› October 2008

Is Compulsory Arbitration a Good Substitute for the Right to Strike in Health Care?

The Persistence of Recruitment and Retention Problems

By Judy Haiven and Larry Haiven

CCPA
CANADIAN CENTRE
for POLICY ALTERNATIVES
CENTRE CANADIEN
de POLITIQUES ALTERNATIVES

Part Three of the series The Right to Strike in Nova Scotia Health Care: Issues and Observations

CCPA
CANADIAN CENTRE
for POLICY ALTERNATIVES
CENTRE CANADIEN
de POLITIQUES ALTERNATIVES

Please make a donation... Help us continue to offer our publications free online.

We make most of our publications available free on our website. Making a donation or taking out a membership will help us continue to provide people with access to our ideas and research free of charge. You can make a donation or become a member on-line at www.policyalternatives.ca. Or you can contact the National office at 613-563-1341 for more information. Suggested donation for this publication: $10 or what you can afford.

ISBN 978-1-897569-12-2

This report is available free of charge from the CCPA website at **www.policyalternatives.ca**. Printed copies may be ordered through the National Office for a $10 fee.

410-75 Albert Street, Ottawa, ON K1P 5E7

TEL 613-563-1341 FAX 613-233-1458
EMAIL ccpa@policyalternatives.ca
www.policyalternatives.ca

CAW 567 OTTAWA

About the authors

Judy Haiven is an associate professor in the Department of Management, Sobey School of Business, Saint Mary's University and a research associate of the Canadian Centre for Policy Alternatives, Nova Scotia.

Larry Haiven is an associate professor in the Department of Management, Sobey School of Business, Saint Mary's University and research associate of the Canadian Centre for Policy Alternatives, Nova Scotia..

Executive Summary

On October 15, 2007, the government of Nova Scotia introduced legislation to ban strikes in health care and community services. Government spokespeople said that the health care system is strung so tightly that it cannot tolerate any disruption.[1] The government has thus decided that health care workers would not be allowed to exercise their full collective bargaining rights.

This paper, the third and last in a series of three, deals with several of the most intractable problems in health care collective bargaining that make withdrawal of the right to strike especially harmful to the health care system. We also see how arbitration is unable to correct for these problems. We focus on a group, herein called "technologists and therapists" (such as laboratory, imaging and other registered technologists, respiratory, physical and occupational therapists and ambulance workers) who have been largely ignored in health care human resource management, despite their importance to effective care delivery. Precisely because of their importance, the problems surrounding their remuneration and working conditions have mounted over the years to the point where serious recruitment, retention and morale problems persist. Denying these groups full collective bargaining rights, we argue, will make things worse, not better. We also look at a recent dispute in Nova Scotia over employer funding of a pension plan that shows just how incapable arbitration is of rectifying large human resource management problems that management seems reluctant to fix on its own.

We have already published two discussion papers on the right-to-strike issue. The first "A Tale of Two Provinces,"[2] argued that making strikes illegal does not make them disappear. Using the comparison between Nova Scotia (where health care strikes have been legal) and Alberta (where they have been outlawed since 1983), we saw over the twenty-four years proportionally more than fifteen times as many person-days involved in Alberta acute-care strikes as in Nova Scotia. We also looked at other groups and other provinces to illustrate the same point.

Our second discussion paper "Taking Care of Emergency Services during Health Care Strikes[3]" looked at whether strikes are as harmful to the health care system as the government and health employers claim them to be. We found that our health care system is subject to far greater

problems than the occasional strike. The under-resourcing of the system is a key challenge to effective health delivery. In many ways, it is analogous to the "lean production" system. In health care, such a super-lean approach renders service highly vulnerable to crises. In her new book *The Shock Doctrine: The Rise of Disaster Capitalism*, Naomi Klein insists that deliberate weakening by governments of public infrastructure and public services opens these services to calls for privatization when predictable crises cause the systems to fail. Given the recent move by the Nova Scotia government to pass orthopaedic surgery to private clinics[4], Klein's analysis seems especially germane here.

While management by stress is totally inappropriate to health care, one of its key tenets is giving power to workers to stop the process by pulling a "red cord" when serious production problems arise. We argued that if Nova Scotia health care is going to be delivered under management by stress, then the right to strike for health care workers is analogous to pulling the red cord.

Introduction

In proposing to ban strikes in health care, the Nova Scotia government insists that compulsory arbitration is a good substitute for the right to use strikes as a last resort if collective bargaining fails. This paper deals with the question of just how good arbitration is at solving the myriad problems facing health care in Nova Scotia. We do so by looking at several intractable problems in provincial health human resources. One of the most serious of those problems is the recruitment, retention and morale of health care workers, especially key professional or "professionalized" staff. These problems are so pressing that only free collective bargaining will suffice. Or to put it in a different way: Removal of the right to strike will allow health care managers to ignore or delay addressing serious problems and will drive those problems underground, only to resurface in ways, many of them unpredictable, that will even more seriously harm our health care system.

Health care is highly labour-intensive (seventy-five to eighty percent of health care budgets go to human resources[5]). It is estimated that close to one million Canadians are employed there[6]. The mix of employees, their tasks and the way they work together is exceedingly complex. Skill levels vary greatly. Many employees have university or college degrees or diplomas. All kinds of specialist professions, semi-professions and occupations abound, for example doctors, nurses, technologists and therapists of all descriptions. Even the less-skilled employees are highly subdivided into specialist groups, like licensed practical nurses and diagnostic technicians, many of them providing crucial assistance to the more highly-trained.

Many occupational groups in health care belong to their own professional societies (e.g. Canadian Association of Medical Radiation Technologists, Canadian Society of Respiratory Therapists, Canadian Nurses' Association, and their appropriate provincial bodies.) These societies, among other things, promote professional development and continuing education, lobby governments to improve working conditions, protect and expand scope of practice and sometimes certify practitioners and engage in complaint and discipline procedures. In some provinces, a separate body (a "college") handles certification and discipline. These occupational groups have a high degree of professional self-

awareness and a strong sense of their professional value as well as rigorous codes of ethics and good practice.

Not only are there professional societies and colleges for many of these occupational groups, most of their members are employed (usually by health care institutions or district health associations) and are thus eligible to join trade unions and bargain collectively with their employers. Accordingly, health care is one of mostly highly unionized industries in the country. The proportion of health care personnel who are unionized is twice as high as the Canadian norm (that norm being about 32%) and almost three times as high in some occupations like nursing, where unionization in hospitals is as high as 90%[7].

Physicians are not, strictly speaking, unionized. Most of them are self-employed and their professional societies (like Doctors Nova Scotia) regularly bargain, not terms and conditions of employment, but rather fees-for-service, with provincial governments. The recruitment and retention problems for physicians are legion, as we have seen clearly in recent years in Nova Scotia. In that sense, personnel shortages are not dissimilar to those among other health care professions. However, because physicians are not unionized and do not bargain collectively under the Trade Union Act, they are not affected directly by the government's threat to withdraw the legal right to strike.[8] Leaving physicians aside in this discussion, we focus on other, unionized, health care workers. We turn our attention to what are known as "allied health professionals," who deliver bedside care and important diagnostic, clinical, rehabilitation, pharmacy and other services in health care institutions. We are talking about such occupations as registered technologists (in such fields as laboratory medicine, medical imaging, radiation therapy), registered nurses, licensed practical nurses, respiratory therapists, physical and occupational therapists, pharmacists, psychologists and social workers (and a myriad of others, some just coming into being.) And we should not forget ambulance service workers, including paramedics and emergency medical technicians.

A Perfect Storm

By the mid-1990s, a perfect storm of factors was brewing that would lead to massive problems of recruitment and retention in most of the allied health professions over the next decade and a half. Among the factors are the following:

Many of these occupations are highly feminized. Even before the severe cutbacks in health care funding of the mid 1990s, shortages had begun to appear. Young women with good mathematics and science grades in high school, once content to become nurses or technologists or physical therapists, were beginning to opt for more lucrative and prestigious occupations[9]. While some men did enter these occupations as pay rose, their advent was insufficient to seriously help the problem.

In the mid 1990s, led by the federal government's austerity program, which was downloaded to the provinces, funding for health care diminished drastically. Health care capacity stalled, complements of allied health professions dropped, and institutions that trained these professionals (like community colleges and universities) cut back their enrollments or cancelled programs entirely. In some provinces, like Quebec, employers offered buyout packages to nurses and others to retire early and many workers accepted.

After a few short years of drastic public service cutbacks, the federal and many provincial governments had gone from deficit to surplus budgets. By the late 90s, health care expenditures did start to grow again, though funding was never fully restored. But now the shortages in the allied health professions had gone from bad to worse.

As a Nova Scotia report cited:

> "The supply of medical radiation technologists and therapists overall dropped 7% between 1998 and 2001, similar to a national trend, said to be caused by expansion in health services, high attrition rates and an underutilization of training capacity.
>
> "A much talked about supply issue both in Nova Scotia and nationally is the significant shortage of registered nurses. Most of the decline in nursing supply occurred between 1993 and 1998, concurrent with the cutbacks associated with hospital restructuring, cutbacks in funding for nursing education programs,

and the transition of nursing from a diploma to a degree."[10]

By the turn of the 21st century, a new spectre was facing health human resource planners: an aging workforce. The age profile had risen and the older cohort was rapidly approaching timely or early retirement. The average age of employed RNs by that year was 44.7[11]. By 2005, more registered nurses in Canada were between ages 50 and 54 than in any other age group. In Nova Scotia, the demographics in this and other allied health professions looked the same[12]. So serious was the situation that many formally retired nurses, technologists and therapists were brought back into the work force part-time and even full-time to plug the gaps. Overtime and extra shifts proliferated. A recent report to the Department of Health states that 56% of laboratory technologists, 60% of health records technologists, 47% of registered nurses and 41% of radiation technologists will be eligible to retire by 2015. The report concludes, "Looking forward, there simply are not going to be enough skilled and trained workers."[13]

Making matters even worse was the new work regime in hospitals. Under what we have labeled the lean production system[14], more patients were treated by day surgery or admitted and released quicker and sicker. This intensified the pace of work for all allied health practitioners. Combined with problems of aging, the increased work pace led to higher rates of stress, injuries and burnout[15].

Both the unions and the professional societies representing these workers' interests began to complain. For example, the Canadian Health Professionals Secretariat reported in 2004:

- In B.C., the Society of Respiratory Therapists found that over four years, B.C. required 298 respiratory therapists to deal with growing demand, but trained only 135. Of these new graduates 39 left the province.
- The Canadian Society for Medical Laboratory Science (CSMLS) has estimated that 44.4% of general medical laboratory technologists in Canada will be eligible to retire by the year 2015. Meanwhile, a recent newspaper article reported that students applying to medical lab technology programs in Saskatchewan have been told they may have to wait 10 years to be admitted even though the province is currently facing a shortage of lab technologists.
- The Canadian Pharmacists Association (CPA) and Health Canada have reported a serious shortage of pharmacists. And on September 8, 2004, Kingston General Hospital announced a recruitment plan in which the hospital will pay employees a cash incentive to recruit pharmacists to the hospital, as part of the hospital's Employees Referral Program. The Chief Human Resource Officer at the hospital said that the new program is a response to the hospital's need to hire seven pharmacists to fill a 30% vacancy rate in the pharmacy department — the highest in the past five years.
- The Canadian Association of Occupational Therapists (CAOT) has reported widespread shortages, along with significant variations in regional distribution and clusters in high-density population areas.
- The Canadian Association of Radiologists has reported shortages in various medical radiation technology professions (this includes x-ray, CT and MRI technologists). In addition, a report issued last fall by the Ontario Association of Radiologists shows that Ontario patients are waiting longer than ever for all kinds of radiology procedures due in large part to shortages of radiation technology professions.
- Of course, both the Romanow Commission and the Kirby Report documented serious

current and impending shortages of various health professionals.

- And finally, throughout their recent meeting, First Ministers repeatedly referred to the immediate and long-term need to address serious shortages for health care disciplines other than nurses and doctors[16].

In Nova Scotia, the situation in many of the medical technologies was in a crisis state. For example, though the province had purchased several new magnetic resonance imaging (MRI) machines to alleviate the waiting lists for this procedure, the waiting lists actually grew longer due to the lack of trained technologists.

A recent *Halifax Chronicle-Herald* article reported the following:

> Mr. Martell [manager of special imaging at the Halifax Infirmary], who went on a cross-Canada recruiting drive last fall, said wages are dissuading some technologists from working in Nova Scotia. Workers here make about $30 an hour compared to $38 in Alberta.
>
> There are no training programs for MRI technologists in Nova Scotia.
>
> 'We need one...so that we can fulfill the needs of Nova Scotians,' Mr. Martell said.[17]

Thus, in the past decade, the issues coming to the collective bargaining table for these groups of workers have been many, complex and difficult. Yet, at the same time, collective bargaining was a relatively new arena for these workers and these issues, as we shall see below.

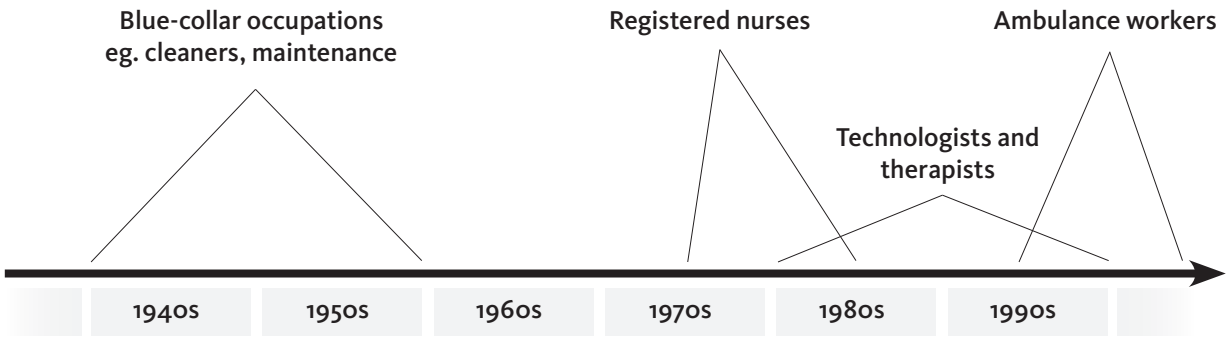
Collective Bargaining and Allied Health Professionals

The progress of collective bargaining for allied health professionals has been extremely uneven. Some groups, especially those with a short bargaining history, have had less success than others have and this presents a problem of major proportions for the health care system across Canada, but especially in Nova Scotia. Even if a particular occupation has fallen behind other occupations across Canada in its compensation and conditions of employment, practitioners in richer provinces like Alberta and Ontario will still be at the "top of the heap." But practitioners, especially mobile younger ones, in provinces like Nova Scotia that offer lower compensation, are often tempted to move to a more generous Canadian locality or to the United States.

A general problem is that allied health professionals approached unionization and collective bargaining quite late compared to their sisters and brothers in the more "blue collar" occupations. Hospital orderlies, cleaners, dietary and maintenance staff had joined unions as far back as the 1940s and had done much of their most successful bargaining during the years of expansion of the public sector and health care system. The "professionalized" occupations, like registered nurses and registered technologists and therapists, resisted unionization until they embraced it in the mid-1970s. Their professional societies had done some bargaining on their behalf, but because these societies were dominated by practitioners in management, such bargaining had been highly compromised. The ethos of "professionalism" in these groups was strong and abjured trade unionism and industrial conflict.

In 1974, the Supreme Court of Canada ruled that these professional societies could not be legal bargaining agents because they were employer-dominated[18]. Afraid of being swallowed up by larger industrial unions, many allied health professionals moved to set up their own unions. Thus, the second half of the 1970s and early 1980s saw a rash of new unions. It was not until the late 1980s, however, that collective bargaining was firmly established for allied health professionals. By then, despite prodigious growth in overall national wealth, we were in an age of public sector cutbacks. The desire of allied health professionals for better terms and conditions of employment ran smack into government austerity.

FIGURE 1 **Accession of collective bargaining rights—various health occupations**



At this point, we need to draw a sharp distinction between registered nurses and all of the other allied health professions.

The rush of applications for collective bargaining rights for allied health professions presented a huge challenge to labour relations boards across Canada[19]. Given the great number of different professions involved (and the relatively small numbers of practitioners in some of them), it was simply impossible to allow each and every profession to have its own union representation. Labour relations boards had to make tough decisions about amalgamating the bargaining rights of several professions. Moreover, groups of health occupations did not seek nor receive bargaining rights at the same time. Some were earlier and others were later. Figure 1 shows a rough timeline. The later a group came to collective bargaining, the more "catch-up" it had to engage in.

Nearly all provincial labour relations boards decided to allow registered nurses to have their own separate bargaining unit. And in most cases, that nurses' bargaining unit was represented across a province by a single registered nurses' union[20], for example, the British Columbia Nurses' Union, the Ontario Nurses' Association and the Fédération des Infirmiers et Infirmières du Québec (FIIQ). Moreover, the registered nurse profession is clearly delineated and there are few clashes among unions over who will represent this group.

Representing a single, homogeneous occupational group, nurses' unions were from the start more united, more determined, more focused, more militant and willing to put their aspirations into action than any other union group. Their training, their work tasks, their labour market position, their strategic place in health care human resources are likewise homogeneous not only within any province but across the country. Many of these unions have affiliated to the Canadian Federation of Nurses' Unions (CFNU) wherein they trade strategies, tactics, information and solidarity. And, by the turn of

the 21st century, many of them had fully joined the mainstream of the labour movement, affiliating to the Canadian Labour Congress.

At the very beginning of their experience of collective bargaining, like all allied health professions, nurses' unions were reluctant to use the strike weapon. They cited ethical considerations and some even had an anti-strike prohibition written into their constitutions. But, within a very few years, practically all nurses' unions had dropped this caveat and by the mid 80s had launched into several waves of strike activity. A major issue, of course, was salaries and benefits. Issues of professional identity such as practice of professional skills, workload and working conditions, occupational health and safety, and recruitment and retention were also hotly contested[21].

Because the work of registered nurses was largely comparable across the country, each successful breakthrough in collective bargaining in one province had an impact on the other provinces. Moreover, nurses' unions early on established their willingness to go on strike, notwithstanding the legal regime (i.e. whether strikes were legally allowed or not.) Thus health care employers and provincial governments were under no illusion that they could ignore the issues when nurses' unions came knocking at the door. Though they came late to collective bargaining, the nurses' unions engaged vigorously in the game of catch-up, and for the most part, succeeded.

The minute we move beyond registered nurses to other allied health professions we run into large collective bargaining problems. In the period between the late 70s and the mid 90s allied health professionals of different types organized themselves, applied for bargaining rights, were granted bargaining rights and began collective bargaining in earnest. Labour relations boards made decisions on which types of workers would be in which "bargaining units.[22]" Most labour boards across the country designated one homogeneous bargaining unit consisting of registered nurses. For other allied health professionals, however, labour relations boards (and Nova Scotia was no exception) designated a heterogeneous polyglot of occupations into a single bargaining unit. Thus, a single bargaining unit represents up to 200 different occupational groups, including the more populous medical laboratory technologists and the much smaller groups like cardiovascular perfusionists, crisis intervention workers and infection control epidemiologists[23]. Not only are there many groups, and not only do they differ in cohort size, but their task sets, their training, their labour market position and their place in the health human resource team can vary greatly. Moreover, the willingness of many of these groups to adopt the strike option came considerably later than with nurses. To further complicate matters, unlike the relatively mature occupation of registered nurse, many of these other groups are still evolving. Indeed, as new medical technologies and therapies emerge and expand, the health care system is constantly throwing up new occupations, especially in metropolitan tertiary care hospitals.

Not the least of the problems of this group is that many emerging occupations (and some long-standing ones) are the subject of jurisdictional disputes between unions. For example, jurisdiction over biomedical engineering technologists is sometimes disputed by two unions: those representing maintenance and trades and those representing allied health professionals. Jurisdiction over licensed practical nurses is sometimes disputed by nurses' unions and those representing auxiliary nursing care. These kinds of disputes weaken the solidarity and strength of any union representing these professions.

Thus, let us now focus exclusively on the group that is having the greatest problems. Rather than "allied health professionals" which includes registered nurses, let us, for convenience, exclude registered and licensed practical nurses and call the remainder "technologists and therapists."

To the great consternation of its practitioners, this group is invariably overshadowed by nurses. This happens not only in the public and popular discourse but also in learned discourse. Despite their importance in the acute health care scheme, laboratory technologists, respiratory therapists, social workers, and their paramedical colleagues are either forgotten, or ignored or lumped in with nurses. Even when this group alone is the centre of a labour relations dispute, to the exclusion of nurses, many who should know better still use the catch-phrase "nurses."[24]

Yet the setting of the remuneration and working conditions of technologists and therapists is one of the biggest challenges facing human resources in acute health care. This is the group that went on strike in Halifax's Capital District Health Authority (CDHA) in 2001 and struck in April 2007 at the IWK Hospital. This group also went on strike twice in the past five years in Saskatchewan. Its members have a huge amount of catch-up to do and thus they are a "challenge from below" not only for health care management but also for their own unions.

In most provinces, these myriad groups are somewhat fortunate that a single union represents them and bargaining is conducted at a single provincial table[25]. So at the very least these issues can be addressed strategically. However, that is not the case in Nova Scotia. The Nova Scotia Labour Relations Board has designated technologists and therapists as belonging to the "health care employees" bargaining unit[26]. Nevertheless, historically this bargaining unit has come to be represented, depending on location, by three different unions: the Nova Scotia Government and General Employees Union (NSGEU), the Canadian Auto Workers Union (CAW), and the Canadian Union of Public Employees (CUPE). Moreover, given the absence of centralized bargaining in the province, each health district negotiates on its own. Therefore, unlike provinces with a single union and central bargaining, Nova Scotia has double or even triple fragmentation of collective bargaining. Thus, ironically, Nova Scotia technologists and therapists have the worst of both worlds: disparate occupations are forced into a single unit; but no single union speaks for their interests across the province.

The difficult problem of dealing with this group of workers combined with their strategic placement at the core of acute health care (the presence of laboratory, imaging and many other technologists is as crucial to acute care as are nurses), could be the reasons that Nova Scotia health care administrators and government have decided it is time to take away the right to strike. Yet just because of the enormity of those problems, compulsory arbitration is an especially poor vehicle to solve them.

Recent experience of collective bargaining and arbitration for technologists and therapists in Nova Scotia

As mentioned above, technologists and therapists, members of the health care employees bargaining unit in CDHA, were at the forefront of the labour relations troubles of the Spring of 2001. It was hardly surprising. Their pay had not only fallen behind that of nurses, it had lagged behind inflation for five years (see figure 2) (while that of nurses had exceeded inflation.)

However, because nurses were also involved in these troubles, because the nurses later threatened mass resignation when the government introduced back-to-work legislation[27] and because of the aforementioned public preoccupation with nurses, the tribulations of the technologists and therapists again faded into the background. Nonetheless, technologists and therapists were arguably the most militant group that year. Indeed, they were the only bargaining group to actually go out on strike in 2001, legally at first, before the government passed Bill 68.[28, 29]

An example of their growing combativeness: In 2001, twice their union (NSGEU) had negotiated tentative settlements with the employer,

the CDHA, and twice these health care employees unit rejected the settlements and sent their union back to the bargaining table. This kind of rejection is not frequent, but it is also not uncommon in labour relations. It often signifies that a union has underestimated the militancy of its members. If the union did not initially appreciate the demands of this group, it surely came to do so.

The Nova Scotia government responded by introducing Bill 68, declaring that all strikes would temporarily be illegal. At first Bill 68 proposed to impose government terms on all of the bargaining tables — what we have called "settlement by fiat[30]." But a political crisis of major proportions ensued. Members of the opposition parties delayed passage of the legislation by filibustering far into the evenings. Mass demonstrations of health care workers surged in front of the legislature. The media was full of stories sympathetic to the workers. Finally, in an act of desperation, NSGEU registered nurses began signing letters of intent to resign. At the same time, the Nova Scotia Nurses' Union ran a series of highly effective pro-nurse advertisements on television. Reeling from the one-two punch, the government's support numbers plummeted[31].

The political stalemate ended in a compromise. The Nova Scotia government, the unions and the employer agreed that the collective agreements in dispute would all go to a single arbitrator for a binding settlement. The arbitrator would make a ruling on three disputes — Registered Nurses, Licensed Practical Nurses and the Technologists and Therapists group. However, the arbitrator was severely limited in the scope of her mandate. The process would be "final offer selection" (FOS). In other words, in any one of these three disputes the arbitrator could choose either the employer's final position or the union's and nothing in between.

There would be no room for nuance, adjustment or sensitivity. In her decision, arbitrator Susan Ashley described the difficulty: "The Selector in an FOS process can only choose one offer in its entirety or the other in its entirety. It has been described as a labour relations form of 'Russian Roulette', where the winner takes all. While such a process, at its best, can operate to force the parties to put forward reasonable proposals which might have the best chance of being selected, it is not a process that works well when the parties' Final Offers are far apart, as is the case here with the wage offers affecting the LPN's and the Health Care unit[32]."

The Ashley arbitration decision reflected the problems mentioned above. Registered nurses are a homogeneous group, with similar, straightforward problems. By comparison, technologists and therapists are a heterogeneous group, with widely different, complicated problems.

The NSGEU's most powerful argument focused on shortages in occupations and pay differentials between Nova Scotia practitioners and those in the rest of the country. Registered nurses were unambiguously behind in both categories. Therefore, it was easy for the arbitrator to choose the union's position over the employers in this dispute. She awarded registered nurses a 17% wage hike over 3 years.

But when it came to the technologists and therapists' dispute, the arbitrator had considerably more trouble choosing a solution. Some practitioner groups were far behind their colleagues in the rest of the country and had severe recruitment problems; others did not. Yet, by the rules of that particular arbitration, the arbitrator could not nuance her award. She had to choose one solution for the entire bargaining unit — either the employer's position or the union's. The arbitrator acknowledged, "Many of the members of this [health care] bargaining unit toil behind the scenes and may have less public contact than the others being considered in this selection. They are an essential and extremely valuable part of the health care system."[33] With almost 200 occupations, the bargaining unit was extremely diverse.

Some large subgroups (like laboratory technologists at 12% of the bargaining unit) had fallen as far behind as registered nurses (or worse). Indeed, those and similar groups of registered technologists and therapists form up to 25% of the health care bargaining unit. But with other subgroups the situation was not as grave. Arbitrator Ashley stated in her decision that her narrow mandate did not allow her to make a separate decision for some groups among the technologists and therapists. "Unfortunately I have no power in this process to separate out particular classifications such as the Medical Laboratory Technologists for special treatment, even though a strong case can be made for such treatment[34]." In a portentous aside, Ashley cautioned the parties "plan now to ensure that the issue is dealt with adequately through a comprehensive strategy, part of which may well include wage incentives such as market adjustments and classification review[35]."

Further, the arbitrator commented that arbitration was a very blunt instrument to address the very complicated problems of recruitment and retention among these groups and recommended that labour and management themselves were best able to work this out between themselves. Without the legal mandate to do the job herself, the arbitrator chose the employer's final offer of a mere 7.5% over three years.

The aspirations of the Nova Scotia paramedical group were thwarted once again. For three more years, their wages and working conditions would fall even further behind their comparators across the country and behind Nova Scotia registered nurses as that group surged ahead. In addition, the union now knew that this was a volatile group with many a reason to feel aggrieved.

When the next bargaining round approached in 2004, the issues of the technologists and therapists were three years worse. The NSGEU volunteered to submit their unresolved issues to arbitration and the employer (CDHA) agreed. Actually, the NSGEU's decision to opt for arbitration was not entirely voluntary. The debacle of Bill 68 in 2001 had badly stung the provincial government, and it subsequently showed signs of wanting to remove the right to strike entirely[36]. However, from the Bill 68 dispute, the government may have learned that tangling with nurses was high-risk activity from a public relations standpoint. On the other hand, a high profile, messy strike by a group that was *not* nurses, might just provide the conditions for the government to institute the permanent strike ban.

However, the union's proposal of arbitration rather than strike seemed so reasonable that a rejection by the employer and government might have looked churlish. The employer and government may also have realized that addressing the problems of this group was long overdue. By proposing "voluntary" arbitration, the union had cleverly dodged a bullet. But, for how long?

The arbitrator chosen by the parties in this instance, William Kaplan, did roll up his sleeves and tackle some of the difficult issues that had accumulated over the years. He enunciated the principle that CDHA was a leader institution in Atlantic Canada and that the remuneration of its technologists and therapists should reflect that position: "…this Board accepts that the claim to be first in Atlantic Canada has more than arguable legitimacy given both the value of the work… and the institution where that work is being performed[37]." Unlike arbitrator Ashley in 2001, Kaplan's mandate allowed him the flexibility to fashion a nuanced award. Accordingly, he provided the largest wage increase that this group had received for a decade and a half.

Where occupational groups had direct comparators in other Atlantic provinces, Kaplan decreed, their wages would be league-leaders. Before Kaplan, some of these groups were more than 16% behind their colleagues in other Atlantic hospitals. Medical laboratory technologists, for example, received a 17% wage increase from Kaplan.

As significant as it was, the Kaplan decision still failed to fully remedy the many problems of technologists and therapists that had built up over the years. Here are some of its shortcomings:

- Only those occupations with direct comparators within Atlantic Canada were fully addressed. Because the Capital District Health Authority runs such a specialized set of hospitals, more than a few of the specialized occupations *have no comparators in Atlantic Canada*. Comparators could be found outside of the region, but Kaplan did not allow these comparisons.
- Accordingly, practitioners in these occupations look not to Atlantic Canada but to Ontario, Alberta and British Columbia, not only for what they might be paid, but for where they might go if they become dissatisfied enough with their conditions of employment in Nova Scotia.
- Up until about twenty years ago, the pay of registered nurses and medical laboratory technologists were very similar but diverged sharply from 1988. This is not because technologists were necessarily improperly compensated back then or properly compensated today. It is because, for all the reasons mentioned above, registered nurses' unions militantly pressed their advantage while those representing technologists did were more constrained in their ability to do so. The Kaplan award, while seemingly generous, hardly began to correct the discrepancy.

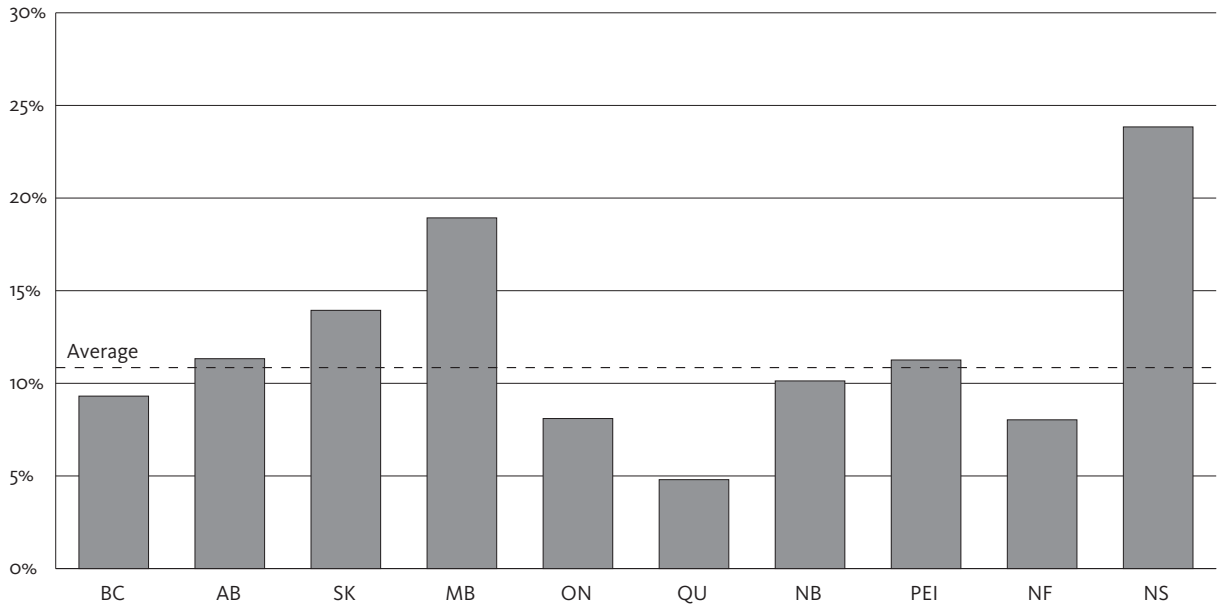
Indeed, in his award Kaplan announced, "However, and for whatever this observation is worth, we are of the view that the asserted relationship between nurses and the medical laboratory technician classification is, at best, of historical interest only and not a factor to be taken into account in deciding this case.[38]" He gave no substantive reason for rejecting the comparison. This may well have been primarily because of employer arguments of inability to pay. Surely significant narrowing of the gap after twenty years would have cost the employer (and the province) a lot of money. Indeed, the larger the gap becomes, the harder it is for the employer to pay and for an arbitrator to make the employer pay. This does not address the fundamental problem of internal equity. Indeed, the union nominee at the Kaplan arbitration (veteran Toronto labour lawyer James Hayes) wrote, "I would have grounded the result on the historical medical laboratory technician [sic]/nurse differential rationale clearly demonstrated by the union."[39] We now examine this comparison more closely.

Historical comparisons between nurses and the technologists and therapists group

One way of examining the problem is to compare the wages of technologists and therapists to those of registered nurses. With comparable levels of preparation (both have required at least post-secondary training and many now require degrees), comparable importance to the health care team, and comparable problems of recruitment and retention, registered technologists and registered nurses have historical reasons to receive comparable compensation. At the very least, the gap between the two arguably should not be as great as it is.

From the early 1970s to the early 1980s, bench-level registered medical laboratory technologists (Med Lab Tech A) in CDHA had actually *been ahead* (up to 13 percentage points) of registered nurses. But by the mid 80s, nurses had moved ahead slightly (three or four percentage points.) As is done from time to time within free collective bargaining, the employer and NSGEU voluntarily submitted the issue to Arbitrator Peter Darby in 1988 and he awarded the technologists parity with registered nurses. In the years subsequent to that decision, however, the technologists' rela-

FIGURE 2 **Percent difference between staff nurses and medical laboratory technologists in Canadian jurisdictions** October 2003



tive pay dropped precipitously so that by 2004 they were 23.84% behind the nurses[40].

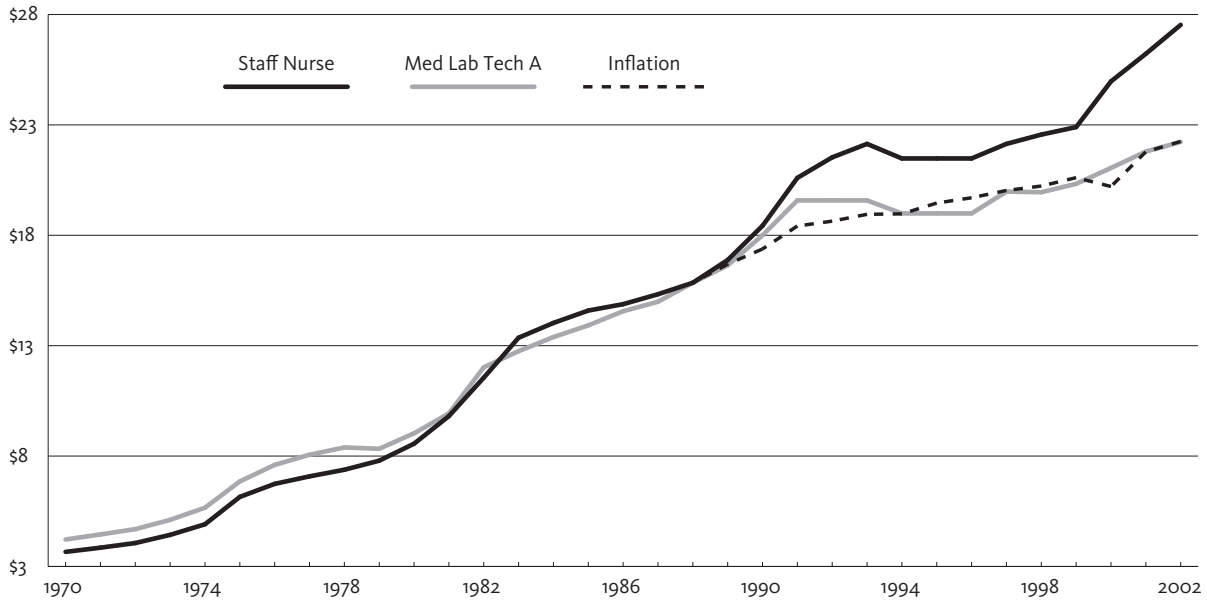
A similar, but less dramatic trend had happened across Canada[41]. But the Canada-wide average differential between the two groups, at 10.65%, was less than half of that in CDHA (see Figures 1 and 2). The growing gap between laboratory technologists' pay and nurses' pay was similar for other groups of registered technologists, such as radiographical techs, health records techs, MRI techs and nuclear medicine techs. For many other groups, the digression was even more dramatic.

Thus by 2004 Kaplan was faced with a very large disparity to rectify. His award, while generous by arbitral standards, was a mere 15%, leaving technologists still seriously behind nurses. Because Kaplan had based his award on CDHA technologists "catching up" and surpassing their counterparts in Atlantic Canada, and because those Atlantic counterparts themselves were seriously behind registered nurses, his award was destined to fail in correcting the large disparity (see Figure 4).

The inability of the Kaplan arbitration to remedy the mounting problem illustrates that problem's persistence, complexity and severity. As arbitrator Ashley said, this is a problem that unions and employers must handle by mutual discussion and negotiation. Yet, without the threat of a work stoppage, administrators have little incentive to respond to the problem themselves in a timely fashion, if at all.

As can be seen from Figure 3 below, Medical Laboratory Technologists (and hence the other bench-level registered technologists) have found it an uphill battle to regain parity with staff nurses. Now, had arbitrators made an explicit comparison between the two groups and decided definitively that the parity should no longer hold that would be one thing. But this has not happened. In fact, the opposite has happened. Arbitrators in Nova Scotia have shied away from making a definitive comparison between the two groups.

FIGURE 3 **Maximum Hourly Wages of Staff Nurses and Registered Technologists before the 2004 Kaplan arbitration**



The "comparability" which arbitrators use so much as a yardstick appears to extend to comparisons between technologists and other technologists only. Moreover, that comparison extends no farther than the borders of Atlantic Canada. Arbitrators appear to avoid tackling the gritty question of exactly how registered technologists compare with registered nurses.

It is true that up to the Bill 68 dispute of 2001, the unions representing technologists and therapists were unsuccessful in rectifying the growing variance with nurses' pay in free collective bargaining. We hardly expect an arbitrator to rectify what the unions were unable to do themselves *with* the right to strike. However, the right to strike itself is one thing. The determination of the workers involved and their unions to use it is even more important. Because of the diffuse nature of this bargaining unit, the determination to threaten and actually strike grew more slowly than it did with the more homogeneous nurses. Moreover, just as this determination finally reached the boiling point among technologists and therapists, the government was trying to remove the right to strike. From 2001, Nova Scotia technologists and therapists demonstrated that they were becoming frustrated enough to try to rectify the imbalance. Their frustration only grew when their aspirations were stymied in the Ashley arbitration. As mentioned above, the union's decision to submit the 2004 dispute to arbitration was not really a voluntary one. It was taken with the sword of government intervention hanging above its head. The union would be damned if it went on strike and damned if it went to arbitration.

Thus, interest arbitration proves to be a very inadequate solution to the persistent and resistant problems of these occupational groups. Arbitration works best where the problems are simpler and where only marginal adjustments are needed. Arbitration is simply not up to the task of addressing big problems of human resource management, recruitment and retention. Seri-

ous bargaining is not possible unless the threat of strike is available to the union: For rectification costs serious money. Take away the right to strike and governments and employers will not have to spend it. As a result, inequities will persist, as will the crisis of recruitment, retention and morale. Effective health care, hence, will be compromised.

Provincial ambulance workers

Another important group of health care professionals that has fared poorly from arbitration is ambulance service employees, especially the three main categories of "paramedic": Primary Care Paramedic (PCP), Intermediate Care Paramedic (ICP) and Advanced Care Paramedic (ACP)[42]. The large problems of technologists and therapists are writ even larger for ambulance workers.

The professionalisation of ambulance workers was even later in coming compared to many of the other paramedical groups. Prior to the 1980s, ambulance workers were expected to do little more than transport the ill and injured to hospital to receive treatment. However, medicine discovered that intervention by trained attendants both on the scene and in the ambulance could save many lives, especially in cases of trauma and cardiac incidents. In addition, advances in the electronic relaying of vital signs to emergency physicians also demanded upgrading of ambulance worker skills. It was not until the 1990s that standardized training of paramedics became widespread. In Nova Scotia, it was not until the late 90s that disparate local ambulance services were finally merged into a province-wide ambulance system. Though the duties and skills of ambulance workers were rapidly increasing, their pay was lagging seriously behind all of the other groups to whom they might compare themselves.

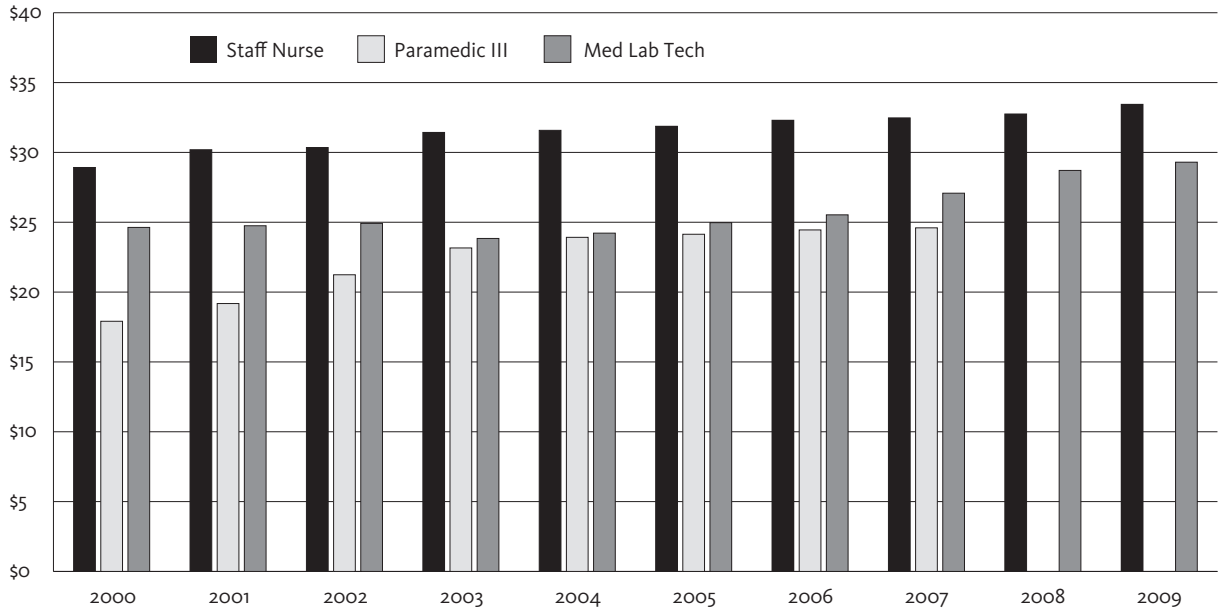
As with technologists and therapists, one useful comparison is with staff nurses. We are not suggesting that ambulance workers are on a par with nurses. Nevertheless, the staff nurse position provides a useful benchmark. Paramedics do not have all of the skills[43] nor perform all the tasks of registered nurses, but their competencies are moving inexorably upward. They perform such operations as initiating and maintaining intravenous therapy, cardioversion (applying electric shock to restore the heart's normal rhythm,) and can interpret 12-lead ECGs. They perform surgical airways and other invasive treatments. They also administer a wide range of medications. Though they operate under strict protocols and often with radio contact with an emergency physician, they often do so under conditions of extreme stress and without direct supervision from a physician.

If unionization came late to the other paramedical professions, ambulance workers were even newer to collective bargaining. And that has plagued the occupation since they became unionized. While several local ambulance services were unionized prior to 1995, it was not until the NSGEU gained certification for the provincial group in 1999 that bargaining began in earnest. The union negotiated a tentative deal but 78% of the workers rejected it. Frustrated by the inability to rectify the inequities in pay and other conditions of employment, 650 provincial ambulance workers went on strike in 2000[44].

The provincial government, faced with a province-wide ambulance strike, tabled legislation to make the strike illegal and to impose binding arbitration. Despite a determined campaign by the union and opposition politicians, the law passed. Nonetheless, there was a consensus, even in government, that a dramatic increase in pay was due[45].

Of the three ambulance arbitrations since 1999, the 2000 round is the only one that made any dramatic changes to the terms and conditions of ambulance workers. With a large amount of catch-up, arbitration awarded roughly a 20% hike in wages, a pension plan, standardized work

FIGURE 4 **Wage comparison staff nurse, med lab tech, and paramedic III**
2000–09 in 2007$ (2008 and 2009 wages based on current rate of inflation)



hours and introduced new or improved benefits and better working conditions.

As with the technologists and therapists, the comparison with registered nurses is the best way of showing how a group is faring. Figure 4 shows how a paramedic III (advanced care paramedic) has compared with a staff nurse from 2000. (Nurses have recently signed an agreement to 2010 while the current ambulance agreement ends in 2008.) The pay of a paramedic III in 1999 (before provincial rates) was around $13 per hour. So the real pay rise from then to 2002 may have been as dramatic as 36%. However, from 2003 to the present, paramedic wages have levelled off and the drive to achieve a smaller pay differential between them and registered nurses has stalled.

The two paramedic arbitrations subsequent to the one in 2000 are the problem here. Attempts to narrow the gap with staff nurses have floundered from 2003 to the present[46]. The crux of the problem is the notion of "comparability." As with the registered technologists and therapists, recent arbitrators seek to find the same or very similar occupations to which to compare the group at hand. But, Nova Scotia arbitrators appear reluctant to look outside of the province or the Atlantic region or to compare paramedic wages to those of Nova Scotia nurses. The only comparable Atlantic group to which arbitrators would look was the small paramedic staff at the QEII hospital in Halifax. This group is not comparable, however, since its duties are much more circumscribed than are those of provincial paramedics. Before 2000, the provincial group lagged behind the QEII group and the first arbitration set out to rectify that by putting the provincial paramedics ahead. But once that had been done, the comparison was moot, except to ensure that the provincial group did not again fall behind the QEII group.

In several other provinces, the wages of paramedics has risen substantially. In Ontario, these wages have jumped as much as 45%[47] from 2001

to the present. They are now as much as 60% higher than in Nova Scotia. To illustrate how far out of alignment this is, consider that the average differential for full-time workers between Nova Scotia and Ontario is about 25%.

It is a major irony that the big increases in Ontario began to appear as the collective bargaining situation of ambulance workers changed. Organization of and bargaining for ambulance personnel in Ontario is not centralized as in Nova Scotia, so it is difficult to generalize. However, prior to 2000, most ambulance workers in Ontario were employees of the provincial government, or hospitals or other institutions for whom the right to strike had been removed and made subject to compulsory arbitration under the *Hospital Labour Disputes Arbitration Act* (HLDAA) or other statutes. In the late 90s, Ontario's Harris Conservative government moved to decentralize and, where possible, privatize health care provision. This meant that a considerable number of ambulance services moved into the "private[48]" sphere, where bargaining was no longer under the HLDAA. *Thus, many ambulance workers now found themselves in a situation where they could strike, and threaten to strike, legally.* It is then no surprise that their wages were able to rise to levels more in keeping with the market and their recognized skills and functions. Ambulance service employers could no longer afford to ignore the problems of ambulance workers' pay.

The average pay of ambulance workers across the country is rising faster than in Nova Scotia. We also know that Nova Scotia practitioners have similar skills and duties to their counterparts across the country. That is evidence that the latter may be due for significant pay rises. But Nova Scotia arbitrators have ignored the rise of ambulance workers' pay in other jurisdictions. They have not given reasons for doing so other than the cost to the employers (and the government.) Arbitration has proven itself a not particularly imaginative process. What we have here is a crisis waiting to happen. It is interesting to note that in the dispute over the proposed removal of the right to strike in 2007-8, the one group that openly vowed to defy such legislation was the ambulance workers[49].

The pension dispute of 2006

The pension dispute of 2006 is a further example of a labour-management disagreement for which arbitration would have been an inadequate or ineffective answer. Moreover, it is likely one more reason why health care employers and government are now touting a ban on strikes.

Pension talk can be complicated so we will attempt to simplify this nonetheless very important, but overlooked, story.

Health care workers in Nova Scotia are covered by a pension plan under the Nova Scotia Association of Health Organizations (NSAHO,) which is the umbrella organization of health care employers in the province. Like many pension plans in union collective agreements, the broad outline of the plan is sketched out in the agreement, but the details are left to a group of pension plan trustees. A minority of trustees is nominated by the union, but more often than not, the pension plan remains an employer-sponsored trust. That was the case here, with union trustees outnumbered by management 4 to 1.

The NSAHO plan involved employees in five unions: NSGEU, CUPE, CAW, NSNU and the Service Employees International Union (SEIU). It also extended to non-union employees. The plan calls for employees to contribute a certain amount of money and for the employers to "top up" the plan with sufficient funds to allow the plan to pay out the promised pensions to retirees.

By 2006, one of the unions involved, CUPE, having considerable experience in pensions, discovered that something was amiss. CUPE claimed that the employers were paying part of their contribution from the plan's surplus, which they are not supposed to do. CUPE accused the employers

of enjoying a "contribution holiday" and taking advantage of employees to the tune of several tens of millions of dollars. As a result, not only had the employee contributions been forced too high, but the employer contributions, which are deferred wages, had been too low.

CUPE and the Canadian Auto Workers union joined forces in placing the pension plan discrepancy on their respective negotiating tables in the 2006 bargaining round with NSAHO. The other unions' bargaining rounds were to come later.

The employers rejected the unions' claim, exhibiting a set of documents they had filed with the Nova Scotia Superintendent of Pensions, purporting to show that no money had been taken from the surplus.

The employers also launched a complaint of "bargaining in bad faith" before the provincial Labour Relations Board. The employers claimed that the unions were placing an impossible burden upon them and that the union's pension proposal was not a proper subject for collective bargaining. The parties to the pension plan, they argued, were not just the CUPE members or the CAW members, but other unions as well. Moreover, they argued, the plan involved employers beyond those for whose employees the unions were bargaining. Thus, the employers argued, it was impossible for a single bargaining agent (union) to change the pension plan and force all of the other unions and employers to comply with the change.

The Labour Relations Board rejected the employers' complaint, insisting that it was not beyond the scope of collective bargaining for a union to ask for changes in a pension plan and it was unfair to remove a pension plan from collective bargaining permanently.[50] The Board sent the parties back to the bargaining table. However, the employers continued to refuse to negotiate as long as the union's pension proposals were still on the table. This in itself could have rendered the employers liable to bargaining in bad faith charges.

At a certain point in these events, the employers abruptly made a correction to their report to the Superintendent of Pensions, showing that the unions' fears had been correct. CUPE and CAW redoubled their efforts and pressed their demands down to the wire, threatening to strike if the employer did not rectify the pension plan imbalance, not only for these two unions but also for the entire plan.

With health care workers poised to walk off the job, the employers finally agreed to set the pension plan right and averted a strike. The employers agreed to make an immediate contribution of $10.6 million and further financial commitments on a go-forward basis.

Because a strike did not happen, the dispute passed under the public's radar. It surely did not go un-noticed by the government of Nova Scotia. Much of the financial burden of this settlement was and would be borne by the government and it is understandable that the government might take the settlement as another motivation to end the right to strike for hospital workers once and for all.

Without the right to strike, it is highly unlikely that the unions would have been able to get the employers to rectify the pension plan imbalance. Even the normally union-unfriendly Daily News said in an editorial, "Work stoppages by employees in essential occupations are never popular and whenever such a walkout occurs, or is threatened, some people demand an end to such employees' right to strike. The public's frustration with public-sector strikes is understandable. But if the hospital workers did not have that right, and had not been willing to use it — what would have happened to their pension plan?[51]"

Even a sympathetic arbitrator would have been unable to do what the unions had done in free collective bargaining. An arbitrator is appointed to settle a dispute between a single bargaining group and its employer. Proposals to include other employers, other collective agreements or multiple bargaining groups would be

beyond the arbitrator's legal jurisdiction to handle[52]. Had no-strike legislation and compulsory arbitration been in effect, the employers could likely well have continued to withhold funds from the pension plan.

Conclusions

Health care employers, like other large and sophisticated employers, are not unresponsive to the needs of their employees. They know how important all of their employees, and especially those providing critical care, diagnostic and therapeutic services, are to the health of patients. They are also well aware, at least theoretically, of a crisis in recruitment and retention among many of those employee groups and how problems of morale can damage care.

But running health care institutions is a complicated business and there are many calls on the attention of managers other than the needs of employees. Also, unfortunately, funding is not flowing like water.

Governments too, have many other items on their plate and sometimes tend not to focus their attention unless a public crisis is at hand.

Luckily, because the health care workforce is highly enrolled in representative organizations, there are unions and professional societies to remind health care managers and governments about the needs of employees if they forget. Even so, unions themselves prefer the role of peacemaker to that of troublemaker, and themselves have to be reminded by their membership of these problems.

But reminders can be ignored or put off. Thus, unions need to threaten to strike in order to catch attention in a system increasingly under stress. We have likened this, in an earlier publication, to "pulling the red cord" of a production line whose progress is temporarily unsustainable.

We have here pointed to three powerful examples of unsustainable problems in health care. We have shown how *the parties themselves* are in the best position to solve them. We are not saying that third-party intervention is never helpful in labour relations. Indeed, it has a long history in Canada. But third-party intervention is not a blanket solution to labour disputes. It works best only under certain conditions. Four questions determine just how effective intervention can be. First, is the intervention voluntary (i.e. have the parties themselves agreed to it) or has intervention been thrust upon them by government fiat? Second, is the intervention binding e.g. does the intervenor have the power to impose his or her solution upon the parties, or are the solutions more in the way of recommendations? Third, is the intervention permanent or

temporary? Fourth, are the issues complex, difficult, and costly or are they relatively straightforward, simple and expensive? We contend that the more compulsory, the more binding, the more permanent the intervention and the more complex, difficult and costly the issues, the less effective intervention will be. On the other hand, the more voluntary, suggestive and temporary the intervention and the more marginal the issues, the more effective intervention will be.

The Nova Scotia government's proposals to end the right to strike in health care and community services would substitute, for the right to strike, intervention that is compulsory, binding and permanent. And, as seen in the three cases used, the issues are thorny, stubborn and resistant to cheap solutions. Arbitration simply will not work to solve these problems. Moreover, such intervention gives the parties, and especially managements and governments, an excuse to put off dealing with difficult and sometimes costly problems.

The right to strike in health care is not a pretty solution to this dilemma. But it is the only one that works.

Notes

1 Parent, Mark. 2007. "Anti-strike plan open to discussion," *Halifax Chronicle Herald*. 28 June: A13.

2 Haiven, Judy and Larry Haiven. 2007. *A Tale of Two Provinces: Alberta and Nova Scotia*. Halifax: Canadian Centre for Policy Alternatives-Nova Scotia. 18 October.

3 Haiven, Judy and Larry Haiven. 2007. *Health Care Strikes: 'Pulling the Red Cord.* Halifax: Canadian Centre for Policy Alternatives-Nova Scotia. 22 November.

4 Gillis, John. 2008. "Province to lease private clinic: $1m plan will take 500 patients from orthopedic waiting lists." *Halifax Chronicle-Herald*. March 13. retrieved March 13, 2008 from http://thechronicleherald.ca/Front/1043304.html

5 Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources (ACHDHR). 2005. *A Framework For Collaborative Pan-Canadian Health Human Resources Planning.* Ottawa: Health Canada. accessed September 5, 2007 at www.hc-sc.gc.ca/ahc-asc/alt_formats/ccs-scm/pdf/public-consult/col/hhr-rhs/PanCanHHR_Framework_sept-05_e.pdf

6 Canadian Institute of Health Information. 2006. *Health Personnel Trends in Canada 1995 to 2004*. accessed July 12, 2007 from http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_21_E

7 Shields, Margot and Kathryn Wilkins. 2005. *Findings from the 2005 National Survey of the Work and Health of Nurses*. Statistics Canada found at http://www.hc-sc.gc.ca/hcs-sss/pubs/nurs-infirm/2005-nurse-infirm/index_e.html on September 5, 2007.

8 Despite not being legally unionized, physicians sometimes go on strike by withholding their services. There have been doctors' strikes in Saskatchewan in the 1960s (over the introduction of medicare) and Ontario in the 1980s (over the ban on extra-billing). Most recently, in 2006, doctors in Newfoundland and Labrador went on strike for 17 days over fees and other matters. See Moulton, Donalee. 2006. "Will arbitration settlement aid MD retention in Newfoundland?" Canadian Medical Association Journal, June 10. 168 (12).

9 Many of the women formerly going into the medical technologies began to go into medicine. The proportion of women doctors quadrupled from 7% in 1961to 28% in 2000 (Crossley, Thomas F., Jeremiah Hurley and Sung-Hee Jeon. 2006. *Physician Supply in Canada: A Cohort Analysis*. Department of Economics Paper Series 2006-2. McMaster University. 4)

10 Health Care Human Resource Sector Council. 2003. *A Study of Health Human Resources in Nova Scotia 2003.* 10.

11 Office of Nursing Policy. 2006. *Nursing Issues: General Statistics.* Ottawa: Health Canada. Accessed at http://www.hc-sc.gc.ca/hcs-sss/pubs/nurs-infirm/onp-bpsi-fs-if/2006-stat_e.html on September 5, 2007

12 A series of reports on different allied health professions prepared by the Health Care Human Resource Sector Council showed registered nurses in 2001 with an average age of 43.9 (29% over age 50), medical laboratory technologists with average age of 44 (17.4% over the age of 50), medical radiation technologists with an average age of 39.9 (20% over the age of 50.) For reports on these and other occupations see http://www.gov.ns.ca/health/hhr/

13 Corpus Sanchez International Consultants. 2007. *Changing Nova Scotia's Healthcare System: Creating Sustainability through Transformation. Final Report.* December. 18.

14 Haiven, Judy and Larry Haiven. 2007. *Health Care Strikes: 'Pulling the Red Cord.'* Halifax: Canadian Centre for Policy Alternatives-Nova Scotia. 22 November.

15 Warren Shepell Research Group. 2004. "Organizational Health & Wellness Trends in the Healthcare/Hospital Sector." Toronto: WarrenShepell, which reaches the following conclusion "Our research suggests that hospital workers are experiencing unique occupational health problems that must be addressed if Canada's hospitals are to deal effectively with future crises and change."

16 Canadian Health Professions Secretariat. 2004. "Allied health professionals key to improving access." accessed at http://www.nupge.ca/news_2004/n16de04b.htm on September 5, 2007.

17 Gillis, John. 2008. "Wait time for an MRI doubles in Halifax; Average is now 200 days, or more." *The Chronicle-Herald* (Halifax). July 18. B1.

18 Service Employees' International Union, Local No. 333 v. Nipawin District Staff Nurses Association, [1975] 1 S.C.R. 382

19 Remember that, by and large, labour relations in health care are strictly a provincial matter. Thus decisions on the structure of collective bargaining were not made on a national, but on a province-by-province basis.

20 In fact, Nova Scotia is the only province where this did not occur. For historical reasons, registered nurses here are split between the Nova Scotia Nurses' Union (NSNU, roughly representing those outside of Halifax) and the Nova Scotia Government and General Employees' Union (NSGEU, roughly representing those in Halifax.)

21 Campbell, Shelagh and Larry Haiven. 2008. "Struggles on the frontier of control over professional identity: Leading cases from Canada." Paper presented at the International Labour Process Conference, Dublin March.

22 A bargaining unit is a group of employees deemed by the labour relations board to be "appropriate for collective bargaining." If they decide to seek union representation, all the employees in a bargaining unit must choose a single union to represent their interests in collective bargaining. All of the groups designated are included.

23 The collective agreement for this bargaining unit between NSGEU and Capital Health lists 180 different occupational groups. See http://action.web.ca/home/nsgeu/attach/Healthcare_Local_42_exp_Oct_31_20091.pdf . Accessed July 15, 2008. A more comprehensive list of occupations has been compiled by the Health Sciences Association of Alberta. See http://www.hsaa.ca/who_we_are/list_of_disciplines. Accessed September 11, 2007.

24 The authors, for example, were chastised bitterly by a medical laboratory technologist for omitting reference to her group in a previous article.

25 For example, in Alberta all technologists and therapists are represented by the Health Sciences Association of Alberta.

26 The Nova Scotia Labour Relations Board has designated four standard bargaining units in acute care: "Nurses", "Health Care Employees," "Office Employ-

ees" and "Residual" (such as maintenance, kitchen, housekeeping and dietary staff)

27 Dooley, Richard 2001. "Nurses 132 notices from mass exodus" *The Daily News (Halifax)* July 5: 5.

28 From interviews with members of the NSGEU health care bargaining unit and union officials.

29 Jackson, David and Amy Smith. 2001. "Anti-strike law passes, workers stay off job." *Halifax Chronicle-Herald*. June 28. A1.

30 Haiven, Larry and Judy Haiven. 2002. *The Right to Strike and the Provision of Emergency Services in Canadian Health Care.* Halifax: Canadian Centre for Policy Alternatives-Nova Scotia.

31 Many newspaper articles describe the dispute over Bill 68. For a summary of the dispute, see Rodenhiser, David. 2001. "Hamm on the Bill 68 fiasco: It was worth it." *Halifax Daily News*. July 8, p. 17

32 Ashley, Susan. 2001. "In The Matter Of: A Final Offer Selection in relation to the wage rates for Registered Nurses, Licensed Practical Nurses, and other Health Care Employees employed by the Employer." Arbitration decision. August. 9.

33 Ashley, Susan. 2001. "In The Matter Of: A Final Offer Selection in relation to the wage rates for Registered Nurses, Licensed Practical Nurses, and other Health Care Employees employed by the Employer." Arbitration decision. August. 26.

34 Ibid. 27.

35 Ibid. 27.

36 In the wake of the Bill 68 dispute, the government had appointed a committee led by Professor Nuala Kenny of Dalhousie University to look into the issue of the right to strike in health care. It had also invited the unions to meet on the issue. But the unions refused.

37 Kaplan, William. 2004. In The Matter Of An Interest Arbitration Between Capital District Health and The Nova Scotia Government and General Employees Union. Arbitration decision. August. 6.

38 Kaplan, William. 2004. In The Matter Of An Interest Arbitration Between Capital District Health and The Nova Scotia Government and General Employees Union. Arbitration decision. August 5.

39 Hayes, James. 2004. Dissent. In The Matter Of An Interest Arbitration Between Capital District Health and The Nova Scotia Government and General Employees Union. August. 6

40 While the unions present strong arguments that the technologist/nurse parity should be maintained, the employers do not. Their arguments centre more on their ability to pay.

41 Some might argue that the disparity between nurses and technologists is one caused by unions, given that, left on their own, employers traditionally paid them similarly. However, prior to unionization, employers paid them similarly poorly. In the race to "catch-up" nurses' unions were more militant earlier. Technologists and therapists seem to finally have woken up and are now pressing their unions to rectify the imbalance.

42 A fourth, less common category is Critical Care Paramedic (CCP).

43 Registered nurses now usually require a four-year BScN degree and the profession is legally regulated by the Nova Scotia College of Registered Nurses. Depending on their level, paramedics usually require several years of training at a post-secondary institution (e.g. Martiime School of Paramedicine, Holland College) and the employer requires them to have a licence to practice. The occupation is not yet self-regulated by its own professional college or society.

44 Smith, Amy and David Jackson.1999. "Province's paramedics on strike; Tories fail to pass bill preventing work stoppage." *Halifax Chronicle-Herald*, October 29. A1

45 See Editorial. 1999. "Paramedics' Pay Way Out of Kilter." *Halifax Daily News*. 16 July and Donham, Parker Barss. 1999. "Accidents Happen if One Happens to You: Do you want to be looked after by someone not making much more than minimum wage?" *Halifax Daily News*. 20 October.

46 So frustrated were the ambulance workers with their lack of progress that they left the NSGEU and chose another union as their bargaining agent.

47 From discussions with representatives of the various Ontario unions representing ambulance workers (OPSEU, CUPE).

48 The municipal sphere in Ontario is also considered to be "private" as far as collective bargaining regulation is concerned.

49 Gillis, John. 2007. "Paramedics say they'll walk if they have to, legally or not." *Halifax Chronicle-Herald*. May 16: A1.

50 Decision #LRB-6068 FINAL ORDER: Canadian Union of Public Employees (and other unions) v. South West Nova District Health Authority District Authority #2. September 6, 2006.

51 Editorial. 2006. "Strike averted—temporarily" *Halifax Daily News*. Oct. 31: 14

52 An arbitrator would not be able to deal with a question beyond her normal jurisdiction like this one unless the employer and/or the government agreed that her scope be enlarged. In a situation where strikes are banned, it is highly unlikely they would agree.

> ABOUT THE CENTRE

The Canadian Centre for Policy Alternatives is an independent, non-profit research institute funded primarily through organizational and individual membership. It was founded in 1980 to promote research on economic and social issues from a progressive point of view. The Centre produces reports, books and other publications, including a monthly magazine. It also sponsors lectures and conferences.

> AU SUJET DU CENTRE

Le Centre canadien de politiques alternatives est un institut de recherche indépendant et sans but lucratif, financé en majeure partie par ses membres individuels et institutionnels. Fondé en 1980, son objectif est de promouvoir les recherches progressistes dans le domaine de la politique économique et sociale. Le Centre publie des rapports et des livres, ainsi qu'une revue mensuelle. Il organise aussi des conférences et des colloques.

CCPA
CANADIAN CENTRE for POLICY ALTERNATIVES
CENTRE CANADIEN de POLITIQUES ALTERNATIVES

www.policyalternatives.ca

> NATIONAL OFFICE

410-75 Albert Street, Ottawa, ON K1P 5E7
TEL 613-563-1341 FAX 613-233-1458
ccpa@policyalternatives.ca

BC OFFICE
1400-207 West Hastings Street, Vancouver, BC V6B 1H7
TEL 604-801-5121 FAX 604-801-5122
ccpabc@policyalternatives.ca

MANITOBA OFFICE
309-323 Portage Avenue, Winnipeg, MB R3B 2C1
TEL 204-927-3200 FAX 204-927-3201
ccpamb@policyalternatives.ca

NOVA SCOTIA OFFICE
P.O. Box 8355, Halifax, NS B3K 5M1
TEL 902-477-1252 FAX 902-484-6344
ccpans@policyalternatives.ca

SASKATCHEWAN OFFICE
105-2505 11th Avenue, Regina, SK S4P 0K6
TEL 306-924-3372 FAX 306-586-5177
ccpasask@sasktel.net

> BUREAU NATIONAL

410-75 rue Albert, Ottawa, ON K1P 5E7
TÉLÉPHONE 613-563-1341 TÉLÉCOPIER 613-233-1458
ccpa@policyalternatives.ca

BUREAU DE LA C.-B.
1400-207 rue West Hastings, Vancouver, C.-B. V6B 1H7
TÉLÉPHONE 604-801-5121 TÉLÉCOPIER 604-801-5122
ccpabc@policyalternatives.ca

BUREAU DE MANITOBA
309-323 avenue Portage, Winnipeg, MB R3B 2C1
TÉLÉPHONE 204-927-3200 TÉLÉCOPIER 204-927-3201
ccpamb@policyalternatives.ca

BUREAU DE NOUVELLE-ÉCOSSE
P.O. Box 8355, Halifax, NS B3K 5M1
TÉLÉPHONE 902-477-1252 TÉLÉCOPIER 902-484-6344
ccpans@policyalternatives.ca

BUREAU DE SASKATCHEWAN
105-2505 11e avenue, Regina, SK S4P 0K6
TÉLÉPHONE 306-924-3372 TÉLÉCOPIER 306-586-5177
ccpasask@sasktel.net