Yorgason** (South) agreed to form the Trial Committee for a one year term.

Jennifer Petruik,
staff nurse,
Royal Alexandra Hospital

Registered Nurses understand how very fragile and precious life is. This understanding dominates our care and is evidenced by our compassion, our touch and our words to patients, their loved ones, our own families and friends. Understanding does not lessen the sadness and grief we experience when someone we know, someone we respect and care for is taken from us.

A sudden and violent end to our love, our friendships and our professional admiration, intensifies our feeling of loss. We search for the reason, to try to understand how the precious life of one so young and hopeful for her own future and that of her daughter can suddenly end. This event is not possible! It is not logical or justifiable! We know in our hearts that this is a bitter reality, a truth and sadness of our society.

I write this for her daughter, hoping that one day she will know that her mother was loved and respected by her professional colleagues. I also write this to the members of our profession, as a call to action. Perhaps through our actions Jennifer's daughter Serena will be granted a small measure of solace in knowing that the tragedy that befell both her parents, served as an inspiration for us to work to end violence, intolerance and abuse in our society.

On behalf of United Nurses of Alberta I extend our deepest sympathies to the family of Jennifer, most especially to Serena.

– Heather Smith, President, UNA

(Donations to a trust fund for Jennifer's daughter may be made at Alberta Treasury Branches)

Protection for Persons in Care

(continued from p. 6)

Ministries may be involved with any investigation, creating a bureaucratic quagmire for complainants, employers, professional associations and service providers. There is no clear standard for determining guilt—which of the legal tests will apply: "balance of probabilities" or "beyond a reasonable doubt"? What will happen if the employer's investigation, the professional body's investigation, a criminal investigation and the Minister's investigation disagree with one another's findings? The Minister is given extensive leeway in recommending actions to be taken. Unfortunately, there is there no appeal process for the Minister's decisions. Can the Minister's decisions be challenged in the Court system?

Conclusion

While the stated goal of the Protection for Persons in Care Act is laudable, the wording of the Act is lamentable. Many concerns still exist about the process of investigation and the application of the terms of the Act. Unfortunately, it appears that the interpretation of the Act will be left to the whims of government over the next few years—that is, until legal challenges clarify what the Act really means for complainants and victims. In the meantime, every employer should establish a process for handling complaints of abuse in their facility and should ensure that employees are up-to-date on what their responsibilities will be under the Protection for Persons in Care Act. Contact UNA's Provincial Office or your Local Executive if you require further information or assistance with a complaint filed under this legislation.

Community Nurses Deserve Equity

Registered nurses working for the Edmonton Board of Health have been working without a collective agreement for nearly 2 years. The Capital Regional Health Authority is refusing to address nurses' concerns about their workplace and is demanding several rollbacks in the contract.

- For nearly 2 years, the Capital Region has said that they don't want to be fair and reasonable in their dealings with their employees. In fact, the employer continued to demand that the requirement for the employer to be fair and reasonable be deleted from the contract until the nurses held an information walk-about on December 8. The employer has now dropped demands for rollbacks in vacation but is continuing to demand rollbacks in scheduling provisions.
- The employer is also dismissing nurses' concerns about patient care and workplace safety. UNA proposed that the Edmonton Board of Health establish committees to address the concerns—so far, the employer is refusing to do so. Nurses who work in facilities such as the Royal Alexandra and University of Alberta have had these committees in place since the early 1980's.
- The Capital region is refusing to return the 5% rollback taken in 1994 to all nurses working at the Edmonton Board of Health.

"Why would nurses working in the Capital Health Authority be treated differently because one works in the community and one works in a facility? We've bridged the gap elsewhere in the province, now we want the CHA to bridge it here too."

— President Heather Smith commenting on Local 196 Negotiations

Executive Board Summary: November 1997

Medicare, negotiations, pensions and an organizational review will be the top issues for UNA's Executive Board in 1998. A one-day Priorities and Planning session, held just prior to the usual three-day Board meeting in mid-November, set out the overall plan for next year. The Board, at its first meeting since the UNA/SNAA amalgamation in October, then handed out related work to each of the Board Committees.

Finance Committee

The Executive Board's Finance Committee is responsible for monitoring and guiding the financial affairs of the union. Committee members include Karen Craik (Sec/Treas), Alan Bieseker (NCD), Tom Kinney (NCD), Darlene Wallace (ND), Marilyn Coady (NCD) and Kathy James (SCD). Challenges facing the Committee this year include funding for increased contacts between Local members in bargaining and their district reps and negotiating committee representatives. The Committee is also examining suggestions for funding for education bursaries/scholarships and for sponsoring research and a conference on the privatization of health care. The Committee will be evaluating the costs of any proposed changes to the organizational structure of UNA.

Legislative Committee

UNA's policies, procedures and Constitution as well as external regulations and laws are overseen and interpreted by this Committee. Chaired by Holly Heffernan (SCD), other Leg. Committee members include Bev Dick (Vice-President), Pauline Worsfold (Transitional Officer), Brent Smith (CD), Diane Poynter (SD) and Denise Palmer (SCD). In 1998, the Leg. Committee will review UNA's policy manual and will assess UNA affiliation with the National Federation of Nurses' Unions. Leg. will also evaluate the new composite Local structure supported by UNA members at the AGM.

Getting to Know UNA: The Executive Board

The 23 members of UNA's Executive Board meet four times each year at UNA's Provincial Office in Edmonton. The Board is comprised of 19 District Representatives, the UNA President, Vice-President, Secretary/Treasurer and, for a one year term, the Transitional Officer.

District Reps are an important part of UNA's organizational structure as they form the link between UNA Locals and the provincial organization. Through the District Reps' participation, activities of the union can be coordinated throughout the Province. The Executive Board is responsible for directing the affairs of the union between Annual General Meetings.

Each of UNA's five districts is represented by District Reps elected by the Local representatives at District meetings. Districts are entitled to one representative for every 1,000 UNA members or part thereof, with a minimum of two representatives per District. North District, Central District and South District each have 2 representatives while North Central has seven and South Central District has 6 District Reps.

Education, Communications, and OH & S Committee

The five District Reps active on the ECOH&S committee include: Donnie Lacey (SCD), Beryl Scott (NCD), Bev Krabsen (SCD), Donita Yorgenson (SD) and Betty-Ann Emery (NCD). ECOH&S develops and evaluates UNA's communication tools (NewsBulletin, UNA STAT, Spotlight, Frontline, computer system, videos, etc.) along with UNA's education strategies (workshops, briefs, etc). The 1998 plans for ECOH&S include ensuring that UNA's education and communication activities provide members with sufficient knowledge of UNA's current structure (including new composite locals) and the development of a mechanism for Provincial Office to gather stats and information from UNA's new Staffing Committees.

Membership Committee

The broad mandate of the Membership Services Committee, assessment and strategy development for UNA membership services, has been undertaken this year by Jacquie Boisvert (NCD), Bridget Faherty (ND), Dorothy Ferguson (NCD), Blanche Hitchcow (SCD) and Nancy Walker (CD). In 1998, the Membership Committee will assess membership concerns for the organizational review and will examine membership attitudes towards negotiations. Incentives for membership participation in UNA will be developed along with an information package about changes to pension plans.

Know Your Rights: Disability Claims

by Janice Peterson, Labour Relations Officer

One of the symptoms of our ailing health care system in Alberta is an increase in injuries and illness and a resulting increase in sick time utilization and disability claims. In dealing with this issue health care employers have adopted an approach similar to that of many other employers in this province. They have chosen to abandon the traditional occupational health and safety credo of prevention in favour of aggressive "claims management".

The focus of this form of claims management is reducing claim costs no matter what the cost to the worker. Effective claims management is the process of assisting the individual to achieve his/her maximum post injury or illness potential by ensuring that their financial, medical, emotional and vocational needs are met. However, in a number of facilities the goal is simply to reduce claim costs by creating barriers to the claims acceptance and/or by forcing the worker off claim as soon as possible.

The reasons for this are quite simple —it comes down to money. Effecting change through the time honored principles of health and safety (identification - evaluation - prevention - reevaluation) is an often time consuming, labour intensive process. Claims management can demonstrate savings quickly with little cost to the employer.

Most of our members who file WCB claims or access LTD benefits have little or no knowledge of their rights and responsibilities under either program. In addition, quite often their first point of contact for information and advice is the occupational health and safety office.

Traditionally occupational health staff aided and advisedd nurses in dealing with health related matters. However, in the new environment of fiscal restraint the focus of most health office staff is now claims management or rather claim cost reduction. Their focus has clearly shifted from being advocates for the injured or ill employee to simply managing the employer's limited resources.

On the whole, our members rarely contact UNA for information and assistance in those crucial early stages of their claim in the mistaken belief that the employer and the LTD provider or WCB are acting in their best interests. Unfortunately for our members this is not always the case.

The majority of WCB and LTD claimants contact UNA when they are notified that their benefits have been denied or suspended. This often occurs many months or even years after their claim was filed. Many of these members were denied or cut off WCB benefits and rather than appeal that decision were then encouraged to transfer on to LTD benefits. This leads to a lengthy appeal process and in some cases litigation in an effort to reinstate benefits.

Just what does this all mean for our members? In most cases "an ounce of prevention is worth a pound of cure". An old saying, but never so true as when dealing with this issue. The following are some of the things you can do to protect yourself:

1. Know what benefits you are entitled to receive and what information you need to provide to obtain those benefits—find out about your rights and responsibilities preferably **before** you are injured. UNA offers information, advice and workshops on benefits—contact your local or the UNA office for more details. WCB produces a Workers Guide to Compensation—call for a copy
2. Don't hesitate to call your local representative or UNA office for information or advice. **We work for you!** Early intervention is the best way to avoid problems in the future.
3. Call UNA if your employer or WCB or LTD refers you a physician or other health care provider. You have the right to choose your own care providers except in very limited circumstances. Check it out with us **before** you attend the examination!

The UNA Constitution will be mailed with the 1998 UNA Membership cards. If you have not received your new membership card by the end of January, contact your Local Executive.

Fast Facts on Health Care Realities

MYTH: Competitive private markets provide cheaper and better care.

FACT: There is widespread market failure in healthcare. This is because the high stakes and imbalance of information make both price and access difficult to control. After all, no one says to themselves "I think I'll go out and find the cheapest chemotherapy for my child or the least-cost heart surgeon for my husband or Mom."

FACT: In 1985 the State of Arizona decided to stop controlling the number of hospitals performing open heart surgery and to allow competitive forces to take over. The number of hospitals doing this surgery in Phoenix rose from four to eleven. A year later, a study showed that the mortality rate for the procedure had gone up 35% while the cost rose 50%.

FACT: In June 1995 in Alberta, a survey of the cost of routine adult eye exams in seven major centres five months after deinsurance found the the average price of an exam had gone up 30%. (Consumers Association of Canada)

MYTH: Offering higher priced private services for those who can afford it will relieve the burden on the public system and increase access.

FACT: Two tier medicine and multiple payers fuel inflation. In the U.S. and other countries (like Australia), private health care costs have risen much more rapidly. This has put constant pressure to on their public systems to increase payment to providers.

FACT: In the US, physician fees for common procedures run 2-3 times that paid by Alberta Health and charges to private US payers and insurers run 4- 5 times as high as Alberta Health. Twenty- five percent of US physicians refuse to treat public patients and many of those who do limit their numbers because of the lower fees.

June 1996 fee	Alberta Health	US Public Plan	US Private
EKG	$ 23.75	$ 57.75	$ 71.25
ECHOCARDIOGRAM	$198.84	$ 723.00	$ 885.00
CATARACT SURGERY	$505.13	$1026.00	$2600.00

FACT: In Alberta in April 1994, a survey was conducted to determine access to cataract surgery through different ophthalmologists. Waiting times for fully insured public surgery averaged 2-6 weeks. Longer waits for fully insured surgery were only encountered by patients whose ophthalmologist had an active private clinic. Some ranged up to a year. Facility fees in these clinics ranged from $700 to $1300 dollars and were 2 to 2-1/2 times the documented per case costs in two Alberta hospitals.

MYTH: The perfect solution to healthcare costs is more public/private partnerships.

FACT: While both public and private players can provide value to a community, the greatest danger for both taxpayers and patients arises from a failure to clearly separate the interests and responsibilities of the private and public sectors.

FACT: Studies in the U.S. have shown that doctors who own diagnostic facilities just happen to order those tests 2-3 times more often than doctors who don't own facilities.

FACT: Legislators in the United States have spent hundreds of millions of dollars in order to restrict and monitor ownership of healthcare facilities and the abuse of self-referral, kickbacks and anti-competitive activities.

FACT: British physicians writing in the British Medical Journal have identified an increase in the number of unnecessary and potentially harmful tests and treatments with the growth of their parallel system.

FACT: Almost every public/private partnership in healthcare in Alberta has involved either the free or undervalued use of public assets, a public subsidy or access to a captive market. This leads to cross-subsidization, decreased transparency and accountability and patients being put in difficult situations.

MYTH: Canadians can no longer afford a universal comprehensive health system.

FACT: If we can't afford the system we have now, we certainly can't afford the alternative. The principles of the Canada Health Act are based on sound economic sense and provide strong social guidelines.

FACT: Private health insurance is neither affordable or available for many families particularly in the absence of a group employer plan. A 1995 UNA survey found only 63% of Albertans had a supplemental health plan.

Susan Mast and her husband, a self-employed contractor, decided not include maternity coverage on their health insurance because it cost an extra $2000 dollars per year.

FACT: Prices and coverage for healthcare varies dramatically in the U.S. from $180 per month to $8000 per month depending on pre-existing conditions, deductibles and coverage. You may also have to pay up front, have large co-payments or experience arbitrary denial of claims and non-renewal of policies.

FACT: In Canada, rising employer healthcare costs are creating problems for companies and many are turning to contract and part-time staff to avoid the costs. A KPMG study found that American employers pay 8 times as much for healthcare as Canadian employers do.

THE FINN LINE

Right-to-work means working for less

by Ed Finn / CALM Magazine

Right-wing business groups, think-tanks and politicians in Canada are now pushing hard for the enactment of "right-to-work" laws in this country, modelled on those adopted by 21 states in the U.S., most of them in the Deep South. Billed as giving workers more rights in their workplace - mainly the "right" not to join a union - "right-to-work" laws really give them only one "right": *the right to work for less.* Almost without exception, wage rates in the "right-to-work" states fall well below pay levels in the states that have refused (so far) to pass such anti-union and antiworker legislation.

What such laws really do is destroy one of the fundamental principles of workplace democracy. By abolishing a key right that gives workers some control over their working conditions and benefits, "right-to-work" denies them the freedom to negotiate basic union security provisions.

What's union security? It's a clause in a collective agreement that obliges all workers who benefit from union representation to share the costs of their union's services and activities. "Right-to-work" laws, however, prohibit labour and management from even bargaining over this issue. They make the payment of union dues completely voluntary.

The result is that free-loaders are able to evade the obligation to support their union. They contribute not a cent toward defraying its operating expenses, but continue to enjoy all the gains and improvements the union manages to negotiate. Their co-workers who do support the union and pay dues are forced to subsidize these free-loaders.

'Right-to-work' promises a magic bullet, but instead delivers a self-inflicted wound.

Over time, this situation undermines the union's ability to serve the workers and to negotiate and police good collective agreements. As its resources diminish, the union is eventually financially drained into oblivion. It loses the support of most of its members and is unable to retain its right to represent them.

And that is what the whole "right-to-work" system is all about - undermining and getting rid of unions. The great majority of workers in the 21 "right-to-work" states now have no unions to bargain for them, to advance and protect their interests. They are completely at their employers' mercy.

The wide gap that has opened up in the United States between the states that have adopted such laws and those that have not has in effect created "two nations" of U.S. states. Invariably, the enactment of "right-to-work" laws is followed by a deterioration in social and economic standards, not just for workers, but for the entire population.

As the AFL-CIO concluded in a recent report on this subject, "right-to-work laws are part and parcel of a low-wage, low-benefit, anti-worker strategy that depresses wages and living conditions." Their adoption "puts a state on the slippery slope to economie and social decline, while doing nothing to stabilize or improve the state's economy."

Governments in Canada that are flirting with "right-to-work" should take a close look at the consequences that are all too evident in the American states that have gone down this road. The comparative statistics show that nearly all the "right-to-work" states rank well behind the other states in per capita personal income, in average weekly earnings, in UI benefits, in on-the-job fatalities, in general health rankings. About the only area in which the "right-to-work" states rank highly is in their levels of poverty.

Let's heed the AFL-CIO's warning: "Legislators should reject the siren song of this illusory economic quick-fix. 'Right-to-work' promises a magic bullet, but what it actually delivers is a self-inflicted wound to a state [or province], to its economy, and to its workers."

Ed Finn ***is a research associate with the Canadian Centre for Policy Alternatives and editor of its newsletter, the CCPA*** **Monitor.**

Found on the UNA Net

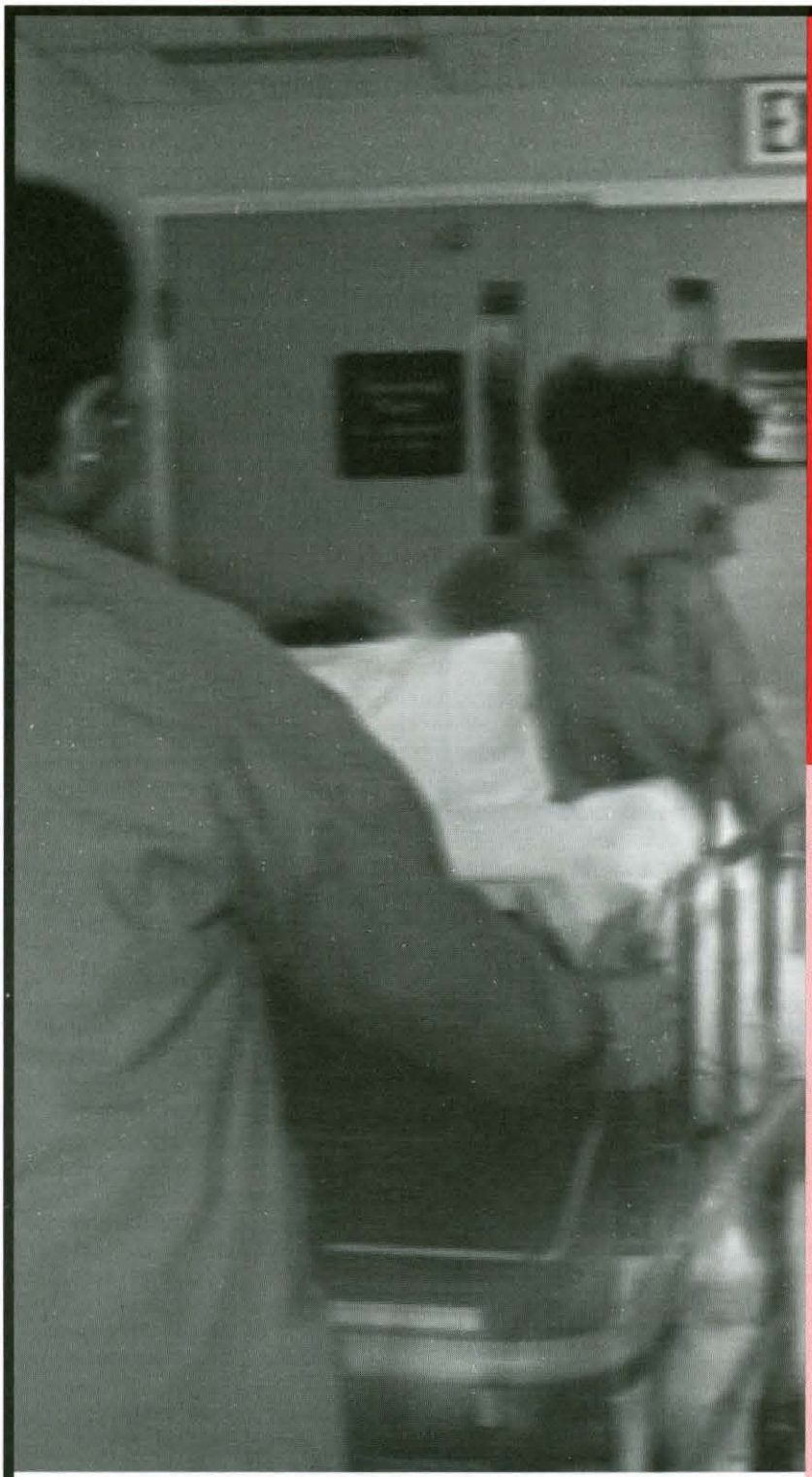
The following discussions are taken from UNA's latest communications tool, the UNA Net – a provincially linked network of computers. This is the forum for discussion of professional issues, a place to get feedback from fellow UNA members and a place to raise issues important to you and your facility. If you have a computer and modem and would like to be part of this network, contact Rena or Florence at Provincial Office.

LPNs Phoning Doctors

- We have a four hour LPN float position on evenings who covers the evening meal break for the RN in OPD. The RN is paid to remain available (in the building) but the LPN does triage to decide if and when to call her back to OPD. Some of the LPNs and doctors wanted the LPNs to be allowed to call doctors and/or take phone orders but that has now stopped. The day shift RN in OPD has her breaks relieved by the OR staff but often it is one of LPNs from OR who relieves them. On nights, the RN is relieved by our RN night float. We have argued that LPNs should not be alone in OPD and should not be doing triage but have not got very far. We intend to pursue it further once our staffing committee is up and running. Any suggestions and any comments on how other places deal with this?
- In our facility, the LPNs will call the Dr. to let them know there is an outpatient. They do not do verbal phone orders. etc. We had a problem with telephone advice being handed out inconsistently and, in a couple cases, serious consequences resulted. The RN is not sitting at the desk waiting to take patient calls so the unit clerk (LPN) hands out advice. Via PRC, we developed a log book which has standard up-to-date info and advice on the most common concerns. These protocols have been approved by the doctors who stand behind the advice given from this book When we log the call, we document the caller name/date/time/concern along with the advice given (e.g. concern re babe's fever, we would document info as per fever guidelines). We are still getting used to actually using the book since when you are the phone you are doing 2-3 other things at the same time. Don't you all know the feeling!
- In this hospital, the LPNs do not phone the doctors. We had a couple try off and on but one doctor would say "Let me speak to the RN" which was very helpful. Also LPNs are not allowed to give phone advice; they are to call an RN to the phone. Our DON actually wrote in our communication book that the most highly qualified person on duty is to give the phone advice. The NAs have tried in the past to answer the phone and were caught giving out advice. We had to PRC this and the result was in our favour.
- We had the same concern. The job description for LPNs in our facility does not provide for LPNs to take phone orders or triage. Our manager is in the process of drawing up a list of duties and responsibilities of LPNs in OPD/ER. The RN is responsible for supervising the LPN. Some of us clearly state what we expect at the beginning of the shift. Our region is in the process of revising the role of the LPN now so I expect to see changes over 3-6 months. We took this issue to PRC and used it indirectly in a Staffing Committee meeting.
- The ER is always covered by an RN here. The RN is to be available at all times during the shift. On rare occasions when chaos is happening on inpatients, the LPN will greet the outpatient and triage with the info to go straight to the RN covering ER who can then choose to handle the outpatient or call in another RN to help (in a pinch we call the OR nurse on call).
- In this hospital, LPNs are never assigned to ER. They do not triage, call docs or take phone orders.
- Our ER/ OPD is covered by an RN and an LPN. On days when procedures are booked, we have experienced concerns with LPNs treating without supervision of the RN (in addition to lack of communication to the RN when she was on break). We took it to the Staffing Committee, recommending hiring of another RN. We're now collecting stats—a time consuming effort.

Work Hardening

- We are having problems with one supervisor in particular with regard to pulling regular staff when someone is on the unit as a part of a work hardening program through GWL. We have had a number of run-ins with her, and are doing so again. Does anyone else have these problems, and if so, how have you approached them?
- I would suggest filing a PRC and/or OH&S as there is obviously a safety problem - otherwise the individual would not be on the work hardening program. We had someone in that category , no problems though. After 6 weeks, the individual was placed in the area, at which time a position was created through position elimination and she took on the complete role independently.
- Our hospital recently had an RN gradually return to work using a series of progressively longer shifts (starting at 4h and increasing to regular 12h shifts) and progressively more shifts in a week and in a row. While she was doing this, she was considered extra staff and the rest of the staffing wasn't affected at all.
- Please explain a work hardening program.
- Work hardening is for those individuals returning to work after an injury or an illness wherein they are not able to return to full duties right away. Great West Life or WCB continues to pay the individual while they work partial hours and gradually build up their endurance until they CAN do a full shift, at which time they return to their regular schedule and the employer pays their wages again.
- Gotcha, and here I thought it was some new invention of management's with the purpose of hardening employees, so we could do more and harder work.
- Work hardening in this facility means that when an employee is cleared to return to work, but are still rehabilitating from their condition, the employer will temporarily place them in another area of less physical stress and demand until such time as they have been rehabilitated. For example, one RN was placed in a clinic for 6 weeks until she could return to her regular ward—the decision of the employer was that the ward was too physically demanding and the risk of reinjury was great. However, if they build the stamina of the individual the likelihood of success (non-reinjury plus return to her unit) is greater.



Never Another Shift Like That

Over and over again, members of United Nurses of Alberta tell us they are working under increasingly stressful Conditions. Shiftwork, under-staffing, higher acuity levels, cutbacks and layoffs have left nurses working harder with fewer resources and sicker patients. The effect is that nurses are becoming more stressed for longer periods of time.

If you are one of those nurses and want help to reduce your work stress, call a member of your UNA **Occupational Health and Safety Committee.** Together you can tackle the problem.

United Nurses of Alberta

CONTACT YOUR LOCAL'S OH & S COMMITTEE.