BUDGET 2020 CONSULTATION

June 2019

The Hospital Employees' Union
www.heu.org

Contents

Introduction

The Hospital Employees' Union (HEU) welcomes the opportunity to share our views and recommendations on Budget 2020 with the Select Standing Committee on Finance and Government Services.

HEU is the oldest and largest health care union in British Columbia, representing more than 50,000 members working for public, non-profit and private employers.

Since 1944, HEU has been a strong and vocal advocate for better working conditions for our members and improved caring conditions for British Columbians who access health care services.

HEU members work in all areas of the health care system – acute care hospitals, residential care facilities, community group homes, outpatient clinics and medical labs, community social services agencies, and First Nations health agencies – providing both direct and non-direct care services.

Our members care deeply about being able to provide good service to the patients, residents and clients for which they care.

Under the BC Liberal administration, HEU members covered by our public sector master collective agreements experienced wage cuts and wage freezes in many contract years. Privatization of services, and contracting out and contract flipping drove down wages and benefits for even more health care workers who now found themselves outside the public master.

Today, the majority of our membership which includes those working for private sector employers, earn pre-tax incomes of less than $50,000 a year. So affordability is a key issue for our members.

That's why the elimination of the MSP premiums and of interest on student loans, and the introduction of the B.C. Child Opportunity Benefit are among the many encouraging steps taken by this government that are improving the quality of life for our members and helping them close the affordability gap.

There is clearly much more to be done however, to make life truly affordable for our members and all British Columbians.

HEU is a proud affiliate of the BC Federation of Labour and fully endorses their recommendations to the Standing Committee.

The Federation's submission reflects the concerns of B.C.'s working people in areas of creating a fair and equitable economy, quality public services for communities and families, and creating and protecting secure and sustainable jobs.

HEU is supportive of many measures this government has taken to improve B.C.'s healthcare system.

The move away from public-private partnership models for the construction and operation of hospitals and other infrastructure, the investment in long-term care staffing to achieve 3.36 hours per resident per day of direct care (hprd), and the steps taken toward the end of sub-contracting of health care services, are welcomed and will result in higher quality, safer and more cost effective services along with increased economic security for workers.

Still our health care system itself needs care and attention to recover from years of budget shortfalls, rapid privatization and the extensive contracting out experienced under the previous B.C. Liberal government.

Our focus in this submission is the continued work of stabilizing the residential care sector with a review of staffing levels and accountability measures, re-establishing a sector wide standard in wages and benefits, consideration of a cap on profits in seniors' care, and increased funding for staffing in assisted living.

We also advocate the development of a capital plan to fund publicly owned health care infrastructure, and a study to consider cost savings to "buy out" P3 projects.

Finally, we are urging a renewed focus on worker health and safety in our health care system.

Stabilize the residential care sector

Staffing levels in residential care

Long-term residential care homes will receive an investment of more than $550 million by 2021 to attain minimum staffing guidelines, established ten years ago, of 3.36 hours per resident day (hprd). This will be the first time since the establishment of the guideline that care home operators will be funded to meet these levels.

This is an important first step towards addressing the care needs of all seniors in residential care, but it is also clear that further action is required to provide an appropriate standard of care.

Research indicates that staffing levels of at least 4.1 hprd for direct care staff alone are the minimum required to avoid deterioration of health in residents in long-term care.[1] A comprehensive review, involving leading health policy and residential care experts, and key stakeholders, should be conducted to establish an appropriate legislated minimum staffing level necessary to provide quality care in the B.C. context.

The review should also make recommendations on accountability measures and standardized funding approaches to ensure minimum staffing levels are met. These measures should include a cap on the level of profits given the significant shift in the ownership of publicly funded care homes to for-profit operators.

Currently, there are too few reporting requirements and too few audits conducted to assess how public monies are being spent.

For example, government funding is provided and intended for wages for staff to care for seniors but with few mechanisms to ensure that the money is in fact spent that way. According to research carried out by the BC Ombudsperson's office and published in their 2012 report, *The Best of Care: Getting it Right for Seniors in B.C.*, only one health authority considered specific wage levels, as criteria when distributing funding amounts.[2]

---

[1] Marvin Feurerberg, Report to congress: Phase II Final Report, Volume I. (Baltimore: Centers for Medicare and Medicaid Services, 2001), MD 21244-1850, 6.
[2] Volume 2, The Best of Care (Part 2) p 217

In other words, an opportunity exists, particularly as for-profit operators' sector share increases, for taxpayers' dollars to be diverted to profit instead of supporting quality care including competitive wages for the workers who deliver this care. It is time to consider establishing a cap on these profits.

Staffing must also be increased in assisted living residences. Despite existing eligibility criteria around mobility and cognitive ability, seniors are entering into these residences with more complex care needs – needs that only increase in their complexity soon after their entry. The result is an already overburdened and under resourced team of care staff struggling to meet the needs of residents.

Contracting out and privatization undermine continuity of care and staff retention

Continuity of staff is a critical determinant for health outcomes in seniors' care.

Almost the entire funded long-term care sector in B.C. was covered by one collective agreement prior to 2002. This meant standardized wages, benefits and working conditions for workers and a level playing field for employers in terms of their ability to recruit and retain staff.

Contracting out, sub-contracting, and increasing reliance on for-profit employers promoted through legislative and policy changes since that time have fragmented the sector. The result is a serious recruitment and retention crisis, and continuing disruptions in care relationships.

The HEU commends the current provincial government for making recent legislative changes including the repeal of anti-labour legislation—the *Health and Social Service Delivery Improvement Act* and the *Health Sector Partnerships Agreement Act* as well as the expansion of the definition of successorship under the *Labour Relations Code*.

These are long overdue steps toward ending contract flipping and the subsequent disruptions in care.

Sub-contracting still remains an option for commercial providers though. Language stipulating the prohibition of sub-contracting must become a mandatory provision in all operating contracts between health authorities and funded care home operators.

There continues to be a disparity of wages and benefits between workers employed by health authorities and those working for private employers, along with sub-contracted service providers.

Care aides, the most numerous occupation group in long-term care, earn $24.83 under the province-wide master collective agreement. Benefits include health, dental and vision, long-term disability, security of work, vacation, sick leave and a decent pension plan.

HEU unionized care aides outside of this agreement make $4 to $8 an hour less in starting wages, with significantly less vacation time and sick leave, and inferior health benefits. The situation is similar for other job classifications.

Thousands of women have been deprived of a pension plan as a result of privatization and contracting out in this sector, a group statistically more likely to live out their senior years in poverty.

This government's efforts to stabilize the long-term care sector through legislation and staffing increases are critical steps to stabilize the workforce and protecting care relationships. This work must continue with the goal of re-establishing a sector standard.

Our union commends the Committee for their Budget 2019 recommendation to "provide additional long-term funding to address community care health human resource recruitment and retention challenges in public, private and non-profit sectors."

Low wages and benefits as outlined above make it difficult to retain experienced care staff, especially in regions where these care staff can work their way into regular positions at care homes with superior wages, benefits, and working conditions.

The industry lobby group for care home operators has for example, been asserting in recent months that 200 care aide positions remain unfilled in B.C.'s Interior region. By contrast, a search on the Interior Health Authority's (IHA) Intranet produces current vacancies for just over forty care aide positions. Health authority employers, signatories to the Facilities Collective Agreement (the main public master agreement) face much less difficulty in attracting workers.

It must be noted that despite the widespread acknowledgement of a recruitment and retention issue, it is not possible to access precise figures tracking turnover, particularly among private long-term care operators. This information should be gathered and made a reporting requirement for funding. It will assist policy makers in better understanding, and addressing the challenges in this sector.

It goes without saying that HEU fully supports the 2019 Committee's recommendation to "Ensure stable, quality care in residential care facilities by reviewing and establishing minimum staffing levels, equalizing compensation, and reviewing sub-contracting of care and support services".

In addition to previous recommendations adopted by this Committee in this area, we believe the following recommendations should be adopted:

- Conduct a comprehensive review, involving leading health policy and residential care experts, and key stakeholders, to establish an appropriate legislated minimum staffing level necessary to provide quality care. The review should also make recommendations on accountability measures and standardized funding approaches to ensure minimum staffing levels are met.
- Explore placing a cap on profits for long-term care for-profit operators in order to maximize public monies used for direct care of seniors
- Track and report staff turnover at funded long-term care facilities regardless of ownership type
- Continue taking steps to end contracting out by including a mandatory provision prohibiting sub-contracting in commercial contracts between health authorities and care home operators
- Increase funding for staffing at assisted living facilities
- Re-establish stable working and caring conditions in the long-term care sector by moving towards sector-wide standards

End the use of P3s and create a capital plan for health infrastructure

Ending the use of Public-Private Partnerships (P3s) for the financing and development of hospital and health care infrastructure is an important step forward in achieving savings and promoting accountability and transparency in the health care system.

The assumptions underlying the business cases for P3s were never made transparent by the former government. An independent study must be undertaken to consider the costs and benefits of 'buying out' existing P3s.

In addition, it is time to re-establish balance in the ownership patterns in long-term care where ownership has shifted significantly away from public and non-profit ownership of funded sites, to those operated on a for-profit basis.

End the use of P3s

Auditors-General of New Brunswick[3] and Ontario[4] have found the use of P3s to be ideologically driven and more expensive than public delivery options. P3s have become part of BC's healthcare infrastructure without transparent business cases and publicly-released costings to demonstrate their fiscal benefits.

Corporate consortia that build P3s finance these developments at a higher borrowing cost than a government financed model. Those higher costs are built into the payments made out of health authority operating budgets over many decades.

The previous government did not issue the Value for Money reports that were used to determine that the P3 option was less costly than traditional public procurement. Those reports should be released now so the public can review these assumptions and calculations.

The government should undertake a study to determine whether there could be savings to the public from buying out currently existing P3 projects, particularly in the health care sector. Such a study should be public and not conducted by institutions with a vested interest in P3s. It should include a review of the actual costs, contract performance, impact on patients, and assumptions around the original Value for Money reports.

Other jurisdictions are reviewing their P3 contracts and some public health authorities have determined that buying out long-term contracts makes sense.

In 2011, the Tees, Esk and Wear Valleys Mental Health Foundation Trust in the United Kingdom took advantage of a clause in its contract to end a hospital P3 deal. It paid £18 million to get out of the contract 23 years early, and now owns the hospital outright and expects to save £14 million over the course of the deal once maintenance and inflation is taken into account."[5]

These same opportunities may exist for us in B.C. and should be carefully examined.

Build public healthcare facilities

As noted above, HEU supports the government's move away from the use of the P3 model for the provision of new hospital infrastructure. And we note that the health ministry has announced a number of new acute care projects – in large communities and small – that are badly needed and very welcome.

---

[3] Auditor General of New Brunswick, "Auditor general finds government decisions had excessive risk with no clear benefit to taxpayers," June 11, 2019, https://www.agnb-vgnb.ca/content/agnb-vgnb/en/media/releases/renderer.2019.06.0375.html

[4] CUPE, "Ontario audit throws cold water on P3 love affair," March 11, 2015, https://cupe.ca/ontario-audit-throws-cold-water-p3-love-affair

[5] Martin Beckford, "Hospital saves £14m by getting out of PFI deal," *The Telegraph*, February 2, 2011. https://www.telegraph.co.uk/news/health/news/8296685/Hospital-saves-14m-by-getting-out-of-PFI-deal.html

We believe it's time for government to develop a capital plan for seniors' care – one that rebalances the ownership patterns in this sector.

The number of funded long-term care beds operated by B.C. health authorities and non-profit organizations decreased by 11 per cent between 2001 and 2016 while the share of beds operated by for-profit operators increased by 42 per cent. [6]

The increase in for-profit operators in the sector is a result of a number of policies and legislation promoted by the previous provincial government. It has been accompanied by downward pressure on wages and an increase in contracting out and contract flipping.

For the past 17 years, most new beds in the long-term care sector have been funded through per diem payments from health authorities to facility operators. Like with P3 hospitals, this model results in higher capital costs (because of higher borrowing costs). Operators divide their per diem payments between care costs (staff, food, activities, supplies), capital costs, administrative costs and profit.

Under this model, care home chains have emerged and they hold an increasingly larger share of the available long-term care bed stock.

Retirement Concepts, for example, holds one out of every 10 contracted care beds in B.C. Most of this stock was purchased by the Chinese insurance company Anbang in 2017. Anbang is now under the control of the Chinese government through its insurance regulator, and is in the process of selling off assets across the world.

On Vancouver Island, five out of the seven funded long-term care facilities that were opened about a decade ago have changed hands. Two were purchased by Retirement Concepts (and now under the control of the Chinese government) and three were purchased by Park Place Seniors Living – the second biggest chain of contracted care homes in B.C.

B.C.'s health authorities have less and less direct control over long-term care facilities in their jurisdiction. HEU believes it is time to rebalance the ownership equation so that a greater share of long-term care capacity is owned and operated directly by health authorities and non-profit groups organizations.

Access to assisted living is another area where the need for a capital building plan is clear.

A B.C. Seniors' Advocate's report of 2018 observes a steady increase in the number of assisted living units built each year since 2014. The report reveals that in 2018 there were 22,826 private assisted living suites in B.C. and only 4,411 publicly subsidized suites in the province. The number of subsidized assisted living units decreased by two per cent in 2017/18 while the waitlist for subsidized suites increased by seven per cent.

Our government must take greater measures to ensure we are meeting the needs of seniors, particularly those in lower income brackets. Private, for-profit interests, left to their own devices will maximize their revenue, as is evidenced in the 'conversion' of subsidized suites at Vancouver's Terraces

[6] Andrew Longhurst. 2017 "Privatization and Declining Access to B.C. Seniors Care: An Urgent Call for Policy Change" (Vancouver, B.C. CCPA 2017), 5.

7th.[7] Long-time residents almost lost their homes when Retirement Concepts, the company that owned the suites, announced it was transitioning to a more lucrative private-pay model and would be evicting them.

Public scrutiny led the company to agree to do the conversion through attrition which means protection for the existing residents. The move from subsidized suites to private pay is a growing trend though, and reason to implement a capital plan for developing public and non-profit assisted living units.

Health authorities and non-profit groups have limited access to capital to develop or expand long-term care and assisted living facilities. HEU believes that it is critical for government to develop a capital building program that can help non-commercial service providers build more seniors' care facilities.

Recommendations

- Undertake a study as to whether there could be savings to the public from buying out currently existing P3 projects, particularly in the health care sector. Such a study should be public, and should not be conducted by people or institutions with a vested interest in P3s. It should review the actual costs, the performance of the contract, the impact on patients, and the assumptions around the original value for money report.
- Develop a comprehensive capital building plan for the seniors' care sector that includes easier access to capital funding for the development of long-term care, assisted living and independent living sites.

Invest in prevention strategies

Address workload to reduce injuries

Low staffing remains a key contributor to workplace injuries. The recent investments in staffing for residential care will hopefully improve not only the level of care residents are receiving but help to lower injury rates in the sector as well.

The rates for long term residential care continue to be four times higher than the provincial average at 8.7 per cent for 2017 and 4 per cent in the acute care sector, a rate that is double the provincial average.

Overexertion is the number one type of injury claim reported, accounting for nearly half of all claims in both acute and long-term care facilities, followed by injuries caused by violence.[8] Overexertion is often the result of patient handling and presents as an MSI.

Injuries related to violence constituted 21 per cent of claims in 2018 in long-term care.[9] Care aides perform tasks that require being in residents' personal space, and are the majority of workers experiencing these injuries. In many cases they are forced to rush care because of unrealistic demands with little time to carry them out. Minimal dementia care training, and insufficient time to implement the training that they have received, are also contributing factors though low staffing is the main issue.

[7] Susan Lazaruk, Vancouver Sun April 11, 2017 https://vancouversun.com/business/local-business/vancouver-retirement-home-residents-facing-eviction-receive-reprieve
[8] Work Safe BC
[9] Ibid

The duration of claims in 2018 for care aides was 39 days, a figure that has risen most years since 2014 and totalled 120, 315 days lost for 2018 or 463 full time equivalent care aide positions for the year.

Costs to the health care system with these rates and durations are high but the injured worker faces mental and emotional costs on top of their financial loss. The impact of violence on care staff, for example, cannot be underestimated and not all of those injured are able to make the transition back to work.

Standardize and coordinate injury prevention programs

Recently negotiated provisions in the Facilities Collective Agreement (covering 44,000 hospital and long-term care workers) master agreement signify a shared commitment by unions, health employers and government to addressing the problem of workplace injuries. These include monies to establish a provincial occupational health and safety entity for health care workers in B.C. and an intervention study on musculoskeletal injuries (MSI). Roughly half of workers in the long term care sector are not covered by this agreement. While they may benefit indirectly from these initiatives, more must be done to standardize and coordinate injury prevention programs across employer groups and collective agreements.

It is time to increase investments in keeping health care staff safe. This is achieved first and foremost through increased staffing to reduce crippling workloads. Sector wide strategies in training and other prevention measures must also be adopted with coordination and consistency across the sector.

Recommendations

- Develop a sector-wide strategy that supports staff by addressing workload through increased staffing
- Standardize and coordinate injury prevention programs across health authorities, employer types and collective agreements

Conclusion and recommendations

The Hospital Employees Union appreciates the opportunity to share our recommendations. We offer perspectives of health care staff who are tasked daily with delivering quality care in acute, residential and community services.

Our Union is excited to experience the changes this government is making to strengthen care in our province including the investment in staffing in long-term care, the repeal of Bills 29 and 94 and changes to the labour code to offer successorship to health care workers. We see each of this as making a significant contribution to stabilize care in B.C.

Still, there is much to remedy after sixteen years of cuts, loss of public assets, and attacks on public sector workers.

In summary we make the following recommendations in the areas of staffing and funding accountabilities in residential care, creating a capital plan and shift to publicly owned and operated infrastructure and injury prevention strategies.

Recommendations

Stabilize the Residential Care Sector

- Conduct a comprehensive review, involving leading health policy and residential care experts, and key stakeholders, to establish an appropriate legislated minimum staffing level necessary to provide quality care. The review should also make recommendations on accountability measures and standardized funding approaches to ensure minimum staffing levels are met.
- Explore placing a cap on profits for long term for-profit operators
- Track and report staff turnover at residential care facilities
- Continue taking steps to end contracting out by including a mandatory provision prohibiting sub-contracting in contracts between health authorities and commercial operators
- Increase funding for staffing at assisted living facilities
- Re-establish stable working and caring conditions by addressing the recruitment and retention issue in the residential care sector though amalgamation of all employers and workers into the provincial master collective agreement

End the use of P3s and create a capital plan

- Undertake a study as to whether there could be savings to the public from buying out currently existing P3 projects, particularly in the health care sector. Such a study should be public, and should not be conducted by people or institutions with a vested interest in P3s. It should review the actual costs, the performance of the contract, the impact on patients, and the assumptions around the original value for money report

- Outline more detail in a capital plan. Publicly owned and operated facilities will increase accountability and cost savings. Such a plan must include acute and seniors care facilities including assisted and independent living

Invest in Injury Prevention Strategies

- Develop a sector-wide strategy that supports staff by addressing workload through increased staffing
- Standardize and coordinate injury prevention programs across health authorities and employer types