

ONTARIO NURSES' ASSOCIATION

SUBMISSION

ON

Bill 100, Protecting What Matters Most Act (Budget Measures), 2019

TO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

Toronto, Ontario

**Queen's Park
Committee Room 151**

May 7, 2019

5:15 p.m.



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Summary of ONA Recommendations for Bill 100

ONA proposes the following recommendations for Bill 100:

1. *The Public Sector Labour Relations Act* (PSLRTA) must continue to apply to all integrations in the health-care sector to achieve the smooth transition and retention of nurses and health-care professionals. To achieve this, we submit that the Act should not be amended.
2. In the event that the government continues to propose amendments to PSLRTA and the *Connecting Care Act*, ONA submits:
 - a. Remove the amendment that repeals section 38 of schedule 1 to Bill 74 (s. 38 of the *Connecting Care Act*). That is, continue to have PSLRTA apply to integrations when an integration occurs that is,
 - i. the transfer of all or part of a service of a person or entity under a facilitation decision of the Agency under section 32 or a required integration order of the Minister under section 33;
 - ii. the transfer of all or substantially all of the operations of a health service provider or integrated care delivery system under a facilitation decision of the Agency under section 32 or a required integration order of the Minister under section 33;
 - iii. the amalgamation of two or more persons or entities under a facilitation decision of the Agency under section 32 or under a required integration order made by the Minister under section 33.
 - b. Substitute the following as section 8 instead of the proposed amendments to section 8 and 9 (with corresponding changes to section 8(2)-8(4):

8 (1) This Act applies upon,

 - a) the amalgamation of two or more health service providers; or
 - b) the transfer of programs, services, functions from one or more health service provider(s) to another health service provider.
 - c. Include Local Health Integration Networks (LHINs) and Ontario Health in the definition of a health service provider in the *Connecting Care Act* and PSLRTA.
3. Reinstate s. 13.2 of the *Pay Equity Act* (PEA).
4. Reconsider the regionalization of public health until further consultation has been completed. Reconsider moving to 100 per cent provincial funding of public health, if the government's objective is to ensure consistent service delivery and better alignment with the broader health-care system.
5. Reconsider a strategy of achieving cost reductions that impact patient care such as through scheduling, sick leave or other collective agreement provisions that will certainly have an impact on the retention of nurses and health-care professionals and the care of their patients.
6. Consider implementing a human resources strategy to retain nurses and health-care professionals, which may include additional one-time funding to avoid layoffs of front-line staff.

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 Finance and Economic Affairs with recommendations from the perspective of front-line nurses and health-care professionals with respect to Bill 100.

ONA strongly opposes the proposed revisions to the *Public Sector Labour Relations Act* (PSLRTA) in Schedule 53. We are very concerned about the consequences that will flow from those amendments, which are being made at exactly the same point in time that the government is planning, encouraging and in some cases, mandating, restructuring in the form of integrations in the health services sector.

We appreciate the government's commitment to integrate the health system, ensuring a seamless system for patients. We also acknowledge that there is a desire to facilitate integration by removing barriers. PSLRTA, however, is not a barrier to integration, but facilitates efficient transitions during restructuring, encourages health-care professionals to move with their work/patients, and with the explicit mandate of ensuring effective services that are affordable to taxpayers.

The public sector, including health, is highly unionized. Restructuring typically involves multiple unions and collective agreements. It is imperative to have a systematic way to determine what bargaining units are appropriate for the successor employer, and what bargaining agents, if any, represent the affected employees.

PSLRTA provides a known and effective regime for ensuring smooth transitions, allowing parties to address the labour relations implications in a proactive way. More often than not, because of the clarity provided by PSLRTA, employers and unions are able to agree on the number and description of bargaining units appropriate for the restructured employer, and have a clear process to follow to determine which bargaining agents represent the units and the negotiation of replacement collective agreements.

In contrast, the sale of business provisions in the *Labour Relations Act* (LRA) have historically not been successful in addressing transfers and integrations in the health sector because the typical indicia of a sale are not present. Often, there are multiple predecessor employers who continue to operate following the restructuring event. And in those rare cases where s.69 of the LRA is applicable, the powers of the Ontario Labour Relations Board (OLRB) are more limited compared to the powers of the Board under PSLRTA. Under s.69, the Board is limited to correcting inconsistencies in “like” bargaining units. Under PSLRTA, the Board has broad powers to determine the number and composition of bargaining units in order to fashion rationalized, appropriate bargaining units. PSLRTA is forward looking, permitting the Board to consider what bargaining unit structure will work for the successor employer, often in advance of the changeover date. This provides a clear path for employers, employees and unions, and fosters the prompt resolution of workplace disputes arising from restructuring. It is precisely because the sale of business provisions are not effective (and in many cases are not even applicable) that the Harris government foresaw the need for special legislation to facilitate its planned integrations and amalgamations. That need for an effective successorship regime in the health services sector remains.

The proposed amendments drastically limit the applicability of PSLRTA at the very time when it is most needed. This will lead to uncertainty and anxiety amongst the front-line employees, including the 65,000 members of ONA, who no longer know what the rules of the game are, or if there are any rules.

As just one example, ONA represents employees at eleven LHINs. There are variations in each of ONA’s bargaining unit descriptions. In most of those, there is at least one other union present in the workplace. The employees at the other LHINs are represented by other bargaining agents. It remains unclear where the work of the front-line employees performing care coordination will go, but, under the proposed amendments, PSLRTA will not apply. They are not health service providers as defined by the *Connecting Care Act* and as such are not covered by PSLRTA.

Furthermore, with the proposal to repeal section 38 of the *Connecting Care Act*, the transfer of LHIN employees under a facilitation decision of Ontario Health or a required integration order made by the Ministry will also not be covered by PSLRTA. It is also not clear that the sale of business provisions would be applicable.

How is the transfer of this work to be effected while protecting the employment of those affected employees? How are the multiplicity of collective agreements and bargaining units to be addressed?

In order to integrate these units, the OLRB needs to have the power to determine the number of bargaining units, description of bargaining units and have access to a process for determining who the bargaining agent will be for those bargaining units. PSLRTA provides the Board with the power to make those decisions, and a mechanism to resolve any disputes, including a process for votes. The LRA does not.

PSLRTA also provides the 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 allows the parties to make agreements or seek orders with respect to those issues, in advance of the changeover data so as to ensure a smooth transition for all parties. This is in contrast to s.69 of the LRA, which is retrospective, allowing the OLRB to make determinations about successor rights of affected unions only after a sale of business has occurred. It does not provide employers, employees and unions with a clear roadmap for making agreements and determinations regarding the continuation of collective bargaining right and obligations.

The Ontario Nurses' Association strongly believes that PSLRTA as it currently exists serves to facilitate the government's objectives. Amendments are not only unnecessary but will almost certainly result in unintended negative consequences for both front-line health-care professionals and their patients, who expect that newly integrated health-care providers will be staffed by experienced health professionals.

While we do not believe that amendments to PSLRTA and the *Connecting Care Act* are necessary, we are making the following recommendations in the event that the government intends to proceed with changes to the applicability of the Act:

1. Remove the amendment that repeals section 38 of schedule 1 to Bill 74 (s. 38 of the *Connecting Care Act*). That is, continue to have PSLRTA apply to integrations when an integration occurs that is,

- a) the transfer of all or part of a service of a person or entity under a facilitation decision of the Agency under section 32 or a required integration order of the Minister under section 33;
 - b) the transfer of all or substantially all of the operations of a health service provider or integrated care delivery system under a facilitation decision of the Agency under section 32 or a required integration order of the Minister under section 33;
 - c) the amalgamation of two or more persons or entities under a facilitation decision of the Agency under section 32 or under a required integration order made by the Minister under section 33.
2. Substitute the following as section 8 instead of the proposed amendments to section 8 and 9 (with corresponding changes to section 8(2)-8(4):

8 (1) This Act applies upon,

- a) the amalgamation of two or more health service providers; or
- b) the transfer of programs, services, functions from one or more health service provider(s) to another health service provider.

3. Include LHINs and Ontario Health in the definition of a health service provider in the *Connecting Care Act* and PSLRTA.

In making these recommendations, we note that the current proposal to amend PSLRTA wrongfully focuses on the transfer of assets, which more often than not does not occur in integrations. In most cases (except for amalgamations to which the Act already applies), the predecessor employer(s) often continue to exist following the integration and so unlike the private sector, integrations and transfers in the public sector rarely involve a transfer of all, or even substantially all, assets. The initial legislation, as passed in 1997, recognized this by referring to “substantial restructuring” as a precondition to the applicability of the Act.

ONA believes that our proposed amendments will facilitate the government’s desire for an integrated health system, while ensuring that the desired transformation occurs in an orderly, prospective fashion, with a view to what bargaining unit structure is appropriate for successor employers.

This is in keeping with the government's vision for an integrated public health-care system, which will put each patient at the centre of a connected system of care that offers high-quality, coordinated care, protecting patients from disruptive transitions throughout the system.¹

Front-line health-care workers are seeking answers to questions such as: who is their employer, who is their bargaining agent, and what are their terms and conditions of employment. PSLRTA provides them with a clear process for determining these questions, the LRA simply does not. Without clear answers, these valuable health-care professionals will seek alternative employment versus moving with their work/patients.

II. **Ensuring Pay Equity Rights for the Health-Care Workforce**

ONA is concerned about the pay equity implications of repealing s. 13.2 of the *Pay Equity Act* (PEA), particularly in light of the Act's remedial purpose of redressing systemic gender discrimination in compensation (s.4 of the PEA). Pay equity plans and the pay equity rights of workers in female job classes should be protected when health care is restructured, transferred, and reorganized.

Currently, ss. 13.1 and 13.2 establish the sale of business scheme under Ontario's PEA whereby if an employer who is bound by a pay equity plan sells a business, the plan transfers to the purchaser, and the successor employer is responsible for making the pay equity adjustments as they were to be made under the existing plan (s. 13.1).

Under s. 13.1(4.1), the sale of business scheme expressly applies to ss. 3 to 10 of *Public Sector Labour Relations Transition Act* (PSLRTA), including, at present, hospital amalgamations (s. 8) and health sector integrations (s. 9).

Pursuant to s. 13.2, the sale of business regime is made applicable to events that PSLRTA applies to in accordance with the *Local Health Systems Integration Act* (LHSIA). This deals with integrations to which PSLRTA is made to apply specifically under s. 32 of LHSIA, including the following: the transfer of all or part of a service of a person or entity under an integration decision; the transfer of all or substantially all of the operations of a health service provider under a Minister's order; or the amalgamation of two or more entities under an integration decision or a Minister's order.

The amendments to the Budget Bill will significantly alter this pay equity regime in that s. 13.2 of the PEA is repealed as is s. 32 of the LHSIA, ensuring that pay equity succession will no longer apply to integrations or Ministerial Orders under s. 32 of LHSIA that PSLRTA applied to prior to the proposed amendments in Bill 100. In doing so, this will limit the breadth of transactions to which the sale of business provisions apply, limiting pay equity rights under the PEA as a whole.

ONA is also concerned about the effects that the proposed amendments to ss. 8 and 9 of PSLRTA will have on the pay equity successorship regime and the pay equity rights of our members. Integrations that do not fall under the proposed s. 8 of Bill 100 as either amalgamations or asset transfers will likely not automatically be subject to the sale of business scheme in the PEA. Because PSLRTA only applies to situations in s. 8 of the amended *Connecting Care Act*, section 13.1(4.1) of the PEA will transfer pay equity plans only in the very clear circumstances that fall under s. 8 of PSLRTA. Other integrations of services and programs will lose their pay equity rights as part of the successorship scheme.

Workers in female job classes should not have to see their pay equity plans and pay equity entitlements disappear because of business transfers over which they had no say. Protecting against such actions was precisely the reason that the sale of business provisions were introduced into the *Pay Equity Act* in the first place.

In 1987, the original *Pay Equity Act* did not include a provision for the sale of a business. Bill 102² amended the Act to enable pay equity plans to be amended and maintained to address these situations and ensure pay equity gains were protected. On December 18, 1991, when the government first introduced the sale of business amendments to the *Pay Equity Act* through Bill 168, the then Minister of Labour stated that the government was fulfilling its strong commitment to correct the historic and systemic under-evaluation of women's work and addressed the sale of business amendment:

The other amendments I will introduce today are of an administrative nature, to refine measures in the original Act. The most important of these will protect pay equity plans when companies are sold, transferred or restructured. Simply put, the purchaser of a business also acquires any existing pay equity plan. This measure ensures that women will not see their pay equity rights vanish or diminish because of workplace transformations over which they have no control.³

The sale of business provisions were broadened over the years with the introduction of s. 13.2 of the PEA to recognize that pay equity rights should be maintained during times of transfers, restructuring, integration, and sales of business.

Workers in female job classes should not have their human rights entitlements limited in these circumstances, and the Act should be broad and robust enough to cover all circumstances that might apply. This approach best aligns with the Act's overall purpose of redressing systemic gender discrimination in compensation. ONA does not believe it was the government's intended result to limit the pay equity entitlements of workers in female job classes. We recommend that the government reinstate s. 13.2 of the PEA.

III. **Restructuring Public Health Units**

On April 11, the government released its first budget. The government announced its intention to restructure Ontario's public health units. This announcement came as a complete surprise to all public health units and their boards of health as they were not consulted. Neither was ONA nor were any of the other unions in public health units. Since that time, while the Provincial Chief Medical Officer of Health has written to boards of health and public health units with additional information, ONA has not received any communication from the government regarding this massive restructuring of vital health promotion and disease prevention programs.

This oversight is certainly not warranted when you consider that ONA represents almost 2,500 nurses and health-care professionals delivering services in 33 of 35 public health units. The government's surprise restructuring of public health units is not part of its plan in the *Connecting Care Act* for transformation of Ontario's health-care system. We have put forward proposals above to address the transition of nurses and health-care professionals under PSLRTA as part of the government's proposed changes in Bill 100, which amend the *Connecting Care Act*. There is no information or plan available, however, as to how the government intends to achieve its restructuring of public health units.

How does the government intend to manage the transition of the nurses, health-care professionals and other staff – moving from 35 health units to 10 regional public health entities governed by boards of health? Even the geographic boundaries of these new ten regional boards are unknown, except that it appears the Toronto board of health will remain in place.

The government's rationale for restructuring public health units is that "the current structure of Ontario's public health units does not allow for consistent service delivery, could be better coordinated with the broader system and better aligned with current government priorities."⁴

At the same time as the government says that consistent service delivery is a primary goal for the restructuring, the government is also shifting more of the share of funding to municipalities from the province, including programs that are currently funded 100 per cent provincially.

This shifting of more funding to municipalities seems to be counterproductive to the government's goal of consistent service delivery and better coordination with the health-care system. Funding programs 100 per cent provincially assures consistent service provision, better coordination and alignment with the government's priorities.

Instead of moving to fund public health solely at the provincial level, the government is reducing its share of funding, downloading funding responsibilities to municipalities, and making this funding change retroactive to April 1, even though municipal budgets have already been finalized. The government will implement the funding changes as below:

- 2019-20 (April 1, 2019): 60% (provincial) / 40% (municipal) for Toronto; and, 70% (provincial) / 30% (municipal) for all other public health units.
- 2020-21 (April 1, 2020): 60% (provincial) / 40% (municipal) for the Toronto Regional Public Health Entity; and, 70% (provincial) / 30% (municipal) for all other Regional Public Health Entities.
- End State 2021-22 (April 1, 2021): 50% (provincial) / 50% (municipal) for the Toronto Regional Public Health Entity; 60% (provincial) / 40% (municipal) for 6 larger Regional Public Health Entities with populations over 1 million; and, 70% (provincial) / 30% (municipal) for 3 smaller Regional Public Health Entities with populations under 1 million.

The government also asserts that this regional restructuring and downloading of funding will be more effective for staff recruitment and retention. It is difficult to fathom the government's reasoning in this instance. Nurses and health-care professionals will be forced to choose between moving to a regional location that is not yet determined or to move into another sector that is closer to home.

This regional strategy combined with a reduced provincial share of funding also relies on the municipal sector replacing the provincial funding, which is certainly not guaranteed as it means another service is reduced.

The government indicates it will achieve annual saving of \$200 million by 2020-2021 related to the cost-sharing change, as well as savings from the proposed creation of 10 Regional Public Health Entities. The government does not commit to reinvesting these savings into Ontario's public health-care system. Are these really savings if municipalities pick up this additional cost? Are these savings achieved by reducing the level of health promotion and disease prevention programs? Are these savings connected to fewer nurses and health-care professionals?

The government also says that it will consider exceptions or "waivers" for some aspects of the Ontario Public Health Standards on a case by case basis as a mitigation strategy. How does allowing some public health units to avoid meeting a public health standard for service advance the government's goal of consistent service delivery? This contradiction remains unanswered. This is also a likely result when municipalities are responsible for a greater share of funding and for decisions about which of the critical health protection and promotion programs and services are now possible.

Public health programs prevent hospital visits that reduce hallway health care. As an example, public health units are mandated by the government to collect all student immunization information under the *Immunization School Pupils Act*. Public health nurses follow up with students and families assessing and advising what vaccines are needed. This often involves help with complex histories, international students and foreign records, including answers to all questions related to vaccines, the health and safety of vaccines, vaccine schedules, and even vaccine hesitancy. Nurses have a vital job in educating the public about the safety of vaccines when there is so much false information telling them otherwise. If there is an outbreak in a school, it is their job to enter into the school and vaccinate the students who are not up to date. For some diseases, timing is everything. In the case of measles, for example, clients must receive the vaccine within 72 hours in order to increase the chance of protection once exposed.

This is where it all starts. This is where nurses can teach first to avoid a hospital visit in the first place. Nurses promote health and wellness to help prevent infections or prevent disease outside the walls of the hospital.

Public health nurses also provide services to vulnerable populations in many communities. How will regionalization assist with the care and services that these communities require?

As a result of the lack of impact analysis on such services, ONA disagrees with the government's broad restructuring proposals for public health and the reduced cost sharing. We recommend that the government reconsider the regionalization of public health until further consultation has been completed. We also recommend moving to 100 per cent provincial funding of public health, if the government's objective is to ensure consistent service delivery and better alignment with the broader health-care system.

IV. Retention and Recruitment of Nurses and Health-care Professionals

Ontario's 2019 budget reveals that the health sector expense is projected to increase from \$62.2 billion in 2018-19 to \$65.3 billion in 2021-22 – representing an annual average growth rate of 1.6 per cent over the period. This growth is unlikely to match the costs of inflationary pressures and will not be sufficient to cover the extra costs from population growth, aging and increased utilization.

One of the ways the government is planning to reduce costs is through initiatives designed to 'optimize' the productivity of the health-care workforce, projecting annual savings of \$250 million by 2021-2022. These initiatives include such areas as 'improved scheduling', attendance management, and reducing the number of overtime and premium rates paid. These are all areas subject to collective bargaining as provisions in collective agreements cover overtime and premium rates, scheduling and sick leave. These provisions are also designed to ensure the right nursing and health-care workforce to meet the needs of patients at the right time.

The government asserts that such changes, unknown at this time, will have no impact on patient care or on front-line staff. Combined with the reduced funding in 2019 for specific sectors, such as hospitals, compared to the amount received in 2018, patient care and front-line staffing is already being impacted.

In the context of current hospital funding, Grand River Hospital in Kitchener announced layoffs to deal with a projected deficit of \$7.4 million, including 25 full-time and 15 part-time registered nurses from in-patient surgery, adult mental health, renal and adult surgical units and geriatrics.

Similarly, last week Orillia Soldier's Memorial Hospital announced 14 layoffs – 9 full-time RNs in the operating room and emergency departments as well as 5 clinical performance specialists – to achieve the hospital's budget initiatives. These layoffs will most certainly impact patient care and removes more than 27,000 annual hours of RN care no longer available to patients in the Orillia community.

The Ontario Auditor General's 2016 Annual Report provided strong evidence for the need to improve RN staffing in our hospitals. The Auditor General found that RN patient assignment is heavier in Ontario than what international best practices recommend. As the Auditor's report notes, comprehensive research shows "that every extra patient beyond four that is added to a nurse's workload results in a 7 per cent increased risk of death."⁵

Ontario already has the lowest RN ratio per 100,000 population in the country over the last three years.⁶ A health human resources strategy for Ontario will also need to plan to replace the one-quarter of RNs currently at retirement age.⁷

Restructuring Ontario's health-care system will not succeed without a plan that provides for an orderly transition and strategy to retain nurses and health-care professionals. As a result, we recommend that the government reconsider a strategy of achieving cost reductions that impact patient care such as through scheduling, sick leave or other collective agreement provisions that will certainly have an impact on the retention of nurses and health-care professionals.

With this in mind, we also recommend that the government consider implementing a human resources strategy to retain nurses and health-care professionals, which may include additional one-time funding to avoid layoffs of front-line staff.

V. Conclusion

ONA welcomes the opportunity to provide our recommendations to the Standing Committee for Finance and Economic Affairs.

We appreciate the government's commitment to integrate the health system, ensuring a seamless system for patients.

ONA believes that our proposed amendments will facilitate the government's desire for an integrated health system, while ensuring that the desired transformation occurs in an orderly, prospective fashion, with a view to what bargaining unit structure is appropriate for successor employers.

For this reason, and to ensure an orderly transition, ONA is calling for the government to make amendments, as outlined above, to Schedule 53 in Bill 100 so that PSLRTA applies to all integrations. This includes ensuring the pay equity rights of the predominantly-female health workforce are upheld during the transformation.

Further, ONA recommends that the government reconsider the regionalization of public health until further consultation has been completed. We also recommend moving to 100 per cent provincial funding of public health, if the government's objective is to ensure consistent service delivery and better alignment with the broader health-care system.

Finally, we recommend that the government reconsider a strategy of achieving cost reductions that impact patient care such as through scheduling, sick leave or other collective agreement provisions that will certainly have an impact on the retention of nurses and health-care professionals and the care of their patients.

With the funding allocated in the 2019 Ontario budget, health-care employers have started to issue layoffs for nurses and other health-care professionals. Patient care will be impacted when thousands of hours of care are cut from our communities. This is not what the government promised. It is time to reconsider the government's transformation agenda and pause until further consultation can be undertaken.

Endnotes

¹ See Preamble in Bill 74, *Connecting Care Act*.

² Bill 102, *Pay Equity Amendment Act*, 1992

³ Hansard Debates, dated December 18, 1991, online: <https://www.ola.org/en/legislative-business/house-documents/parliament-35/session-1/1991-12-18/hansard>

⁴ 2019 Ontario Budget, p. 119.

⁵ 2016 Auditor, p. 470.

⁶ Canadian Institute for Health Information (CIHI). *Regulated Nurses, 2017*. ONA calculations based on CIHI data as CIHI no longer reports nurse to population ratios.

⁷ College of Nurses of Ontario. *Membership Statistics Report, 2017*.