Vol. 16, No 1, December 2005

Actualités

JOURNAL OF THE FIIQ

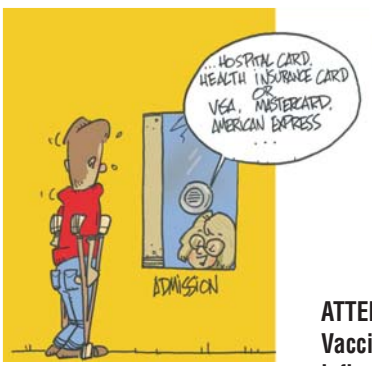
Chaoulli-Ménard Report

The Chaoulli decision: how should it be interpreted?

Profile and critique of the Ménard Report

SOLUTIONS FOR PROVIDING CARE!

Summary



Cover page :
SOLUTIONS FOR PROVIDING CARE!
Photographer :
Jacques Lavallée

Actualités

Vol. 16, No 1, December 2005

FIIQ Actualités, the journal of the *Fédération des infirmières et infirmiers du Québec* (FIIQ), is published three times a year and has a distribution of 56 500 copies.

- **Conception and writing:** Communication-Information Service consultants: Sara Lapointe, Micheline Poulin
  Executive Committee member in charge: Lina Bonamie, President
- **With the help of:** Consultants: Hélène Caron, Brigitte Doyon, Line Lanseigne, Lucie Mercier, Florence Thomas
- **Translation:** Martine Eloy, consultant
- **Secretarial work:** Céline Bourassa, Sylvie Provost
- **Graphics:** Josée Roy, graphiste
- **Illustrations :** Richard Cameron Morneau, *The avian flu*; Yves Lessard, *caricature Chaoulli*; Christian Verreault, *2005 Annual OHS Week*
- **Photography:** Jacques Lavallée
- **Printing:** Caractéra

ISSN 1203- 9837

Occupational Health and Safety
2005 Annual Week

For your protection and for the protection of those around you, keep an eye out for the calendar *Each gesture counts* posted in the centres of activities and on the union bulletin boards in your institution.

You can also consult it on the FIIQ web site: <http://www.fiiq.qc.ca/sst_semaines.htm>.

DANGER! BARBARIAN INFECTIONS! Each gesture counts

Interview

Meeting with Lina Bonamie

At the Convention last June, Lina Bonamie was elected President of the *Fédération des infirmières et infirmiers du Québec*. New functions, a new organization greeting new union representatives and new challenges; there is plenty to keep Madam Bonamie busy in the period of change which the Federation Is undergoing! In order that you may learn a little about this committed woman and trade unionist, the *FIIQ Actualités* team has interviewed her.

Madam Bonamie, you have a key position with important professional responsibilities which require great availability. What led you to run for the position of President?

With the strength of my experience as member of the Executive Committee for 14 years, and the many issues for which I was responsible over the years, running for president was an opportunity for me to take up new challenges within the Federation in order to contribute to its development. I wanted to take on the challenge of harmonizing not only the collective agreements, but also our ways of doing things, and to participate in the evolution of the new FIIQ+. union force.

What are the main challenges which you would like to take on during your mandate?

I want nurses, nursing assistants, respiratory therapists and perfusionists to feel comfortable in their workplaces and to perform their duties in working and living conditions that encourage them in the pursuit of their career. I also hope that members and union representatives will feel that they have an active role in their renewed organization and that harmony will develop within all categories of professionals that we represent. For me, working actively to counter the invasion of the public network by the private sector, which our government is insistently trying to push, is a priority. Finally, I would like to pursue awareness-raising work among our members on the negative effects of a certain globalization.

Lina Bonamie

- Graduated in 1975 from *Cégep Maisonneuve*
- Nurse at *Hôpital Maisonneuve-Rosemont*
- Union activist since 1989
- member of the Executive Committee of the Federation since 1991
- Executive officer responsible for various sectors: Negotiation, Task and Organisation of work, Social Security, Occupational Health and Safety
- President since June 2005

You have recently been in Argentina where you attended a meeting of the *Public Services International* (PSI). What was the object of your visit?

Let us first say that the Inter-America region of the PSI brings together 98 organisations affiliated in 35 countries, for a total of around 3,300,000 public service workers. During this meeting, where more than 17 countries were represented, we established the bases of a pan-American coalition on health and social services within the PSI. We drew up a plan of action over a three-year period. This action plan is in line with the objectives pursued by the PSI, that is to say: to oppose the efforts by certain governments and other bodies to lower the standards of health services and reduce their accessibility, develop union strategies to fight against privatisation, sub-contracting and commercialisation of services; struggle for the improvement of the working and living conditions of health and social services workers, and for the creation, development and freedom of their unions.

During this visit, did you see different forms of unionism and to which type does the Federation identify?

Its more or less the same as in Quebec or in Canada, except in Argentina where physicians are unionized. Unions, like ours, have objectives which go far beyond the defence of the working conditions of their members. Several unions support social and community movements, and are opposed to the anti-union and anti-social policies of their respective governments. Moreover, representatives are critical of globalization and its consequences for workers and their families. Thus, the Federation shares several points with all the members of the pan-American coalition of the PSI.

The new configuration of the Federation gives it greater union force. In your opinion, what kind of leadership will it be able to exercise in the health sector and at the political level?

I believe that with the force of the 56,500 professionals that we represent, we will exercise a leadership in the field of health and in the union world. Being grounded in daily reality, we are able, without being alarmist, to give the public and the government the true picture of the situation regarding health care and services and demand improvements in the health-care network. Representing the majority of caregivers in each institution, we will have definite power on the organisation of work and care, and our union actions will make it possible to improve our work environments.

In closing, bridging professional and personal life is one of the Federation's priorities. Do your responsibilities leave room for your personal life?

Yes, but with the support and many concessions of those around me! I have the privilege of having a network of very understanding friends and family who excuse me for arriving late or being absent. However, I take the time to entertain my passion for travelling, for movies and gardening, and I draw energy from the practice of my favourite sport, jogging.

Health commissioner

In February 2004, the Federation presented a brief to the National Assembly of Québec concerning the introduction of the position of Health and Welfare Commissioner (Bill 38) and appeared before the *Commission des affaires sociales* to denounce, once again, the re-engineering of the State launched by the Charest government. This bill was finally adopted in June 2005.

Besides contesting the abolition of the *Conseil médical du Québec* and the *Conseil de la santé et du bien-être*, the FIIQ alerted the minister of *Health and Social Services*, Philippe Couillard, to the dangers of this bill. Indeed, the *Health and Welfare Commissioner*, rather than being the guardian of the health and social services system, will henceforth be *responsible for appreciating the global performance of the health and social services system* in view of improving its efficiency and effectiveness. It will thus have the responsibility to identify the major issues at stake in the health-care system and to propose choices with regard to *accessibility, integration, insurability and funding of the services, health and well-being determinants, ethical aspects related to health and well-being, drugs and technological advances.*

According to the FIIQ, the introduction of these mechanisms making it possible to make choices in an economic perspective will enable the government to bring into question the delivery of public services, to reduce the number of insurable services and to pursue the State disinvolvement which began with its election. This bill was highly controversial and was the object of strong opposition, particularly with regard to the mode of appointment of the Commissioner and the loss of the *Conseil de la santé et du bien-être*, whose approach was based on health determinants. We fear that the principles that guided health policies will disappear and that they will be replaced with economism.

Despite its abolition, the *Conseil de la santé et du bien-être* pursued the work which it had conducted since its creation in 1993 to ensure the transition to the agency that the *Health and Welfare Commissioner* will represent. It drew up, among other things, a *Draft declaration on rights and responsibilities in health and well-being* which it will submit to the chosen Commissioner. This proposed bill, for which the FIIQ was consulted, constitutes an interesting document with regard to the rights of citizens with regard to health and well-being. The Commissioner will be appointed in December and he will come into office in April 2006. Keep an eye out for more information on this.

Florence Thomas, consultant, Health-Care Sector

Reform of democratic institutions and revision of the electoral system

The work of the *Commission spéciale sur la Loi électorale (CSLE)* and the *Comité citoyen sur la réforme des institutions démocratiques* began on November 1, 2005 and will continue until March 2006. The Commission will begin by hearing experts on the matter. Then, Quebec groups, regional groups and citizens will be heard in the context of a travelling consultation that will visit 16 Quebec cities.

This reform represents a unique and historic occasion to review certain aspects of the functioning of Quebec democracy, in particular the electoral system, a system designed to transpose the vote of citizens into a number of seats at the National Assembly. More than a debate between politicians, this consultation concerns and is addressed to the entire population.

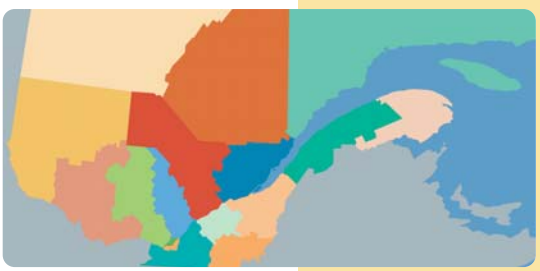
For the FIIQ, a revision of the electoral system should redress the shortcomings of the current electoral system in order to eliminate the distortions between the will of the people and the number of seats obtained by the parties, put an end to political swing of the pendulum that results from bipartism which is not necessarily representative of the current trends of thought, uphold measures that promote the presence of women (currently 32% of the deputation) and persons of other origins in power, and ensure fair representation of all regions.

The Federation will therefore recommend, by way of a brief to the *Commission des institutions démocratiques*, that the proposals contained in the proposed bill be revised and that Quebec adopt a proportional electoral system that would make it possible to reach the following objectives:

- reflect as accurately as possible the popular vote;
- make possible equal representation between men and women;
- encourage representation that embodies Quebec ethnocultural diversity;
- promote political pluralism;
- reflect the importance of the regions.

The FIIQ encourages all its members to speak up. Quebec is one of the last countries not to have changed its electoral system. After more than 30 years of debates, here is an opportunity that we must not miss if we want the National Assembly to truly reflect our aspirations!

Florence Thomas, consultant, Health-Care Sector



For more information, consult the FIIQ web site:
<http://www.fiiq.qc.ca/reforme_scrutin.htm>

When and how can you express you point of view?

Information and schedule of the consultation:
<http://www.assnat.qc.ca/fra/37legislature1/commissions/csle/index.shtml>

Youth action strategy
The Youth Committee speaks up

The announcement of a public consultation on Quebec youth aroused the interest of the Federation, 14% of whose membership is composed of young people. It gave the mandate to the Youth Committee to analyse the consultation document *Stratégie d'action jeunesse 2005-2008* of the Quebec government. At the end of August, the outline of an opinion on this strategy was presented by a member of the Youth Committee, Jérôme Rousseau, and Michèle Boisclair, 1st Vice-President.

The field of health at the forefront

Since the Federation occupies a place of choice in the field of health, the Youth Committee addressed the youth action strategy by way of the social, cultural and economic health determinants such as the social support networks, the level of schooling, life habits, the level of income and one's social situation. Reflections, worries and avenues of solution were presented concerning four of the five orientations proposed by the government's action strategy: to improve the support offered to young people; improve the health and well-being of young people; foster young people's educational success and entry into the workforce.

Of course, the provision of a new generation of caregivers could not be ignored since the shortage in this sector affects young people directly. They must practise during the first years in a very difficult context, which has an impact on the problem of attraction and retention of the labour force. For the Youth Committee, intergenerational links must be created and valued, and mentorship is one of the avenues that should be implemented in order to consolidate and create these links. It promotes the transmission of know-how, knowledge and experience, in addition to consolidating links between individuals. However, true political and collective will for change must be initiated by the creation of this type of link, which cannot rest only on individual will. Thus, provisions for the retention of persons who could play the role of mentors must be introduced.

Strategic choices

Among the other conclusions put forward, the Committee recommends, among other things, the centralisation of information portals that reach young people in order to ensure greater coherence and greater complementarity of the services designed for the young. Besides centralising information, we must disseminate it and make it available. Services must also be accessible. Thus, the Committee proposes that advantage be taken of the already existing structures, like CLSCs and youth centres, to implement true coordination and orientation measures for services to the young.

Concerning sound life habits, the Committee recommends the promotion of a preventive approach rather than a curative one, controlled by State and by public health policies. He suggests that a system of vigilance be introduced to counter certain endemic problems like obesity. The Committee also believes that we should proceed to systematic screening in high-risk environments, by way of CLSCs, childcare centres, schools and other institutions. CLSCs demonstrated their capacity to establish programmes in partnership with living environments, a process the Committee believes should be encouraged and funded.

Timely initiatives and actions

The consultation document on the *Stratégie d'action jeunesse 2005-2008* only deals partially with the problems encountered by the young and neglects certain other aspects of their reality. In this instance, all the difficulties and consequences engendered by teen-age pregnancy for young people, but also for society as a whole are not discussed. Problems related to mental health and their impact on individuals and the community are only briefly touched upon. According to the Youth Committee, addressing these issues only in the end, by way of their extreme and visible effects, like suicide, amounts to neglecting prevention and taking important risks. The whole issue of post-secondary studies and their funding was also ignored.

The Committee considers that this action strategy is raises concerns because it addresses the policy towards youth, in a piecemeal fashion, only through issues chosen by the government, and not from a global perspective. The questions raised do not address the responsibility of the State in any way, but rather confirm the view that it is an individual responsibility to find solutions to our problems

Finally, the Youth Committee regrets that there is no evaluation of the accomplishments and investments of the Parti québécois's *Plan d'action jeunesse 2002-2005*. It asked that the government evaluate what was accomplished in order to make adjustments. The Committee also wants the government to exercise leadership and to clearly demonstrate that youth is an important concern.

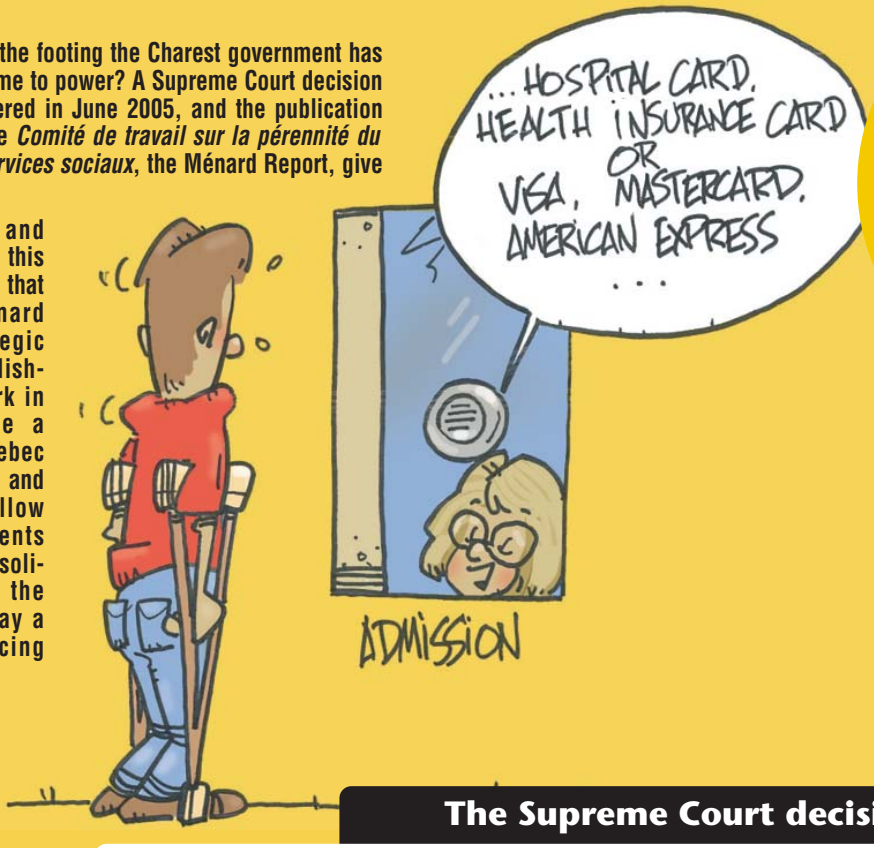
Sara Lapointe, consultants Communication-Information Service

For more information:
FIIQ brief:
<www.fiiq.qc.ca/memoires.htm>
Youth portal Espace J:
<www.espacej.gouv.qc.ca>

Is quick action needed?

Will two-tier medicine find the footing the Charest government has been waiting for since it came to power? A Supreme Court decision in the Chaoulli case, rendered in June 2005, and the publication last July of the report of the *Comité de travail sur la pérennité du système de santé et des services sociaux*, the Ménard Report, give reason to fear the worst.

The government's false and simplistic interpretation of this judgment and the follow-up that will be given to the Ménard Report represent a strategic opportunity for the establishment of a private network in Quebec. This would be a setback for the entire Quebec population. The Federation and all its members must follow these recent developments closely. Mobilization and solidarity are essential and the Federation intends to play a major role in denouncing two-tier medicine.



The Chaoulli decision: how should it be interpreted?

On June 9, 2005, the Supreme Court rendered a decision that risks having major political repercussions not only in Quebec but in the rest of Canada. A deeply divided Court, by a four to three margin, ruled in favour of the appellants, Dr. Jacques Chaoulli and a patient, George Zeliotis. They contested the validity of the prohibition of private health insurance in Quebec for medically required care offered by physicians who are non-participants in the Quebec health insurance plan *(Régie de l'assurance maladie du Québec - RAMQ)*.

The Supreme Court decision

While the Superior Court and the Court of Appeal had dismissed the petition, the Supreme Court reached a contrary conclusion on the basis of the *Quebec Charter of Human Rights and Freedoms*, which guarantees the "*right to life, and to personal security, inviolability and freedom.*" Essentially, the judges' reasoning is as follows: given that health care is subject to waiting periods, that waiting lists are a form of rationing and that the consequences of wait times increase the risk of mortality, in the case of cardiovascular surgery for example, the Court concluded that the right to life is affected by the delays inherent in the waiting lists and that, consequently, this prohibition contravenes the *Quebec Charter*.

However, the *Quebec Charter* provides that the prohibition of private insurance could be justified or deemed valid in certain circumstances. To justify this prohibition, private insurance must firstly aim to preserve the public system and impair the right to life. After examining the experts' evidence and analyzing the situation in the other provinces of Canada and in certain countries of the *Organization for Economic Cooperation and Development (OECD)*, the judges concluded "*that public health services are not threatened by private insurance"* and that *"the prohibition is not necessary to guarantee the integrity of the public plan.*"

Three of the four majority judges then analyzed the *Canadian Charter of Rights and Freedoms* which, in Section 1, protects "*the right to life, liberty and security of the person.* " Nobody may be deprived of this right except in accordance with the principles of fundamental justice. For this purpose, the rules of law must not be arbitrary. In the present case, three judges considered that the prohibition against taking out private insurance is arbitrary because other democracies succeed in providing medical services at more affordable prices, without resorting to a government monopoly. Finally, they concluded that the prohibition cannot be justified in a free and democratic society and that it goes beyond what is necessary to protect the public system.

The dissenting judges

For the three dissenting judges, this is essentially a political debate which should not be settled by judicial means.

From the outset, they expressed the view that a health-care system based on ability to pay rather than on need is contrary to the *Canada Health Act*. They then pointed out that Quebec does not prohibit private health care but wishes to discourage its proliferation. They also noted that authorization of private insurance is an inevitable prerequisite for the development of a parallel private health-care sector. Although they acknowledged that wait times impair the life and safety of some Quebec residents in certain circumstances, the dissenting judges considered that there is no impairment of the principles of fundamental justice of the *Canadian Charter*. Indeed, in their opinion, *health care to a reasonable standard within a reasonable time* is not a legal principle; there is no societal consensus regarding this objective and, finally, it is difficult to draw the line between what is reasonable and what is not.

The dissenting judges, unable to conclude that the Government of Quebec has made its choices *arbitrarily*, concluded that the impairment of the right to life does not violate the *Canadian Charter*. Regarding the *Quebec Charter*, these judges pointed out that *those who seek private health insurance are those who can afford it and can qualify for it. They are the more advantaged members of society. They are differentiated from the general population […] by their income status*. In conclusion, the judges considered that the choices made by the National Assembly are justifiable under the *Quebec Charter* and that *shifting the design of the health system to the courts is not a wise choice*.

The Charest government misinterprets the decision

When Premier Jean Charest claims to have received an order from the Supreme Court that calls two Quebec laws into question, he gives the Supreme Court judgment a scope it does not really have.

First of all, the Court only invalidates two sections, not two entire laws. Secondly, the Court was deeply divided on the entire interpretation of the evidence. And finally, the Court suggests that, apart from the prohibition of private insurance, different means are available to the government to ensure the integrity of the public system. Yet the authorization to take out private insurance represents a real threat to the sustainability of the public health-care system: it is the endorsement of two-tier medicine, with one health-care system for those who can afford to pay and another for those who cannot. Moreover, trade agreements whether the *North American Free Trade Agreement (NAFTA)* or the *General Agreement on Trade in Services (GATS)*, a compulsory agreement for the member countries of the *World Trade Organization (WTO)* such as Canada, have not really excluded health and social services from their field of application. Two offensives are currently being conducted to have the health-care network fall under the jurisdiction of these agreements: the introduction of competition, put forward by the Clair and Menard reports, and the opening to of the sector to private insurance by the implementation of a mixed health-care system. These aspects, which have not been taken into consideration by the Supreme Court, must be vehemently opposed.

Stubbornly refusing to resort to the notwithstanding clause as some constitutional experts suggest and as the official opposition demands, Premier Charest claims he wants to respect the right to life as defined in the *Quebec Charter*; he maintains that he does not want to *eliminate the right to life*. The use of the notwithstanding clause is far from a unanimous option, but is only one of the means that could be used. In fact, when the Premier claims to have received an order from the Court and when he says that he refuses to *eliminate the right to life*, it must be understood that he sees this decision as an almost unhoped-for political opportunity for his government to introduce fundamental changes in the public health-care system, changes that up to then were politically unthinkable.

The Government of Quebec has obtained a 12-month delay from the Supreme Court to apply this decision and has postponed the tabling of a consultation document to January 2006, in order to avoid making health a Federal election issue. A parliamentary committee will follow and a bill would then be adopted in June. Stay tuned for a debate that is taking on crucial political importance.

Lucie Mercier, consultant,
Health-Care Sector

FIIQ demonstration on June 10, 2005 to denounce the Supreme Court judgment.

Profile and critique of the Ménard Report

In the wake of the Charest government's action program, *Shine Among the Best*, and the *Forum des générations (2004)*, the *Comité de travail sur la pérennité du système de santé et des services sociaux du Québec* has launched an urgent call to reform the funding of the health and social services system[1].

***If quick action is needed*, as states the Committee chaired by Jacques Ménard of MBO Financial Group, this is because Quebec isn't competitive enough economically. Even though it is currently among *the richest on the planet*, Quebec is still not as rich as the United States and Ontario. In response to the question, *what is hindering its economic growth?*, the Committee answers: funding of government programs, especially those of the *Ministère de la Santé et des Services sociaux*. The low growth rate of Quebec's productivity, rapid demographic decline and population aging, which would be greater in Quebec than elsewhere, are worsening the situation. This is a series of inevitable factors that would compel the *new generation* to bear a very heavy tax burden, if nothing is done.**

Fatalistic projections

The Committee primarily bases its arguments on demographic and economic projections. Thus, the low rate of population growth and population aging would boost the demand for services. In addition to this, there is the increase in diagnostic and therapeutic practices, and the cost of prescription drug insurance, which is the second leading expenditure item since 1998-1999. This systemic growth of expenditures would be combined with Quebec's fragile economic position, absorbed by the public debt, and its shrinking pool of workers, directly affecting GDP growth and Quebec's bond rating.

In response to this gloomy picture of the future of public finances and the health-care system, the Committee offers remedies that are essentially financial and economic. This does not prevent it from introducing proposals that concern such fields as the organization of the network and orientations in social prevention. The Committee bases these proposals on moral principles such as equity, solidarity and individual and collective responsibility. It also proposes management orientations such as accountability and public funding. In this regard, it notes that the recent judgment of the Supreme Court of Canada, more commonly known as the Chaoulli decision, offers *an exceptional opportunity* to reaffirm public funding of the health-care system and resort to the private sector.

So-called private services henceforth will include those provided by for-profit private businesses, social economy enterprises, the community sector, volunteers and natural caregivers.

Solutions that increase the tax burden of Quebecers

The solutions presented by the Committee meet the twofold objective of increasing the efficiency of services and funding in health-care. It is thus necessary to *provide the best possible care and services at the lowest possible cost* and mobilize more capital. Various avenues are thus explored and consolidated around nine measures:

1. Pay down the public debt by creating a heritage fund from the increase in Hydro-Québec rates.
2. Measure the growth of health-care spending by aligning it with the growth of the GDP, while funding the excess costs from other sources.
3. Correct the fiscal imbalance by fair and equitable equalization payments.
4. Improve the health-care system's performance so that Quebecers *get their money's worth*.
5. Resort to the private sector to *realize additional gains*.
6. Create an insurance plan against loss of autonomy and for other missions such as programs for youth in difficulty. This plan would include all the budget appropriations allocated to the services covered by the government, plus compulsory contributions and interest income. The priority objective of this program would be to strengthen residual autonomy. It would only respond to the needs evaluated, rather than all needs.
7. Create a health and social services account to identify expenditures and modes of funding.
8. Introduce new fiscal or parafiscal measures. The QST is chosen by the Committee because it represents a major revenue source and does not hinder exports or business because the inputs[2] are already the object of tax credits. The most disadvantaged individuals could benefit from tax credits,
9. Create a special annual Parliamentary Committee to evaluate the overall performance of the health-care system through the health and social services account.

Even though the report argues repeatedly that Quebecers are overtaxed, it must be noted that all of these measures will increase the personal tax burden. Indeed, the increase in Hydro-Québec rates, the compulsory contribution to the insurance plan against loss of autonomy, and the increase in the QST are all direct or indirect taxes.

1. Comité de travail sur la pérennité du système de santé et des services sociaux du Québec, *Pour sortir de l'impasse : la solidarité entre nos générations, Rapport et recommandations, Tome I, Tome II : Annexes*, July 2005. To consult or download the report: <http://www.solidaritedesgenerations.qc.ca>.
2. Factors involved in the production of goods (energy, material, etc.).

Regarding the second lever proposed by the Committee, an improvement of efficiency, the solutions call for systematic reliance on the private sector to foster competition. public-private partnerships (PPP) will thus be used for construction projects, outsourcing and subcontracting for food services and housekeeping, and private suppliers for *sociosanitary* services and the purchase of diagnostic or therapeutic hospital services. The social economy and community sectors, volunteers and natural caregivers will be asked to contribute to services provided to people who are losing their autonomy.

Unacceptable recommendations

It is deplorable that the Committee is composed mostly of people from the business community. Indeed, seniors and people who are losing their autonomy were not consulted, even though they will directly suffer the impacts of the solutions proposed by the Committee. Also, professionals, the community sector, women's groups, volunteers and natural caregivers are no longer represented, even though they play a part in the solutions.

The Committee bases its arguments on the notion of economic growth measured by the gross domestic product (GDP). However, this indicator, which represents the simple value of all goods and services produced in a given year within a country's borders, provides a limited and incomplete measurement of wealth, solely in monetary terms. Indeed, the GDP does not account for activities and effects that are not quantifiable monetarily, and produced *outside the market*, such as volunteerism and domestic work, which would account for 32% to 77% of the GDP[3]. Nor does it account for the harmful effects of air and water pollution on human health. The GDP thus is not a reliable indicator of a country's wealth.

Most of the solutions envisioned will entrench the increase in health and social services outside our public network and create new classes of well-paid, underpaid or unpaid workers. Regardless of whether the services are provided by for-profit or non-profit enterprises, or by families or charities, the report does not account for the services already provided within this sphere and favours this avenue, assuming in advance that this is necessarily more efficient than in the public sector because it costs less.

Remarkably, among the measures envisioned, it is never proposed that solutions be studied for the real control or reduction of significant problem expenditure items, such as prescription drugs and technology. On the contrary, the Committee justifies this increase in expenditures as benefiting innovation and the development of these industries. However, the increase in prescription drug expenditures essentially corresponds to the date of creation of the insurance plan (January 1, 1997) and sheds light on one of this plan's effects – inflation of expenditures through the increased cost of prescription drugs and the greater number of prescriptions. This factor is absolutely not considered or questioned, except within the perspective of the creation of a Supplemental Plan for services related to loss of autonomy. The preference is thus to increase the contribution by individuals to augment the health-care system's funding. Moreover, a corporate contribution is not considered at all, even though, as Yves Séguin, former Minister of Finance in the Charest government recently pointed out, *Quebec's fiscal policies* regarding corporations *are among the most favourable compared to all other industrialized countries*[4].

Finally, this report gives rise to numerous questions about methodology, interpretation of data and conclusions, which cast doubt on the Committee's recommendations and their impacts on the Quebec health and social services system.

Another step towards government disengagement

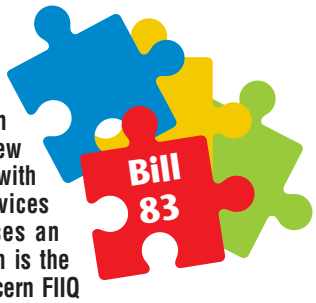
In the light of the Government of Quebec's recent statements regarding the introduction of funding and the institutionalization of delivery of private services funded by the public, it is clear that the report is constructed to promote the greater development of the private sector. If the government acts in accordance with these statements, the principles of free and accessible health care contained in the *Canada Health Act* would be called into question and health care would become an open market for the private sector. The government would then have the possibility of no longer providing services to people who are losing their autonomy and of delegating these services to businesses, volunteers and families. This report thus marks a strategic moment in the establishment of a private health and social services network in Quebec, because it precedes the bill that will be tabled in 2006 to introduce private service delivery in our system.

With the support of the business community, the Jean Charest government is pursuing its objective of disengagement from the State's essential missions.

Florence Thomas, consultant, Health-Care Sector

3. Florence Jany-Catrice, Jean Gadrey, *Les nouveaux indicateurs de richesse*, Collection Repères, La Découverte, Paris, 2005, 123 pp.
4. Yves Seguin, « Le fardeau fiscal des entreprises », *Le journal de Québec*, November 10, 2005.

Organization of Work
Clinical projects



Bill 83, the *Act amending the Act respecting health services and social services and other legislative provisions*, was adopted on November 28, 2005. The main objective of this bill is to support the new organisation of work models introduced with Bill 25, that is the integrated local services networks. To this end, the bill proposes an *organisational and clinical project*, which is the responsibility of the CSSS, but which concern FIIQ members to the utmost point.

What is an organisational and clinical project?

According to the MSSS, *the clinical project of the local network refers to a process designed to meet the health and well-being needs of the population within a given territory on the basis of the various service delivery models adapted to local realities, articulated one to the other and that cover all the interventions related to the promotion-prevention of health and well-being, diagnosis, interventions or treatments, the follow-up, adaptation and support for social integration, rehabilitation and end-of-life support. It takes ito account the role and responsibilities of the sectorial and inter-sectorial stakeholders and the potential for contribution of the various actors. It supposes that the various actors are made accountable for the services they offer to individuals and to the population, and for the resources made available to the them*[1].

Thus, organisational and clinical projects offer the opportunity to question and adapt the delivery of care and services to the new reality of the local services networks. To this end, the local body, that is the CSSS, will have to: determine its service offer, draw up an inventory of the current resources and those needed to carry out the project, identify the gaps that need to be filled to reach the objectives of quality, accessibility and continuity of care and services, identify the models to be maintained, strengthened or introduced, and determine the roles and responsibilities of the stakeholders concerned. The reorganisations will be based on service programmes and they will be guided by two fundamental principles: populational responsibility (that is that the interveners are called upon to share responsibility collectively for the population in a given territory) and the hierarchisation of services (which proposes to ensure that first, second and third line services are more complementary in nature and to facilitate the passage of persons from one level of service to the other by way of pertinent mechanisms).

As prescribed in Bill 83, the local body is entrusted exclusively with the responsibility to define the organisational and clinical project for the territory it serves. However, since it will modify to various degrees and in various ways, the organisation of care and the work of health professionals, it is in the interest of the latter to play an active role in the work around the organisational and clinical projects.

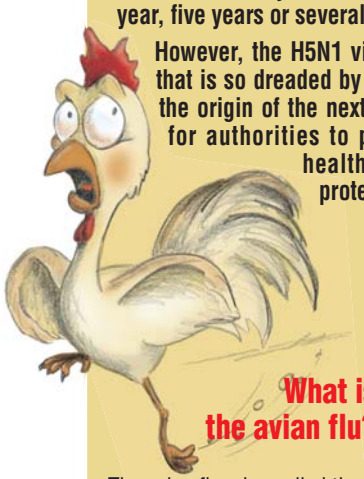
The FIIQ is convinced that this is key to the success of the project, since this project will take form through professional practices. Moreover, it is an opportunity for health professionals not only to contribute to the reorganisations being put forward by the government, but also to make the best of these.

Brigitte Doyon, consultant, Task and Organisation of Work

1. Ministère de la Santé et des Services sociaux, *Projet clinique - Cadre de référence pour les réseaux locaux de services de santé et de services sociaux - Document principal*, Québec, La direction des communications du MSSS, octobre 2004, p. 6.

The avian flu

These days the question is on everyone's lips: are we prepared to face a possible avian flu pandemic? Last October 21, on Radio-Canada television, the programme *Zone Libre* presented a report on this subject entitled *La grippe qui tue…*, an unequivocally alarmist title. According to the inquiry carried out by the journalist Claude Sauvé, a world-wide epidemic is unevitable, but experts in the field do not know when it may break out. In the coming months, in one year, five years or several years?



However, the H5N1 virus, responsible for the avian flu that is so dreaded by experts, will quite probably be at the origin of the next pandemic. It is therefore crucial for authorities to prepare adequately and for the health personnel to obtain maximum protection.

What is the avian flu?

The avian flu, also called the avian influenza or bird flu, is a contagious viral disease provoked by the avian influenza A virus, which can affect all bird species including poultry (chickens, turkeys, quails, guineafowl), pet birds, exotic or wild birds. Moreover, studies have revealed that a small number of mammals, like pigs, seals, whales, minks and ferrets can also become infected by a subtype of the avian influenza virus. Among these species, pigs are the only which could represent a risk, as minimal as it may be, for human health.

There are several subtypes or strains of type A avian influenza virus depending on two proteins (H and N antigens) present on the surface of the virus, that is 16 subtypes, H1 to H16, and nine subtypes, N1 to N9, and as many possible combinations of the virus strains. Only subtypes H5 and H7 are recognized for having become highly pathogenic and responsible for a large number of deaths among birds, in particular the virus H5N1 responsible for the type A avian influenza infections reported to have occurred since December 2003 in Asia, and which required the slaughter of millions of chicken to prevent the outbreak of new cases of infection and which caused human victims.

In British Columbia, in March 2004, 36 industrial poultry farms were infected by a different and less pathogenic strain of avian flu, the H7N3, which also infected two workers in charge of destroying the chicken. These workers developed benign symptoms, namely a conjunctivitis and a runny nose, both of which completely disappeared.

Is avian flu transmitted to humans?

The different strains of the avian flu virus do not usually infect species other than birds and sometimes pigs. However, the transmission to humans of the virus found in infected birds can occur when a person is in direct contact with the droppings of these birds, or with the environment of a contaminated poultry farm, or with raw or insufficiently cooked poultry products. On the other hand, the risk of human-to-human transmission of the virus is very low and almost non-existent. Until now, there is no documented case of such transmission.

How can we explain the climate of fear surrounding the avian flu?

The fear which prevails world-wide is the result of the fact that the current outbreaks of bird flu in Asia could be a fertile ground for viral rearrangement. The possible presence in a person of the usual flu virus (H3N2) and the avian flu virus (H5N1) would give these viruses the opportunity to exchange genes, which could engender a new hybrid sub-type of the flu virus having the potential

to cause a pandemic since it would not only be extremely virulent but also transmissible from one human being to another. According to the Public Health Agency of Canada, if such a rare event was to occur, there would be immediate serious consequences for human health worldwide. No one would be protected against this new virus and it would take from four to six months to develop a vaccine.

How can we protect ourselves?

Whether or not they are in contact with micro-organisms like the *microbacterium tuberculosis*, the *Clostridium Difficile* bacterium or the usual flu virus, it is essential that health professions protect their own health and those of the people around them by applying, in a systematic way, the basic measures and the additional precautions adapted to each situation. This is certainly the best way to reduce, if not eliminate, the risks of contracting or transmitting an infectious disease[1].

We must constantly be vigilant!

Hélène Caron, consultant, Occupational Health and Safety Sector

1. Sources :
http://www.phac-aspc.gc.ca/publicat/daio-enia/index.html
http://www.inspection.gc.ca/english/anima/heasan/disemala/avflu/avflufse.shtml
http://www.inspection.gc.ca/english/anima/heasan/disemala/avflu/bacdoc/avflutypese.shtml
http://www.msss.gouv.qc.ca/en/sujets/prob_sante/avian.php
http://www.hc-sc.gc.ca/dc-ma/avia/index_e.html

ATTENTION!

Vaccination against influenza: what are your rights?

Once again this year, employers strongly urge caregivers to be vaccinated against influenza. In the case of an outbreak, they tend to follow the recommendations formulated in the *Protocole d'intervention*[1] produced by the *ministère de la Santé et des Services sociaux (MSSS)*, including the recommendation to exclude from work persons in contact with beneficiaries who have refused to be vaccinated and to take antiviral medication. It is important to know that:

- A person has the right to choose to be vaccinated or not, to take medication or not.
- A employer who requires that caregiving personnel be vaccinated or take medication, failing which they can be excluded from work, must be able to demonstrate that the measure taken against the employee concerned is the one that least infringes on her rights.
- Among the measures which can be taken by the employer to prevent the transmission of influenza, there are some which have much less impact on the employee's rights, like maintaining her at work providing that she applies the basic preventive measures and additional precautions at all times (hand washing, wearing a mask, gloves and a gown).
- If the employer nonetheless decides to exclude the employee from work, he cannot do so without continuing to pay her salary, in accordance with the principle of the smallest possible infringement on her rights.

In short, even in a context of outbreak, your rights must not be infringed upon! Consult your local union team if necessary.

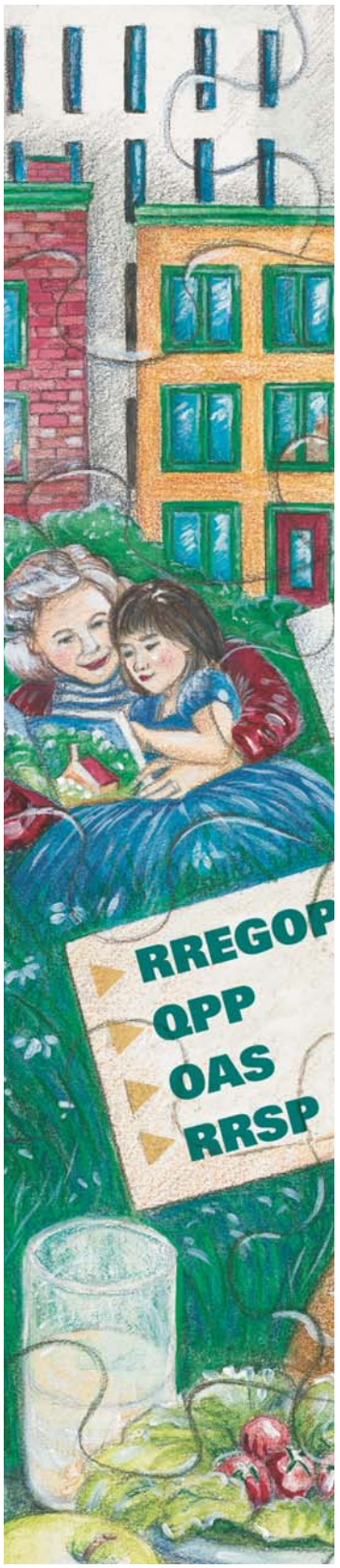
Hélène Caron, consultant, Occupational Health and Safety Sector

1. <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2003/03-222-01.pdf>

Did you know that CSST benefits are subject to a new tax measure?

Since 2004, a new tax measure, adopted by the Quebec government, is in effect. According to this measure, persons who have received CSST or SAAQ benefits must complete a tax adjustment when producing their income tax report. These persons must now pay taxes on the benefits received beginning in the year 2004, which reduces the net amount that they have in the end. The amount that you are required to pay appears on the *relevés 5 and relevés 5 supplémentaires* sheets issued by the CSST for income tax purposes. The government justifies the adoption of this measure by the fact that a person who receives such benefits would have an available income superior to the one which she would have received if she had remained at work. If this measure concerns you, it is therefore recommended, in order to avoid any annoyance, that you plan to save the amount of income tax that will have to be paid in the course of the following year, when the moment comes to file your tax return.

Social Security
Sources of income during retirement



The ABC of a good financial preparation for retirement is to know what sources of income you will have when you stop working. Although the amount of income available during retirement varies from one person to the next, the sources of income are the same for everybody.

Firstly, there are the pension benefits paid by the public pension plans – the Quebec Pension Plan (QPP) and the Old Age Security plan (OAS) – then, the benefits which come from your contribution to a private pension plan Only 42% of Quebec workers benefit from a private pension plan. As employees of the health-care network, your contributions to the RREGOP will entitle you to a pension which, in most cases, will be the most important source of income during retirement. Finally, the trust estate accumulated during your active working life - investments, RRSPs, real estate, etc. – may be another source of revenue.

Benefits form public plans

- **QPP**

  If you have contributed to the Quebec Pension Plan, you are entitled to a monthly pension calculated on the basis of your work income since 1966. This pension will be paid without an actuarial reduction beginning at the age of 65. However, you can ask to begin receiving it at the age of 60 years. In this case, an actuarial reduction of 6% per year of anticipation will be applied. In 2005, the maximum monthly amount which can be received by a person who asks for her pension at 65 years of age is $828.75 per month.

- **OAS**

  If you have spent at least 10 years in Canada, you shall be entitled at the age of 65 to the Old Age Security pension of Canada. It is a monthly pension and you must request it six months before your 65th birthday in order to begin receiving it. It currently represents $479.83 per month if you are entitled to a full pension, which is the case if, among other things, you have lived in Canada for at least 40 years after the age of 18. If your pension income is low, you could also be eligible to a guaranteed income supplement.

The benefits from private plans (RREGOP)

The annuity paid by your private pension plan, RREGOP, includes the basic pension to which may be added a pension credit, lifetime annuity and temporary annuity if you worked in the public network before joining the RREGOP.

- **The basic pension**

  It is an annual pension that will be paid when you retire and which corresponds to your years of contribution to the RREGOP. To establish the amount of this pension, CARRA will use the following formula:

  2% X no. of years of service (for calculation purposes) X average pensionable earnings (for the 5 best-paid years) = annuity

  Example :

  2% X 25 years X $48,000 = $24,000

  The years of service used to calculate the pension include:

  - The years of service during which you contributed to your pension plan;
  - The years of service bought back (with the exception of the redemption of years of service prior to your participation in RREGOP);
  - The years for which you obtained recognition for participation without contributing, either for a period of disability or a maternity leave.

  Thus, the higher the number of years used to calculate the pension, the higher the amount of the pension.

The pensionable earnings correspond to the salary in the salary scale. It includes additional remuneration (post-graduate studies), but does not include premiums and overtime. To establish the average pensionable earnings, CARRA will calculate the average of the five years when your pensionable earnings were the highest.

Since you receive other income form the public plans, your pension will be reduced at the age of 65 years as follows:

0.7% X no. of year of service (for calculation purposes) X average MPE[1] (for the last 5 years) = amount of the reduction

When CARRA confirms the amount of your pension annuity, it will also indicate the amount of the reduction. You will thus be able to know the amount of your pension when you reach 65 years of age.

Pension credit

The pension credit is a pension annuity that is added to the basic pension. It is a set amount which, in many cases is minimal. The amount of your pension credit appears in your statement of contribution that CARRA sends you in the column entitled "Remarques." To be entitled to a pension credit, you must meet one of the following conditions:

- Have bought back years of service performed, before your participation in the RREGOP, in an institution covered by the RREGOP or which would have been covered if it had not stopped existing;
- Have contributed to a supplementary pension plan (SPP) before joining the RREGOP plan.

The additional lifetime pension and the temporary pension

When you are entitled to a pension credit, it will be revalued by way of additional pension benefits that will add to the amounts of your pension credit and your basic pension. The first pension is a lifetime one whereas the second is temporary and will be paid to you until the age of 65. Here is how to calculate these amounts of additional pension annuities:

Lifetime pension

1.1% X no. of years of service (giving right to a pension credit) X average pensionable earnings (of the 5 best paid years) = lifetime annuity

Example :

1.1% X 5 years X $48,000 = $2,690

Temporary pension

$230 X no. of years of service (giving right to a pension credit) = temporary pension (until 65 yrs)

Example :

$230 X 5 years = $1,150

1. Amount of maximum pensionable earnings set by QPP.

The trust estate

You can complete your income with personal savings and investments in a Registered Retirement Savings Plan (RRSP). This type of investment allows you to increase your retirement income and save taxes the year of your contribution.

Line Lanseigne, consultant, Social Security Sector

For more information :

<www.carra.gouv.qc.ca/>
<www.rrq.gouv.qc.ca/fr/programmes/regime_rentes/>
<www.dsc.gc.ca/fr/psr/pub/sv/sv.shtml>

Training sessions for local negotiation committees

Since the beginning of the month of October, training sessions on local collective bargaining are being held to train the members who were elected to the local negotiation committee in each institution. Close to 600 members will thus be trained. This training is the starting point of the local negotiations. The themes discussed include team work, the local negotiation structure, the steps in the negotiation process, the analysis of the general context, the legal framework, the matters to be negotiated and how to make strategic use of the media. Training sessions will continue to be offered until mid-February. Comments to date are very positive and the committees feel better equipped and prepared to begin the local negotiations.

Moreover, a training session on local negotiations will soon be offered to lead representatives and presidents of affiliated unions.

POSTE-PUBLICATION
Convention 40007983

FÉDÉRATION DES INFIRMIÈRES
ET INFIRMIERS DU QUÉBEC

Jean-Philippe Lefebvre, 8 years

The members of the Executive Committee
and all the employees of the Federation
wish you a Merry Christmas
and a Happy New Year 2006.

▼ RETURN ADDRESS

Head Office
2050 de Bleury, 4th floor, Montréal (Québec) H3A 2J5
tel: : (514) 987-1141 1 800 363-6541 fax: (514) 987-7273

Quebec City Office
1260 Bd Lebourgneuf, # 300, Québec (Québec) G2K 2G2
tel: (418) 626-2226 1 800 463-6770 fax: (418) 626-2111

web site: www.fiiq.qc.ca ● e-mail: info@fiiq.qc.ca