

The Right to Strike and the Provision of Emergency Services in Canadian Health Care

by Larry Haiven and Judy Haiven

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About the Authors:

Larry Haiven is associate professor in the Department of Management, Faculty of Commerce, Saint Mary's University, Halifax. He is also the chair of the research advisory committee of the Nova Scotia chapter of the CCPA.

Judy Haiven is assistant professor in the Department of Management, Faculty of Commerce, Saint Mary's University, Halifax and a research associate of the Nova Scotia chapter of the CCPA.



CANADIAN CENTRE FOR POLICY ALTERNATIVES
410-75 Albert Street, Ottawa, ON K1P 5E7
tel: 613-563-1341 fax: 613-233-1458
email: ccpa@policyalternatives.ca
<http://www.policyalternatives.ca>

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Executive summary

Once again Canada's health care sector has been rocked by strikes and near misses. Since 1999 almost 200,000 employed health care workers across the country have engaged in or threatened various forms of job action. In some cases the disputes have lasted over a month. In all cases the health care system has been thrown into turmoil. If health care labour relations were a national and not a provincial affair and had all of the disputes occurred together, then these disputes would be seen by all as a symptom of a national crisis of epic proportions – a crisis of health care employment.

In every dispute there arises the perennial issue of the right to strike. Should workers whose jobs are considered “essential” have the right to withdraw their labour and should their employers have the right to lock them out? The reason the issue is so crucial is that two “rights” appear to be in collision. On the one hand, we have the right of users of the health care system to obtain care and not be subjected to conditions unnecessarily dangerous to life and limb. On the other hand we have the right of those who deliver the care to decent terms and conditions of employment, to negotiate those terms and not have those terms imposed upon them. The same issue persists across Canada yet there are many different responses by employers and governments.

The authors draw from twenty-five years of experience as practitioners and scholars in the field of health care industrial relations. They look at a wide range of disputes and conflict regulation efforts to reach the following conclusions:

1. Strikes happen! It matters not what form of law a government chooses to use to regulate industrial conflict in health care, industrial conflict occurs. Even outlawing strikes entirely (permanently or temporarily) does not prevent strikes from taking place. Even substantial fines and other penalties do not prevent health care workers from staying off the job. Conflict is often a necessary ingredient to the resolution of labour disputes. It cannot be eliminated by a legislative snap of the fingers.
2. There are several models of regulation of work stoppages that exist across the country. Sometimes strikes are allowed; sometimes they are forbidden and sometimes they are contained. None of these models is perfect. Each has its advantages and disadvantages. There is no facile solution to the problem. But we will argue that removing or constraining the right to strike are unworkable and counterproductive.
3. Third-party intervention in industrial conflict can be helpful. But not if it is used as a binding and permanent solution. A fundamental, inescapable ingredient of successful industrial relations is voluntarism.
4. It is erroneous to assume that employers and unions in health care are somehow balanced in their bargaining power, more erroneous to assume that unions have an advantage. Even where the striking employees are key players in

direct patient care, employers have great power advantages and the playing field is strongly tilted in their favour. Even where strikes are allowed, unions do not necessarily “win” them.

5. Work stoppages in health care are never total. First, health care workers are assembled into different bargaining groups which negotiate with employers separately. It is rare that more than one group is on strike at any one time. Second, in even the most rancorous quarrels, unions of striking health care workers arrange to provide emergency services during stoppages. Where strikes are legal, sometimes the law stipulates how emergency services will be provided; sometimes the law is silent, leaving it to voluntary negotiation between employers and unions. In cases where strikes are illegal there is, of course, no provision for emergency services. This is ironic because banning strikes is supposed to eliminate uncertainty but often ends up producing it and often exacerbating it.
6. An ominous new development is the trend of governments to impose what might be called “settlement-by-edict”. One of the fundamentals of a modern industrial democracy is free or collective bargaining. Yet, though it goes against all the precepts of voluntaristic collective bargaining, governments are increasingly overriding the negotiation process to avoid work stoppages. Increasingly governments are making strikes illegal. In the past, they would impose binding third-party “interest” arbitration as a substitute. But governments are now going one perilous step further. When a strike happens, increasingly governments will not only legislate an end to the strike’s legality, they will also ordain the precise wages, benefits and collective agreement language by which the parties will have to abide. This has been done by governments of all political persuasions.
7. Ironically, governments are finding that the Draconian solution described above does not succeed in ridding them of their labour problems. Indeed, it often makes the groups of workers angrier and is often perceived by the public as manifestly unfair. Often it prompts the unions involved to defy the back-to-work orders. Even if the strikers succumb, another, more desperate stratagem emerges: groups of valuable workers threaten resignation – a form of industrial suicide, if you will. While mass resignation is meant primarily as a threat and has never come to fruition, few rational Canadians wish to see push come to shove.
8. Labour disputes in health care mirror another key area of contention – the future of Canada’s public health system. Canadians are deeply concerned about the capacity of the health care system to deliver the amount and quality of care we need when we need it. There is increasing public distrust of governments’ abilities as “steward” of the system and increasingly unions are framing their labour disputes as over the quality of the system. In the case of nurses especially, health care workers arguably manage to wrestle successfully with governments as stewards of the system. Governments that declare war on health care workers risk being seen as declaring war on health care.

Introduction

Once again Canada's health care sector has been rocked by strikes and near misses. Since 1999 almost 200,000 employed health care workers across the country have engaged in or threatened various forms of job action. In some cases the disputes have lasted over a month. In all cases the health care system has been thrown into turmoil. If health care labour relations were a national and not a provincial affair and had all of the disputes occurred together, then these disputes would be seen by all as a symptom of a national crisis of epic proportions – a crisis of health care employment.

There have been a number of threatened or actual doctors' strikes as well: a seventeen-day stoppage in Newfoundland and Labrador in October 2002, a strike in 2001 in New Brunswick, in 1999 in Montreal and British Columbia and a narrowly averted one the same year in Alberta. While doctors are striking for many of the same causes as other health care workers, for the most part they are independent entrepreneurs and our purpose in this paper is to discuss strikes and emergency services provision by health care *employees*.

In every dispute there arises the perennial issue of the right to strike. Should workers whose jobs are considered "essential" have the right to withdraw their labour and should their employers have the right to lock them out? The reason the issue is so crucial is that two "rights" appear to be in collision. On the one hand, we have the right of users of the health care system to obtain care and not be subjected to conditions unnecessarily dangerous to life and limb. On the

other hand we have the right of those who deliver the care to decent terms and conditions of employment, to negotiate those terms and not have those terms imposed upon them. The same issue persists across Canada yet there are many different responses by employers and governments.

We will use the word "essential" sparingly in this essay because to do otherwise would be to engage in a tautology. Properly speaking, there are no gradations. Using the term "essential" makes a presumption of absoluteness even if unintended. But, as we shall see, there is considerable latitude in the concept of "essentiality" as it applies to provision of health care services. And there is considerable opportunism in the use of the term. For instance, the number of employees that management of a health care institution deems sufficient during "normal" (i.e. non-strike) operations sometimes proves to actually be *less* than it deems to be necessary during a strike. Suffice it to say that the concept of essentiality is highly contested terrain. We will, rather, use the term "emergency" to describe the services or coverage to be provided by striking employees.

The authors feel daunted by the challenge of arguing in an arena that is so fraught with both emotion and human peril. There are certainly those who are far more expert in the intricacies of medicine and health care administration. Yet the notion of expertise is not value-free. The more one is an expert in one thing, the less one tends to be an expert in others. Let us say merely that it is time that considerations of medicine and health care administration be tempered by considerations of those who provide those

services as it is impossible to separate one from the other. The authors have been following industrial conflict in Canadian health care for more than twenty-five years, as practitioners and academics. This article draws from both practical experience and scholarly study and is a modest attempt to reconcile the two considerations.

Let us start with a selection of cases in the last four years alone that illustrates the diversity of approaches and some emerging trends (see Table 1 also):

Recent health care strikes and strike threats

- Technologists, physiotherapists, pharmacists, social workers, respiratory therapists and 25 other groups of workers in the Health Sciences Association of Saskatchewan held a 29-day strike in September/October 2002. It was the first strike in the union's thirty years of existence. Saskatchewan health workers have the legal right to strike and the provision of emergency services is voluntarily negotiated between union and management. The provincial NDP government exhibited patience by declining to intervene to end the strike as it did with nurses in 1999. Like other "allied health professionals" ¹ across the country, the 2500 workers had been eclipsed by the more high-profile nurses and saw their working conditions and real wages deteriorate throughout the 90s.
- The Summer of 2002 saw a number of walkouts by nurses in Montreal hospitals on the issue of overcrowding in emergency rooms. ER nurses at the Montreal General Hospital staged their second walkout of the Summer when 62 patients were crowded into an ward meant to hold 20. That walkout ended when hospital officials agreed to reduce the number of patients to 47 by transferring some to other hospitals. But soon afterward emergency-room nurses at Sacre Coeur Hospital walked off the job for three and a half hours citing lack of staff before officials assured them that staffing was due to increase. No disciplinary action was taken against the nurses.
- In the Spring and Summer of 2002, Prince Edward Island nurses, frustrated with the slow progress of bargaining under regime where strikes are not legal, waged a successful campaign of media advertisements that effectively embarrassed the provincial government into negotiating rather than resorting to arbitration. The president of the nurses' union was preparing to sit in in the Premier's office to highlight her members' claims.
- In the Spring of 2002, nurses in Saskatchewan and Manitoba, in separate negotiations, won wage increases of 20 percent (over a period of three years in Saskatchewan; over a period of two and a half years in Manitoba). In both cases, nurses had the right to strike and the governments (both NDP) resisted the temptation to take it away (as the Saskatchewan government had done to nurses in 1999.) In Saskatchewan, emergency services agreements are voluntary; in Manitoba they are compulsory. In both provinces, the unions had given strike notice but settled before a walkout occurred. A slogan of the Manitoba Nurses Union during their dispute was "bargaining for the future of healthcare."

- A year earlier, in June 2001, Nova Scotia faced an impending strike by three groups: registered nurses, licensed practical nurses and allied health professionals. Health care workers had suffered a 10% cut in their real wages since 1991 through wage freezes and rollbacks. Health care strikes are usually legally allowed in that province and emergency services provision is voluntary. But the Progressive Conservative government of Premier John Hamm introduced temporary legislation making the threatened strikes illegal. The legislation also gave the government power to impose the terms of a collective agreement. Allied health professionals actually walked out briefly while the strike was still legal. After massive demonstrations at the legislature, a stinging series of pro-union television advertisements, over 1600 nurses signing letters of resignation and public opinion turning sharply in favour of the workers, the government backed off and reached agreement with the unions and the health employers to submit their disagreements to “final offer selection.” The arbitrator opted for the unions’ proposal for registered nurses but sided with the employers for the other occupations.
- Around the same time, nurses and allied health professionals in British Columbia were locked in a struggle with their employers and the new Gordon Campbell Liberal government. Strikes were legally allowed in BC but emergency services agreements were compulsory. After a several-week overtime ban by nurses and a brief walkout by paramedical workers, the government passed legislation outlawing work stoppages for three years and imposing terms of settlement on the unions. A threatened mass resignation of nurses (à la Nova Scotia) failed to move the government (which held all but two seats in the legislature). Nurses received a wage increase of 23.5% over three years but other occupations came up with less. Six months later the government legislation ripped up and rewrote many of the employment security provisions in health care collective agreements.
- The same Spring of 2001 saw a five day strike by New Brunswick acute health care support staff ². The strike began legally, though under legislative provisions 3500 of the 6000 workers had been declared “essential” by the Labour Relations Board and compelled to work. Despite this, the government passed legislation outlawing the strike completely and giving itself the power to impose terms of settlement. Labour and management came to an agreement to avert the strike just before the law could be enforced. A few months later, a legal strike by nursing home employees ended similarly, just before anti-strike legislation could be enforced.
- Even in Ontario, where hospital workers do not have the right to strike at all, nurses in the 2001 bargaining round showed their impatience and displeasure with negotiations by implementing work-to-rule policies and refusing to work overtime and extra shifts. Such measures can have almost as much disruptive effect as an all-out strike. Indeed, they are technically strikes under labour law. That the employers did not move to invoke legal sanctions illustrates just how careful they can be not to strike a match in a tinderbox.

- Health care workers in Alberta have not had the legal right to strike since 1983. But in the Spring of 2000 more than 10,000 licensed practical nurses and other support staff at 159 Alberta hospitals and continuing care facilities walked out illegally for 48 hours. The strike was settled with the personal intervention of Premier Ralph Klein. Under the permanent strike ban, health unions and members engaging in illegal strikes face heavy penalties, which in this case came to a \$200,000³ fine for the union and the suspension of dues for two months, costing it an additional \$400,000. Despite these penalties, the illegal strike paid off: though the employers original offer was 9% over three years, the union won a 16% raise over two years for LPNs. Support workers also won “no contracting-out” language.
- Saskatchewan saw health care strikes handled in two very different ways in 1999 and 2000. While such strikes are not normally illegal, in April 1999 the government intervened to ban a strike by 8,000 nurses as soon as they walked out. Despite protestations by employers that they could not weather a strike, the nurses defied the strike-ban for ten days and received a court-imposed fine of \$125,000. They settled for 13.7% over three years to break through the government’s mandate of 6% over the same period. A year later, the same government, faced with a strike of 12,000 general support workers, *declined* to intervene. Six days later the parties settled at a 9% raise over three years.
- Ambulance paramedics in Nova Scotia went on strike in October 1999, as the law in that province allowed them to do. Recently unionized, they were far worse than health care workers in pay, benefits and hours of work. As it was later to do in the Spring of 2001 with nurses and allied health professionals, the Conservative government passed a law banning the strike. Eighteen hours into the strike, the parties reached an agreement to submit the dispute to mediation-arbitration. Unable to resolve the dispute by negotiation, the arbitrator awarded a 20% raise over three years. This did not satisfy the ambulance workers’ aims, but it was a far greater amount than the government hoped to pay. Coming just before negotiations with other health care unions, the award alarmed the government and made it extremely wary of arbitration in the future.
- Two health care strikes hit Newfoundland in a year-and-a-half. As in Nova Scotia, health care employees had seen their real wages drop throughout the 1990s from government freezes and rollbacks. Health care strikes are not illegal in that province but the Labour Relations Board can deem a proportion of employees “essential” and unable to strike. In March 1999, the province’s 4600 nurses, at the time the lowest-paid in the country, walked off the job to attain wages closer to the Atlantic norm, more full-time employment and a decrease in their workloads. Nine days into the strike, the Brian Tobin Liberal government passed legislation making the strike illegal, imposing the terms of a collective agreement and threatening heavy fines for individual strikers and their union. The union reluctantly complied. The government’s imposed terms left nurses no further ahead but the government promised action to hire

more nurses and convert part-time jobs to full-time.

- In October 2000, about 700 Newfoundland radiological and laboratory technologists walked off the job for eight days in the middle of their collective agreement. As elsewhere in Canada, “wildcatting” as this is called, is always illegal. The strikers said they were fed up with the slow pace of a “job reclassification process” meant to rectify the growing gap between their pay and that of nurses. The employers’ association obtained a court injunction ordering strikers back to work and launched contempt of court actions. The strike was settled when government agreed to appoint a mediator to help with the reclassification.
- The longest nurses’ strike in Canadian history occurred in Quebec in June and July of 1999. Health care strikes are technically legal in Quebec. But the law says that up to 90% of workers in a health care establishment are “essential” and unable to strike ⁴. Penalties for violating this legislation are severe - from fines to strikers losing two days’ pay and one year’s seniority for every day on strike. For each day on strike, the union loses twelve weeks of dues. Health care unions tend to view the law as tantamount to banning strikes entirely. The nurses’ strike began when 47,500 union members refused to work overtime. This escalated into two day-long walk-outs and finally spread to all health care facilities in the province. Unable to bring the nurses to heel with the existing legislation, the PQ government of Lucien Bouchard removed the right to strike entirely and upped the penalties. But union members continued their

walkout, to an outpouring of public sympathy, including polls showing majority public support and 120,000 signatures on a petition. The government and the union reached a tentative agreement on July 18 but union members rejected it despite the recommendation of their leaders. The strike continued another six days, when the exhausted nurses returned to work, their union internally riven by dissent.

Initial observations

A number of initial observations can be gleaned from these examples:

1. Strikes happen! It matters not what form of law a government chooses to use to regulate industrial conflict in health care, industrial conflict occurs. Even outlawing strikes entirely (permanently or temporarily) does not prevent strikes from taking place. Even substantial fines and other penalties do not prevent health care workers from staying off the job. So contentious have the market and workplace pressures in health care delivery become that it is impossible to avoid conflict. Even where excellent relations exist between unions and employers, there will be issues on which they will not or cannot agree without at least some conflict. But, as will be shown below, good relations help immeasurably to diminish the strife. The point is that conflict is often a necessary ingredient to the resolution of labour disputes. It cannot be eliminated by a legislative snap of the fingers.
2. There are several models of regulation of work stoppages that exist across the country. Sometimes strikes are allowed;

Table 1
A Selection of Health Care Strikes and Near-Strikes in Canada 1999-2002

Province	Model of regulation in operation	Year	Group(s) of employees (bargaining units) involved	Special action taken by government, gov't agency or employers to deal with strike?	Strike? Legal or illegal	Result
Saskatchewan	unregulated	Autumn 2002	allied health professionals ¹ (acute care)	None	legal strike	dispute settled after 29-day strike
Quebec	regulated ²	Summer 2002	registered nurses (acute care)	None -	illegal wildcat strike during term of contract; at 2 hospitals in Montreal	dispute resolved within days
PEI	permanent strike ban (PSB)	Summer 2002	registered nurses (acute care)	n/a	no strike; other civil disobedience planned before settlement	collective agreement reached before arbitration
Saskatchewan	unregulated	Spring 2002	registered nurses (acute care)	n/a	strike vote taken	dispute resolved before strike
Manitoba	regulated ³	Spring 2002	registered nurses (acute care)	n/a	strike vote taken	dispute resolved before strike
Nova Scotia	unregulated	Spring 2001	registered nurses; allied health professionals (acute care)	Ad hoc legislation passed banning strikes for both groups and giving gov't power to impose contract terms	5-day legal strike by allied health professionals until strike ban; mass resignation of RNs threatened	all parties agree to final offer arbitration; gov't withdraws strike ban legis'n
British Columbia	regulated ⁴	Spring 2001	registered nurses; allied health professionals (acute care)	Ad hoc legislation passed banning strikes for both groups and imposing contract terms	nurses overtime ban; allied health professionals strike for 1 day	RNs threaten mass resignation; both groups submit to imposed terms
New Brunswick	regulated ⁵	Summer 2001	support staff ⁶ (long term care)	Ad hoc legislation passed banning strike and giving gov't power to impose contract terms	no strike	agreement reached just before strike ban effective
New Brunswick	regulated (see above)	Spring 2001	support staff (acute care)	Ad hoc legislation passed banning strike and giving gov't power to impose contract terms	no strike	agreement reached just before strike ban effective

Ontario	PSB	Spring 2001	registered nurses (acute care)			work-to-rule and ban on extra overtime to protest slow negotiations (technically these constitute strike)	agreement reached; no action to discipline union
Newfoundland	regulated ⁷	Autumn 2000	X-ray and laboratory technologists (acute care) ⁶	employers get court injunction & launch contempt of court action	8 day illegal wildcat strike during term of contract	strike ends when government agrees to appoint mediator to help resolve dispute	
Alberta	PSB	Spring 2000	support staff (acute care)		48-hour illegal strike	agreement reached and strike ends - healthy raises for LPNs; \$400,000 in penalties to union	
Saskatchewan	unregulated	Spring 2000	support staff (acute care)		six-day strike	agreement reached and strike ends	
Nova Scotia	unregulated	Autumn 1999	ambulance paramedics	Ad hoc legislation passed banning strike	18 hour legal strike until legislation effective	parties agree to arbitration, which awards healthy increase to union	
Saskatchewan	unregulated	Spring 1999	registered nurses (acute care)	Ad hoc legislation passed banning strike and imposing contract terms	Nurses defy strike ban for ten days	agreement reached and strike ends; nurses win more than in original legislation; \$125,000 in penalties to union	
Newfoundland	regulated (see above)	Spring 1999	registered nurses (acute care)	Ad hoc legislation passed banning strike and imposing contract terms	Nurses obey strike ban	nurses submit to contract terms	
Quebec	regulated (see above)	Spring-Summer 1999	registered nurses (acute care)	after several weeks of legal strike, gov't passed ad hoc legislation banning strike	longest nurses' strike in Canadian history; illegal for 21 days	union returns to work on government's terms; large penalties for union and participating nurses	

¹ Such as technologists (e.g. laboratory, radiology), respiratory therapists, physiotherapists, social workers etc.

² In Quebec acute care hospitals, the Labour Code insists that 80% of the regular complement of employees work during a strike.

³ First employer designates "essential" employees. If union disagrees, Labour Relations Board decides

⁴ Unions and employers attempt to agree on emergency services regime; if disagree, arbitrator decides.

⁵ Unions and employers attempt to agree on emergency services regime; if disagree, Labour Relations Board decides.

⁶ E.g. housekeeping, dietary, auxiliary nursing, maintenance staff

⁷ Unions and employers attempt to agree on emergency services regime; if disagree, Labour Relations Board decides.

⁸ Wildcat strike (during term of collective agreement) to protest slow pace of job reclassification (to rectify growing gap between them and nurses).

sometimes they are forbidden and sometimes they are contained. None of these models is perfect. Each has its advantages and disadvantages. There is no facile solution to the problem. But we will argue that removing or constraining the right to strike are unworkable and counterproductive.

3. It is erroneous to assume that employers and unions in health care are somehow balanced in their bargaining power, more erroneous to assume that unions have an advantage. Even where the striking employees are key players in direct patient care, employers have great power advantages and the playing field is strongly tilted in their favour. Even where strikes are allowed, unions do not necessarily “win” them.
4. Third-party intervention in industrial conflict can be helpful. But not if it is used as a binding and permanent solution. A fundamental, inescapable ingredient of successful industrial relations is voluntarism.
5. Work stoppages in health care are never total. First, health care workers are assembled into different bargaining groups which negotiate with employers separately. It is rare that more than one group is on strike at any one time. Second, in even the most rancorous quarrels, unions of striking health care workers arrange to provide emergency services during stoppages. Where strikes are legal, sometimes the law stipulates how emergency services will be provided; sometimes the law is silent, leaving it to voluntary negotiation between employers and unions. In cases where strikes are illegal there is, of course, no provision for emergency services. This is ironic because banning strikes is supposed to eliminate uncertainty but often ends up producing it and often exacerbating it.
6. An ominous new development is the trend of governments to impose what might be called “settlement-by-edict”. One of the fundamentals of a modern industrial democracy is free collective bargaining. Yet, though it goes against all the precepts of voluntaristic collective bargaining, governments are increasingly overriding the negotiation process to avoid work stoppages. Increasingly governments are making strikes illegal. In the past, they would impose binding third-party “interest” arbitration ⁵ as a substitute. But governments are now going one perilous step further. When a strike happens, increasingly governments will not only legislate an end to the strike’s legality, they will also ordain the precise wages, benefits and collective agreement language by which the parties will have to abide. This has been done not just by governments of the right, such as the BC Liberals or the Nova Scotia and New Brunswick Conservatives, but also by governments of the centre and left-centre. Indeed, the first recent incident of settlement-by-edict occurred almost simultaneously in the Spring of 1999 by two governments, the Tobin Liberals in Newfoundland and the Romanow NDP in Saskatchewan.
7. Ironically, governments are finding that the draconian solution described above does not succeed in ridding them of their labour problems. Indeed, it often makes the groups of workers angrier and is often perceived by the public as manifestly unfair. Often it prompts the un-

ions involved to defy the back-to-work orders. Even if the strikers succumb, another, more desperate stratagem emerges - groups of valuable workers threaten resignation – a form of industrial suicide, if you will. While mass resignation is meant primarily as a threat and has never come to fruition, few rational Canadians wish to see push come to shove.

8. Labour disputes in health care mirror another key area of contention – the future of Canada’s public health system. Canadians are deeply concerned about the capacity of the health care system to deliver the amount and quality of care we need when we need it. There is

increasing public distrust of governments’ abilities as “steward” of the system and increasingly unions are framing their labour disputes as over the quality of the system. In the case of nurses especially, health care workers arguably manage to wrestle successfully with governments as stewards of the system. Indeed, the Manitoba Nurses Union quite explicitly appealed to public unease with their slogan in the 2002 dispute. Governments that declare war on health care workers risk being seen as declaring war on health care.

To begin, let us look more closely at this sometimes mysterious realm of health care collective bargaining.

The structure of health care collective bargaining

In Canada, jurisdiction over both health care and employer-employee relations lies primarily with the provinces⁶, with each province handling similar problems a little differently. So it is necessary to generalize.

There are several common features: Provincial governments spend more money on health care than any other activity (between thirty and forty percent of budget). Health care is labour-intensive (seventy-five to eighty percent of the health care budget is in employee compensation). It is estimated that a million people are employed in health care (Sutherland and Fulton 1990, 69). Perhaps a quarter of Canadians are related to them. Thus, sheer numbers alone would suggest that relations between health care employers and employees are a crucial element of public policy.

Even more important is the fact that many health care employees perform tasks directly related to the life and death of patients/clients. Moreover, the mix of employees, their tasks and the way they work together is exceedingly complex. Skill levels vary greatly. All kinds of specialist professions, semi-professions and occupations abound e.g. doctors, nurses, technologists and therapists of all descriptions. These occupational groups each have their own interests. And these interests are expressed through several different kinds of organizations, all of which compete for power, influence and remuneration in the medical division of labour (Daly and Willis 1989; Larkin 1983; Torrance 1987).

The interests and affairs of some professions are represented by several organizations. Those with the power to cause harm

are sometimes regulated by a government-mandated "College" (e.g. College of Nurses, College of Physicians and Surgeons). Many groups are also represented by "professional societies" (e.g. national and provincial level Association of Medical Radiation Technologists, Registered Nurses' Association.) In many provinces, these societies play the role of a regulatory College as well.

Most occupational groups are also represented by trade unions. Health care is one of the most highly unionized sectors of the economy. Across all of health care, over 66% of employees (and 83% of nurses) are covered by trade unions. In British Columbia this rises to 78% and 93%, respectively. (Akyeampong 2000). In acute care, the proportion would be considerably higher. So it is safe to say that health care is one domain where attempting to bring about change without negotiation is folly.

In discussing the right to strike, we are primarily interested in unions and how they bargain with employers in health care.

Subsectors in health care

There are five major informal divisions in health care across the country. *Acute care*, consisting largely of hospitals providing intensive treatment and surgery, is the largest in employment and expenditure. *Long-term care*, the second largest division, comprises institutions where more chronic and long-lasting conditions are best cared-for. *Home care* includes the care of patients in private homes with nursing, homemaking, meals and various types of therapy. *Community care* comprises public health (health educa-

tion and promotion, preventive home visits, disease control and sanitary inspection) and day care (treatment programs, often on a non-residential basis, at places like addiction centres). In some provinces, like Quebec, the boundary between acute care, community care and social services may disappear at such centres. A final division, *mental health care*, where patients are institutionalized, can also be identified. It is in acute care and long-term care that most disputes arise, though home care is a growing area where a great potential for conflict exists.

Employers' associations

Early in the last century, health care was largely funded by charities, non-profit organizations, religious orders and municipalities. In the forty years after the second world war, however, provincial governments increasingly took on funding responsibility, though they did not directly own or run most health care institutions. The legal employer was usually the board of directors of the institution or some level of government. Within each of the above divisions, employers would often unite into associations to share resources in such functions as advocacy, insurance, procurement, pensions and employee relations. Thus, representing employers in collective bargaining we have organizations like the Ontario Hospital Association, the British Columbia Health Employers Association, the Nova Scotia Association of Health Organizations.

Growth of unions

Before the huge growth of the health care system, universal Medicare and large-scale unionization of health care employees (a process completed by the late 70s), man-

agement of individual institutions would negotiate by themselves, or assisted by their employer association, with groups of employees within their walls. The first groups of employees to join unions were blue collar workers (e.g. dietary, housekeeping, auxiliary nursing and maintenance). Until the late 1970s, "professionalized" employees (e.g. interns and residents, registered nurses, registered technologists and therapists) either did not bargain collectively or did so through their professional societies. These employees later formed full-fledged unions ⁷.

But negotiations within single health care institutions became rarer as unions flourished. In most provinces central bargaining by employee group in each sub-sector emerged as the norm. This occurred by statute, by government encouragement, voluntarily, or by combinations among the three though not in all provinces for all employee groups ⁸. Thus, for example, the nurses union and the employers of nurses in acute care hospitals would meet at a central table and negotiate terms for nurses across the province. Similar arrangements prevailed for other employee groups. The arrangement was convenient for both unions and employers, especially where the employees concerned were skilled (like nurses). Although an ensuing strike could end up province-wide, the efficiencies outweighed the risk.

Pressures on collective bargaining

Throughout the 1990s, several phenomena combined to put inexorable pressure on health care workers' collective bargaining.

Regionalization

In the 1990s all provincial governments except Ontario ⁹ began to divide the health

care domain up into regional health authorities. For example, Saskatchewan formed 32 (later reduced to twelve) separate health authorities. Nova Scotia divided into four (later increased to nine). Previously independent subsectors were consolidated geographically and the district health authority became the employer rather than the boards of separate institutions. This resulted in the integration of services across the district. For example, all maternity care might move into a single hospital. All emergency care might move to another. The health district might take over long term care hospitals. Home care and public health might now be offered through the district. Employees would move more easily between institutions and jobs because they would take their seniority with them. Some health care facilities were closed entirely.

Power to deal with unions moved both up from individual institutions and, in some cases, down from the provincial government. However in most cases, and especially in the case of the more skilled groups of workers, central bargaining has persisted. This means that in most provinces when a group of health care workers has a dispute, it is with all of the employers in the province for that sector. For example, it may be allied health professionals in hospitals in British Columbia, or nurses in long term care in Manitoba, or general support workers in home care in New Brunswick.

Health care restructuring involved some wrenching changes, dislocations and job losses for health care employees, not the least of which was inter-union rivalry over which bargaining agent would represent the new, merged groupings of employees. The collective bargaining regime was sorely tested in the process.

Downsizing

Regionalization and restructuring combined with the mid-90s recession to shrink health care budgets. Complements of health care workers across the country began to shrink. What had been a shortage of skilled workers temporarily became a glut. In many provinces, employers shed workers through a mixture of layoffs, early retirements and buyouts. For a brief period, the vaunted shortage of nurses and technologists seemed to vanish.

Because health care had been such a stable, if not growing, industry to this point, collective agreements were mostly silent on the difficult issues of downsizing. Unlike in, say, the forest or automotive industries, unions and managements had little experience in and few tools for dealing with “labour adjustment”¹⁰. This situation put even more strain on collective bargaining. The Romanow Report indicates an 8% drop in RNs and a 21% drop in LPNs per 100,000 people over the decade. (Romanow, 2002, 93).

But the situation was to change in the late 90s as the economy improved and institutions readjusted to increased demands. A monstrous shortage of nurses and technologists (and several other skilled occupations) came surging back, again burdening collective bargaining.

“Hospital model” vs. “hospitality model”

For many years, what might be called the “hospital model” of employment had afforded a labour market shelter where workers, especially those at lower skill levels (who were the first to unionize) could negotiate better employment security, pay and conditions than counterparts outside of the public sector. Health care employers and governments had seen patient care as a

continuum where better working conditions for employees guaranteed quality service. A housekeeper, dietary aide or maintenance worker was considered part of a larger health care team.

But by the 90s the hospital model was beginning to come apart. Pressure to save money became relentless. At the same time, standards of critical clinical service quality had to be maintained. To accommodate, employers hastened two trends that had already begun. First there was the subdivision of skilled occupations into gradations of proficiency and compensation, a kind of “salami-slicing” of the internal labour market. Thus the corps of registered nurses would give way to a combination of nurses, licensed practical nurses and nursing aides¹¹. The corps of registered technologists and therapists would subdivide to add unregistered assistants and technicians. Each skill swath would have different duties in the division of labour. Moreover, the pay gap between nurses on the one hand, and other allied health professionals (e.g. technologists, physiotherapists), on the other, which was negligible in the 1970s, began to move apart through the 80s and 90s, as nurses used the superior bargaining clout borne of homogeneity.

Second, there began an assault on the working conditions of the less-skilled groups. Beginning outside the acute care subsector (and especially in long-term care, much of which is in the private sector) employers began to consider these employees as part of what might be called a “hospitality model.” In other words, the wages, working conditions and employment security of housekeeping, dietary and maintenance workers came to be compared to those of hotel workers,¹² with the accompanying lower wages and employment security.

Then employers in acute care began to adopt the hospitality model for lower-skill

employees. While collective bargaining with registered and licensed nurses, technologists and therapists proceeded as before (though not without conflict), negotiations with other employees took a different turn. Hospitals either began to drive these employees’ employment terms down or sought to contract their work out to the private sector entirely.

Old collective agreements and accords made conversion to the hospitality model troublesome for health care employers. So some governments began to help them by changing laws to weaken collective bargaining, make arbitrators more employer-friendly and, in the case of British Columbia, tear up and legally prohibit negotiated employment security agreements.

More work to do

With regionalization, downsizing and rationalization, many health care workers found their work intensified. This was especially true for nurses. Not only were there fewer of them in many cases, but patients also entered hospitals at higher stages of acuity and left sooner than they had before. Employees soon complained of fatigue and less time or no time to do important tasks, like intimate patient care, counselling, training and routine maintenance. In the downsizing, one of the first cadre to go were the non-union and therefore vulnerable first line supervisors. Far from being the fat of the system, supervisors had often been the essential lubricant that helped the system function smoothly by organizing tasks and schedules, training employees and filling in for absentees. Their scarcity often proved to be a great burden.

Dropping real wages

For those workers who remained after downsizing and contracting out, there was

more work to do, at lower pay. Throughout the recession of the mid-90s, the real wages of much of Canada's working population dropped. But for public sector workers, the situation was worse. In most provinces, governments froze wages for several years. In some provinces, governments dropped wages and/or forced employees to take days off without pay (e.g. Alberta, Ontario, Nova Scotia). Most of Canadian workers managed to make back what they had lost by 2000 but health care workers did not. In Nova Scotia, to use one example, the real pay of health most care workers had dropped by 10% from 1991 to 2000. On the other hand, national productivity had risen in the same period by about 25%.

By the turn of the century, as the economy improved, this situation had created a huge pent-up drive to catch up, especially among those employee groups most able to take advantage of their integral role in the health care system. Staff doctors, nurses and other licensed professionals were determined to stop the slide in their standard of living.

Summary

Together these features of the labour market created pressures that made conflict inevitable. What is surprising is not how much there has been but rather why there is not more. Perhaps the dedication of health care workers to their patients and clients is the answer.

“Standard” bargaining units

Understanding how health care workers have been divided into bargaining groups is a fundamental in appreciating industrial

conflict. Labour Relations Boards are the agencies who decide the structure of collective bargaining in any workplace or set of workplaces. A “bargaining unit” is a group of employees that is considered by a Labour Board to be “appropriate” for the purposes of collective bargaining. Boards use the test of “community of interest” to determine which units are appropriate. As with other things in labour relations, this differs somewhat from province to province. However, there are some general rules:

Acute care

Usually labour boards do not like to designate more than one or two bargaining units in a single workplace or under a single employer. But in an acute care hospital, with its multiplicity of employee groups, the following four groups commonly get their own bargaining rights:

- Interns (and sometimes medical residents)
- Registered and graduate nurses
- Allied health professionals (i.e. diploma and degreed technologists and therapists such as laboratory technologists, respiratory therapists, psychologists)
- General support workers (licensed practical nurses, housekeeping, laundry, dietary and maintenance)

The haphazard evolution of labour policy means that for every rule there are exceptions. In Manitoba, nurses and licensed practical nurses are together in single bargaining units. In some parts of some provinces, technologists are part of the general support workers bargaining unit. Alberta has recognized separate “professional” and “technical” paramedical units (though they will soon become one) and a separate unit for licensed practical nurses, making

for six units. In Quebec, some of the paramedical professions each have their own unit. In Nova Scotia, licensed practical nurses sometimes are put together with nurses, and clerical workers have their own bargaining unit apart from other support workers. In some provinces, some stationary engineers and maintenance workers retain their own bargaining autonomy.

Other health sectors

The situation is somewhat simpler in other health subsectors. In long-term care, labour boards often certify two units, one of registered nurses, another of all other occupations. In home care, boards will often do the same. Public health workers are often put together in one bargaining unit.

The structure of bargaining units is illustrated in Figure 1.

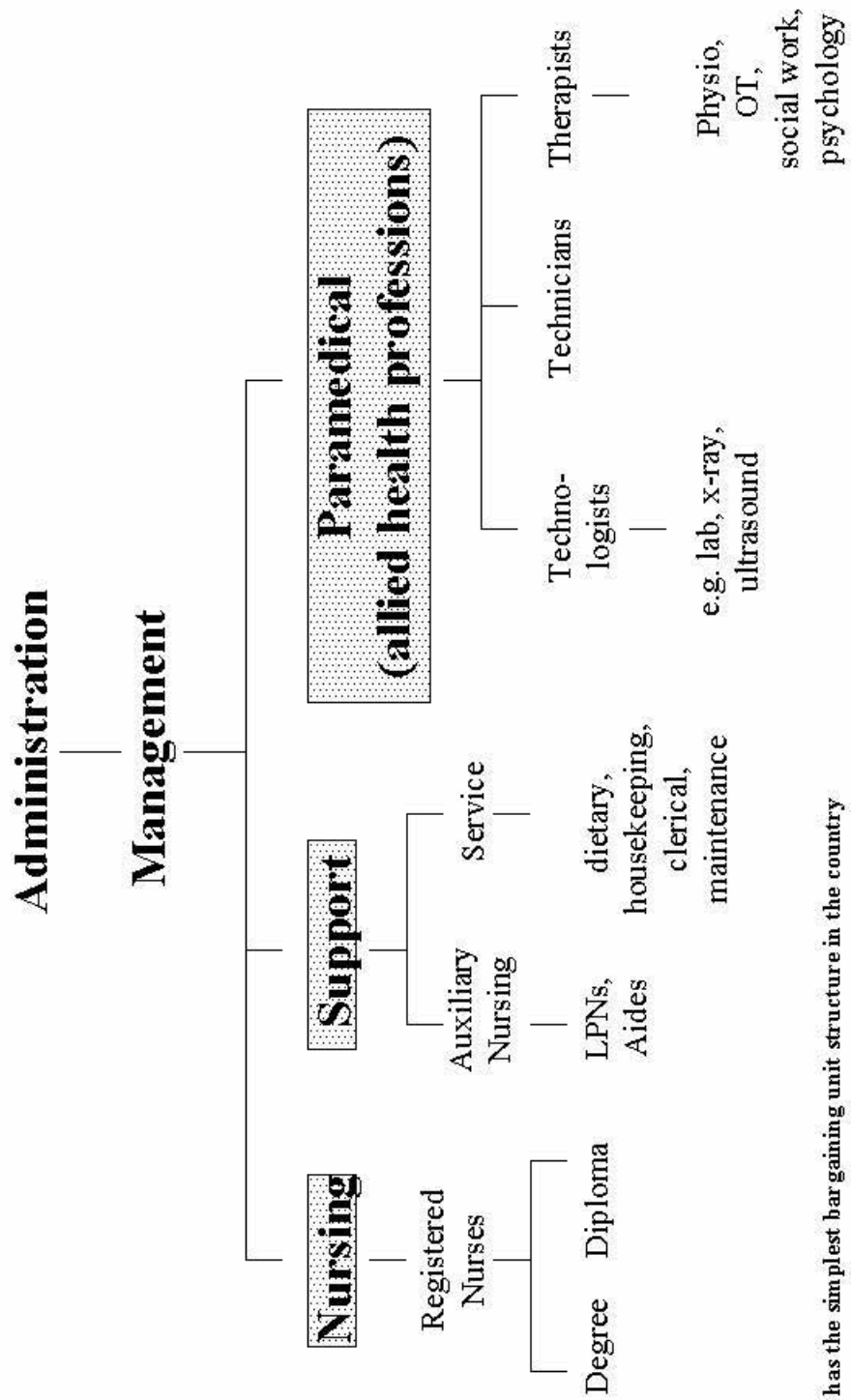
Representation by unions

Those are the *units* of employees considered appropriate for unionization. Another question entirely is which *bargaining agent* or union will represent them. This is an area of some complexity as unions compete fiercely for health care workers. For example, across the country and even often within a single province, general support

workers may be represented by the Canadian Union of Public Employees, the Service Employees International Union, the provincial government employees union, the Canadian Auto Workers, the United Steelworkers of America and several others. Allied health professionals may be represented by the government employee unions, or independent Health Sciences Associations. Registered nurses are the exception to this rule as they are usually represented by a single nurses' union in each province¹³. Moreover, in some places, a group of employees eligible for unionization may not be in a union at all¹⁴.

Indeed, except for nurses, seldom can a single union come to the bargaining table claiming to represent *all* employees of a certain type. So, for example, for general support workers, Alberta health employers might bargain with CUPE and the Alberta Union of Provincial Employees. For allied health professionals, Nova Scotia employers might bargain with the NSGEU, CUPE or the CAW. To force simplification, the British Columbia government in the mid-90s forced unions representing similar occupations to form a council, speaking with a single voice at a bargaining table. But other provinces have so far resisted this much rationalization of collective bargaining.

Figure 1
Bargaining Unit Structure in Acute Health Care
 British Columbia Model¹



¹BC has the simplest bargaining unit structure in the country

The government's role in health care collective bargaining

Provincial governments have an ambiguous and difficult relationship with health care collective bargaining. On the one hand, they supply the funds from which health care employers pay employees. Any compensation increase helps to set or threatens to break a pattern for other public sector personnel. Thus provincial governments try to influence the outcome of negotiations. Moreover, if there is a problem in employer-employee relations in health care, the government inevitably ends up bearing the responsibility of setting it right. From labour disruptions, to shortages of nurses and technologists, to failing employee morale, everything that makes for poorer health care ends up in the government's lap. Thus strong forces pull governments into involvement in the collective bargaining process.

On the other hand, governments have good reasons to keep their distance. They are *not* the employer and too much involvement undermines the authority of the actual employers. A one-size-fits-all approach across a province may not be appropriate for all employee issues. Sometimes, when governments are *too* involved in collective bargaining, they find themselves on one side of a dispute, with employers and employees making common cause on the other. The more governments are involved, the more

politicized bargaining becomes, to the extreme where every problem in the collective bargaining process is delivered immediately to the government's doorstep.

Governments play many roles in the health care collective bargaining process. As well as being paymaster, they sometimes actually sit at the bargaining table. Even when absent, they are a vigorous "ghost" at the table. As legislators, governments also make the rules by which employers and unions play. If the parties come to an impasse, government plays a further role as intermediary through its mediation services. And if the impasse cannot be settled and the rules of the bargaining game are broken, governments act as enforcers and punishers.

Notwithstanding the degree of formal government involvement, all governments are pulled into the fray when collective bargaining erupts into open conflict for more than a few days and when the quality of health care appears to be threatened. All eyes are on the provincial government in a health care strike. The pressure to "do something" can be inexorable. Standing by and allowing matters to run their course requires nerves of steel, though in the end, we will argue, this is the best of all possible choices.

The right to strike in Canada

Strikes are a paradox. In order to protect or improve their terms and conditions of work, workers refuse to work. In order to improve their pay and employment security, they go without pay and without work. And they do so regardless of, and sometimes in response to, the difficulty of doing so. The first recorded strike in Canadian history may be as far back as 1794 by a group of voyageurs in the fur trade, in conditions not exactly favorable to strikes. Indeed, the strikers did not win and their leaders lost their jobs (Lipton 1973, 1). Just because a strike has little chance of success has never deterred sufficiently frustrated workers. Before 1872, it was illegal for workers in Canada to form unions and to strike. And employers could sue strikers for damages incurred in any strike. In this industrial prehistory, the state would also frequently send soldiers to assist employers in putting down strikes. And still that did not stop determined groups of workers. Therein lies the key to understanding the importance of the right to strike.

Even under such an inhospitable legal regime, under the right economic conditions workers were in a position to drive their demands home. This occurred particularly in times of labour shortage and in key industries. In response to a wave of industrial unrest and to attract votes from the newly enfranchised working class, Parliament de-criminalized unions and strikes in the 1872 Trades Unions Act. But, says historian Craig Heron, “it was no Magna Carta for Canadian workers.” (Heron 1996, 16) Nothing compelled employers to recognize or bargain with unions. Employers could, and often did, still dismiss striking workers. And the state still obliged employers by

supplying them with bodies of armed men, as it did most famously in the Winnipeg General Strike of 1919 and the Stratford General Strike of 1933. Indeed, it is said that at one point in the 1920s over half of the Canadian armed forces were stationed in the Cape Breton Island coalfields at the request of employers¹⁵. The use of large numbers of armed people in strikes persists to this day.

Unable to crush worker militancy, Canadian governments have long quested to regulate and constrain strike activity. Spurred by workers in crucial industries like railroads flexing their industrial muscle, Parliament in 1900 established a conciliation service and in 1907 enacted the Industrial Disputes Investigations Act. The IDIA gave the government the power to declare strikes illegal and appoint an inquiry tribunal¹⁶. Even this restriction did not prevent illegal strikes from happening, sometimes across entire cities, as marked the general strike wave of 1919-20.

While the 1920s and early Depression saw union militancy fade under repression and poor economic conditions, new industrial unions¹⁷ emerged in the 1930s and 40s amid an unprecedented resurgence of industrial unrest. Unlike their counterparts in the United States, where the new era of industrial relations law began with the 1935 Wagner Act, Canadian business and government leaders were slow to come to terms with the new reality. It took the labour relations crisis of the Second World War to prompt Canadian governments to adjust public policy to upgrade the regulation of industrial conflict.

Modern industrial economies needed to bring collective bargaining into the mainstream, to both legitimize and control unions, and, in Canada's case, to forestall the growing popularity of left wing parties¹⁸. Seizing jurisdiction for labour matters from the provinces under wartime conditions, the Mackenzie-King government introduced Order-in-Council 1003 in 1944. PC 1003, as it is known, secured the right of unions in the private sector to represent units of employees, forced employers to bargain in good faith with them and protected striking workers from dismissal. The legislation adopted many features of the US law, now called the "Wagner model." After the war, when the provinces resumed control of labour relations, they replicated the model. The modern regime of collective bargaining as we now know it had arrived. While industrial conflict did not disappear, it became more ordered, more predictable and more stable as unions adapted to the law and became more conservative and more "responsible." Like all systems of democracy, the system of industrial democracy operates best under a form of "consent" and consent must be negotiated. But consent is nothing without the opportunity to not consent.

Indeed, effective collective bargaining and the right to strike are conceptually inseparable, linked in a dialectical embrace. As long as the parties are talking frankly and openly with each other about the issues nearest to their hearts and enterprises, the chances of conflict and disfunctionality in the workplace are reduced. However, without the ability to strike or lockout they cannot talk frankly and openly with each other.

Thus the goal of the modern collective bargaining regime was not to eliminate strikes. In fact, it recognized the principle of the right to strike and lock out as a cornerstone of the system. In most cases, espe-

cially in the private sector, modern labour law made the strike weapon more accessible to workers, as one of the only ways in which labour could even modestly counter the power of employers. Ironically, conflict of this type was considered an antidote to conflict. Like boxers in the ring under the Marquis of Queensbury rules, the parties could flail away and do some harm to each other but the whole exercise was more cautionary than catastrophic. Unable to reach agreement without open conflict, they eventually reach a settlement through conflict. Strikes and lockouts are not only intended to inflict harm on the other side. By absorbing pain, a party also signals to the other side just how serious it is about its bargaining issues.

Indeed, industrial conflict, be it the inflicting or the suffering, is nothing more or less than a method of sending important messages to the other side. Some would ask if there are not more civilized methods of sending messages. There are. But it is an unfortunate fact of industrial relations that civilized messages are all too often dimly received, if at all. To put it charitably, top managers of employing organizations have a lot more on their minds (like running the enterprise and ensuring it continues from day to day) than the welfare of their employees. To put it less charitably, many managers simply do not care very much unless the problems of their employees become manifest - like a drop in productivity or a rise in absenteeism, quits, sabotage, injuries and workplace deaths. And strikes.

Samuel Johnson said that "when a man knows he is to be hanged in a fortnight, it concentrates his mind wonderfully." And in labour relations, there is nothing that equals the prospect of (for the worker) going without pay or (for management) going without a workforce, to induce paying serious attention to resolving problems. For

both sides, the prospect of a strike or lock-out makes them think very carefully about just how dear their bargaining positions are.

If collective bargaining and the right to strike and lockout was important for the operating of a modern industrial democracy, it was doubly so for those sectors where the service provided is crucial to society and where employees are highly-trained, highly motivated and highly autonomous and where it is *really important* for managers to receive the messages employees are trying to send them, for the sake of both the employees and the joint venture they are undertaking. Like health care.

While most health care and municipal workers received collective bargaining rights in the late 1940s, it was not until the late 60s and early 70s that most provincial and federal government employees received similar rights.

But no sooner had the new regime taken hold than governments across the industrialized countries, and especially in Canada and the US, started retreating from the forward point of progress in empowering unions. As Panitch and Swartz (1993) have so ably shown, in the 1980s and 90s there was a massive retrenchment in Canada, restricting the ability of unions to organize, engage in collective bargaining and carry out in industrial action. Indeed, while many of the original tenets of the Wagner model formally remained in legislation, governments and the courts resorted more and more often to “exceptional measures,” such as temporary strike bans, imposed terms of settlement, forced continuation of collective agreements, compensation rollbacks and compulsory days off without pay (e.g. Rae Days in Ontario). The introduction of the Charter of Rights and Freedoms did nothing to improve the position of labour, as the Supreme Court of Canada ruled that the Charter did not include the right to

strike or collective bargaining. So common were these “temporary” restrictions that Panitch and Swartz have dubbed the retrenchment a regime of “permanent exceptionalism.”

The ban on strikes during the term of the collective agreement

But even in the beginning of modern Canadian industrial relations law, a serious limit to labour’s power was inserted. A key feature of the Canadian version of the Wagner model, one which distinguishes Canada from most other industrial democracies (and from the US Wagner Act and its successors) was a ban on strikes while the collective agreement is in force. That restriction exists to this day.

In Canada the law distinguishes between two types of strike: those that occur when a collective agreement is being negotiated and those that occur after negotiations are over and the collective agreement is in force.

“Collective agreements” are documents that summarize what unions and employers have negotiated and agreed to. In Canada they generally run two to three years. Unions can strike and employers lock out legally only during the period they are actually negotiating the collective agreement. But once the document is agreed to and signed, such action becomes illegal. Should workers conduct “mid-term” or “wildcat” strikes, their legal protection from dismissal disappears and employers can invoke other sanctions against their union and against union members.

Thus, unlike many other jurisdictions in the world, Canadian employers know precisely the few-and-far-between occasions

when their workers can strike and they can usually make appropriate arrangements to prepare. Inventories can be eliminated. There is time to hire replacement workers (or place the advertisements in prominent locations to scare potential strikers). Production or service delivery can be transferred to other locations where there is no union or where the union cannot legally conduct a sympathy strike¹⁹.

One rationale behind the strike ban was to cut the incidence of strikes. But if that was the justification, it did not work. For much of the half-century following the Second World War, Canada led the world in strike activity (Lacroix 1986). *Moreover, it also led the world in wildcat strikes, despite the legal prohibition.*

The sole jurisdiction in Canada that rejected the strike ban was Saskatchewan, whose Trade Union Act, from 1944 to 1983²⁰, allowed strikes at any time. One would expect that province over those forty years to have lead the country or at least been among the leaders in mid-term strikes but the statistics do not agree. Indeed, mid-term strike activity was slightly less than the national average during that time.

High strike activity and union strength

Some people see the high record of strike activity in Canada and suggest the reason is that Canadian unions are too powerful. But one only need look at other countries with much stronger labour movements which have far lower strike records. The Scandinavian countries, for example, have close to all workers unionized and have among the world's lowest records of industrial conflict.

Some (e.g. Korpi and Shalev 1980, 1979) have argued that low strike activity

and high union density are related because where a union movement is powerful, it is incorporated into the political mainstream of the country. The struggle between labour and capital is transmuted from the floor of the workplace to the floor of the legislative assembly.

Indeed, Canada's high record of strike activity may well be because Canada's labour movement is *too weak*, or at least not strong enough.

Canada, with around 30% of its workforce unionized, sits around the middle of the international pack in union density. Collective bargaining in Canada is among the most decentralized and balkanized in the world. Where in other countries bargaining take place at the level of an entire industry, or region, or even across entire companies, collective bargaining in Canada for the most part²¹ takes place at the level of a single enterprise. Thus Canadian unions are seldom, if ever, in a position to concentrate their firepower. While the Canadian labour movement is linked to a political party, the NDP, that party has never been close to gaining political power federally. Union members are more likely to vote for other parties than for the NDP. Where the party has governed provincially, it has more often than not tried to distance itself from the union movement. NDP governments in Ontario and Saskatchewan have had running battles with labour. In summary, while it is far from powerless in its impact, labour in Canada is simply not considered as a significant player on the political/economic scene.

Canada's labour movement is at one and the same time too weak and too strong: too weak to have a full-fledged seat at the national political/economic table²²; too strong to be pushed aside completely. Canadian unions are just strong enough to provide employers with a determined resistance

when those employers attempt to push them around. Because strikes during the term of a collective agreement are illegal, workers and their unions tend to shepherd their feeling of outrage, simmering in resentment until the legal opportunity to vent arises, or sometimes before it does. Because bargaining is so diffuse, many of these strikes last a long time, leading to Canada's cumulative high strike activity record.

In countries with more powerful labour movements than Canada's, unions are taken more seriously by the powers that be. While occasional conflict does erupt, stronger unions tend to keep their powder drier, using the threat of industrial conflict more often than the actuality. Canadian law and policy tends to infantilize unions, treat them like errant children. Is it any wonder, then, that the unions respond with bitterness and anger?

Critiques of the strike ban

The ban on midterm strikes has been disparaged in the past by respected commentators on industrial relations.

In 1965, after a rail strike over unilateral management changes, the federal government appointed a commission to inquire into its causes. The report recommended giving the unions a veto over any "material" change within the term of the collective agreement i.e. the right to negotiate and strike in the middle of the contract term.

The federal Task Force on Labour Relations in 1968 recommended a similar approach.

"that the absolute ban on work stoppages during the term of the collective agreement be partially lifted; the parties would be at liberty in negotiations to opt out of the no-strike no-lockout provisions and resort to economic sanctions in the case of disputes relating to permanent displacements resulting from industrial conversion occurring during the life of the collective agreement" (Task Force, 1968, 174).

The chair of that task force, H.D. Woods himself is reported to have told a conference that:

"The legislative ban on strikes during the working agreement should be repealed...unions are losing confidence in the process. It is simply not resolving disputes equitably and promptly. It is in fact bad law." (Little, 1974, 3)

In this paper we are not discussing the right of health care workers to strike within the term of the collective agreement. Rather we are discussing the right to strike when the agreement has expired. Yet, many of the same arguments apply, only more forcefully. If there are dangers and impracticalities in banning strikes during the contract term, then those dangers and impracticalities are compounded if the right to strike is taken away entirely or rendered meaningless or ineffective. It is useful at this point to canvass the various options open to Canadian governments in coming to terms with industrial conflict in health care.

Three models of dispute resolution and emergency services management

When we talk of emergency services and strikes in health care, we usually focus on two health subsectors: acute care and long-term care²³. It is here that strikes can potentially have their most adverse effects. Across the country, governments have followed three distinct models of dealing with industrial conflict and emergency services in health care. These three models refer to the *permanent* legislative regime. As we shall see, governments can also introduce *temporary* legislation to deal with strikes and lockouts and emergency services. In any discussion of industrial conflict, we usually talk about both strikes and lockouts²⁴. But for our purposes here, we will talk only of strikes, since lockouts in health care seldom, if ever, occur. “Strikes” can cover both instances.

Permanent strike-ban (PSB) model

Some provinces have passed permanent legislation banning strikes in the crucial health care subsectors entirely. Ontario has done this since 1964 with its Hospital Disputes Labour Arbitration Act (HLDAA). Alberta amended its Labour Relations Code in 1983 to outlaw strikes in hospitals. Prince Edward Island has also had such a provision in its Labour Act for some time.

In all three of these provinces, the right to strike has been replaced with binding interest arbitration. That is, if the parties are unable to reach an agreement by themselves, all outstanding issues in dispute are submit-

ted to a third-party who makes a legally binding decision on their outcome. The already-agreed-to issues plus the arbitrator’s decision form a new collective agreement.

The most common type of arbitration, called “conventional” allows the arbitrator considerable freedom to fashion a settlement. The settlement might contain some items from the union’s wish list, some from the employer’s and some compromises. Another type of arbitration, called “final offer selection” enjoins union and management each to submit its own comprehensive proposal for settlement to the umpire, who is limited to choosing one or the other, winner take all.

Naturally, because strikes are not anticipated, there is no provision in legislation for emergency services. There are, however, penalties for violation of the no-strike clauses. First, strikers forfeit their legal protection against dismissal. Second, employers can ask the Labour Relations Board to declare the strike illegal. This declaration can then be lodged in a provincial superior court with the force of a court order. Continued defiance of the court order can invite a citation of contempt of court on both the unions and striking employees. Penalties for contempt of court can vary from civil (fines) to criminal (fines and imprisonment.) In addition, in Alberta, the Labour Relations Code allows the suspension of dues payment to the offending union for one to six months (which amounts to a fine) and the removal of the union’s right to represent employees. Quebec, which all but forbids strikes, has similarly grim penalties.

Unregulated strike (URS) model

Except for the three provinces above, all the rest allow strikes and lockouts to occur in health care. In most of these provinces, there is some legislative provision that compels the provision of emergency services. However, in two provinces, Saskatchewan and Nova Scotia, there is no such provision. That means that health care unions are able to strike at the end of their collective agreement and any arrangements for the provision of emergency services are up to *voluntary* negotiation between unions and employers.

Regulated strike (RS) model

In all other provinces where strikes are allowed, there is some legislative provision compelling the union to provide a certain level of emergency services during a strike. These legislative provisions are of several types:

- In some jurisdictions (Federal, BC, New Brunswick) the unions and employers get first crack at trying to negotiate an emergency services plan by designating which employees will stay on the job during a strike. If they cannot agree, then a third-party, like the Labour Relations Board or an independent arbitrator, will make the decision. In the federal public service ²⁵ the union can choose to either strike with such designation *or* to submit to binding arbitration.

- In some jurisdictions (e.g. Manitoba, Newfoundland) the employer will first designate “essential” employees. If the union disagrees, it can appeal to the Labour Relations Board.
- In Quebec, the law, from the start, designates between 60 and 90 percent of employees in health care institutions (depending on the type of institution) as “essential”. The province’s Essential Services Commission helps to interpret disputes within these guidelines. So restrictive is this variant of the RS model that some critics argue it is really a permanent strike ban.

Temporary measures

Notwithstanding the *permanent* measures described above, all Canadian governments have the power to depart from them and impose other means to deal with strikes and emergency services. Several provinces (e.g. BC) allow the cabinet or a minister to decide if a strike causes a situation dangerous to public safety or health. In that case, emergency measures can be imposed to end or curtail the strike. All governments have the power to reconvene their legislature and pass new legislation ending or curtailing an actual or impending strike for a certain period of time. Examples in the recent past are legion. Usually the ad hoc legislation renders the strike illegal. In many instances in the past, the legislation substitutes binding arbitration to resolve issues in dispute. However, a disturbing trend in recent years has been for the legislation to specify the terms of settlement or to put that decision into the hands of the government.

The models evaluated

Criteria to measure efficacy

The above models for handling health care industrial conflict have been in use in Canada for a long time. It is unlikely that a model exists that has not been conceived before. So we will evaluate how well the existing models work to regulate health care industrial conflict. To do so, we need to establish criteria.

But so portentous are the issues involved and so heated the question that it is a fallacy to think that we could come up with a single set of universally-acceptable criteria. This is not a value-free question. The criteria we use depend on political values. At the beginning of this essay, we suggested that two rights or values appear to be contending. On the one hand, there is the value of health care users obtaining care without subjection to unnecessary danger. On the other hand there is the value of employees receiving good terms and conditions of employment and being able to negotiate those terms through unions and collective bargaining. It is useful to employ a trichotomy of political perspectives (Godard 2000, 11-20). Those with a more “unitary²⁶” perspective would try to give unimpeded access to health services higher weight. Those with a more “radical” perspective would stress equity for the disadvantaged and rectification of power imbalances in society.

A third perspective, pluralism, marks the broad mainstream of “expert” commen-

tators in industrial relations and public policy makers. Pluralism sees many competing societal forces contending for rights and resources. Its quest is for “balance” between the pursuit of efficiency and the pursuit of equity.

Thus, labour law authority Paul Weiler has suggested that a “sophisticated” industrial relations system must do the following:

- 1 foster meaningful collective bargaining for the employees,
- 2 produce decent and sensible collective agreements for the parties, and
- 3 minimize individual unrest and the harmful effect on the general public (Weiler 1980).

Adell, Grant and Ponak (2001) in their study of emergency services in several public sector services, define the following criteria:

- 1 ensuring provision of “essential” services
- 2 impact on efficiency of collective bargaining
- 3 ability to foster voluntary and peaceful settlement of collective bargaining
- 4 acceptability of outcomes to employers, employees and the public

All of this sounds very reasonable. What could be more fair than “balance” that values health delivery as well as collective bargaining?

There are a number of serious problems with what might be called the “pluralistic fetish.”

The pluralistic fetish

First, and most importantly, this perspective makes the bold assumption that contending interest groups are *already* relatively evenly balanced and that mere tinkering with the machinery is required to set things right. In this case, pluralists presuppose that health care employers and groups of unionized employees have power resources that are within range of each other. Sometimes the scales may be tipped toward the employers. Sometimes the unions have the upper hand. The pluralist goal, it then follows, is to make sure that neither side has too much of an advantage.

What is conveniently ignored is that relations between labour and capital are manifestly *not* balanced. In the private sector²⁷, except for discrete and short-lived instances, capital fights labour, as Alan Fox has said, with one hand tied behind its back (Fox 1973, 211). While strikes can cost them profits, employers, as a rule, have far deeper pockets than unions. In both private and public sectors, employers have at their disposal the day-to-day privileges of ownership (which gives them free rein to run the workplace as they wish, even where unionized). They have an industrial relations system that tightly constrains when workers can legally withhold their labour (see above) and allows employers to hire replacement workers or use other employees not on strike²⁸ if they wish. They have a judicial system that ensures that picket lines are hobbled and that criminalizes and punishes those who would arrange otherwise. They have police who will physically maintain access to premises. In the private sector, usually the disputes occur far from public view. Where disputes do attract attention, there is the media who often distort the public view, by sensationalizing the few work stop-

pages that do occur, especially in the rare occasions when violence erupts (and, under the circumstances described above, it is a wonder that it does not erupt more often).

On top of all of this, the economic power of unions has slowly drained away in a neoliberal macroeconomic atmosphere that has been far from “full-employment” for the better part of twenty-five years. Long periods of falling real wages have been punctuated by small boomlets too short for labour to regain its forward momentum. Indeed, so tamed did labour become that the longer economic boom of the late 1990s proceeded without labour recapturing the economic position it held a decade earlier.

Occasionally, under a confluence of auspicious conditions, a private sector union may have its employer “over a barrel” at the precise time when it can legally strike. On such occasions, the employer can usually purchase peace at a very reasonable price. Private sector employers are nothing if not pragmatic. They are mostly profit-makers and money is the bottom line. If they must pay for labour peace, they do so and wait until conditions are better to roll back or make back the labour gains.

Strikes in the public sector

In the public sector, there are a few differences. In some ways, public sector employers are *more* powerful than their private sector counterparts. Public sector employers often have deeper pockets than many private sector employers. On the other hand, where profit-making employers inevitably lose profits during a strike, a public employer usually *saves* money when its workers walk off the job (some estimates have the Ontario government saving \$350 mil-

lion in foregone wages during the 51-day public service workers strike in 2002.) So it is wrong to assume that public sector employers are automatically more vulnerable to strikes than in the private sector.

However, public sector unions have some advantages over their private counterparts. Their strikes are seldom hidden away out of public view and almost instantly emerge into the full light of day. Indeed, public sector strikes usually impact on, not the employer or its profits, but the users of the services withheld - the so-called "public." Unlike the employers, most users of public services do not have deep pockets. And they feel a withdrawal of services almost immediately. The "pain" of a garbage collectors', bus drivers' or nurses' strike is felt much more quickly than an autoworkers or a supermarket workers' strike. Thus pressure for an end to a public-sector strike emerges much more readily than in the private sector. In opportune circumstances, this can help the union.

But the assumption that public sector strikes necessarily give labour an intolerable power advantage over the public and hence governments, is the second fallacy of the pluralistic fetish. The battle for public opinion in such strikes is crucial and it is often the union that loses that battle. Some would bar the strike option from all public sector workers who are in a position to discomfit members of the public. Adell et al (2001) found managers of public transit who argued for a strike ban. After two weeks holding their noses from garbage rotting in the 2002 summer sun, many Torontonians who otherwise support the right to strike were willing to hold their noses at a legislative end to the walkout.

Yet Canadians as a whole show a surprising tolerance for strikes by those in public service. A recent poll (Leger Marketing 2002) suggests that a majority of Canadi-

ans are not in favour of removing the right to strike from nurses, teachers and civil servants. For the most part, Canadians are willing to wrestle with the inconvenience of public sector strikes as one of the costs of living in a democratic society.

Strikes in health care

However, most pluralists would restrain only those who can cause *harm* to the public. The assumption is that health care workers are *more* essential to public health and safety than other public sector workers and hence have bargaining power unequal to employers. Logically then, in the pluralistic fetish, the right to strike for health care workers must be curbed or limited so as to rectify that imbalance.

However, there are numerous problems with these assumptions about health care workers. There have been precious few, if any, objective investigations into what has *actually* happens in health care strikes and in the delivery of emergency services in those strikes, as opposed to what is *feared* might happen. We will make an admittedly cursory examination of several instances below. There is much research still to be done, especially employing a rigorous epidemiological approach. At what point does mere inconvenience to managers or the public become a threat to life? There is enough evidence from those work stoppages that have happened in health care to show that the issue is far from clear.

Types of emergency service during strikes

Before looking at the advantages and disadvantages of the different models of health care strike regulation, it would be instruc-

tive to expound briefly on the provision of “emergency services” by striking health care workers. The typology was developed by the authors after studying this phenomenon in several nurses’ strikes across the country (see also Haiven 1995). While variations may occur, a threefold typology is helpful.

No matter which of the above models we are looking at, when a strike occurs in health care, union members (especially those in crucial occupations such as nurses, diagnostic technologists and registered therapists) do not withdraw all services. The union forms an overall strategy for how it will handle the provision of emergency services and union locals in individual institutions interpret that strategy to meet local conditions in the institution. How well health care institutions cope with the strike depends on what kinds of services striking employees will (or are forced to) perform. To better understand the discussion of emergency services in strikes, we can differentiate between three categories or levels of service or coverage provided by strikers: “contingent”, “non-contingent” and “guaranteed” services. The first two are voluntary for the union; the third is compulsory. These are discussed with reference to nurses but can encompass strikes by other employees as well.

Contingent services

“Contingent” coverage depends upon the acuity of individual patients. It usually works this way: The local union decides whether to provide emergency personnel based on its assessment of the level of severity for an individual patient or in a particular unit. The union allows its members to attend to patients whose lives are in danger. Once the union assesses the patient to be “stable”, the contingent service is withdrawn and the patient is left to other, non-striking

hospital staff. For example, Jane Patient, having been admitted to the cardiac care unit with chest pains, shows signs of a heart attack. Or Baby Jones, in the perinatal intensive care unit, stops breathing. Deciding that the non-union staff in the unit cannot handle the situation themselves, the nurse in charge calls the union’s emergency assessment team, located 24 hours on-call nearby in the hospital. The team rushes to the site of the call and participates in the emergency treatment. If more nurses are necessary, the team may call in backup from the picket line. When the team judges the emergency to be over, all union nurses withdraw and the emergency assessment team goes back to its waiting location until the next emergency call.

Non-contingent services

In “non-contingent” coverage the local union agrees to provide nurses to a particular hospital unit regardless of the level of acuity of the patients in that unit or where it deems all patients to be in life-threatening situations. An example would be an agreement by the union to provide a certain level of round-the-clock staffing in a perinatal intensive care unit or a renal dialysis unit. Only these units receive round-the-clock coverage. Other units, however, are subject to only contingent services.

Guaranteed services

Guaranteed” services are similar to “non-contingent” services except for the fact that the local union is obliged by some sort of binding agreement to provide these services throughout the strike. The union cannot withdraw its members’ services on pain of legal sanction. In the most extreme case, where strikes are banned entirely, nurses are obliged to provide services in all hospital units. So, for example, an arbitrator or the

labour relations board has ordained that the union must provide 100% of “normal” coverage in intensive care, emergency and renal dialysis, 70% coverage in other critical care units and 40% coverage in all other units.

From the point of view of the health care institution, “contingent” services are the

most uncertain and “guaranteed” are the most certain. It should be remembered, however, that no level of service, even legislated, is guaranteed if the union chooses to defy the rules or the law. Indeed, as we shall see below, attempts to force health care workers to provide guaranteed services may backfire.

Evaluation of the three models

It is one thing to know that three models of strike regulation exist across the country. It is quite another to know how well they really work. To evaluate the models, we must know not only how many strikes they have prevented or failed to prevent but also how they manage when strikes actually happen. There are a limited number of strikes that have occurred in health care across the country and thus an even smaller number falling under each of the models. Adell, Grant and Ponak (2001), in their very useful book, look briefly at health care among two other sectors (municipal blue collar and public transit) and in only five provinces and consider only three strikes. Other than that study, there has been no in depth consideration of this question. What follows is an attempt to broaden the field.

Permanent strike ban (PSB) model evaluated

The great attraction of the PSB model is that it promises to eliminate the problem of strikes. *If* such action is necessary to prevent harm to patients, *if* there is a workable substitute for the loss of the strike weapon and *if* the unions are willing to abide by the prohibition, the PSB eliminates the problem of strikes completely.

The devil lies in the “ifs.”

Is such action necessary to prevent harm? As shown above, there are different types of unionized health care workers, from general support workers, through allied health professionals, to nurses. These occupations vary in their direct impact on the

health and safety of patients. There are large numbers of employees whose absence on strike may be an inconvenience but does not approach an emergency. If protection of the public from imminent harm is the concern, then why would it be necessary to keep dietary staff, cleaners and maintenance workers on the job in a hospital any more than in a meat packing plant? We will explore just how “essential” other employees who have a more crucial impact on patient safety under “regulated strike model,” but certainly an outright ban on health care strikes is a fine example of overkill.

Is interest arbitration a workable substitute?

Is there a workable substitute for the right to strike? This problem is directly connected to the problem of the willingness of unions to abide by the strike ban. Governments that ban strikes must substitute some other method by which unions and employers can resolve their differences if they come to an impasse in negotiations. That method must be acceptable or at least tolerable to both the unions and the employers in order to work.

We have mentioned the current proclivity of governments to temporarily end strikes ad hoc and impose “settlement by edict” (legislating the terms of settlement and giving no say to the parties). But it would be foolish to do this permanently. It puts the final nail in the coffin of collective bargaining. There is simply no point in the parties negotiating seriously if they know the government will impose a settlement at every impasse - a settlement in which they

have little or no say. Without even the faintest glimmer of hope for free collective bargaining, unions have virtually nothing to lose if they engage in massive civil disobedience. It is almost an open invitation to illegal strikes, returning full circle to the problem that modern collective bargaining law was introduced to avoid.

Governments that have *permanently* banned strikes (Ontario, Alberta and PEI) have all substituted binding arbitration. But even the arbitration substitute is far from acceptable to employers and unions, and to governments. Perhaps the biggest problem is its permanence. Parties that might be willing to accept the occasional settlement by a third party find that arbitration is a poor fixed solution.

Problems for employers

For the employer side (and that includes governments) the worst aspect of arbitration is that it effectively takes the final outcome of negotiations out of their hands. Indeed, that is the main reason why governments who might be sorely tempted to impose this regime don't do it. To be sure, interest arbitration is a conservative exercise. Seldom do interest arbitrators make earth-shattering awards to unions. But sometimes, when unions have especially powerful arguments for redress, an arbitrator will do something dramatic. And employers and governments don't like it.

A recent example is the Nova Scotia ambulance paramedics dispute of 1999. The provincial ambulance service was late to be consolidated and the workers late to unionize. So there were large disparities between paramedics and comparators in Nova Scotia and other provinces. Nova Scotia employs the unregulated strike model but when the ambulance workers threatened a strike, the government moved ad hoc to ban the strike, imposing interest arbitration. It was no sur-

prise when the arbitrator awarded a raise of 20% over three years. But the government of John Hamm was shocked, especially given that the rest of the health care sector was due to negotiate new agreements the following year. It feared that the ambulance award might set a precedent²⁹. That was one reason the government was doggedly unwilling to agree to arbitration for other health care workers the following year when it introduced another ad hoc strike ban (permanent exceptionalism, indeed!) The government eventually opted for final offer arbitration only under duress.

The Nova Scotia government is now trying to find a permanent solution to health care disputes that does not contain any of these messy problems. As with the Philosopher's Stone, it will search in vain.

A not-so-cynical observer might suggest that what governments really want is for interest arbitrators to always side with them, without this fact being immediately obvious to everyone concerned. Of course, this is impossible, but that doesn't stop governments from trying. Ontario and Alberta both have the permanent strike ban model and their governments have grown irritable with the independence of arbitrators and their occasional insistence on defying government mandates. In response, both provinces have legislated criteria that attempt to limit arbitrators' discretion. Arbitrators are enjoined to consider the ability of employers to pay, current trends in pay settlements in the private sector, and other such concerns. When these were introduced in Alberta, some of the most respected arbitrators simply refused to do any more interest arbitrations. Of course, union cynicism grew by leaps and bounds and several swore never to submit themselves to such a biased procedure. But those arbitrators in both provinces who still do arbitrations have found creative ways to circumvent the re-

strictive criteria when they deem it necessary. For instance, after taking great care to “consider” ability to pay and private sector comparisons, they will award what they think appropriate in the circumstances. This is not to say that they go out of their way to side with unions. They seldom do. But sometimes, as in the Nova Scotia ambulance workers case above, they find it impossible to side with the employers.

Not content with banning strikes, substituting arbitration, imposing narrow constraints upon arbitrators, and the high incidence of conservative arbitration awards, the Harris Conservative government in Ontario was still vexed by arbitration. In 1997 it was about to introduce sweeping restructuring in health care, closing and merging hospitals. It decided an obstacle was the arbitrators themselves – they were simply too independent-minded to trust in expediting the restructuring agenda. The government introduced Bill 136 which proposed that, for any collective agreement problems arising from the restructuring, a panel of government-appointed adjudicators would render judgement. When this proposal met a barrage of criticism, the Harris government proposed to appoint retired judges and others unfamiliar with the industrial relations scene. The employers, represented by the Ontario Hospital Association, did not object to these high-handed attempts to rig the system. Only a concerted refusal by several unions to accept the move and a court decision³⁰ against it stayed the government from its course.

So even where the PSB model exists, employers and governments have been loath to leave the final decision to arbitrators. For good reasons or ill, they do not trust arbitration to serve their interests. But unions too are distrustful of arbitration as a permanent substitute for the right to strike – even where the arbitrators are nominally

independent. And that distrust has produced exactly what the PSB model was meant to avoid – strikes.

Problems for unions

Though employers and governments occasionally find interest arbitration awards unpalatable, it is more often the unions that consider themselves disadvantaged by arbitral conservatism. Indeed, interest arbitrators tend to depart from the unadventurous norm only when the union has fallen seriously behind some other group of workers. Arbitration, especially permanently ordained arbitration, is a poor vehicle to produce the creative breakthroughs that are sometimes required in labour relations.

When the Alberta government introduced the PSB model in 1983, the nurses’ union, UNA, made two bold announcements: First, it would never submit its bargaining issues to arbitration even if this meant temporarily negotiating substandard settlements; Second, it refused to be bound by the strike ban. It would await an opportune moment to strike, law or no law. Alberta nurses were as good as their word, walking out in 1988 amid preparations for the Calgary Winter Olympics. The employers, the government and its agencies engaged in a clumsy comedy of errors trying to manage the crisis. Before the strike had begun, the employers rushed to the Labour Relations Board to prevent the union from holding a strike vote. When the Board, in the middle of the night, issued the declaration, it predictably made union members even more determined, threw gasoline on the fire and aroused public outrage. With picket lines up all over the province, some rednecks suggested that striking nurses all be thrown in jail or at least fired. Employers launched contempt of court proceedings against the union and leading members. But even the

eventual million dollars of fines did not deter the dogged nurses. It would not be an exaggeration to suggest that the Getty Conservative government ended up with egg all over its face. The strike lasted 19 days and ended only when the union had negotiated an acceptable deal. While this was not quite the amount it was hoping for, that would have to wait until the next round of bargaining, in 1990 where, in a kind of delayed reaction, out of the glare of the media, it achieved a shortened work week, a 19% wage increase over two years and a further increment worth 3% as well as several other improvements.

This was not the only act of defiance of the legislation. The nurses' union held a strike vote in 1997 which, despite the 1988 Labour Board decision, employers prudently declined to challenge. It can be argued that since 1988 the union has been able to parlay the threat of a strike into settlements that have kept its members among the best-paid in Canada, and, arguably, better paid than had they accepted arbitration or were under a regime that allowed them to strike legally!

Nurses occupy a special place in the hearts of Albertans and Canadians and have lived an almost charmed life. But other groups of health care workers have not fared as well. Allied health professionals have regressed from their prior parity with nurses. General support workers have done even worse. Unlike nurses, they were unable to climb back out of a five percent wage cut imposed by a deficit-panicked Klein Conservative government in 1994. In return for this concession, the government pledged forms of job security. When, in 1995, the government broke its pledge by proposing to contract out laundry services, CUPE members in Calgary wildcatted and the province stood on the brink of a general strike by all health care unions. Personal

intervention by the premier was necessary to calm the crisis.

The Alberta Union of Provincial Employees strike of 2000 has already been described. Its origins lay in the mounting frustration of provincial LPNs with a series of arbitrated settlements under their former unions. The LPNs finally opted for the more militant Alberta Union of Provincial Employees (AUPE), which made it clear publicly and unapologetically that it would back an illegal strike. The nurses' union had shown that meek acceptance of arbitration would not work to redress long-standing inequities. Again the premier's personal intervention was needed to douse the prairie fire.

Thus, far from putting labour unrest to sleep, as the Alberta government perhaps hoped in 1983, the strike ban has arguably produced more trouble: several high-profile illegal strikes and strike threats which have seriously debased health care industrial relations. Unions which have gone for several years without resort to a strike have merely stoked their sense of grievance. The alternative of interest arbitration has appeased neither the unions nor the employers. It is also arguable that the illegality of the strikes has exacerbated the tendency of interference by politicians, most notably Ralph Klein, to the considerable dismay of health care employers.

While the strike ban in Ontario has elicited fewer acts of open defiance, when the dam bursts, it is dramatic. CUPE members staged a tumultuous eight-day strike by hospital general support workers in 1981 (see White, 1990). Insisting that two decades of arbitration awards had left them with substandard conditions of employment, 14,000 nursing assistants, orderlies, dietary, housekeeping and maintenance staff walked out illegally, against the initial advice of their leaders. There were 3,400 suspensions,

5,500 letters of reprimand and 34 dismissals (which were commuted by grievance arbitration later). Three union leaders, including CUPE's national president, were jailed, transforming erstwhile equivocators into heroes. As in Alberta, the government found it had moved from a problem of consensual and orderly negotiation to one of naked coercion and correction. Citizens, most of whom would never consider breaking the law the day before the strike, were potential criminals the next day.

In the fractious 1990s, as both NDP and Conservative governments wrestled to slash public spending, Ontario health care unions, even the normally conservative nurses union, threatened more than once to engage in the same insurgent activity. In 1997, CUPE took strike votes in health care bargaining units across the province, achieving majorities in the 80 to 90% range. As mentioned earlier, nurses staged an overtime ban in Ontario in 2001.

Thus it cannot be said that either unions or employers or governments find the arbitration substitute tolerable on a permanent basis. This solution, which might, to the untutored, seem eminently reasonable, does not prevent governments from undermining and sabotaging its operation nor does it thwart unions from rejecting it in desperation and going on strike anyway.

Arbitration not a long-term solution

For the simple fact is that over the long run an arbitrator cannot know as well as labour and management what is in the best interests of those two parties. Generally, arbitration has been oversold as a solution to labour-management problems. As in a marriage, two parties can indeed benefit from time to time by having a third party come in to assist them in dealing with each other. It might even be helpful for the third party

to take decisions out of their hands for a short period. In other words, non-binding mediation³¹ can be very helpful and even the occasional binding arbitration can help the parties overcome an impasse (though it works best if the parties themselves have voluntarily agreed to be bound by the decision and have not had arbitration thrust upon them.) But as a long term solution, arbitration is not the answer. A relationship cannot survive without irreconcilable conflict unless the parties roll up their sleeves and get down to the business of working out their own problems.

A good example how arbitration works along with industrial conflict can be taken from the October 2002 physicians strike in Newfoundland and Labrador. So far apart were the government and the doctors before the strike that arbitration was not on the agenda. However, after a seventeen day strike, not only were the parties more amenable to arbitration, but the terms of reference under which an arbitrator could operate had to be hammered out. It is a fact of industrial relations life that open conflict *and* arbitration often work where arbitration alone will not.

Industrial relations scholars have identified two related problems that can emerge where binding arbitration becomes a permanent fixture. The "chilling effect" occurs as the parties see no use in engaging in serious bargaining because a third party will settle their disputes. The "narcotic effect" refers to the continuous reliance on an arbitrator to settle disputes.

Third-party intervention is one tool among others to help the parties out of a jam, but it is not a panacea. The more often it is used, the less effective and less accepted it becomes. Since the level of mutual acceptance of a model is a key factor in its success, the PSB model is the least stable and least workable one.

Some say that change of a model always brings friction and acceptance of a model may increase over time, like a virtuous circle. But if twenty years is any yardstick, this is certainly not the case in Alberta. Ontario is sometimes given as an example. But a closer look shows that the lack of open warfare masks just how close that province has come to the brink since the 1982 CUPE strike. The lack of open warfare may not reflect acceptance but rather fear by all parties, and especially employers and government, of provoking a vicious circle.

All that is needed is one illegal strike to prove all suppositions wrong. Once the union throws caution to the winds, a political crisis, of greater or lesser proportions, ensues. If the union is appeased by winning a more generous settlement, then striking illegally is shown to be a stratagem that (despite the penalties imposed) pays off. If the strike is crushed, usually by overwhelming retribution, resentment proliferates and workers lose even more faith in the ability of the system to deliver justice.

Impact on delivery of emergency services

But perhaps the most dangerous consequence of the permanent strike ban model is its impact on the delivery of emergency services during strikes. As mentioned earlier, the PSB model by its very nature does not anticipate emergency services because strikes are forbidden. Under models which allow strikes, unions, especially those of professionals, are careful to provide emergency services, whether these are voluntary or compulsory. But the rancor generated during an illegal strike may put such good faith in jeopardy.

An excellent illustration of this irony occurred in Alberta, an excellent case study of “before” and “after” a model change. Before the government permanently banned

strikes in 1983, the nurses’ union walked out legally three times. In those legal strikes, there were always three hospitals in the province where it was illegal to strike because the government owned and operated them. The United Nurses of Alberta honoured this prohibition and these hospitals came to act as a safety valve during the three legal strikes.

This changed once all strikes became illegal. In the 1988 strike, angry UNA members walked out at every hospital where they were employed, even at the former safety valves³². So heavy did the animosity between union and management grow in some of these hospitals that emergency services provision suffered. Unlike managers with experience of strikes, the neophytes were loath to work with the union, a crucial component of successful emergency services provision. Union members responded with matching enmity. While the union maintained between 40 and 50 percent staffing levels in Edmonton, those levels are reported to have fallen to between 10 and 20 percent in Calgary. As we shall see in more detail, a certain minimum level of mutual civility is crucial during a strike for the most effective provision of emergency services. The PSB model is the least capable of ensuring that civility.

Another intriguing and ironic phenomenon transpired during the 1988 UNA strike. In previous legal strikes, the union had had its share of “scabs” i.e. nurses who spurned the union’s strike call and faced union discipline to cross the picket line. But in the 1988 *illegal* strike, with far heavier penalties from the courts facing striking nurses, the number of scabs dropped precipitously. In its comprehensive strike ban, the government had somehow boosted union solidarity³³.

So chastened was the Alberta government by these experiences that in the early 1990s its Department of Labour contem-

plated legislation to end the permanent strike ban. But the drift to the right under Ralph Klein and the rise of the Reform Party in that province closed off that policy option.

An insidious assumption

Perhaps the most insidious assumption used to justify curtailing the right to strike in health care is that, given the unfettered right to strike, health care workers *will always win those strikes*. This is simply not so. Where the unregulated strike model exists and governments resist the temptation to resort to back-to-work legislation, observation readily reveals that unions, despite their vaunted strength, lose those strikes as often as not. Even nurses, who have more public support than any other group of employees, don't always win.

Of course, it is difficult to say definitively whether a union has “won” or “lost” a strike. Every dispute ends in a compromise of sorts. For good strategic reasons, unions always put a maximalist position forward publicly and always have a minimum acceptable position in reserve. Even union members, even members of bargaining committees and certainly outside industrial relations analysts may not be privy to such information. But such a position always exists and can often be intuited by diligent observers. A win, then is anything considerably exceeding that minimum position. A loss is anything considerably less. While a draw may be all that can be salvaged from a dispute, the sacrifice of going on strike may make the draw very costly to the union.

One can look at several strikes to see what happens in jurisdictions with the unregulated strike model when governments decline to interfere. In the 2002 allied health professionals strike in Saskatchewan, after

29 days the union was able to win only a modest portion of what it set out to gain. In the 1991 Saskatchewan nurses' strike, the government (a Conservative government no less!) waited more or less patiently for the union to tire of the strike and for public support of nurses to flag. The Manitoba nurses strike of the same year, that included both RNs and LPNs, lasted thirty days, the second longest in Canadian history! In both of these, nurses returned to work arguably without a union “win.”

Another useful example comes not from health care but a related public sphere – the civil service. Ontario had permanently barred its civil servants (government employees) from striking for some thirty-five years on the grounds that government services were too important to be withheld. During the Bob Rae NDP regime, the Ontario Public Service Employees Union (OPSEU) campaigned successfully to have the ban lifted. When the über-Conservative Mike Harris government assumed office, it did not, as expected, remove the right to strike. Rather, it went to the mat with the union twice in six years over the big changes it wanted to bring about in the structure of the public service. If, as some have suggested, the government was using the strikes as a vehicle to smash the union, then the union's emergence intact from the strikes as a victory. But it emerged bloody and weakened. Moreover, it could not complain that it had been denied the right to strike.

On the other hand, heavy-handed intervention by governments has often led to the exact opposite result. In 1999, the Saskatchewan government, trying to maintain a balanced budget, had considerable public support in its campaign to keep all public workers to a 2%, 2% and 2% compensation rise formula over three years. Nurses struck to break the pattern and public sup-

port hung in the balance. But rather than allow the strike to run its course and wait for public support for nurses to ebb away, the Saskatchewan government stepped in to declare the strike illegal as soon as it began. When the nurses defied the legislation, public support swung away from the government, which was perceived as a bully. This helped the nurses to break the pattern. Likewise, before it outlawed health care strikes entirely in 1983, the Alberta government lost its patience with strikes in 1977, 1980 and 1982 ordering nurses back to work. Again, these ham-fisted tactics won support for the union and helped it to better settlements than it might otherwise have achieved. Indeed, in her trenchant critique, Hibberd suggests that, but for government intervention, internal crises would have led to the union's resolve fatally weakening:

“Through the process of interest arbitration, nurses received awards in excess of what was legally permissible in 1977 and what was institutionally feasible in the third dispute. As well, the evidence overwhelmingly suggests that government intervention prevented the collapse of the union in 1977, the collapse of the strike in 1982 and what would most certainly have been the loss of leadership credibility with the union.” (Hibberd, 1987: 219)

Discipline

Once a union defies a legislative strike ban, governments find themselves in a terrible dilemma, a classic enigma of law enforcement. Even if the strike is ended in a reasonably amicable way, there is still the question of penalties for the violators of the law. Having forbidden strikes and having threatened sanctions for transgression, it is impossible to declare an amnesty. To do so would invite repetition of the defiance. In-

deed, such is the case even if the penalties are insufficiently heavy.

But how heavy should the penalties be? If the potential punishments are too harsh, out of proportion to the offence, the government invokes cynicism by both potential offenders and the public. Moreover, imposition of excessive discipline garners public sympathy for its victims.

The level of legally prescribed discipline for violating strike bans (or failing to provide emergency services in accordance with the law) varies across Canada. Some of the various types of prescribed penalties (e.g. dismissal, fines, withholding of unions dues) has already been canvassed. Where contempt of court is involved, judges vary in how harshly they punish illegal strikers and their unions.

Yet no quantum of punishment seems successfully to have prevented illegal strikes in Canada. Quebec has an excruciating array of retributions on hand to deal with the problem. And both the Essential Services Council and the government are canny at devising new ones. It may be that they have deterred some health care strikes. But they have not deterred them all. Quebec nurses in 1999 were fully aware of the consequences they faced in going on strike because they had faced them in 1991.

The colloquial term for pursuing retribution is to go after someone “with a vengeance.” When employers and the government go after striking health care workers with ever more formidable penalties, they are often perceived as obsessed with vengeance invoking nothing less than a crisis of legitimacy. This risk prevails even if the strikers succumb. Moreover, attempts to smash a fly with a sledgehammer often look ridiculous. Attempts by the Alberta hospitals and government to prevent and then end and then punish the 1988 nurses’ strike took on this aspect. Similar actions by the Saskatch-

ewan government in 1999 had similarly costly results.

The important question that arises then is: Is it necessary for the activity to be illegal in the first place?

Summary

So numerous and strong are the arguments against the permanent strike ban model that it would hardly seem necessary to enumerate them. But such is not the case. Simplistic solutions to complex problems retain an evergreen allure. In some souls hope springs eternal that the problem of strikes can be erased with a magic wand. It is hoped that the foregoing analysis has tempered that hope with realism.

Regulated strike model evaluated

This is the model that most of the provinces employ. As mentioned above, it *seems* the fairest because it does not outlaw strikes and yet submits the strike threat to some kind of balanced, thoughtful intermediation. It *seems* to temper the right to strike with the assured provision of emergency services. But appearance and reality are quite different. As with the permanent strike ban model, the devil is in the “ifs”: *If* the process of designating “essential” employees is acceptable to the parties, *if* the process is truly voluntaristic, *if* the process is not open to abuse by management and *if* the process does not end up causing the strike to actually last longer. As will be seen, this model too is replete with problems.

How essential?

We have seen above that the absence of support staff like housekeeping, maintenance and dietary does not create any more

of a public emergency than one would find in a strike at an automobile plant. But what about nursing, diagnostic (laboratory and imaging) and therapeutic (respiratory therapists, physiotherapists) staff i.e. those whose work has more direct impact on patient care? Just how “essential” are they? To be sure, long run effective health care delivery demands an appropriate complement of direct care providers and diagnosticians. But how long can health care institutions risk operating temporarily without them? How many are enough for the minimum necessary care? These questions are open to considerable controversy, as we shall see below. For example, in several instances in recent years health care managers have claimed that they could not operate more than a few days, nay hours, without nurses. Yet nurses have gone on strike anyway, for several weeks and, in some cases, for up to a month. The health delivery system survived. Not without inconvenience or even problems. But that is what strikes are all about.

In the Saskatchewan nurses’ strike of 1999, the government outlawed the walk-out as soon as it began yet nurses continued to strike for ten days. Some health authorities responded by flying “critically ill” patients out of the province. These actions certainly heightened the sense of impending disaster. But the nurses’ union maintained many, if not all of the evacuations were not necessary and even some doctors claimed that they were questionable. In the Manitoba nurses’ strike of 1991, not only registered nurses but licensed practical nurses as well were on strike. Yet the strike dragged on for a month. The point here is that there is a tendency to panic when those directly involved in patient care threaten to strike. It is understandable. But it is not necessary nor advisable. There are several reasons why health care institutions can survive a drop in the number of direct health

care practitioners, even for some considerable period of time.

It should not be forgotten that health care institutions often substitute other workers for those on strike. There are supervisors and other trained individuals who fill in as practitioners. In most provinces, there is no ban on replacement workers (or “anti-scab” legislation.) Although wholesale substitution of trained staff is not practical, it is not uncommon for outside nurses and technologists (those who are retired, or are working outside the profession) to come in to work during a strike³⁴. Interns and residents on strike can be replaced by physician specialists from the outside. During a nurses’ strike, interns and residents can assume some higher order nursing tasks (e.g. catheterization, administering medications) while support staff can perform some of the more mundane nursing tasks. Remember that different bargaining units seldom, if ever, are in a position to go on strike at the same time and that labour law obligates those not on strike to work. Sometimes critical tasks overlap. For example, both nurses and respiratory therapists intubate patients with breathing problems. Respiratory therapists, nurses and physiotherapists all help patients resume breathing after surgery.

In addition, all health care unions who go or threaten to go on strike make plans and provisions for emergency services. This is the case even in the unregulated strike model, where final disposition is in the hands of the union. Especially for unions representing those workers whose work has the greatest impact on patient health and safety (e.g. doctors, nurses, paramedicals) the provision of emergency services is crucial in the all-important appeal to public opinion. Moreover, the standards of all of these professions include codes of ethics which forbid putting patients and clients in danger. These ethical codes are an essen-

tial part of the syllabus of professional societies. More importantly, they are burned deep within the psyche of individual practitioners.

Now, some would argue that the mere act of going on strike vitiates this code. But that has proven to be an extreme position. Doctors, nurses and paramedical professionals have all gone on strike and have not been charged by their regulatory bodies with professional misconduct. As will be seen below, even the leanest form of emergency service may still provide a high degree of care. What may seem like intolerable uncertainty to health care managers may not be so for patients.

Furthermore, over and above any professional ethical code, there is a strong bond between health care practitioners and their clients/patients. For example, in several nurses’ strikes across the country, strikers have been known to visit their patients or at least receive word of their progress during the strike. This close regard is often reciprocated by hospitalized patients show up on picket lines or write letters to newspapers and politicians to support strikers. Nurses’ unions have agreed to keep certain units like palliative care open though patients there may be stable and not in need of emergency care. The reasons have more to do with empathy and concern than emergency.

The point here is that, over and above the explicit contract between union and management, there is an implicit contract between groups of health care workers and those who require their care. The greatest strength of these groups comes from that bond and the greatest weakness occurs when that bond is broken. While that contract is not broken by the mere act of going on strike, health care unions can rely on public support only so long as they are not seen to be neglectful of necessary care.

Problems with designation

The regulated strike model involves a process of designating certain groups of strikers as “essential.” The process usually consists of two phases: first, there is the initial attempt at designation; second, if there is disagreement with the designation, there is an appeal to a third party. The initial designation can be done by labour and management jointly negotiating (Federal, BC, New Brunswick, Newfoundland), by management unilaterally (Manitoba) or by statute (Quebec, wherein the Labour Code specifies that a minimum percentage of strikers must work during a work stoppage). The second phase kicks in when the parties are unable to reach agreement or one of the parties, usually the union, objects to the designations made by management. In this second phase, the dispute is resolved by some form of third party intervention (the Labour Relations Board, an independent arbitrator, or, in Quebec, the Essential Services Council.) What marks all of the variations of the regulated strike model is the final and binding nature of the designation process. Whatever voluntarism may or may not exist in phase one, in the end there is no voluntarism by the end of phase two.

The problems of third-party intervention in “essential” services designation are similar to those in any labour dispute. As mentioned above, while non-binding intervention and the occasional binding intervention may assist the parties in resolving impasses, permanent removal of voluntarism does not work to deliver mutually satisfying solutions. Indeed, it makes matters worse.

However, the use of compulsion in emergency services designation is *even more* fraught with problems than in ordinary collective bargaining. A brief look at the levels of designation will reveal a persistent

problem of *overdesignation*. Both employers and third parties inevitably err egregiously toward the side of caution, ostensibly to reduce the risk to public health and safety but in what may really be taking the easy way out. In a time when health care institutions have radically downsized already, the numbers can often present a blatant irony. If, as is sometimes argued in health care strikes, even small reductions in the complement of employees presents a danger to public safety, then what of overzealous pruning of hospitals amid restructuring?

The Quebec situation is the most extreme. By specifying in the Labour Code that 90% of those usually at work on a shift in long-term care and 80% in acute care must work during the strike, the government to all intents and purposes imposed the permanent strike ban model. By so doing, they have really invited defiance. Quebec unions certainly regard it that way and have acted accordingly, several of them striking in open contempt of the law. Adell, Grant and Ponak (2001, 79) report that even employers admit that the rules render a legal strike toothless. Indeed, one employer they interviewed summed it up well:

“The quotas, as they stand, are completely unrealistic. The legislation conveys the message that everything is essential. How can we say that when we’re making major cuts in the whole health system? This approach just invites radical action [by the unions.] Why can’t we base our essential services on how we staff the hospital on weekends and summer holidays?” (ibid. 79)

So preposterous is the legislation that there is talk of it being removed and replaced with something less obviously restrictive³⁵. Whether, as in Alberta, political inertia and

ideology favour the status quo, remains to be seen.

But even in those provinces where the proportions are not specified in advance, there is a problem of overdesignation. As Manitoba nurses approached a strike deadline in 2002, management at one hospital designated as “essential” *125% of its normal complement*. Similar situations were reported across the province. Whether this was a cynical move by management, hoping that the Labour Relations Board would reduce it on appeal to 100%, or some sort of perverse political statement is not known. Similar problems were encountered in the 1989 BC nurses strike.

In Newfoundland, if a majority of employees under the Public Service Collective Bargaining Act are designated essential, the union can apply to have *them all* declared essential. In this way, the law recognizes that overdesignation can make a strike meaningless.

A guiding precedent for overdesignation was provided in 1982 by the Supreme Court of Canada³⁶. Under the Public Service Staff Relations Act, the Canadian government had designated practically all air traffic controllers as essential. On appeal, the union was successful in convincing the Public Service Staff Relations Board that only a small core of truly emergency services were necessary. However the courts ruled that a much more liberal interpretation was allowed. This decision gave a green light to third parties deciding on essential services to essentially abdicate responsibility for carefully nuanced designation.

Binding third party decision-making in emergency services designation suffers from all of the problems of third party decision-making in interest arbitration, and more. A third party called in to adjudicate a dispute over emergency services will almost inevitably err excessively on the side of caution.

Employers will always exaggerate the number of employees and services they consider “essential.” They will do this first, because they feel an extreme position is a convenient bargaining gambit. Second, running an institution during a strike is a massive inconvenience, a massive headache. Which employer in her right mind would propose more inconvenience? Third, employers are understandably afraid that lack of staff might lead to patient harm, a consequence for which they are ultimately responsible. But employers are notoriously unable to distinguish between annoying inconvenience to themselves and harm to patients. The fact that Canadian employers have over the past twenty years regularly predicted disaster in strikes and then managed to cope is proof of this.

Third parties adjudicating emergency services are usually specialists in labour relations, not in the running of health care institutions. In normal contract disputes, many of them are adept at cutting through the technical jargon and self-interested malarkey of both sides. The consequences are pay and working conditions. But when the issue is framed as “life and death,” the task is much more daunting. Moreover, there is concern that the third party will bear some of the blame if an error is made. Even in the unlikely event that the third party were very knowledgeable in health care administration, that knowledge would invariably carry with it a managerial bias. So coming down on the far side of caution is natural and inevitable.

But it is not only employers and third parties who err on the side of caution. Unions do it as well, and for some of the same reasons. Nobody on either side of a dispute wishes to have a patient come to harm due to the strike. Even in the unregulated strike model, as we shall see below it may take a

union several tries before it gets the amount of emergency coverage close to right.

Summary

Thus, while permanently giving power to a third party to resolve disputes over emergency services may seem to the layperson to be a good compromise between the no-strike model and the unregulated model, reality is much more complicated. The provision of emergency services is not a static process, but a very dynamic one. Any attempt to predetermine and rigidify the amount of coverage inevitably leads to overdesignation. While it may be true that unions themselves err on the side of caution when they hold the right to determine that coverage, they are able to make adjustments as the strike wears on. They are able to withdraw and redeploy services as the conditions demand. This state of affairs can achieve two salutary purposes: true emergencies are conscientiously attended to yet the strike does not drag on.

For one of the serious problems of overdesignation is that, far from spawning emergencies, the strike is so benign in the short term that it actually drags on causing greater problems in the long run for the union, the management or the public. It is arguable that a shorter, sharper drop in health services (other than true emergencies) is less harmful to the health care system than the deterioration that accompanies a longer, corrosive dispute.

While there has been little study of the effects of strikes by other health care workers, strikes by doctors have received considerable attention. It is not just folklore that death rates do not rise and sometimes decline during doctors' strikes (Salazar et al. 2001; Siegel-Itzkovich 2000; Bukovsky et al. 1985; Steinherz 1984; James 1979). Evidence from several such strikes indicates that the short-term postponement of elective

procedures eliminates or postpones the risks inherent therein. On the other hand, long term problems can arise from long-term work stoppages³⁷.

Another study provides food for thought. Two University of Toronto doctors examined 3.8 million emergency-department admissions in Ontario over ten years and found that weekends had a significantly higher death rate than weekdays (Bell & Redelmeier 2001). But it is likely that the weekend problem is not simply one of reduced staff. The authors suggest that lack of supervision and adequate communication are as important a factor as staffing. One can surmise that it is the unannounced and "routine" drops in hospital staffing that carry the greatest danger to patients, rather than strikes, which are well-publicized and for which conscious preparations are always made by both administrators and striking staff.

In essential services disputes, as in labour relations proper, the use of third parties can be helpful. An "honest broker" can often break down mutual distrust and cajole the parties toward a compromise to which they were headed in any case. But the key to success is voluntarism. Third parties are most useful when they mediate, or when they arbitrate at the request of the parties, or where arbitration is an occasional thing. Permanent compulsion is no permanent solution.

The unregulated model

Having discussed at length the shortcomings of the other two models, this section will be briefer. Also, because this essay finds the unregulated model more acceptable or "less unacceptable" than the others, it will reverse the order of argument in this section, beginning with disadvantages.

The primary disadvantage of the unregulated model is uncertainty. Of course, there is no guarantee that the other two models will provide certainty either, especially if the union decides to flout the legal restrictions. But the unregulated model must unabashedly put its faith in the ability of voluntarism to solve the problem of emergency services and this is a difficult challenge for health care administrators and politicians. As mentioned earlier, governments face tremendous pressure to “do something” about a health care dispute that threatens serious curtailment of services. And administrators would be crazy to want to depart from “business as usual” in an industry where uncertainty is so much part of “usual.”

One of the prime managerial responses to uncertainty is to attempt to nail down as many certainties as possible. And knowing exactly how many employees or services one can “count on” appears to be a comfort.

However, it can be argued that such rigidity is precarious. Health care, especially acute care, is notoriously dynamic. Even the “normal” complement of employees may not be enough to cover surges in acuity due to mishaps like multi-automobile crashes or other disasters.

Rapid response to such surges at any time depends crucially on good relations between employer and union. This is even more critical during a strike. Given that the parties are in dispute and that less than the full complement of workers is present at work, what is needed is not rigidity, but flexibility. Even where a compulsory designation regime exists, a strike gives the union more power than usual, especially when conditions depart from the norm. What is required is a flexibility in which the union is a full partner. The following are some examples from the unregulated model.

Far from shirking on service provision in the unregulated model, unions often themselves err on the side of caution, for two reasons: They are afraid of harming patients and they are just as afraid of forfeiting all-important public opinion.

Nurses unions striking in the unregulated model in Saskatchewan (1988) and Manitoba (1991) found that they were providing a level of coverage that was too generous and that worked against their interests. Using our demarcation of three levels of emergency service above, the unions began by providing *non-contingent* coverage, maintaining 100% coverage of several units. Management, assured that these units were fully covered, proceeded to move non-bargaining-unit nurses to other wards. As the strikes wore on, the unions began to see that they were “taken advantage of,” and would have liked to cut back on the levels of service provided. But because they had “promised” management to provide these high levels, that reduction was seen as renegeing on a commitment and provoked some management resentment. Indeed, some Manitoba nurses have attributed the 30-day length of their strike as evidence that coverage was too high. In Saskatchewan, the union determined that if it were to strike again, it would reduce the amount of non-contingent coverage and move to a contingent coverage model. This it did in its next strike, in 1991.

Likewise, in preparation for an impending 2001 strike, the Nova Scotia Nurses’ Union arguably designated too many non-contingent services. But, as union leaders suggest, they needed to assure management and the public of their bona fides. In the absence of real experience in a strike, it was better to be safer than sorrier.

Informed by its 1988 experience, the Saskatchewan Union of Nurses, in the 1991 (legal) and 1999 (illegal) strikes, provided

mostly contingent services. Hospital managements had few prior assurances of coverage except for a union commitment not to allow a true emergency to develop. Across the province, the management reaction can be divided into two types: those who decided to trust and work with the union and those who did neither. Which of the two types of reaction prevailed depended considerably on the climate of the relation between union and management that preceded the strike, although the larger and more complex urban hospitals had more reason to find it necessary to cooperate.

Those managements who decided to cooperate with the union found that the local unions were prepared to jump in in true emergencies and responded to those situations with perhaps more nurses than would be the case under normal conditions. But once the union had assessed that an emergency had stabilized, it just as quickly withdrew its members.

The points in using these examples from the unregulated strike model are several. They show that the provision of emergency services is not a static process, but a very dynamic one. Any attempt to predetermine and rigidify the amount of coverage inevitably leads to overdesignation. But it may also lead to inability to deal with larger emergencies. It may also needlessly exacerbate tensions during the strike. While it may be true that unions themselves err on the side of caution when they hold the right to

determine that coverage, they are able to make adjustments as the strike wears on. They are able to withdraw and redeploy services as the conditions demand. This state of affairs can achieve two salutary purposes: true emergencies are conscientiously attended to yet the strike does not drag on.

We return to our point about the dangers of infantilizing labour which, we have argued, is a factor in the overall high level of strike activity in Canada. Law and public policy has eroded since the heyday of modern industrial relations. Mature labour relations policy regulates industrial conflict not by outlawing it nor by curtailing it so much that conflict is impossible. Refusing to trust unions to police themselves is an invitation to disorder.

As mentioned above, in 1965, an inquiry into a railway strike suggested that it was the inability of the union to have an ongoing say in rapidly changing conditions that produced conflict. It suggested giving unions more, not less, power. Mr. Justice Samuel Freedman of the Manitoba Court of Appeal rejected the argument that this would result in industrial relations chaos:

“A power of veto is not necessarily an inherently vicious thing. It is the irresponsible abuse of that power which is vicious and should be condemned...is it not something which is encountered every day whenever two contracting parties sit down...” (Canada, 1965, 96)

Conclusion

Whenever strikes in health care loom on the horizon, inevitably the chorus arises that governments should “do something.” Undoubtedly the most difficult challenge for any government is to *do nothing*. The legislators who originally installed the unregulated model in Alberta, Saskatchewan, Manitoba and Nova Scotia are to be congratulated (though their successors succumbed temporarily or permanently to perceived expediency.)

The problem of strikes in health care and the provision of emergency services are no different than any other kind of industrial conflict. It is something that democratic

societies must live with and manage. But it must be managed not only with procedural finesse. Like most other problems in industrial societies, industrial conflict has its antecedents in structural inequality. The upsurge in strikes in recent years is a result not only of the general *weakness* of Canada’s working people vis-a-vis capital and the state, but of the particular *strength*, indeed the *essentiality* of health care workers to a modern industrial state. If they are too important to be allowed to be absent on strike, then their terms and conditions of employment are too important to be ignored.

Endnotes

- ¹ Allied health professionals, otherwise known as “paramedicals” (not to be confused with ambulance “paramedics”) are diagnostic and therapeutic occupations like laboratory and radiological technologists, respiratory therapists, physiotherapists and social workers.
- ² Support staff include employees in housekeeping, maintenance, dietary and auxiliary nursing.
- ³ The courts had initially imposed a fine of \$400,000. This was four times the previous largest fine for a single instance of contempt. On appeal, the fine was reduced to \$100,000. (Lancaster House 2000).
- ⁴ The direction that so many employees be at work during a strike has sometimes produced the paradoxical result that more are expected to be at work during strikes than during non-strike times.
- ⁵ There are two types of arbitration in labour relations. In “rights” arbitration, an adjudicator makes a binding decision in a dispute over the application, interpretation or alleged violation of an already-existing collective agreement. In “interest” arbitration, the adjudicator settles a dispute over *what terms and conditions will go into* a collective agreement that is under negotiation.
An example of rights arbitration: An already-existing collective agreement says employees will be paid overtime after 7 3/4 hours. An employee is not paid accordingly, and s/he launches a grievance claiming the collective agreement has been violated. If the parties cannot resolve this question, a rights arbitration will decide whether the agreement has been violated.
- ⁶ The federal government does have jurisdiction over a very small number of federally-based health institutions.
- ⁷ Labour Relations Boards and the courts ruled that nurses and paramedical employees could not be represented in collective bargaining by their professional societies because those societies included many managerial employees as members, subjecting the collective bargaining to undue employer influence. See *Service Employees’ International Union, Local 333 v. Nipawin District Staff Nurses Association of Nipawin et al.* (1973), 41 D.L.R. (3d) 6, [1975] 1 S.C.R. 382, [1974] 1 W.W.R. 653. After this ruling, nurses and paramedical employees rushed to form their own unions rather than be “swept into” the same bargaining units as blue collar employees.
- ⁸ Though the norm, central bargaining does not exist in all provinces for all bargaining groups. Nova Scotia still has not achieved full central bargaining and Ontario’s central bargaining is also incomplete.
- ⁹ Ontario is the only province to have resisted this trend, though the amalgamation of hospitals in some regions has produced a similar effect.
- ¹⁰ Several provinces attempted to help health care unions and management deal with labour adjustment in the 1990s by establishing provincial health care adjustment plans. They established funds to assist with cross-placement, counseling, retraining, early retirement etc. In some cases agencies and a secretariat were provided. The most comprehensive of these was in British Columbia (later dismantled under the Campbell Liberals.)
- ¹¹ The trend away from registered nurses and toward LPNs and aides was not universal. Some Canadian hospitals have realized efficiencies while clinging to an “all-RN” model of nursing.
- ¹² Indeed, this is a strategy that several in the long-term care industry openly admit to using.
- ¹³ The two exceptions are Manitoba, where registered nurses and LPNs are in the same bargaining unit (but both represented by the Manitoba Nurses’ Union) and Nova Scotia (where representation is split between the Government Employees Union and the Nurses’ Union.)
- ¹⁴ For example, nurses at the Sick Children’s Hospital in Toronto and several others in Southern Ontario are not unionized. However, as the country moves toward regional health authorities which amalgamate many institutions

- under a single employer, several non-unionized groups of health workers are being “swept into” unions.
- 15 From information provided at the Miners’ Museum, Glace Bay, Nova Scotia.
- 16 According to Russell (1990) the IDIA had the effect of weakening those unions who had the industrial muscle to strike.
- 17 Industrial unions represent all workers, regardless of occupation, usually in an entire workplace (e.g. Autoworkers Union, Steelworkers Union). The other type of union “craft” unions, represent one particular occupation only (e.g. Plumbers Union, Nurses’ Union.)
- 18 At the end of the war, the Cooperative Commonwealth Federation (CCF) Party was in power in Saskatchewan and was seriously threatening to win the Ontario provincial and the federal election.
- 19 As a rule in Canadian collective bargaining, each physical location belonging to an employer is a separate and distinct bargaining unit. It is highly unlikely that the collective agreement expiration dates of unionized workplaces of a single employer are the same, even if the union is the same. Moreover, it is not unusual for several unions to represent different workplaces of the same employer. Cooperation between different unions is not unheard of, but the temptation to earn overtime dollars often overcomes any tendency toward solidarity.
- 20 The Saskatchewan anomaly ended in 1983, when Conservative Premier Grant Devine introduced a ban on mid-term strikes.
- 21 In only a few instances in Canada does bargaining take place over an entire industry. Only in government services and health care does bargaining transpire over an entire province and then only by separate bargaining groups (e.g. air traffic controllers, postal workers, nurses, paramedicals, hospital general support workers.) Even in the automobile industry, bargaining occurs company by company. Even where the employer is the same across the country or province, each unionized location will constitute a single bargaining unit, with its own collective agreement.
- 22 The only province where unions have achieved any sort of political and economic status deserving of the name is Quebec, as exemplified by the 2002 state funeral of labour leader Louis Laberge.
- 23 Although it was a province-wide strike in Manitoba home care that prompted the then Progressive Conservative government to introduce a draconian Essential Services Act in 1996.
- 24 A lockout occurs where an employer, rather than a union, takes the first step in bringing about a work stoppage. Just as union members can refuse to work further their position during a dispute, an employer can refuse to provide work to the union members.
- 25 These are direct government employees as opposed to private sector employees who come under federal jurisdiction.
- 26 For a fuller description of the “unitary,” “pluralist,” and “radical” perspectives on industrial relations, a very good summary is available in Godard 2000, 11-20. Briefly, unitarists value societal order, market forces and maximizing efficiency most highly. Pluralists value most a balance between efficiency and equity. Radicals prefer elimination of inequalities, injustices in society and system-wide power imbalances.
- 27 The private sector consists of *for-profit* and *not-for-profit* employers. For our purposes here, we will use private sector as synonymous with for-profit.
- 28 British Columbia (for now) and Quebec have a law that restricts employers in their use of replacement workers or “scabs” during strikes. Ontario briefly had such a provision but it was removed when a labour-unfriendly government took power.
- 29 Unlike judges, arbitrators are not bound legally by the decisions of previous arbitrators, in either grievance or interest arbitration. Arbitrators can and do disagree with other arbitrators. That said, however, the decisions of previous arbitrators can be persuasive. Unions entering negotiations attempt use earlier settlements as a springboard.
- 30 *CUPE and SEIU v. The Minister of Labour for Ontario* (2000), 51 O.R. (3d) 417 (C.A.)
- 31 In mediation a third party helps labour and management reach an agreement but does not impose one on them. In arbitration, the third party imposes an agreement on them.
- 32 At this time, nurses at the University of Alberta Hospital were in a separate union and worked during all of these strikes.
- 33 A similar phenomenon is reported in the comparison between legal nurses’ strikes in Sas-

katchewan (1988 and 1991) and the strike rendered illegal in 1999.

³⁴ Practitioners who are members of the striking union or who might like to work in a unionized workplace, or those sympathetic to the union, often choose not to cross a picket line. But there are others for whom crossing the picket line is less troublesome.

³⁵ Personal communication with ex-deputy minister of labour.

³⁶ *Canadian Air Traffic Control Association v. Canada*, [1982] 1SCR 696 (SCC)

³⁷ Doctors' strikes in Israel in 1973, 1983 and 1999 all demonstrated this phenomenon. Of the 1999 disputes, one medical administrator compared short-term to long-term effects, "Mortality is not the only measure of harm to health. Lack of medical intervention can lead to disability, pain, and reduced functioning. Elective surgery can bring about a great improvement in a patient's condition, but it can also mean disability and death in the weakest patients." (Siegel-Itzkovich 2000, 1561)

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