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DE LA SANTÉ
DU QUÉBEC

ACTUALITÉS

SEE P.4

BRIEF INTERVIEW
Practical solutions
to the problem
of workforce shortage

SEE P.5

CASTONGUAY REPORT
Towards a new social contract?

SEE P.8

STATUS OF WOMEN
International Women's Day

Reassignment of pregnant or breast-feeding workers

According to the recent demographic data, there is currently a baby boom in Quebec. In 2006, the birth rate reached a peak unmatched in ten years and this trend seems to be holding firm. Care professionals are also contributing to increase the number of births. In this context, it seems appropriate to discuss the rights of pregnant and breast-feeding workers, and the questions raised by a request for protective reassignment.

CONT'D P.11

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SUMMARY

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The economic autonomy of women: a collective force

To celebrate March 8, 2008, the *Intersyndicale des femmes*, of which the FIQ is a member, produced a pamphlet with talking points on this year's theme. This pamphlet is available on the Federation's web site www.fiqsante.qc.ca and at the local union office. An attractive pin was also produced by the *Collectif 8 mars*. ■

The Castonguay Report: far from shelved

The Task Force on Health Funding released its report on February 19. Although its mandate concerned the funding of the health and social services system, this subject is only discussed in three of the document's 17 chapters. Mr. Castonguay acknowledged that funding was not the most important theme, but that governance was fundamental.

A REPORT THAT LACKS UNANIMITY

One of the co-chairs dissents

Two co-chairs were appointed to assist Mr. Castonguay. The *Action démocratique du Québec* chose Joanne Marcotte, a notorious neoliberal, while the Parti Québécois designated Michel Venne, Chair of the *Institut du Nouveau Monde*. Their report was supposed to be tabled in December 2007, but this was delayed until February 15, 2008, due to the difficulty for the Task Force's members to reach a consensus. One of the co-chairs, Michel Venne, even recorded his dissent on three points of the report regarding privatization.

The government's reactions

At a press conference, the Minister of health and social services severely criticized the content of the Castonguay Report, giving the impression that he disavowed it completely. However, a few days later, he nuanced his position considerably and finally stated that he only rejected one of the 37 recommendations, the increase in the Quebec sales tax (QST). He considers that this will be contrary to his government's position. However, we must not forget that Mr. Couillard has already claimed *the right to change his mind*, which, based on his past performance, is generally only a matter of time. Thus, in the February 22 edition of Le Devoir, the editorial board quoted Mr. Couillard, who described some of the report's proposals as "fascinating". The day before, he had even announced that some recommendations on budgeting of public institutions would be applied as of spring 2008, in three regions of Quebec.

The Minister of Finance, Ms. Jérôme-Forget, who spent $500,000 to produce the document, simply affirmed that she rejected the QST as a means of increasing funding. Not a word on the rest of the content. However, her prebudget consultations regarding an increase in worker productivity implied that she endorses many of the aspects presented. It is also interesting that Joanne Marcotte, one of the Task Force's co-chairs, described the Castonguay Report as "old hat".

As for Premier Jean Charest, he affirmed that there was no question of increasing the tax burden in Quebec. Portrayed by the media as totally rejecting the report, the Premier nonetheless endorsed all the recommendations regarding increased productivity and revision of methods, including decentralization of decision-making.

According to the FIQ, the media are wrong in giving the Castonguay Report a premature burial. The recommendations presented, far from being "shelved" as the media claim, are already being implemented. The entire chapter on seniors with loss of autonomy and the new budget allocation modes were already being applied well before the Task Force received its mandate. In fact, the report only discusses these questions in greater depth.

DID THE TASK FORCE HAVE A DOUBLE MANDATE: ONE OFFICIAL AND ONE UNOFFICIAL?

Following the 2007-2008 Budget Speech, the Task Force on Health Funding received its mandate. Officially, Claude Castonguay, who has worked in the insurance field for close to thirty years, was appointed to "formulate recommendations on the best ways to ensure adequate funding of the health care system". However, in the preface to the report, the Task Force points out that society is going through profound transformations under the pressure of trade liberalization and globalization. Unofficially, its purpose would be "to adapt the social policies arising from the Quiet Revolution to the new economic context and to globalization". However, there is nothing in the body of the report on this subject, as if it were an unstated objective of the Task Force's unofficial mandate.

But what exactly is contained in this document, over 300 pages long, which primarily focuses on freedom of choice and ways to increase productivity, in which unions are portrayed as interest groups and the business community as the saviours of humanity? In this issue, we present a summary analysis of the Castonguay Report's highlights. ■

Lina Bonamie

Lina Bonamie, President

BRIEF INTERVIEW

ACTUALITÉS
PAGE 4

Practical solutions to the problem of workforce shortage

FIQ Actualités asked a few questions to the executive officer in charge of the Task and Organisation of Work Sector, Sylvie Savard, with regard to the progress of the work at the T*able nationale du projet de main-d'œuvre* for the health and social services network.

Marie Eve Lepage, consultant
Communication-Information Service

MADAM SAVARD, CAN YOU TALK TO US ABOUT THE MANDATE OF THIS CONCERTATION TABLE?

The main concern of the organisations participating in this consensus-building table is to find practical solutions to the problem of nursing personnel shortage. Special attention is devoted to the evolution of this glaring shortage problem. Thus, participants would like to analyse and understand the situation in order to propose solutions to put a halt to certain practices, such as recourse to private agencies and compulsory overtime, among others. Recommendations will then be made to Minister Couillard.

CAN AVENUES OF SOLUTION BE IDENTIFIED?

The consensus-building table receives material from three sub-committees whose main lines of work are the organisation of work, working conditions, and conditions of practice and continuing professional education. Certain tangible measures have already been proposed at a meeting held last January 29.. Avenues of solution concerning training seemed to have the approval of the committee, but there will have to be modifications and other discussions will be needed.

WHAT ARE THE OBJECTIVES OF THE THREE SUB-COMMITTEES ON WHICH THE FIQ SITS?

The sub-committee on the organisation of work wishes to find solutions in order that full use be made of all the competencies of care professionals. Thus, the accessibility, safety, quality and continuity of services to the population will be ensured. Bill 90 will undoubtedly be a very useful tool in view of this.

The sub-committee on the conditions of practice and continuing professional education, for its part, hopes to promote the creation of a modern and stimulating work environment for professional practice and development.

Finally, the sub-committee on working conditions wishes to obtain recognition for the inconveniences of nursing work. The arrangement of work time will certainly have to be revisited. ■

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1

2

Castonguay Report
Towards a new social contract?

3

1. - 2. Having gathered early in the morning in front of the Quebec City Convention Centre, SISP representatives greeted Claude Castonguay just before the official presentation of the recommendations contained in his report.

3. SISP representatives went to Parliament to present 16,000 postcards signed by the members of the union organisations that compose the *Secretariat Intersyndical des Services Publics*.

Through the 37 recommendations contained in its report, the Task Force on Health Funding proposes to redefine the social pact binding the Quebec government and population for the past forty years. It thus proposes a new social contract, based on hitherto unknown values and principles of the right to health care: universality, solidarity, equity, efficiency, responsibility and freedom. This last principle, which implies the freedom to choose by whom, how and when the patient will be treated, represents the paramount principle of economic liberalism applied to the health-care sector. Except for universality, these principles have nothing to do with those entrenched in the Canada Health Act: universality, accessibility, public administration, comprehensiveness and portability.

PROPOSALS ON THE ORGANIZATION OF SERVICES

The Task Force's mandate was related to funding questions. However, the vast majority of the recommendations (31 of 37) strangely concern services in the broader sense. Many proposals concern network governance, institutional management, the organization of care and services, budgeting and the role of the private sector. Here are some examples.

NETWORK GOVERNANCE

For the Task Force, this means redefining the roles of the different levels of the health and social services network. In the report, the provincial governance structure will include the Ministère de la Santé et des Services sociaux (MSSS), the *Régie de l'assurance maladie du Québec* (RAMQ) and a new body to be created, the *Institut national d'excellence en santé* (INES). The role of each of these organizations will be redefined. INES, created by merging existing bodies[1], will have the mandate of perpetually reviewing the basket of services covered by the public health-care system. At the regional level, the existing regional and social services agencies will become buyers of services from regional public and private providers. These agencies will be reduced from 18 to six or eight.

The service producers will include institutions, health clinics and all other public and private providers. The health and social services centres (CSSS) will play a coordinating role: they sign contracts with the regional agency, contracts replacing the management agreements currently in force. The health clinics will be responsible for managing their financial resources, and their professional and technical personnel, and they will also sign contracts with the regional agency. Moreover, the physicians working at the health clinic will sign a contract with the hospitals; these rules will also apply to specialized medical centres (SMC) and associated specialized medical centres (ASMC).

HEALTH CLINICS

In the report, "health clinics" is a generic term, including a variety of organizations such as medical practices, family medicine groups (FMG), network clinics, cooperatives and CLSCs. All these organizations thus will be covered by the contribution of $100 per year per adult proposed with regard to funding for users wishing to register with a clinic. This contribution will be payable upon registration and is an eligible expense for personal income tax purposes. Its purpose is to develop a sense of belonging. In fact, it will be a first step leading to funding of the clinics by capitation[2] and may include consultations with medical specialists.

THE BOARDS OF DIRECTORS OF THE AGENCIES AND INSTITUTIONS

The boards of directors of the regional agencies and the public institutions will be reviewed and no longer include more than five to seven members. Contrary to what is currently the case, the directors will no longer be chosen on a representative basis. The boards of directors will appoint the executive directors, whose remuneration will increase and who will also receive bonuses. The evaluation of the institutions' performance will be part of the duties of the executive directors. In particular, this evaluation will consist of comparing the productivity of the public or private institutions, and identifying particularly productive programs or management modes.

THE HEALTH AND SOCIAL SERVICES CENTRES

The mission of the CSSS will remain the same, namely care and coordination within the local network of services. However, new tools may be useful to performing its mandate: liaison officers, information technology and the Electronic Health Record, strengthening of cooperation between general practitioners and medical specialists, and incentives to encourage reduction of wait times. In the medium term, the remuneration of family physicians should evolve towards a mixed system, including funding tied to the number of

1 The *Conseil du Medicament du Quebec*, the *Agence d'évaluation des technologies et des modes d'intervention en santé* (AETMIS) and the *Commissaire à la santé et au bien-être*

2 Capitation: the mode of remuneration of physicians in Great Britain, Sweden and Norway is called capitation. It consists of a lump sum paid to the physician or practice by a person residing in the same region or registered on the list of subscribers. Most often, capitation is composed of a basic fixed fee associated with various packages and payment by the act.

Source: Wikipedia, L'encyclopédie libre, [Online]: http://fr.wikipedia.org/wiki/Capitation (page consulted on February 24, 2008)

CASTONGUAY REPORT (CONT'D)

ACTUALITÉS
PAGE 6

1

2

1. In the afternoon, during a press conference, SISP union leaders commented these recommendations.

2. A demonstration was organized in front of the hotel where Claude Castonguay presented his report to the *Board of Trade of Metropolitain Montreal*.

registered patients for whom they accept follow-up and takeover responsibilities. In other words, the system will evolve toward funding by capitation and the amount will be paid to the health clinic, not to the CSSS.

AN INCREASED ROLE FOR THE PRIVATE SECTOR IN FIVE KEY FIELDS

The Task Force identifies five fields in which the role of the private sector can be expanded. First of all, it says it is favourable to mixed medical practice, meaning practice both in the public sector and in the private sector, but on three conditions:

- there must be a sufficient number of physicians in the region;
- an agreement must be signed between each physician, and his or her institution;
- the income from private practice must be limited to a percentage of what is earned in the public sector.

Moreover, the Task Force favours duplicate private insurance for all the services offered by the public plan, in the name of freedom of choice. Next, it considers that private care can be offered in public institutions to diversify the sources of institutional funding. It also proposes that a transparent tendering process be introduced in the public network to award contracts to associated specialized medical centres. This process would be the same as the one already in force in the municipalities, involving competition of public and private providers.

Finally, the report proposes that certain institutions be administered by specialized management companies, which would be bound to the institutions by contract. In fact, these are public-private partnerships in hospital centres. The northern and southern suburbs of the Island of Montreal are particularly targeted, given the deficit of acute care beds. Michel Venne disserted on this question, as well as on duplicate private insurance and mixed medical practice.

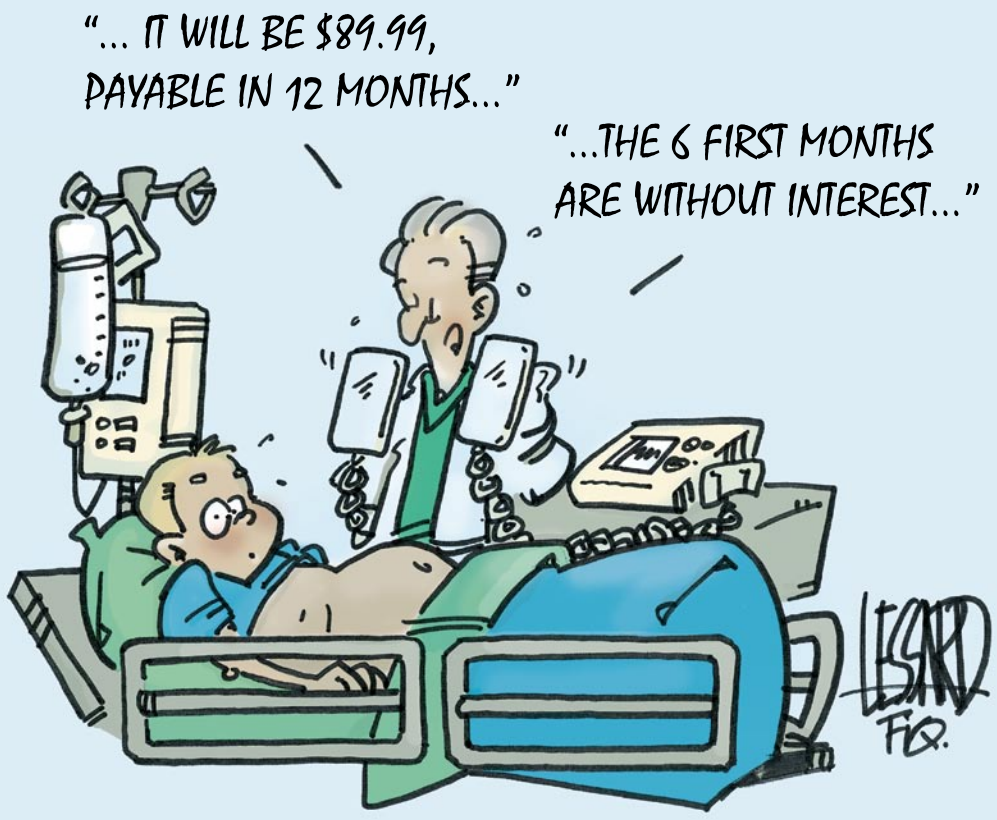
BUDGETING OF HEALTH AND SOCIAL SERVICES INSTITUTIONS

The Task Force proposes major changes to the budgeting methods of public institutions. It wants the institutions to change from a historical budget to activity-based budgeting. Thus, each of the institution's activities or each care episode will be defrayed on the basis of a fixed amount. The amount will be disbursed when the service is produced, with the patient thus becoming a source of revenue instead of a source of expenditures for the institution. Presented as a novelty, this funding method has been applied gradually in the health-care network for several years. Already contained in the Clair Report in 2000, this method was recommended in the Bédard Report published in 2002. The Minister of health and social services has also announced a deeper extension of this form of budget allocation, as of April 2008, in the regions of Quebec City, the Saguenay and the Eastern Townships. This funding method, already applied in France, has turned out to be simply disastrous.

HIGHLY DEBATABLE FUNDING PROPOSALS

With regard to funding, the proposals consist of increasing individual participation, particularly the patient contribution:

Increasing the Quebec sales tax by 1%	$1.3 billon
Imposing a deductible starting in 2009 (T-4 health) on net household income	$500 million
Covering the deficit of the Basic Prescription Drug Insurance Plan (RGAM) by increasing members' contribution	$211 million
Joining a health clinic (contribution of $100 per year per adult) (optional)	Unquantified Estimated at $480 millions
Excluding hostelry from health care	Unquantified
Reviewing the basket of insured services	Unquantified
Reviewing accommodation of seniors with loss of autonomy	Unquantified
Extending the purchase of duplicate private insurance to all health services	Unquantified
Different scenarios for review of administrative expenses and user fees	Between $301 million and $436 million
TOTAL	**Between $2,792 billion and $2,927 billion**



The report proposes that the revenue from the GST and the deductible contribute to a Stabilization Fund dedicated to health care. The FIQ, through the SISP, is favourable to a proposal like the increase in the Quebec sales tax. On the other hand, the imposition of a deductible, a sort of tax on illness, appears absolutely unacceptable to the Federation. In all, the efforts asked of the Quebec public exceeds $3 billion. Yet the private sector, which has seen its contribution to government revenue decrease by about $5 billion over the past eight years, is not solicited in any way by the Task Force's proposals. The SISP believes that the financial effort cannot rest solely on the shoulders of citizens and users of health services.

CONCLUSION

The Castonguay Report goes far beyond a mere increase in the Quebec sales tax. In particular, the issues related to governance, though harmful to the health-care system, appear to be very important. Far from promoting a promising vision for the future of the public health-care system, this report presents a neoliberal vision. In this context, the emphasis placed on the QST is only a smokescreen, the better to hide the real aims underlying this document. ■

Lucie Mercier, consultant
Socio-political Sector

CASTONGUAY REPORT (CONT'D)

ACTUALITÉS
PAGE 7

1

2

1. The presidents of the union organisations of the SISP distributed flyers at the entrance of the Berri-UQAM metro station. From left to right: Michel Sawyer (President, SFPQ), Dominique Verreault (APTS, President), Réjean Parent (CSQ, President), Lina Bonamie (FIQ President) and Gilles Dussault (SPGQ President)
2. Jonquière under the snow. On the right: Nancy Michaud, SPSIC grievance agent in Chicoutimi

In the heat of action

A CONTESTED NOMINATION

When the last budget was made public by the Quebec government, there had been strong opposition by various actors to the appointment of Claude Castonguay at the head of the *Task force on the funding of the health-care system*. It was clear at the time that Mr. Castonguay did not have the neutrality required to fill the mandate in an ethical and democratic way.

Lina Bonamie, President of the Federation, wrote an open letter on this issue in the June 2 and 3, 2007 edition of the daily, *Le Devoir*. This letter is available on <www.fiqsante.qc.ca>, in the section "*Communiqués de presse*.".

THE SISP CAMPAIGN "PUBLIC HEALTH CARE, I SUPPORT IT!"

From January 30 to February 13, in all regions of Quebec, the members of the organisations which compose the *Secrétariat intersyndical des services publics* (SISP) distributed close to 200,000 flyers. In the context of the presentation of the Castonguay report, this operation was designed to promote a public, accessible and quality health-care system and to make the public aware of the dangers of privatisation.

FEBRUARY 19, 2008 : DISCLOSURE OF THE CASTONGUAY REPORT

Having gathered early in the morning in front of the Quebec City Convention Centre, the SISP greeted Claude Castonguay just before the official presentation of the recommendations contained in his report.

In the afternoon, during a press conference, SISP union leaders commented these recommendations.

Moreover, SISP representatives went to Parliament to present 16,000 postcards signed by the members of the union organizations of the *Secrétariat intersyndical des services publics*.

HAVE YOUR MONEY'S WORTH

On the next day, February 20, Claude Castonguay presented his report to the *Board of Trade of Metropolitain Montreal*. The SISP was deeply shocked by the announcement of this conference, especially since Mr. Castonguay promised the business community that they would have their money's worth!

Thus, a demonstration was organized in front of the hotel where the conference was being held. ■

Activists showed initiative by distributing pamphlets in various busy spots: the entrance of subway stations, arenas during hockey games, shopping centres, etc.

"Public health care, we can't afford to go without it!"

Public solutions are healthy

For nearly two decades, the health and social services system has been called into question from all sides. According to some, privatization is the only solution to the staff shortage, longer waiting lists, and underutilization of infrastructures or equipment. Whether by shifting the delivery of services to the private sector or funding via private insurance, elected officials and business lobbies claim that it's impossible to stop the machine. In fact, there is no political will, and no courage, to stop it.

What about public solutions? What do people have to say who believe that it's possible to maintain a universal, accessible and publicly-funded health and social service system? What do people have to say who believe that this system must respond fairly to the public's health-care needs rather than to the market-driven visions of a certain elite? What do people have to say who believe that a health and social service system must remain public to serve everyone's interest?

On March 15, 2008, the *Fédération interprofessionnelle de la santé du Québec* (FIQ) will participate in a reflection and discussion forum with the aim of proposing public solutions to ensure the sustainability of the Quebec health and social service system.

This day, initiated by the *Coalition Solidarité Santé*, of which the FIQ has been a member for many years, will be held at *Collège de Maisonneuve* in Montreal from 8 a.m. to 5 p.m. Over 300 activists from all backgrounds will be present, including unions and community organizations.

Given the concerted offensive to which the public health-care system is victim and in the wake of the tabling of the Castonguay Report, it is high time to prove that this system is not only viable but effective. This day will rally the forces who still believe in the public health-care system and propose public solutions to convince the elected officials to stop the privatization express train before it's too late. ■

Florence Thomas, consultant
Socio-political Sector

A small contribution to the Solidarity Fund QFL RRSP with each paycheque is all you need to enjoy the simple pleasures of retirement.

Your local representative (LR) can help you enrol in the Fund's RRSP. Ask your union or **Alain Desrochers**, FIQ coordinator at the Fund, for the name of the LR in your workplace.

EXAMPLES OF PAYROLL DEDUCTIONS WITH IMMEDIATE TAX SAVINGS
2008 TAXATION YEAR[1] (26 pay periods)

TAXABLE INCOME FROM	CONTRIBUTION PER PAY	TAX SAVINGS (APPROX.) CREDITS	+ RRSP	NET PAY REDUCTION (APPROX.)	TOTAL INVESTED PER YEAR
$15,000 to $37,500	$40.00	$12.00	$11.56	$16.44	$1,040
	$100.00	$30.00	$28.90	$41.10	$2,600
	$192.31	$57.69	$55.58	$79.04	$5,000
$37,501 to $37,885	$40.00	$12.00	$13.16	$14.84	$1,040
	$100.00	$30.00	$32.90	$37.10	$2,600
	$192.31	$57.69	$63.27	$71.35	$5,000
$37,886 to $75,000	$40.00	$12.00	$15.36	$12.64	$1,040
	$100.00	$30.00	$38.40	$31.60	$2,600
	$192.31	$57.69	$73.85	$60.77	$5,000

[1] Tax rate in effect on January 1, 2008.

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March 8th International Women's Day

The origin of International Women's Day dates back to 1909, when the American Socialist Party organized a demonstration called Women's Day in favour of women's suffrage. In 1911, a first official celebration was held in Germany, Austria, Denmark, Switzerland and the United States, but it was only in 1914 that European women marked the event on March 8.

In Quebec, this day was celebrated for the first time in 1971. At the time, the *Front de libération des femmes* was demanding the right to free abortion on demand, and a Quebec-wide campaign was launched on March 8. Subsequently, women's groups, unions and community organizations ensured that International Women's Day was celebrated each year, just as it is in the rest of the world.

WHY INTERNATIONAL WOMEN'S DAY?
This day is an opportunity to reflect on the situation of women and the means to be used and the actions to be taken so the legal equality becomes equality in fact.

KEY DEMANDS
The theme of International Women's Day 2008 is "The economic autonomy of women: a collective force". Economic autonomy refers to a stable financial position with decent living and working conditions.

This theme is articulated around three main demands:

- Increase the minimum hourly wage to $10.16 to assure everyone of an annual income equivalent to the low-income threshold.
- Increase the number of places in CPE childcare centres and adjust services for workers who have atypical schedules.
- Work/family reconciliation policy to help improve the situation of women on the job market.

Needless to say, a positive response to these demands would contribute to the achievement of the values of equality, justice and freedom, and especially to gender equality. ■

Julie Lejeune, consultant
Status of Women Sector

QUEBEC COALITION AGAINST SEXIST ADVERTISING

The *Coalition nationale contre les publicités sexistes* (CNCPS), a non-profit coalition against sexist advertising, was created recently, but its official launch will only be held in May. This coalition, which conveys values that promote gender equality, aims at eliminating sexist advertising by publicly denouncing it and demanding its withdrawal.

The CNCPS startup committee, of which the FIQ is part, is currently in a recruiting period. Individual membership only costs $10 a year. The form is available at <www.fiqsante.qc.ca/dossiers/conditionFeminine.php>. The Federation invites all its members to join.

PROPOSED AMENDMENT TO THE CHARTER OF HUMAN RIGHTS AND FREEDOMS

Last December, the minister responsible for the Status of Women, Madam Christine St-Pierre, presented Bill 63, *An Act to amend the Charter of human rights and freedoms*, and designed to confirm the importance of the principle of equality between women and men. By way of this bill, the government hopes to respond to the many concerns that have arisen in Quebec society with regard to the respect of equality between women and men in a context of religious plurality and ethnic diversity.

Thus, the notion of equality between women and men will henceforth appear in the 3rd paragraph of the preamble to the *Charter of Human Rights and Freedoms* which reads as follows: *"Whereas respect for the dignity of human beings, equality of women and men, and recognition of their rights and freedoms constitute the foundation of justice, liberty and peace."* A new article is also introduced in the Charter: *"The rights and freedoms set forth in this Charter are guaranteed equally to women and men."*

The *Intersyndicale des femmes*, of which the FIQ is a member, presented a brief in full support of these amendments. For the *Intersyndicale*, the addition of the principle of equality between women and men in the preamble of the Charter reminds governments, public institutions and society in general of the importance of evaluating actions, legislation, programmes and policies from the standpoint of discrimination against women.

The *Intersyndicale* also believes that, though these amendments are one step towards equality between women and men, they must be accompanied by awareness-raising and popular education campaigns in order to be fully effective.

At the time of going to press, the hearings on Bill 63 were not yet completed. ■

The right to abortion is now 20 years old

Twenty years ago, women obtained the right to abortion. On January 28, 1988, the Supreme Court of Canada ruled that Canada's abortion legislation was unconstitutional and therefore nullified it. Since then, Canada has treated abortion like any other medical procedure.

Despite this advance, the right to abortion is still threatened by certain groups. Women still have to struggle and pursue their demands to preserve this right.

ACTUALITÉS
PAGE 9

The more things change, the more they stay the same!

In December 2006, Bill 33 amended the *Act respecting health services and social services*. This bill, which created specialized medical centres (SMC), provides that in addition to hip or knee replacement or cataract extraction, "any other specialized medical treatment determined by regulation of the Minister" may be provided in these centres.

In this context, last November 14, the Charest government published a proposed regulation in the Gazette officielle du Québec. After this publication, the public and the organizations concerned had 30 days to submit their comments. Despite this very short deadline, the FIQ produced an opinion on the subject. The Federation immediately denounced the fact that the *Minister of Health and Social Services* ensured that the public consultations coincided with the holiday period, just as he had done for the adoption under closure of Bill 33 (S.Q. 2006, c.43). In the Federation's view, the Minister and the Quebec government are thwarting the most elementary rules of democracy.

THE OBJECT OF THE PROPOSED REGULATION

The proposed regulation introduces Section 1, providing for all the treatments which must be provided in an SMC unless they are provided in an institution. Thus, Section 1 entrenches two places where specialized medical treatments can be provided: SMCs and institutions, without specifying whether they are public or private, and regardless of whether the public network has the capacity to offer these services. Unreasonable wait times thus no longer justify resorting to the private sector, even though they were the reason for the White Paper on Guaranteeing Access, presented in spring 2006, and Bill 33.

Centralized management of access to specialized and superspecialized services was supposed to standardize the waiting lists and improve their management. Thus, the Minister of Health and Social Services granted the public institutions a two-year deadline to implement this new tool. However, without waiting for the concrete results of this mechanism, and without any justification regarding the existence of unreasonable waiting lists, the government is now rushing to expand the list of treatments that can be provided in an SMC. In this context, the FIQ found the presentation of this proposed regulation to be totally unacceptable. It also appears that the unreasonable delays were used as false pretexts to hide the real objective, which the government could not admit, namely to liberalize the public health-care network.

The FIQ therefore took a position against Bill 33 and cannot support the false objectives it underlies. As it pointed out in its September 2006 brief, *Des cliniques publiques financées publiquement* (Publicly-funded public clinics), the government is opening the door to subcontracting of all ambulatory surgery to the SMCs, even though the Minister had promised that these centres would only be used for excess surgical volume. The recent signing of a contract between *Hôpital du Sacré-Cœur and Centre médical Rockland* MD, on the pretext of increasing accessibility, will deprive the public institution of part of its annual budget, half a million dollars for the six months the agreement will last. Access to care for some could well mean a lack of services for others.

Like its underlying legislation, the FIQ attacked this proposed regulation as unacceptable and called for its withdrawal. ■

Lucie Mercier, consultant
Socio-political Sector

Coming up!

The 52nd Session of the United Nations Commission on the Status of Women was held in New York from February 25 to March 7, 2008, on the theme "Financing for Gender Equality and the Empowerment of Women." Representatives of the Federation attended and a report on the event will be published in the next FIQ en Action.

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ACTUALITÉS
PAGE 10

Return to work of a RREGOP retired employee

Last December, Bill 52 was ratified by the National Assembly . Thus, certain provisions of the *Act respecting the Government and Public Employees Retirement Plan* were modified, in particular regarding the return to work of retired employees.

FORMER PROVISIONS

Before these modification, the law provided for two situations for a retired employee of 65 years who returned to work:

1. Employment occupied before January 1, 1983

When the retired employee had worked in a job covered by the RREGOP before January 1, 1983:

- If she had chosen not to contribute to the RREGOP, she could have cumulated both her pension and her salary;
- If she had chosen to contribute once again to the RREGOP, she could not cumulate her pension and her salary. Her pension annuity was suspended proportionally to the service that was credited*.

However, at the age of 65, regardless of the choice of the retiree, the pension was suspended proportionally to the credited service.

2. Employment occupied after December 31, 1982

When the retiree had occupied for the first time an employment covered by the RREGOP after December 31, 1982:

- She could not cumulate her pension and her salary. She could choose to contribute to the RREGOP once again or not and, in both cases, her pension was suspended proportionally to the service credited or that would have been credited if she had contributed.

At the age of 65, the situation remained the same for the retiree.

SINCE THE DECEMBER 2007 MODIFICATIONS

Since last December, new provisions are in effect and their effect is retroactive to January 1, 2007. Henceforth, a retiree who returns to work, regardless of her age, no longer contributes to the RREGOP and accumulates both her pension and her salary.

Transitional measures

If a retired employee returns to work and she occupied an employment covered by the RREGOP on December 31, 2006 or after this date, one of the following situations applies:

1. Employment occupied before January 1, 1983

Si une retraitée ayant du service avant le
If a retiree who has service before January 1, 1983 had chosen to contribute to the RREGOP once again, she can:

- Remain in this situation until she stops working once again;
- Choose not to contribute by responding to the notice that she will receive from the CARRA within the prescribed deadline. In this case, her participation ceases retroactively to December 31, 2006. The contributions paid will be reimbursed including interests and the pension will be recalculated.

2. Employment occupied after December 31, 1982

If a retiree does have any service before January 1, 1983, or if she is 65 years and more, her participation in the RREGOP ceases and it is cancelled for the year 2007 (if applicable). The contributions paid will be reimbursed with interests and her pension annuity will be recalculated.

CARRA and local teams can provide more information on this subject. ■

Diane Bouchard, consultant
Social Security Sector

* Credited service: period during which the employee contributed, or was exempted from contributing due to disability or a maternity leave..

REASSIGNMENT OF PREGNANT OR BREAST-FEEDING WORKERS (CONT'D)

ACTUALITÉS
PAGE 11

What are my employer's obligations when I submit a protective reassignment certificate and how far can the employer go in terms of reassignment? Does the employer have the right to change my job description, reassign me to another department or assign me to clerical duties? Do I have the right to contest this assignment? What happens if my employer does not offer me an assignment immediately? Will the employer have the right to recall me to work later?

Working women are increasingly aware and informed of the dangers present in their workplace. Sometimes this environment is inappropriate to their state of pregnancy. The work environment in which care professionals operate is stressful and complex. They often have to adopt stressful postures, lift heavy loads, handle various biological and chemical agents, and deal with a difficult and sometimes aggressive clientele.

Previously employers almost systematically withdrew pregnant or breast-feeding workers with a RPTE[1] or RPTA[2] certificate from the workplace. However, a new trend has emerged in the past few years: instead, employers are now reassigning care professionals who exercise their rights under the CSST safe pregnancy program (*Pour une maternité sans danger*). The professional's workstation is now reorganized so that she can stay on the job as long as possible. The staff shortage prevailing in the health and social services network does not seem to be totally unrelated to this phenomenon...

REASSIGNMENT OF A PREGNANT OR BREAST-FEEDING WORKER

Firstly, it is important to remember that an application for protective reassignment of a pregnant or breast-feeding worker is not a request to stop work but an implicit request for assignment to duties that do not involve dangers for the pregnant worker or for the unborn or breast-feeding child. Thus, a worker who furnishes a certificate to her employer that her working conditions may be physically dangerous to her unborn or breast-feeding child, or to herself by reason of her pregnancy, may request reassignment to duties involving no such risks that she is reasonably capable of performing (sections 40 and 46 of the *Act respecting occupational health and safety* (AOHS).

Thus, the employee must obtain a medical certificate from the physician responsible for her institution's health services or from another physician, who must certify that the employee's working conditions involve physical dangers for the unborn or breast-feeding child, or for herself. The production of such a certificate automatically constitutes an application for assignment to duties free of danger, and the employer necessarily must act on it. Otherwise, the professional may stop work and file a claim at the CSST to receive the benefits to which she is entitled.

THE EMPLOYER OFFERS AN ASSIGNMENT

The worker then receives all the benefits of her previous job and may return to this job at the end of her assignment or at the end of the cessation of work.

If the employer offers the pregnant or breast-feeding worker an assignment, she has the right to know what this assignment involves, so that she can evaluate with her physician whether the new duties involve dangers. If new dangers are apprehended or the same dangers are still present, the worker must procure a new protective reassignment certificate from her physician so that the physician considers these new dangers. It is important to mention that the attending physician, and not the employer, has the power to decide on the worker's ability to work.

If the employer reassigns the worker to new duties which she does not believe she is reasonably capable of performing because she does not have the required abilities or aptitudes, or the necessary training, she may contest this assignment following the procedure prescribed in the AOHS. She may also request information from her union team but, most of all, she must never remain in doubt.

Moreover, the employer could assign the pregnant or breast-feeding worker to her own workstation, either by modifying certain duties or by issuing instructions so that she is no longer exposed to dangers. The AOHS does not require an assignment to other duties; the assignment may be considered in compliance with the law if the duties no longer involve the dangers covered by the certificate issued by the worker's physician.

However, a danger-free assignment requires more than personal protective equipment, such as gloves or a mask. For an assignment to be considered suitable, the danger must be completely eliminated from the workstation. Universal measures, even when applied rigorously, contribute to reduce the risks of infection but do not eliminate the danger. Moreover, adequate equipment necessarily must be provided to all workers.

The fact that the worker can request assistance from her colleagues, as needed, depending on their good will or availability, cannot be considered an assignment that eliminates risk, because the risk still remains present.

Finally, sometimes the employer reassigns the care professional to various duties, such as record-keeping, telephone follow-up of patients or development of nursing care and treatment programs. In addition, with the recognition of the nurse clinicians, a nurse holding a university degree could also be called on to perform clinician duties, even if her usual position does not include them.

Whatever the case may be, even if these assignments seem to comply with the AOHS, it is still prudent to obtain your physician's approval. A care professional must not lose sight of the fact that an assignment must never be detrimental to her health and safety, or that of her child.

The employer may recall a pregnant or breast-feeding worker at any time, even after complete withdrawal from work, if there is an available assignment which he can offer her. Unless the new duties involve dangers or she is incapable of performing them, the professional must accept this assignment.

MAJOR DECISIONS THAT RAISE QUESTIONS

In a recent decision (November 2007), the *Commission des lésions professionnelles*, after hearing a contestation by the worker (a nurse) of a decision by the CSST review body concerning her assignment to clinico-administrative duties, ruled that the assignment was in compliance with the AOHS because it did not involve the biological danger apprehended by the worker (risk of cytomegalovirus contamination). In their testimony, the experts argued that the risk of indirect transmission of the cytomegalovirus by cutaneous contact with contaminated objects is possible (handling of files and office equipment), but very negligible, so that it does not constitute a danger within the meaning of Section 40 of the AOHS.

In a second decision (July 2007), the *Commission des lésions professionnelles* concluded that the working conditions of the assignments proposed by the employer (triage room, ambulatory section of the emergency department and trainer in the beds 1 to 7 section) for two nurses were in compliance with the

Risk vs. danger

Notions emerging from the jurisprudence

According to the *Commission des lésions professionnelles*, the notion of "danger" refers to a real threat, while the notion of "risk" refers to a possible but uncertain event.

The right of the pregnant or breast-feeding worker to be reassigned to other duties is linked to the existence of a danger. On several occasions, the court has reminded the parties that it is unnecessary to prove a total absence of danger to maintain a pregnant worker at work. It considers that it must instead ask whether it is likely, in view of the circumstances, that the apprehended danger will occur. The court also points out that it is impossible to eliminate all the risks in a work environment or elsewhere, and that even activities of daily living involve risks.

1 Protective reassignment of the pregnant worker
2 Protective reassignment of the breast-feeding worker

AOHS, because they did not involve physical dangers for the workers or for the unborn child. The court reminded the parties that, even though the elimination of all risks is impossible, the preponderant evidence proved that the risks still present were negligible and did not correspond to the notion of "danger" contemplated in Section 40 AOHS.

Pregnant or breast-feeding care professionals should be aware of this new trend in assignment, which unfortunately leads to new difficulties. Once they exercise their right to protective reassignment of a pregnant or breast-feeding worker and the employer offers an assignment, they will have to be doubly careful and request an exhaustive evaluation of the new duties to ensure the absence of danger.

Finally, faced with decisions regarding reassignment of pregnant or breast-feeding workers, it is essential to remain vigilant, ask questions, be informed, not remain in uncertainty and, more than ever, make representations to the employer to avoid harmful consequences. The care professional has the right to experience her pregnancy under the best possible conditions and avoid risks that are sometimes difficult to suspect. Moreover, the individual nature of the application for protective reassignment of a pregnant or breast-feeding worker means that each case is a special case and must be analyzed from the unique perspective of a worker exercising her right.

After all, pregnant or breast-feeding care professionals need not be the hostages of a network short of resources by being assigned to duties that involve dangers. The FIQ remains very concerned about the health and safety of its members. ■

Marie-Julie Milord, consultant
Occupational Health and Safety Sector

Special measures in the Ottawa Valley region

In June 2007, due to the important workforce shortage that prevailed in the region, a special status was granted to the Ottawa Valley region. Thus, the MSSS allocated nearly 10 million dollars for innovative measures.

NURSING AND CARDIO-RESPIRATORY CARE PERSONNEL
For several years, given the proximity and the working conditions offered, many care professionals from the Ottawa Valley region in Quebec chose to work in Ontario. During the summer and fall 2007, the FIQ and its affiliated unions, the MSSS and regional partners worked to identify measures that would make it possible to solve the problems related to the retention and attraction of personnel.

In this perspective, certain pilot projects were set up at the *CSSS de Gatineau*. Among others:

- Compensation for evening work: the premium was raised from 4% to 12% of the salary;
- Compensation for night work: the premium can reach 18% of the salary depending on the seniority of the employee;
- Setting up of a training programme for nursing assistants, giving them access to the nursing profession;
- Granting of a lumpsum amount for "moving-in" expenses of $3,000 for newly-hired professionals from the outside the region;
- Major recruitment campaign;
- 12-hour schedule with voluntary participation: salary increase of 7%;

Since the introduction of the pilot projects on the arrangement of work time is fairly recent, their impacts cannot yet be assessed. In fall 2008, an evaluation will be carried out by the parties concerned.

Finally, the MSSS explained that these measures could also be introduced in the other health institutions of the region. ■

**A new edition of the *Logbook for pregnant or breast-feeding care professionals* will be available soon.
Copies will be sent to all local teams.**

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