GUARDIAN

THE VOICE OF THE HOSPITAL EMPLOYEES' UNION • WINTER 2006 • VOLUME 24 NUMBER 4

What's at stake

Why it matters

Taking back the "conversation" on health

Here are the solutions

WINTER 2006

GUARDIAN

FIRST PAGE REPORT

Let's cut to the chase ...

CONVERSATION OR LECTURE? Last fall the provincial government called for a province-wide "conversation" on health. But so far it looks a lot more like a lecture, with every indication that the B.C. Liberals have already made up their minds about where they want this discussion to go

First, the province's finance minister laid the foundation for the conversation with her now infamous prediction that unless spending is dramatically curbed, health care will consume 71 per cent of the provincial budget by 2017.

That claim has since been discredited by several economists and policy analysts – and most recently by B.C.'s former deputy minister of health Penny Ballem – who point out that per capita health spending in B.C. has fallen substantially in relation to other Canadian provinces over the past few years.

Next, the Premier exposed the conversation's ideological underpinnings by selecting privatization promoter Brian Day to open the $10 million exercise at a provincial congress of community leaders and politicians.

And finally, if those signs weren't obvious enough, the government effectively shut health care workers out of the conversation's 16 regional forums, where citizens from all walks of life are invited to provide government with their views on the future of B.C.'s health care system.

Instead, health care workers will be segregated into their own meetings without the ability to exchange views with others in their communities.

WE WON'T BE MUZZLED The union's secretary-business manager Judy Darcy says government's decision to exclude health care workers from broad, community discussions won't stop HEU members from having their say.

"We're not about to sit back quietly and let this conversation unfold without being heard," says Darcy. "When it comes to patient care, our members not only know the challenges first-hand, they know the solutions – solutions that can make our public health care system stronger and more accessible than it is now."

She says health care workers have a unique responsibility and a pivotal role to play in strengthening public health care, "especially in the face of a well-funded effort by private medical businesses to undermine it."

"If our members are excluded from government's regional forums," she says, "they will find other ways to speak out. And I guarantee, they won't be muzzled."

HAVE YOUR SAY To assist HEU members in making the most of these opportunities, this special issue of the *Guardian* is dedicated to providing the facts, the solutions and the tools needed to effectively advocate for positive changes in health care delivery.

We hope our readers will share the information in these pages with all those who are looking for real answers to health care's challenges. And we encourage everyone to stay in touch with the "conversation on health" by checking out the union's website on a regular basis at www.heu.org

Speak out

HEU members are on the front line – you know what works and what doesn't. You know just how precious our public health care system is for all British Columbians. And you have the ability to advocate for the patients and residents you care for. As a citizen and as a health care worker, your voice matters. Your voice needs to be heard.

- **Contact** your MLA, write to your local paper, call in to radio talk shows and provide family and friends with factual information about public solutions for health care.
- **Urge** your MLA to hold a public forum on health care.
- **Participate** in community-based forums, and watch for public events sponsored by the BC Health Coalition.
- **Register** your views with the government's health conversation. The easiest ways are to leave a voice message on their toll-free line at 1-866-844-2055; send an e-mail to ConversationonHealth @Victoria1.gov.bc.ca; or contribute to their online discussion at: www.bcconversationonhealth.ca
- **Attend** one of 16 government-sponsored forums for health care providers. Watch the HEU website and your local bulletin boards for dates and locations.

IT'S TIME to get down to the real solutions for public health care.

JUDY DARCY

The signs are there: members are on the move

Just a few weeks ago, more than 1,300 clerical members – one out of five – responded to an on-line survey where they provided direct input into a benchmark review negotiated last spring.

Earlier in December, more than 420 applicants answered a call for participation on province-wide union committees – six times the number of available positions.

Those are just two recent indications that members are taking a renewed interest in the work of their union and they want to get more involved.

This bodes well for the year ahead where there will be plenty of opportunities to participate and influence the union's direction.

This bodes well for the year ahead where there will be plenty more opportunities for members to participate and influence the union's direction.

In March, the union's fourteen province-wide committees will meet in a joint session with your provincial executive to establish common priorities and strategic work plans for the next two years.

And those provincial committees will also establish action networks made up of the hundreds of members who applied to work with them – along with other interested members.

We're going to use these networks to tap into the energy and interest members have expressed in wide-ranging issues like the challenges facing our young workers, ongoing health and safety issues in the workplace and occupation-specific concerns.

In April, more than a hundred members will gather in Burnaby for an HEU equity conference aimed at making the union more responsive to the diverse membership it represents.

Following up on the directive from last fall's convention, the union will also hold five regional meetings in April – the first of what will be twice-yearly gatherings where locals will be able to coordinate their work on a regional basis.

And this year, we have put in place an ambitious education program for 2007 – including a summer school this June – that will provide members with the tools they need to advocate and organize in their workplaces and communities.

All of this is taking place against the backdrop of a government "conversation on health" where – despite the talk – it looks as if the B.C. Liberals have already decided that we can't afford public health care. Our union is working with the rest of the labour movement and our community partners to make sure that the alternative – more cuts, closures and the privatization of everything from hospitals to health insurance – doesn't become the new normal in B.C.

Whether it's advancing solid, public solutions that strengthen medicare or advocating for workers' rights on the shop floor, there's every sign that HEU and its members are up to the challenge.

voice.mail

Unit coordinator education day

Unit coordinators are working together to provide support and education on professional issues.

The BC-Health Unit Coordinators Coalition is organizing the "first annual unit coordinator education day", which is taking place at the HEU provincial office in Burnaby on April 21, 2007 starting at 8:30 a.m.

The BC-HUC is also looking for people to voice their opinions.

First, you can join the members' only BC-HUC Google chat group that is used to discuss ideas and thoughts, as well as provide a sounding board for your frustrations. You can log in to the site at ‹http://groups.google.ca/group/BC-HUCs›

Second, the BC-HUC coalition is looking for unit coordinators to form a taskforce to act on issues that are important to unit coordinators. We meet once a month on a Saturday.

If you are interested or if you have any ideas contact Jennifer Cass at Jennifer181@hotmail.com or Liz Halloran at khalloran@shaw.ca.

If you would like to get involved in planning and organizing this education day or would like to give us information on what you would like learn at the education day, please contact Soraya Spier at sspier@telus.net or myself at sharper@vcn.bc.ca.

This is your day. Let's make it count!

We hope to hear from all unit coordinators. If there is an issue you would like to be heard, please contact us or become part of the task force.

Get involved in your profession!

DONNA HARPER
CHUC
Lion's Gate Local

Welcome to our world

As an immigrant, wherever I go I hear flattering remarks about the importance of immigrants to Canada. Politicians and labour leaders alike talk about the major role immigrants have played in the prosperity and development of this country.

But the question is: are we really doing enough to help immigrants, in particular the migrant workers? Do we really know the challenges and difficulties many immigrants face everyday of their lives? What do we really know about the pain and suffering they endure?

Imagine yourself in a new country where an entirely new language must be learned and understood just to survive.

Imagine yourself living in a tiny cold basement suite with very little food and very little money, knowing that it will run out in a few days or weeks.

Imagine yourself going to work everyday and after working very hard you continue to be harassed, intimidated and abused.

Imagine yourself being injured at work and pretending that you're well because you don't want to miss that one day's pay or you fear losing your job.

Imagine struggling to get up to grab a glass of water because you are sick, and there's no one there to help you.

Imagine being lonely, homesick and depressed and there's nobody there to talk to because your family and friends are thousands of miles away.

Well, brothers and sisters welcome to our world. You are fortunate if you only have to imagine such circumstances. For many immigrants, these situations are a daily reality; it's how we live our lives.

Some of us are immigrants. Some of us are not. But all of us have a role to play in stopping the suffering, injustices and humiliation that affects so many immigrants.

After all, aren't we are all human beings?

BONI BARCIA
St. Michael's Local

MARK YOUR CALENDER

Regional meetings set for April

Regional meetings are set to begin in April. They are the first to be organized using the new regional structure ratified by delegates at the union's 25th biennial convention.

Following recommendations from the 18-month consultation, *Task Force for a New Union,* delegates voted to amend HEU's constitution and create the following five regions: Vancouver Coastal, Fraser, Interior, Northern and Vancouver Island.

The amendment also created four additional regional vice-president positions on the Provincial Executive to replace the fourth and fifth vice-president and two member at large positions.

Meetings for each region will be held on the following dates.

VANCOUVER COASTAL: April 11-12

FRASER: April 16-17

VANCOUVER ISLAND: April 19-20

INTERIOR: April 23-24

NORTH: April 26-27

Locations will be announced closer to the meeting times.

news

PHSA Compass members awarded first contract

The new collective agreement includes wage hikes and more

It took eleven long months, a 99 per cent strike mandate and Labour Relations Board mediation, but in the last days of 2006 HEU members employed by Compass in the Provincial Health Services Authority were finally awarded a first collective agreement.

Kathy Perkins (care aide), **Noel Gulbransen** (HEU bargaining representative) **and Deborah Stanlow** (care aide) **discuss the union's bargaining proposals in preparation for further contract talks with Good Samaritan's Christensen Village in Gibsons.**

First contract bargaining for HEU's 115 members, who provide nursing and support services at the assisted living/complex care facility, began in early December.

The three-year contract, issued by LRB mediator-arbitrator Don Munroe on December 21, includes wage increases of up to 27 per cent along with other provisions.

HEU secretary-business manager Judy Darcy says that the collective agreement will provide the basis for strengthening members' rights in the workplace through a strong system of shop stewards, a solid local union and active health and safety committees.

"Compass workers should be proud of what they've accomplished over the last three years, in the face of an employer who was determined to deny them the most basic union rights."

The contract expires on September 30, 2008, at which time wages covering most of the 250 dietary and housekeeping workers will equal those contained in HEU agreements with Aramark and Sodexho, which expire on the same date.

"Our members have earned this collective agreement and the respect for their work that comes with it," says Darcy. "Now we must focus on making the union stronger on the ground and prepare to make more gains in 2008," says Darcy.

For most workers, the hourly wage will rise from $10.25 an hour to $10.56 on September 18, 2005; $12 an hour on September 18, 2006; $12.59 an hour on September 18, 2007; and to $13.05 an hour on September 18, 2008.

That's a total increase of 27 per cent over the term of the new collective agreement.

Other classifications will also see hourly wages rise to between $13.65 and $17.92 by September 2008.

Those members who worked for Compass on September 18, 2005 – the start date of the agreement – and who are still employed by the company will receive retroactive payments based on the wage schedule contained in the contract.

The first agreement also contains improved harassment protection, sick time, seniority provisions, better access to training and improved job posting language. There's also better protection for members who are required to move between work sites – an issue of particular importance to housekeeping staff. Compass is now required to cover transportation-related costs for those who are reassigned to another work area after reporting for their shift.

Although Munroe did not award a merged seniority list for Morrison and Crothall, he did recognize the union's shop steward structure. Under the terms of the agreement, a Morrison manager, for example, must recognize an HEU steward from housekeeping who may be representing a food service worker.

HEU now has collective agreements with Sodexho, Aramark and Compass covering 2,400 cleaning and dietary staff in the Lower Mainland, Fraser Valley and on the Sunshine Coast.

But more than 700 Compass workers on Vancouver Island are still waiting for a first contract. The LRB is expected to appoint a mediator-arbitrator to those negotiations in the New Year.

LRB appoints arbitrator in Compass-VIHA talks

The Labour Relations Board has appointed a mediator/arbitrator to assist HEU and Compass in reaching a first collective agreement, covering more than 700 union members on Vancouver Island.

Stan Lanyon, a former chair of the LRB, was appointed under Section 55 of the *B.C. Labour Code*.

Section 55 is designed to help reach first collective agreements through a process of mediation and arbitration. It was used to reach first contracts for 250 Compass workers in the Provincial Health Services Authority – and for more than 1400 Sodexho workers in 2005.

Lanyon will hold hearings where both HEU and Compass will make presentations. But at press time, dates had not yet been confirmed. It's expected that he will issue a decision establishing a first contract after these hearings.

This is the second stage of the Section 55 process. In the first stage, mediator Grant McArthur issued a report after attempting to mediate an agreement with the two parties.

He recommended that the main outstanding non-monetary issue – a single seniority list for all VIHA members – along with other administrative issues, should be determined by the Comnpass arbitration for PHSA. That arbitration is now concluded.

McArthur also recommended that all remaining issues in Compass VIHA bargaining – including wages, retroactivity, sick leave and the term of the collective agreement – go to binding arbitration.

HEU members working for Compass on Vancouver Island gave their bargaining committee a 96 per cent strike mandate last October. The union subsequently applied for mediation and arbitration under the *Labour Code*.

Compass members on Vancouver Island were the last group of workers employed by the "Big Three" – Aramark, Sodexho and Compass – to join HEU.

Negotiations for a first contract began in April 2006.

COFFEE BREAK

Here's a small sample of blunders, scams and foolhardy ideas carried out by some of the world's biggest corporations.

Segway Inc. was forced to recall 23,500 high-tech electric scooters because of a software glitch that could make the wheels suddenly reverse direction.

On a hot day in June, Snapple abandoned an attempt to erect the world's largest popsicle. The 24-foot-tall, 35,000-pound frozen treat began melting faster than expected as it was hoisted upright in New York's Union Square Park. (The record is a 21-footer, erected in more temperate Holland.)

A recent on-line journal – supposedly written by a young couple crossing the U.S. in an RV and camping in Wal-Mart parking lots – turned out to be... surprise...a creation of the large PR firm, Edelman. The -backed scam was apparently an effort to improve the megastore's lagging public reputation.

Amid rising concerns about child obesity, General Mills launched a campaign about the health benefits of breakfast – promoting such nutritious foods as Cocoa Puffs and Count Chocula.

Days after praising the potential of its new cholesterol drug, the world's largest pharmaceutical company – Pfizer – was forced to shut down the drug's clinical trials after a number of participants died or developed heart problems.

ChoicePoint – a major U.S. company that stores personal credit card information – admitted to selling the data of 145,000 people to a number of unauthorized recipients, including an identity-theft ring in Los Angeles.

Following a string of mysterious laptop explosions – including one caught on video at a conference in Osaka, Japan – Dell Computers initiated what some are calling the largest battery recall in history. Sony, the supplier, agreed to share the costs of replacing a whopping 4.1 million defective batteries.

And in the Pacific Northwest, several McDonald's outlets have outsourced their drive-through functions to remote call centres.

This list is compiled with thanks to Business 2.0 and PR Week magazines.

http://money.cnn.com/magazines/business2/business2_archive/2006/01/01/8368135/index.htm

Union education and training a top priority

HEU's education department has been working overtime to provide union members with a wide range of training opportunities.

This fall, more than four hundred members signed up for workshops aimed at building their skills and revitalizing the union's activist base.

Courses included intermediate shop steward training, union activism, demystifying classification and health and safety training.

Education director Juli Rees says the shop steward course focused on providing members with the knowledge and skills they need to enforce new and existing collective agreement rights in the workplace.

Health and safety training, delivered in Vancouver and Victoria, gave many new HEU members working for Aramark, Sodexho, and Compass practical information about their rights to a safe workplace and the tools they need to protect those rights on the ground.

And about 100 Licenced Practical Nurses were trained as advocates to help their colleagues use the new Professional Responsibility Form (PRF) negotiated during spring bargaining.

For more information on HEU's education programs watch your local bulletin board, talk to a member of your local executive or check out the HEU website.

B.C. labour vows to fight private clinics, P3s

The B.C. labour movement is taking aim at the expansion of private clinics as well as privately-financed hospitals and other public projects.

Delegates to the 50th convention of the B.C. Federation of Labour were unanimous in their call for all levels of government to enforce the Canada Health Act and shut down the operations of the Urgent Care Centre – a private emergency clinic operated by the False Creek Surgical Centre.

Federation president Jim Sinclair urged union members to step up the fight to protect public health care for future generations so that "no young person will be asked to cross their fingers" because they can't afford their health care.

"It's unconscionable that any Canadian who requires emergency care would ever have to reach for their Visa card," said Sinclair.

HEU's top officers joined Sinclair and other health union leaders to lobby Vancouver city councilors to deny the clinic operators a business license because of their plan to bill patients directly for emergency care.

The Urgent Care Clinic – which opened on December 1, the final day of the B.C. Federation of Labour convention – reached a last-minute deal with the provincial government in which it agreed not to charge patients for "medically necessary" services.

Dozens of HEU delegates rally in front of Vancouver City Hall to call for the cancellation of a business license for a private emergency room.

Subsequently, the private clinic shut it's doors to MSP claims, citing financial reasons.

Delegates also opposed the B.C. Liberal government's mandate that all infrastructure projects valued at over $20 million be automatically considered as public-private partnerships (P3s).

Workers from the health care, municipal, education and construction sectors spoke out against the loss of public accountability and increased costs that result from P3 privatization.

"There is no place for profit in health care," said one HEU delegate.

"The principle is the same in education, transportation, water, all public services. This is not a medieval society. Public services are social responsibilities."

Delegates also questioned how Partnerships BC – the provincial government agency charged with promoting P3s – could also be responsible for evaluating whether infrastructure projects were good candidates for this form of privatization.

<<newsbites>>

Conservatives slash funds for women's equality

Women across the country are demanding the Conservative government repeal its massive cuts to Status of Women Canada (SWC) – the federal agency responsible for promoting women's equality.

In September, Stephen Harper announced that the government would eliminate 40 per cent of the agency's $11.5 million budget, effective April 1. Since then, the government has made plans to close 12 of the 16 regional SWC offices across Canada.

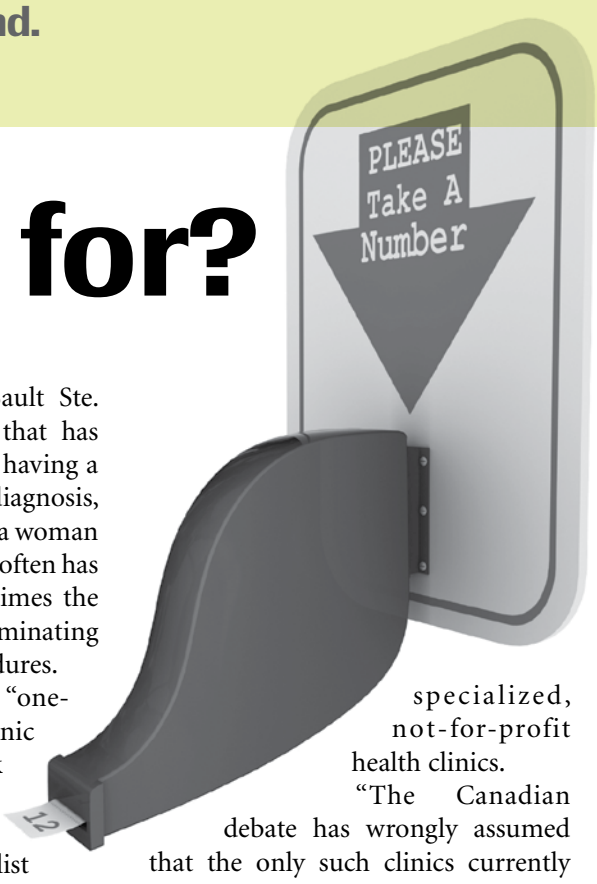
And the budget cuts were just the beginning. The Conservatives also whittled down the agency's scope of work, eliminating the words equality from their mandate and website and abolishing all grants connected to advocacy, lobbying and research on behalf of women. The federal government gave Canadians further insight into their priorities when they modified the agency's funding criteria, allowing for-profit organizations to apply for the remaining limited resources.

Despite heritage minister Bev Oda's claim that Canadian women no longer need the research and advocacy work funded by SWC, the numbers tell a different story. The income gap between men and women in Canada continues to be the fifthp largest among the world's industrialized countries. It's estimated that close to one million Canadian women are either physically or sexually assaulted each year and approximately 38 per cent of Aboriginal women in Canada live below the poverty line.

Women's equality organizations, who address these kinds of issues, have a legacy of working for many laws and policies Canadians now take for granted. These include the introduction of maternity benefits, changes to spousal assault laws and

While the media continues to pump out bad news stories about lengthy waits for elective surgery, diagnostic treatment and prompt emergency room care, effective public health care solutions are at hand.

What are we waiting for?



In recent years, effective public health care solutions have emerged in B.C. and other parts of Canada. The problem is, very few British Columbians know about them. And governments have been slow – if not downright reluctant – to take those real innovations and replicate them throughout the system.

If they did, the proponents of privatized, two-tier health care would not be able to use the wait list issue to their own advantage – taking public health care dollars and turning them into profits for private shareholders.

"The enemies of medicare have used the legitimate public concern about delays in the system to peddle ill-advised policies such as for profit delivery and private finance," says health policy analyst, Dr. Michael Rachlis, in *Public Solutions to Health Care Wait Lists.*

"Even (former) Alberta Premier Ralph Klein admitted in a candid moment that sending patients to private clinics in his province will cost more than if the services were provided in the public sector," he says.

In 2001, Morris Barer, Robert Evans Patrick Lewis and Rachlis co-authored a key research study – *Revitalizing Medicare: Shared Problems, Public Solutions.* It not only describes numerous innovations and best practices already operating within the public health care system, it challenges governments to put those solutions into mainstream practice for the benefit of all Canadians.

"Those with an agenda of undermining medicare are helped by the creation of doomsday scenarios that bear little resemblance to reality," they warn, adding that "there is a great deal of money to be made by wrecking medicare."

For the record, here are a few proven public innovations, that if put into practice, would resolve the wait list issue, restore confidence in medicare and render private medical businesses irrelevant.

Many delays for care are due to poorly designed services, not a lack of resources. The problem is a bottleneck at the doorway.

According to Rachlis' research, many delays for care are due to poorly designed services, not a lack of resources. The problem is a bottleneck at the doorway.

Solutions for clearing that bottleneck abound: pool wait lists among physicians; clear backlogs by temporarily adding more resources; keep public operating rooms working to full capacity; and consolidate "multi-step care" for those who need to see a succession of specialists.

Take the example of a Sault Ste. Marie breast health centre that has reduced wait times, between having a mammogram and getting a diagnosis, by 75 per cent. At this facility a woman with a positive mammogram often has the ultrasound – and sometimes the biopsy – on the same day, eliminating lengthy waits between procedures.

In North Vancouver, a "one-stop" joint replacement clinic has cut the average 50- week wait time to between two and four weeks for hip and knee surgeries. In this specialist clinic scheduling is centralized, care is coordinated and the patient has the option of seeing the clinic's first available surgeon.

In a hospital setting, life saving emergency operations often take precedence over elective surgeries. But not every surgery needs to be performed in a hospital. Rachlis and others call for shifting as many minor procedures and low-risk elective surgeries as possible to short-stay, specialized, not-for-profit health clinics.

"The Canadian debate has wrongly assumed that the only such clinics currently in operation are for-profit business," says Rachlis. But in fact Toronto's Surgicentre, part of Trillium Ontario's public hospital, is the largest not-for-admission surgical centre in North America.

And Manitoba's Pan-Am Clinic, which operates as a unit of the Winnipeg Regional Health Authority, also provides the efficiencies private clinics have capitalized on, without siphoning public dollars to shareholders.

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Private clinics just make things worse

Research studies show that for-profit medical clinics don't reduce wait lists in the public system, they actually make them longer.

- In countries like New Zealand and England where parallel private systems exist, more people wait longer in the public system.
- Research in England, Australia and Canada shows that in those parts of the country where there are parallel, private sugeries – those in public hospitals will wait longer.
- Surgical procedures in for-profit clinics cost more. That's because they must pay for advertising and show a profit for shareholders. It's a drain of scarce public health dollars.
- Health care professionals can't be in two places at once. A parallel private system takes badly needed doctors and nurses out of our public hospitals, making waits longer.
- Studies show that publicly-funded hospitals are more efficient and provide a higher quality of care at a much lower cost, both in terms of mortality rates and price.

amendments to human rights statutes to prohibit sexual harassment and discrimination based on pregnancy and sexual orientation.

Instead of building on these successes, the huge cuts are, "reversing strides that have been made over the last 20 and 30 years," says Joanne Hussey, founder of the website, thewomenarenangry.org

Women like Hussey and Audra Williams, who runs statusreport.ca, are among many others – unions, organizations and individuals – who are determined to not only reverse the cuts to SWC, but to strengthen the agency whose work to support women's equality is far from over.

Global unions kick off G8 lobby on AIDS

In the lead up to World AIDS Day, December 1, labour unions launched a six-month campaign to press governments to make AIDS a regular issue at G8 summit meetings.

Alan Leather, chair of the Global Unions' AIDS Program steering committee, said, "By making AIDS a regular feature of this and future G8 agendas, we will use our energy to fight AIDS rather than fighting to make sure it is recognized as an issue worthy of constant attention."

In 2005, 2.9 million people died of AIDS-related illnesses and 4.3 million became newly infected. The global AIDS epidemic continues to grow, outpacing the efforts to effectively respond.

An estimated 2.3 million children now live with AIDS and an estimated 15 million are AIDS orphans. Young people already account for half of all new HIV infections and between 5,000 and 6,000 young people, aged 15 to 24 years, aquire HIV each day.

Another huge fine for Wal-Mart

For the second time in less than a year, an American jury found that Wal-Mart unlawfully withheld wages from workers who were pressured to skip breaks and work off the clock.

The latest case stemmed from a class-action lawsuit on behalf of 187,000 Pennsylvania workers. The jury found that Wal-Mart must pay $78 million to its current and former employees in that state for violations that occurred from 1998 through May 2006.

The company said it will appeal, and issued a statement that "systems have been improved over the years to help ensure that all associates receive their scheduled breaks."

But downplaying the problem will not help, say attorneys for the workers, who predicted that the judge in Pennsylvania may increase the huge fine by $62 million for damages, because the jury also found the company acted in bad faith. *(UCS/CALM)*

Budget focuses on strengthening union

The union's Provincial Executive has approved the operating budget for the next fiscal year – ending December, 2007.

It is the first budget prepared by HEU's new financial secretary.

Donisa Bernardo says the union's revenue has stabilized over the last three months, making it easier to project future revenues with greater accuracy.

She notes that the union is projecting a $317,325 budget deficit, which will be reviewed by the Provincial Executive in June, 2007.

"This budget reflects many of the strategic priorities set out by delegates at our October convention," says Bernardo. "It's a solid budget that will allow us to get down to the business of rebuilding and strengthening the union."

Those strategic initiatives include campaigns to protect public health care, enforce collective agreement rights on the ground, and lay the groundwork for bargaining with Compass, Aramark and Sodexho in 2008.

"Unlike last year's budget, which required that we focus substantial resources on bargaining in the facilities, community health and community social services sectors, this budget's focus is primarily on rebuilding and strengthening the union at all levels," she says.

"This has been one of the benefits of securing four-year agreements in these sectors."

Other budget highlights include funds to support: two regional meetings in each of the union's five regions; 14 sub-committees of the Provincial Executive and their outreach activities; the union's summer school and a provincial equity conference currently being planned for April 3 & 4, 2007.

"Additional resources have also been allocated to both education and servicing, as well as to the union's classification department – on a temporary basis – to clear the back log of job review requests," says Bernardo.

"This budget reflects many of the strategic priorities set out by delegates at our October convention."

Donisa Bernardo

Bernardo notes that one per cent of all dues revenue will be set aside to replenish HEU's strike fund. "We want to make sure the union is in a strong bargaining position when contracts expire in 2010," she says. "That means we need to begin rebuilding our strike fund now, in 2007."

She says that the monies set aside from the signing bonus deductions will be used to fund the contract implementation committees and ensure they have appropriate staffing. Those committees include the early intervention program, the education fund, policy tables for the nursing team, the clerical benchmark review and the benchmark review for patient care technical, beginning April 2007.

Bernardo says the union is also "working closely with CUPE National to access funding available for cost-shared campaigns and organizing new members in health care."

Copies of the budget will be sent to all HEU locals.

PATTY GIBSON
HEU COMMUNICATIONS OFFICER

FRED MUZIN

PRESIDENT'S DESK

A challenging year ahead in 2007

As we start the New Year with great hopes and expectations, the challenge to establish priorities seems overwhelming.

The pressure by the provincial government to sell off public assets and resources continues to accelerate. Examples include the leasing of BC Rail for a thousand years; developing coal–fired electricity generating plants in Princeton, Tumbler Ridge and elsewhere; exporting our water and raw logs; further erosion of our public medicare system; the Premier's directive that public private partnerships (P3s) must be promoted for all projects; and removing land from the Agricultural Land Reserve for development.

So where do we start? As health care providers we need to be integral to the Premier's Conversation on Health that kicks off in Kamloops on Groundhog Day. There are many workable public solutions to problems that have emerged in health care – opening closed ORs, increasing home support, developing and using our human resources more effectively, fast tracking the creation of more long term care spaces, opening primary community health centers with salaried physicians, expanding Pharmacare, targeting aboriginal health, eliminating contracting out and dealing with short staffing throughout our health care facilities.

The 24 per cent child poverty rate in B.C. is absolutely disgraceful.

But we will not be able to create a more sustainable system as long as we ignore factors that increase the demand for health care services – the social determinants of health. Access to education, poverty, homelessness, mental illness, and child care are all factors that impact an individual's health.

Formal public education provides the best opportunity for the greatest number of people to advance. But under funding, student debt, and curriculum limitations are eroding this benefit. Lifestyle counseling about the social impacts of substance abuse, smoking, exercise and proper nutrition is also needed to improve health outcomes.

Poverty, inadequate housing and homelessness all lead to poor health. We can dramatically improve the situation by increasing welfare rates and allowing supplemental income, providing neonatal education and affordable child care, immediately raising the minimum wage to $10 an hour, promoting affordable transit, and building low cost housing.

The 24 per cent child poverty rate in B.C. is absolutely disgraceful, especially in light of the growing gap between the rich and the poor as a result of the Liberals' taxation policies.

It's critical that we develop a society where people with mental illness or other disabling conditions can live with dignity and support, so they are not relegated to begging and attempting to survive on the streets. Hopelessness does not result in vibrant health.

We need to educate people, recruit more activists and build strong coalitions to achieve these solutions. Unless we are serious about dealing with these social determinants of health, our medicare system will continue to be built on a house of cards.

<<newsbites>>

Human Rights Conference creates declaration

More than 60 HEU members attended CUPE's first-ever National Human Rights Conference in Vancouver this past November, where they endorsed a declaration to strengthen diversity in the union.

"The Vancouver declaration unifies our efforts to promote human rights, equality and diversity," said CUPE national president Paul Moist.

"It will build on CUPE's important work in the struggle for equality for all and guide the work of our committees, conferences and conventions at all levels of the union."

The declaration includes the creation of a human rights course incorporating the work of the conference as well as initiatives to increase diversity and ensure that all levels of the union – committees, executive and staff structures – reflect the full diversity of CUPE's membership.

HEU president, Fred Muzin, says the conference was another important step towards making the labour movement relevant and responsive to every union member.

HEU members discuss the issues at CUPE's first National Human Rights Conference in November.

"A decade of equity work within HEU has achieved a great deal, but this work is far from complete," says Muzin. "We need to continue to push – nationally, provincially and within our local unions – to make every member feel included in our labour family."

HEU will hold an equity conference next April in Burnaby.

"CUPE's organizing, bargaining, activism and international work will be stronger thanks to the participants of the Our Voices Rising human rights conference and the Vancouver Declaration," added Moist.

Visit cupe.ca where highlights, keynote speakers, workshops and presentations are available.

> From the humanitarian standpoint, there is, we believe, **an obligation on society to be concerned with the health of its individuals.** But on the economic side, investments in health are investments in human capital…they pay great dividends to a nation that looks after the health of its people.
>
> EMMETT HALL, FORMER SUPREME COURT JUSTICE

WHAT'S AT STAKE? The case for public health care in Canada

If you were listening to CBC radio on November 2, 1964, you may have heard Supreme Court Justice Emmett Hall give that answer to the question, "Why is universal health care important?"

Hall's answer is as good now as it was then. It sums up the strength and purpose of public health care. It reflects an extraordinary sense of fairness – a belief that Canadians continuously affirm and of which we are rightly proud.

Our unique brand of universal health care – enshrined in the *Canada Health Act* – has defined us to the world and to each other. And while other governments have created their own variations, none compare to the public health care system we created 40 years ago.

TWO TALES ON ONE CONTINENT

Shortly after World War II, Canadians turned their attention to enriching our society by expanding on our democratic values of fairness, justice and equality for all. Universal health care, that is health care for everyone regardless of ability to pay, was the concrete expression of those beliefs.

At the same time, the two-tiered, private, for-profit medical model was flourishing in the United States. Americans largely accepted the argument that each individual had the 'right' to buy medical care. In the U.S., it was all about one's ability to pay.

And it still is.

Today's promoters of private health care in Canada don't like the 'ability to pay' description. They claim that it's all about 'choice'. But 'choice' is a loaded word.

Former TD Bank CEO Charles Baillie, in his 1999 speech to the Vancouver Board of Trade, countered the 'choice' argument when he emphasized private health care's fundamental relationship to private insurance.

Baillie told his business audience that when it comes to private health insurance, most Canadians likely think they would be eligible for coverage and that they could afford it. But he cautioned people to remember how private insurance actually works.

"There is rating. There is discrimination. For those in high risk groups, that means, at best, very high premiums – or, at worst, no coverage," Baillie said.

Statistics back this up.

According to the Washington, D.C.–based National Coalition on Health Care nearly 47 million Americans were uninsured in 2004, the latest year data is available. U.S. surveys show that the main reason people are uninsured is the high cost.

Americans know all about 'ability to pay'. Nearly 50 per cent are very worried about paying more for health care and insurance; 42 per cent are very worried about being able to afford health insurance at all; and 75 per cent want universal health coverage.

Every 30 seconds in the United States, someone files for bankruptcy after suffering a serious health problem.

THE NAFTA THREAT

British Columbians' rejection of American-style health care is solid. It is so solid that in the 2006 Throne Speech, the Campbell government felt the need to deflect attention away from the U.S. system to Europe, where there are mixes of public and private health care.

"Why are we so quick to condemn any consideration of other systems as a slippery slope to an American-style system that none of us wants?" went last February's throne speech.

Here's why.

Canada is a party to the one of the most controversial treaties ever signed by our federal government – the North American Free Trade Agreement – and that's something that no European country has to deal with. Once B.C., or any jurisdiction in Canada, formally sanctions a mix of public and private health delivery, NAFTA will kick in, allowing U.S. health corporations the ability to move into Canadian health care with the same rights to public funding as Canadian companies.

"In no time, the public system would be bankrupt," predicts Council of Canadians chair Maude Barlow, "and we would have an Americanized corporate health care system."

Take the example of the powerful American health insurance industry, which has so far succeeded in blocking comprehensive public insurance south of the border.

As noted UBC health economist Robert Evans told the *Guardian* in 2005, "The insurance companies are standing at the border with a policy in one hand and NAFTA in the other."

In no-NAFTA Europe, these are not issues. But here in Canada, they are.

A GIANT LEAP BACKWARD

Under our single-payer, tax-funded system, Canada has contained costs while producing health outcomes that are similar or better than comparable countries.

Canada spends 9.9 per cent of its gross domestic product (GDP) on health care – less than Switzerland, Germany and France; and a lot less than the U.S. spends at 15.3 per cent (OECD, 2006).

U.S. public health care per capita spending (medicare, Medicaid and Veterans Administration) covers only 26 per cent of its population, but is higher than public spending for universal health care in Europe, Australia and Canada.

Introducing a public/private mix is a backward move. It means returning to the days when people didn't go to the hospital because they couldn't afford to, when families had to choose between medical attention and food on the table, when some bartered with a doctor for basic care – and others went without health care entirely.

Clearly, there is nothing "forward-thinking" or "innovative" about heading back to a time when the profit motive dominated health care delivery.

The case for public health care is as strong as ever. It's where our focus needs to stay if we are to continue to provide Canadians with universally accessible health care.

Evidence and experience shows there are concrete, practical solutions to deal with emerging problems in public health care delivery. They're at the core of the national commission on health care headed by Roy Romanow in 2002. And many have been introduced in other parts of the world, as well as at home.

It's time to put them into practice. If we don't, we risk robbing Canada's future generations of their fundamental right to quality care, regardless of ability to pay.

FOUR STEPS to stronge

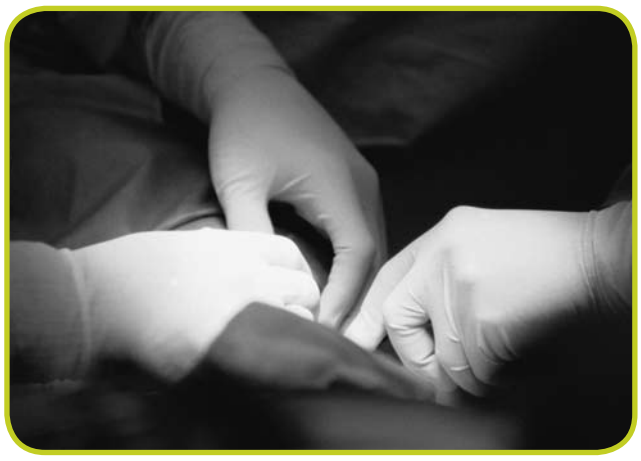
1. BRING IN PUBLIC CLINICS AND STREAMLINE WAITLISTS

Lengthy waits for elective surgeries are at the core of many British Columbians' frustrations with public health care – described by some as "Medicare's Achilles Heel." Until public solutions are implemented province-wide, medicare will not be able to reach its true capacity to meet our health needs.

Manage the lineups

If you've ever waited in line at a movie theatre or a hockey arena you know that a long line doesn't mean there aren't enough seats inside for everyone. You end up waiting because the process for entering the building isn't streamlined.

In the case of elective surgeries, systems for decreasing wait times have been developed based on the principle of reducing the bottleneck at the doorway and coordinating patient flow. Solutions include pooling doctors' individual waitlists, coordinating multi-step procedures for those who need to see a series of specialists, clearing backlogs with temporary injections of resources and using the full capacity of public operating rooms.



In Sault Ste. Marie, one streamlined breast health centre reduced the wait between a patient's mammogram and her diagnosis by 75 per cent. A woman with a positive mammogram often has her ultrasound – and sometimes a biopsy – on the same day, eliminating lengthy waits between procedures.

In North Vancouver, a "one-stop" joint replacement assessment clinic employs five orthopedic surgeons who work collaboratively to better manage referrals and coordinate lists. This clinic has reduced wait times from 50 weeks to between two and four weeks.

Open public surgery clinics

Unlike private clinics, public surgical clinics have shown they can reduce wait times without siphoning public dollars into shareholders' pockets and draining health care professionals from the public system. They guarantee that the benefits of shorter wait times are enjoyed equally by all, not just by those who can afford the boutique care of private medical businesses.

A 2004 pilot project at Richmond Hospital created dedicated operating rooms for orthopedic surgeries and increased OR efficiency. Their efforts paid off. Surgery waits were reduced by 75 per cent. Waitlists were shortened by 27 per cent and costs. And decreased by 25 per cent.

Similar examples across Canada include Toronto's Surgicentre, part of Trillium Ontario's public hospital, and Manitoba's Pan-Am Clinic, which operates as a unit of the Winnipeg Regional Health Authority.

The solutions are clear. Make sure hospital ORs are fully utilized. Open public surgery clinics as needed and fund them on an ongoing basis. If these measures were adopted, wait times could be dramatically reduced and long-term costs greatly controlled.

2. KEEP PEOPLE OUT OF ERs WITH BETTER COMMUNITY CARE

Hospitals are the most expensive place to provide medical care. But people are forced to turn to ERs and hospitals when they lack better options for their care. Overcrowded hospitals are a sign that we have not provided adequate alternatives.

Boosting preventative care and community-based services that provide more after-hours access can prevent health crises from developing and enable patients to be released from hospitals once their conditions stabilize.

All this relieves pressure on our hospitals and ERs.

Support people in their homes

Home support provides cleaning and cooking, medication management, personal care, and social support for frail seniors and people with disabilities. It acts as an early warning system and helps to address emerging health problems before they become crises, making it possible to delay and even avoid the use of more expensive long-term care and hospital services.

In Denmark, the government introduced national legislation that provided home visits to citizens 75 years and older. They created this program after a local study

found that small amounts of homecare went a long way towards reducing long-term care costs and homecare services. In contrast, B.C. has reduced home support access by more than 50 per cent since the mid 1990's.

Improve residential care

Between 2001 and 2004, government cut more than 2,400 long-term care beds. This shortage leaves seniors in hospital beds, waiting to be placed in long-term care.

Another expensive consequence of these cuts has been the increased transfer rates from residential care to hospital ERs. In 2005, long-term care residents were transferred to ERs 54,000 times. That's 2.5 transfers for every publicly funded long-term care bed in B.C.

These transfers are also a result of inadequate staffing and training and the increased complexity of residents' needs. Without enough staff to monitor changes in residents' health, ensure that they get proper nutrition and fluids, turn them or assist them with walking, residents are more likely to end up with pressure sores, pneumonia, dehydration, malnutrition and broken bones from falls – conditions that often result in hospitalization.

A multi-disciplinary team of health professionals that includes doctors, nurse practitioners, pharmacists, rehabilitation staff and nutritionists also reduces trips to the ER. In the Netherlands, where they have introduced these kinds of care teams into their nursing home sector, transfer rates are below 10 percent a year.

er public health care

Create 24-hr community clinics

Like a traditional doctors' office, community health centres are often the first point of contact in the health care system. But they do more. They offer a team of health professionals – physicians, nurse practitioners, counselors, outreach workers, pharmacists, dieticians, social workers – who can provide a wide range of health services that can prevent and manage many conditions that lead to hospitalization.

ER and hospital visits are often the last resort for people who are not able to access any other services. Those with chronic conditions, whose health is vulnerable and who require ongoing care, are particularly dependent on hospitals to meet basic health needs. There is ample evidence showing that more 24-7 primary care clinics in communities reduce pressure on hospitals and ERs.

Keep vulnerable citizens healthy

In late November, 2006, health authorities reported a sharp increase in the number of Vancouver's Downtown Eastside residents who were being hospitalized for two to four weeks with a severe strain of pneumonia. Officials believed that living conditions – cramped single room hotels, inadequate nutrition, untended chronic illnesses and more – led to the outbreak and the high rate of hospitalization.

Neglecting peoples' basic needs, like decent housing and food, puts pressure on our health care system in the long run. This outbreak could have potentially been avoided if these residents had the resources for improved health and decent living conditions.

Those who live with mental health issues are another segment of the population who benefit greatly from preventative care. With early intervention and client-friendly community health programs people with serious and persistent mental health issues are less likely to end up in crisis and in the hospital.

3. GET MORE VALUE WITH OUR TAX DOLLARS

Canada's single-payer, tax-based health care system is remarkably efficient. We spend about half as much on health care, per capita, as our American cousins, who pay almost three times as much in administration costs we do in Canada. Canada's and B.C.'s so-called spending problem has less to do with a lack of funds as it does with how those funds are used.

To meet our health care needs and keep heath care spending within our means, we need to take full advantage of the efficiencies we can achieve within our single-payer, tax-based model.

Control drug costs

Drugs are now the second highest cost item in the whole health care system. That's due to higher levels of prescription drug use, and the large price tag that comes with "new" pharmaceuticals, which are most often variations on less expensive, generic drugs.

There are solutions. B.C.'s reference-based drug program saves Pharmacare close to $50 million a year by covering the most cost effective options in five drug categories. If this was expanded to cover a broader range of drug groups, more could be saved.

Another program, based in North Vancouver, educates doctors directly about the costs and benefits of brand-name and generic pharmaceuticals, making them less reliant on drug company advertising. Started in 1993, this initiative now saves $1.50 for each dollar spent to run the program. There is no reason it could not be expanded to reach doctors across the province.

Provincial governments also need to work with their federal counterparts to create a national drug strategy – one that uses our national bulk purchasing power to get better deals on pharmaceuticals, expands the reference-based program into a national drug formulary and better regulates the costs of brand-name and generic drugs.

Stop wasting money on P3s

British Columbians are told that by financing and building projects like hospitals and roads through public private partnerships (P3s) money will be saved.

They're being sold a bill of goods.

There's plenty of evidence from Britain, Australia and other parts of Canada that P3's actually drive up infrastructure costs, and result in shoddy construction and reduced services.

But here in B.C. the provincial government has mandated that all public projects over $20 million must be considered as P3s.

The fact is, the public sector can borrow capital at lower interest rates than the private sector. And even Partnerships BC, the government agency charged with boosting P3s, admits that the construction costs of the new P3 Abbotsford Hospital will be $35 million more than if it was built publicly.

Other provincial governments are wising up to P3s.

Nova Scotia scrapped a plan to build the province's new schools as P3s. And Ontario recently exempted health service delivery from all its P3 plans due to concerns about quality and accountability.

So where are the benefits? When the accounting is done, all the projected P3 savings turn out to be based on hypothetical assumptions.

In the UK, after a fifteen-year experiment with P3 schemes, tax-payers are outraged over cost over-runs, shoddy construction, and inadequate service levels.

4. INVEST IN B.C.'S HEALTH CARE WORK FORCE

One of the single greatest challenges facing the long-term sustainability of our public health care system is the severe shortage of health care workers.

Fund education programs

Training more health professionals means putting additional funding into post-secondary programs. It also requires innovative approaches to educate existing health professionals and upgrade their skills. With this investment, we can start to reverse the current skills shortage.

Train and certify internationally educated health professionals

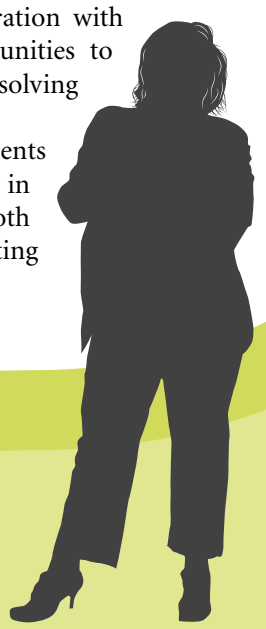
In B.C. thousands of health professionals are not able to work in their chosen profession. But if we put in place the technical upgrading and English language programs needed to train and certify these health care workers, the supply of appropriately trained staff could be significantly increased.

Right now, the Hospital Employees' Union is working in partnership the Vancouver Coastal Health Authority to support internationally educated nurses, who are working in non-nursing roles, to become licensed practical nurses. This initiative could be expanded to include more health authorities and a broader range of health professionals.

Value our existing workforce

Our limited human resources make it essential to ensure health professionals are working to their full scope of practice, in collaboration with each other and with opportunities to contribute their expertise to solving workplace problems.

It is important for governments to value all those who work in health care if they want to both attract and retain new and existing workers.



Many experts – those whose job it is to wade through the numbers – have found that publicly administered health care gets the best value for money. Here's what they say about the economics of health care in B.C. and Canada.

Who says we can't afford our public health care system?

ARE OUR HEALTH CARE COSTS OUT OF CONTROL?

"Perhaps the most misleading charge that public health care is unsustainable has been Finance Minister Carole Taylor's assertion that by 2017 health care will consume over 70 per cent of the provincial budget. This statistic is driven entirely by a rigged estimation of future expenditures on health care and other aspects of the provincial budget. And ultimately, it is measuring the wrong thing – what matters is the share of total income [GDP] we spend on health care, not the share of the provincial budget."

Marc Lee
Senior Economist, Canadian Centre for Policy Alternatives

"As a proportion of B.C.'s economy over the past two decades-plus, health expenditures have ranged from a low of 5.8 per cent (1988-89) to a high of 7.5 per cent (2002-03). The annual average was 6.6 per cent…There is no evidence of an explosion. Nor does the latest finance department forecast suggest that one is expected in the near future… Health spending, then, is increasing as a proportion of the government's annual budget, only because the budget itself is growing smaller in relation to the B.C. economy."

Will McMartin, *political commentator*

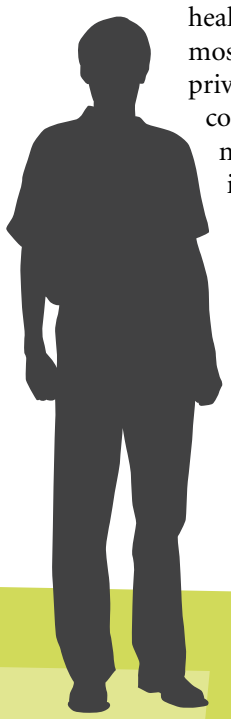
"Provincial health spending this year will be about 7.3 per cent of GDP… Spending in taverns and restaurants, by comparison, represents almost four per cent of GDP; seven per cent for health care doesn't seem unreasonable."

Paul Willcocks, *B.C. syndicated columnist*

WHAT ARE THE REAL COST ISSUES?

"The areas where costs are growing fastest in health care are in fact precisely those with the most private involvement: pharmaceuticals and private health care premiums. That is where costs are growing in the double digits – at more than twice the rate of inflation. If there is a real concern with costs, it is to those areas where private firms are most active that our governments should be turning their attention."

Diana Gibson & Colleen Fuller,
University of Alberta's Parkland Institute



"The principle driver in Canada of rapid cost escalation is the replacement of older, off-patent drugs with new patented ones at prices that may be ten times higher. These are marketed as superior, but the regulatory process does not require new drugs to be tested against those they will replace..."

Dr. Bob Evans, *Associate Director, Centre for Health Services and Policy Research, UBC*

WHAT ARE PUBLIC HEALTH CARE'S COST ADVANTAGES?

"The system covers everyone. Therefore, economies of scale are maximized. There is no rating or discrimination. Therefore, large administrative savings occur. The system is financed through general revenues. Therefore, there is no costly stand-alone collection system. And payments are provided directly to physicians. Therefore expensive multi-stage billing is avoided. In other words, not only is our system more fair than the alternative, it is also more affordable."

A. Charles Baillie, *Former Chairman and CEO, Toronto Dominion Bank of Canada*

WILL PRIVATE HEALTH CARE SAVE PUBLIC DOLLARS?

"Over the decade, expenditures in the public sector increased by 40 per cent, in the private sector by 145 per cent. This should provide a note of caution to those who would advocate for a greater role for the private sector in personal health care… the control of public expenditures was pronounced through the 1990s. There was no such evidence of control in the private sector…"

Dr. Hugh Scott MD, *President and CEO, Scarborough Hospital, former Executive Director, McGill University Health Centre*

"We've now found that the profit motive leads to increased deaths in both hospital and out-patient settings… Private for-profit facilities have to generate profits to satisfy shareholders and pay taxes, and typically these two expenditures are in the range of 10 to 15 per cent of expenses. Not-for-profit facilities can spend this money on patient care. The higher death rates result when for-profit companies cut corners to make sure they produce the required profit margin."

Dr. P.J. Devereaux, *MD, Department of Medicine, Faculty of Health Sciences, McMaster University*

"To set aside our single-payer, publicly funded, universal health care system would not simply be a moral error. It would be a grave economic error as well. The fact is, the free market, efficient and desirable as it is, cannot work in the context of universal health care... the reality is that demand will not be matched by supply. In other words, some people will always be left out."

A. Charles Baillie, *Former Chairman and CEO, Toronto Dominion Bank of Canada*

IS OUR PUBLIC HEALTH CARE SYSTEM SUSTAINABLE?

"Canada's public system is strongly sustainable. The crisis of costs has been inflated by the misuse of statistics. The public is being deliberately and cynically misled. The fact is that the amount we spend [in Canada] on hospitals and physician services (medicare) has remained stable since about 1970 at 4 and 4.5 per cent of GDP."

Diana Gibson & Colleen Fuller,
University of Alberta's Parkland Institute

"Ultimately, 'unsustainability' is a matter of government choice. Any public program, including health care, can be made "unsustainable" by sufficiently large tax cuts... "

Dr. Bob Evans, *Associate Director, Centre for Health Services and Policy Research, UBC, Professor, Department of Economics, UBC*

"The Canadian people have been talked into believing for a number of years now that their country is suddenly poor and that their governments are capable of doing very, very little. This is a surprising state of things at a time when federal government spending is at a 50-year low in terms of percentage of GDP."

Dr. Paul Leduc Browne, *Author and Professor, Department of Political Science, University of Quebec*

"The bulge of seniors is expected peak around 2031, and will be declining thereafter. So we have lots of time to gradually respond to the challenges posed by an aging population… If [B.C.'s] future economic growth rates remain consistent with those over the past quarter-century (5.7 per cent per year), we actually have scope to expand health care services."

Marc Lee, *Senior Economist, Canadian Centre for Policy Alternatives*

In the wake of the Supreme Court of Canada decision, which struck down a ban on private insurance for services covered by public health insurance in Quebec, benefits advisors raised the alarm about rising costs for employers.

Medicare gives Canadian companies a competitive edge

In mid-November, the CEOs of the "Big Three" automakers pitched U.S. president George Bush on the need for better health care coverage to bolster their sectors' prospects.

Chrysler, Ford and General Motors had booked third quarter losses totaling about $7.4 billion US attributable in part to the soaring costs of providing health care.

GM summarized the meeting this way: "We understand we have to win in this market alone, but there are issues of national importance like health care and trade that affect the competitive balance."

That's an understatement.

In 2005, GM spent $5.3 billion US on health care for more than 1.1. million employees, retirees and dependants.

That's about what Canada's four Atlantic provinces spend in total on health care for their 2.3 million residents.

The cost of health care coverage going into your American-made vehicle exceeds the cost of the steel – more than $1000 US.

The Canadian Autoworkers estimate that by comparison, the big three spend a little more than $100 US per vehicle on health care costs in their Canadian manufacturing plants.

Universal public health insurance – medicare – means direct savings on labour costs of about $6 an hour (US) for their Canadian employees.

The New York Times opined that Canada's public insurance system was a big factor in Toyota's 2005 decision to build its RAV4 mini-SUV plant in Ontario despite lucrative location incentives offered by a number of U.S. states.

"In America, basic health care insurance is a privilege; in Canada, it's a right," wrote Times columnist Paul Krugman. "And in the auto industry, at least, the good jobs are heading north."

The Canadian medicare advantage isn't confined to the auto industry with its high rate of unionization and strong employee benefit programs.

The CAW estimates that health benefits account for about $2 US an hour in other parts of the U.S. economy – or about $4,000 to $6,000 US each year. Canadian payroll costs are about a quarter to a third as much.

But the comparative advantage for Canadian companies is at risk if provincial governments and the courts expand the role of private insurers in covering what are currently publicly insured health services in this country.

In the wake of the 2005 Chaoulli decision – where the Supreme Court of Canada struck down a ban on private insurance for services covered by public health insurance in Quebec – benefits advisors raised the alarm about rising costs for employers.

Hewitt Associates advised its clients to "review benefits plan documents and related contracts (including union contracts) to ensure private services are not automatically covered."

Mercer Human Resource Consulting commented that more private insurance could "signal a new trend which would increase current pressures on Quebec employers to broaden their group insurance coverage."

The stakes in the medicare debate are huge – not just for families – but for the long-term profitability and competitiveness of Canadian companies.

MIKE OLD
HEU COMMUNICATIONS DIRECTOR

THE COST TO AUTOMAKERS FOR HEALTH BENEFITS: Universal health insurance programs are a key factor in attracting manufacturing jobs to Canada.

Made in Canada $100 (US) per car

Made in the United States $1000 (US) per car

Health benefits at increased risk

Cuts to B.C.'s drug plan coverage and the delisting from MSP of insured services like eye exams, physiotherapy and podiatry, are having an impact at the bargaining table.

The building and construction trades unions estimate that the 2002 cuts by the B.C. Liberals increased health and welfare plan costs by up to 19 per cent.

The Municipal Pension Plan, which covers most HEU members, estimatesthat the cuts to Pharmacare alone would cost about $5 million a year.

Liberal cuts increased 'health and welfare' plan costs by up to 19 per cent.

And the Communications, Energy and Paperworkers Union says the MSP delistings mean additional costs to 400,000 unionized workers and their employers of about $48 million annually.

If the B.C. Liberal government further reduces MSP coverage – and allows more private insurance to cover delisted services – the cost pressures on union members and their employers could get worse.

Just look south of the border:

- since 2000, health insurance premiums have increased 87 per cent while wages have increased by 20 per cent
- health insurance is the fastest growing cost for employers and could overtake profits by 2008
- average employee contributions to health plans have exploded by 143 per cent since 2000
- workers are paying $1,094 US more in premiums for family coverage now than six years ago

>>voices>>

A 2002 KPMG report shows Canada has a 14.5-per-cent cost advantage for employers over the United States.

Universal public health care is good for business

Public health care is good for business, but don't take my word for it. Recent signals from some corporations suggest they too understand the competitive advantage of medicare.

In 2002, a joint letter from the Canadian Auto Workers, General Motors, Ford and Daimler Chrysler stated that public health care "accounts for a significant portion of Canada's overall labour cost advantage in auto assembly, versus the U.S., which in turn has been a significant factor in maintaining and attracting new auto investment to Canada."

Top corporate advisors have also defended our public health care system's competitive advantage. A 2002 KPMG report shows Canada has a 14.5-per-cent cost advantage for employers over the United States. The co-author of the KPMG report concluded that the universal health care system "is a significant factor" in keeping employers' private benefit costs down.

But in British Columbia, we have already seen the erosion of this advantage when Gordon Campbell delisted critical health services like physiotherapy, chiropractic care, naturopathy, massage therapy and non surgical podiatry services.

For many unionized workers it meant relying on group benefit plans that they negotiated with their employers to cover the costs. For many non-union workers, it was time to pull out the credit card or go without.

B.C.'s 500,000 union members now spend $60 million per year on these delisted services – that's $37 million a year more than it would cost through the public system.

Gordon Campbell has already reduced our competitive advantage by selling assets like B.C. Rail and B.C. Hydro which provided cheap transportation and cheap power.

There's no sign he'll be any different when it comes to defending our medicare advantage.

Public health care is an asset – not the burden that the B.C. Liberals try to portray. Workers get it. Some businesses get it. Isn't it time that we work together to stop Gordon Campbell from throwing it away.

JIM SINCLAIR • PRESIDENT
BC FEDERATION OF LABOUR

WORTH TALKING ABOUT

In community clinics across B.C. workers are providing comprehensive, patient-oriented care that helps keep people out of hospitals. It's low-cost, it's efficient and it's an effective solution to public health care challenges.

Community clinics offer a kinder, more efficient model of health care

From behind her desk at Vancouver's Mid-Main Community Health Centre, Irene Clarence is helping Tommy Douglas' dream unfold.

Fourteen hundred kilometres to the north, tucked into a Nisga'a health centre, Elaine Moore is honouring the same dream.

Both women help run centres where health workers deliver a range of primary care to their communities — something that Clarence calls the "second stage" of Douglas' grand vision for a seamless public system of acute and primary care.

As B.C.'s health "conversation" unfolds, both women, together with the teams in their centres, are an example worth noting. They offer a cheaper, kinder and more efficient alternative to for-profit medical businesses that are too often presented as the only option.

Teams at both centres are also proving that community-centred care can be delivered in any setting — from highly rural to densely urban.

The Nisga'a centre

For Moore, treasurer at the Nisga'a health centre in New Aiyansh, the goal is to provide practical, culturally appropriate care to the rural and sometimes isolated people who live as many as 90 kilometres from her centre — and 110 kilometres from the nearest hospital in Terrace.

With three satellite clinics in nearby communities, the centre treats both Nisga'a and non-Nisga'a patients. The larger centre in New Aiyansh offers a mini version of emergency care as well.

Moore says that the most important focus for the centre is culturally sensitive care — staff who offer treatment with an understanding of the clients and their beliefs. It's a challenge at times to find staff who "get" the job, but making the effort pays off.

When an elder arrives, for example, as many as 20 or 30 people – "a whole slew of family and friends" – will be part of whatever treatment and care is recommended, and the staff accommodate them.

They also act as liaisons in cases where language is a concern. Simple things like describing ailments or the intensity of pain become imprecise or even impossible in a second language, Moore explains, and that can seriously impede diagnosis and treatment.

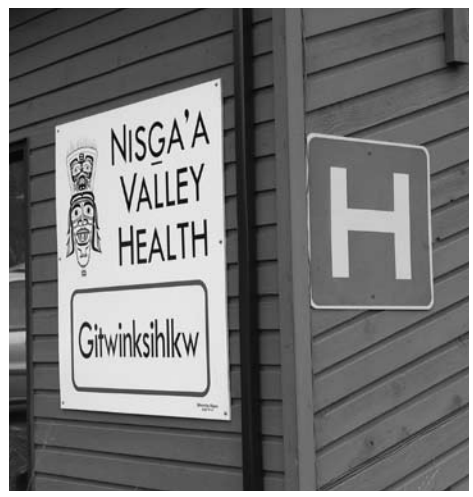
"There's a huge language barrier for elders," says Moore. "They have their own identity in their language, and when they speak English, it never comes out the same. In our language there are words for specific feelings or body issues."

The centre offers assessments by doctors or nurses, as well as home-care support and team meetings that put everyone "on the same page" in assisting patients.

There are mental health programs and community wellness offerings that include youth workers who keep kids busy and off the streets. Staff also make home visits to the chronically ill or bed-ridden.

The dentist from the New Aiyansh clinic travels on scheduled trips to the other centres. And even the local fire department, which provides emergency response, helps out with transportation for patients.

In effect, it's a service aimed at keeping the community healthy, whatever it takes.



The most important focus for the Nisga'a health centre is delivering culturally appropriate care by staff who understand the clients and their beliefs.

The Nisga'a model, like the one at Vancouver's Mid-Main, is gathering growing support.

Dr. Susan Harris, head of family practice at Children's and Women's Hospital in Vancouver, is one of many advocates for a stronger primary care system — one that involves the whole health team in providing care.

Harris is trained in traditional delivery, but now argues for alternatives to the standard fee-for-service model in health care, and has noted that more young doctors are thinking outside that box as they launch their careers.

Mid-Main clinic

Back in the halls of the brightly painted Mid-Main clinic in central Vancouver, Clarence focuses on a massive challenge — finding "creative solutions" to funding a centre with fee-for-service billings by staff who actually work on salary.

The goal is to provide care for neighbourhood residents that is as varied as their individual human needs.

Mid-Main's first step is to see people the same day they call.

Offering an appointment two weeks later means that patients either go without care or drift away to walk-in clinics or emergency wards, Clarence says.

That type of care often means two or three workers ultimately treat a patient for the same condition. In the end it is more inefficient and more expensive.

By contrast, patients at Mid-Main can be streamed to doctors, nurse-practitioners, a pharmacist, dietician or counsellor, depending on need. Any or all of these staff then become part of a patient's care team that "can address people in all of their complexities," Clarence says.

The system works so well in drawing out a variety of perspectives and expertise that "it's an eye-opener for workers at times," she laughs.

"This is the second stage of medicine that Tommy Douglas envisioned. The first was acute care, and we did that. But the second stage was integrated community care, and it never happened."

Group visits can allow a single doctor to see, for example, a dozen diabetic patients in 90 minutes.

Patients can visit a round of stations to have blood pressure checked, feet examined and to take part in a group discussion. They can also spend some time with one another in a supportive setting.

Eight-week "mindfulness" groups offer patients with chronic conditions a way to deal with their realities and often help them to develop self-care routines that reduce their dependence on health-care services.

With doctors on call 24 hours a day, patients can use the groups as an alternative to emergency-room visits in off hours, drastically cutting costs to the public system.

The team approach not only helps patients to access outside care, it also provides consistent treatment even within the centre. For example, because the clinic treats only neighbourhood residents, one community health nurse deals with all the centre's patients, allowing her to become a reliable contact when they need assistance.

Diabetic patients in need of a podiatrist can use the clinic to book appointments with the specialist who makes weekly visits to the centre – leaving less-mobile patients closer to home in a comfortable setting, and with familiar staff who are able to oversee after-care.

Everyone from staff doctors to the on-call pharmacist make housecalls for the home-bound, allowing them to "peek inside the fridge, see why things may not being going well," Clarence says.

So with such demonstrated success, what will it take to establish similar community alternatives to the traditonal fee-for-service physician's office?

According to Clarence, what's needed most is funding that "matches reality." Her centre stays afloat on the money that comes in from fee-for-service billings and the occasional grant. But it takes endless time, effort and creativity – plus dedication by the centre's workers – to stretch that money to cover the centre's services.

But she, like Moore, is convinced it should be done. "This is the second stage of medicine that Tommy Douglas envisioned," Clarence says. "The first was acute care, and we did that. But the second stage was integrated community care, and it never happened."

"What we are doing here is what he envisioned, care that starts here and flows right through hospitals and beyond. That's our goal."

CHRISTINA MONTGOMERY

what we're up to

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HEU lab techs secure their safety rights

Perserverance pays off. When HEU members who collect blood samples from inmates at a Victoria prison raised alarm bells about the security issues they faced, officials were initially slow to act.

But the Royal Jubilee lab assistants didn't stop there. They feared for their safety

In late November they contacted the union and were reminded they had the right to refuse unsafe work. So they filed a grievance and put management on notice that they were prepared to suspend their weekly blood collection at the Wilkinson Road maximum-security jail unless their safety concerns were addressed.

The lab assistants say they were often left alone in a locked room with an inmate without guard supervision. Their main fear was that a prisoner could rip a syringe out of their hands and use it against them.

Wilkinson Road jail houses inmates who are already convicted of violent crimes, or who may be awaiting trial. Many carry blood borne infections such as HIV or Hepatitis C.

Members' actions sparked a meeting between the Vancouver Island Health Authority and B.C. Corrections officials.

The result? Their complaint was finally taken seriously. The prison's warden agreed to ensure a guard would be with them at all times and make sure all security protocols would be followed in future.

The eight lab assistants provide blood collection services at the Wilkinson Road jail and the Williams Head jail. They visit the jails once a week for about two hours while they collect blood samples from up to 15 inmates.

Workers' right to join union upheld

Two workers who were fired during an HEU union drive last September have been offered their jobs back at Crestview Manor in Creston.

Golden Life Management, the assisted living facility's operator, admitted to interfering with workers' rights to join a union. In the agreement reached between HEU and the company, Golden Life Management promised not to obstruct workers' efforts to organize in the future and agreed to reimburse the two workers their year and a half's lost pay.

The original unfair labour practices complaint filed by HEU against the company has now been withdrawn. The complaint argued that Golden Life Management had violated the BC Labour Relations Code, which guarantees that every employee is free to be a member of a union and that an employer cannot discipline or dismiss an employee for organizing in their worksite.

Emil Shumey, HEU's Kootenay regional director, described the agreement as a victory not just for those at Crestview Manor, but for all the workers in Creston and around B.C. "It should assure them," said Shumey, "that they can exercise their right to join a union in the future without fear of retribution from the employer."

Gitx'san members fight concessions

Gitx'san health care workers are refusing to give up the unique cultural provisions of their collective agreement in their latest round of bargaining with the Gitx'san Health Society (GHS).

Talks broke down in an October mediation session between the HEU and the

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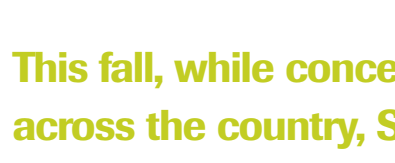

The facts behind Canada's biggest drug scandal

This fall, while concerns about health care spending echoed across the country, Stephen Harper's Conservative government quietly extended drug patent protection by three years for 25 per cent of all brand name drugs sold in Canada.

These new regulations will consume millions of taxpayers' health care dollars at a time when pharmaceuticals are already the fastest growing segment of Canada's health care spending.

According to the Canadian Health Services Research Foundation, spending on prescription drugs is skyrocketing. "Canadians spent a whopping 18 billion on prescription drugs in 2004, up 600 per cent since 1985," they report.

With extended protections, brand-name drug companies will maintain their continued monopoly on sales – which allows them to set the kinds of prices that fuel soaring costs - while generic drug manufacturers will remain shut out of the market.

At the same time, many of these so-called new patents are simply variations on existing drugs – different enough to extend patents and increase costs, but not enough to provide significantly improved health outcomes.

Canada's Patent Medicine Review Board reports that, of 117 drugs with new ingredients introduced between 1998 and 2002, only 15 provided a substantial improvement over existing options.

According to the British Medical Journal, these "me too" drugs are responsible for 80 per cent of the increased drug expenditures.

Alan Cassels, a leading author and drug policy researcher, explains it this way: older versions of a simple anti-inflammatory arthritis medication might cost $15 a month, while the news ones might cost $80 a month, even though both result in the same outcome.

"We're not talking twice as expensive, we're talking four or five times as expensive," he says. "When you look at the evidence, you find these new drugs are often no more effective and in some cases they're less safe."

Patents are not the only problem. Another large contributor to drug costs comes, again, from governments' role in drug procurement.

Australia and New Zealand are two examples where lower costs were achieved, in part, because their governments use the bulk purchasing power that comes when you're negotiating on behalf of millions of buyers.

But not in Canada. "Everyone essentially pays the retail cost for every pill," writes researcher Armine Yalnizyan, "even when hundreds of millions of pills are dispensed annually."

"We're not talking twice as expensive, we're talking four or five times as expensive. When you look at the evidence, you find these new drugs are often no more effective and in some cases they're less safe."

KICKING THE HABIT

Like many solutions to improve public health care, there are a range of tools governments could use to reduce public and private expenditures on prescription drugs.

In 1995, British Columbia introduced a reference-based drug program that saves close to $50 million a year.

The system identifies and groups drugs that serve the same medical function and then pays only for the ones that get the most value for money. This process is used in insurance programs around the world including in Germany, the Netherlands, Sweden, Denmark, New Zealand, Spain, the US, Italy and Australia.

Many, including the Romanow Commission, have called for this same kind of coordination to be used across Canada in a national drug formulary that has the potential save hundreds of millions every year.

Other solutions include changing patent laws so generic drug producers can offer less expensive options; strengthening current price controls; instituting nation-wide bulk purchasing and educating doctors about costs and benefits associated with various prescription drugs.

"Doctors don't know much about comparative drug prices," says Cassels. "They could be prescribing drugs that are a lot more expensive than they need to be."

In North Vancouver, a pro-gram that provides education to doctors in their offices, is proving to be an effective antidote to aggressive advertising by pharmaceutical companies. It's estimated that these companies spend more than $30,000 per doctor per year on promotions.

The program is also a significant cost-saving measure – for every dollar it spends, it saves $1.50.

Many policy analysts and public health care advocates are calling on governments to implement these kinds of efficiencies and use the savings to fund a national pharmacare program for all Canadians.

Currently, Canada and the US stand alone as the only two industrialized countries without a national public drug plan.

OLIVE DEMPSEY
HEU COMMUNICATIONS OFFICER

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GHS-hired representative over the employer's insistence on dramatic concessions. These include the elimination of all collective agreement references to Ayoo'kum Gitxsan – the Gitx'san hereditary law – as well as the removal of provisions that allow workers to honour their traditional responsibilities and practices such as Clan obligations, food gathering activities and funeral customs.

The GHS has also asked for a 25 to 35 per cent cut in members' wages and benefits, despite reporting a surplus in their 2005/2006 fiscal year.

The union's bargaining committee spokesperson, Peggy Underhill, says they will not move backwards on the historic gains made when they negotiated their groundbreaking agreement in 2001.

"We are proud of our collective agreement," says Underhill. "It meets our community's health needs and respects and reflects Gitx'san cultural practices and values. We will not turn back the clock and start over."

HEU and the Gitx'san bargaining committee have invoked the binding tribunal clause of the current agreement, and are working to finalize an arbitration date for early spring, 2007.

Clerical workers respond to survey

More than 1300 clerical workers responded to the union's recent Clerical Benchmark Review Survey, providing essential information for the three-year benchmark review process.

The survey data will be analyzed over the next few months by the review committee, which is made up of three HEU members, one union staff person, a representative of the B.C. Government and Service Employees' Union, and employer representatives.

The Committee's summary report will be sent to all members who completed the survey and will be posted on the HEU website.

The benchmark review committee was created in July, as part of the $3 million cumulative funding negotiated in 2006 bargaining. The funding is being used to conduct the benchmark review and fund wage adjustments.

Thinking outside the box pays off

Members of HEU's South Okanagan Local are starting off the new year with an important resolution to their staffing problems, thanks to a creative solution reached between the union and the employer in November.

A lack of casual staff at South Okanagan General Hospital, Sunny Bank Centre and Sagebrush Lodge had been causing burnout among resident care staff at the three facilities. Without enough casual LPNs, care aides and rehab assistants to cover sick time and vacations, staff working in the facilities were experiencing significant workload problems.

Local vice-chair Rhonda Bruce says, "Staff would always step up to the plate when needed, even if it meant working long hours or not getting time off."

So last July, the amalgamated local came up with an idea to create positions that would "float" between the facilities. Bruce says management initially thought it couldn't work because of seniority issues, but were willing to consider a common float pool.

By November HEU and the employer had a signed a memorandum of agreement with expanded float pool language, enabling them to hire two full-time LPNs, one full-time care aide, and one full time rehab assistant to serve the three sites. Bruce says the float positions will be hired in the new year.

JANUARY
FEBRUARY
MARCH

JANUARY
Local executive elections held at the first regular meeting of the year

JAN. 21 – FEB. 16
CLC Pacific Region Winter School, Harrison Hot Springs

JANUARY 22 – 25
Provincial Executive Meeting

FEBRUARY 18
Chinese New Year- the year of the Pig

FEBRUARY
Black History Month

MARCH 5 – 9
Provincial Executive Meeting

MARCH 8
International Women's Day

MARCH 17
Global day of Action against War

MARCH 21
International Day for the Elimination of Racism

MARCH 22
Provincial Executive Meeting with all sub-committees

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AGREEMENT NUMBER 4007486

Film Festival showcases documentaries to change our hearts and minds

A youth orchestra in Venezuala uses music to change the lives of hundreds of thousand of Venezualan children. A Canadian rock band meets with youth in a war zone in the Congo. And musician Michael Franti takes us into the conflicted Middle East.

These are just some of the stories audiences will hear at the sixth annual World Community Film Festival in Vancouver, organized by the international solidarity organization, Codevelopment Canada.

"Sounds of Resistance" is the theme of this year's festival, which showcases documentaries on social justice and environmental issues from around the globe.

HEU, along with other labour and community organizations, are proud supporters of the popular cultural event.

This year's films also include The Devil's Miner, a story about 14 year old Basilio and 12 year old Bernardino, two brothers who work in the dangerous Cerro Rico silver mines of Bolivia. The boys spend their days chewing coca leaves to stave off hunger and stay alert during their long hours underground. They also make sure to present offerings to the malevolent spirit, El Tio, a miner's only hope of salvation in a place where legend tells them God will not enter.

While the films are engaging and powerful on their own, the festival aims to increase the audience's awareness and inspire them into action.

***The Devils Miner* is an award-winning film about the harsh realities and persistence of hope in Bolivia's silver mines.**

"We are delighted to be able to present so many powerful films," says festival coordinator Erin Mullan, "especially those that show how music can be a catalyst for social change."

The three-day festival includes panel discussions and a social justice bazaar where film-goers can buy fairly-traded products and connect with organizations working for social and environmental change.

Why Wait *(continued from page 5)*

Here in B.C. a pilot project at Richmond hospital provides similar efficiencies. In the Richmond pilot, two operating rooms in an existing hospital were dedicated exclusively to orthopedic surgery. The result after two years: waitlists were reduced by 27 per cent; wait times were reduced by 75 per cent; and operating room efficiencies improved by 25 per cent. This success has now been incorporated into Ontario's provincial strategy for reducing wait lists and times – but here in B.C. it has only been replicated at one hospital, UBC.

It's little wonder our public hospitals are overcrowded. They're operating to overcapacity. The acceptable occupancy rate for hospitals is about 85 per cent – that's so there's room to deal with emergencies – but here in B.C. many hospitals are operating at more than 95 per cent capacity.

Add to that the lack of long-term care beds available for seniors (there's been a net reduction of 1400 beds since 2002), cuts to home support and inadequate funding for mental health, and what you have are overcrowded hospitals and long waits for emergency care.

This wouldn't be the case if hospital beds that were cut in recent years, were restored, and seniors and others didn't have to depend on hospitals because other forms of care are not available to them.

Again, the solutions are there. Open up more long-term care beds and improve seniors' care at home and in care facilities. Create more primary health care clinics that remain open on a 24-hour basis. These clinics provide comprehensive care by allowing nurses and other health care professionals to practice to their full potential and work as a team.

The result is better care, less reliance on emergency departments and hospitals, and a more efficient system overall.

So if the solutions are there, and they can happen within our public health care system, the only real question remaining is this: what are we waiting for?

PATTY GIBSON • HEU COMMUNICATIONS OFFICER.

HEU PEOPLE

In memoriam

Members of HEU's Lillooet local lost a valued co-worker in late October with the sudden passing of **Nina Joanne Decristafaro.** Descristafaro was only 36 years old.

Her memorial service was held at Mountain View Lodge where she had worked as a care aide. Descristafaro had also worked with Lillooet's Home Support Services. Prior to moving to Lillooet in 2005, she was employed at New Vista care home in Burnaby.

DECRISTAFARO

Descristafaro is survived by two children – a son and a daughter – and her companion Gillian.

HEU was sorry to learn of the passing of **John Weisgerber** in early December at the age of 84. Weisgerber began working in the St. Paul's laundry in the 1950s, and later earned his power engineer ticket after attending night school, which prepared him for a position in the hospital's power plant.

Remembered as a dedicated local activist, Weisgerber was as a shop steward and in later years worked as an HEU servicing representative in the Interior and on Vancouver Island. He later returned to health care after accepting a position at Saanich Hospital, where he worked until his retirement.

Weisgerber is survived by his beloved wife and childhood sweetheart Viola and their children Linda, Louise and John, grandchildren and extended family.

Retirement notes

The *Guardian* wishes to acknowledge and congratulate the following members, employed by Simpson Private Hospital in Langley, who have recently retired.

After 25 years of service, **June Hammond** has left her position as head housekeeper. June was active in her local as both a conductor and warden.

Dietary aide and cook, **Gurmail Chhina** left her position to spend more time with her family after 11 years of service.

Frances Ann Metcalf began her retirement in May 2006 after 19 years working as a care aide. Local offices held during that time included trustee, conductor and warden.

And care aide **Laurice Welch** retired from her job following 16 years of service.

Welcome back

Many will remember returning staff member, **Jennifer Whiteside**, from her days as a servicing representative at Children's and Women's Hospital, G.F. Strong and VGH. After working as a labour relations officer with the BC Nurses' Union, Whiteside is back at HEU's provincial office, this time as a research analyst.

WHITESIDE

"Research is an exciting opportunity to take my on-the-ground knowledge and experiences and apply them on a broader scale while working on issues at the policy level," says Whiteside.

She is currently working with HEU members who sit on the residential care aide committee, examining quality of care and staffing issues. Whiteside is also looking at the impact of privatization on members employed by multinational corporations like Sodexho, Compass and Aramark.

Her research on economic justice for privatized workers is part of the union's upcoming community campaign for living wages.

UPCOMING CONFERENCES

HEU Equity Conference
April 3rd & 4th 2007
Richmond Inn, Richmond, B.C.
For more information contact your local executive and check out www.heu.org.

Jobs & Justice Conference
March 29th to 31st
Organized by the Canadian Centre for Policy Alternatives.
Maritime Labour Centre Vancouver, B.C.
For more information visit www.policyalternatives.ca

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One union, many colours! Working across our differences! To participate, please call and leave us your name!

PRESS 2

First Nations

First Nations members would like to hear from you! Please call if you would like to help educate our union sisters and brothers on issues that affect First Nations People.

PRESS 3

Lesbians and Gays

For support: afraid of being identified, feeling isolated, want to know your rights? Call for information on same sex benefits, fighting homophobia and discrimination.
www.pridepages.org

PRESS 4

People with disAbilities

If you are on WCB, LTD, or if invisibly or visibly disabled in the workplace, let us know how the union can better meet your needs.
www.alberni.net/PeopleWithdisAbilities

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Talk to us Toll-Free!

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DESIGN CONSULTATION
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PRODUCTION & PRINTING
Broadway Printers

The *Guardian* is published on behalf of the Provincial Executive of the Hospital Employees' Union, under the direction of the following editorial committee:

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