Strengthening Public Health Care

Submission to the Advisory Panel reviewing Regional Health Authorities in Saskatchewan

Canadian Union of Public Employees

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TABLE OF CONTENTS

Executive Summary

The Canadian Union of Public Employees (CUPE) has prepared this submission to the Advisory Panel reviewing the Regional Health Authority (RHA) structures in Saskatchewan.

Our submission focusses on the importance of maintaining and strengthening our publicly-funded, publicly-administered and publicly-delivered health care system in the province. CUPE believes that the Advisory Panel must hold firm to the principles of Medicare as it considers options for restructuring our health care system.

Saskatchewan and other provinces have gone through various forms of regionalization in the last 25 years. Experience shows us that health care restructuring is a major undertaking that will disrupt the established systems and relationships for providing health care. The disruptions to health regional structures will create chaos and stress for residents, health care workers, administrators and health care organizations for many years. Therefore any change to RHAs requires comprehensive, evidence-based study and evaluation, meaningful consultation with all stakeholders and careful planning.

Consultation process is flawed

CUPE believes that the consultation process for this review is woefully inadequate because:

- The deadline to prepare submissions is too short and does not provide enough time to prepare thoughtful and thorough submissions;
- There is not enough time for the panel to meet with all stakeholders and individuals who will be impacted by restructuring;
- The government has not provided any rationale or background information to explain why RHAs need to be restructured;
- There is a lack of trust with this government based on negative experiences in past consultations.

Past experience with regionalization

The Advisory Panel should heed mistakes from past reorganizations of health regions. Past reorganizations of health care had difficult transitions, even though there were extensive consultations with the public and communities. Rushing through this review could lead to more challenges and confusion than in the past. Small communities should not lose their voice in a larger structure.

Health reorganization should be evidence-based

The decision to reduce health regions must be weighed against the costs associated with disrupting health services and the possibility that patients and residents will suffer as new health regions restructure. Evidence-based decisions must be used to inform change.

The government's motivation for restructuring health regions appears focused on cutting costs. Provincial funding to RHAs, however, has been flat or negative for the last four years. The government has reduced funding to RHAs at the same time it has directed them to reduce wait times, reduce sick time and overtime, and create new positions for its Lean initiative.

It is unlikely that reducing the number of RHAs will produce significant savings. The total RHA board and senior management remuneration in 2015-16 was $20.5 million, a fraction of the total provincial health budget of $3.8 billion. The senior managers of larger RHAs will have heavier responsibilities and will likely be given higher salaries to compensate, eroding any cost savings of fewer regions.

Saskatoon and Regina Qu'Appelle health regions announced massive layoffs in September, in some cases of critical frontline positions such as two audiologists in Saskatoon. The Advisory Panel must be careful that their recommendations do not add to the reduction of front line staff. The Panel must include Kaizen Promotion positions and 3sHealth in its review to reduce administration.

Prioritize the social determinants of health

One positive outcome of health regionalization was the focus on a population health approach. The Advisory Panel must ensure that reducing the number of health regions does not weaken the health system's ability to address the social determinants of health.

Preserve our publicly-funded, publicly-administered and publicly-delivered system of health care.

CUPE categorically opposes the privatization of health care services. The Advisory Panel's survey questions suggest a hidden agenda to promote more private delivery or private sector oversight to our provincial health care system.

3sHealth's mandate of developing provincial shared services in health care has already begun the process of privatization. The first business case for shared services that 3sHealth developed resulted in the privatization of hospital laundry services. University of Winnipeg economists

analyzed the business case for laundry privatization and found that privatization will cost the provincial economy $42 million over ten years. CUPE health care workers report that privatized hospital linens are poor quality and often in short supply.

Health regionalization's objectives included greater coordination and integration of health services. With privatization, services are fragmented, more costly and there is less transparency and accountability. The long struggle to obtain a copy of the contract for privatized hospital laundry through Freedom of Information legislation illustrates the loss of accountability with privatization.

Recognize the contributions of health care workers and their Charter rights

Our public health system works best when staff work in collaborative teams, are engaged and valued. It is absolutely critical that we value these complex relationships and maintain healthy labour relations in our health care system.

Section 2(d) of the *Canadian Charter of Rights and Freedoms* guarantees freedom of association, which has been held in a number of cases to protect the right of workers to join or form a union, without interference from the Government in the selection or formation of the union.

The Dorsey bargaining units have allowed health sector employers and unions to engage in a meaningful, productive collective bargaining process over successive contracts. Our members are very concerned that further reorganization of bargaining units may remove them from their communities of interest, and limit their access to a meaningful collective bargaining process.

We are gravely concerned that any further reorganization of bargaining units in health care, without adequate consultation, will trigger expensive, multi-party litigation similar to the essential services litigation started in 2008 against the Government of Saskatchewan, which continues to be litigated eight years later, despite the Supreme Court of Canada's 2015 decision upholding the unions' claims in *Saskatchewan Federation of Labour v. Saskatchewan,* [2015] 1 SCR 245.

Introduction

The Canadian Union of Public Employees is the largest union in Saskatchewan, representing approximately 30,000 public sector workers, of which 14,000 work in health care. Our union represents health care providers in five health regions: Regina Qu'Appelle, Sun Country, Sunrise, Prince Albert Parkland and Prairie North. We also represent health care staff in four community clinics and in two personal care homes.

Health care restructuring is a major undertaking that will disrupt the established systems and relationships for providing health care in the province. Since the early 1990s, this province has appointed three Commissioners to conduct a review of health care (Murray 1988, Fyke 2000, Dagnone 2008), restructured health boundaries twice, and reorganized union bargaining units under the Dorsey Commission in 1997.

Our union knows from these past reorganizations that disruptions to the current configuration of health regions will create stress and chaos in the system for years, impacting all residents who use health services and health care workers who provide services. This is an undertaking that should not be done hastily nor without careful consideration and comprehensive public consultations.

In our submission we will highlight the importance of comprehensive public consultations before health regions are restructured, outline the principles we believe should form the basis of any reorganization, and raise concerns about the current push by 3sHealth and the provincial government for greater centralization and privatization of health support services.

The Consultation Process is Flawed

The Minister of Health announced the appointment of this Advisory Panel to review Regional Health Authorities (RHA) structures on August 18. The Minister also set September 26 as the deadline for written submissions, providing a mere 25 working days for anyone to prepare submissions.

CUPE asserts that the consultation process is woefully inadequate. We find the following faults with it:

- The timeline to prepare submissions is too short: only 25 working days. This is not enough time for any organization or individual to prepare a thoughtful and thorough submission. It does not allow organizations to consult with their own membership on the issues.

- The Advisory Panel's timeframe and schedule to meet with stakeholders and the public is insufficient and precludes any meaningful consultation. The Advisory Panel summoned all health care unions, representing over 39,000 health care workers, to a two-hour meeting with one week notice. Although we appreciated the willingness of the panelists to answer our questions, we believe that each union deserves dedicated time with the panel to present and discuss its submissions. It is extremely unlikely that the panel will have had the time to meet with all stakeholders and individuals who will be impacted by any decisions made to restructure our health care system.

- The government has failed to present a rationale or any background documentation to elucidate why RHAs need to be restructured at this time. A meaningful review process should, at the very least, identify the problem to be addressed. It would also have been helpful to have documentation that outlines the current RHA and provincial health structures and roles. The Minister of Health has not provided any background information or rationale for this review. He mandated the Advisory Panel to reduce the number of RHAs and to consider ways to consolidate or deliver health services on a provincial basis, but has not identified the problem. This process should not be focused on looking for a problem to fit the Minister's solution of fewer RHAs.

- There is a significant lack of trust with this government because of our negative experiences in past consultations on labour legislation reform, essential services legislation and shared services in health care. Although the Advisory Panel told health care union representatives that the purpose of this review of health regions was not motivated by a desire to cut costs, the only public statements from this government indicate that this is, indeed, about cutting costs.

In late April, well before the provincial budget was released, Premier Wall told the *Leader Post* that he would "fulfil his election promise of cutting administrative spending at regional health authorities and [direct] $7.5 million in savings toward front-line care at long-term care facilities. He indicated the budget could set the stage for a year of consultations to "achieve the right balance of administration in the public sector, front-line service delivery, and savings."[1]

We assert that the government has an obligation to hold comprehensive and meaningful consultations before embarking on any restructuring of health regions. The Advisory Panel should recommend more public consultation.

[1] D.C. Fraser, "Saskatchewan deficit to be higher than expected; big changes possible for health and education systems," *Regina Leader Post*, April 22, 2016.

The Experience of Regionalization in Saskatchewan

The idea of creating regional authorities to deliver health care services in Canada first emerged in recommendations of task forces and commissions in the 1980s.[2] In Saskatchewan the Murray Commission, appointed in 1988 by the Conservative government of Grant Devine, issued a report after two years of study recommending the consolidation of over 435 hospital, long term care and health agency boards into 15 health regions.[3]

The reasons Murray argued for a regional health structure included: to bring health services under local, democratic control; to rationalize and coordinate health services within a geographic region to meet health needs of the population; and to shift the focus of health services from acute care to long-term and community care, given the aging population.[4]

The Devine government did not implement Murray's recommendations but shortly after Roy Romanow's NDP government came to power, health reform became a priority because of the financial crisis the new government inherited. In 1992 Health Minister Louise Simard held public consultations on appropriate boundaries, which resulted in the creation of 32 health districts (twice the number recommended by Murray). Although the new health districts were expected to rationalize health services, Marchildon points out that the government made the decision to close 52 rural hospitals and convert most into long-term care or wellness centres before the new districts were operational.[5] New health districts were formally established in 1993.

Eliminating over 400 boards of hospitals, long term care facilities, ambulance, home care and other health agencies and consolidating services under new health districts had a major impact on union representation and inter-mingling of bargaining units. The new employers inherited multiple collective agreements and several unions with overlapping representation of classifications. The government appointed James Dorsey to recommend appropriate bargaining units.

In 1997 the Health Labour Relations Reorganization Commission, headed by James Dorsey, made recommendations to replace 538 bargaining units with 45. He also identified which unions would represent employees in those bargaining units with each health district employer. Dorsey wrote that "the structures for orderly collective bargaining established by the regulations will enable both

[2] See: Boychuk, Terry, "After Medicare: Regionalization and Canadian Health Reform," CBMH/BCHM, volume 26:2, 2009; Lewis, Steven and Kouri, Denise, "Regionalization: Making Sense of the Canadian Experience," HealthcarePapers, Volume 5, no. 1, 2004.
[3] Gregory Marchildon, "Regionalization and Health Services Restructuring in Saskatchewan," Draft conference paper presented to Queen's University November 17, 2005.
[4] Marchildon (2005) and Boychuk (2009)
[5] Marchildon, p.10.

service delivery integration and, over time, the development of consistency in terms and conditions of employment."

The NDP government decided to review health structures once again in June 2000 when it appointed Kenneth Fyke to the Commission on Medicare. The government mandated Fyke to develop "an action plan on the long-term stewardship of our publicly-funded, publicly-administered Medicare system." The review took place over 10 months and Fyke presented his final report to the government in April 2001. The Commission's review was comprehensive: it received submissions from 155 individuals and organizations and completed questionnaires from 35,000 people.

Fyke made comprehensive recommendations on how to improve public health care and recommended the creation of 9 or 11 health districts by amalgamating the existing districts rather than entirely redrawing boundaries "to keep the legislative and legal complexities of transition to a minimum."[6] The government did not adopt Fyke's health boundary options but instead decided to consolidate the 32 health districts into 12 Regional Health Authorities (RHAs). The northern health authority of Athabasca, which operates under partnership with the federal government and Dene nation, remained intact.

Reorganizing health regions once again created overlapping union jurisdictions within the health providers bargaining unit of the new health employers. This created disruption in health labour relations and led to divisive representation votes among the provider health care unions. The new regional structure did not correspond to either of the recommended boundaries of Fyke, who promoted the amalgamation of existing districts to create regions of similar geographic and population size (except for Regina and Saskatoon). The government's decision to redraw boundaries thus created more hurdles to the coordination and delivery of health services.

The Advisory Panel should heed the mistakes from past reorganizations of health regions and ensure smoother transition for future restructuring. Some of the key lessons we learned from past restructuring include:

- Even with extensive public and community consultations, health regionalization has been a difficult process. This Advisory Panel has only two months to develop recommendations and has limited ability to consult the public. The Advisory Panel should request more time and suggest that the government ensure broad public consultation before it decides on any health region structure.
- Each round of regionalization in Saskatchewan (and in other provinces) professes to create more effective and efficient ways of delivering health care and to shift emphasis from acute care to community care and health promotion. But the objectives of regionalization have

[6] Commission on Medicare, p. 58.

also been about cost savings. For four years in the mid-1990s after health districts were first formed, health care expenditures in Saskatchewan declined at 0.6% per year.[7]

- The last regionalization process in 2002 did not change the Dorsey established bargaining units of health care classifications. The representation votes that occurred among unions were the result of overlapping union jurisdiction within the new health employers. To ensure labour stability, the Advisory Panel should not recommend any changes to established health bargaining units.
- Reorganizing health regions into specific geographic areas allowed health regions to develop population health approaches to the delivery of health care services. Any new regional structure has to ensure that the regions are not so geographically large that smaller communities lose their voice in the structure. Rural communities have lost services in past regionalization and their access to quality public health services must be protected.
- The experience across the country shows that frequent changes to health region structures, and poorly-executed management, caused major disruptions to the system and took precious time away from patient-focussed improvements in health care delivery.[8]

Principles for Health Care Structuring

The Minister of Health has mandated the Advisory Panel to reduce the number of RHAs and to consider ways to deliver services provincially. The government has not provided any principles to guide the Advisory Panel in its consideration of health restructuring, unlike what was provided to previous health reviews.

CUPE emphasizes that the Advisory Panel must set out a list of principles to guide health care restructuring. The health care unions in the province developed the following principles that we believe should guide this process:

1. Health care unions, their respective employers, and the Government of Saskatchewan share a commitment to work together in support of Better Health, Better Care, Better Value, and Better Teams for the people of the province.

2. Health care restructuring is a matter of the utmost importance and should be the subject of sustained and evidence-based study and evaluation, meaningful consultation with all stakeholders, and careful planning.

[7] Fyke, Kenneth, Commission on Medicare, p.71

[8] Canadian Foundation for Health Improvement, Toward the Triple Aim of Better Health, Better Care and Better Value for Canadians: Transforming Regions into High Performing Health Systems, March 2016.

3. Health care restructuring must be guided by a commitment to high quality and safe health care delivery. The contribution of all members of the health care sector is essential to ensure patient safety and positive patient outcomes.

4. Health care restructuring must put the values that define this vital public service at the forefront of change: health care in Saskatchewan must be accessible, universal, comprehensive, publicly-administered, publicly-funded, and delivered on a not-for-profit basis.

5. Health care restructuring must ensure a governance structure that is accountable and responsive to diverse community perspectives and needs, including the particular needs of rural, urban, northern, and indigenous residents of the province.

6. Health care restructuring must respect the constitutional and union rights of health care workers and ensure the continuation of a stable and predictable labour relations environment in terms of union jurisdiction and representation.

Any decisions on health reorganization must be based on evidence

Health care restructuring should only be done if there is solid evidence that fewer health regions will contribute to better health outcomes and improved quality of care for residents of the province. The decision to reduce health regions must be weighed against the costs associated with disrupted health services and the possibility that patients and residents will suffer as new health regions adjust to serving a larger population. The current health regions have taken over a decade to develop the complex coordination of health services to the population they serve.

As Dr. Barbara Clow wrote in her report on health care restructuring in Nova Scotia:

> "…restructuring health care is never a neutral undertaking. It always has a price tag – both literally and figuratively – for those managing and delivering care as well as for those needing and receiving it. Organizational changes, leadership changes, workforce changes and community changes take time, money, and energy away from the real work of planning and delivering excellent health care."[9]

The government has not provided any rationale for reducing the number of health regions nor has it identified any problems with the existing structure.

[9] Barbara Clow, PhD, Healthcare Restructuring in Nova Scotia, September 3, 2013.

We are concerned that the government's key motivation for restructuring health regions is to reduce costs, which may not even be realized by restructuring. The government's motivation for creating this review are murky at best, especially when, for the last four years, the government has underfunded health regions while requiring them to comply with provincial directives (Lean, reduce wait times, reduce sick time and overtime). The change in provincial funding to RHAs has been flat or negative in the last four years (see Table 1). These funding reductions have happened at a time when RHAs need to address the needs of an aging and growing population, including unique health needs of many new Canadians.

The table below shows provincial funding to RHAs adjusted for inflation and population growth.

Table 1 - Provincial funding to RHAs 2010-11 to 2015-16, deflated per capita *(in 2002 dollars)*

	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Total Prov Health Budget*	$ 2,375.27	$ 2,476.47	$ 2,515.94	$ 2,539.45	$ 2,499.40	$ 2,515.74
Prov funding to RHAs*	$ 2,051.35	$ 2,160.01	$ 2,158.87	$ 2,186.41	$ 2,157.69	$ 2,174.65
% change Health budget-year		4.26	1.59	0.93	-1.58	0.65
% change RHA funding/year		5.30	-0.05	1.28	-1.31	0.79

**in thousands of dollars*
CUPE Research

Is the government focusing on reducing the number of health regions because it knows that it has already squeezed all it can from the RHAs' budgets? Both Saskatoon and Regina Qu'Appelle health regions recently announced they are reducing full time equivalent positions by 70 and 120 respectively. Global TV news reported that RQHR "was directed [by government] to reallocate $1.47 million from administrative spending to front-line services in long-term care."[10] The Advisory Panel must be careful that its proposals do not exacerbate the job loss of frontline workers in RHAs.

Will reducing RHAs produce savings?

A review of the 12 health authorities' board and senior management expenditures (see Table 2) reveals total spending of $20.5 million in the 2015-16 fiscal year. Considering that the total Ministry of Health budget for the province is over $3.8 billion in 2016-17, reducing the number of RHAs will produce relatively minor savings to overall provincial health spending.

[10] Alexa Huffman, "Regina Qu'Appelle Health Region to issue layoff notices," Global News, September 16, 2016.

Table 2 - Saskatchewan Regional Health Authorities Board and Senior Management Expenses, 2015-16

RHA	Board expenses	CEO compensation	Senior Management salaries	Population Served
Regina Qu'Appelle	$80,413	$434,568	$3,053,135	289,362
Saskatoon	$36,323	$495,263	$3,017,883	342,362
PA/Parkland	$111,538	$292,144	$2,158,274	81,641
Prairie North	$116,106	$357,005	$1,231,058	82,499
Sunrise	$63,920	$319,223	$1,255,724	58,923
Sun Country	$53,519	$300,500	$990,129	59,690
Cypress	$54,058	$298,421	$1,858,252	44,897
File Hills	$59,451	$333,385	$2,255,613	54,000
Heartland	$53,359	$301,077	$1,448,882	44,256
Kelsey Trail	$73,208	$254,822	$939,637	42,143
Keewatin Yatthe	$78,659	$231,712	$689,062	12,193
Mamawetan Churchill River	$81,785	$188,791	$711,541	24,442
sub total	**$862,339**	**$3,806,911**	**$19,609,190**	**1,136,408**
Total Board and Senior Management			**$20,471,529**	

NOTE: Senior Management salaries column includes CEO compensation. CEO salary shown separately in order to show variation in pay.

sources: *2015-16 Annual Reports for each Regional Health Authority*

2015 covered population, Saskatchewan Health reports 2,573 people in the Athabasca Health Authority

Consolidating health regions could result in increases to individual CEO and senior management salaries to compensate for their expanded responsibilities. This happened after the last regionalization process in Saskatchewan and in other provinces like Alberta. We could not access online annual reports of Regina Qu'Appelle Health Authority (RQHR) prior to 2010, but in the last six years the salary of the CEO increased by 42.1% (from $305,921 to $434,568 in 2016). We expect that the salaries of other regions' CEOs increased by similar percentages.

Rather than reduce overall administrative salaries, consolidating health regions will likely spur the creation of new positions to coordinate services. Our members recall that, after the last restructuring of health regions, many new coordinator jobs were created to manage delivering services to more communities. After Alberta collapsed its RHAs into a single agency, it had to create a number of management and administration positions "in order to make the system function efficiently."

A recent report on regionalization by the Canadian Foundation for Healthcare Improvement noted that there is a lack of evidence that savings occurred after regionalization and that there are significant costs involved when restructuring the system.[11] Alberta academic Cam Donaldson points out that the creation of Alberta Health Services did not generate any savings. He wrote,

[11] Canadian Foundation for Healthcare Improvement, P.18.

"…we seem to have gone from a situation where the collective deficit of the former health regions (in May 2008) was $97 million to one where the deficit for the whole system was reported as $1.1 billion in June 2009."[12]

Alberta also had unforeseen costs incurred from moving patients greater distances, which decreased the expected economic benefits of centralization, and increased the out-of-pocket expenses of patients and families.[13]

The Advisory Panel's review also needs to analyze the changes to the health workforce in the last ten years, to assess the balance between administrative positions and front line workers. The government made its election promise to reduce administration costs after it had mandated Kaizen Promotion offices with abundant staff in each health region and after it had supported the creation of 3sHealth, whose top four managers together made over $1.1 million last year.[14] Accordingly, Kaizen positions and 3sHealth must be included in this review.

Health care reorganization must ensure that the delivery and quality of health care services is improved, not compromised.

Prioritize the social determinants of health

One positive outcome of health regionalization was the greater focus on a population health approach. For example, if a health region had a high proportion of its population that was at risk for diabetes, that region could develop health programs to reduce this risk. Similarly, if a health region had an aging population, it could develop programs that met the needs of a senior population.

If the province moves to larger geographical health regions or one mammoth Provincial Health Authority, it may be more difficult for the new regions to assess the specific needs of the local communities and to deliver appropriate health services.

Increasingly health researchers and governments recognize that social determinants of health – such as income, employment, working conditions, education, affordable housing, early Childhood development, social safety networks, gender, race and ability – are the greatest factors that determine a person's health. Health regions need to be organized to work with other agencies and government departments to address the social determinants of health and reduce health inequities.

[12] Donaldson, Cam. "Fire, Aim.. Ready: Alberta's big bang approach to health care disintegration," Law and Governance, Longwoods, 14(3), August 2010.
[13] Canadian Foundation for Healthcare Improvement, p.18.
[14] 3sHealth Annual Report 2015-16.

Recently a group of physicians called for the government to declare a public health state of emergency in response to the extremely high rate of HIV and AIDS in the province, which is double the national rate.[15] The doctors pointed out that each new case of HIV is estimated to cost $450,000 in medication, and $1.4 million through a patient's lifetime. An upstream approach to reduce the rate of infection and a strategy for early identification and treatment would improve the lives of thousands of vulnerable people and reduce downstream costs.

The Advisory Panel needs to consider how reducing the number of health regions will address pressing health issues such as the high rate of HIV and AIDS, and other social issues that impact health status.

Preserve our publicly-funded, publicly-administered and publicly-delivered system of health care

Some of the questions posed in this consultation's survey suggest a hidden agenda to promote privatization. For example, they refer to "barriers to innovation" in the current system, invite input on the "mechanisms" of delivery, and ask whether private enterprise would be best to provide oversight to a provincial health system.

CUPE categorically opposes any privatization or expansion of private delivery of health care services. We strongly oppose any suggestion that private enterprise could provide oversight to a provincial health system. In fact, this government has already inserted a private business approach to health care delivery which, we believe, has contributed to rising costs in health care. We question whether further privatization of health services delivery would comply with the *Canada Health Act*, which is required in order to receive federal transfer payments.

The recommendation of Patient First Commissioner Dagnone for shared services in health care lead to the creation of 3sHealth (Health Shared Services Saskatchewan) and a move toward more privatization. 3sHealth has identified a long list of "back office functions" for which it has been developing business cases for shared service delivery.

While CUPE agrees that bulk purchasing among health regions is cost efficient, we believe that the push for provincially-delivered health support services is erroneous. The first business case considered by 3sHealth was for hospital laundry and it decided to completely privatize the service. We will outline why the decision to privatize laundry was not in the best interests of the health care system, the province's finances and the economy.

[15] "Sask doctors call for state of emergency over HIV rates," CBC Saskatchewan, September 19, 2016.

Privatization and false savings: the example of laundry privatization

In 2013, 3sHealth made the short-sighted and irresponsible decision to privatize provincial laundry services on the premise that this would save money. A research report by University of Winnipeg economists confirms that the decision to privatize laundry will cost the government more in the long run.

In their 2014 analysis of the laundry privatization business case, economists Hugh Grant, Manish Pandey and James Townsend conclude that the purported savings of privatization are overstated and based on flawed assumptions. Based on 3sHealth's own numbers in its business case, the economists concluded that privatized laundry will only save between $13 and $17 million over 10 years, not the $97 million claimed by the government.[16]

But even those modest savings are derived from the same flawed assumptions and incomplete information in the business case. Most of the savings purportedly achieved through privatization are based on lower wages. The business case did not provide any information on the wages that would be paid in the privatized plant (only the total wage bill in the first year), but assuming that the private plant would require the same number of workers as one public plant (the comparator in the business case) the private company K-Bro Linens would be paying only $8.35 an hour – well below the legal minimum wage.[17] The business case had assumed a higher number of workers in a new public laundry facility than in a private plant, which does not make sense because a brand new plant should require the same number of workers to operate, no matter if it is public or private. This is one of many flaws that demonstrates that the business case did not do a fair comparison of the public versus private option.

The business case also limited its comparative analysis to a ten-year period when, if the province had invested in new laundry plant and equipment, the life of a public laundry facility would have extended to at least 30 years. By comparing the costs of a public and private laundry plant over ten years, the public option automatically became more expensive as the costs were amortized over ten rather than 30 years. Anyone paying a mortgage knows that your monthly costs increase as you shorten the term of the mortgage.

The business case also failed to examine the economic impact of laundry privatization on the provincial economy. The University of Winnipeg economists examined the impact of the loss of employment income and local spending on the economy and calculated a loss of $89 million over 10 years to the provincial economy. After taking into account the presumed savings with a privatized laundry service, there would be net loss of $42 million to the economy. The City of

[16] Hugh Grant, Manish Pandey and James Townsend, *Short-Term Gain, Long-Term Pain: The Privatization of Laundry Services in Saskatchewan*, CCPA Saskatchewan, December 2014.
[17] Ibid., page 14.

Prince Albert, where one of the largest laundry facilities was located, would be hit particularly hard with a decline in regional GDP of $3.7 million.[18]

Another major problem with the privatization of laundry – and something Health officials also raised as a concern – is that the government has given K-Bro Linens a provincial monopoly to clean hospital linens. Ministry of Health briefing notes warned that doing this would make the province a "price taker," and put it in a vulnerable position in 10 years when it has to negotiate a new deal.

It is not certain if the contract 3sHealth negotiated with K-Bro Linens will achieve the savings claimed in the business case. The contract was kept secret for about two years until the Information and Privacy Commissioner determined in a review for CUPE that the contract should be made public. Our reading of the contract shows that K-Bro will receive annual increases based on a number of factors. The contract also provides for an automatic increase in the laundry rates that K-Bro charges health regions in the event that its employees unionize and their wage rates increase. The low wage "advantage" that won K-Bro the contract could disappear quickly, with the result that health regions will pay more for linens than the business case anticipated.

We have provided detail about the recent privatization of hospital laundry services for a reason. The Advisory Panel has a mandate to examine how to best deliver health services provincially. The Panel needs to understand that privatized health support services do not automatically save money and create efficiencies and it must reject privatization as an option.

Privatized laundry services will not save money and our members report to us that the quality of linens from K-Bro is worse than when the public laundry plants did the work. Front line workers are regularly rejecting "clean" linens and spending time looking for clean linens, thus increasing the number of steps they take daily in the workplace – contrary to Lean goals of reducing steps. A recent letter to the editor indicates the public has noticed shortages of linen since privatization. The man wrote: "My mother was recently admitted to the Pasqua Hospital and there was a chronic shortage of new laundry, staff told me that this was the norm."[19]

Privatization fragments the health care system

If the goal of this review is to develop more coordinated and effective ways of delivering health care services, then privatization must not be considered under any circumstances. In fact the goal of regionalization from the beginning has been to address atomization and fragmentation of health

[18] Ibid., p.20.
[19] Howard Brass, "Is this privatization at all costs?" *Regina Leader Post*, September 24, 2016, p. A8.

services. Why would the province consider more privatization when this only increases fragmentation and lack of accountability for health services?

The contracting-out of surgeries and diagnostic services to private clinics are examples of fragmented health services. The government boasts about shorter wait times for surgeries and diagnostic imaging in this province and gives the credit to private clinics. It is critical to point out, however, that the wait times went down because the government poured money into this project. The same amount of money provided to the public system would have also decreased wait times and, more importantly, would have built capacity in the public sector. Now that the government is not so flush with money, wait times are increasing once again.[20]

In Alberta, the government began contracting-out surgeries to private clinics in the 1990s. When the Calgary-based Health Resource Centre (HRC) was facing bankruptcy in 2010, Alberta Health Services had to temporarily bail out HRC so patients scheduled for surgery at the private clinic would not suffer with longer waits.[21] Stephen Duckett, the former CEO of Alberta Health Services, looked at the cost of publicly funded procedures and found that public hospitals were doing the same work for considerably less.[22] HRC went bankrupt and Alberta Health Services met its surgical demand by expanding its public surgical capacity.

The Saskatchewan government ignored the Alberta evidence and argued that private clinics were needed to address the backlog. There was no analysis, however, of whether wait times were symptomatic of a temporary backlog or a permanent demand.

In this time of austerity, will surgical capacity within the RHAs be reduced because of funding cuts? Will the government continue to depend on costly private clinic contracts or will they also subject to cuts?

When government finances are tight, why would we continue to funnel public funds into the profits of private clinics?

Government must expand public home care services

Through the province's first round of regionalization, home care services were brought under the authority of health districts. This enabled health districts to develop a continuum of care from acute to long-term and community, meeting one of the goals of regionalization. Home care workers

[20] See Sask Surgical Initiative website: www.sasksurgery.ca
[21] Diana Gibson and Jill Clements, Delivery Matters: The High Costs of For-Profit Health Delivery in Alberta, Parkland Institute, April 2012.
[22] Rick Janson, "Former health services chief says privatization among reasons Alberta health costs so high," Longwoods Essays, September 2014.

became employees of health districts/regions, were integrated into regional health strategies and the more consistent labour conditions resulted in reduced staff turnover.

Although our model of integration is good, Saskatchewan has the second lowest spending on home care services after Prince Edward Island.[23] Publicly-delivered home care services need to be expanded to ensure that seniors and others who need support are able to stay longer in their homes independently. Too many families are having to look to private agencies to supplement the limited hours provided by public home care.

Other provinces that use private agencies to deliver home care services do not have the same level of coordination and continuum of care that Saskatchewan has. Private agencies can charge up to $24 an hour for home care services but only pay their staff $12 an hour, creating constant turnover and inconsistent service. Because private agencies are not integrated with the public health system, they do not have the ability to access additional resources if the patient's needs change.

We are concerned that the Saskatchewan government is considering expanding private home care services. We believe that the Advisory Panel must recommend the preservation and expansion of public home care services to avoid fragmentation of this important health service.

The government must dramatically increase its funding to public home care and ensure that services remain publicly-delivered and under the direction of health regions.

[23] Laura Ross MLA, *Focus on the Future: Long Term Care Initiative*, A Report to the Honourable Don McMorris Minister of Health, 2010.

Governance, Transparency and Accountability

In our provincial health care system, there exist numerous health entities with varying levels of public accountability and transparency for their decisions. Board members of the RHAs are not elected but appointed by the government. 3sHealth is a new non-governmental entity that has representation on its board from RHAs and the private sector. The Saskatchewan Association of Health Organizations (SAHO) bargains on behalf of the RHAs. The Minister of Health provides directives and funding to the RHAs.

The health care organizations have overlapping – sometimes competing – mandates and the level of transparency and accountability to the public varies with each organization, even though all are funded by public dollars. The ability of RHAs to make decisions, especially about resource allocation, without the Ministry of Health or politicians micro managing or interfering with those decisions is a constant tension in this province and across the country.[24]

Although RHAs and the Ministry of Health are covered under Freedom of Information legislation, neither SAHO nor 3sHealth are subject to the legislation. Because of the lack of transparency, it is impossible for the public to know how decisions for service delivery -- such as the recent privatization of laundry services – are made. Does 3sHealth act on behalf of the Ministry of Health, the RHAs, or its appointed board? How can we hold these health agencies to account for their claims of savings if they refuse to release documents?

In December 2013, 3sHealth signed a 10-year contract with K-Bro Linens for the provision of hospital laundry services. When CUPE requested a copy of the contract from the Ministry of Health through an Access to Information Request, the Ministry replied "…the Ministry has performed a search for this record and has determined that this record does not exist within the Ministry of Health." The same request to five RHAs resulted in four responses stating "no record existed."

The Sunrise Health Authority, however, replied that the record was in the hands of third parties (3sHealth and K-Bro) and that it would request a copy. The third parties denied the request claiming the contract was a trade secret and its disclosure would create great economic harm. But because Sunrise had requested a copy, CUPE was able to request a review from the Information and Privacy Commissioner of 3sHealth's decision to deny us access to the contract.

On July 17, 2015 Privacy Commissioner Ron Kruzeniski issued Review Report 082/2015 in which he determined that, even though Sunrise did not possess a copy of the contract, it did have "control"

[24] Canadian Foundation for Healthcare Improvement, p. 35.

over the record because 3sHealth negotiated the contract on behalf of Sunrise. The Commissioner also dismissed K-Bro's claims that the contract qualified as a trade secret.

Kruzeniski recommended that Sunrise Health Region provide the applicant (our union) with a full copy of the Master Services Agreement (contract) between 3sHealth and K-Bro Linen. In addition, the Commissioner recommended that the Minister of Health designate 3sHealth as a health organization under *The Regional Health Services Act*. If 3sHealth had this designation, it could fall under LA FOIP.

Unfortunately, the Ministry of Health has not taken any measures to comply with the above recommendation (the Privacy Commissioner can only make recommendations, unlike many of his counterparts in other provinces who can make binding orders).

This example highlights the lack of transparency and accountability with 3sHealth, an organization that was established to find ways to deliver a wide range of services such as hospital laundry, medical transcription, Information Technology, laboratory services, medical imaging, food services and others provincially.

The Advisory Panel must examine the measures for public accountability and transparency for organizations like 3sHealth. We ask you to recommend that 3sHealth, and any other new provincial health body, be subject to LA FOIP.

Recognize and value the contributions of healthcare providers and respect those providers' Constitutional rights

Our health care system is a labour intensive 24-hours a day, 7-days a week operation. Health care workers have demanding, stressful jobs but are drawn to the work because they care about their patients and residents. Frontline staff are the backbone of public health care.

Our public health system works the best when staff work in collaborative teams, are engaged and valued. It is absolutely critical that we value these complex relationships and maintain healthy labour relations in our health care system.

In its deliberations, the Advisory Panel must consider the importance of engaging front line workers through their unions, respect the employees' Constitutional right to choose their union, and take measures to prevent disruption and chaos that would result from forcing representation votes between unions.

Section 2(d) of the *Canadian Charter of Rights and Freedoms* guarantees freedom of association, which has been held in a number of cases to protect the right of workers to join or form a union, without interference from the Government in the selection or formation of the union: *Mounted Police Association of Ontario v. Canada (Attorney General),* [2015] 1 SCR 3. As we have stated earlier, the current bargaining units in health care are the product of an extensive Consultation (Dorsey) which preserved the workers' choice of union while promoting stable labour relations in health care service delivery. In CUPE's experience, the Dorsey bargaining units have allowed health sector employers and unions to engage in a meaningful, productive collective bargaining process over successive contracts. Our members are very concerned that further reorganization of bargaining units may remove them from their communities of interest, and limit their access to a meaningful collective bargaining process.

In the past, legislative reorganization of bargaining units has unfortunately resulted in expensive and protracted litigation in Nova Scotia, Alberta, and Quebec. In *Health Services and Support – Facilities Subsector Bargaining Assn. v. British Columbia*, 2007 SCC 27, [2007] 2. S.C.R. 391, the Supreme Court advised governments and government employers that unions have a right to "meaningful discussion and consultation" with respect to any government action or legislation that could impact the collective bargaining process. The Court also held that any government action or legislation that would nullify meaningful terms in existing collective bargaining agreements would be unconstitutional.

We are gravely concerned that any further reorganization of bargaining units in health care, without adequate consultation, will trigger expensive, multi-party litigation similar to the essential services litigation started in 2008 against the Government of Saskatchewan, which continues to be litigated eight years later, despite the Supreme Court of Canada's 2015 decision upholding the unions' claims in *Saskatchewan Federation of Labour v. Saskatchewan,* [2015] 1 SCR 245.

Conclusion

The Advisory Panel faces a difficult challenge: you must recommend fewer regional health authorities, as mandated by the Minister of Health, and you have to provide a rationale for doing so.

The experience of regionalization in this province and across the country is that this process has been driven by the need to find cost savings by eliminating administrative boards and by rationalizing and integrating health services. The trend in the last decade has been to consolidate into fewer health regions or one provincial health authority, as in Alberta. Marchildon asks in a recent paper "why there is such dissatisfaction with regionalization that political leaders are willing to gamble on greater centralization, despite the near chaos it caused in Alberta?[25]

The Premier made a promise to the electorate that he would cut administration in health regions and direct $7.5 million to front line staff in long term care. There is no doubt that long term care desperately needs more front line staff. The residents in long term care homes are older, more frail and have higher levels of acuity than a decade ago. In a recent survey, our members who work in long term care reported heavy workloads and not enough time to provide quality care to residents. They feel frustrated at always having to rush through their day and worry about increased risk of injury to themselves and their residents because of workload.[26]

We are not convinced, however, that restructuring health regions will resolve the issues in long term care or in other areas of health care.

There are cost drivers or inefficiencies in our health care system that, if addressed, could create more savings and better health care. The fee-for-service method of remunerating physicians, for example, is costly and not the most efficient way of ensuring health outcomes. The Canadian Foundation for Healthcare Improvement (FHI) report points out "…given that physicians control over three-quarters of health expenditures, their disengagement from the system constitutes one of the largest limitations of regionalization in Canada."[27]

Research shows that an inter-disciplinary team approach to delivering health care is a more effective model for providing health care. Community clinics in the province have physicians on salary who work collaboratively with nurse practitioners, nurses, nutritionists, physiotherapists and others. If this model were expanded in the province, it would improve the quality of health services to patients.

[25] Gregory Marchildon, "The crisis of regionalization," Healthcare Management Forum, 2015, vol 28(6) 236-238.
[26] Canadian Union of Public Employees, Caring for a Week: Workload and Staffing Survey, April 2016.
[27] Canadian Foundation for Healthcare Improvement, p. 21.

A national pharmacare plan, currently being discussed by the Parliamentary Standing Committee on Health Care, would reduce overall prescription drug expenditures in Canada by 41% and would address the problem of appropriate prescribing. This would create more savings for the provincial government (and individuals) than any tinkering with the regional health structure. Several study participants in the CFHI regionalization report said "the inadequate financial coverage of essential drugs in ambulatory care settings is a major roadblock to maintain people in the community and to the optimal use of non-hospital services, thus contributing to overutilization of hospital services and driving health care costs up."[28]

CUPE believes that any proposals to restructure health regions must be transparent, evidence-based and implemented only after comprehensive and constructive consultations with the public. If union jurisdiction is impacted by restructuring, the Constitutional rights of workers must be protected and meaningful consultation must be held with unions.

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[28] Ibid., p.35

Summary of Recommendations

- The Advisory Panel must set out a list of principles to guide health care restructuring.

- The government has an obligation to hold comprehensive and meaningful consultations before embarking on any restructuring of health regions. The Advisory Panel should request more time and suggest that the government ensure broad public consultation before it decides on any health region structure.

- Any new regional structure has to ensure that the regions are not so geographically large that smaller communities lose their voice in the structure.

- Health care restructuring should only be done if there is solid evidence that fewer health regions will contribute to better health outcomes and improved quality of care for residents of the province.

- The Advisory Panel's review also needs to analyze the changes to the health workforce in the last ten years, to assess the balance between administrative positions and front line workers. Kaizen positions and 3sHealth must be included in this review.

- The Advisory Panel needs to consider how reducing the number of health regions will address pressing health issues such as the high rate of HIV and AIDS, and other social issues that impact health status.

- The Panel must reject privatization of health services as an option recognizing that privatized health support services do not automatically save money and create efficiencies.

- The Advisory Panel must recommend that government dramatically increase its funding to public home care and ensure that services remain publicly-delivered and under the direction of health regions.

- The Advisory Panel must examine the measures for public accountability and transparency for organizations like 3sHealth. We ask you to recommend that 3sHealth, and any other new provincial health body, be subject to LA FOIP.

- The Advisory Panel must consider the importance of engaging front line workers through their unions, respect the employees' Constitutional right to choose their union, and take measures to prevent disruption and chaos that would result from forcing representation votes between unions. To ensure labour stability, the Advisory Panel should not recommend any changes to established health care bargaining units.