

**ONTARIO NURSES' ASSOCIATION**

**SUBMISSION**

**ON**

***Bill 74, The People's Health Care Act, 2019***

**TO**

**STANDING COMMITTEE ON SOCIAL POLICY**

**Toronto, Ontario**

**Queen's Park  
Committee Room 151**

**April 1, 2019**

**4:20 p.m.**



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## **Summary of ONA Recommendations for Bill 74**

ONA proposes the following recommendations for Bill 74:

1. The *Public Sector Labour Relations Act* (PSLRTA) must continue to apply to all integrations in the health-care sector. To achieve this, we make the following recommendations:
  1. Remove Health Programs Initiatives (continued as Ontario Health) from section 1 of Ontario Regulation 386/07 Prescribed Agencies, Crown as Employer.
  2. Amend PSLRTA to add Ontario Health to the list of employers subject to a Health System Integration under section 2 of PSLRTA.
  3. Amend *Connecting Care Act* to include Ontario Health in the definition of Health Service Provider.
2. Current employees of the LHINs should not be subject to the *Crown Employees Collective Bargaining Act* (CECBA).
3. Strengthen the Preamble to Bill 74:
  - a. Incorporate the principles referenced in the *Local Health Systems Integration Act* (LHSIA) to the five principles of the *Canada Health Act*, as well as adding the principle to promote the delivery of public health services by not-for-profit organizations, into the preamble of Bill 74 so that the people of Ontario know what to expect in the coming transformation of their health-care system.
  - b. Contextualize all references to health-care spending in terms of building capacity for better and safer patient care for all Ontarians.
  - c. Draw from the preamble of the LHSIA and commit to public accountability and transparency to demonstrate that the health system is governed and managed in a way that reflects the public interest.
4. Explicitly commit to build additional not-for-profit capacity in Ontario's public health-care system, and to remove references in all sections to "a person or entity" and references to "non-health" organizations that remain undefined in the legislation and that may lead to further privatization.
5. Strengthen full accountability and transparency in the public interest in Bill 74:
  - a. Board meetings of Ontario Health should be open and Board meetings should be published on a website.
  - b. Add a robust public engagement process and a more transparent process for the designation of integrated care delivery systems by the Minister.
  - c. Make it a requirement to publish any human resources adjustment plan as part of any integration or transfer, and to publish both decisions not to proceed with an integration and when the Minister allows an integration to proceed.
6. Insert into section 15 in Schedule 3 of Bill 74 that any integration or transfer is deemed to be a sale of business under section 13.1 of the *Pay Equity Act*.

## I. Introduction

The Ontario Nurses' Association (ONA) is the union representing 65,000 registered nurses (RNs) and health-care professionals, as well as 18,000 nursing student affiliates, providing care in hospitals, long-term care facilities, public health, the community, clinics and industry.

ONA welcomes the opportunity to provide the Standing Committee on Social Policy with recommendations from the perspective of front-line nurses and health-care professionals with respect to Bill 74.

ONA's members in the Local Health Integration Networks (LHINs) are a broad and diverse health-care professional group. The vast majority of our members are regulated health professionals involved in the provision of front-line care: RNs, Nurse Practitioners, Registered Practical Nurses, Care Coordinators, Social Workers, Occupational Therapists, Physiotherapists, Long-Term Care Placement Coordinators, Rapid Response Nurses, Nurse Clinicians, Advanced Practice Nurses, Nurse Educators, Consultants (such as palliative, wound care, etc.) and health-care professionals. Front-line Care Coordinators constitute a large portion of ONA's LHIN bargaining units. Care Coordinators, as a job requirement, must be regulated health professionals.

Every day, ONA members at the LHINs provide essential front-line services to Ontarians. Care Coordinators coordinate care for Ontarians, from children through to palliative patients, ensuring that patients receive the services they need. Long-Term Care Placement Coordinators ensure Ontarians access the right long-term care facilities when they are needed. Since the introduction of Bill 74, ONA has received an unprecedented number of inquiries from our members. ONA members share the government's commitment to ensuring that Ontarians have access to the best quality in front-line health-care services. But they also want to know what this all means to front-line workers: Who will be their employer? Who will be their bargaining agent? Will they have a collective agreement? What will be the terms of their employment? Will they follow their work and continue to be employed?

The preamble of Bill 74, the *People's Health Care Act* states that the people of Ontario and their government believe that their health care system should be centered on people, patients, their families and their caregivers. ONA shares that belief.

Every day, nurses face the challenge of caring for their patients within a health-care system that is not integrated, that is under-resourced and that is difficult to navigate.

Nurses want to bring forward our solutions, which will need resources – both financial and human – in order to chart a course for a future that is patient-centred, integrated and coordinated. Our recommendations are designed to ensure those beliefs are realized as Ontario embarks on major changes to its health-care system.

## **II. Application of the Public Sector Labour Relations Transition Act (PSLRTA)**

### *Successor Rights at Ontario Health*

The Health Programs Initiatives, now called Ontario Health, is a prescribed “Crown Agency” within the scope of the Crown Employees Collective Bargaining Act (CECBA – Regulation 238/07: Prescribed Crown Agencies). If that remains the case, under the model where Ontario Health becomes the successor employer to the existing 14 LHINs, the result will be that former LHIN employees will become subject to a legislative regime that is distinct and that will impact the lives of front-line workers and by extension the labour relations environment within which health care is delivered: a regime different than used both as employees of the LHINs, and not long ago, as employees of the CCACs. There are a number of labour relations implications to changing the legislative regime.

Currently, any restructuring of the LHINs is covered by PSLRTA. The LHINs are not prescribed agencies of the Crown under O. Reg. 386/07. Additionally the LHINs are employers falling within the definition of employers who may be affected by a health service integration under s. 2 of PSLRTA.

Bill 74 substantially alters this state of affairs. Under O. Reg. 386/07, Health Program Initiatives is an agency of the Crown. Under s. 9(5.1) of PSLRTA, the Crown is not a successor employer under PSLRTA. If Ontario Health remains a Crown agency, PSLRTA will not apply to the transfer of the LHINs to Ontario Health. The same would be the case if the work of care coordinators or other front-line health-care workers currently employed by the LHINs is subsequently transferred to another employer, even if that new employer were not a Crown agency.

Instead, Section 69 of the *Labour Relations Act*, the sale of business section, will apply to both types of transaction. In ONA's submissions, this will cause substantial labour relations problems.

Under s. 69 of the Labour Relations Act (LRA), Ontario Health will step in to the shoes of the LHINs with respect to existing collective bargaining agreements and obligations. The powers of the Ontario Labour Relations Board (OLRB) under s. 69 are considerably limited compared to the powers of the Board under PSLRTA.

Under s. 69, the OLRB is limited to correcting any inconsistencies in "like" bargaining units. Under PSLRTA, the OLRB has broad powers to determine the number and composition of bargaining units, and to fashion rationalized, appropriate bargaining units. Many health-care employers are presently subject to a "patchwork" of numerous bargaining units that have been organized over time. Under PSLRTA, the OLRB can create the bargaining unit structure that is most appropriate to the successor employer's operations. These important powers limit the possibility of fragmentation and jurisdictional disputes (see, e.g., the Health Sciences North example of the Board creating a consolidated and efficient bargaining unit).

Section 69 of the *Labour Relations Act* is simply not equipped to deal with the complexities of restructuring and reorganization in the health-care sector like the PSLRTA.

ONA holds bargaining rights at 11 of the 14 LHINs. There are variations in each of ONA's bargaining unit descriptions from LHIN to LHIN. Several other unions also represent bargaining units in a number of the LHINs. In order to integrate these disparate bargaining units into Ontario Health, the OLRB will be required to determine the number of bargaining units, the scope of those units, and the bargaining agent or agents. This integration is likely to require run off votes to determine the bargaining agent for the eventual bargaining units. PSLRTA provides clear mechanisms for making the necessary determinations. The LRA does not.

PSLRTA contains other provisions that address key issues such as the determination of seniority rights, the creation of a composite collective agreement, the term of composite collective agreements, the rights of currently non-union employees, and other matters. PSLRTA was specifically drafted to deal with successor rights in the public sector, and particularly health-care integrations. Excluding the transition of the LHINs to Ontario Health from the application of PSLRTA is directly contrary to the government's goal of promoting efficiency in health care.

Labour relations upheaval is directly contrary to the goal of centering health care on people, patients, their families and their caregivers. Through the labour relations stability and certainty provided under PLSRTA, the needs of patients can best be served consistent with the legislative objectives.

#### *Continued Application of PSLRTA to Future Transfers*

The PSLRTA is specialty legislation designed to facilitate the transfer of collective bargaining rights and obligations during public sector integrations. It is designed for application in the public sector, where integrations may include multiple employers, and a multiplicity of bargaining units and bargaining agents. PSLRTA grants the OLRB broad powers to determine (1) the number of bargaining units appropriate for the successor employer's operations, (2) the scope of those bargaining agents, and (3) the bargaining agent that will represent those employees. It also provides parties with a clear roadmap for the determination of seniority, the continuation of composite collective agreements and the negotiation of replacement collective agreements. It is prospective legislation that plans for the future and that allows parties to make agreements or seek orders with respect to these issues in advance of the integration date, allowing for smooth integrations.

In contrast, s. 69 of the LRA is a retrospective provision that is backward looking and only allows the OLRB to determine successorship rights of affected unions after a sale of business has occurred. It does not provide employers and unions subject to an integration with a clear roadmap for making agreements and determinations regarding the continuation of collective bargaining rights and obligations.

Under PSLRTA, public sector employers and unions are frequently able to come together to reach mediated agreements without resort to the litigation. If some of the integrations contemplated under the *Connecting Care Act* fall under the LRA because they involve Crown employees to whom PSLRTA does not apply, it is foreseeable that there will be protracted litigation under the LRA. This would be contrary to the intent of Bill 74, which is designed to center health care on people, families, patients and caregivers. Front-line care staff want to know who they will work for, who their bargaining agent will be, and what collective agreement they will be employed under. PSLRTA provides clarity and predictability; the LRA does not.

To ensure this clarity and predictability is maintained, ONA strongly recommends:

- Amend PSLRTA to add Ontario Health to the list of employers subject to a Health System Integration under section 2 of PSLRTA.
- Amend Connecting Care Act to include Ontario Health in the definition of Health Service Provider.

### III. **Crown Employees Collective Bargaining Act**

#### *Collective Bargaining Dispute Resolutions Mechanism*

CECBA is premised on application to the right to strike sector, with provisions for the negotiation of essential service agreements negotiated for the duration of a strike or lockout under the Act.

ONA submits that the essential services provisions under CECBA are not appropriate for the unionized employees of the LHINs who will become employees of Ontario Health under Bill 74. It is likely that many, if not all, of these employees would be subject to an essential service agreement under CECBA, rendering the right to strike meaningless. CECBA does not provide the mechanism of interest arbitration as an alternative dispute resolution mechanism to strikes or lockouts. In the absence of a functional mechanism to resolve contractual disputes, labour relations problems can be anticipated.

As the health system becomes more integrated under Bill 74, labour relations of the front-line workers should also be integrated. ONA members working in the hospital and long-term care sectors do not have the right to strike, due to the essential nature of their work and potential disruption to the health-care system that would follow a cessation of work. ONA takes the position that the same considerations apply to the community sector generally, and the work of front-line LHINs employees in particular. It does not make sense to have these employees governed by legislation that does not apply to any other front-line health-care employees.

#### *Grievance Settlement Board*

The front-line health-care providers who work in the LHINs are currently covered by the *Labour Relations Act*. Grievances are heard by an arbitrator (or panel) constituted under the *LRA* and the applicable collective agreement, and costs are borne by the parties.

These front-line health-care workers in the LHINs are subject to the same grievance arbitration system as employees in other health-care sectors (such as hospitals, long-term care, and public health).

Moving the LHIN employees to the CECBA would mean that grievances would be heard by the Grievance Settlement Board (GSB), a public board of arbitration. These employees would be the only front-line health-care employees subject to this grievance arbitration system. This would cause a number of problems:

- The GSB was set up to deal with the grievances of employees employed directly by the Ontario government, or provincial crown agencies. The GSB does not have expertise in the health-care sector. That expertise lies with the private arbitrators chosen by the parties to health-care collective agreements, who have developed expertise over many years of resolving disputes in this sector.
- There are limits on the GSB's jurisdiction to deal with certain types of disputes, particular to the public service. For example, the GSB lacks the jurisdiction to resolve classification disputes.
- ONA is committed to maintaining a system in which the parties to the dispute (union and employer) mutually choose a private arbitrator and bear the cost of the arbitration proceeding.
- The GSB has at times had a large backlog of grievances. ONA and the LHINs have the ability to address the priority and timing of the resolution of their disputes under the LRA and collective agreements, including use of the expedited arbitration provisions in the LRA. Under the CECBA, the parties would lose the ability to prioritize the resolution of their disputes.
- Most GSB hearings are held at the board's office in downtown Toronto. Front-line health-care workers employed by the LHINs are employed across the province. These employees are currently able to have their arbitrations heard near their workplaces. Moving arbitrations to the GSB would mean significant travel costs and inconvenience for both ONA and the employer.

- The GSB is administered jointly by the GSB Governing Counsel, which is comprised of the Ontario Public Service employer, crown agencies and the unions who represent the affected employees. If front-line health-care workers employed at the LHINs are added to the jurisdiction of the GSB, it would add to the number of unions currently at the table. This would needlessly complicate discussions and decision-making.
- There are approximately 7,000 LHINs employees who would be added to the jurisdiction of the GSB, which already covers approximately 70,000 public servants and crown employees. A 10 per cent increase in the number of employees whose grievances are heard by the GSB would cause unnecessary administration costs to Ontario taxpayers.

For the reasons we have outlined, there is no reason to remove front-line health-care workers employed by the LHINs from their current system of grievance arbitration and move them to the flawed processes at the GSB.

#### **IV. Articulating the Goals of Ontario’s Public Health-Care System**

The preamble to Bill 74 outlines the principles the government puts forward to represent the vision behind the structural transformation of Ontario’s public health-care system.

While the preamble recognizes the important goals of a health-care system that has the patient at its center and that is publicly funded, the government must clearly state that Ontario will firmly stand behind the overarching goals of medicare, including public health-care delivery by not-for-profit providers.

In the preamble to the *Local Health System Integration Act, 2006* (LHSIA), for example, the government expressly committed to “the principles of public administration, comprehensiveness, universality, portability, accessibility and accountability as provided in the *Canada Health Act* and the *Commitment to the Future of Medicare Act, 2004*; and “to the promotion of the delivery of public health services by not-for-profit organizations.”<sup>1</sup>

We call on the government to incorporate these principles into the preamble of Bill 74 so that the people of Ontario know what to expect in the coming transformation of their health-care system.

If the government continues to exclude these principles, it will be a clear signal to the people of Ontario that the private, for-profit sector will be granted significantly greater market share in the transformed health-care system. We caution that this would necessarily result in negative impacts on the quality and safety of patient care and for Ontario's health-care workforce.

We also know from the preamble to Bill 74 that the government's vision for Ontario's health-care system is focused squarely on a reduction in spending on health care as the government will "constantly promote better value," "ensure best outcomes for every dollar spent," and are committed to a "sustainable" system "built to last."<sup>2</sup> However, these objectives are disconnected from the overall outcome of better and safer patient care for Ontarians.

We call on the government to contextualize health-care spending in terms of building capacity for better and safer patient care for all Ontarians. That is what Ontario patients and their families expect of its health-care system and of its government.

Finally, we call on the government to draw from the preamble of the LHSIA that commits to "public accountability and transparency to demonstrate that the health system is governed and managed in a way that reflects the public interest." This is what Ontarians understand is meant by governing for the people.

## **V. Building Not-For-Profit Capacity in a Public Health-Care System**

A major question unaddressed by the government is how the structural changes proposed in Bill 74 will create more capacity in the public health-care system to deliver the care required by patients on waiting lists and lined up in corridors in hospitals.

The Auditor General, for example, noted in her 2015 Annual Report that "home care used to serve primarily clients with low to moderate care needs, but now serves clients with increasingly more complex medical and social-support needs." The Auditor also documents issues of duplication and omission in the contracts with about 160 private sector service providers delivering home care services, and comments on the resulting commercial confidentiality in the current model so that the true costs remain unsubstantiated.

We do not see any provision in Bill 74 to specifically address the fragmentation and duplication of services in the delivery of home care by primarily for-profit providers under the current model of managed competition. It is unknown where and if this model will transfer intact into the transformed health-care system. We recommend against it and to build capacity in the public system as the alternative.

There are restrictions in s. 33(2)(g) and (h) that restrict the Minister from ordering an **amalgamation or transfer of all or substantially all** of the operations of not-for-profit health service providers or integrated care delivery systems with for-profit health service providers or integrated care delivery systems. Other types of integrations under Bill 74 are not specified under these restrictions and other persons or entities are also not included.

In fact, there are provisions related to other integrations in Bill 74 that appear to open the door to further participation by the for-profit sector in Ontario's public health-care system. This is a warning signal of the government's intention.

At a very top level, section 48(1)(a) provides that Cabinet may make regulations "specifying **persons or entities** that are **included** or excluded from the definition of health service provider. In addition, Cabinet is given the power in section 48(1)(b) to exempt "the Agency, a health service provider, an integrated care delivery system or **any other person or entity** from any provision of this Act or the regulations...." These are unusual powers that remain unexplained and do not define for what specific purpose they might be necessary.

The Minister may designate under s. 29(1) "a person or entity, or a group of persons or entities, as an integrated care delivery system." There is no specific requirement, however, that an integrated care delivery system deliver health services on a not-for-profit basis as are spelled out under the Minister's restrictions in the orders in section 33 above.

A further source of power is vested with the Agency (Ontario Health) to provide funding under s. 21(1) with respect to health services, noting the Cabinet regulation-making power above, and under s. 21(2) with respect to **non-health** services. While the non-health services are intended to "support the provision of health care," they remain undefined and may lead to further privatization.

Further, the Agency may integrate the health system under s. 31(a) by “providing or changing funding” to the organizations as above in section 21. This could include further for-profit health or non-health organizations.

This could also mean that the Agency may facilitate or negotiate an integration under s. 31(b) between providers or systems and “a person or entity...which supports the provision of health care.” Such a person or entity are undefined and are not restricted to not-for-profit organizations. Taken together, the above provisions outline a system in Bill 74 where decisions by the Minister and the Agency on funding and integrations may result in additional for-profit delivery of health-care in Ontario. We do not believe this is in the public interest.

We do not believe the addition of for-profit delivery to integrated care delivery systems is a good use of limited public resources, and it will perpetuate the needless and wasteful expenditure of public resources on the current process of contracting to private sector providers in home care and in long-term care. It does not allow for public accountability and transparency for clients, residents and families because of the restrictions and barriers imposed by commercial confidentiality. For example, Ontario's current managed competition model siphons profit from public funding that should be designated for the delivery of home care. If this model continues under the proposals in Bill 74, the needed additional funding for capacity in home care and long-term care that we need to reduce existing waiting lists will flow to profit rather than to more care and more front-line staff to deliver that care.

It is for all of the above reasons that we recommend that the government explicitly commit to build additional not-for-profit capacity in the public health-care system, and remove references in all sections to “a person or entity” and references to “non-health” organizations that remain undefined in the legislation and may lead to further privatization.

## **VI. Accountability, Transparency and the Public Interest**

In addition to our concern we raised earlier about the need to include a principle in the Preamble related to accountability and transparency, we note a number of other areas in Bill 74 that restrict accountability and transparency that are essential to protect the public interest.

It is unclear what the relationship will be between the staff of the Ministry of Health and Long-Term Care who are part of the Ontario Public Service and the staff of the Agency, which is set up as an agent of the Crown. But, the requirements for open and accountable decisions by the Agency seem to be lacking.

There is no requirement in Bill 74 that meetings of the Board of the Agency be open to the public or that minutes of the meetings be posted on a public website. The only requirement is that the Board of no more than 15 members is to meet at least four times each year.

This is insufficient to hold the Board accountable for decisions in the public interest. We recommend open Board meetings and the minutes of Board meetings to be published on a website.

Unlike the Local Health Integration Networks, the Agency has a very limited obligation under s. 44(1) to “establish mechanisms for engaging” with stakeholders (patients, families, caregivers, health sector employees and others) “as part of their operational planning processes.” Additional detail may be set out in regulations.

The Minister is also given exclusive power to designate an integrated care delivery system without specifying in Bill 74 the criteria for qualification or for notice to, submissions from, or consultation with, the public prior to designation by the Minister.

Finally, there are **limited** requirements for notice and consultation regarding integrations and transfers contemplated under Bill 74. When the Agency issues an integration by way of a facilitation decision under s. 32, or the Minister issues an order and integration decision under s. 33, the Agency or Minister are required to “give the decision to the parties to the decision and publish it on a website” (s. 34(3)). Prior to issuing an order and making a decision on an integration order, the Minister must provide notice of at least 30 days and publish the proposed order on a website (s. 33(3)). Submissions may be made on the proposed order no later than 30 days after published on the website (s. 33(4)).

There is also a requirement for parties to an integration decision to “develop a human resources adjustment plan” but there does not appear to be a requirement to make this plan public.

The accountability framework for integrations by health service providers or by integrated care delivery systems operates only when the Minister issues a decision ordering **not** to proceed with the proposed integration (ss. 35(6) and (8)) and **may** publish the decision on a website. It is unclear how the public could make submissions if the Minister is not required to publish the decision. There are also no provisions related to public accountability when the Minister simply allows the integration to proceed.

To ensure full accountability and transparency in the public interest, we recommend a robust public engagement process and a more transparent process for the designation of integrated care delivery systems by the Minister. We also recommend it be a requirement to publish any human resources adjustment plan as part of any integration or transfer, and to publish both decisions **not** to proceed with an integration and when the Minister allows an integration to proceed.

## **VII. Ensuring Pay Equity Rights for Women’s Work in Health-Care**

Section 15.1 in Schedule 3 to Bill 74 – which concerns repeals, revocations and consequential and related amendments – provides that s. 13.2 of the *Pay Equity Act* (PEA) is amended by adding reference to the *Connecting Care Act* at the end. Accordingly, if Bill 74 is passed, section 13.2 of the PEA would read as follows:

*13.2 Section 13.1 applies with respect to an event to which the Public Sector Labour Relations Transition Act, 1997 applies in accordance with the Local Health System Integration Act, 2006. 2006, c. 4, s. 50 (1) or the Connecting Care Act, 2019.*

This raises a concern for ONA as to the applicability of section 13.1 of the PEA in an event to which PSLRTA does not apply. The extent to which any affected employer's liability for historical inequities will follow any integration or transfer must be made clear in all instances. It is important, therefore, that Bill 74 explicitly recognizes that pay equity rights continue through any integration or transfer.

We recommend that an additional provision be inserted into section 15 in Schedule 3 of Bill 74 to be clear that any integration or transfer is deemed to be a sale of business under section 13.1 of the *Pay Equity Act*.

Otherwise, Bill 74 removes protections of the pay equity rights for female-dominated health-care workers with the failure to include section 13.1 of the *Pay Equity Act* in the case of all integrations and transfers. Without the insertion of section 13.1, Bill 74 amounts to an attack on the full valuing of women's work in the health-care system.

Bill 74, rather than protecting the pay equity plans and claims of systemic pay discrimination for women working in the LHINs, excludes these women from the protective mechanism of s. 13.1 of the *Pay Equity Act*. We caution the government to seriously examine and to rectify this inequity.<sup>3</sup>

## VIII. Conclusion

ONA welcomes the opportunity to provide our recommendations to the Standing Committee for Social Policy.

Ontario nurses look forward to a future public health-care system that is patient-centred, integrated and coordinated.

For this vision to be realized, building additional not-for-profit capacity in the public health-care system must be a priority goal.

For this reason, and to ensure an orderly transition, ONA is calling for the government to make the following amendments to Bill 74:

- To strengthen the Preamble,
- To strengthen accountability and transparency,
- To ensure the *Public Sector Labour Relations Act* continues to apply to all integrations in the health-care sector,
- To ensure employees of the LHINs are not subject to the *Crown Employees Collective Bargaining Act*,
- To make it explicit that any integration or transfer is deemed to be a sale of business under section 13.1 of the *Pay Equity Act*, and
- To explicitly commit to build additional not-for-profit capacity in Ontario's public health-care system, and to remove references in all sections to "a person or entity" and references to "non-health" organizations that remain undefined in the legislation and that may lead to further privatization.

Ontario nurses are certainly disappointed the government did not consult with or draw upon our expertise with respect to a health-care transformational strategy. We look forward to actively participating in implementation decisions to ensure sufficient nurse and health-care staffing is available to deliver the coordination and continuity of quality care for our patients.

## **Endnotes**

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<sup>1</sup> Preamble to Local Health System Integration Act, 2006.

<sup>2</sup> Preamble to the People's Health Care Act, 2019.

<sup>3</sup> The Supreme Court of Canada in the important 2018 pay equity case, *Quebec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services Sociaux* 2018 SCC 17, held that legislation that denied a group of women access to retroactive pay equity adjustments was unconstitutional and violated s. 15 of the Charter. The Court clearly stated that “leaving wage inequities in place makes women “the economy’s ordained shock absorbers.” The Court went on to state that pay equity legislation targets women in redressing the pay discrimination they have suffered, but that the limits to access to retroactive pay equity adjustments drew distinctions based on sex.