HEALTH SCIENCES ASSOCIATION | DEC 07 / JAN 08 | VOL. 28 NO. 6

THE Report

PROTECTING MEDICARE

PRIVATIZATION AND TRADE AGREEMENTS THREATEN PUBLIC HEALTH CARE

We've talked: now let's protect public health care

by REID JOHNSON

Reid Johnson, HSA president

As the finishing touches were being put on the 1500-page report from the BC government's year-long *Conversation on Health*, Health Minister George Abbott continued to pussy-foot around the issue of increased privatization of our health care system.

Following a meeting with former UK Health Minister Frank Dobson who warned Abbott about going down the privatization road, Abbott told *The Tyee*, a Vancouver-based independent online daily magazine, that the information "won't keep him and his government from implementing what Abbott called 'cautious, incremental reforms' in BC's health care system."

This, even as the central message coming out of the *Conversation on Heath* is that British Columbians believe in "A strong and sustainable public health care system that delivers services to all British Columbians regardless of where they live, their incomes or their backgrounds and cultures."

The *Conversation on Health* report, released November 30, didn't come with any earth-shattering announcements from government about their plans for our health care system. But there are some very strong signs that government is speaking out of both sides of its mouth.

While the health minister led the announcement with strong statements about the public support for a public system, the report suggests that the year-long exercise hasn't produced the answers government was looking for:

> *While the vast majority of those in attendance at the forums were in support of the continuation of public health care in British Columbia, this same level of support was not as clear through the other avenues of input in* the Conversation on Health. *The debate between those in support of some element of private sector involvement in health care delivery and those who suggested a fully public delivery model and funding system continues to be fractious.*

The continuing challenge in this debate is to ensure government does not dismiss the public support for a publicly funded, publicly delivered system.

You'll recall that Premier Gordon Campbell was front and centre in announcing the process, and he was unequivocal in saying he wanted British Columbians to consider an increase in private, for-profit involvement in the public system.

In the 2006 Throne Speech, the government's position was clear:

> *Why are we so afraid to look at mixed health care delivery models, when other states in Europe and around the world have used them to produce better results for patients at a lower cost to taxpayers?*
>
> *Why are we so quick to condemn any consideration of other systems as a slippery slope to an American-style system that none of us wants?*

And in the first *Conversation on Health* consultation session in October 2006, the headline speaker, hand-picked by Premier Gordon Campbell to open the *Conversation*, was Dr. Brian Day, owner of the False Creek Surgical Centre and vocal proponent of increased private involvement in our health care system.

Mr. Campbell said he wanted to hear from British Columbians about their expectations and hopes for the future of our health care system through the *Conversation on Health.*

More than a year and 12,000 submissions later, we now have in front of us a 1,500 page summary report that government's first take on is that British Columbians value our public health care system.The health minister said this month that we can expect to start seeing legislation, regulation and policies that address changes to the health care system sometime this coming spring.

While initial indications are that the government heard British Columbians' commitment to a publicly funded, publicly delivered, accessible and equitable health care system, it is up to each and every one of us to continue to work to ensure that government's actions reflect the commitment to a public system so strongly and consistently expressed during the *Conversation on Health.* R

Reid Johnson is president of the Health Sciences Association of BC

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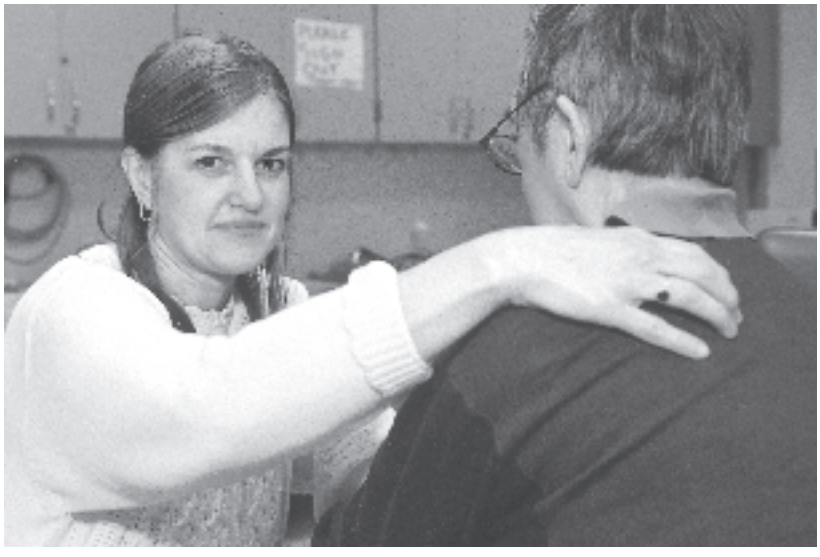

NEWS

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THE FRONT COVER

Every day, HSA members are making a difference. Our union's 15,000 members work in health care and social services all around the province.

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Pacific Blue Cross avoids use of Social Insurance Numbers for claim identification

by DAVID CRUMPTON

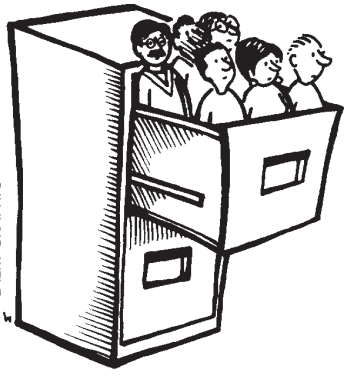
For more than 65 years Pacific Blue Cross (PBC) and its predecessor organizations have been protecting the personal information of employees and their families.

Currently, PBC uses both Social Insurance Numbers (SINs) and non-SIN identification numbers to identify individuals (members) covered by its benefit plans. PBC is legally required to collect and report SINs for tax-reporting purposes (e.g. for taxable disability plans).

Protecting SIN information

In April 2005, the Office of the Information & Privacy Commissioner for British Columbia published guidelines for the collection, use and disclosure of SINs by private sector organizations in accordance with the requirements under the *Personal Information Protection Act*. To comply with these guidelines, PBC does the following:

- We advise our members in writing at the time of collection that we are collecting the SIN for identification or income-reporting purposes only.
- We give our members the option of not providing the SIN, unless it is legally required.
- We make it clear that providing the SIN is not a condition of coverage with PBC.
- Our members may withdraw consent to collect and use the SIN after providing it, unless it is legally required. In these situations we will assign a non-SIN identifier.
- We take reasonable security arrangements to protect our members' personal information from unauthorized collection, access, use, disclosure, disposal or destruction.
- Our employees are bound by a code of conduct that insists on strict confidentiality of personal information. Access to SINs is restricted to those employees who require the information to do their work.



CALM GRAPHIC

Editor's note: This article was provided by Pacific Blue Cross (PBC) in response to HSA's concerns about PBC's use of members' Social Insurance Numbers in identifying claims.

Moving away from using SINs when possible

While we are continuing to use SINs for some of our members, we are moving to non-SIN identification numbers as much as possible. Members assigned a unique non-SIN identification number receive a new PBC identification card, and are advised to use this number when making a claim and corresponding with us. The non-SIN identifier reduces the risk of identity fraud in the event that the new identification number is disclosed to a third party and better enables us to protect our members' personal information.

Since January 2006, PBC has not collected SINs from members, except for tax-reporting purposes. We have encouraged employers/plan sponsors to provide us with a payroll number or other job-related number rather than SINs to identify their employees. For individual members who do not want to give their SIN, we provide a unique non-SIN identification number.

PBC is switching identification numbers from SIN to non-SIN for its employer/plan sponsor groups on a scheduled basis over the next several years. The change requires considerable planning and testing to ensure that the transition for our members and employers/plan sponsors is transparent and smooth. In addition, we will continue to accommodate the request of employers/plan sponsors who wish to change to non-SIN identifiers. The Office of the Information & Privacy Commissioner supports our decision to move all remaining groups to non-SIN identifiers (unless legally required) as soon as we are able.

Pacific Blue Cross recognizes its responsibility to members and will continue to protect the privacy and confidentiality of its members' personal information. This is in line with our mission to remain the most trusted and reliable provider of cost-effective, life and disability coverage for our members. R

David Crumpton is the Director of Audit Services and Chief Privacy Officer for Pacific Blue Cross.

News

CML Healthcare members ratify collective agreement

HSA members working at CML Healthcare, a private provider of medical diagnostic testing services, ratified a new collective agreement in mid-December.

The agreement was ratified by a 78 per cent vote in favour. For members in the Lower Mainland locations of CML Healthcare, it is a first agreement, as earlier this year they joined the existing bargaining unit representing their colleagues on Vancouver Island.

Highlights of the agreement include:

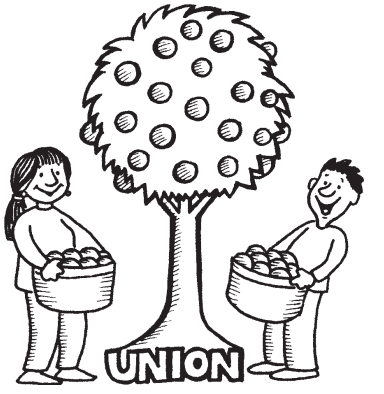
- Significant wage increases with an emphasis on improving starting wages
- Increased staffing to alleviate workload
- Occupational Health and Safety committee structures to address long standing safety issues at the Lower Mainland sites

CML Healthcare has a number of locations on Vancouver Island and the Lower Mainland.

Dietitians ask for parity with colleagues in health sector

Bargaining for a first collective agreement is well under way for 19 dietitians at Dial-a-Dietitian.

Chief Steward Joanna Drake is excited to be a member of the bargaining team. She outlined what the group hopes to achieve in this round of negotiations. "The priority for bargaining is to develop a contract that offers better benefits," she said. "We're looking for improved security through a pension plan, better health benefits, and the creation of a long-term disability plan."



Senior labour relations officer Josef Rieder is heading talks. "At a bargaining proposals meeting held this summer, the dietitians decided to ask for equity with fellow dietitians covered by the health science professionals' provincial agreement," he said. "Currently, their wages are similar to those on the provincial health wage scale – with the key difference being that they don't have the benefit of the provincial agreement's classifications system. This means many of these members are being paid grade one rates, yet there are several individuals who would meet the test for a higher grade level if they had the HSPBA classification system," he said.

"In addition, we aim to make gains in benefits, as well as persuade the employer to take part in the Municipal Pension Plan," he said. "They currently have a very good employer-matched RRSP. But this doesn't measure up to the pension plan – and because this is a public-sector employer eligible to join the plan, we hope to show that this move makes sense."

"In all, we're aiming for wages and benefits identical to those enjoyed by their colleagues working in provincial health, with some adjustments to reflect the fact that Dial-A-Dietitian is an independent, standalone, non-HEABC facility," Rieder said.

He noted that talks have been positive, although slow: "Because it's a first collective agreement, the employer has been wanting to go over each article in quite a bit of detail. But generally, it's going really well," he said. "We've had eight bargaining days since summer, with more scheduled in the new year."

Dial-A-Dietitian is a free nutrition information service, funded by the Ministry of Health and operated by NutritionLink Services Society. Dietitians answer calls from the public, other health professionals, and the media. Between April 2006 and March 2007, Dial-A-Dietitian answered 22,553 calls.

When they joined HSA this year, the dietitians chose the union with the greatest community of interest.

"The Dial-A-Dietitian staff chose HSA because we were looking for a union that understands the needs of health professionals," Drake said. "We wanted to join a union of like members."

The members elected Drake as chief steward and Linda Kirste as assistant chief. Together with chief negotiator Josef Rieder, they make up the bargaining team.

"Dietitians work in diverse areas of the health care system - from acute care hospitals and public health," Kirste said. "While dietitians at Dial-A-Dietitian come with various types of experiences, many have worked in acute care settings. Working at Dial-A-Dietitian appeals to many staff because callers for nutrition information are motivated and ready to make positive health choices."

Rieder praised the efforts of the team: "They're awesome," he said. "They're intelligent and capable, and at the same time they're fun: it's a great committee." R

BC government urged to listen to Conversation on Health results

As part of the wrap-up to the months-long *Conversation on Health*, the BC government released at the end of November a summary of input: voices of British Columbians from across the province.

The key message delivered to government is that British Columbians believe in a strong and sustainable public health care system. BC residents want to preserve and strengthen the public health care system and ensure there is access to health care services regardless of where people live, or how much money they make.

"BC's citizens and health professionals were clear in their desire to protect a public health system and to stem the incursion of private, for-profit interests," said HSA President Reid Johnson.

"We heard from dozens of HSA members who attended *Conversation* forums all around the province," he said. "They were unanimous in reporting that the vast majority of people at every forum supported public funding and public delivery of health care, and opposed for-profit health care.

"Dozens of HSA members who attended *Conversation* forums all around the province reported unanimously that the vast majority of people at every forum opposed for-profit health care."

"I sincerely hope BC's government will take this to heart. Even with pressing shortages in many health professions, our system is the one that works – and people have come to recognize that increasing private involvement in health only siphons badly needed funds and personnel into a for-profit system, aggravating shortages and wait lists," he said.

Leslie Dickout, Medicare campaigner for the BC Health Coalition, agreed. "British Columbians value public health care. They know there are challenges, but they also know there are proven, evidence-based public solutions. And they want their government to get to work and act on those solutions," she said.

Dickout said the BC Health Coalition will be watching closely to see if government's actions in the coming months reflect the direction from British Columbians coming out of the Conversation.

"While government says they've heard the concerns, only their actions will tell if they're prepared to take their lead from the public.

"So far, their actions have spoken louder than their words. For example, while the *Conversation* was still going on, the Ministry of Health continued on a course to increase involvement by the private sector in the public health care system," Dickout said.

Meanwhile, Canadian Doctors for Medicare (CDM) and The Council of Canadians were concerned that the BC government is deeply out of sync with the public when it comes to health care accessibility.

According to the Council of Canadians, the *Conversation on Health* input summary firmly validates a public system – in direct contrast to a decision by Health Minister George Abbott only days earlier.

"The Health Minister was seemingly unaffected by the results of the Medical Services Commission investigation that sanctioned the Copeman Clinic," said Carleen Pickard, BC Regional Organizer for the Council of Canadians. "This clinic makes people pay thousands of dollars before they can see a doctor – it's clearly a barrier to access."

CDM and the Council of Canadians are calling

on the BC government to release the entire report of the Medical Services Commission investigation into the controversial Copeman Clinic.

Dr. Danielle Martin of Canadian Doctors for Medicare said access to family physicians and primary health care is an issue for all citizens, but she notes most patients cannot afford to pay the thousands of dollars charged by the Copeman clinic.

"If the BC government has concluded, based on the report of the Medical Services Commission, that the Copeman clinic is not breaking the law by charging fees as a condition of gaining access to medical services, it has an obligation to release that report."

In a news conference announcing the *Conversation*'s input summary, Minister Abbott acknowledged the proliferation of private clinics in BC and spoke openly in favour of their expansion. He referred specifically to the Copeman Clinic, False Creek Surgical Centre and the Cambie Surgery Centre acknowledging that private surgeries and private health care delivery is growing in the province.

"BC residents were clear in the *Conversation on Health* that they want publicly-funded and publicly-delivered health care. The summary of the *Conversation on Health* reflects this," said Pickard. "The BC government should be reflecting the will of the people and shutting down private clinics."

With concerns raised about the legality of these clinics, it is long overdue for the federal government to get involved, said Guy Caron, Health Care Campaigner for the Council of Canadians.

"The federal government is responsible for enforcing the Canada Health Act, but has been silent on the proliferation of private clinics, not only in BC, but across the country," Caron said. "There is no leadership on the issue of privatization and these private clinics that charge people money to access services continue to operate unchecked. Where is the federal government on this issue?" R

ACTIVIST PROFILE

New activist brings energy, excitement

by LAURA BUSHEIKIN

Jean Lee was an HSA member for 18 years without giving much thought to what she could do for the union, or what it could do for her.

"I had no clue," says Lee ruefully.

This changed radically last February when Lee reluctantly accepted the position of General Steward for St. Paul's Hospital, where she is a laboratory technologist specializing in microbiology. During her steward training, she attended a talk given by an HSA staff member about the state of British Columbia's health care system and about the then-upcoming *Conversation on Health*. Lee was galvanized.

"I was so happy to have had the training I'd had. I knew what was going on, what I wanted to say and how to say it."

"I realized I had no idea what was going on with our health care system. I had no idea what the *Conversation on Health* was. I got really excited, and really upset," says Lee. She jumped head first into activism and hasn't looked back since.

Her union put her in touch with the BC Health Coalition and the Canadian Centre for Policy Alternatives. To augment her HSA training, she began attending events sponsored by these organizations, learning all she could, as fast as she could, to make up for 18 years of passivity.

This summer, empowered by all she had learned in her three months since her political awakening, she attended the Richmond session of the *Conversation on Health*.

"I was so happy to have had the training I'd had. I knew what was going on, what I wanted to say and how to say it."

Lee's activism is not limited to formal events, however. She sees – and takes – any opportunity she can to spread the message that our health care system is threatened.

"The seniors had a rally every time there was a session of the *Conversation on Health*, giving out pamphlets to the public. I started going too, giving them our pamphlets and talking to them," she said.

"I go to the BC Health Coalition's rallies. I talk to my peers in the lounge at work, telling them to do more than just complain. I tell them: here, read this information and write a letter. I try to get them involved and keep them informed," says Lee.

As an immigrant from the Philippines, Lee has always appreciated the publicly-funded health care system that values the importance of care, rather than the ability to pay.

"In the Philippines there is no universal health care. You have to pay for everything. If you have no money, you will not be treated. You just die, or you sell everything you have so you can be treated," she says. She gave birth soon after moving to Canada, and although she had no Canadian health insurance, she was immediately given treatment – then offered a long-term monthly payment plan to cover the medical costs. That option made medical care accessible to her.

It would have been different back home in the Philippines, she says. Women who can't afford hospital care give birth at home, even when there are dangerous complications. "You can die; your baby can die," says Lee. "It's so good here in Canada."

She is appalled to see the Canadian system being eroded. "When I hear, for example, that BC is gearing towards privatization of health care, it scares me.

"For instance, we've privatized the cleaners. So the cleaners are from a private company and not from the hospital. In some cases they may not have the proper training for cleaning a hospital, and bacteria

Jean Lee
Laboratory Technologist
St. Paul's Hospital

can be picked up and and transfered from room to room. I'm a microbiology technologist and I'm scared. I don't want to get sick," she says

Another critical issue is human resources.

"We are short in all the health science professions. There is nobody to do all the work. If you have a private hospital it will collect more money and so it will pay more, so of course the public hospital people will be siphoned off to work in the private facility. Then what happens to the hospital?" she asks rhetorically.

"By 2015 we'll be so short of staff we'll have a hard time coping. Many highly-trained HSA members will be retired by then. It will be sad to leave a workplace where there's no one to replace you."

Health science professionals can end up overlooked in discussions about health care workers, she says.

"The government has already done something for doctors and nurses. They are the obvious ones, the ones people talk about. But what about the others? The medical technologists, pharmacists, physiotherapists – there are so many of us, and we are not visible. The policy makers and the public don't always know what a health science professional is. People are not always aware that we are critical.

"I'm the one who works on the tests to find out if you are sick. The doctor takes the specimen – say, a swab. We culture it, put in onto a plate, incubate it, check to see what pathogens are growing. We find the organism that's causing the problem. We isolate it, identify what it is, and test it against the antibiotics that will kill it. We're working behind the scenes. People don't know that," says Lee.

She values the work HSA does to change this. "One of HSA's mandates is to make us more visible," she says.

Lee plans to stay active in the union, her workplace and her community.

"I love being a steward," she says. "I'm happy that I am more informed now." She enjoys the rallies, the meetings, and the learning curve. And she has a passion for empowering other people to find their political voices, just as she found hers.

"For instance, I have an older friend I regularly visit. She is a retired nurse with slight Parkinson's. I tell her what's going on with health care. I sit at the computer with her and show her how to get involved. I showed her where she can give her opinion on the *Conversation on Health* site. I told her, you have to at least write down something that you feel in your heart; you have to find your voice. Say what you need. Say *something*. She did it! And she was happy.

"Every time I get the chance, I talk to people. Some are receptive; some aren't.

"Someone somewhere will pick up on it. You just have to keep pushing and explaining. That's all there is to it," says Lee. R

Power and confidence: through union involvement and training, Jean Lee has learned her words and opinions can help shape a better system

PHOTO COURTESY JEAN LEE

MEMBER PROFILE

ALS: when a physiotherapist is diagnosed

by YUKIE KURAHASHI

When she answers the door to her suburban Victoria home, her face lights up. She seems just as she's always been: lively, with that mischievous light in her eyes. But former HSA board member Jenny Robertson is facing new challenges.

An occupational therapist is just heading out the door, saying her goodbyes and rattling off last-minute instructions; Robertson nods and smiles. Then, in response to a question, she carefully articulates what sounds at first like a series of open vowel sounds. She is starting to lose control over the muscles in her tongue and throat.

Robertson has been diagnosed with ALS – or amyotrophic lateral sclerosis, also called Lou Gehrig's Disease. ALS is a progressive neurodegenerative disease. As a physiotherapist at GF Strong in Vancouver, Robertson saw, assessed, and helped treat many clients with the disease. She never dreamed she'd one day become a client.

"It started with weakness in my knee, after an injury," she says, sometimes speaking with the aid of her brand new keyboard communication device.

"This is new, I'm still getting used to it," she adds as an aside, before continuing.

"Anyway, five months later, it was my thumb. I lost feeling in it. And then my tongue. My *tongue*," she points.

Anguish clouds her face for a moment. She stops typing, and slowly enunciates: "I knew. Because I'm a physio, I knew what it was. Because of the motor weakness and tongue involvement, I was afraid it was ALS."

Robertson was made to wait three months to see a specialist. "That was February 2007," she says. "By that time I was already off work. December. December 2006. I had to stop working."

For the first time – as she talks about her work – Robertson betrays her grief. "I loved my job," she says, and her eyes fill with tears. "*I loved my job*. I loved it."

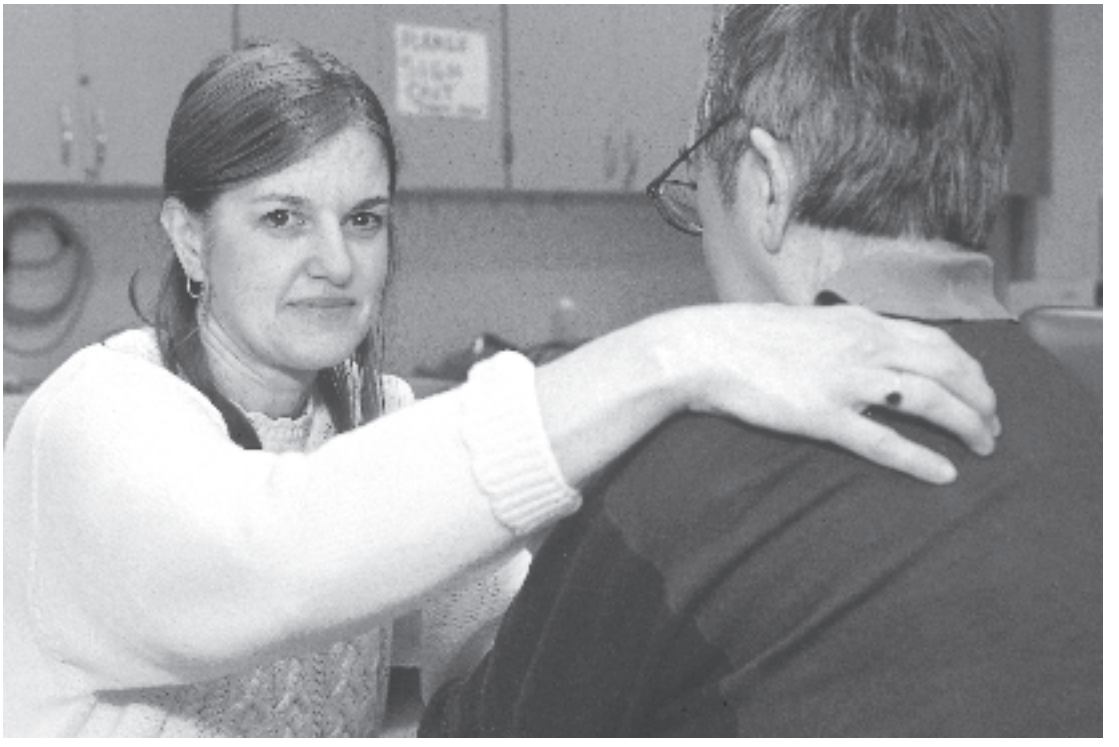
And so she kept working. Even though she could no longer see clients, Robertson continued preparing her presentation for the World Confederation for Physical Therapy, to take place that summer. "I still went to the conference," she says. "I was surprised by the distances I had to walk at Canada Place, and that was tough, but I'm so glad I went. It was great to see people learning from the research we put into our poster."

In addition, Robertson was originally scheduled to teach a post-conference course. "But I mostly observed and helped with paperwork. This was hard – I knew it was the end of my career, maybe the last thing I would do – but I still have one research paper," she smiles. "I just have to read it over and approve it, and have it published," she says.

"The people who see me at GF Strong's ALS team were my coworkers just a few months ago. It's really hard. But I'm so grateful."

Since her diagnosis, she has had to make many changes. Just months ago, she sold her apartment in Vancouver. For the first time, Robertson now lives with her partner. "It's so nice to live together, finally," she laughs.

Jenny Robertson
Physiotherapist
GF Strong Rehabilitation Centre



Although ALS forced her to stop working last December, Jenny Robertson is still passionate about physiotherapy.

Robertson is a former chief steward at GF Strong in Vancouver, as well as a former Region 4 representative on HSA's Board of Directors. But through all her years of activism, few colleagues suspected a long distance love affair.

"We met seven years ago," she says, blushing. Where? "At our 30th high school reunion," she says. And smiles, withholding the punchline.

"He was my boyfriend in high school."

Why did they not live together before?

"Because I loved my work," she says. "*I loved my work*. I loved it. I loved being a physio."

Her partner, Gary, now looks after many of the household chores and helps ensure Robertson has all the supports she needs. "He's been so wonderful," she says.

Her expertise as a physio is constantly in use – this time, for Gary, and for herself. "It helps me advocate for myself," she says. "And I can also educate Gary, because often he doesn't understand the needs or the equipment.

"Increasingly, I need to use the equipment not because I absolutely need it but because I want to save my energy," she says.

The occupational therapist visiting that day had been fitting Robertson for her first motorized wheelchair. After helping her set it up, they tested it on the steep incline of the driveway.

It's obvious she relishes talking about the complexities of this process. "She helped me choose the appropriate wheelchair. To do that, she takes various measurements including my leg length and back width. Then we need to determine the future needs for the chair, and consider tilt and recline," she explains.

"Then there's something called a Roho cushion. What's a Roho cushion? It redistributes weight evenly to prevent pressure sores, and they also have to adjust the level of inflation to the individual.

"I go to the ALS team at GF Strong," she says. "The people who see me there were my coworkers just a few months ago. It's really hard. But I'm so grateful."

Recently, after being assessed by a speech / language pathologist, Robertson was supplied with the keyboard communicator. Because she is starting to have difficulty swallowing, she was advised to make alterations in her diet.

"I'm now modifying my food so it's easier to swallow," she said. "The speech / language pathologist also referred me to a dietitian. Together, they advised that I add smoothies to my diet to increase my weight. I'm also grinding up salads and soups, and I've been advised to eat slowly and take smaller bites," she says.

"Sometimes I've been frustrated because I was so fiercely independent before," she says. "So, getting used to asking for help really hurt. That's still hard for me."

Robertson explains that for a patient like her with ALS, doctors play only a minor role. "It's health science professionals who are the most necessary part of the ALS team," she says. "I'm so grateful for all the help and assessments I've had from my colleagues. They are really, really, dedicated."

'D' sounds are becoming tougher for her to pronounce. She repeats herself.

"*Dedicated*. And caring. I know it's tough for them, too." R

Jenny Robertson is a physiotherapist, and has represented Region 4 on HSA's board of directors. She has also been a member at large for Region 4, as well as chief steward for GF Strong Rehabilitation Centre in Vancouver.

Terminating your pension membership

Q: Unfortunately, I have to move to Ontario to care for my elderly parents. What happens to the contributions I've made toward a pension if I stop working for my current employer?

A: When you stop working for an employer in the Municipal Pension Plan, you remain a plan member for one year from the date you leave your job. At the end of one year, and as long as you have not begun receiving your pension or started contributions to the Plan again, you can make some choices about your pension contributions.

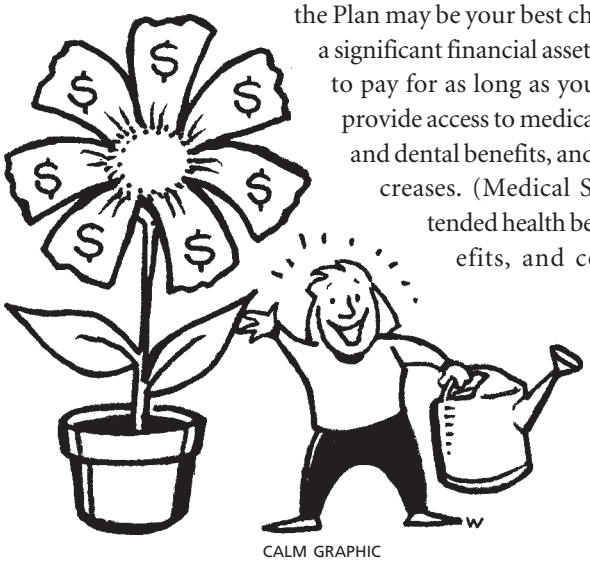
Your options

If you start contributing to the Plan again within one year of ceasing employment, your pension membership will continue. If you do not start contributing to the Plan again within one year, your options are shown below.

Leave your service on deposit

You can leave your contributions on deposit with the Plan for a future pension. This can be beneficial if you think you may work in the future for an employer that belongs to the Plan. By leaving your contributions on deposit, you may increase your eligibility for certain benefits or future plan improvements.

Even if you don't anticipate returning to work for a plan employer, leaving your service on deposit in the Plan may be your best choice. A pension is a significant financial asset that will continue to pay for as long as you live. It may also provide access to medical, extended health and dental benefits, and cost-of-living increases. (Medical Services Plan, extended health benefits, dental benefits, and cost-of-living increases are not guaranteed.) For more information about the value of your pension, see the Plan's website, or contact the Plan.



CALM GRAPHIC

You may apply for your pension to begin at your earliest retirement age even if you reach that age within a year of leaving your job.

Transfer your service to another plan

In some cases you can transfer your pension from one plan to another. For more information, contact the pension plan.

Take a commuted value payment

The commuted value of a pension is the amount of money that needs to be set aside today, using current interest rates, to provide enough funds at retirement to pay your pension.

You have options to consider when your Plan membership ends.

A commuted value payment must be transferred to a locked-in retirement plan, unless it qualifies as a small benefit refund under the *Pension Benefits Standards Act.* Locked-in means the pension plan funds must be used to provide a lifetime pension benefit.

If the pension plan calculates a commuted value for you, the amount is guaranteed until a specified date, as indicated on your *Termination Selection Statement*, which we will provide to you.

Normally, pension members are not eligible to receive a commuted value payment once they reach earliest retirement age 55. However, members who terminate employment at age 54 have a one-time opportu-

In this regular feature, the Municipal Pension Plan answers frequently-asked questions. See pensionsbc.ca for more information about the Municipal Pension Plan.

nity to request a commuted value payment when they terminate their membership.

The *Income Tax Act* limits the amount of a commuted value payment that can be tax-sheltered. Any part of your commuted value that is over the limit must be taken as a refund and will have income tax withheld.

Take a refund

If you are not eligible for a pension or a commuted value (for example you are under age 60 with less than two years of contributory service), you may be able to get a refund of your pension contributions plus interest. Refunds are subject to income tax.

Unusual circumstances

If you are appealing the termination of long-term disability benefits, or if you are appealing/grieving your dismissal from employment, call the Municipal Pension Plan before you take a commuted value payment or a refund. The pension plan will explain how choosing either of these options may have irreversible consequences. You should also ask about possible disability benefits from the Pension Plan, if applicable.

Income tax

Tax will not be deducted on payments to a registered retirement savings plan (RRSP, locked-in or not locked-in), life income fund (LIF), or the registered pension plan (RPP) of a new employer. Tax will be deducted on cash payments.

Tax is withheld according to Canada Revenue Agency's flat rates of 10 per cent to 30 per cent depending on the payment amount. More or less tax may be payable when you file your income tax return. If you are not a Canadian resident, the tax rate varies from country to country (25 per cent is common).

Marriage breakdown

A pension is a family asset. If your marriage breaks down, it may affect the payment of benefits that have been quoted on your *Termination Selection Statement*. Contact the Municipal Pension Plan for details. R

Options available after terminating your Municipal Pension membership

Age at time of termination	Under two years of contributory service	Two or more years of contributory service
Under 55	Refund of contributions with interest	Deferred pension or locked-in commuted value. The deferred pension is payable no earlier than age 55 and is reduced if it commences before age 60 unless age and contributory service total 90 or more.
55 but under 60	Refund of contributions with interest	Immediate or deferred pension. The pension is reduced if it commences before age 60 unless age and contributory service total 90 or more.
60 but under 65	Immediate or deferred pension. The pension is reduced if it commences before age 65.	Unreduced pension
65 or over	Unreduced pension	Unreduced pension

Committees

UNION POLICIES

HSA's guiding principles now viewable online

by BRUCE MacDONALD

HSA has a new more convenient way for members to view our union's policies.

HSA members often have questions about how our union is governed, who makes decisions, what the decisions are, and how they might affect members. For example, the following are frequently asked questions:

- How does HSA decide what educational opportunities to offer?
- What is the "Defense Fund" and how does HSA decide how much money goes into it?
- Who serves on HSA committees?
- Which expenses will HSA cover for time spent by members on HSA activities?

Answers to all these questions are guided by policies developed and approved by HSA's board of directors.

What is the purpose of policies?

Policies are the guiding principles of an organization. They provide direction on how to organize our work.

Where do our policies come from?

Many of our policies originate from resolutions approved at the union's annual convention.

Delegates to the annual convention are elected by members, who entrust delegates to set the direction for the union's governance. The union's board of directors then is charged with deciding what actions follow, and how these actions will be carried out. Written policies clarify the board's decisions.

Who writes policies?

The board of directors oversees policy development. In 2004, the board approved the creation of a policy writing committee: the Constitutional and Organizational Policy Committee (COPs). This committee meets three or four times a year to review and revise policies. Board committees, such as Education, Political Action, Run for the Cure, and others, assist COPs and the board with input into policies that affect their work. HSA has excellent staff members who provide background and assistance to develop and implement policies.

Why are policies developed?

A few years ago, HSA initiated a policy development project. The board and staff realized we were not as clear as we wanted to be about some policy areas and that policies were not as easy to use or access as we members desired. As a result, the board allocated a small amount of resources dedicated to developing a common format and approach to policy development. We learned that policies are "liv-

ing" and evolving documents that reflect the values and philosophy of the organization, rather than static ones. HSA was at the stage of our development where we needed a rigorous process to oversee policies.

The need for new policies may come from individual members who identify a gap, from committees that oversee various activities (such as scholarships), or from staff who identify a need for updates. Sometimes, a policy that seemed just right needs tweaking to be clearer because it doesn't work for you, the member! COPs now vets all policy updates and additions – and even deletions when a policy outlives its usefulness. COPs takes all the recommended changes to the board for approval.

To ensure that members have access to information in a timely fashion, the policies are now available on the members-only section of the HSABC website. To find them, you must log into the union website at hsabc.org. If you are not already a registered user, you will require your member ID number, which you can find on the mailing label of your membership magazine, *The Report.*

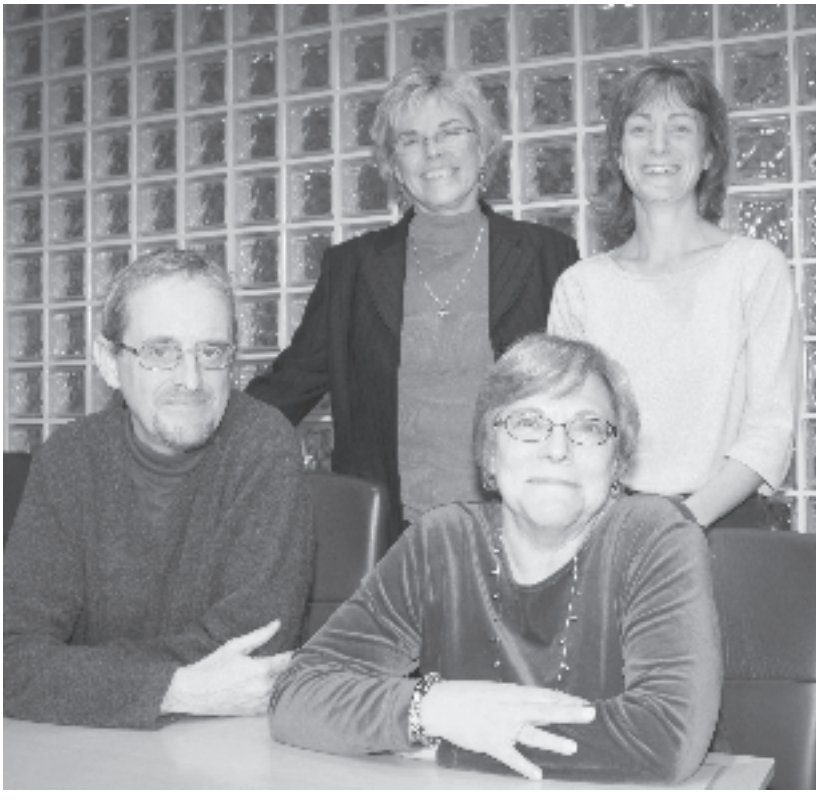
The policies are online at *Resources > Member only resources > HSA policies.* You will notice that each policy has a disclosure and use statement at the top which states:

"This information is for HSA members only. You agree to use this information for HSA purposes only, and will not copy or distribute any of these materials without approval from the HSA head office (contact your chief steward)."

We ask that if you view any of the HSA policies, you respect that they are provided for your use only.

Please take a moment to review this new feature on the website, and to provide any feedback you may have. R

Bruce MacDonald is chair of HSA's Constitutional and Organizational Policy Committee, and represents Region 3 on the union's board of directors. View HSA's policies on the union's website at www.hsabc.org



HSA's Constitutional and Organizational Policy Committee, clockwise from left: Bruce MacDonald (Chair, Region 3 Director), Susan Haglund (Executive Director of Operations), Thalia Vesterback (Region 9 Director), and Lois Dick (Region 10 Director).

CONTRACT INTERPRETATION

It's your right: questions and answers about your collective agreement rights

Regional seniority

by MIRIAM SOBRINO

This question about regional seniority arose from discussions at a regional meeting held this fall on Vancouver Island.

Q: I understand that it was mandated by the union over ten years ago to pursue a provincial wide seniority list, allowing members to travel to any hospital in the province. What concerns me is the ability to jump into a different city, ahead of local workers.

Seniority lists within a geographical area make sense to me, as long as it is possible to commute between workplaces. However, authority wide jumping could cause the displacement of families.

My family's home is Nanaimo. I took a risk coming here. I quit a full time job in Vancouver to take a casual position here in Nanaimo.

As a casual, I am not guaranteed shifts. It is irrelevant that I have always managed to get enough work, by accepting a crazy schedule of days and nights. Like many HSA members, I pay my mortgage one paycheck at a time.

You told me you feel such a displacement is unlikely, but you do admit it is possible. What are we gaining for that risk?

I understand the gain for those with seniority. But how will it benefit the rest?

There is no need for our members to jump in on a position that might have had a casual working five hard years to create: not even the jumper would want that.

Why can't an employee's benefits and seniority still transfer to a hospital after the local staff have had a chance at the position? Once working in the facility, they would then be able to use their seniority to apply for new openings, just like any other local worker.

I was casual for three years. I recently got a temporary part time, and in six months will likely be casual again. If things go well, there will be a full time position within the next three years. But not if I get bumped.

In an era of shortages, you say there will be lots of work. Things change.

I humbly ask you to respond to me by putting this before our members in our news magazine, The Report.

To the members, I request you respond by email, telephone, snail mail, or just shout. Log onto the website and let HSA know how you feel on this issue. Because once it changes, we can never go back.

Chris Semrick
Respiratory Therapist
Nanaimo

This column is designed to help members use their collective agreement to assert or defend their rights and working conditions. Please feel free to send your questions to the editor, by fax, mail, or email yukie@hsabc.org. Don't forget to include a telephone number where you can be reached during the day.

CALM GRAPHICS

Continued from previous page

A: The issue of regional and provincial seniority is one that HSA members have considered at the bargaining table and at conventions for several years.

In 1996, the union held a special convention on the issue. Province-wide seniority was debated at length and in depth, as a wholesale change in the organization of health care delivery changed the shape of health regions, as well as the structure of health care bargaining. Subsequent conventions have seen delegates uphold the principle of regional and provincial seniority, identifying it as an important job security provision.

Collective agreements are developed and evolved in the best interests of the workers whose rights and benefits are governed by that collective agreement. Principles to pursue in collective bargaining are debated and voted on by representatives of the membership to ensure the bargaining principles reflect the interests and desires of the membership. Currently, the Health Science Professionals' collective agreement recognizes institution-based seniority, except in the case of vacancy postings or by mutual agreement between the employer and union – which is what is being negotiated within VIHA.

The application of seniority in a fair manner is a challenge for all unions. In some instances unions have to be prepared to abrogate seniority rights for some members. For example unions are obligated by the provisions of the Human Rights Code to weigh the interests of disabled workers versus senior able bodied workers in a fair and transparent process. Otherwise the union can be liable for damages under the Human Rights Code for the failure to accommodate disabled workers.

In this instance, we are negotiating a broader geographical seniority list. This will provide more economic security for those workers covered by the broader seniority list. For example a reorganization with job loss will allow regular employees to take vacancies rather than bumping junior regular employees.

This change may mean you are on the casual list for a longer period of time than you otherwise would have been. However, you would not have lost your job, while the senior regular employee may be facing a real job loss. In periods of downsizing or layoffs, protecting job security for the most members of the union by a fair and transparent system is the union's primary responsibility. R

FIGHTING POVERTY

Dietitians validate call for higher minimum wage

On the sixth anniversary of the last increase in BC's minimum wage, a broadly based delegation including low income earners lobbied politicians in Victoria for a raise and delivered to the Campbell government the names of 40,000 British Columbians who have so far signed the $10 NOW petition at bcfed.ca.

The $10 NOW lobby team met October 31 with Labour Minister Olga Ilich and NDP leader Carole James. And they hosted a lunch attended by more than 30 MLAs from both parties to make the case that BC's minimum wage should be boosted to $10 an hour to give 250,000 low paid workers a long overdue raise.

The delegation, led by BC Federation of Labour president Jim Sinclair and secretary treasurer Angela Schira, included representatives of young workers and students, poverty experts, people with disabilities, and an Anglican priest – along with low wage earners Valerie Rogers and Brent Frain, who work at a McDonald's restaurant in Langley.

"How is a person making $8 an hour supposed to live?" Rogers asked in the meeting with the labour minister. Although Ilich told the delegation they had made a compelling case that she would take back to her colleagues in the Legislature, Gordon Campbell had a different message. The Premier told reporters that the door was closed on an increase.

Dietitians among key validators

The minimum wage campaign has the support of key validators, including various chambers of commerce, child poverty and housing advocates, and Dr. Perry Kendall, the provincial health officer.

Two groups of nutrition experts also raised voices of concern: the Dietitians of Canada and the Community Nutritionists of BC say the working poor don't earn enough to buy basic foods required to remain healthy. These two groups are calling on the Campbell government to increase BC's minimum wage to a level that brings minimum wage workers above the poverty line.

Sinclair says the lobby efforts in Victoria were positive and he pledged that the labour movement's campaign would continue until the minimum wage is increased and tens of thousands of workers brought up to the poverty line.

"We're definitely not going to give up," he says.

"Mr. Campbell had no problem voting himself a 54 per cent wage increase, but won't do the same for minimum wage earners," Sinclair said. He noted that if low income earners received the same increase as the Premier, the minimum wage would be $12.32. R

BEHIND CLOSED DOORS

Understanding TILMA and the threat to democracy

by ALEX HEMINGWAY

On April 28, 2006, having held no public consultations and preceded by only a few scant press releases, the governments of British Columbia and Alberta announced the signing of a sweeping new accord: the Trade, Investment and Labour Mobility Agreement (TILMA).

The BC government has touted the agreement, which came into force on April 1, 2007, as an important means to "removing barriers to interprovincial trade, investment and labour mobility." However, a closer look reveals a strikingly different picture.

"Bizarre methodology"

Canadian Centre for Policy Alternatives economists Marc Lee and Erin Weir deconstruct the "bizarre methodology" of a government-sponsored Conference Board report, outlining TILMA's alleged economic benefits in their February 2007 analysis: *The myth of interprovincial trade barriers and TILMA's alleged economic benefits.*

While the Conference Board report claims interprovincial barriers cost the provincial GDP (a measure of the overall size of the economy) an astounding 3.8 per cent annually, the government later downgraded their estimate to one per cent. However, independent analyses from an array of economists, including the former head of the Canadian Economics Association, go much further, suggesting TILMA "will have almost no effect on interprovincial trade flows" and emphasizing that "interprovincial trade barriers are already very low," likely less than 0.05 per cent of the GDP.

In fact, even before the introduction of the barrier-reducing Agreement on Internal Trade (AIT) in 1995, a federal government commission acknowledged, "the direct costs of existing interprovincial trade barriers appear to be small" and "not sufficient to justify a call for major reform."

Since Canada already has the AIT, and interprovincial barriers are "very low," the question arises: does TILMA have another purpose?

Sweeping rights for investors

TILMA's sweeping scope is perhaps the agreement's most startling characteristic. Under its "No Obstacles" clause, TILMA bars any government measures that "operate to restrict or impair" investment. By their very nature many government measures – including the administration of universal public health care – are included.

Health care programs are only the tip of the iceberg. "Measures" are defined in TILMA to include "any legislation, regulation, standard, directive, requirement, guideline, program, policy, administrative practice or other procedure." The "No Obstacles" clause thus allows extraordinary restrictions on the powers of democratic government.

Taking a page from NAFTA's most controversial provisions, TILMA allows corporations to seek millions of dollars in damages from governments for violations of the agreement, including measures that

Under TILMA, private health care companies could seek millions of dollars in damages and push government policy towards expanding for-profit health care.

"restrict or impair investment." A trade panel, unaccountable to the public, is empowered to rule and decide damages in such disputes.

Consider that under NAFTA's procedures – which are actually more protective of government measures than TILMA's – a US chemical company was able to launch a dispute against Canada for banning the gasoline additive MMT, a suspected neurotoxin. The dispute led to the ban's repeal. The federal government paid $13 million in damages to the plaintiff, Ethyl Corporation.

Unlike the AIT and NAFTA, TILMA includes no screening process for frivolous claims. Complaints can be launched over "any matter regarding the interpretation or application of [the] Agreement." Furthermore, TILMA does nothing to prevent claimants from repeating the same complaint if the offending government measures persist.

Not only are governments and other public institutions subject to massive fines for violations of TILMA, but the agreement is also expected to create "a 'chill' effect whereby governments eliminate measures or decline to introduce new ones to avoid TILMA challenges."

Under threat: health, education, environment

While TILMA includes a list of exceptions from the agreement, it's most notable for its omissions. Exceptions include a few aspects of forestry and fishery policy, water resources, and some social policy areas, among others. Astonishingly, exceptions do not cover health care, education or many environmental protection measures, for example.

A number of areas fall under the category of "transitional measures," which will be fully subject to the provisions of TILMA on April 1, 2009, unless the provincial government explicitly intervenes to exempt them. These areas include, among others, "measures of or relating to Crown corporations, government-owned commercial enterprises, municipalities, municipal organizations, school boards, and publicly-funded academic, health and social service entities." Moreover, even during the transitional period, these institutions are forbidden from "amending or renewing" measures "that would decrease consistency with [TILMA]."

The only other way to avoid TILMA's sweeping prohibition against measures that "operate to restrict or impair investment" is for governments and other public institutions to demonstrate that a given measure is meant to achieve a "legitimate objective," as defined by the agreement.

However, even if a measure qualifies as a legitimate objective, an additional onus is on government to prove that the measure is not more restrictive to investment than "necessary" and is not a "disguised restriction" to investment.

Although protecting the environment and providing health and social services are listed as "legitimate objectives," they may be extremely difficult to uphold under TILMA because of the additional "necessity" requirement. Remarkably, the agreement ultimately leaves such crucial decisions to an unelected, unaccountable trade panel.

Continued next page

Understanding TILMA and the threat to democracy

Continued from previous page

Gives advantage to for-profit health care companies

Health care and education represent two particularly important public services that could face serious challenges under TILMA.

Our universal public health care system prohibits private care for medically necessary procedures and uses public money to fund individuals' health services, measures that arguably restrict and impair private investment in health care.

Indeed, in the words of constitutional lawyer Steven Shrybman, "Virtually every element [of] provincial health-care frameworks curtail investment, and many affect interprovincial trade in services and labour mobility." Consequently, under TILMA, private health care companies could seek millions of dollars in damages and push government policy towards expanding for-profit health care.

Similarly, in the realm of post-secondary education, private institutions could claim that the government funding of public universities and colleges clearly puts private institutions at a disadvantage, impairing investments in these entities. Such complaints under TILMA could cost the government millions and ultimately threaten the public education system.

There may be a few worthwhile ideas to be gleaned from the arguments of TILMA proponents. Regulatory differences do exist between provinces, and some may be unnecessary.

As an economic analysis by the Canadian Labour Congress notes, "In fields where provincial governments wish to harmonize their regulations, they can do so by jointly adopting common standards. This process hardly requires a sweeping agreement like TILMA… [which] would achieve harmonization by defining regulatory differences as trade barriers and pushing provincial standards down to the lowest common denominator." R

This article is excerpted from a paper by Alex Hemingway.

CORRECTION

In the last issue of *The Report*, we mistakenly printed a photograph of Jo Lecompte alongside an article highlighting union activist Vikki Tellier. At left is a photo of Vikki Tellier.

Your messages are being heard

by REBECCA MAURER

HSA has long struggled with the challenge of getting our voice heard amongst the long list of organizations striving to bend the government's ear.

This challenge is made even greater due to the infrequency of meetings (most organizations are lucky to get even one meeting a year in Victoria), the diversity of our membership, and the complexity of issues that our members face on the job. Half-hour meetings with government ministers and their senior staff simply aren't an effective way to move forward on our issues.

With that in mind, the HSA board of directors approved a pilot project in 2002 that paired union activists with their local MLAs in order to educate them about the role HSA members play in the delivery of health care and the issues our members face at work. The idea was to focus less on "lobbying" and more on building relationships in the community. The Constituency Liaison Project started with six activists who were asked to meet with their local MLA on a regular basis, to develop a good working relationship that would facilitate the exchange of information and to inform them about specific issues of importance to the union.

To support these members, HSA held a training workshop to teach the basics of government relations and to provide tools such as briefing notes and background papers that constituency liaisons could use to inform their MLA about the issues.

The project was an immediate success. HSA members are well-educated, articulate and your work is interesting and varied. The stories that the constituency liaisons brought with them captured the attention of the MLAs and in some cases, educated them about a part of the health care system they knew little about.

Over the past five years, the project has grown from six to 35 constituency liaisons who meet regularly with government and opposition MLAs in communities all over the province. Every year, HSA holds at least one training session for constituency liaisons, who are invited to attend the union's fall regional meetings to report on their activities.

In addition to meeting with MLAs at their offices, some of HSA's constituency liaisons have arranged for their MLAs to tour local health care facilities, to get a first hand look at the work our members perform, and to speak with members about the challenges they face in delivering services. Other constituency liaisons have been invited by their MLAs to participate in local health care forums or are called upon when the MLA has a health care-related question.

In 2004, HSA constituency liaison argued successfully for an expansion of the loan forgiveness program to cover more health science professional disciplines. This year, HSA's constituency liaisons are playing a key role in the union's campaign for increased training spaces for health science professionals.

Rebecca Maurer, Director of Strategic Communications & Member Development

While far more needs to be done to address the acute shortages in our disciplines, the government does seem to be getting the message and has recently announced increased training spaces for both laboratory and diagnostic imaging technologists, as well as a plan to expand physiotherapy training to northern BC. It's not enough but it is a step in the right direction and HSA's constituency liaisons were pivotal in bringing attention to this issue.

HSA hopes to expand this very successful project to include more MLAs in even more communities across BC. Members interested in learning more about the project or putting their name forward to serve as a constituency liaison, should contact the head office. R

A new perspective at the table

by SUZANNE BENNETT

Suzanne Bennett, Region 1 Director

When I joined the board of directors of HSA in 2006, I was the first board member who came from the community social services sector. While the majority of the union's members work in the health care system, five per cent of the membership works in this sector.

In my region – the North Island – members working in this sector represent 30 per cent of the HSA members.

When the position became vacant in 2006, the timing was right for me personally to put my name forward as a representative to the board who could bring not only a regional perspective to our union's leadership, but also a voice from an important sector of our membership.

In the 1990s, HSA vigorously pursued new members who worked in community social services. Members from the John Howard Society in Courtenay, where I work as a youth addictions counselor, joined HSA in 1995.

Four years later, those members went out on a four-week strike.

It was just the most amazing time – we were new to being organized in a union, and it was the first time we ever took job action. People's pride increased around being in this field and doing this kind of work because there was finally acknowledgement in the bargaining process about the value of our work.

Earlier this year, there was another first for a representative from the social services sector of the membership of HSA, when I was elected by the board of directors as the union's vice-president.

As vice-president I am Chair of the Resolutions Committee, responsible for the shepherding of all resolutions to the union's annual convention. I am also a member of the executive committee, and have the responsibility for taking on the duties of the president in his absence.

At the board table, I have an opportunity to bring the perspective of members from outside of the formal health sector to HSA deliberations about internal union issues to HSA's involvement in the wider labour movement. It is also my role to make sure the other board representatives understand the issues that face members from the social services – as well as the members from the health sector from my region.

I was extremely pleased this year when our national union, National Union of Provincial and General Employees (NUPGE), held a national social services workers conference to share information and develop strategies.

At that workshop, participants discussed the steadily declining federal funding since the 1960s, health and safety issues, and environmental issues. The delegates made a number of recommendations, including calling for increased occupational health and safety training, and incorporating compensation for violence, bullying, and stress in workers' compensation programs.

Delegates to that conference also recommended that a National Appreciation Day for Social Services Workers should be observed – a recommendation that NUPGE accepted.

I am pleased that I and my professional colleagues have in HSA a union that has welcomed, listened to, and included members of the social services community in a meaningful and positive way, and look forward to continuing to represent all the members in my region at the board table. R

Suzanne Bennett is HSA's vice president and represents Region 1 on the union's board of directors.

EQUALITY AND SOCIAL ACTION

Committee urges awareness

HSA's Committee on Equality and Social Action encourages members to take note of the following dates:

March 8
International Women's Day

March 21
International Day for the Elimination of Racial Discrimination:
www.un.org/depts/dhl/racial

April 22
Earth Day

April 7
World Health Day: www.who.int/en

April 17
Equality Day (Canada)

Wanted: auction items

HSA's Committee on Equality and Social Action is seeking items for its annual silent auction. Donate your pottery, art, fabric craft, or other fabulous contribution to a good cause!

This year the committee is looking for your help in deciding where to direct the money raised. If you know an orphanage in South or Central America that needs funding, please contact Pam Bush at the HSA office.

HSA's Committee on Equality and Social Action distributed various awareness stickers and posters this past year, including this one for the International Day of Peace.

HEALTH SCIENCES ASSOCIATION OF BC

THE Report MAGAZINE

The Report is dedicated to giving information to HSA members, presenting their views and providing them a forum. The Report is published six times a year as the official publication of the Health Sciences Association, a union representing health and social service professionals in BC. Readers are encouraged to submit their views, opinions and ideas.

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Holiday best wishes

In past years, the Health Sciences Association has marked the holiday season with cards of thanks and greetings to activists, colleagues, supporters and suppliers. It's our way of thanking you for the work you do with us throughout the year.

This year – as we have done in recent years – the HSA instead made a financial contribution to the Canadian Association of Food Banks. The association works towards province-wide distribution of goods, helping support families throughout the province year-round. You can find out more about the Canadian Association of Food Banks at www.cafb-acba.ca

Thank you for your support, and please accept my best wishes for the holiday season on behalf of the HSA Board of Directors and staff.

Reid Johnson, President

HSA

Health Sciences Association
The union of caring professionals

www.hsabc.org