BRIEF

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HEALTH AND SOCIAL SERVICES
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Bill 10: A necessary bill that skips over the essential

FIQ | SECTEUR PRIVÉ

Foreword

The Fédération interprofessionnelle de la santé du Québec–FIQ and the Fédération interprofessionnelle de la santé du Québec | Secteur privé–FIQP represent over 80,000 healthcare professionals in nursing and cardio-respiratory care, which constitutes the majority of nurses, licensed practical nurses, respiratory therapists and clinical perfusionists in Quebec health and social services institutions. The FIQ and FIQP represent healthcare professionals with diverse work experience who provide care across all areas of the health and social services network. The FIQ and FIQP's strong foundation in the health network enriches their expertise, which is valued and recognized by decision-makers from all backgrounds.

As first-hand witnesses of the healthcare system's daily operations, healthcare professionals see the effects of socioeconomic inequality on the population's health, as well as the sometimes deplorable impacts of the decisions made at all levels of the political and hierarchical structure. The FIQ and FIQP are labour organizations with a nearly 90% female membership. Members are both healthcare professionals, public and private network employees, as well as citizens who use these services. Through their orientations and decisions, the FIQ and FIQP strive to protect social gains and to achieve greater equality and social justice.

Driven by their mission, the FIQ and FIQP have always actively participated in consultations that are historically significant for Quebec's health and social services system. Whether it comes to bills that aim to modify its operation or any other relevant topic, the Federations have always worked to defend the interests and concerns of its members and the population.

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Introduction

1

They say it on every platform: healthcare professionals who left the public network for employment agencies were turning to the only option that seemed to be able to give them a bit of a break, better work-family balance, and better salaries, albeit artificially inflated. Above all, they left a ship that has been taking on water for years thanks to budget cuts, a lack of clinical leadership, and defective and dehumanized management. Private agencies providing independent labour capitalized on these gaping, obvious cracks. The deterioration of network employees' working conditions has become a real business opportunity. These companies exploit the distress of healthcare workers. They present themselves as partners or key actors in the health network, when in reality they are just sucking its lifeblood and endangering care continuity by destabilizing work teams. Health institution managers first saw them as a life raft and offered them contracts on silver platters. Then they became dependent on them, eventually prioritizing them to the detriment of their own employees. They are so dependent that now they call on independent labour regardless of the impact on care quality.

At the heart of the issue of independent labour are the healthcare professionals--nurses, licensed practical nurses, respiratory therapists and clinical perfusionists--who stayed in the public network and whose burden has gotten heavier, sometimes at the expense of the care quality they provide or their own health. They accumulate mandatory overtime (MOT), undesirable shifts,[1] forced transfers, work overloads, job title substitution, work on suffering teams and deal with contingency plans. They are in charge of ensuring patient care continuity as the network falls apart.

It is for them that the Fédération interprofessionnelle de la santé du Québec–FIQ is demanding the end of unequal working conditions, demanding the gradual elimination of private healthcare employment agencies. They are the reason why the FIQ has been demanding mechanisms to eradicate independent labour (IL) for over a decade. Mechanisms that could have been included in Bill 10.

However, this is not the bill the Federation has been waiting for. In this brief, the FIQ will explain its profound disappointment in this bill. The Federation will also present the elements that, according to its members, should have been in the bill to make it a truly effective piece of legislation that could have given the government the means to achieve its ambition to eliminate the use of IL.

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[1] By undesirable shifts, the FIQ is referring to evening, night, or weekend shifts or shifts on statutory holidays.

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First, it is crucial to reiterate the reasons why the FIQ insists on abolishing the use of private agencies once and for all, in part by way of a strong and restrictive law.

Recommendation 1

Amend Bill 10 so that it is truly restrictive and provides the groundwork to tackle what should have been at its very essence, i.e., the elimination of the use of IL in the public health network.

Why is the FIQ demanding the elimination of IL?

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It goes without saying that the hiring of IL increased during the COVID-19 pandemic, which explains, in part, the increase in spending on it. But the roots of the IL scourge go back about fifteen years. In 2010, former FIQ president, Régine Laurent, said: "The day-to-day short-sighted management is responsible for the current labour shortage hitting healthcare institutions."[2] Over a decade later, current FIQ president, Julie Bouchard, is denouncing the same situation: "These private companies have always recruited right from the network and then rented out their services to the network for a much higher price, resulting in the network's dependence on this work force. Instead of making life easier for agencies, we must permanently break the vicious circle we are in. Those who are loyal to the network are getting the worst end of the deal, have to do mandatory overtime (...)."[3] Successive governments have caused the public health network to crumble with budget cuts, unfulfilled commitments, structural reforms, concessions to private health companies, and short-sighted budgetary and administrative imperatives, which swung the door wide open for private agencies.

BECAUSE THE USE OF AND PUBLIC SPENDING ON IL KEEPS INCREASING

The proportion of hours worked by IL has gone up by 208% since 2016, while IL hiring costs have skyrocketed by 380% in the same amount of time.[4] In some regions, the situation is even more dire. For example, in Abitibi-Témiscamingue, agency workers currently make up 16.2% of the workforce when it only constituted 2.3% of the workforce in 2016.[5] As regards public spending, the figures are even more revealing: in six years, the government spent 3 billion dollars on the services of private agencies,[6] nearly 2 billion dollars of which has been spent since 2020. It is clear that this practice is both detrimental for the healthy administration of public funds, as well as for

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[2] Maude MESSIER. « Un recours systématique aux agences privées d'infirmières ». *L'Autre journal*, 2010, [Online, French], [https://lautjournal.info/articles-mensuels/287/un-recours-systematique-aux-agences-privees-dinfirmieres].

[3] Éric DESCHENE. « Réseau de la santé : la FIQ veut que Québec mette en place des mesures pour soutenir ses membres ». *Journal de Lévis*, July 14, 2022, [Online, French], [https://journaldelevis.com/1067/Politique_.html?id=103886].

[4] Fanny LÉVESQUE. « Québec veut abolir le recours aux agences privées d'ici 2026 ». *La Presse*, February 15, 2023, [Online, French], [https://www.lapresse.ca/actualites/sante/2023-02-15/main-d-oeuvre-independante/quebec-veut-abolir-le-recours-aux-agences-privees-d-ici-2026.php].

[5] Thomas GERBET and Daniel BOILY. « Québec a dépensé 3 milliards $ dans les agences privées de santé en 6 ans ». *Radio-Canada*, February 14, 2023, [Online, French], [https://ici.radio-canada.ca/nouvelle/1956130/agences-placement-privees-sante-quebec-ftq-projet-loi-dube].

[6] *Ibid.*

the human resources management in the public health network. In 2020, public network institutions' spending on IL was equal to 28.9% of employment agencies' total revenue.[7] Given the institutions' growing dependence on their services, agencies clearly seized the business opportunity and significantly increased their prices. Consequently, it has been shown that the hourly cost of independent labour went up much faster than that of employees in the public network.[8] This inequality is not however limited to salary increases. It also directly affects healthcare professionals' working conditions. The FIQ's healthcare professional members are very angry about this injustice.

BECAUSE THE WORKING CONDITIONS OFFERED TO AGENCY HEALTHCARE PROFESSIONALS ARE UNJUST COMPARED TO THOSE OFFERED IN THE PUBLIC NETWORK AND SUBSEQUENTLY ENCOURAGE THE EXODUS OF PUBLIC NETWORK EMPLOYEES

How can an employer explain having a healthcare professional leave a job in the public healthcare network only to return and practice there with a higher salary, exempt from the inconveniences their colleagues who remained in the public network have to endure? This unacceptable situation is a daily occurrence in the health network. For several years, healthcare professionals from agencies have had to do very little mandatory overtime (MOT) unlike network employees who are forced to do it or face disciplinary measures or sanctions. Agency workers also get total control over their schedule, while FIQ members have to cover required evening, night and weekend shifts in addition to being stuck with schedules that are not posted in advance and are often changed at the last minute. Managers also frequently refuse FIQ members' requests for days off or vacations. During the pandemic, agency staff was even able to refuse to work in hot zones while health and social services network (RSSS) professionals were subject to decrees that denied their rights, which are stated in the collective agreement. Still today, agency workers frequently obtain attractive shifts while public network employees have to fill in gaps on undesirable shifts.

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[7] Anne PLOURDE. *Les agences de placement comme vecteurs centraux de la privatisation des services de soutien à domicile*, Institut de recherche et d'information socioéconomiques, January 2022., p. 1.

[8] Anne PLOURDE. *Les agences de placement comme vecteurs centraux de la privatisation des services de soutien à domicile,* Institut de recherche et d'information socioéconomiques, January 2022., p. 10.

TO COUNTER THE EXODUS OF WORKERS TO PRIVATE HEALTHCARE COMPANIES

How can an employer facing a shortage of qualified, experienced labour let a situation that is accelerating the exodus of its own staff continue? The wheel just keeps turning, causing an increase in the number of MOT shifts, the non-replacement of members on care teams, the work overload and job-title substitution. It should therefore come as no surprise that healthcare professionals are thinking about leaving the network because it doesn't show recognition for their true value.

That said, the healthcare professional "shortage" that network managers and the government like to talk about to justify the use of IL is not the root cause of the disproportionate growth of agencies. As the Institut de recherche et d'informations socioéconomique points out: "Network institutions are massively turning to IL because the workforce exists; it just isn't employed by the RSSS."[9] Since the nurse and cardio-respiratory workforce pool is limited, healthcare professionals who work for agencies or private companies are not employed by the public network. The government continues to favour the relocation of public network activities to the private sector, which promotes the exodus of healthcare professionals. Just think of family medicine groups (FMG) (which replaced CLSCs as a point of access to front-line care), the 29 contracts granted to specialized medical clinics (SMC) to perform surgeries, and the upcoming building of private mini hospitals, while the plans to modernize the Maisonneuve-Rosemont hospital are being sabotaged, even though it is in dire need of increased hospital capacity. When the government is spending public money in the private sector rather than on giving its own staff better salaries and good working conditions, it cannot be surprised that people are deserting it for the private sector. Clearly, healthcare "business partners" have become the health network's "competitors" for recruiting labour. It is up to the government to set up strong measures to stop this hemorrhaging and redirect investments and the workforce to the heart of our healthcare system, the public network.

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[9] Anne PLOURDE. *Les agences de placement comme vecteurs centraux de la privatisation des services de soutien à domicile*, Institut de recherche et d'information socioéconomiques, January 2022, p. 12.

BECAUSE HIRING IL DESTABILIZES THE ORGANIZATION OF WORK AND CARE CONTINUITY

IL has many potentially harmful effects on the quality of care and they deserve to be highlighted. While professionals working for employment agencies have the same healthcare skills as those working for the RSSS, hiring IL has impacts on the organization of work and provision of care. Hiring IL means that new healthcare professionals are constantly arriving. Because new workers do not know the team, processes or workplace, they are less efficient than their experienced colleagues. This is true in all sectors of activity and in all settings, including in health care, which can affect the quality of care.

However, the main way IL is causing a deterioration in the RSSS's care quality is by disrupting its care continuity. Care continuity is a key way positive results are obtained in health care.[10] Conversely, the discontinuity of care creates complications and a deterioration in patients' health conditions.[11]

"Continuity of care addresses 'the extent to which healthcare for specified users, over time, is smoothly organised within and across providers, institutions and regions, and to which extent the entire disease trajectory is covered.'"[12] As such, care continuity is particularly critical when there are multiple requirements that stretch out over a long period and must be provided by an interdisciplinary team.[13] The care provided in RSSS institutions usually meets all of these criteria. As such, it is crucial for the RSSS to do what is necessary to ensure the continuity of care and nursing administrations must pay attention to the impacts of hiring IL on care continuity. When they don't, it puts care quality at risk.

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[10] THE COLLEGE OF FAMILY PHYSICIANS OF CANADA. 2021, *The Value of Continuity—Investment in Primary Care Saves Costs and Improves Lives* [Online], [https://www.cfpc.ca/CFPC/media/Resources/Health-Care-Delivery/Continuity-of-Care-one-pager-ENG-Final.pdf] (Consulted on February 21, 2023).

[11] OIIQ. 2014, *Optimiser la contribution des infirmières et infirmiers pour améliorer l'accès aux soins, assurer la qualité et la sécurité des soins et contrôler les coûts*. Presented as part of the work of the Commission de révision permanente des programmes on October 21, 2014.

[12] FOR A HEALTHY BELGIUM. No date, *Continuity of care* [Online], [https://www.healthybelgium.be/en/health-system-performance-assessment/quality-of-care/continuity-of-care] (Consulted on February 24, 2023).

[13] CHU SAINTE-JUSTINE. Comité de bioéthique, 2010, *La continuité des soins : une responsabilité collective : avis du comité bioéthique du CHU Sainte-Justine*. Éditions du CHU Sainte-Justine. [Online, French], [https://www.chusj.org/CORPO/files/d7/d7a0e8c1-a189-45b7-957b-757525978033.pdf] (Consulted on February 22, 2023).

How does IL disrupt the continuity of care in the RSSS? First, IL is an additional actor that must be integrated into the complex chain of care provision. Its integration does not add to the quality of care, unlike interprofessional teamwork. The integration effort is significant given the proportion of IL workers in RSSS institutions and some centres of activities. A current overview drawn up by over 32 unions,[14] and covering almost all Quebec institutions, shows that some centres of activities have reached substantial levels of dependence on IL, sometimes accounting for as much as 80% of the resources necessary for required patient care.

Care continuity requires that professionals communicate with each other.[15] They have to pass on relevant information to the other professionals during their shifts. They must also pass on information to professionals who will take over after their shift.[16] These professionals must review and understand the information communicated at the beginning of their shift. IL often brings people who do not know the institutions they are working in. They aren't very familiar with the setting, organization of work (e.g., access codes for places and materials, each person's role and the guidelines to follow), the other workers, patients, etc. The agency professional will pass on information they don't know well to professionals they barely know. This does not support care continuity. Nothing can compensate for experience and good knowledge of a care setting.

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[14] FIQ internal research.

[15] CHU SAINTE-JUSTINE. Comité de bioéthique, 2010, *La continuité des soins : une responsabilité collective : avis du comité bioéthique du CHU Sainte-Justine.* Éditions du CHU Sainte-Justine. [Online, French], [https://www.chusj.org/CORPO/files/d7/d7a0e8c1-a189-45b7-957b-757525978033.pdf] (Consulted on February 22, 2023).

[16] Myriam BRISSON, Éric ROY, Martine GAGNÉ and Martin SIMARD. 2022*, Assurer la continuité des soins : une question de sécurité* ! [Online, French], [https://www.oiiq.org/assurer-la-continuite-des-soins-une-question-de-securite#:~:text=L'infirmi%C3%A8re%20qui%20exerce%20dans,professionnels%20qui%20prendront%20sa%20rel%C3%A8ve] (Consulted on February 24, 2023).

Moreover, the inquiry report aimed at evaluating the aspects that ensure the quality of medical and nursing services at the Institut universitaire de gériatrie de Montréal (IUGM) and at the Herron CHSLD during the first wave of COVID-19 revealed that the care continuity was "clearly compromised" due to the incomplete transmission of information by personnel 'who had no knowledge of the setting and clients.'"[17] Although the Herron CHSLD is a private CHSLD that is not under agreement, the problems observed in this inquiry also apply to the RSSS institutions. Agency professionals do not know the setting or the patients. As such, passing on information requires more time and the information is misunderstood by the agency personnel, which compromises care continuity.

Collaboration between professionals is also essential to care continuity.[18] As such, hiring IL generates iniquity that hinders collaboration and, in turn, care continuity. When an institution calls on agency personnel, it risks bringing in professionals who perform the same tasks but for different pay. According to the same inquiry report on the first COVID-19 wave, the salary iniquity between agency workers and CHSLD employees reduced the cooperation between workers.[19] This probably contributed to the poor care continuity observed. Several studies have shown that whenever continuity fails, collaboration is almost always at the root of it.[20]

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[17] COLLÈGE DES MÉDECINS DU QUÉBEC, OIIQ, and OIIAQ. January 2021, *Rapport d'enquête sur la qualité des services médicaux et des soins infirmiers au CHSLD Herron et à l'institut de Montréal durant la première vague de la pandémie de COVID-19*, p. 45.

[18] CHU SAINTE-JUSTINE Comité de bioéthique. 2010, *La continuité des soins : une responsabilité collective : avis du comité bioéthique du CHU Sainte-Justine*. Éditions du CHU Sainte-Justine. [Online, French], [https://www.chusj.org/CORPO/files/d7/d7a0e8c1-a189-45b7-957b-757525978033.pdf] (Consulted on February 22, 2023).

[19] COLLÈGE DES MÉDECINS DU QUÉBEC, OIIQ, and OIIAQ. January 2021, *Rapport d'enquête sur la qualité des services médicaux et des soins infirmiers au CHSLD Herron et à l'institut de Montréal durant la première vague de la pandémie de COVID-19*.

[20] Michèle CLÉMENT and Denise AUBÉ. 2002, *Continuity of care: a solution? Perspective of people with dual disorders* (French). Santé mentale Québec. Volume 27, number 2. Pages 180 to 197.

Team stability is inherent to care continuity.[21] And staff instability hinders this continuity. Unfortunately, the RSSS treats professionals, especially IL, as interchangeable workers. Any skilled professional would have a hard time practicing according to professional standards in an unstable environment. The "catastrophic effects of the very high employee turnover rate on the quality of care" were highlighted in an inquiry report on the quality of medical and nursing services during the first wave of COVID-19.[22]

While it may be possible for the same agency professionals to work in the same units of care, it would require RSSS managers to make a coordination effort that is far from guaranteed. In many RSSS institutions, the IL turnover rate is so high that the agency healthcare professionals change every day. This destabilizes regular work teams. Orienting and training IL workers adds to network employees' workload and fatigue on almost every shift. The care teams have to adapt and change how the care is organized based on the fact that some of the IL resources will only be present for one or a few shifts.

Moreover, the hiring of IL in some institutions triggered an increase in staff turnover due to the salary iniquity between the agency and institution personnel. The inquiry report on the first wave of the pandemic[23] showed that certain groups of beneficiary attendants discouraged newly hired people regarding their salary. Several employees called in sick on weekends in order to work elsewhere, which generated high staff unavailability.

For these reasons, the inquiry report made the following recommendation:

"(...) that the DON [directors of nursing] and the SAPA [Support Program for the Autonomy of Seniors] program director take the necessary measures to

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[21] Michèle CLÉMENT and Denise AUBÉ. 2002, *Continuity of care: a solution? Perspective of people with dual disorders* (French). Santé mentale Québec. Volume 27, number 2. Pages 180 to 197.

[22] COLLÈGE DES MÉDECINS DU QUÉBEC, OIIQ, and OIIAQ. Janvier 2021, *Rapport d'enquête sur la qualité des services médicaux et des soins infirmiers au CHSLD Herron et à l'institut de Montréal durant la première vague de la pandémie de COVID-19,* p. 45.

[23] COLLÈGE DES MÉDECINS DU QUÉBEC, OIIQ, and OIIAQ. Janvier 2021, *Rapport d'enquête sur la qualité des services médicaux et des soins infirmiers au CHSLD Herron et à l'institut de Montréal durant la première vague de la pandémie de COVID-19.* p. 20 and 70.

ensure the stability of care team members in the two institutions targeted by the inquiry."[24] (unofficial translation)

In light of this finding, the RSSS should eliminate the hiring of IL with a strong and restrictive bill since it destabilizes its staff. It should be an urgent priority for clinic management teams, including directors of nursing, all across Quebec. They should be held accountable for eliminating it, in collaboration with the MSSS provincial nursing care and services administration.

Recommendation 2

Because the very operation of employment agencies destabilizes the organization of work, team stability, and consequently the continuity of care, the FIQ recommends that Bill 10 stipulate that institutions' nursing administrations be responsible and held accountable for eliminating the use of private healthcare agencies in collaboration with the provincial nursing care and services administration and the entire MSSS.

[24] COLLÈGE DES MÉDECINS DU QUÉBEC, OIIQ, and OIIAQ. January 2021, *Rapport d'enquête sur la qualité des services médicaux et des soins infirmiers au CHSLD Herron et à l'institut de Montréal durant la première vague de la pandémie de COVID-19*. p. 20 and 70.

Bill 10: the government traded firmness for flexibility

In December 2022, the government updated a pamphlet intended for network managers, inviting them to, in particular, limit the use of IL and to present bi-monthly reports to the ministry to demonstrate their good faith. This first step was a result of a commitment made in the last provincial negotiations with the goal of continuing to reduce the hiring of IL. This pamphlet, dating back to 2011, had already been updated a few times without making a significant impact on the use of IL. In parallel, the Ministry of Health and Social Services (MSSS) recently launched a call for tenders aimed at putting certain limits on private agencies, to reduce the iniquity between the network personnel's and the agency personnel's working conditions. The FIQ took note of these first steps. Unfortunately, these two actions had little impact in the field. The pamphlet does not include any sanctions for non-compliant managers and does not impose the MSSS's vision. As for the call for tenders, it has been suspended because agencies have challenged it in court because they are upset at the prospect of having their room to manoeuvre and profit margin limited.[25] There was also a complaint filed over the same call for tenders with the Autorité des marchés publics earlier this year. This situation proves that as long as there are private agencies, they will contest any attempts to impose limits on them. That is why it is important that the bill aim to eliminate IL in the public network and not just limit it.

THE INTENTION OF THE BILL: TO LIMIT, NOT ELIMINATE

For the Federation, which is demanding the progressive elimination of IL, the objective of Bill 10 is not ambitious enough. "Limiting" the use of IL lacks boldness and determination. As for any product in a market, the demand for independent labour varies based on several contextual, societal, political, economic and demographic variables. In 2011, the pamphlet to limit the use of IL managed to reduce it by over 11% in two years.[26] However, because the objective was not to eliminate but only limit IL, this pamphlet's impact was short lived. As soon as the opportunity arose, i.e., when healthcare professionals left the network because of their intolerable working

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[25] Fanny LÉVESQUE, *Un appel d'offres d'envergure suspendu,* La Presse, January 19, 2023, [Online, French], [https://www.lapresse.ca/actualites/politique/2023-01-19/main-d-oeuvre-independante/un-appel-d-offres-d-envergure-suspendu.php]. And Louise LEDUC, *Les agences privées de placement gagnent une manche contre Québec*, La Presse, March 8, 2023, [Online, French], [https://www.lapresse.ca/actualites/sante/2023-03-08/cour-superieure/les-agences-privees-de-placement-gagnent-une-manche-contre-quebec.php]

[26] Sara CHAMPAGNE, *Diminution du recours aux infirmières d'agences privées.* La Presse. December 6, 2012, [Online], [https://www.lapresse.ca/actualites/sante/201211/30/01-4599287-diminution-du-recours-aux-infirmieres-dagences-privees.php].

conditions, private agencies took over the market once again. The Ordre des infirmières et infirmiers du Québec's numbers are clear on this: "The proportion of members whose main employment was through an agency had been declining since 2012-2013, but has been increasing again since 2020-2021. In 2021-2022, it reached a level similar to that in 2012-2013."[27] The rise in this trend has been evident for a few years and is not solely due to the pandemic.

So, if the government's goal is truly to cut the public network off from IL, then the bill must not stop at limiting it, but work to eliminate it completely. Otherwise, this situation is likely to just repeat itself endlessly. Especially since the government chose a regulatory route rather than a legislative one to introduce this change. As soon as the public network is vulnerable, it will be child's play for agencies to rewrite the rules to their advantage with no legislative restrictions.

Recommendation 3

The FIQ recommends changing the intention of Bill 10 so it aims to progressively and clearly eliminate IL in the public healthcare network and not merely limit it.

CHOOSING THE REGULATORY ROUTE OVER THE LEGISLATIVE ONE

The FIQ believes that the government should have included clear guidelines in the bill (rather than reserving them for a regulation) in order to counter the response of the private agencies. To enable the government to reach its objective to wean the public health network off of IL, the bill should not only have sent a strong message but also included guarantees.

The government clearly had leeway to include certain limits in the bill, but it preferred to take the regulatory route. It isn't hiding the fact that it developed a taste for the latitude acquired during the pandemic when it was governing by decree. Putting a limiting framework for IL in a regulation allows the government to modify it without consultation, opposition or debate with opposition parties and civil society, including unions. Operating by regulation no doubt gives the government greater flexibility and prevents it from having

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[27] OIIQ. *Rapport statistique sur l'effectif infirmier et la relève infirmière du Québec.* 2020-2021, p. 25, [Online, French], [https://www.oiiq.org/documents/20147/13882675/Rapport_statistique_2021-2022-1.pdf].

to go through a more transparent, democratic process, which is essential when dealing with an issue that has as many impacts on the health network.

Simply writing limits in a regulation means they can be changed based on the political interests of the day. Consequently, by not making any legally binding constraints, we cannot tackle IL over the long term in the RSSS.

As such, Bill 10 is leaving out the essential and staying silent on the nature of the requirements imposed on independent labour agencies as well as the maximum length of the transition period that should, ultimately, lead to their elimination. The Health Minister clearly stated that this strategy was deliberate because it offers more flexibility for implementing its plan. Unfortunately, these objectives are not included in this bill, which means we do not get to debate the matter.

As the representative body for over 80,000 nurses, licensed practical nurses, respiratory therapists and clinical perfusionists, the FIQ likely understands better than anyone the impact that progressively cutting off IL will have on care professionals' workload and the network's organization, particularly in regions that are highly dependent on IL, such as Abitibi-Témiscamingue and Bas-Saint-Laurent. The FIQ believes that agencies should be eliminated progressively to limit the negative impacts on healthcare professionals and patients, especially in the most affected regions. That said, the FIQ firmly believes that there should have been strong, clear guidelines for its progressive elimination in the bill.

Bill 10 doesn't include the guidelines or standards that institutions should follow before turning to IL (imposition of MOT and undesirable shifts, maximum rate, deadline, etc.). The fast deadline that the government bragged about in the press conference is not included in the bill. It also does not define the different regional categories (urban settings, adjoining sectors, remote sectors). As such, these are just good intentions and nothing more.

Recommendation 4

The FIQ recommends that all guidelines necessary to progressively eliminate IL (annual targets for IL hiring, deadlines, regional category definitions, basic criteria for government calls for tenders) be included in Bill 10 and not in a later regulation. This modification is essential to ensuring that Bill 10 truly guarantee the progressive elimination of IL.

CONDITIONS THAT ENSURE THE SAFETY AND CONTINUITY OF CARE

Even though hiring IL alters the safety and continuity of care, the bill does not stipulate any specific conditions to ensure care quality. As a reminder, Section 5 of the *Act Respecting Health Services and Social Services* (AHRSSS) includes the right to care continuity:

"Every person is entitled to receive, with continuity and in a personalized and safe manner, health services and social services which are scientifically, humanly and socially appropriate."[28]

Despite this obligation, management decisions impact care, which doesn't always seem to be taken into account. Nurses, licensed practical nurses, respiratory therapists and clinical perfusionists have always said that the staff is not interchangeable and that the decisions made in the RSSS should always be based on the impacts on patients and healthcare professionals.

The removal of IL must focus on the quality, safety and continuity of care. This is an extremely important responsibility that falls to the directors of nursing and other clinic directors. Healthcare professionals' working conditions and practice must also be respected throughout the transition period for eliminating IL.

Recommendation 5

The FIQ recommends that Bill 10 include conditions and criteria to ensure the right of patients to receive safe, quality, humane care during the transition period leading to the elimination of IL in the public healthcare network.

RIGOROUS WORKFORCE PLANNING

The RSSS's current dependence on IL can be traced back to management decisions made in recent years. Last-minute resource planning that makes it impossible to have sufficient staff to face the typical unforeseen events in

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[28] ACT RESPECTING HEALTH SERVICES AND SOCIAL SERVICES. Chapter S-4.2. Légis Québec. [Online], [https://www.legisquebec.gouv.qc.ca/fr/document/lc/S-5?langCont=en#se:4] (Consulted on February 24, 2023).

health care[29] and the lack of attention given to workforce planning are the main culprits. Workforce planning allows you to determine future needs, taking into account all the factors, including the sociodemographic variable. Therefore, the FIQ recommends that rigorous workforce planning be done continuously at the local and provincial level, as often as needed to eliminate the hiring of IL. Without adequate staff planning, it is impossible to use the proper strategies to ensure the right number of required professionals throughout the RSSS.

Unfortunately, the last large-scale provincial workforce planning exercises for healthcare professionals, done jointly and transparently, date back to the early 2000s[30] when the RSSS and population's healthcare needs were very different. Useful workforce planning must go beyond the basics and avoid having groups working in silos that exclude labour organizations. Unfortunately, these are the avenues that the Ministry of Health and Social Services seems to currently recommend.

For over 20 years now, the scientific literature has been unanimous: sufficient and stable care teams are necessary for the safety of patients and healthcare professionals. What's more, the Organisation for Economic Co-operation and Development (OECD), following the COVID-19 pandemic, empasized the importance of investing substantial resources in the promotion of staff attraction and retention.[31]

Recommendation 6

The FIQ recommends that Bill 10 include an ongoing workforce planning process to ensure sufficient staff to provide the public health network's service offer without hiring IL.

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[29] Louis GUERTIN. 2021, *Splendeurs et misères du temps supplémentaire obligatoire.* CAIJ, Volume 492 — Recent developments in labour law.

[30] Examples of such exercises include the Forum national sur la planification de la main-d'œuvre infirmière and the Groupe de travail sur la planification de la main-d'œuvre infirmiers et infirmières auxiliaires. Their reports were submitted in 2001.

[31] ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT. 2023, *Ready for the Next Crisis? Investing in Health System Resilience.*

THE END OF INIQUITIES

The FIQ believes that Bill 10 should include government measures to put an end to the iniquities between the working conditions of nurses, licensed practical nurses, respiratory therapists and clinical perfusionists in the public network and those of agency personnel until the hiring of IL has completely stopped. For example, **the FIQ believes it is unacceptable that a network employee would be transferred or have their schedule changed because agency personnel refuses to work undesirable shifts or to work in certain centres of activities.**

These measures should ensure that RSSS employees are prioritized and the hiring of IL is a last-resort solution.

Recommendation 7

The FIQ recommends that the following measures be included in Bill 10 during the transition period leading up to the full elimination of IL:

- **That institutions only grant occasional assignments to private agency professionals in order to prioritize granting extended assignments to public network healthcare professionals when they are available;**
- **To avoid transferring network healthcare professionals or changing their schedules, and that institutions fill the need by transferring or hiring a private agency healthcare professional who meets the position's requirements and/or by changing their schedule;**
- **That the institutions' nursing administrations, in collaboration with the provincial nursing care and services directors, take concrete measures so that the inconveniences and burden of ensuring the follow-up of care are equitably shared by network healthcare professionals and agency healthcare professionals since they work on the same teams, under the same control and supervision;**

- To reduce the rates that agencies can charge as much as possible and to prohibit agencies from charging for overtime done by the employees it assigns at the rate of time and a half;[32]
- When there are desirable and undesirable shifts to fill, that institutions be obliged to prioritize their staff for the desirable shifts;
- That the Ministry of Health and Social Services impose restrictive measures and penalties on agencies that do not follow the rules and/or that use pressure tactics, like threatening to withdraw their resources from institutions in an attempt to be exempt from the rules;
- That the Committee on Health and Social Services be given a temporary mandate to evaluate the impacts of independent labour on the remuneration of government employees and on patients and the quality of care with the elimination of IL as the main objective. This mandate should culminate with a proposed process to set the maximum rate agencies can charge to maintain balance in the placement of permanent staff within the healthcare institutions. The Committee should submit a report on this.[33]

DECREASE AGENCIES' CAPACITY TO RECRUIT

Since 2011, the measures intended to restrict agencies from approaching and recruiting RSSS healthcare professionals did not achieve the hoped-for results. Far too often, the rules were not followed.[34]

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[32] It is understood that the employee is entitled to be paid at time and a half for the overtime done.

[33] A similar law was adopted in March 2022 in Oregon, U.S., which will take full effect in July 2023 and in Connecticut, U.S. See: [Online], [https://olis.oregonlegislature.gov/liz/2022R1/Downloads/MeasureDocument/SB1549/Enrolled].

[34] In compliance with the pamphlet from 2011, it was prohibited to work in the same region if the person had a job with the regional institution. Therefore, an employee who had a job in a Montreal institution could be assigned through an agency in the Laurentians, Lanaudière, Laval and/or Montérégie. The pamphlet was then updated in 2021. It is now prohibited to assign an employee in the region through an agency if the employee is already employed by an RSSS institution. Even the stricter rules adopted by order have been difficult to apply.

That is why the FIQ believes that Bill 10 must explicitly stipulate the measures to reduce the agencies' ability to recruit healthcare professionals from the public network until IL has been completely eliminated.

Recommendation 8

The FIQ recommends that Bill 10 prohibit employment agencies from assigning a healthcare professional who is already employed by a public institution, or who left this employment within less than one (1) year, in the same or an adjacent administrative region.

ADOPTING AN ACTION PLAN AND IMPLEMENTING MONITORING AND FOLLOW-UP MEASURES

To eliminate IL in the RSSS, it is essential that each institution come up with an action plan tailored to its situation, its level of dependence on IL, and its targets. One of the guiding principles for institutions undergoing this transition is to ensure the follow-up, continuity and quality of health care. They must also ensure that the appropriate monitoring and follow-up mechanisms are in place.

Right now, the IL hiring rate is one of the health and social services management indicators, but decision-makers are interested in global data related to all the hours worked in the institution.[35] The institutions' annual reports mention this, but the information contains few details and is incomplete.

The hiring of IL doesn't seem to elicit a reaction from decision-makers at the clinical level either. And yet, expert organizations like the United Kingdom's National Institute for Health and Care Excellence recommends evaluating the level of dependence on temporary staff as one of the care safety indicators to monitor.[36]

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[35] MINISTRY OF HEALTH AND SOCIAL SERVICES. *Répertoire des indicateurs de gestion en santé et services sociaux.* 2022, [Online, French], [https://msss.gouv.qc.ca/repertoires/indicateurs-gestion/indicateur-000055/?&txt=ind%C3%A9pendante&msss_valpub&date=DESC].

[36] NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE. 2014, *Safe staffing for nursing in adult inpatient wards in acute hospitals.*

Recommendation 9

The FIQ recommends for the transition period leading up to the full elimination of IL that Bill 10 stipulate:

- That each institution is obligated to submit an action plan to the Health Minister for approval that is adapted to the reality of its situation to put an end to the hiring of IL by the deadlines set out in the law;
- To adopt much more detailed management indicators for the hiring of IL (e.g., by facility, job title, centre of activities, shift, etc.);
- That each institution is obligated to publicly post and update monthly data related to IL to ensure that the rules, timelines set out in the law, and action plans are followed;
- That each nursing administration and other concerned clinical administration is obligated to take action and immediately take measures to comply with the action plan when there is a high rate of IL use in certain clinical settings or has been for a sustained period;
- That the ministry and provincial directors of nursing care and services, as well as the concerned professional orders, automatically intervene when the hiring of IL exceeds the targets or remains steady despite the deadlines;
- The obligation to implement measures to mitigate the potentially negative effects of IL on the quality of care, such as prohibiting job-title substitution and setting up communication mechanisms to facilitate the reports between shifts.

Given certain institutions' level of dependence on IL, combined with heightened attraction and retention problems in regions like Abitibi-Témiscamingue, it is clear that some institutions will have more difficulty eliminating IL from their facilities.

That is why the FIQ proposes the following measures, in addition to those mentioned above, to reach the goal of eliminating IL in the RSSS.

MEASURES TO ENSURE INSTITUTIONS COMPLY WITH THE OBJECTIVE TO ELIMINATE IL

Up until now, it is apparent that the government has been unable to get institutions to follow the rules to limit the use of IL. Consequently, stronger measures are required to ensure the guidelines, targets and rules are adopted.

We have seen that tolerating and letting agencies grow has led to a parallel set of working conditions that can significantly hinder the retention of employees in the RSSS. The salary gaps and differences in the schedules were so flagrant during the pandemic that the government attempted to set out guidelines via ministerial order to correct the situation.[37]

Nonetheless, certain institutions that are now dependent on employment agencies let agencies dictate the rules and not the government.

The FIQ would like to mention that the penal provisions in Bill 10 that include fines for non-compliance with the law or regulations are a step in the right direction.

Recommendation 10

Until IL is completely eliminated, the FIQ recommends:

- Stipulating that the fines imposed be used to fund the creation of stable positions, professional development, and the improvement of working conditions in the RSSS;
- Obliging institutions to comply with the corrective measures announced by the MSSS;
- Sanctioning whoever uses tactics to pressure an RSSS institution or manager or who threatens to withdraw resources in an attempt to violate or bypass the rules set out in the law or regulations.

[37] However, not all agencies follow these regulations and institutions admitted that they were unable to follow the rate ceilings because they couldn’t find staff that would work in those conditions.

MEASURES TO STRENGTHEN MONITORING AND ENFORCEMENT

Institutions are not using employment agencies' services because of their nursing care expertise. They use them because they provide professionals who have the necessary expertise that can be integrated into a care team.

In hospitals and CHSLDs, the only authorities who monitor and control the care provided in workplaces are the institution and DON. The agencies do not have access to the workplaces, to the patient files, or to the workplace's professionals. When an institution integrates IL into its care teams, it isn't delegating its mission, its role or its responsibilities in terms of the performance, quality or continuity of the care provided in its facilities. It is the only one responsible.

Nonetheless, too often we witness managers and nursing administrations sidestep responsibility when it comes to this temporary workforce, which is always there in reality.

The institution is the one that is accountable for the care provided in its facilities, and as such, it is essential that it immediately carry out the monitoring and control required for all of the personnel on its care teams.

Recommendation 11

The FIQ recommends that Bill 10 specify the accountability and responsibility of institution managers regarding all of the personnel that makes up the care teams and that it strengthen the control and monitoring of personnel and care quality in its facilities until IL is completely eliminated in the public network.

Conclusion

The Health Minister is hard at work on his health plan. As regards the elimination of IL, Bill 10 should have been the cornerstone of this effort. However, for all the reasons previously stated, it is nothing but an empty shell, intentions without a solid foundation, lacking a clear objective and timeline.

Even though ultimately the goal behind ceasing the use of IL is to bring agency workers back to the public healthcare network, the government should first achieve another top objective in the health plan: make the healthcare network an employer of choice. As such, FIQ members' working and salary conditions will have to be improved through the negotiation process. It would be risky for the government to mix the two very separate processes. It is the government's responsibility to take action for the common good by putting an end to the disloyal, commercial practice of private healthcare agencies, which costs a lot in public funds, and by making the informed choice to invest more in the public healthcare network.

For years, the FIQ has wanted to set up winning conditions for healthcare professionals. It promotes its solutions on all available platforms, including in provincial negotiations. The various recommendations stem from an extensive reflection on the future of the public health and social services network as well as on the real and sustainable improvement of healthcare professionals' working conditions. Our demands are legitimate and it would be inappropriate to place the blame for the government's failure to eliminate IL on our labour organization. Bill 10 is a governmental bill and it is up to the government to make it work.

However, improving the attraction and retention of healthcare professionals in the public network will require more than the elimination of IL. While we count 2,400 nurses working for private agencies out of the 82,271 nurses registered on the Ordre des infirmières et infirmiers du Québec's table for 2021-2022[38] (i.e., 3%), over 9% of nurses work in the private sector, including all employers.[39],[40] So, eliminating agencies without improving salaries, reducing workloads, or ensuring work-family balance, along with continuing to organize healthcare professionals' work with the false belief that they are interchangeable, will only push these healthcare professionals toward other

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[38] OIIQ. *Rapport statistique sur l'effectif infirmier et la relève infirmière du Québec*. 2021-2022, p. 19. [Online, French], [https://www.oiiq.org/documents/20147/13882675/Rapport_statistique_2021-2022-1.pdf].

[39] OIIQ. *Rapport statistique sur l'effectif infirmier et la relève infirmière du Québec*. 2020-2021, p. 25. [Online, French],[https://www.oiiq.org/documents/20147/13882675/Rapport_statistique_2021-2022-1.pdf].

[40] Note that the number of licensed practical nurses and respiratory therapists working in the private sector and for private agencies is unknown.

private healthcare companies. Remember that the last governments did not limit opportunities to work in the private healthcare sector, on the contrary.

While the FIQ strongly denounces the fact that Bill 10 does not measure up to the government's commitments to truly eliminate IL from the health network, the Federation intends to closely follow the work on developing the regulations set out in section 1 of the bill. And even if the regulation publication process does not include consultations or debates, the members of the Committee on Health and Social Services can rest assured that the FIQ will issue additional comments to complete this analysis and to oversee the progressive but definitive elimination of private health agencies in Quebec.

Recommendations

Recommendation 1

Amend Bill 10 so that it is truly restrictive and provides the groundwork to tackle what should have been at its very essence, i.e., the elimination of the use of IL in the public health network.

Recommendation 2

Because the very operation of employment agencies destabilizes the organization of work, team stability, and consequently the continuity of care, the FIQ recommends that Bill 10 stipulate that institutions' nursing administrations be responsible and held accountable for eliminating the use of private healthcare agencies in collaboration with the provincial nursing care and services administration and the entire MSSS.

Recommendation 3

The FIQ recommends changing the intention of Bill 10 so it aims to progressively and clearly eliminate IL in the public healthcare network and not merely limit it.

Recommendation 4

The FIQ recommends that all guidelines necessary to progressively eliminate IL (annual targets for IL hiring, deadlines, regional category definitions, basic criteria for government calls for tenders) be included in Bill 10 and not in a later regulation. This modification is essential to ensuring that Bill 10 truly guarantees the progressive elimination of IL.

Recommendation 5

The FIQ recommends that Bill 10 include conditions and criteria to ensure the right of patients to receive safe, quality, humane care during the transition period leading to the elimination of IL in the public healthcare network.

Recommendation 6

The FIQ recommends that Bill 10 include an ongoing workforce planning process to ensure sufficient staff to provide the public health network's service offer without hiring IL.

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