Dispute Resolution in Healthcare and Community Services Collective Bargaining

REPORT SUMMARY

Written Submissions - Discussion Paper June 2007

Introduction

In May, 2007, the Premier asked Nova Scotia Environment & Labour (DEL) to lead a dialogue exploring dispute resolution in healthcare and community services collective bargaining. To this end, the department prepared a discussion paper which provided an overview of the current dispute resolution processes in the province and an examination of two alternative models: interest arbitration and essential services. The paper was circulated to stakeholders (including employers and unions who would be affected by any legislative changes) and also posted on the DEL website. Comments were invited between June 19th and July 20th to provide the opportunity for all key stakeholders and Nova Scotians to express their views and concerns on this important issue.

The written submissions have been carefully reviewed and a summary of their contents is detailed below.

A. Submissions Received

DEL received a total of 59 written submissions which can be broken down as follows:

Nursing Homes (funded by Department of Health): 28
District Health Authorities: 9
Homes for Special Care (funded by Community Services): 7
Home Care/Support Services: 4
Associations: 4
Other: 3
Hospitals: 1
Consultants: 1
Public: 1
Federation of Labour (FOL): 1
(on behalf of NSNU, CUPE, CAW, NSGEU, SEIU, IUOE)

The vast majority of submissions were received from employers and/or employer associations. Those submissions focus on dispute resolution in healthcare and community services collective bargaining and overall they validate the comments in the discussion paper.

In contrast, the submission provided by the FOL, on behalf of a coalition of healthcare unions, is opposed to the alternate dispute resolution models set out in the discussion paper and its focus is on health and community care issues generally.

B. Underlying Theme - Patient Care

The employer submissions stress the importance of public safety and continuity of care. As a result, they are in favour of a dispute resolution mechanism to resolve the issues after all other options are pursued during the collective bargaining process. None of the Employer submissions were in favour of retaining the right to strike or lock out.

The FOL states that the coalition of unions is unanimous in its opposition to replacing the existing system with interest arbitration or essential services. In this regard, it relies on the Kydd Report and recommendations from the 1992 Commission (see Appendix B of the Discussion paper). It stresses the importance of focussing on the other "real problems" in the health and community care sectors (wait times, recruitment, and retention) and emphasizes that these problems will only be further exacerbated with proposed legislative amendments to remove the right to strike.

It is important to note, however, that every submission stresses the importance of patient care and acknowledged the strain on our current systems because of factors including higher acuity levels, multiple diagnoses, an aging population, and limited human resources.

C. Options Presented

The discussion paper presented two alternative models: interest arbitration and essential services. It should be noted that no other alternatives were presented for consideration in the submissions received.

The majority of submissions (42) contain comments expressly supporting a fair and meaningful collective bargaining process, including replacement of the right to strike/lock out with interest arbitration when the parties reach an impasse in their negotiations.

None of the submissions indicated that an essential services model would be appropriate.

It should be noted that some submissions did not comment on a preference respecting either of these alternatives but noted that they were in favour of a fair dispute resolution model rather than the existing right to strike/lock out model.

D. Additional Comments on the Impact of Work Stoppages or Impending Work Stoppages

The discussion paper included a detailed analysis of interest arbitration including the pros and cons associated with this model of dispute resolution. Many of the submissions provided additional information/comments. Some examples are produced below :

District Health Authorities

- It has been our experience that during a strike and/or while planning for a potential strike there is a negative impact on the provision of health services to our population. Planning, in and of itself, shifts our attention from the provision of effective and safe health services and distracts our health care teams. Given the current system where the filing of a conciliation officer's report triggers a mandatory 14 day count down to a legal strike or lock out position, implementation of the plan to achieve a reduction in the level of services being provided occurs well in advance of being in an actual strike or lockout position (Annapolis Valley Health, p. 1).

- As one of the only provinces in Canada that gives healthcare workers an unrestricted right to strike with no legislative negotiation, it has been necessary for CDHA to rely upon a voluntary process under the collective agreement. Through this process, the parties attempt to designate those employees deemed to provide "emergency" services only.

  This process depends upon the good faith of the union whose fundamental interest is to exert pressure upon the employer through the threat of work disruption. Also, "emergency" services contemplates a much lower standard of care and staff levels than "essential services" and therefore place patients at great risk (Capital District Health Authority, p. 4).

- In public sector bargaining, it is rare lately that a strike vote is taken when bargaining is at the breaking point but it is usually carried out early in the process. In other words, the membership may not have a final say on a strike (South Shore Health, Addendum,p.1)

- We live in an area where services are shared across sectors. For example, two of our smaller facilities i.e. Guysborough and Canso , the hospital and nursing home are housed in the same building. Support and other services are shared daily. Any alteration of these services impact the elderly who are living in their homes under the classification of a nursing home. Clearly their care and safety should never be jeopardized by a potential strike or a strike (Guysborough Antigonish Strait Health Authority, p.2).

Nursing Homes:

- The lives of our residents and their families were severely impacted. Residents received minimal care and socialization activities were absent. They received care from care givers they did not know and expressed anxiety and worry about their own health and well -being as well as for their families and the staff.

  Family members reported severe distress, impact on health and disruption of their lives as they spent long hours assisting with the care of their family member. They crossed picket lines against the wishes of staff who normally cared for their loved ones and whom they had grown to trust. Many of these relationships took months to heal (Harbourstone Enhanced Care, p.2).

- Much time had been expended in continency planning, putting measures in place to minimize safety risk to the residents. Because this is the residents' home, there were no options to close units or 'discharge' (Northwood Incorporated, p.2).

Associations

- While it's clear that strikes will deprive Nova Scotians of access to health services, what isn't so clear is the impact of threatened strikes. In late October of 2006, workers represented by CUPE and CAW and employed by eight Nova Scotia districts gave notice of their intention to strike. Eleventh hour negotiations actually prevented that strike from occurring, but well before that agreement was concluded, hospitals found it necessary to commence a lengthy process of discharging patients, cancelling surgeries and other procedures. Clearly, hospitals cannot perform surgeries if the required post-surgical care cannot be provided with safety and with certainty. That bargaining dispute of last year will not show up in your statistics as it did not conclude in a strike. The disruption to health care was, nonetheless, very significant (Nova Scotia Association of Health Organizations (NSAHO), p.2).

- The discussion of essential services model in the June 2007 discussion paper emphasizes institutional care. The majority of continuing care recipients are not in nursing homes or residential care units. They are in family homes (Caregivers Nova Scotia, p.2).

Consultants

- Unions have taken advantage of the trend towards centralized or lead table bargaining to align expiry dates of all Collective Agreements to a common date. By achieving this, they have created vulnerabilities in the sector and have increased their leverage by effectively using the threat to sector wide disruptions of services to achieve favorable settlement terms. This trend has also greatly reduced opportunities for employers to effectively plan for strikes, since clients cannot be relocated to other facilities in adjacent areas when the entire sector is impacted by the work stoppage (CML Consultants, p.2)

- The mandate in long term care is the provision of quality care to clients in need of such care. Providers have responsibilities, professionally and otherwise, to be diligent in delivering such care. Over the last few rounds of bargaining, the brinkmanship adopted as bargaining strategies by parties operating at a provincial level have created unreasonable and unnecessary risk and fiscal pressures for those responsible for delivering the service. Risk management and due diligence responsibilities of providers requires them to implement strike planning or essential services measures thereby expending valuable service hours and dollars to prepare for an event that all parties seem to agree will not be permitted by government (CML Consultants, p.3)

E. Comments on Work Stoppages and Statistical Data

The discussion paper included background information related to work stoppages in these sectors as well as a statistical summary of legal and illegal strikes between 1971 and the present.
The key message contained within some employer submissions was that while the statistics were accurate in terms of the number of work stoppages (both legal and illegal), these statistics alone under represent the impact of work stoppages because the threat of a work stoppage is as disruptive and impacts on service delivery even if a strike is averted.

A number of the employer submissions also provided a first hand perspective of their experience and the impact of strikes. In addition, some submissions provided detailed information related to specific service delivery impacts when strikes are threatened.

The FOL raised questions related to the relevance of the statistical data and how work stoppages are tabulated. It stated that there have been only 3 legal hospital strikes since 1971 and only 2 one day strikes in the past 15 years.

The FOL also suggested that the statistics may be misleading and over represent the problem because illegal strikes will not be prevented by the removing the right to legally strike and should not be included in the data. (It should be noted that 27 of the 101 strikes were identified in Appendix A as illegal).

F. Factual Error

Through this process one factual error in the discussion paper was brought to our attention and we thank the parties for the opportunity to provide the appropriate clarification.

On page 3 of the discussion paper it was incorrectly stated that the IWK Health Centre was not unionized until after the merger with the Grace Maternity Hospital in the 1990s. In fact, the IWK healthcare bargaining unit was certified as the IWK Technical Association in 1975. The nurses, however, were certified in the 1990s when the merger occurred with the Grace Maternity Hospital.

G. Suggestions/Recommendations

The following is a summary of more specific suggestions/recommendations contained in the submissions:

1. Encourage government as part of the review to speak with geriatricians and psycho - geriatricians about the impact of strikes on residents' healthcare status including long -term effects;

2. Consider final offer selection as a form of interest arbitration (this was recommended in a number of submissions noting that it was successfully used to end the IWK Health Centre/NSGEU dispute);

3. Provide clarity regarding implementation processes/strategies to assist with further discussions related to interest arbitration models (for example: selection/appointment process for arbitrators);

4. Define parameters around a binding arbitration process with consideration to factors including: cost, time lines, expertise of arbitrators, penalties for illegal action, use of binding arbitration for first contracts, and issues that can be referred to arbitration;

5. Legislation for interest arbitration needs to include certain principles such as the equal application of wages (with consideration to the Atlantic Canada marketplace), health, and pension benefits across the province; and

6. Consider all forms of arbitration and the one selected must strike balance between fairness to employees and employers.

Next Steps.....

The above-noted summary of feedback received on the department's discussion paper will be posted on the department's website for public review. The government will now consider the comments.

We would like to thank those organizations and individuals that provided written submissions to the department on this very important issue. Your input is appreciated and valued.