CUPE Nova Scotia

Submission

Nova Scotia Health Services and Insurance Act

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Danny Cavanagh, President
CUPE Nova Scotia

271 Brownlow Avenue
Dartmouth, NS B3B 1W6
Cellular: (902) 957-0822
Office: (902) 455-4180
Fax: (902) 455-5915
Email: cupenovascotia@tru.eastlink.ca

CUPE Submission: *Nova Scotia Health Services and Insurance Act*

The Canadian Union of Public Employees applauds the Government of Nova Scotia on the development of the *Health Services and Insurance Act*. This proposed legislation demonstrates leadership in the promotion of a vision for public health care of which the residents of Nova Scotia can be proud. Below, CUPE urges this Government to take further measures to make Nova Scotia the Canadian leader in defending and improving Medicare.

Introduction

1. The Canadian Union of Public Employees is Canada's largest union, with more than 610,000 public sector members working in almost every community across the country. We have submitted our views and recommendations to various provincial and territorial governments. Recently we submitted to a committee of the Senate of Canada: Senate Standing Committee on Social Affairs, Science and Technology regarding the Examination of the progress in implementing the 2004 10-Year Plan to Strengthen Health Care: http://cupe.ca/updir/Submission_to_the_Senate_November_2011-0.pdf.

2. In Nova Scotia, we proudly represent over 18,000 working women and men. Our members work on the front lines of our communities. They are taxpayers and users of public services in the Province. They are proud of the role they play in delivering public services to the people of Nova Scotia in health care, community and social services, education, public utilities, housing, libraries, municipalities, post-secondary education, early childhood education and care, airlines and many more sectors of the economy.

3. CUPE members are on the front lines daily providing direct care to patients in hospitals, long-term care facilities and in home and community care settings. Our members are deeply concerned about health care as workers, and as members of families and communities who rely on our public health care system.

4. We estimate almost eight thousand (8,000) of our members are directly involved in the provision of health care to the people of Nova Scotia. CUPE members work in eight of the District Health Authorities in the Province providing professional health care, administrative and general support services to patients across the Province. CUPE members work in more than sixty (60) long-term care facilities providing hands on care, and general support services to vulnerable residents. More than three hundred (300) CUPE members also work as home support workers in the Province.

The Constitution Act, 1982

5. Members of CUPE in Nova Scotia are acutely aware of their residency in a "have not" Province. Things have changed from the heady days of 1867 when Nova Scotia was a partner in Confederation. The *British North America Act, 1867* was repatriated to Canada in 1982. With it came the *Constitution Act, 1982* with its commitment to equalization payments set out in Part III as follows:

> (1) Without altering the legislative authority of Parliament or of the provincial legislatures, or the rights of any of them with respect to the exercise of their legislative authority, Parliament and the legislatures, together with the government of Canada and the provincial governments, are committed to

(a) promoting equal opportunities for the well-being of Canadians;
(b) furthering economic development to reduce disparity in opportunities; and
(c) providing essential public services of reasonable quality to all Canadians.

(2) Parliament and the government of Canada are committed to the principle of making equalization payments to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation.

6. One of the public services the people of Nova Scotia hold most dearly is the provision of health care. We believe as residents of Canada we are entitled to this public service. Further, we believe we are entitled to comparable levels of public services, at reasonably comparable levels of taxation, regardless of where we live.

7. For this, among other reasons, CUPE members were deeply concerned by the unilateral actions of the Federal Government when Finance Minister Flaherty announced on December 19, 2011 significant changes in the funding for major transfer programs, including Canada Health Transfer, Canada Social Transfer and equalization to the provinces. These changes include moving to a per capita funding formula with the Canada Health Transfer regardless of the health needs of the residents of the various provinces.

8. As Premier Dexter said on January 13, 2012:

> *Health care remains the number one priority of Nova Scotians and Canadians. Ensuring all provinces can provide similar public health-care services, at similar costs, is paramount.*
>
> *The differences that exist among the regions are very real. The new federal funding formula for the Canada Health Transfer will place a greater burden on poorer provinces with weaker economies and aging populations.*
>
> *If the rationale behind moving the Canada Health Transfer to a per capita formula is to ensure fairness, then the same rationale should be applied to equalization, and the cap on equalization should be removed.*
>
> *Nova Scotia has the oldest and fastest aging population in Canada. In 2010, about 16 per cent of the population were 65 or older. This age group accounts for about half of provincial and territorial hospital expenditures. Nova Scotia has the highest prevalence of chronic disease in Canada and spends more on drugs per capita compared to most provinces.*
>
> *The province contributes about 80 per cent of health-care funding for Nova Scotians, with the federal portion sitting at about 20 per cent.*[1]

9. We have asked Premier Dexter to continue to stand firm in opposition to this new "health transfer plan" which means the loss of significant funding to each of the Provinces. We were pleased to see Premier Dexter, as Chair of the Council of the Federation meeting held in Halifax July 2012, denounce the cuts in the final press release of the meeting of July 27 which read, in part, as follows:

For health, the federal government's Canada Health Transfer (CHT) will be reduced by almost $36 billion, in total, over the 10-year period from 2014/15 to 2023/24 compared to the arrangements currently in place. This will bring the federal share of health care costs to less than 20 per cent, compared to about 50 per cent originally.

In the shorter term, the 5-year period from 2014/15 to 2018/19, provinces and territories will receive, in total, about $23 billion less than under the current arrangements, with the CHT accounting for about $7 billion of the reduction and Equalization accounting for about $16 billion. The Working Group did not estimate Equalization implications beyond 2018/19.[2]

10. We are pleased with the pressure our Province continues to place on the Federal Government. While recognizing provincial responsibility for the provision of health care, and the forward looking thinking in the proposed legislation, we know our residents cannot truly provide the health care they need and deserve without a commitment from the Federal Government to provide appropriate financial resources.

The Legislation

Preamble:

11. CUPE applauds the government on the strong statement of support for public Medicare articulated in the Preamble to the legislation. Missing, however, is a statement identifying the specific primary goals of Medicare to provide accessible, high quality, safe care, and to promote health equity.

Further, *public delivery* of health care -- essential for quality, access and accountability -- is equally important to sustainability and must be referenced in the Preamble.

Purpose (3)

12. The *Canada Health Act* sets out the overarching template for Medicare; it represents the broadest consensus of the value Canadians place on Medicare. Although the principles of the *Canada Health Act* (CHA) are referred to in the Preamble to this legislation, the Nova Scotia government should confirm its commitment to the *Canada Health Act* by articulating the five criteria and two conditions of the CHA in the body of the *Nova Scotia Health Services and Insurance Act*.

To qualify for federal funding under the *Canada Health Act*, each province and territory must (1) establish health insurance plans that meet the five criteria of the Act - public administration, accessibility, comprehensiveness, universality and portability, and (2) ban extra-billing and user charges for such insured services.[3]

Insured Health Services (4)

13. Federal cuts to the Interim Federal Health Program, which severely limit health care benefits for refugees, is a move widely condemned by health care providers, refugee advocates and the public.

14. Notwithstanding changes to the extent of the cuts initially announced by the federal government, many refugees continue to be denied access to health care. Provincial governments must pressure the federal government to reverse this decision in its entirety and cover refugee health costs until the federal program is fully restored.

15. Several organizations have forcefully and eloquently articulated the devastating effects of elimination health benefits:

- Canadian Doctors for Medicare: http://www.canadiandoctorsformedicare.ca/special-alert-cuts-to-refugee-health-care-hurt-us-all.html
- Healthy Debate: http://healthydebate.ca/opinions/ten-reasons-why-the-refugee-health-care-cuts-are-a-bad-idea
- Canadian Doctors for Refugee Care: http://www.doctorsforrefugeecare.ca/further-reading-survey.html
- Canadian Medical Association July 2012 statement:http://www.cma.ca/cma-mds-reinstatement-care-refugees
- The Wellesley Institute on the real cost of cutting refugee health benefits http://www.wellesleyinstitute.com/publication/the-real-cost-of-cutting-refugee-health-benefits/
- CUPE: http://cupe.ca/health-care/refugee-health-care-investment-charity http://cupe.ca/health-care/stand-refugee-health-cuts-day-action

Advisory Committees and Experts (9)

16. This section should require the identification of any conflict of interest on the part of any experts the Minister might consult, and establish mechanisms to control against any conflict of interest.

Agreement with Professional Organization (10)

Listing and De-listing Services

17. CUPE recommends that Medicare coverage decisions must be based on evidence, using a process that is transparent, accountable, and free from self-interest. It is critical that decision-making about what services are publicly funded be democratic and evidence-based.

18. In a study of the decision making process in Ontario, researchers identified lack of transparency in the principles that guide decision making ". . . thus allowing the possibility that self-interest or irrelevant considerations guide . . . decision making."[4]

19. It is CUPE's understanding that in Nova Scotia decisions regarding listing and de-listing of insured services are the matter of negotiation between the government and Doctors Nova Scotia. This process is not transparent nor does it serve the interest of public accountability. CUPE recommends that committees charged with making or recommending decisions about listing and de-listing services should include health care providers, government health officials, and advocates of patients and the public interest. Committee membership and decision-making must be governed by strict conflict of financial interest rules. There should be a mechanism for complaints and appeals. The activities and

reports of such committees should be public and readily accessible. (According to sections 2.2 and 2.4 of the *Canada Health Act* Annual Report 2010-2011, the Master Agreement Steering Group (MASG) is charged with approving or denying a proposal to insure a service. The MASG Committee is comprised of equal representation from Doctors Nova Scotia and the Department of Health and Wellness. Similarly, the de-insurance of insured physician services is accomplished through a negotiation process between the Doctors Nova Scotia and the Physician Services Branch of the Department of Health and Wellness.)[5]

20. With an expanded mandate, Ontario's Health Service Appeal and Review Board may provide a model for other provinces to consider. (More will be said on this point in comments below regarding the Insured Health Services Appeal Board.)

21. Regarding section 10.3, CUPE supports collaboration among health professions and urges the government to expand teamwork initiatives to all health care workers. CUPE members working either as direct care providers or in supportive roles are members of the health care team and have an important role to play in delivering quality care. Teamwork is increasingly recognized as an important element of a good practice environment and health care outcomes. Research shows that management and organizational practices of open communication, staff empowerment, and relationship-oriented leadership are associated with improved quality of care.[6]

22. CUPE endorses a shift away from the business model of independent physician practice to community health centres with salaried staff.[7] Community health centres (CHCs) provide integrated, comprehensive primary care through team-based inter-professional practice and community governance, operating not-for-profit. CUPE believes that salary payment, common to many CHCs, is another essential element.

23. The NS government is introducing alternatives to fee-for-service physician payment[8] and should go further, but how primary care is delivered and governed is perhaps more important than the payment method. Without changing delivery and governance towards the CHC model, the government risks paying more without getting better patient outcomes and service delivery.[9]

Audit of Providers (15)

24. CUPE views robust audit provisions as an essential feature of public accountability. The legislation must provide the government with sufficient authority and resources to thoroughly monitor and investigate any provider or group of providers that receives compensation under the legislation – and to impose penalties for non-compliance. The provision should cover all funded providers, including hospitals. Oversight must be independent of provider and commercial interests.

25. Nova Scotia can learn from the recent experience of British Columbia. The Medical Services Commission of BC conducted a multi-year investigation into extra-billing allegations at Specialist Referral Clinic (Vancouver) Inc. and Cambie Surgeries Corporation. The recently released report of the investigation found significant evidence of illegal billing practices:

• extra billing had occurred at both SRC and CSC on a frequent and recurring basis, contrary to the Act;
• the extra billing would often overlap with physician claims of MSP;
• charges to beneficiaries for benefits rendered at SRC or CSC by an opted out physician, exceeded the value of what the beneficiary could claim from MSP, where we could determine such MSP values; and,
• a high degree of business relationships existed between SRC, CSC and their physicians with respect to extra billings or charges exceeding what a beneficiary could claim from MSP. (p. 4)

26. The report further states that the auditing process was hampered by "...courteous but only limited cooperation from the President, management and staff of SRC and CSC...no access to the financial reports and ledgers of SRC and CSC . . . (and) the degree of completeness of patient records at SRC and CSC for audit purposes."[10]

27. An earlier audit of another private clinic was also restricted[11], and problems in the BC audit system continue today. While the BC legislation was somewhat improved six years ago, tougher fines have not been enacted,[12] and the MSC report describes limitations in their audit powers. The BC audits also show that we need audit governing and administration bodies to be independent of provider and commercial interests[13] and obligated to report publicly.[14]

28. Nova Scotia should study the BC experience and revise this legislation to ensure robust auditing rules, processes and oversight.

Healthcare Acquired Infections

29. Each year in Canada, over 220,000 hospital acquired infections result in 8,000-12,000 deaths. At least 30 percent of these infections are preventable. Rising infection rates are resulting in higher levels of morbidity, mortality, length of hospital stay, health care costs, and institutionalization. The direct costs of hospital acquired infections in Canada are estimated to be $1 billion annually. On top of that are costs borne by patients and volunteer caregivers as well as program costs for home and community care.[15]

An extensive investigation by USA Today into C-difficile rates in the US suggests that the bacteria is responsible for as many as 30,000 deaths per year. The report identifies reduced housekeeping staff as one of the causes:

Many hospitals and nursing homes lack programs to track and limit the use of antibiotics that allow C. diff to thrive. And studies show that patients' rooms often aren't cleaned sufficiently.

Hospitals have cut housekeeping budgets up to 25% in recent years, according to the Association for the Healthcare Environment, an arm of the American Hospital Association. And the group's surveys show that many hospitals spend as little as 18 minutes cleaning a patient's room. That's well below the 25-30 minutes the group's studies have identified as optimal.[16]

30. The Nova Scotia government passed legislation earlier this year requiring public reporting on patient safety indicators, starting with hand hygiene adherence, and promised a full surveillance system in the future.[17] CUPE congratulates the government on this important step and urges it to implement a complete patient safety program as a top priority. The provincial strategy to prevent and control health care associated infections and medical errors must include dedicated funding for microbiological cleaning standards, more in-house cleaning staff, lower hospital occupancy, and mandatory public reporting of incidents, deaths, and factors.[18] Ontario experience suggests public reporting on C. difficile has been effective.[19]

31. Further, CUPE recommends that the auditing provisions of the *NS Health Services and Insurance Act* be expanded to include regular audits of health care medical errors and healthcare associated infection risks/outbreaks. CUPE recommends a provincial audit system, overseen by the Auditor General, with publicly reported results, based on microbiological testing and the monitoring and assessment of a range of factors critical to hospital cleanliness and infection control, including but not limited to:

- intensity and frequency of cleaning;
- training and support for all cleaning and infection control staff;
- staff to patient ratios;
- adequacy of cleaning supplies and equipment;
- staff retention and job satisfaction;
- compliance with Workers' Compensation Board requirements and occupational health and safety practices, and;
- whether or not the service is contracted-out, and the ownership status of the contractor.

Staffing Standards

32. Staffing is the most important determinant of quality of care, and this legislation should include a staffing standard. Minimum nurse-to-patient staffing ratios have been legislated in California since 2004 and have contributed to better patient outcomes and better working conditions for nurses.[20] Staffing levels and regulated standards in residential long-term care are well-documented as leading determinants of quality.[21]

33. There is also significant and robust evidence that understaffing and contracting out of health care cleaning contribute to increased infection rates.[22] In recent testimony to the Senate Standing Committee on Social Affairs, Science and Technology, Dr. Michael Schull from the Institute for Clinical Evaluative Sciences acknowledged the role of cuts to cleaning staff:

> *The [funding] cuts in the 1990s certainly had something to do with the decision to cut support staff because they were not a priority and cuts had to be made. I think we now know it was a mistake and we are starting to reinvest in those basic services.*[23]

34. Legislated staffing standards should cover all health care workers, not only direct care staff.

Opting Out (21)

35. The proposed legislation allows providers to choose whether to operate within or outside of the public system (opting out). CUPE recommends that this legislation follow the example of Ontario and prohibit providers from opting out of the public insurance system.[24]

Direct Billing (22)

36. CUPE recommends that this legislation prohibit private insurance for publicly insured services as is the case in Alberta, British Columbia, Manitoba, Ontario and Prince Edward Island. Providers should be prohibited from charging any person/entity other than the provincial plan for an insured service. Under such conditions the provisions of section 25: No Reimbursement for Services Provided by an Opted-Out Provider would not be necessary.

37. Protecting Medicare as a single-payer system is critical. Private spending represents around 30 percent of total health care spending in Canada, one of the highest levels among OECD countries. Within that, private insurance is rising faster than other sources of finance.[25]

38. For all but a privileged few, private health insurance undermines access, choice, and cost-effectiveness. Jurisdictions with parallel public and private insurance have developed complex and costly regulatory frameworks, and still there are negative impacts on the public system.[26] Australia, after expanding private health insurance, now faces longer public wait lists, higher overall costs, and unequal access to care.[27] Both the Romanow and Kirby Commissions soundly rejected the private insurance model.[28]

39. Canada's international trade obligations will seriously constrain public policy flexibility if private investors are given a greater role in the health care system. Canada's obligations under the North American Free Trade Agreement and the General Agreement on Trade and Services make it exceedingly difficult for governments to abandon or even scale back privatization. If private health insurance is allowed to expand, the safeguards in this legislation could become much harder to defend.

40. Another issue is the formidable resources and influence of the private insurance industry. In the United States, we have seen this lobby frustrate even modest proposals to reform that country's hopelessly inefficient and inequitable health care system. Transnational insurance companies do not dominate the health care market in Canada as they do in the U.S. It would be prudent to keep it that way.

41. Finally, given the complexity of the regulatory regimes involved, the bans on private health insurance provides a backstop if other regulatory barriers to privatization fail.[29]

Extra Billing (23)

42. The co-mingling of insured and uninsured services should be prohibited by the legislation. There are fundamental issues of fairness and equity of access at issue when the co-mingling of insured

and uninsured services in the same facility is permitted. This issue was analysed in a paper published by the Romanow Commission, where it was described as endangering the sustainability of the public health care system. As the author put it: "The co-existence within the same institutions of insured and uninsured services, with the mechanisms described above, offers a structure that is not only conducive to but inherent in the two-tier system, in which one client's money and private insurance coverage give him or her priority over another whose coverage is limited to public insurance."[30]

43. Patients in Nova Scotia are at times subjected to fees for "incidental" expenses for services such as telephone consultations, prescription renewals or the preparation of documents relating to employment or insurance. Some physicians charge for these services by way of annual block fees, which represent a significant financial barrier to accessing the publicly funded services offered by that provider. Block fees are largely unregulated with the exception of Ontario.[31]

This Nova Scotia legislation should regulate block fees by:

- establishing a cap on block fees;
- requiring that unutilized fees be returned to the patient;
- requiring that patients have the option of paying for services only if and when they are required; and
- prohibiting health care providers from withholding service to patients who decline to pay a block fee.

Queue Jumping (24)

44. CUPE recommends the stronger wording of the Ontario legislation. Section 17 of the *Commitment to the Future of Medicare Act* provides:

> *17. (1) No person or entity shall,*
>
> *(a) pay or confer a benefit upon any person or entity in exchange for conferring upon an insured person a preference in obtaining access to an insured service;*
>
> *(b) charge or accept payment or a benefit for conferring upon an insured person a preference in obtaining access to an insured service;*
>
> *(c) offer to do anything referred to in clause (a) or (b) . . .*
>
> *(3) A prescribed person who, in the course of his or her professional or official duties, has reason to believe that anything prohibited by subsection (1) has occurred shall promptly report the matter to the General Manager.*

Insured Health Services Appeal Board (26)

45. The establishment of a Board to hear appeals on matters related to coverage is a welcome move. Nova Scotians should not be required to seek redress in the courts in appeals decisions related to

coverage. CUPE is concerned however, that the proposed composition (minimum of five representatives, three of whom would be providers, one lay person and one chair) gives providers veto power. Further, with an expanded mandate and more balanced public representation, the Board could fulfil the need for a transparent process governing listing and de-listing decisions, in addition to the mandate to adjudicate appeals.

46. CUPE recommends consideration of the composition of the Ontario Health Service Appeal and Review Board (the "Ontario Board"), which is composed of at least 12 members, all cabinet level appointees. To ensure balance and independence, no more than three members can be physicians, and there can be no members from the public service.[32]

47. Mechanisms should also be implemented to require public reporting of Board decisions.

Kickbacks/Self-Referrals

48. *The Health Services and Insurance Act* should prohibit a physician from (a) paying or offering to pay kickbacks to or from any person, and (b) referring patients to clinics he or she owns or operates.

The Nova Scotia College of Physicians and Surgeons has established a non-binding guideline which identifies as a conflict of interest:

> *Accepting kickbacks, referral fees, or engaging in fee-splitting. This includes taking or receiving remuneration in the form of a commission, discount, or refund from a person who fills a prescription issued by the physician or who makes or supplies appliances.*[33]

49. A non-binding guideline from the providers' own regulatory body is not sufficient to avoid conflicts of interest. The best example of regulation of physician self-referral is in the bylaws of the Saskatchewan College of Physicians and Surgeons, section 9.1.[34]

50. Physicians are the gatekeepers of the health care system. Given the increasing presence of private clinics in the Canadian health care system, stronger regulation is warranted. The US experience shows us that physician kickbacks and self-referrals lead to unnecessary referrals for some patients, longer waits for others and increased costs overall.[35]

Health policy experts have identified serious gaps in regulation in this area and recommend more stringent regulation and a shift in the lead enforcement institution from licensing authorities to provincial ministries of health.[36]

Private clinics

51. CUPE strongly recommends that the government and health employers reverse any contracting-out to private clinics.

52. The number of private for-profit clinics and the scope of services they sell have been steadily increasing in Canada.[37]

53. Nova Scotia has not been immune to the development of a private for-profit health care sector. Notwithstanding the report from Nova Scotia in the *Canada Health Act Annual Report 2010-2011* that there are no private clinics in Nova Scotia providing insured services, there are private surgical and diagnostic clinics.

54. A 2008 investigation led my Natalie Mehra identified one surgical clinic (Scotia Surgery), one MRI clinic and three laser eye surgery clinic.[38] The report estimated that 10 per cent of Nova Scotia's ophthalmologists were working in the private sector. The report identified staffing at the Scotia Surgery Clinic as follows:

> *Medical staff: five oral surgeons, three orthopaedic surgeons, and five plastic surgeons were associated with the centre as of December 2007; however, surgeons from anywhere in the province can book surgeries at the clinic. After the clinic opened in 2005, at least two of their surgeons were hired away from QEII Health Sciences Centre as well as anaesthesiologists.*

55. The operation of private clinics has clearly resulted in a transfer of human health resources from the public to the private sector. Already in 2005, CUPE called attention to the private sector poaching of health care providers from the public system.[39]

56. In March 2008, the Nova Scotia health minister Chris d'Entremont announced that the province has signed a one year, $1-million contract allowing surgeons with the Capital District Health Authority to use private operating-room facilities owned by Scotia Surgery Inc. in Dartmouth for an estimated 500 surgeries.[40] As opposition leader at the time, Darrel Dexter criticized the government, saying "The result is that they're taking money out of the public system and putting it into a private facility."[41]

57. The NS government should force an end to the contracting out of hospital services, including the contract with Scotia Surgery.

Public Private Partnerships

58. CUPE recommends that all public infrastructure, including health care infrastructure, be financed, owned, managed and operated publicly.

59. We continue to call on this Government to soundly reject “P3” projects. This is particularly important in such fundamental public policy areas as health care. CUPE has raised concerns repeatedly with the Minister of Health, Maureen MacDonald. We are concerned about the policy of this Government to continue to provide public money to for-profit operators of long-term care facilities. (letters dated January 29, 2010 and April 1, 2010)

60. We refer you to an October 2009 CUPE study *Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care* which presents strong evidence that for-profit ownership leads to lower staffing levels, poorer quality of care, and higher costs for residents.[42]

61. Auditors General reports in Quebec and Ontario have recently found that in terms of methodology P3 promoters compare P3s only with the most costly form of traditional procurement. Ontario's Auditor General identified the design/build process as a form of traditional procurement that might have offered better value for a hospital project:

> *With a contract of this size, best practices call for a business case to assess the costs and benefits of a range of alternative procurement models, to allow the option that offers the best value for money to be chosen. One approach is a value-for-money assessment that captures the total estimated cost of the traditional public-sector delivery of an infrastructure project through a design-build approach and compares that to the estimated delivery cost of the same project using a P3 model.*[43]

The Quebec Auditor General reached the same conclusion saying:

> *PPP Québec chose to compare the PPP method with the conventional method (public sector) without having evaluated other possible methods such as the management and turnkey methods, which could have improved the efficiency of this sector.*[44]

62. The Manitoba government is currently considering legislation, *The Public-Private Partnerships Transparency and Accountability Act*. With improvements in transparency and accountability, this legislation could serve as a model for the regulation of P3s in Nova Scotia.[45]

Whistleblower Protection

63. The NS *Health Services and Insurance Act* should include robust whistleblower protection. Patients are among the most vulnerable in society because of their deteriorated health status and, often, their lack of family to support and monitor their care. Workers should be encouraged to report on incidents or conditions that negatively affect care.

Whistleblower protection in this legislation must prevent employers from disciplining for any reason someone who has engaged in whistleblowing, unless the employer has first proven to a labour tribunal that it was not in any way motivated by retaliation and that there is just cause for the discipline and the penalty. The law should provide a mechanism for immediate reinstatement should the employer impose discipline without first proving its case. Without such protections, workers are held back from advocating for safe care.

The need for whistleblower protection for health care workers was identified by the Commission to Investigate the Introduction and Spread of SARS in Ontario:

> *Ontario health care workers need whistleblower protection to ensure that public health risks are reported promptly to public health authorities without fear of consequences. Without this protection, fear of workplace consequences might discourage the timely*

disclosure of public health risk. Front line health care workers made enormous sacrifices during SARS. They are entitled to be protected when they raise an alarm to protect public health.[46]

In conclusion, CUPE reiterates our deep appreciation of the commitment to Medicare shown by this government. We look forward to the opportunity to consult on the development of the regulations to this important piece of legislation.

Yours truly,

Danny Cavanagh
President, CUPE Nova Scotia

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c: Paul Moist, National President, CUPE
Jacquie Bramwell, Atlantic Regional Director, CUPE

Endnotes

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On the need for changes to equalization, see Canadian Union of Public Employees. July 2012. *Submission to the Standing Committee on Finance for its 2013/14 Pre Budget Consultation.* http://cupe.ca/updir/201314_Pre_Budget_Consultation.pdf

[2] The Council of the Federation. July 27, 2012. « Fiscal Arrangements. » http://novascotia.ca/cof/docs/Fiscal-Arrangements-July-27-FINAL.pdf

[3] *Canada Health Act*. http://laws-lois.justice.gc.ca/eng/acts/C-6/FullText.html

[4] Flood, C.M., Tuohy, and Stabile (2006). "What is In and Out of Medicare? Who Decides?" In Colleen Flood (Ed.) *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press.

[5] http://www.hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2011-cha-lcs-ar-ra/index-eng.php#ns-ne

[6] Canadian Union of Public Employees. May 2012. *Submission on Nursing Team Innovation to the Premiers' Health Care Innovation Working Group* http://cupe.ca/ckfinder/userfiles/files/Innovation%20report(1).pdf

[7] Canadian Association of Community Health Centres. *About Community Health Centres.* Accessed August 16, 2012 at http://www.cachc.ca/?page_id=18

[8] "Fee-for-service is still the most prevalent method of payment for physician services. However, there has been significant growth in the number of alternative payment arrangements in place in Nova Scotia. In the 1997-1998 fiscal year, about 9 percent of doctors were paid solely through alternative funding. In 2010-2011, approximately 26 percent of physicians were remunerated exclusively through alternative funding. Approximately 67 percent of physicians in Nova Scotia receive all or a portion of their remuneration through alternative funding mechanisms." *Canada Health Act Annual Report 2010-2011* http://www.hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2011-cha-lcs-ar-ra/index-eng.php#ns-ne

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