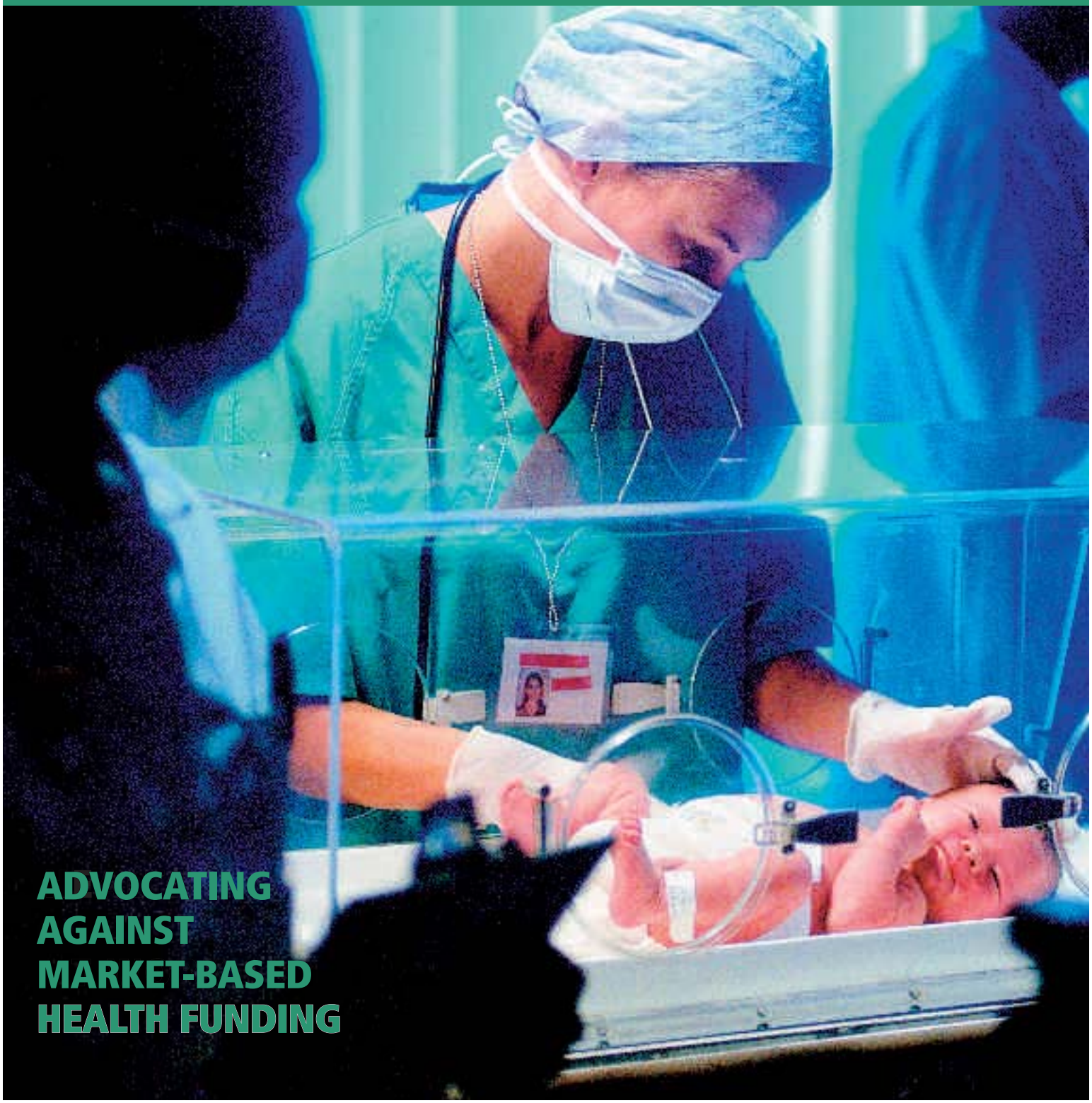
HEALTH SCIENCES ASSOCIATION | APRIL / MAY 08 | VOL. 29 NO. 1

THE Report



ADVOCATING AGAINST MARKET-BASED HEALTH FUNDING

MESSAGE FROM THE PRESIDENT

Charting our course together

by REID JOHNSON

A year ago, delegates to HSA's convention gave me a mandate to lead your union into the future.

Reid Johnson, HSA president

On the eve of the union's 37th convention, I've taken this opportunity to look back at the past year and consider what I, and your board of directors, have done collectively to honour that mandate.

Over the course of the year, I have had countless occasions to represent HSA in a wide range of circumstances. I've had numerous encounters with HSA members in their worksites, at meetings and various events. I've met with health authority CEOs, government ministers, opposition MLAs, other labour leaders and members, bureaucrats, educators and students. No matter where I go or who I talk to, I know that HSA members are respected for your high standards of professionalism – whether it's at your day job, as a union activist, or a community advocate.

No matter where I go or who I talk to, I know that HSA members are respected for your high standards of professionalism.

What I've heard from members is that your priority is for your union to represent your concerns, and that your union is an effective advocate on your behalf.

On that front, we've had many significant successes. We negotiated a settlement in the wake of the Bill 29 court decision. We've moved forward on grievances and workers' compensation claims, we've made headway on occupational health and safety issues at many worksites, and we've negotiated for improved working conditions in new certifications outside the four main public sector collective agreements.

We're also looking to the future needs of members, adding specialized staff to address labour relations and classifications matters, a dedicated pensions and benefits advocate, and a costing analyst to prepare us for an important round of collective bargaining in 2010.

On the broad topic of shortages – an issue that affects each and every HSA member in some way – the topic is on the agenda for every meeting and every event that I attend. We've had success in getting the media's interest on this story. We've also delivered the message to the decision-makers in government.

While our focus has been on shortages in the health science professions, our members in the community social services are feeling the crunch too. And we are working to raise awareness on that front.

We were fortunate to have Suzanne Bennett, HSA's first board member and vice president from the community social services sector, among HSA's delegation to a national meeting sponsored by our national union, NUPGE, to share experiences and ideas for improving the conditions in the sector across the country.

Just last month the Social Planning and Research Council of British Columbia released a report on the challenges of recruitment and retention in the community social services. Low wages, unstable funding and lack of recognition of the importance of the work our members do in the sector were all identified as barriers to recruitment and retention. As members of the Community Social Services Bargaining Association, we are working with other unions to advance these issues as we look forward to bargaining in 2010.

But, just because the message is out there, it doesn't mean government and employers are prepared to do anything about it… yet. We still have a lot of work to do.

And that's what this year's convention – the lead-up to a critical round of bargaining in 2010 is all about: Charting our Course for the future.

I look forward to seeing many of you at convention this year, and many more of you throughout the coming year as I continue to meet with members in your communities to hear from you what HSA should be doing for members today and as we chart the course together into the future. R

Reid Johnson is president of the Health Sciences Association of BC.

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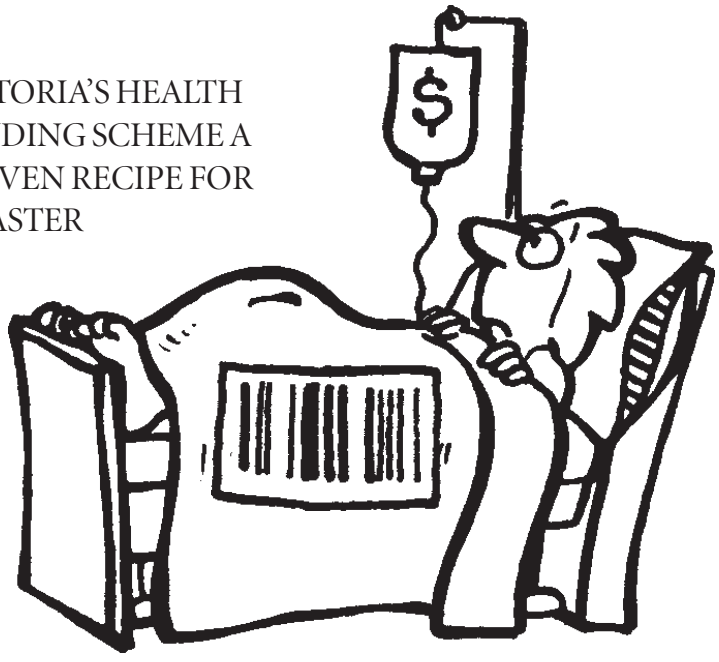

THE FRONT COVER

Increasingly, HSA members are facing excessive workloads – exacerbated by staffing shortages in many health care and social service professions.

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News

Val Avery

Valerie Avery new Region 2 Director

HSA members in Region 2 have elected Valerie Avery, a physiotherapist at Royal Jubilee Hospital, as their representative on the union's Board of Directors.

The other candidates for election were Derrick Hoyt, a pathologist's assistant at Royal Jubilee Hospital, and Anna Morton, a social worker at Queen Alexandra Centre for Children's Health.

Valerie has been a member of HSA for 17 years. She has served as a General Steward, Assistant Chief Steward, Chief Steward, Member-at-Large, District Representative, Relief Labour Relations Officer and as a member of the Provincial Bargaining Committee for the last round of health science professionals bargaining.

The HSA board of directors congratulates Val on her election.

She will assume office at the close of the 2008 HSA convention.

Heather Sapergia

Heather Sapergia new Region 10 Director

HSA members in Region 10 have elected Heather Sapergia, a medical laboratory technologist at Prince George Regional Hospital, as their representative on the union's Board of Directors.

The other candidate for election was Mandi Ayers, a medical laboratory technologist at Bulkley Valley District Hospital.

Heather's activities in HSA include terms as an OH&S Steward, General Steward and Chief Steward. She has twice acted as an HSA job action coordinator during job action and is a Constituency Liaison, meeting regularly with her local MLAs to keep them aware of HSA members' concerns.

The HSA board of directors congratulates Heather on her election.

She will assume office at the close of the 2008 HSA convention.

BC health care forum draws standing room only crowd

On April 11, just hours after Health Minister George Abbott tabled controversial amendments to the Medicare Protection Act, more than 200 people attended a public talk by physicians and international policy experts about the dangers of continued health care privatization in British Columbia.

Dr. Michael Klein – physician, researcher and founding member of the Canadian Doctors for Medicare – told the gathering that health care funding has remained stable as a percentage of both the BC and Canadian economies over the past decades.

"Health care spending is only increasing relative to the province's budget because the government is cutting taxes and other services like education and social programs," said Klein. "Appropriate investments, resourcing, and implementation of public innovations are the real answers to sustainable, universal health care."

Dr. Wayne Hildahl, CEO of the Pan-Am Clinic in Winnipeg, told his own story about the successes of his formerly investor-owned clinic, once it was integrated into the local public health authority.

"What we have accomplished at the Pan-Am Clinic proves that the efficiencies from a publicly accountable, multi-disciplinary, collaborative approach to health care are superior to the private-sector model," he said.

Dr. Allyson Pollock, head of the Centre for International Public Health Policy at the University of Edinburgh, outlined the dangers of public-private partnerships (P3s). "P3s are very much a European export to countries like Canada, and are now being used to sell off all pieces of the public sector, including health care," he said. "P3s are placing assets that should belong to your children and grandchildren into the hands of corporations and big banks."

Joyce Jones, BC Health Coalition community co-chair, said the event's popularity is a clear sign that government continues to ignore the messages from their own Conversation on Health. "British

Columbians do not want more profit-driven health care," said Jones. "They want government to put in place the many positive public innovations that exist here in B.C. and across Canada that will strengthen health care for all."

Youth-focused workshop available on health care systems and threats

Wait times, facility fees, P3's, and more – how did health care get so complicated, and how can we bring it back to taking good care of each other? The BC Health Coalition and Check Your Head have developed a workshop that can help groups – especially youths – learn what we can do to protect our health care from the coffers of business, and keep it in the hands of all people.

Health Care: The Price is Right? is a workshop that delivers a unique, youth-accessible opportunity for dialogue and information on various encroaching threats to medicare, providing a space for much-needed youth-to-youth education on systems of health care.

Through facilitated discussions and interactive activities, youth explore the values behind universal care, encounter the realities of for-profit health care, and learn about the threats that for-profit participation pose to Canada's system. Using role-plays, games and case studies, participants engage in discussion about health care as the right of all people.

Workshop participants are provided with information about campaigns of the BC Health Coalition and others working to keep health care public and invited to brainstorm ways to take proactive steps toward the good health of their communities.

Interested? Contact CYH or BCHC to book your workshop:

Check Your Head: 604/685.6631
contact@checkyourhead.org

BC Health Coalition: 604/681.7945
campaigner@bchealthcoalition.org

Current disputes

This is a listing of current disputes involving affiliates of the BC Federation of Labour. Please respect the unions' picket lines in the following disputes, and do not patronize these businesses until the dispute is settled.

For more information, check the BCFL website at www.bcfed.ca.

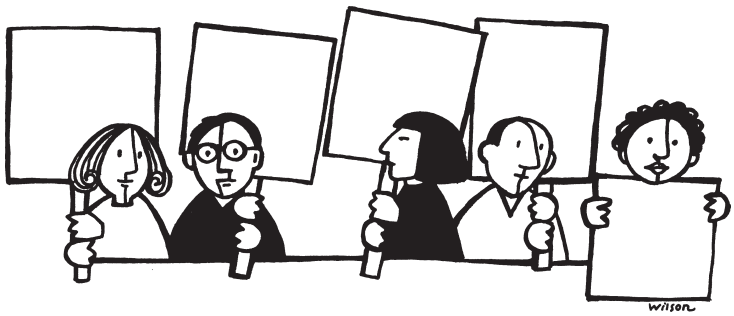
International Brotherhood of Electrical Workers (IBEW) Local 213 – VS – Sears Canada (Burnaby)
Major Issues: Wages, Working Conditions, Benefits
Commenced: October 1, 2007

Construction Specialized Workers Union (CSWU) Local 1611 – VS – Service Corporation International Canada (SCIC) (Burnaby, Kelowna)
Major Issues: Concessions, Wages
Commenced: March 14, 2008

United Food and Commercial Workers Union (UFCW) Local 1518 – VS – Vancouver Native Housing Society (Vancouver)
Major Issues: Wages, Job Security
Commenced: March 13, 2008

Construction and Specialized Workers' Union, Local 1611 – VS – Wescon Enterprises Ltd. (Trivern) (Armstrong)
Major Issues: Seniority, Benefits, Concessions
Commenced: July 25, 2001

United Steelworkers (USW) – VS – TimberWest (British Columbia)
Major Issues: Safety, Hours of Work, Contracting Out, Job Security / Severance
Commenced: July 21, 2007



BOYCOTTS

Sears Canada – CLC/BCFL – IBEW 213
Non-Union Postal Outlets – CLC/BCFL – CUPW
Philips Electronic Products, Quebec – CLC – USW 7812 R

News

PHOTO COURTESY JACQUI MOFFATT

Jacqui Moffatt, occupational therapist at Ridge Meadows Child Development Centre, submitted this photo of her fundraising team for the Easter Seals 24 hour Relay for the Kids. Last year, the relay raised $1.2 million to send 900 children with disabilities to Easter Seals Camps.

Occupational therapists and friends run for kids

On June 14 2008, a group of occupational therapists and friends are dressing in pink and heading to Swangard Stadium in Central Park, Burnaby to participate in the Easter Seals 24 hour Relay for the Kids. Participants walk or run – relay style – the four kilometre loop around Central Park.

Thanks to this community fundraiser, more than 900 children with disabilities from across BC are able to participate in one of the BC Lions Society's three Easter Seals Camps

In its 28th year last year, more than 130 teams – made up of over 4,000 participants – raised over $1.2 million.

This event means more than just sending kids to camp. It gives children with disabilities a place to go where they're free from life's daily challenges. It provides them with opportunities to participate in activities they may not usually have the chance to experience, like scaling a climbing wall, fishing, canoeing, horseback riding and even sleeping under the stars.

The camping programs are designed to enable these children to discover and strengthen their individual abilities. They are encouraged to gain new skills, develop new friendships, gain confidence, and independence - attributes that will help them to succeed in life.

Check www.24hourrelay.com for more information, or call the BC Lions Society for Children with Disabilities at 604/873.1865.

To inquire about joining team Pink Power email: jcmoffat@interchange.ubc.ca.

Pandemic precautions: How ready are we?

New data from more than a dozen European countries, Canada and the US shows a higher percentage than usual of flu viruses that are resistant to Tamiflu, a top antiviral drug that has been stockpiled by countries around the world for possible use in a flu pandemic.

In a study released last week, the European Centre for Disease Prevention and Control (ECDC) found that Tamiflu doesn't work in about 13 per cent of H1N1 viruses, the main flu strain causing illness this year. In Canada the data shows more than a 10 per cent resistance rate. Normally, resistance levels are well below one percent.

Leading infectious disease experts are concerned that if the resistance becomes widespread, Tamiflu, one of the tools for fighting a flu pandemic, might become useless and they are anxiously monitoring any further spread of the resistant H1N1 strains.

The World Health Organization (WHO) said it cannot explain this Tamiflu resistance.

"I think this is a very concerning change in influenza virus resistance patterns," said Dr. Frederick Hayden, a leading antiviral expert and a member of the World Health Organization's Global Influenza Program.

The WHO's Global Influenza Program held a special teleconference of about 50 scientists from leading influenza laboratories around the world last week to try to get a handle on how far this resistance has spread and what is driving the spread.

"These new findings highlight the importance of ensuring that Canadian efforts to prepare for a pandemic are continuous and evolving," said James Clancy, National President of the National Union of Public and General Employees (NUPGE). "Canada should ensure our plan for stockpiling antiviral drugs doesn't rely exclusively on Tamiflu."

The National Union has been pushing governments in Canada to ensure there is adequate preparedness and protection of critical health and safety infrastructure and supplies in the event of pandemic.

A comprehensive report on pandemic planning in Canada is available from the National Union at www.nupge.ca. The report presents an overview of what Canadians need to know about the threats that pandemics pose and what governments in Canada are doing to prepare for them.

See the pandemic preparedness checklist on the next page for an aid to taking stock and planning.

Continued next page

Have you ever been yelled at, threatened, hit, or worse, while at work? WorkSafeBC wants to hear your story.

WorkSafeBC is creating a series of short videos to raise public awareness about violence towards health care and social services workers. Most British Columbians are unaware that these workers experience more violence on the job than police officers.

WorkSafeBC is interested in hearing about violent incidents that had a significant impact on you, your co-workers, and/or your family. They are also looking for stories from workers who have to deal with angry and frustrated people on a regular basis.

If you are interested in having your story told, please send a short summary of the incident(s) and the impact it had on you, along with your contact information, to: michael.sagar@worksafebc.com. If your story is chosen for filming, the video producer will contact you.

The videos are being produced by Brian Schecter, in collaboration with Maria LaRose. They will air on Shaw Cable and will also be posted on YouTube and the WorkSafeBC website.

CALM GRAPHIC

Continued from previous page

In case of a pandemic: minimizing risks and confusion with effective planning

Is your workplace prepared for a possible influenza pandemic? Do your co-workers know what steps will be required? Do you?

The importance of adequate planning for pandemic influenza is two-fold: first, to reduce risks for health care workers; and second, to ensure the continuity of health care services to the public.

During the SARS epidemic, workers at BC's health facilities proved exemplary in handling infection control and patient treatment. Diligent planning and continued regular protocol reviews are crucial to protect both patients and health care workers.

The Canadian Health Professionals' Secretariat has a well-articulated pandemic planning guide, viewable at www.nupge.ca. An accompanying checklist outlines best practices.

HSA continues to lobby employers for effective preparedness. In addition, Maureen Headley – HSA's Executive Director of Labour Relations and Legal Services – represents HSA on an industry task group for pandemic planning in BC. "This is a multi-faceted and complex strategic planning initiative," she said. "This industry task group's recommendations are being incorporated by health care facilities across the province."

For more information, see the research paper by the Canadian Health Professionals' Secretariat at www.nupge.ca, or contact HSA's Occupational Health and Safety Officer. R

PANDEMIC PLANNING:

This checklist is generic, rather than detailed and exhaustive. This should be just one tool in the response of health science professionals to shaping Canada's pandemic influenza plan.

1. Written plan
There is a written pandemic influenza plan for my workplace that has included input from health and safety representatives and union officials. It clearly identifies the person authorized to implement the plan and the organizational structure that will be used. The plan has been distributed to all employees.

☐ completed ☐ in progress ☐ not started

2. Multidisciplinary planning committee
The plan includes a multidisciplinary planning committee (including a union representative and a worker health and safety representative) that has been assigned to address pandemic influenza planning and a specific individual has been assigned responsibility for coordinating the plan.

☐ completed ☐ in progress ☐ not started

3. Points of contact
Local, provincial and national public health points of contact have been identified for information on pandemic influenza planning resources and someone has been assigned responsibility for monitoring public health advisories and updating the planning committee and coordinator.

☐ completed ☐ in progress ☐ not started

4. Information on coordinating
The planning coordinator has contacted other local, provincial, national pandemic planning groups to obtain information on coordinating the facility's plan with other plans.

☐ completed ☐ in progress ☐ not started

5. Communication plan
An internal and external communication (including inter-facility communication) plan has been developed to ensure delivery of timely and accurate information. A specific individual has been assigned responsibility for communications with public health authorities, staff, unions, health and safety committees and patients.

☐ completed ☐ in progress ☐ not started

6. Surveillance and detection
A policy is in place for surveillance and detection of the presence of pandemic influenza in staff and residents. A system is in place to monitor for, and internally review transmission of, influenza among patients and staff in the facility. Information from this monitoring system will be used to implement prevention interventions.

☐ completed ☐ in progress ☐ not started

7. Infection control plan
An infection control plan has been developed for reducing spread of pandemic influenza at the worksite, including:
- information promoting hygiene etiquette;

☐ completed ☐ in progress ☐ not started

- more frequent cleaning on premises;
- an admission protocol to evaluate incoming patients for pandemic influenza and the appropriate placement and isolation of patients with pandemic influenza-like illness.
- criteria and protocols for closing units or the entire facility to new admissions and for enforcing visitor limitations.

8. Labour legislation and standards

☐ completed
☐ in progress
☐ not started

The plan clearly states that all labour legislation and standards and Occupational Health and Safety legislation will be fully respected and it allocates the necessary resources to protect employees.

The plan contains detailed health and safety measures and procedures developed with health and safety committees to protect employees.

The health and safety section of the plan includes consideration of the hierarchy of controls: engineering controls, administrative controls, work practices and personal protective equipment.

The plan specifies that all employees be protected using at the minimum a fit-tested NIOSH approved N95 respirator, which is designed to protect against 95 per cent of all airborne particulates.

9. Education and training

☐ completed
☐ in progress
☐ not started

The plan includes a policy that all employees will receive education and training so that protective equipment is used properly at all times and other safety measures are implemented consistently and effectively.

A person has been designated with responsibility for coordinating education and training so that all staff understands the health risks present in an emergency situation, basic prevention and control measures for pandemic influenza, and how to self-assess and report symptoms of pandemic influenza before reporting for work.

Easily-accessible information on pandemic influenza and relevant facility policies have been developed and a plan is in place to disseminate these materials to staff and patients.

10. Anti-virals and vaccinations

☐ completed
☐ in progress
☐ not started

The plan includes a protocol and system for the use and monitoring of anti-viral drugs and vaccinations for staff. The plan includes provisions for prophylaxis to staff as negotiated in a collective agreement or protocol or as recommended by public health departments.

11. Sick leave and family leave

☐ completed
☐ in progress
☐ not started

The plan respects the sick leave and family leave policies outlined in the collective agreement, and establishes leave policies to address issues unique to a pandemic, and includes a non-punitive policy that addresses the following situations:

- the needs of symptomatic staff;
- the needs of staff at increased risk of complications (e.g. pregnant women);
- the family responsibilities of staff (e.g. they may need to care for family members who become ill or may need to look after their children because of day care and school closures).

The plan is in compliance with reporting requirements under health and safety legislation and workers compensation legislation.

12. Mental health resources

☐ completed
☐ in progress
☐ not started

The plan includes the dissemination of materials, which list mental health resources that will be available to provide counseling to staff during a pandemic.

13. Surge capacity

☐ completed
☐ in progress
☐ not started

Issues related to surge capacity during a pandemic have been addressed including:

- a contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services and plans for employee absences;
- an individual has been assigned responsibility for conducting a daily assessment of staffing status and needs during a pandemic;
- protocols are in place that deal with issues related to staff who work in multiple facilities;
- a contingency plan has been developed to address likely shortages of beds and supplies including personal protective equipment.

Victoria's health funding scheme a recipe for disaster

"Patient-centred funding" an acknowledged disaster in the UK

by JOYCE JONES

The BC government's recent Throne Speech and budget confirm that they plan to impose a health care financing scheme that received virtually no public support during last year's *Conversation on Health*. Their plan puts a dollar sign on the head of every patient and forces hospitals to compete with each other and with private for-profit clinics for the most 'profitable' cases and funding.

A market-based model is what Canadians left behind decades ago, when we decided that health care was not a commodity but a right for all. And based on the experience in Britain, the people of British Columbia are unlikely to appreciate a step back in time.

This so-called "patient-centred funding" method has been a disaster in the UK and their government is now trying to limit the market forces it unleashed - the same forces the government of British Columbia plans to introduce here.

At the moment, hospitals in BC receive a guaranteed level of financing each year. Now, the government says it intends to make hospitals compete with one another to win patients and funding.

At the moment, hospitals in BC receive a guaranteed level of financing each year. Now, the government says it intends to make hospitals compete with one another to win patients and funding.

In August 2007, British doctors wrote to the Canadian Medical Association cautioning them about this scheme. British doctors warned their Canadian counterparts that the "English Experiment" has done enormous damage in their home country.

For example, hospital competition has slowed the spread of new ideas as each facility hoards their innovations or successes, lest a competitor gain an advantage.

Financial incentives also push hospitals to select for high-volume, simple procedures, and discourage them from treating those with more complicated needs.

If hospitals cannot provide a service for the set price, they are forced to either subsidize it from other parts of their budget or cut it all together. Several children's hospitals in England are under threat for just this reason, as the complex procedures they provide are proving to be 'unprofitable' in the government-created health care market.

Small and rural hospitals – a particular concern in Canada – are especially vulnerable as it becomes 'unprofitable' for them to provide specialized services.

This leaves the elderly (and their families), the poor, and those with multiple health issues stranded without local access to the health services that meet their needs.

For hospitals and other providers, services that are 'profitable' become the priority at the expense of other 'high cost' complex procedures.

This new market also adds enormous administrative costs, making our system more like the costly and bureaucratic US system. Hospitals have to prepare bids, which costs time and money. Lawyers and accountants have to be paid by both sides. Clinicians have to divert time from treating patients to update and check records and bills. Funding appeals have to be made and reassessed, which means

more time and money diverted from patient care.

None of this is necessary in our current model. A 2006 study found that while hospitals in England were able to reduce the costs of certain procedures, they faced increased costs for price negotiations, data collection, monitoring and enforcement.

What advocates of privatization won't tell us is that treatment-by-barcode in England has proven to be less efficient. Since the system came into effect, admissions from the ER into the hospital have gone up a whopping 18 per cent while emergency room visits have increased only three per cent.

This illustrates the upheaval and instability such artificial markets create in public health care and why for the first time in its history, the National Health Service faced massive deficits last year, forcing hospitals to close down services and ask nurses and other health care providers to work for free.

Across Canada, governments have not reinvested adequately in health care, even as surpluses rise. Our universal health care system is now vulnerable to attacks by those who would like to see public health care dollars siphoned off into investor-owned private clinics and for-profit insurance.

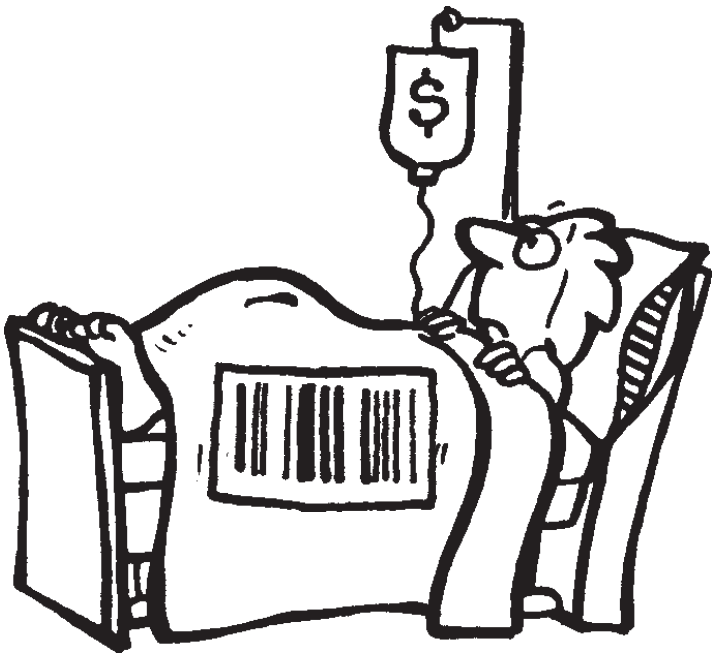
There is no shortage of innovative and cost-effective solutions to strengthen and improve public health care - solutions based on collaboration and co-operation, not competition.

These include streamlined public surgical clinics, improved multidisciplinary care in 24 hour community health centres, reference-based drug pricing and many others that are already successful across the country.

These solutions were advocated consistently by the public during BC's *Conversation on Health*. These solutions show that we do not need to turn patients into commodities to improve health care. R

Joyce Jones is the Co-Chair of the BC Health Coalition.

In August 2007, British doctors wrote to the Canadian Medical Association cautioning them about this scheme. British doctors warned their Canadian counterparts that the "English Experiment" has done enormous damage in their home country.



Identifying and alleviating excessive workload

Workload and resulting stress is a chronic problem in HSA workplaces, both in health care and in the social services sector. HSA members know first hand that BC is experiencing a shortage of skilled, highly-trained health care and social services staff.

CALM GRAPHIC

And BC is not alone. In 2005, health science professionals working in Ontario hospitals ranked stress and workload as the top issues in a health and safety survey conducted by the Ontario Public Service Employees' Union. These results are consistent with the conclusions of several recent national reports, including the Romanow report, the Kirby report and the Health Council of Canada report.

All documented a connection between shortages and poor working conditions confronting health science professionals.

Similarly, working overtime is an increasing trend, along with workers who skip work breaks in an attempt to keep up with ever-increasing workload. Poor working conditions lead to profound morale problems that affect not only today's care providers but also discourage young people from entering these disciplines.

HSA's *Workload Investigation Tool* is an analytical guide to identifying key problem areas.

Tracking excessive workload is the first step in clearly identifying and analyzing a problem. HSA's *Workload Investigation Tool* is an analytical guide to identifying key problem areas, and has become a valuable aide with which members can work towards a solution.

For example, do you often feel you have to work through meal breaks? Are you able to take your annual allotment of vacation, or have you experienced cancellations due to workload? How long is your department waitlist for patients and clients? Do you often work unpaid overtime?

Many HSA members feel pressured to "finish up" after hours. But this adds up quickly. If you work a four-day workweek, thirty minutes of unpaid overtime every day adds up to a full day of unpaid work every month, or roughly twelve days of work a year: three full workweeks on your four-day schedule!

There is not quick fix to many workload problems, but some can be solved or alleviated with the aid of the union. As a first step, your HSA steward can advise you and your co-workers on how to discuss your issues with your supervisor, and advocate on your behalf if grievance procedures are required.

Pursuing resolution to unacceptable or dangerous workloads is a rigorous process. Nothing will change unless workers analyze all of the factors contributing to unsafe workloads, and work together to take daily action – supporting each other to work at a safe, reasonable pace.

This includes an end to "free" or unpaid overtime. Charging for overtime helps to document workload. This data can help managers advocate for more resources, or consider alternative delivery of service models to make working conditions reasonable. Unless HSA members are constantly vigilant, and are aware of their rights under their collective agreements, the situation will only worsen. R

Copies of the Workload Investigation Tool – customized to your work type – are available from your steward. If you have further questions or concerns, contact your steward or HSA's Occupational Health and Safety Officer.

Rotational shiftwork linked to fatigue

Too tired to work? WorkSafeBC Regulation can provide relief

Despite well-documented risks, alternating or rotational shiftwork remains a significant part of many HSA members' work schedules.

This is exacerbated by staffing shortages, resulting in an increase in extra and extended shifts, as well as constantly changing schedules that cycle from days, afternoons, nights, and overnight.

As cited by the Canadian Centre for Occupational Health and Safety, "interest in the effects of shiftwork on people has developed because many experts have blamed rotating shifts for the 'human error' connected with nuclear power plant incidents, air crashes, and other catastrophic accidents."

Because HSA members are entrusted with critical health care and social services procedures affecting the health and lives of patients and clients, battling the strain of irregular scheduling is of ongoing concern.

"Many workers find that shiftwork disrupts their family and personal life and leads to health problems including chronic fatigue and gastrointestinal disorders," notes CCOHS. "Scientific studies throughout the world have shown that shiftwork, by its very nature, is a major factor in the health and safety of workers.

"A shiftworker, particularly one who works nights, must function on a schedule that is not natural," according to CCOHS, which can:

If you feel you must remove yourself from work because of fatigue, the reasons must be clearly enunciated to your supervisor.

- upset one's circadian rhythm (24-hour body cycle),
- cause sleep deprivation and disorders of the gastrointestinal and cardiovascular systems,
- make existing disorders worse, and
- disrupt family and social life.

HSA continues in a variety of lobbying initiatives to improve awareness and alleviate problems encountered by members working rotational shifts.

To stave off the effects, you can maintain a healthy diet, and do your best to establish effective transitional sleep patterns. But what if one day you know you just can't function at work because of accumulated fatigue?

If you are too fatigued to perform your work safely, inform your supervisor.

WorkSafeBC Regulation 4.20 "Addressing Impairment in the Workplace" states that workers and employers must consider "fatigue" as a potential source of impairment – among other concerns – thus causing risk of injury to workers and/or clients.

WorkSafeBC also states in Regulation 4.19 [1] that a worker "must not knowingly do work where the impairment may create an undue risk to the worker or anyone else." Nor can an employer assign a worker to duties where such impairment may create an undue risk.

If you feel you must remove yourself from work under these circumstances, the reasons must be clearly enunciated to your supervisor – and your union steward should be notified immediately.

As this action would be taken under provisions of the Workers' Compensation Act, no discriminatory action can be taken by your employer. HSA is in the process of producing an information package for all stewards with details on this legislation pertaining to impairment due to fatigue.

As well, the union is urging that the effects of rotational shiftwork be placed on the agenda for joint occupational health and safety meetings at all HSA workplaces. R

Contact your steward or HSA's Occupational Health and Safety Officer for more information.

For more detailed research and information on the effects of rotation shiftwork, see Canadian Centre for Occupational Health and Safety: www.ccohs.ca/oshanswers/work_schedules/shiftwrk.html

PROFESSIONAL PROFILE

Residential care rewarding

by ANNE LECLERC

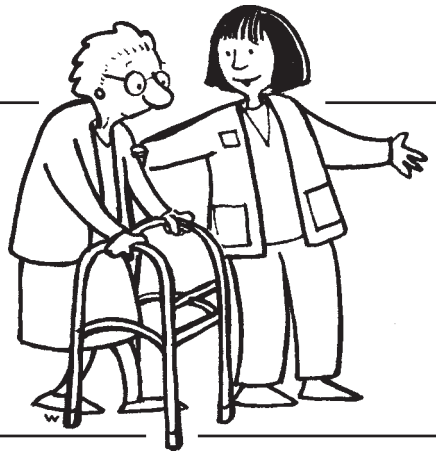
Employment in a residential care facility can be very rewarding! After working in a 52-bed hospital in northwestern British Columbia for over two decades, I accepted the challenge of working at St. Vincent's Langara – a large urban residential care facility caring for 221 elders.

The facility is run by Providence HealthCare, a faith-based organization. My experience as a working manager in a busy small town hospital ensured I had mastered many of the clinical and supervisory skills required for the job. It was explained to me that the physiotherapist's role would be primarily consultative in nature, performing assessments and formulating recommendations.

The setting is such that the allied health staff works closely together to form a strong team of dedicated professionals striving to ensure the elders receive the best possible care for their "golden years."

The setting is such that the allied health staff works closely together to form a strong team of dedicated professionals striving to ensure the elders receive the best possible care for their "golden years." Each caregiver displays compassion towards the residents. The result is a high quality establishment ensuring comfort, enjoyment and maximizing the resident's abilities for as long as possible.

Diagnoses can often be complex in nature. For example, a resident may have a combination of chronic diseases such as diabetes, congestive heart failure, chronic obstructive pulmonary disease, and dementia. Initial assessments are performed by the physiotherapist to determine a baseline functional assessment. The resident's transfer ability is determined, and care guides are completed specifying the appropriate methods to be used during patient transfers (i.e. total mechanical lift, sit-to-stand lift, one



In health care and social services all across BC, HSA members are the key. We welcome your stories.

If you like to work with elders in a supportive, satisfying environment, I recommend considering residential care as an alternative.

person assist, etc) thereby minimizing the risk of injury to the staff and resident.

Ambulation and rehabilitation potential are identified early on, and appropriate steps are taken to facilitate these treatment areas. Mobility aids are prescribed when deemed appropriate by the physiotherapist. Exercise programs can be tailored to the individual needs of a resident, and family and companions can be coached to help the resident with the individual exercises.

The physiotherapist works closely with the rehabilitation assistants in the management of the group exercise programs. At our facility, there are numerous established exercise programs such as weight training, hemi exercise, and aerobic exercise classes. "Let's dance" is a fun mobility program conducted in collaboration with the discipline of music therapy. Two new programs are "Balance Training" and "Get Moving Outdoors."

Elders are screened for suitability for programs by the physiotherapist. All classes are well attended by residents and programs are reviewed regularly. The rehabilitation therapists provide a stimulating exercise environment that is both safe and fun for the residents.

The physiotherapist may also be consulted on an individual basis for pain management, bed positioning, respiratory care, footwear assessment, or to conduct a comprehensive post fall assessment.

Other skills required for this role include competence in program planning, effective communication skills, and an innovative mind. Problem solving abilities are often challenged.

If you like to work with elders in a supportive, satisfying environment, I recommend considering residential care as an alternative. It is challenging job and our skills as allied health professional are so important and appreciated! R

Anne Leclerc
Physiotherapist
St. Vincent's Langara

Anne Leclerc is a physiotherapist at St. Vincent's Langara in Vancouver.

PHOTO COURTESY JEAN LEE

MEMBER PROFILE

Making a difference in Vancouver's Downtown Eastside

by LAURA BUSHEIKIN

Vancouver's Downtown Eastside, known as the "worst postal code in Canada" due to the despairingly high level of drug addiction, homelessness, mental illness, extreme poverty and general social dysfunction experienced by its residents, is 'the office' for HSA member Sandra Boyd.

Her clients have both a mental health and addiction problem, which is commonly referred to as a concurrent disorder. She works with them to support them in getting the services they need, and to stabilize their lives and health as much as possible.

Boyd, a social worker, is a Client Care Coordinator with the Urgent Response Team of the Vancouver Coastal Health Authority, working with about 20 colleagues as part of an innovative program that aims to bridge clients to a network of services and facilities.

In describing a typical client, Boyd paints an overwhelming picture: "Many clients have had untreated health problems for many years. It could be social anxiety or chronic depression all the way up to untreated schizophrenia. Many have chronic poly-substance misuse issues over many years. They may have started drinking or smoking cigarettes as young as 10 or 12 years old and now, 20, 30, or 40 years later, they are maybe still drinking alcohol and also doing crack cocaine. They are often chronically or cyclically homeless, living sometimes in a single-room-occupancy (SRO), sometimes on the street, sometimes couch surfing or using the shelter system.

"The clients often have complex medical problems such as HIV, Hep C, or COPD (chronic obstructive pulmonary disease). Intravenous drug users can end up with abscesses and infection that can require intravenous antibiotics and many times they have difficulty complying with twice daily visits to the hospital for treatment.

"Many of them have no financial assistance because they're not able to jump through the hoops to get it. They've been living outside, so they often have street feet – it's like trench foot; they've been wearing the same shoes and socks and their feet are wet the whole time. It's terrible," says Boyd

It would be easy to think of these as hopeless cases and just give up. But Boyd says there is much that can be done to measurably improve her clients' health and life situations. This leads to more efficient use of healthcare and community resources; in particular, reducing visits to hospital emergency rooms – one of the program's goals.

The key is setting realistic goals.

"You have to measure success in increments," she says. "For instance, someone has an addiction problem and an untreated mental health problem and is homeless, and has become a frequent user of Emergency. If I can stabilize them in an SRO with a primary care physician and they get onto appropriate meds for their mental health problem, but they continue to use drugs, I would still consider this a huge success because they are no longer on the street, no longer homeless, no longer

"Even though I had worked as an outreach worker for six years in Toronto, nothing could have prepared me for the serious drug problems that are here."

Sandra Boyd
Client Care Coordinator
Urgent Response Team, Vancouver
Community Mental Health

untreated in their mental health problems, and no longer a frequent Emergency user."

Boyd says her 16 years of social work experience have given her the maturity to stay focused on what works, rather than getting overwhelmed with all the challenges. "I have a lot of experience to fall back on in terms of boundaries. It's a nice place to find – that place of compassion and caring without over-investment. To find the balance where you are present to your client, present in their lives, but you can go home at night and live your own separate life," she said.

Boyd, who is an HSA steward, earned her Bachelor of Social Work at Ryerson University. She joined the Urgent Response Team when the program was starting up in 2005.

One thing she loves about the program is that it allows her to get out into the community where the clients live.

"We work from an assertive case management model," she explains. "We don't wait for them to come to us; we go out to where they are. I have the autonomy to help a client follow through with their plan rather than just giving them a phone number or directions to somewhere." This includes going with clients to appointments or sitting down with them to fill out income assistance or disability claim applications.

The program also liaises with agencies to improve services. For instance, they have partnered with the Ministry of Employment and Income Assistance to address barriers facing Urgent Response Team clients. "The URT has made some amazing strides forward in terms of trying to reach out and connect with the most vulnerable in our community," Boyd said.

She likes the community and feels relatively safe on its streets, although she doesn't want to minimize the extent of the problems there.

"When I first moved here, even though I had worked as an outreach worker for six years in Toronto, nothing could have prepared me for the serious drug problems that are here." At the same time, she says, it is a neighbourhood. "But it takes a while to see that. As a passerby, you're not going to stop at the Eastside Coffee Bar and get a coffee. You have no idea that Tom, who runs the coffee shop, makes some of the best organic Americanos and lattes in the city. But you'd never stop because it's on Powell Street and doesn't even look open. This is a community you really have to be in before you know what it's about."

Her job gives her an advantage, she says. "Our jackets say Vancouver Coastal Health. That says 'we will help you.' I can walk down the street at night in the pouring rain and I never have any problems."

It may be a tough assignment, but Sandra Boyd is clearly happy to take on the challenge. R

Sandra Boyd's clients face multiple challenges: addiction, homelessness, mental health issues, and concurrent health problems. With Boyd's help, her clients find homes, financial assistance, and much-needed treatment.

Escalating shortage of lab professionals threatens patient care

For National Medical Laboratory Week in April, Canada's largest organization of health science professionals is sounding alarm bells that accessible and high quality patient care is threatened by an escalating shortage of medical laboratory technologists across the country.

Lab techs constitute fifteen per cent of HSA's membership of 16,000 members across BC.

"Most governments are in denial about the escalating shortage of medical laboratory technologists," says Elisabeth Ballermann, co-chair of the Canadian Health Professionals Secretariat (CHPS). "They need to wake up and take urgent action otherwise patient care in this country is going to be seriously compromised."

The Canadian Society for Medical Laboratory Science has warned that almost 50 per cent of medical laboratory technologists will retire in the next decade.

National Medical Laboratory Week was celebrated April 13-19 across Canada.

Medical laboratory professionals are an essential component of Canada's health care system. The results of medical laboratory tests provide crucial information to doctors so that they can accurately diagnose, treat and monitor patients. Moreover, the ability of the public health system to detect an infectious disease outbreak and identify the cause depends on a strong, well-functioning laboratory system.

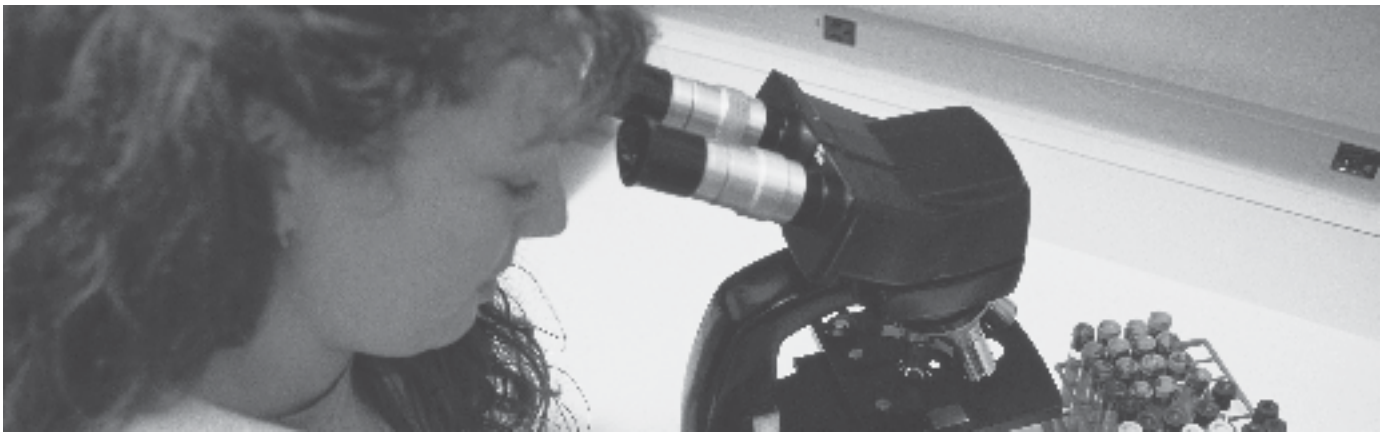
In the early 1990s, most provincial governments reduced the number of medical laboratory training programs, resulting in fewer technologists graduating every year and producing the current level of shortages. Many groups are warning that these shortages will escalate rapidly as large numbers of older workers begin to retire. The Canadian Society for Medical Laboratory Science (CSMLS) has warned that almost 50 per cent of medical laboratory technologists will retire in the next decade.

"The decrease in graduates means there is already a severe shortage," says Ballermann. "If you combine that with the predicted retirement rate it means that our already-stretched laboratory system is going to face even more pressure."

The CHPS wants provincial and federal governments to develop a national strategy and to put additional resources into attracting and retaining medical laboratory technologists.

"The strategy must include more funding to create hundreds of new positions in education programs and clinical training, and it must include a plan to recruit people to fill those positions," says Ballermann. R

HSABC is a founding member of the Canadian Health Professionals Secretariat, a national advocacy body representing more than 60,000 unionized health science professionals who deliver the diagnostic, clinical and rehabilitation services essential to timely and quality health care.



Changes to disability pension

Q: I am currently on a disability pension from the Municipal Pension Plan. I heard that there were recent changes to the plan; will I be affected?

A: Access to Municipal Pension Plan (MPP) disability pensions may change for some plan members because of a decision made by the Municipal Pension Board of Trustees. The changes outlined below will not affect anyone who is currently receiving an MPP disability pension, or who terminates employ-ment before July 1, 2008.

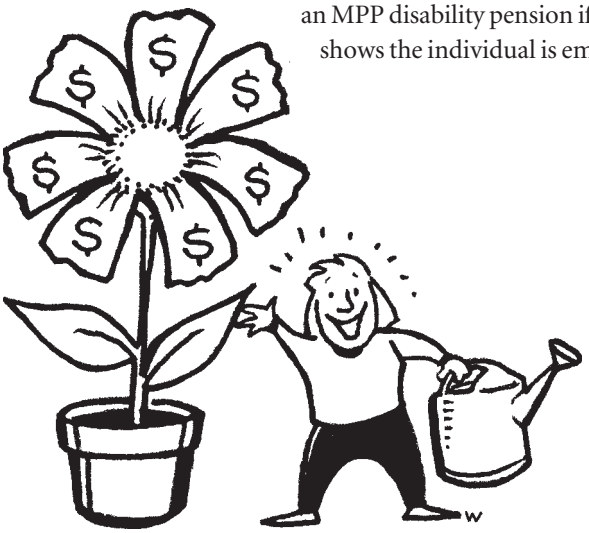
The definition of "totally and permanently disabled" now clarifies that access to a disability pension is based on a medical assessment, not on the employer's ability to offer a suitable job to a disabled employee.

This means an individual may not be eligible for an MPP disability pension if a medical assessment shows the individual is employable elsewhere.

Disability pensions will now be calculated to reflect whether an employee worked full time or part time before their disability. This will ensure that disability pensions are calculated fairly for part-time and full-time employees.

Before applying for an MPP disability pension, plan members must apply for employer group disability benefits (LTD) if they are available. LTD benefits can offer advantages over an MPP disability pension. For example, while members are receiving approved LTD benefits, the value of their pension continues to increase even though the member doesn't make contributions to the Plan. Members who have accepted a lump-sum payment to settle an LTD claim are not eligible for a disability pension from the Plan. R

To learn more about disability pensions and employer LTD benefits, see the Disability Pensions *and* Long-term Disability Benefits *fact sheets available from the Municipal Pension Plan. Please contact the Plan if you want to discuss your particular situation.*



CALM GRAPHIC

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

Would you prefer to receive all HSA mailings (including *The Report*) via email only? Send a message to memberlist@hsabc.org with your name and preferred home email address.

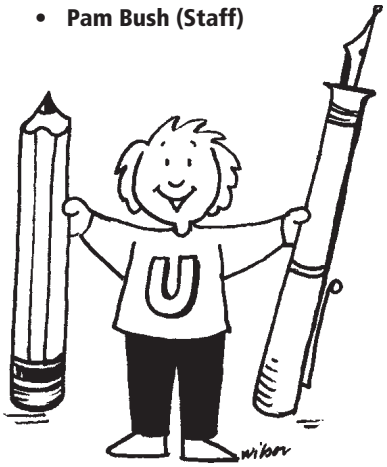
Include "paperless option" in your subject line.

If possible, please also include your member ID number, which appears on your mailing label on *The Report*.

Committees

HSA's Committee on Equality and Social Action:

- **Agnes Jackman (Chair)**
- **Kimball Finigan**
- **Joan Magee**
- **Chris Semrick**
- **Sze Yan Wong**
- **Pam Bush (Staff)**



Writing a letter to your local paper or elected representative can start positive changes in your community

EQUALITY AND SOCIAL ACTION

Starting with small steps

by CHRIS SEMRICK

Equality, social action: strong words, but what do they mean? As a first time member of the Committee for Equality and Social Action (CESA), I struggle with this question.

As union members, you and I pay union dues. That money is used to run the organization that supports us – you and me – and protects our rights as workers. As members of the Health Sciences Association, we recognize that our own life and health is directly affected by the lives and health of the people who live in this small world with us.

Long ago, the members of our association decided that a portion of the dues we pay should also be used to help the people who are not so fortunate to have a union to advocate for their rights and a fair wage.

We have become complacent in our western society: many in the world cannot make enough to buy fresh food for their families despite working in excess of 70 hour work weeks. Conditions are dangerous, the pay is terrible and workers' rights do not exist.

But people are also starving right here, on the streets around us. Some are there from mental illness, poor life choices and addiction, but there are also women and children lost in their flight from abuse. Regardless of the circumstances that put them there, we all benefit when we give them help up.

So, a portion of the dues you and I pay goes to support equality and social justice. It is the duty of CESA to take this 0.45 per cent of revenue and direct it to further the committee's mandate. That mandate is directed by you, the HSA members, through resolutions passed at convention.

While 0.45 per cent does not sound like a lot of money, when you multiply it by the dues of more than 15,000 members, it adds up. This year, you were part of $47,000 in equality and social action donations. I encourage you to check out the committee's annual report for a list of recipients.

I feel good that we are giving. I feel good how the money was distributed. A lot of people will be helped. But I can't help but feel there must be more.

Surely it is my responsibility as a committee member to make some lasting contribution towards equality and social action beyond just handing out money – but what can I do as a single person?

The answer is not much. But when you multiply my "not much" by the "not much" of 15,000 others, well suddenly you have a little bit more.

The new question becomes, how do I motivate you to get off the couch and take action?

And, what action would I have you take? There are so many righteous causes; how do you know where to invest your time?

Climate change, environmental degradation, consumption, oil, war, human rights:

where does one even start? I find myself overwhelmed by it all.

Thus I find myself doing nothing at all. Well, not quite nothing. I recycle. I've placed three wine bottles filled with water in the tank of my toilet, and save over two liters of water a flush, not to mention that if it's yellow, I let it mellow.

There are other things we can do to help out our world.

I guess even writing this article is action, and if the action you take in return is to write a letter, all that much the better. Write letters to your newspapers, write letters to your representatives of government. I am told that a politician sees one letter as representing one hundred votes, and politicians are known to move where the votes are.

Or at least we hope that would be the case. Often politicians will not stray far from where the money is, and that is where we too hold power. Our wealth is not concentrated like that of a multi-national corporation; but without us, the corporation is worth nothing.

I try to buy local whenever I can. Locally grown, locally made. I eat healthier when my food wasn't picked unripe and driven up in a truck. My couch was made in Vancouver, ensuring at least one more day's work for someone local.

We the people make the whole system work. Without labour, there is no wealth; without purchase there is no market. The choices we make as consumers have the ultimate influence on our world.

Our unions link us together as both workers and consumers. Becoming active in the union is another way to effect social change. We must remember that the union is us – the members – not an office in the city. As a corporation is worthless without its customers, a union is feeble without the support of its members.

I encourage you to check out HSA's website. Check out the link to CESA. Start paying attention to the daily activities of your life and try to see the impact they are having on the world around you.

Please, join us in making a difference. R

Chris Semrick is a respiratory therapist at Nanaimo Regional General Hospital.

HSA's Committee on Equality and Social Action encourages awareness of these upcoming dates:

May 1: International Labour Day (May Day)

May 17: International Day Against Homphobia
www.homophobiaday.org

May 28: International Day of Action for Women's Health

June 21: National Aboriginal Day

A tasty way to help the planet

Delegates to last year's HSA convention voted to encourage all members to support local farming. Check out **www.eatlocal.org** to find a farmers' market near you!

CONTRACT INTERPRETATION

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

Returning to work after a period of disability

by ALISON HIETANEN

Q: I'm covered by the health science professionals contract, but I was injured on the job. Currently, I am on an accepted long term disability claim and receiving monthly benefits. I now feel well enough to try returning to work. What steps should I take? Do I have to return to full-time employment right away, or could I ask to start with part-time duties?

A: It's great news that you're feeling better and are interested in going back to work.

The process for returning to work following an absence due to illness or injury is medically driven. This means – before anything – your treating physicians must be in agreement that you are well enough to contemplate going back to employment.

In order to initiate the process, your doctor must provide you with a medical letter confirming that you are cleared to return to work in some capacity. The letter must also set out any associated functional limitations and restrictions which must be considered when drawing up a return to work plan. The letter would then be sent to your case manager at Great-West Life (the insurer).

In the event your doctor advises that you are able to return to the workplace without any functional limitations or restrictions, your employer would be notified by Great-West Life that you are ready to go back. A meeting will be scheduled between yourself, the employer and a union representative to determine when you will start, and which job you will return to. The long term disability plan and collective agreement set out that:

Upon return-to-work following recovery, an employee who was on claim for less than twenty-four (24) months shall continue in her/his former job; an employee who was on claim for more than twenty-four (24) months shall return to an equivalent position, exercising her/his seniority rights if necessary, pursuant to Article 6.04 of the Master Agreement.

Generally, if an employee has been away from the workplace for an extended period of time for medical reasons, a graduated return to work schedule will be prepared by the parties to assist the employee with a safe and healthy increase in hours and duties.

Frequently, doctors will advise that while they support the return of the employee to the workplace, there are functional limitations and/or restrictions which will affect the nature of the return. The doctor may also recommend additional support services to assist the employee in preparing for going back to an employment environment.

When this occurs, if appropriate, Great-West Life

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

will forward the employee's file to the rehabilitation services division of Healthcare Benefit Trust – the administrator of the LTD plan. A rehabilitation consultant will be assigned to review the medical information on file and determine what rehabilitation services are suitable to expedite the return to work, and ensure it has the greatest likelihood of success. The types of assistance offered may include:

- case management and coordination of rehabilitation services
- referral to community resources for treatment such as work conditioning or counselling
- vocational assessment and guidance
- funding for rehabilitation services or retraining programs
- functional capacity evaluations
- job demands analysis

Each employee's situation is unique. Any rehabilitative intervention provided will be dependent upon the physician recommendations, as well as the employee's education, skills and experience.

The language of the long term disability plan allows for employees to undertake a gradual return to employment while continuing to receive LTD benefits. For this benefit to apply, a rehabilitation plan must be prepared which is acceptable to the employee, the employee's physician, and the Healthcare Benefit Trust.

The employee returns to the workplace in accordance with the terms of the plan, and will be paid by their employer for any hours worked. The employer will report all hours worked to Great-West Life, and the monthly LTD benefits will be adjusted as necessary. Under this language, an employee can keep all earnings plus their monthly LTD benefit, as long as the combination of the two does not exceed 100 per cent of the current rate of pay for their pre-disability job. Once that threshold dollar amount has been reached, Great-West Life will deduct from the monthly LTD benefit any earnings over and above that 100 per cent figure.

As noted above, if an employee has been on LTD claim for 24 months or less, they will return to their own job or, if on claim for longer than 24 months, to an equivalent position. However, employees are sometimes unable to return to their former occupation due to permanent medical restrictions limiting the nature of the work they can undertake.

In such cases, the employer has a statutory duty to accommodate the employee. This means that the employer must undertake a vigorous search to locate an alternate job for the employee.

This alternate job must be a match to their stated medical restrictions, as well as their skills and experience. This obligation extends to the point of undue hardship. In other words, the employer must demonstrate that they have made every effort to find alternate work but have been unable to locate any options for the employee which could be implemented without causing undue hardship to the employer.

Ideally, your return to work will be smooth and seamless. The union is available to support you through every step of this process for a successful return to work.

Ideally, your return to work will be smooth and seamless. The union is available to support you through every step of this process for a successful return to work. R

For more information, or for help with your return to work, contact Alison Hietanen at the HSA office.

Keeping in touch with HSA retirees

HSA's board of directors congratulates recent retirees, and encourages them to stay in touch with the union.

Retiring members receive free mailings of *The Report*. In addition, HSA will pay for a one-year membership in the BC Federation of Retired Union Members (BC FORUM).

BC FORUM provides members with a range of products including travel, medical and dental insurance, plus income tax and financial planning services. BC FORUM is a non-profit society founded by the labour movement, dedicated to the interests of members and their families, as they move into their retirement years.

Retirees will also be invited to sign up on a dedicated HSA e-mail list that will alert them to events and activities in their communities they have indicated an interest in such as preserving medicare, improving pensions, or other community-based campaigns.

HSA continues to issue retirement certificates to retiring members. If you know of a colleague who is about to retire, please contact the union. R

CALM GRAPHIC

HSA salutes recent retirees:

Ben Birovchak
Nuclear Medicine Technologist
VGH

Margaret Bryce
Medical Laboratory Technologist
Creston Valley Hospital

Susan Carter
Dietitian
VGH

Peter Chen
Medical Radiation Technologist
VGH

Eva Chew
Medical Laboratory Technologist
VGH

Wendy Clarke
Medical Laboratory Technologist
Langley Memorial Hospital

Maureen Desborough
Physiotherapist
Holy Family Hospital

Ronald Downes
Medical Laboratory Technologist
Tumbler Ridge Health Centre

Angela Fairleigh
Occupational Therapist
VGH

Beverley Feick
Medical Radiation Technologist
Surrey Memorial Hospital

Leslie Gordon
LTC Case Manager
Vancouver Coastal Health Authority

Peter Hamilton
Polysomnographic Technologist
UBC

Jo-Anne Horn
Registered Psychiatric Nurse
Ocean View Guest Home

Valerie Hunt
Medical Laboratory Technologist
Peace Arch District Hospital

Britta Jensen
Medical Radiation Technologist
VGH

Lucilla Lo
Cardiology Technologist
VGH

June Low
VGH

Hilary MacInnis
Occupational Therapist
St. Joseph's General

Hazel Mackie
Occupational Therapist
VGH

Shirley Matkowski
Medical Radiation Technologist
VGH

Briege McConville
Cardiac Ultrasound Technologist
VGH

Danese McDonald
Social Worker
VGH

Denis Merlo
Diagnostic Medical Sonographer
Kootenay-Boundary Regional Hospital

Mary Morita
Medical Laboratory Technologist
VGH

Lucette Mowrey
Cardiology Technologist
Surrey Memorial

Dianne Neratini
Physiology Technologist
VGH

Maureen Ooka
Medical Radiation Technologist
VGH

Patti Pedersen
Physiotherapist
Cariboo Memorial Hospital

David Purdie
Medical Radiation Technologist
VGH

Laura Reston
Medical Laboratory Technologist
Children's & Women's

Graham Rogers
Clinical Perfusionist
VGH

Meribeth Ruckman
Psychologist
GF Strong Rehab.

Wayne Saffran
Registered Psychiatric Nurse
Peace River Haven

Peter Schable
Medical Radiation Technologist
Royal Columbian Hospital

Sandra Schmidt
Medical Radiation Technologist
Dawson Creek & District Hospital

Tom Shenton
Social Worker
VGH

Victoria Sirosky
Registered Psychiatric Nurse
East Kootenay Regional Hospital

Randi Sowerby
Pharmacist
Mission Memorial

Runa Steenhuis
Psychologist
VGH

Denise Swift
Medical Laboratory Technologist
100 Mile & District Hospital

Perry Taylor
Physiotherapist
Holy Family Hospital

Joanne Va den Ouden
Medical Laboratory Technologist
Surrey Memorial Hospital

Carol Zupan
Medical Radiation Technologist
VGH

Congratulations! For new retirees, HSA pays for a one-year membership in the BC Federation of Retired Union Members (BC FORUM), providing a range of products including travel, medical and dental insurance, plus income tax and financial planning services.

New legislation to prohibit age discrimination

by MAUREEN HEADLEY

Widely described as the end of mandatory retirement, the BC Human Rights Code has been amended (effective January 1, 2008) to prohibit age discrimination against those who are over 65 years of age.

Most obviously, this means that a person cannot be forced to retire because they have reached the age of 65. It also means that an employer cannot discriminate in the terms of employment because of a person's age.

This change reflects the reality that many people, including many HSA members, are already working past the age of 65. For example, it is common for older workers to retire and return as casuals, giving up the seniority and benefits that they have accumulated throughout their careers. It will now be possible for these workers to keep working under the same conditions as they enjoyed prior to reaching age 65.

An employee who chooses to continue working past the age of 65 should receive all of the same employment benefits as his or her younger coworkers.

Of course, all workers must be able to perform the *bona fide* occupational requirements of their jobs. If an older worker becomes unable to do her job, she may be terminated in the same manner as any other worker.

An employee who chooses to continue working past the age of 65 should receive all of the same employment benefits as his or her younger co-workers. However, there are many employment benefits that involve age distinctions of one kind or another.

- Pension and other retirement benefits that obviously become available only at specified ages (often combined with years of service).
- Benefits such as life and disability insurance that may become more difficult to obtain or prohibitively expensive as a person ages.
- Benefits such as extended health and dental coverage that are available but may become more expensive as a person ages.

Collective agreements (including the health science professionals' collective agreement) and contracts of insurance often provide that certain benefits, such as LTD, terminate at age 65.

There are also age distinctions in provincial and federal legislation that regulate employment benefits. For example, a person is required to begin receiving pension benefits by age 71 even if they are still working. This will normally mean that the person loses the right to accrue pensionable service.

Until recently, income tax rules prevented a

person from contributing to a pension plan and at the same time receive benefits from that plan.

For a worker who is old enough to be eligible for a pension, this rule means that she is either receiving less compensation for her work than younger workers because she is not accruing pension benefits, or she is giving up her earned entitlement to a pension. Recent changes allow for "phased retirement" where a person continues to accrue service while receiving a partial benefit, but most pension plans have not yet incorporated that possibility.

To address the legitimate age distinctions that can be contained in benefits plans, the *BC Human Rights Code* allows age discrimination that relates to "*the operation of a* bona fide *retirement, superannuation or pension plan or to a* bona fide *group or employee insurance plan*." The *Code* also allows distinctions on the basis of age that are "*permitted or required by any Act or regulation*."

It is not yet clear what kinds of distinctions will be considered *bona fide*.

In deciding this question, it is important to remember that the *Human Rights Code* protects basic and fundamental human rights. The right of a worker over the age of 65 to be free from discrimination should only be limited for good reason.

HSA takes the position that all age distinctions must be justified. That is, if a distinction is necessary to protect the continued viability of a pension or insurance plan and there is no reasonable alternative, that distinction can be maintained. If a distinction is not reasonably necessary, it should be eliminated or replaced.

Maureen Headley, Executive Director of Legal Services and Labour Relations

For example, it ***is not*** discrimination for a pension plan (which exists for the purpose of providing income in retirement) to set a "normal" and "early" retirement age and to provide benefits only to those have reached that age. It likely ***is*** discrimination for an employer to deny extended health coverage only to those over age 65.

In the coming months, HSA will be meeting with employer associations to review existing age distinctions. We would be interested in hearing from members who continue working past the age of 65 about any changes that are made to your working conditions. Email your experiences or concerns to webmaster@hsabc.org. R

Maureen Headley is HSA's Executive Director of Legal Services and Labour Relations.

Why I love convention

by BRUCE MacDONALD

Bruce MacDonald, Region 3 Director

Like many of you, I have recently become quite interested in the American presidential election campaign. Obama, Clinton, McCain – it seems to have everything: racial politics, gender politics, age politics, class politics, regional politics.

Americans are grappling with numerous questions at the same time: how important is it for our leaders to provide inspiration, practical experience, strong values, flexibility, maturity, and humour? Does the campaign process — caucuses, primaries, debates, advertising — help or impede the choice of quality leadership?

At a somewhat less grandiose level, our HSA convention also deals with all of the above issues.

I love going to our convention! It uplifts, it always challenges, it sometimes annoys, and it stimulates. It is also vitally important to our union's functioning. HSA's constitution gives all power to our convention:

> *The Annual Convention when in session has all legislative, executive, judicial and administrative powers of the Union. (Article 7, Section 1)*

Convention provides direction to the president and the board of directors on all areas of union governance. It is truly the supreme governing body, and it, in turn, is governed by *you*, the member.

Delegates come from all regions. Every chapter is entitled to at least one delegate. Chapters over 50 members are entitled to more than one delegate. (It is worth noting that large chapters rarely fill their delegate entitlement and are, therefore, under-represented at convention.)

What happens at convention? Many of our 16,000 members have never participated in an event like convention.

Someone once said that civilization is a 3,000 year conversation. HSA's 250 or so delegates gather in one room to try to move that conversation forward. We have resolutions that go to the heart of what democracy is: Should we strive for regional, professional, or gender parity on our boards and committees? How do we ensure that members of very small or very large chapters have proper representation? How do we balance urban and rural interests? How active should HSA be in local, provincial, and federal politics? How should HSA participate in our communities and our world in other areas that might seem to have little directly to do with unions? Should we have a representative voting process, like convention itself or the American caucuses, or should we have direct democracy with one member one vote, like the American primaries?

This last issue will actually be discussed at the 2008 convention, as the Elections Committee will report on a study the board commissioned on the pros and cons of changing our presidential election to a "one member, one vote" system. And this study itself came in response to a resolution from last year's convention.

But if convention were only about "issues," I could happily stay home and read the news online. But convention is really about people, and that is the life of it. So here's why I really love to go to convention:

1. I get to meet activists from many other regions. As a Lower Mainland urban person, I get to learn about rural areas with no radiation technologist within 100 miles. Delegates from those areas get to learn about large chapters trying to handle several dozen grievances simultaneously.

2. I get to marvel at people's energy, creativity, and bravery.

3. I get to feel a bit of humility when I see how involved some people are in their communities. It challenges me. I ask myself, where do they find the energy? And then, how am I using my time? Recently, I signed up for a project next month which will count the homeless in Vancouver. I might well have done this without convention of course, but convention is one more important piece of the fabric of life that connects me with larger issues – in this case, homelessness in my downtown Vancouver neighbourhood. I see other people doing more in their world. It looks like fun, and I want to join!

4. I get to feel pride when HSA members take on difficult issues and even run for political office. So many times we've heard of HSA members putting aside fear and walking into that constituency office to discuss shortages, or budget shortfalls and how they affect our members, clients, families, and patients.

5. I get to feel conflict. Not always fun, but sometimes necessary. If someone says something I disagree with – and it happens *every* year, *several* times! – I get to examine that conflict in myself. Sometimes I form a response and get up to the microphone. And sometimes, to my shock and amazement, a delegate says something that actually changes my mind.

We have resolutions that go to the heart of what democracy is: Should we strive for regional, professional, or gender parity on our boards and committees? How do we ensure that members of very small or very large chapters have proper representation?

6. Finally, I get to see the organic development of our union. Resolutions on the floor can be changed and moulded to better reflect the wishes of the group. Individual conversations enlighten the group conversation. Consensus emerges, or issues get sent to the board for more study.

Then, after it's over, I have the privilege of going back to the board and using the direction we get from convention to implement the resolutions that have been passed. I can't emphasize enough how seriously the board takes convention. To quote the constitution again:

> *The Board of Directors is the supreme governing body of the Union* **when the Convention is not in session** *(my emphasis), subject to the provisions of the Constitution. (Article 8, Section 1)*

By the time you read this, it will be too late to become a delegate at the 2008 convention, but I hope more members will consider it next year. It really is your way to have a voice, and you might just find it's way more interesting and fun than you expected. R

Bruce MacDonald represents Region 3 on HSA's board of directors.

LETTERS

THE REPORT WELCOMES YOUR LETTERS. PLEASE KEEP THEM BRIEF AND TO THE POINT — ABOUT 200 WORDS, IF POSSIBLE. PLEASE TYPE THEM.

Colleagues raise funds for Dave Bland Scholarship Fund

On March 7, we celebrated the memory of our colleague, Dave Bland, with an evening of art, music, song and tributes – and raised $7000 for the Dave Bland Scholarship Fund.

Dave was a vocational therapist with the Richmond Mental Health Team from 1978 until 2005. He was murdered in the parkade at the Team Office on January 19, 2005 as he left work. He is remembered by friends, relatives and colleagues as a gentle and conscientious man who was passionate about his work and life. Vancouver Coastal Health Authority and the Richmond Mental Health Team sponsored the event.

The fundraiser was held at the Gallerie Waterside in Richmond, home and gallery of local actor and artist Colin Foo. Admission was by donation and the proceeds raised will go to the scholarship established in Dave's memory to assist mental health consumers to pursue their education goals.

The inaugural event was a great success. In addition to the funds raised, it was a very moving and heartening evening for us, Dave's former colleagues. We have tended to be very private in our grief; this event gave us a chance to open ourselves up to the community, and share in a celebration of the life of our friend.

There was food, entertainment by local musicians, a silent auction including one of Colin Foo's paintings, and a 50/50 draw. It was such a success that we're already planning for next year's celebration. We hope that you will join us next spring.

I would like to take the chance to say a few words about Dave Bland. I had worked closely with Dave for five years at the time of his death. He was a wonderful colleague and friend. Dave's death had a profound impact on most of his colleagues, as well as many of the clients he worked with over the years.

As a result of Dave's death and the way that he died, many changes were made to our work site and I think many other sites within health to try to prevent future violence.

As his former colleagues, we have chosen to celebrate his life rather than commemorate his death and started the Scholarship Fund as a way to continue his work and remember him in a positive way.

Dave was a passionate man who stood for client centeredness, integrity and honesty in work and supporting mental health consumers to pursue their dreams. He was also a huge sports fan (especially golf, basketball and baseball) so we have an annual Richmond Mental Health Service Provider and Consumer baseball game named in his honour each July with prizes and a big barbeque. It's the community mental health event of the season in Richmond!

This fundraiser is a chance to raise awareness about his life and legacy and to remember him. I hope that many of you are able to support the Scholarship Fund either by making a donation, however small – and joining us at our event next spring.

Susan Rechel
Occupational therapist
Richmond Mental Health

Donations to the Dave Bland Scholarship Fund can be made payable to:

Richmond Hospital Foundation: Dave Bland Scholarship Fund
The Richmond Hospital Foundation
7000 Westminster Hwy
Richmond, BC V6X 1A2

For further information, please contact Susan or Ruby at the Richmond Mental Health Team at 604/273.9121.

KIM STALKNECHT PHOTO

HSA's BOARD OF DIRECTORS back row from left: Thalia Vesterback, Bruce MacDonald, Marg Beddis, Joan Magee, Brian Isberg, Kimball Finigan. front row from left: Agnes Jackman, Lois Dick, Reid Johnson, Rachel Tutte, Suzanne Bennett.

Health Sciences Association
The union of caring professionals

BOARD OF DIRECTORS

HSA's Board of Directors is elected by members to run HSA between Annual Conventions. Members should feel free to contact them with any concerns.

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YUKIE KURAHASHI PHOTO

April 28: Day of mourning for those killed or injured on the job

PHOTO: HSA president Reid Johnson and Region 7 director Marg Beddis lay a wreath at last year's Day of Mourning ceremonies in Surrey

April 28 marks the Day of Mourning, a day dedicated to those workers in BC who have become disabled or been killed due to unsafe work environments.

In BC, an average of 180 workers die each year as a result of accidents at the workplace.

On April 28, a number of ceremonies will be held throughout the province. HSA is proud to support the labour movement in organizing and participating in these events.

We are particularly mindful of the risk of injury and death at this point in time, due to the major cutbacks proposed and instituted in the workers' compensation system by the Liberal government.

Workers' Compensation Board inspection reports in the past 10 years have dropped by 50 per cent, orders written on employers have been reduced by 44 per cent, and employer penalties decreased by 71 per cent. All this while the rate of injuries and fatalities remains constant.

The provincial Liberal government instructed the WCB to deregulate and streamline its services, both in the area of workplace safety and compensation for injured workers. The result: a gutting of regulations designed to protect workers and reduction in services and levels of benefit to the injured.

We mourn the loss of lives and the ongoing dismantling of the system.

HSA members are urged to participate in functions in their community. For information or events in your area please check the BC Federation of Labour's website at www.bcfed.ca. R

Fight for the living. Mourn for the dead.