United Nurses of Alberta
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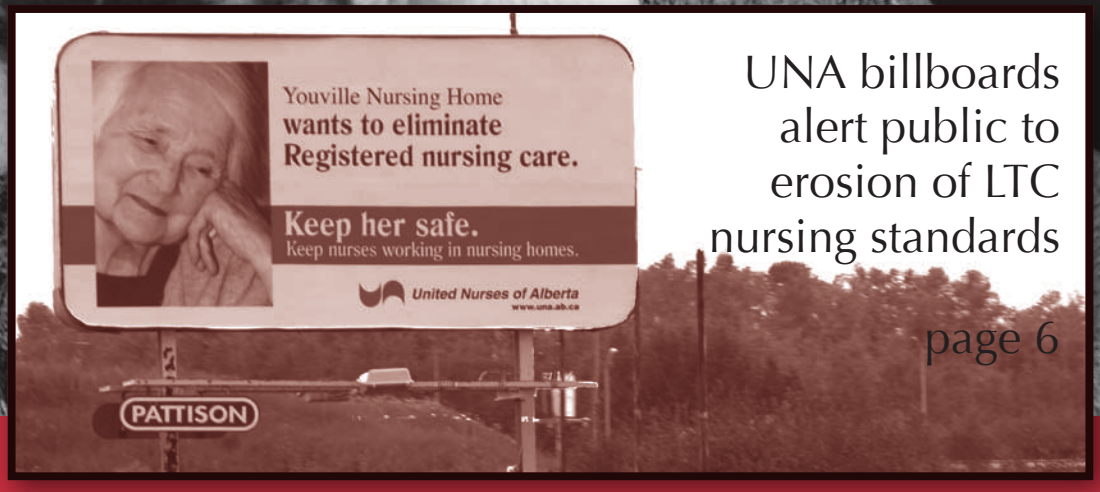
Warehousing the old?

Controversy grows around standards in long-term care

In Alberta some Long-term care Employers are holding up the nurses' contract



UNA billboards alert public to erosion of LTC nursing standards

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Premiers' health deal gets money but no protection against privatization

Having the federal government reinvest $41 billion in health care is a great improvement, say nurses, but the complete lack of "strings" attached to the funding, or any protection against privatization is concerning.

Premier Ralph Klein, who missed most of the First Ministers' meeting, appeared to be dismissive of the deal. "I really don't want anything. I want to be left alone so we can get on with reforming our health care system to make it sustainable."

Before his promised "public consultation", Ralph Klein is already saying he will proceed with his plan for health reforms and justify it by being re-elected.

"That shows how much of a sham the "consultation" and even the election are. Talk about your gong show," says Heather Smith.

Alberta nurse Pauline Worsfold, Secretary Treasurer of the Canadian Federation of Nurses Unions (CFNU), joined a large group of public health advocates who were a major presence at the First Ministers' meeting. The Canadian Health Coalition took advocates to the site in a double decker bus draped with a banner that read "2-tier is for buses."

At the talks, Pauline asked Gary Mar directly three times whether the ministers would address private delivery. Mar could only repeat that it was not on the agenda.

"They've made a deal on money without real commitments to public care," says Heather Smith. "This allows a covert ability for provinces to continue down the for-profit delivery path. Clearly with the asymmetrical agreement on health care on delivery, privatization must have been part of the talks that went on behind closed doors."

Maude Barlow of the Council of Canadians, and Shirley Douglas and Kathleen Connors of the Canadian Health Coalition at the Ottawa talks.

Also in Ottawa were left to right Mike McBane (Health Coalition), Kathleen Connors, Pauline Worsfold (CFNU), Mary Clarke (Newfoundland and Labrador Health Coalition), Debbie Forward (president of the Newfoundland and Labrador Nurses' Union), Rosalie Longmore (president, Saskatchewan Union of Nurses), Cindy Wiggins (CLC) and Barb Byers (Executive Vice-President of the Canadian Labour Congress (CLC).

EMPLOYERS REFUSING TO NEGOTIATE NEW CONTRACT

The CCEBA group of Long-term Care Employers is refusing to reach a settlement for a new contract and UNA has applied for compulsory arbitration and has also not ruled out job action to reach an agreement.

"These Employers are absolutely stubborn about not reaching an agreement," says UNA President Heather Smith. "We've charged them with not negotiating in good faith at the Labour Relations Board, but it appears we will have to take some action to get them to a settlement. This affects not just these CCEBA Locals but all the Locals involved in provincial bargaining. Job action certainly is an option, as is arbitration in this case. Arbitration could effectively impose most of the industry standard on these Employers as well."

There are about 500 nurses who work in 15 facilities covered by the CCEBA, the Continuing Care Employers Bargaining Association agreement and by Bethany Care Society – Cochrane which still insists on bargaining separately.

UNA has concluded agreements for over 20,000 nurses, including those who work for the Provincial Health Regions, Good Samaritan Society, Alberta Cancer Board, Extendicare and several smaller Employers.

"Other Employers generally match the provincial agreement and the industry standards it sets," Heather Smith says. "These few Employers saw an opportunity to wedge their nurses away from the provincial talks and are trying to impose different working conditions on them. It won't work in the long run because nurses know they can sooner or later get a position working in a contract that has those standards."

LTC contract could be off to arbitration or province-wide job action

There are over 140 other facilities providing long-term care were nurses work with the standards of the provincial agreement, including nurse-in-charge. Although they are funded in the same way, these 15 facilities said they could not agree to the same proposals and had to have rollbacks, including rollbacks to nurses' health benefits because of financial incapacity. The 15 facilities include the Capital Care subsidiary of the Capital Health Region, the Carewest subsidiary of the Calgary Health Region, several facilities operated by the Bethany Care Society, St. Michael's Health Centre in Lethbridge, Youville Home in St. Albert and St. Michaels Health Care Centre in Edmonton.

Bargaining talks ended July 15 after a brief effort by mediator Michael Necula. New negotiation dates are being set.

UNA laid a complaint of failing to bargain in good faith at the Labour Relations Board. Part of that complaint was that these Long-term Care Employers were refusing to provide financial information to substantiate their financial concerns.

"These facilities are funded in exactly the same way the others are," notes David Harrigan. "It has nothing to do with finances, they have the same money the others do."

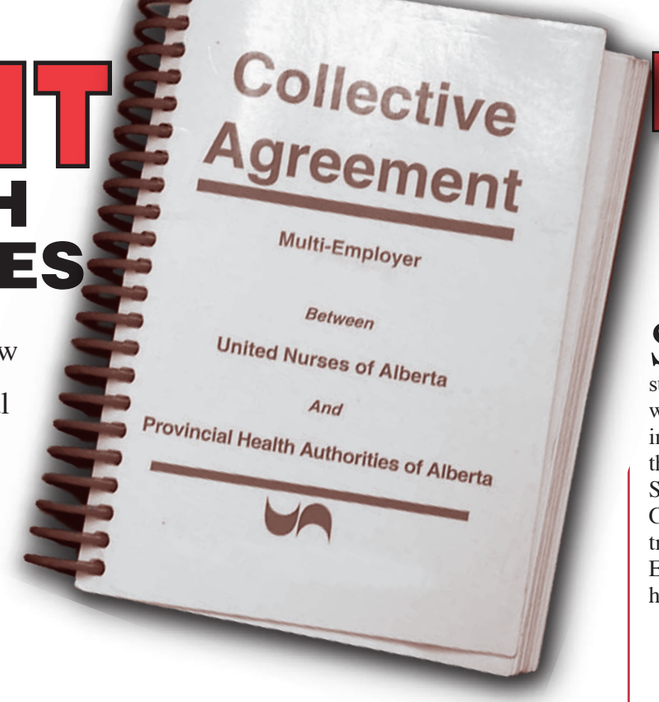
After the complaint was laid CCEBA wrote to UNA to say money is NOT an issue in the talks and they will now supply financial information.

Nurses at an informational picket outside the Norwood Care Centre in Edmonton. Nurses have held demonstrations outside many of the CCEBA facilities in recent months.

Warehousing the old

Long-term care standards and services are attracting considerable attention in the media. CBC broadcast a 3-part documentary, "Rage against the darkness". MacLean's magazine carried a significant report including some startling numbers. There were an estimated 3.9 million Canadians aged 65 or older in 2001, 67 per cent more than in 1981. The number of seniors will grow to 6.7 million in 2021 and 9.2 million in 2041 up to nearly one in four Canadians. Health Canada reports that only about seven per cent of Canadians who are 65-plus now live in long-term-care facilities. That could grow to 469,000 institutionalized seniors by 2021, and 644,000 by 2041. Pressure will grow to provide quality care, more than what MacLean's dubbed "prisons for the aged."

NEW AGREEMENT
COMES INTO EFFECT WITH SOME SIGNIFICANT CHANGES



Nurses heaved a province-wide sigh of relief with the ratification of the new provincial collective agreement, an agreement that avoided a huge upheaval from Bill 27 changes. But the new agreement includes significant changes of its own. After the hefty retro pay cheques have been cashed, (taking over a year to reach a contract is like a forced savings plan!) many nurses are now adapting to the changes in the agreement.

MULTIPLE POSITIONS GET COMBINED INTO ONE

NURSES DO NOT LOSE FTE

Because Bill 27 and the new agreement are amalgamating all the Employees of each Health Region into one bargaining unit, nurses will no longer have different "Employers" or different positions at different Health Region sites. For the many nurses who have worked more than one job, those positions will be combined into a single one. There will is to be no loss of FTE for the nurse in the process, unless the positions combined FTE (Full-time Equivalent) is greater than 1.0, greater than a full-time position. If a nurse's combined FTE is greater than one, than the nurse must decide how to trim the position back to no greater that 1.0 FTE. For nurses who work casual shifts at a different site, those shifts will now be added to their hours, and will attract seniority, sick leave and vacation bank. They can also attract overtime.

For example:

A nurse working .4 FTE in a hospital and .2 FTE at another site (or community) would now have a .6 FTE position. If the shift schedule is not contract compliant the Ers have to make it compliant at the next change of rotation, or within one year at the latest.

YOU CAN TAKE IT WITH YOU

PORTABLE SENIORITY WITHIN HEALTH REGIONS

Seniority will now be portable, not only within a Health Region, but effectively province-wide to all the Health Regions, as well as to other Employers who the provision in their collective agreement. So far that only includes The Good Samaritan Society, the Cancer Board and Shepherd's Care Millwoods.

RECAPTURING FORMER SENIORITY

To make the change in seniority fair, there is also a provision for recapturing former seniority with a UNA Employer. The main restriction is that there could not have been a six month gap in service, although detailed provisions do apply. Employers are slated to put out entirely new seniority lists in the next short while. Nurses can challenge their seniority date on the list, and if they provide proof of previous service, they can add that service to their seniority. Nurses can provide proof of former service, pay stubs or employment records, or they can swear an affadavit on former service. The proof goes to your Local representatives. UNA Locals all have more information on recapturing seniority.

For example:

A nurse who started at the Foothills Hospital on March 1, 1999 and quit on Feb. 1, 2001, but began a new position at the Red Deer General on May 1, 2001 would now have her seniority date adjusted to include the 23 months at the Foothills.

However a nurse who worked in a UNA site then worked out of province, or at a non-UNA employer for greater than six months and then returned to a UNA position would not be able to claim the original work time.

NEGOTIATIONS UPDATE

NEW NEGOTIATIONS FOR NEW MEMBERS FROM OTHER UNIONS

A new round of negotiations is starting up in September to bring in the new member nurses who had been represented by other unions . As a result of Bill 27 nurses who worked with Health Region in other unions are now UNA members. But they kept their former contract conditions. The new negotiations will focus on bringing these members into the UNA agreement.

SOME CONTRACT ISSUES REMAIN UNCLEAR

The Negotiating committee will also be back meeting with PHAA to resolve collective agreement details that are unclear in the document. Most of those details deal with seniority, multiple positions, benefits, the grievance process, the new transportation payments and finalization of the Local Conditions language.

SEVERAL OTHER UNA CONTRACTS SETTLED

Since the settlement in the main Health Regions contract, UNA has successfully concluded negotiations with several other Employers. Also included in the provincial round of talks, the Alberta Cancer Board, the Good Samaritan Society and Good Shepherd's Care Millwoods all concluded new contracts. The CCEBA group are the only Employers in the provincial round who have not settled.

FOREST GROVE REACHES AGREEMENT

UNA has successfully negotiated a new agreement for nurses at the Forest Grove long-term care facility in Calgary. The agreement was reached on August 6, 2004. UNA members hold their ratification vote on the agreement on August 20. The contract wins close to parity with the provincial agreement, including provincial salary rates retroactively to April 1, 2003. The rates also now include steps 8 and 9, which means many of the senior nurses will be getting significant retro pay payments.

FIRST CONTRACT FOR VENTA NURSES

Nurses at the Venta nursing home reached their first negotiated UNA agreement in July. The new contract represented a great improvement in conditions for the dozen nurses working at the private facility. With close to provincial salary rates and many of the advantages of the provincial Agreement, the new contract also gets the nurses almost complete parity with the provincial benefits package, a major increase from the $50 a month benefit allowance they had before. There were also major improvements in sick leave and many other provisions. Congratulations to LRO Brent Smith and the Venta negotiating team.

EXTENDICARE LOCALS REACH NEGOTIATED SETTLEMENT

UNA Locals in negotiations with Extendicare reached an agreement that includes many of improvements in the provincial contract. The UNA Extendicare Negotiating Committee and spokesperson LRO Pippa Cowan signed a memorandum of settlement on July 28 and Extendicare nurses will be voting on it on September 8.

Negotiations reached the same salary increase as the provincial settlement as well as an increase to the Extendicare RRSP plan and an increase in their weekend premium from $1.00 to $1.45 an hour, effective August 1. They also negotiated new terms on severance and on Decreasing and Increasing regular hours of work.

Extendicare Locals

#117 Extendicare Edmonton North,

#170 Extendicare Leduc,

#189 Extendicare Fort MacLeod,

#209 Extendicare Mayerthorpe,

#215 Extendicare Viking, and

#224 Extendicare Athabasca.

CANADIAN BLOOD SERVICES START TALKS

Canadian Blood Services nurses' contract talks started off in September with talks scheduled into October. The contract expired the same time as the provincial agreement, at the end of March in 2003. Blood Services negotiations were held off, however, until the new provincial agreement was concluded.

CFNU plays key role in Premiers' health talks

A proposal from nurses to bring a national pharmacare program gathered major momentum when the provincial Premiers adopted it at their July meeting. Unable to agree on much in the area of health care reform, beyond the need for more federal funding, the Premiers seized on the pharmacare idea as a high pressure technique to "upload" health care costs to the federal government.

"Pharmacare would be a giant step forward for Canada," said Linda Silas, president of the Canadian Federation of Nurses Unions. "It could be the first significant reform of Medicare in 40 years."

Pharmacare was just one of the ideas in the research paper that the Canadian Federation of Nurses Unions provided the Premiers. The paper made a strong case for the federal government to:

- upload provincial drug program, and costs, to the federal level.
- play the crucial role of public financier for this wave of necessary capital investments.
- coordinate and shoulder most of the costs of training this cohort of health professional graduates.

The Premiers' pharmacare proposal met with considerable skepticism however, including from national health Commissioner Roy Romanow. In his report, Romanow had called for a national drug plan to cover only "catastrophic" drug costs. Prescription drugs represent by far the largest area of rising costs in the health system. In 1980, $1.3 billion was spent on prescription drugs in Canada, about 5.8% of total health care spending. By 2001, the percentage had doubled to 12%, and the prescription drug bill was $12.3 billion.

UNA BILLBOARD HIGHLIGHTS RN CARE

Nursing standards and nurse-in-charge is a major issue in the negotiations and UNA has mounted a billboard campaign to highlight how this could affect residents. Featuring a portrait of an older woman the billboards say, "Long-term care facilities want to eliminate registered nursing care. Keep her safe. Keep nurses working in nursing homes." The billboards are going up in Edmonton, Calgary and Lethbridge. In Camrose, UNA has placed ads on the local cable television network.

The billboards highlight the fact that consistent staffing by Registered nurses, the nurse-in-charge, is a major issue in the talks. CCEBA has also refused to meet the provincial agreement standards in health benefits, vision care, and the night shift premium. In fact they want to cut vision care benefits. They refuse to agree to portability of seniority or to the severance provision.

"These long-term care operators want to eliminate the nurse-in-charge, a quality of care standard that has been negotiated with other long-term care providers in the province," says David Harrigan, UNA's director of labour relations and chief negotiator. "This is a major quality of care issue for nurses, but it isn't the only issue here. These Employers clearly appear to be looking for a confrontation not an agreement," he said.

"By eliminating nurse-in-charge, they could lay off all their Registered nurses," David Harrigan points out, "and they would have no obligation to pay them any severance." He also notes that the largest Employers in the group are subsidiaries of the Capital and Calgary Health Regions, Capital Care in Edmonton and Carewest in Calgary. "We successfully reached an agreement for over 20,000 Health Region nurses, but these same Health Regions are blocking a deal for fewer than 500 RNs in their long term care facilities," David Harrigan said.

RALPH TURNS
Mr. Nice
FOR THE ELECTION

Premier Ralph Klein surprised observers after the Premiers' meeting when he was quoted in the news media saying an increase in federal funding would make medicare sustainable again and eliminate the need to develop private, for-profit delivery models in the province. The position represented a total turn around for the Premier who has long bemoaned the "unsustainability" of medicare and the importance of "choice" in the health system.

At about the same time Calgary Health Region CEO Jack Davis announced that their planned new hospital would NOT be built as a private P3. That put an end to the flagship privatization project, and not coincidentally, neutralized a potential political hot button issue.

Then the province announced it was canceling the much-reviled health care premiums… for all seniors and restored other seniors' benefits they had cut over the last few years.

This dramatic change in health care rhetoric has set political analysts into a furor of speculation about whether the provincial government really was abandoning its long pursued goal of privatizing health care. The government has apparently postponed until after the election the promised "consultation" on health care options, including more fees, higher premiums and possibly violating the Canada Health Act. These health reform ideas were shut down by the Conservative caucus, which appears to have no stomach for campaigning on a medicare-busting platform.

The caucus, by the way, is far from unified. The Edmonton members appear to want a more moderate tone, which contrasts sharply with some of the more right-wing rural MLAs. They are also lining up for the impending Conservative leadership contest. That battle, given the immensely high stakes – control over billions of dollars in resource revenue, will likely prove to be an ugly one.

One take coming from various analysts is that Premier Klein wants one more election to go very well. He wants more than anything else just to be liked and to go out hugely successful. He will try desperately to avoid losing seats in Edmonton, which are very much in danger according to inside reports on Conservative party polling.

The sense is that even the health care meeting with Prime Minister Martin in September won't cause the Conservative's privatization ideas to flare up. Although he may complain, the projection is that Premier Klein will take the increase in federal funding without a major war on Ottawa.

The Premier has toned down his rhetoric. The Conservatives will NOT be campaigning for a clear mandate to privatize (and "profitize") health care. Albertans can breathe a well-deserved sigh of relief. That is of course until after the election when Klein wraps up his career, hopefully without too much in the way of fireworks. With any luck his legacy won't include a last minute gift to corporate health care.

IMPROVING MEDICARE WITH PHARMACARE

Many Canadians have a shock when they are discharged from hospital with a prescription to fill and a drug bill that can be in the hundreds of dollars. As medicine relies more and more on drugs and as drug prices rocket sky-high, the security provided by medicare can start to seem thin.

In fact medicare, which only covers physicians fees, hospitalization and dental surgery, now only covers about 42 percent of the total health care spending in Canada. Pharmaceuticals have increased dramatically in cost and in share of health care spending. In 1980, $1.3-billion was spent on prescription drugs in Canada, about 5.8% of total health care spending. By 2001, the percentage had doubled to 12%, and the prescription drug bill was $12.3-billion.

Roy Romanow recommended a gradual introduction of drug coverage into medicare through a "catastrophic" drug costs plan, which would cover costs for a family or patient when they went over a certain amount. That is sometimes called "last dollar" coverage, because it pays the last part of the bill. Medicare is often called "first-dollar" coverage because it covers physician and hospital costs right off the top.

New federal Health Minister Ujjal Dosanjh is ruling out complete pharmacare, saying it's too costly. Cost estimates range from $10-billion to $13-billion a year. But he does indicate that "catastrophic" drug coverage, as promised by Liberals during the election, is on the table.

Drug costs are the fastest rising component in medicare costs as well. If the federal government handled drug costs it would cover about $750 million out of Alberta's annual health care bill, for example.

CFNU's pharmacare idea

"After a decade of downloading, the federal government should upload some health costs and delivery, and it should start with public drug programs. Such streamlining would introduce better clinical evidence and cost discipline in how new drugs are added to formularies, improve uniformity of access to pharmatherapy across the country, and use single purchaser power to get better bulk buy prices. Over time this shift could relieve the provinces and territories of more than $7.6 billion in public expenditures (and rising), create a wider range of policy levers to manage costs in the future, and introduce a mechanism for expanding pharmacare in order to manage more effectively the cost escalation in drug purchases overall."

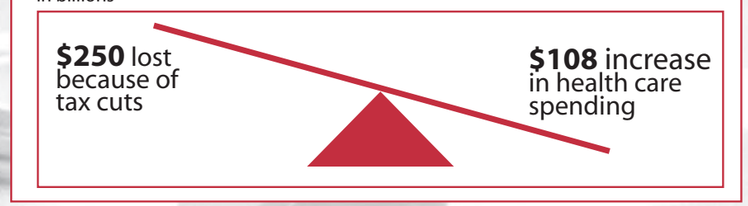
– from Can we afford to sustain Medicare? A strong role for federal government CFNU's research paper presented to the Premiers.

"If there's one word I hate, it's unsustainable. I don't even know what it means."

Hugh Scott is one prominent doctor who is speaking out in the health care debate. Scott, who is a former executive director of the Royal College of Physicians and Surgeons and currently heads the McGill University Health Centre says: "Health care is not crowding out other programs, instead it is not experiencing the same degree of cutbacks. It is deficit elimination and tax cuts that are crowding out new initiatives." Quoted in a Toronto Star column, Scott points out that health care costs are rising only slightly faster than the Canadian economy is growing. But because of huge tax cuts, overall public expenditures are dropping. In the column Scott cites numbers to show this is the case. In 1993, provincial program spending accounted for 17.5 cents out of every dollar made in Ontario. Health made up 6.3 cents out of that. By 2003, the government's share of every dollar of economic output had shrunk to 12.4 cents and health accounted for 5.8 cents of that.

HEALTH SPENDING DROPPING

Since 1996 tax cuts, a bigger fiscal "threat" than more health spending

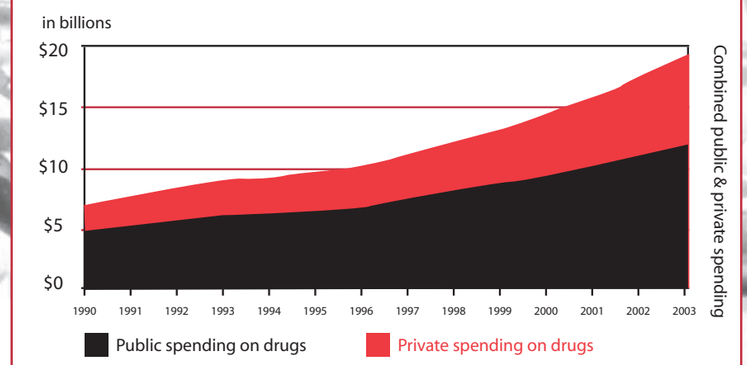


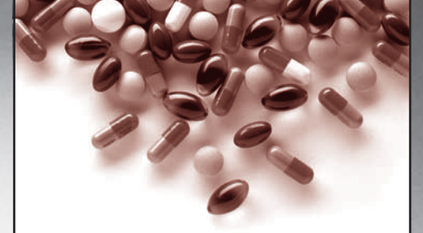
The CFNU commissioned study prepared by researcher Armine Yalnizyan showed that public health spending has been dropping relative to the overall economy (from 7.4% of GDP in 1992 to 6.7% of GDP in 2002), That dramatic decline that has only been matched by Finland, they note, while for almost every other country health spending was rising.

Overall government spending in Canada has been cut significantly, which is what really makes it look as though health care spending is going up. Yalnizyan cites federal Finance numbers that show that tax cuts took almost $250 billion out of public spending since the late 1990s. At the same time health spending has been the least cut public spending program making it appear to be growing rapidly in proportion. Yalnizyan points out that "tax cuts are, by far, the most costly single initiative undertaken by provincial and federal governments in recent years."

"Given the priority placed on scaling down revenues and expenditures, governments' capacity to reinvest in health care plus a wider range of programs has been explicitly and deliberately limited. That has nothing to do with the sustainability of increases in health care. It has to do with the sustainability of a major tax cut agenda, a fact that is coming home to roost in the frequently invoked phrase that the status quo is no longer an option. Elected officials of all political stripes are now facing an unappetizing choice – maintain tax levels and cut services; or maintain services and increase taxes. There are no free lunches."

Since 1990 public spending on drugs has tripled, to $7.6 billion, and private spending has reached $12 billion





WHY DRUGS ARE EXPENSIVE

QUESTION:

We all know drugs are expensive. But doesn't that reflect the high cost of researching and developing new drugs?

ANSWER:

No. That's what the drug makers would like you to think. But it's simply not true. In 2002, the biggest drug companies spent only about 14% of sales on research and development and 31% on what most of them call marketing and administration. They consistently make more in profits than they spend in R&D. And their profits are immense. In 2002, the combined profits of the 10 drug companies in the Fortune 500 were $35.9 billion. That's more than the profits for all the other 490 business put together, if you subtract losses from gains.

– Former New England Journal of Medicine editor Marcia Angell interviewed in the Los Angeles Times, August 9, 2004.

Thank goodness for medicare!

The Stollery Children's Hospital Foundation raised some eyebrows with its fundraising appeal featuring faces of children and price tags on medical procedures. Thank goodness this is Canada and we don't put price tags on taking care of our children.

EMPLOYERS COVERING ALL PRESCRIPTION RECEIPTS BACK TO APRIL 1, 2001.

ALL MEANS ALL

In the 2001 provincial collective agreements, a new prescriptions benefit came into effect. The plan must provide 80% direct payment provision for ALL physician or dentist prescribed medication.

The Employers refused to change their benefit plans and only paid for medications which were approved by their plan - normally only for those that required a prescription and were on their list.

UNA's belief was that "all" means "all." If a doctor wrote a prescription for vitamins, it must be paid by the insurance.

UNA filed grievances at all Employers. The Union went to two arbitrations - one for the Provincial Health Authorities of Alberta (PHAA) agreement and one for the Continuing Care Employers Bargaining Association (CCEBA). UNA was successful at arbitration.

The Employers still did not change their plan, and instead proceeded to the Court of Queens Bench to try to have the arbitration decisions overturned. PHAA, CCEBA and the Good Samaritan Society all agreed that once the matter was concluded in the courts, they would provide full reimbursement for all prescriptions, provided that receipts were kept, and would apply the agreement.

The Employers lost at the Court of Queens Bench. The court said that "all means all".

The Employers then appealed to the Alberta Court of Appeal. To the best of our knowledge, there was no one in the province who believed that they stood the slightest chance, but that did not seem to matter.

Finally in July, UNA received notice that PHAA had withdrawn the appeal.

CCEBA, however, who informed UNA that they did not have enough money to pay the change in vision care, is continuing to pay their lawyer to proceed to the Court of Appeal. They still insist that for long term care nurses, "all" means "some."

SUBMIT ALL RECEIPTS FOR REIMBURSEMENT

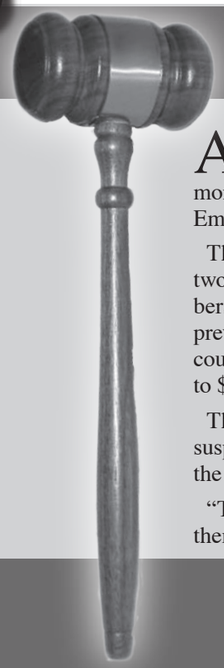
Any prescription benefits that were refused by the Employer – back to April 1 of 2001 – will now be covered.

Any nurse who had a prescription denied for reimbursement should re-submit the receipt and it will be reimbursed. Prescription receipts that were never submitted should also be sent in now for reimbursement.

Some Employers are developing specific procedures for dealing with prescription receipts that were:

- initially denied, but now must be covered
- old and never submitted
- new and have not yet been submitted.

Check with your Employer on their procedure and if there are any problems contact your Local or your Labour Relations Officer.



COURT STRIKES DOWN AUPE DUES SUSPENSION

An Alberta Court of Queens Bench Justice has quashed the Alberta Labour Relations Board penalty of a two-month dues suspension for the Alberta Union of Provincial Employees.

The LRB had imposed the penalty after the May 2000 two-day strike by Licensed Practical Nurses, AUPE members. It would have cost the union over $1 million. AUPE previously had been penalized for the walkout by the courts and fined $400,000, which was reduced on appeal to $200,000.

The Judge's ruling upheld the three arguments against the suspension that were first made by UNA as an intervenor at the original LRB hearing on the AUPE strike.

"The LRB did go well beyond its mandate, and we told them so at the time," says UNA's Director of Labour Relations David Harrigan. "The Board is supposed to be an impartial body that facilitates labour relations, not an instrument of the government or of Employers."

After the LRB had made this now overturned ruling, UNA withdrew its representation on the Board. "It's clear now that we were correct to pull out of the Board when it went too far," he said. "The Board is supposed to be fair and neutral. If it even appears that it is doing the government's or the employer's bidding, it has lost its credibility."

UNA also has an on-going case before the courts that the LRB was biased by government intervention in its implementation of Bill 27.

When the LRB was holding the hearing on AUPE, UNA's counsel Lyle Kanee argued that the law allowed the LRB to suspend dues deductions in in order to end an illegal strike but not to punish the union for striking. The power was, he argued, remedial not punitive. The second point was that it could only suspend dues during a strike, not, punitively, after it was over. UNA also made the case that the LRB needs to do this on its own initiative, not at the request of the Employer. In this case, the LRB was acting on an application from the Provincial Health Authorities of Alberta.

It was these three points, made initially by UNA, that the Justice used in his ruling against the dues suspension. The Justice found that the LRB could direct a dues suspension but that the directive could only be issued when a bargaining unit "is on strike", not against a bargaining unit that "was" on strike. The Judge said "the intended purpose of section 114 is primarily remedial……Its purpose is to deter, to bring to an end, and to remedy an unlawful strike."

COMPASSIONATE CARE LEAVE IN NEW CONTRACT

A provision in the new contract allows nurses to take up to six months unpaid leave to care for a terminally ill family member. Nurses can take advantage of the federal Compassionate Care plan under the federal Employment Insurance (EI) program. The EI compassionate Care plan provides benefits – about 55% of regular income to a maximum of $413 a week – for up to six weeks.

In the UNA provincial contract provision Employers will continue to cover their share of a nurse's benefits for the six months.

This new provision follows the inception in January of the new EI Compassionate Leave, which covers leave to care for a gravely ill spouse, child, or parent. Anyone who has paid EI premiums and worked 600 hours or more is eligible for the Compassionate Care benefit. You need a Record of Employment from the Employer and there is a two week "waiting period" (like a two-week deductible clause) before benefits begin. A doctor needs to provide a certificate indicating there is a serious medical condition with a significant risk of death within 26 weeks. The six weeks of leave can be taken at any time in that 26-week window. The six weeks can be shared between different family members. For example a sister could take two weeks and a brother four weeks to provide care for their mom.

The Terminal Care Leave provision in the UNA contract covers the same family members as EI, including only spouses, parents and children or the parents or children of a spouse or common law partner. The gravely ill family member can be anywhere in the world, as long as a doctor's certificate can be produced for them.

Many family members are not yet taking advantage of the Compassionate Care benefit. Nurses can inform relatives of patients that more information is available from Human Resources. The information, and application forms can be found on the website: www.canada.gov.ca.

UNA First Year Nursing Scholarship

United Nurses of Alberta gives out three $750 scholarships each year to first year nursing students who are related to a UNA member. The award is intended to encourage young people, particularly those with a family history in nursing, to take up the profession.

The deadline for applications is October 15 each year. Applicants need to write a short 250 word essay on the topic, "How does the United Nurses of Alberta impact nursing worklife?" They must also supply documentation, including letters of reference from both a family member and a non-family member. The awards are announced early in the following year.

More information and the application form is downloadable from the membership page on the UNA website http://www.una.ab.ca/subpages/nursingscholarship.shtml.

LATEX ALLERGY... POTENTIALLY A CAREER LIMITING PROBLEM

A British nurse was awarded nearly $1 million in compensation earlier this year for having to give up her profession because of her latex allergy. The 37-year-old nurse had to quit after the allergy led to asthma and even anaphylactic attacks. After the sensitivity built up over years, Alison Dugmore found that just coming into contact with colleagues who had worn latex gloves or latex dust in the air was enough to set off a reaction.

Latex allergy has become a recognized Occupational Hazard that has been increasing steadily since Universal Precautions came in because of the necessity of avoiding exposure to HIV or Hep B. According to some experts we are only now beginning to see the effects of many years of exposure to latex gloves.

Johanna Haagsma, a UNA member in St. Albert has written a review of research on the topic. She concludes that the growing problem makes it important for health services to switch to latex free or latex safe environments. In particular she notes that changing to non-latex gloves would be an important step forward.

The use of No Powder and Low Protein gloves is not acceptable to individuals already sensitized to latex she points out.

Gloves are the main way health workers come into contact with latex, but many other products, from face masks to catheters, bandages, tourniquets, tape, and stethoscope and blood pressure cuff tubing often also contain latex.

Many health workers already are sensitized. Johanna Haagsma notes one study of 247 OR nurses, 17 of whom showed sensistivity. Ten had itchy hands, nine had hives and ten had swollen, burning or itchy eyes. Asthma is another concern, with powdered latex gloves that spread latex dust in the air the main culprit.

Patients who come into contact with latex products repeatedly over time are also at risk. Spina Bifida patients and those with genitourinary abnormalities requiring catheterization show the highest rates of latex sensitivity, with up to three quarters of the patients affected. Health care workers are the second highest risk group, showing even higher rates of sensitivity than do rubber industry workers.

"We need to make our institutions latex-safe," Johanna Haagsma concludes. In her paper she notes that elastomere-nitrile or polyurethane gloves are good alternatives to latex, although more expensive. She points out that the costs connected to a worker disability or to just one lawsuit from a patient or health worker could greatly outweigh the extra expense.

Latex allergy: A true latex allergy is an allergic reaction to the proteins that are contained within natural latex rubber (from the sap of the rubber tree, Hevea brasiliensis). Reactions similar to those from the natural latex proteins may be reported when exposed to synthetic latex material. If this is the case, it is likely not a reaction to the natural proteins in the sap from the rubber tree, but a reaction to the chemicals used in the manufacture of the synthetic rubber. As these chemicals may be found in both natural and synthetic latex products, it is important to distinguish whether the reaction is to the natural rubber proteins or the chemicals used in processing.

REACTIONS:

There are three different kinds of reactions that have been found in those using latex products.

IRRITANT CONTACT DERMATITIS(ICD)

ICD is not a true allergy. It is the development of dry, itchy, irritated areas on the skin, usually the hands, through direct contact. The reaction is caused by irritation resulting from the use of gloves and other latex products. Reactions can also be caused by repeated washing and drying of skin, incomplete hand drying, use of cleaners and sanitizers, and exposure to powders used in gloves.

CHEMICAL SENSITIVITY DERMATITIS (CSD)

CSD is an allergic contact dermatitis that results from exposure to chemicals added to latex during harvesting, processing or manufacturing. These added chemicals can cause poison ivy type reactions with a delayed hypersensitivity. Symptoms can develop 24-48 hours after contact and may include oozing blisters.

LATEX ALLERGY

True latex allergy can be more serious than either ICD or CSD. Expressed as immediate hypersensitivity, the allergic reaction is triggered by exposure to the latex proteins either through direct contact with the rubber, or through contact with powder used to increase glove comfort. This powder can absorb latex proteins and carry them onto the skin or into the air where they are inhaled. Though the levels of protein exposure needed to develop sensitivity are not known, very low levels of protein exposure can cause reactions in sensitized individuals. In general, latex allergy follows a graduated sensitivity level, although there is a wide range of potential reactions:

MILD REACTIONS	SEVERE REACTIONS
skin redness	runny nose
rash	sneezing
hives	itchy eyes
itching	scratchy throat
	asthma
	Rarely, anaphylactic shock

Nursing News

UNA's first all-Employee Local at Agapé Hospice in Calgary

Welcome to one of the newest UNA locals, Local #232 at the Salvation Army Agapé Hospice in Calgary. Nearly 40 people are included in the UNA's first "all employee" local that includes RNs and all the non-management staff of the Hospice. They recently elected their first executive: President – Terry Tomlinson, Vice-president – Tricia Rogers, Secretary – Helen Keintz and Treasurer – Heather Gladstone. The Local members also voted to select their first bargaining committee and are preparing to begin negotiations for a first contract.

The LRB held a hearing in Calgary on UNA's application for certification for Agape Hospice and ruled as it was neither a nursing home nor a hospital it should be an all-Employee unit. The 39 Employees include cooks, dietary aides, unit clerks, a social worker, even a chaplain, as well as Registered nurses. The Employees voted in favour of joining UNA and now have begun their own Local.

Nurses run against Tories in provincial election

Several active UNA members have begun their campaigns for the Legislature in the upcoming provincial election. The election is widely predicted to be called in late October for a vote in late November.

Laurie Lang, President of Local #183 at Alberta Hospital is running for the NDP in Edmonton Manning. Laurie has run in provincial elections before. Former provincial Board Member Holly Heffernan from the Rockyview Hospital is running for the NDP in Calgary Glenmore. Joyce Thomas is back for more, having just run in the federal election. She's letting her name stand again, also for the NDP in the Livingston-Macleod constituency. Joyce works at the St. Michael's Health Centre in Lethbridge.

Bridget Pastoor, who is a UNA member at Edith Cavel Care Centre in Lethbridge, is also an elected City Councillor. She is running for the Alberta Liberal Party in Lethbridge East, the seat formerly held by Liberal leader Ken Nichol.

New Brunswick nurses forced to brink of strike

FREDERICTON: New Brunswick's nurses voted 98.18% for province-wide strike action and were approaching the strike deadline when a tentative settlement was announced on September 8th. Contract talks with the government and the provinces 4900 hospital nurses had broken off and discussions through a commissioner were unsuccessful. The main points of contention are salary and length of contract. Nurses were asking for wage parity with their Atlantic counterparts from the beginning of their contract throughout the duration of the contract. NBNU nurses had been compensated at an average of 14% below fellow nurses in PEI, Newfoundland and Labrador and Nova Scotia. They have been the lowest paid nurses in the country for the last two years.

The nursing shortage is severe in the province, according to the Nurses Union: "New Brunswick is so short of nurses, we had to work over 250,000 hours of overtime last year to keep up... The province is short of nurses now. 50% of NB nurses will retire in the next 13 years. We don't graduate enough new nurses in the province to keep up… Therefore New Brunswick will not have the quality of health care they expect and deserve."

Calgary backs down on P3 hospital

Jack Davis of the Calgary Health Region says the city's new southeast hospital will not be a private partnership and will be completely run by the Region. It's a dramatic change of course for the hospital that Premier Klein and Finance Minister Pat Nelson had said would be a flagship P3 project in the province.

Davis told the Calgary Sun that a hospital is "much more complex than an office building".

"There will be no P3. We're going to build the building. We will have full control of the hospital," he said.

The new plan is to float a public bond to finance the hospital, but ownership and control of the facility will be completely public. The 350-bed hospital is supposed to open in 2009.

Is Ottawa failing to defend Medicare?

A judge is set to decide whether the federal government is violating the Canada Health Act through its loose monitoring of the health system and its failure to stem a dramatic growth in for-profit, private care. A coalition including the Canadian Federation of Nurses' Unions asked the Federal Court to order the government to take more responsibility in enforcing the five bedrock principles of medicare by withholding money from provinces that don't live up to the terms. "There's a law and the minister of health is not above the law," said Michael McBane, coordinator of the Canadian Health Coalition. "We're looking for a shot across the bow from a federal judge saying, 'look, you have duties and you better start taking them seriously'."

The kids are alright at the Alberta Federation of Labour (AFL) camp held last summer at the Goldeye Centre in Nordegg. UNA 2nd Vice-President Jane Sustrik reports that the growing number of youth attending the camp kept her busy as the camp nurse. But she says she had a great time again, and so did the kids.

Nurses helped out at the Edmonton Labour Council's annual Labour Day picnic in Edmonton. On hand were Pauline Worsfold, Secretary Treasurer of the Canadian Federation of Nurses Unions, (and working recovery at the U of A), Heather Smith, UNA President and Barb Byers Vice President of the Canadian Labour Congress.

Study shows errors increase when hospital staff nurses work twelve or more hours at a stretch.

A new study published in Health Affairs (July/August 2004) shows that the risk of errors increased significantly for nurses who work shifts longer than twelve hours or who are on overtime or working over 40 hours in a week. The American study had 393 hospital staff nurses fill in spiral-bound logbooks for over 5,000 shifts. The researchers concluded that "The long and unpredictable hours documented here suggest a link between poor working conditions and threats to patient safety." They report that although the occurrence of documented errors did not increase until shifts went over 12 hours in length, there were more near misses for all shifts over 8.5 hours. The authors also noted that nurses working twelve-hour shifts reported significantly higher absenteeism rates and less job satisfaction than nurses working traditional eight-hour shifts.

Women hold nearly half the unionized jobs

Statistics Canada reported recently that nearly half the union members in Canada are now women. Women's share of unionized jobs rose by nearly four times from 12% in 1977 to 48% in 2003. The government statistics agency said the change came about because more women are in the workforce and because more women work in the public sector, which is more heavily unionized than the private sector.

Far more women are working than they were 30 years ago. In 2003, 57% of all women aged 15 and over had jobs, up from 42% in 1976. The opposition is true for men where the numbers are falling. In 1976, 73% of men had paying jobs. That dropped to 68% by 2003.

For women the largest increase was for women with children. Last year 72% of all women with children under age 16 living at home were part of the employed work force, up from 39% in 1976.

Striking group home workers in Ituna, Saskatchewan swapped picket signs for giant-sized hands to parade through the town to urge local residents to lend them "a hand" to get the employer back to the bargaining table.

The employer, Deer Park Villa, refuses to resume contract negotiations until the workers "cave" on seniority rights.

The 27 CUPE members at Deer Park Villa walked off the job June 3 after the employer refused to bargain fair seniority language. The workers have been trying to negotiate their first collective agreement for more than a year.

All invited to Rainbow Gala

Nurses from Local #301 at the University of Alberta Hospital are once again inviting UNA members to join them in their annual Rainbow Gala. The big party at the West Edmonton Mall Fantasyland Hotel is a fundraising effort for the Rainbow Society of Alberta. For many years the UNA Local has held events to support the Society, which helps make dreams come true for seriously ill children.

The Gala includes a lovely dinner and dance, a silent auction and a fashion show, with UNA members modeling!

The Rainbow Gala this year is on Thursday, October 14, 2004. Tickets are $50 each or a table of ten for $450. For more information or tickets call the Local #301 office at: 407-7453.

united nurses of alberta

2004 ANNUAL GENERAL MEETING

SPEAKERS

Michael McBane

Of the Canadian Health Coalition

...an up to date report on the politics of medicare and the fight to preserve our public health system.

Addictions: Illness or Crime?

An Expert Panel discussion.

Shaw Conference Centre, Edmonton

October 26, 27, 28, 2004

United Nurses of Alberta
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