

A Return to Wage Discrimination

Pay Equity Losses
Through the
Privatization
of Health Care

by Marjorie Griffin Cohen
and Marcy Cohen

APRIL 2004



CANADIAN CENTRE FOR POLICY
ALTERNATIVES – BC OFFICE

A Return to Wage Discrimination

Pay Equity Losses Through the Privatization of Health Care

By Marjorie Griffin Cohen and Marcy Cohen

April 2004

ISBN: 0-88627-384-6

About the authors

MARJORIE GRIFFIN COHEN is an economist who is a professor of Political Science and Women's Studies at Simon Fraser University. She is currently Chair of Women's Studies. Her most recent publications are *Training the Excluded for Work: Access and Equity for Women, Immigrants, First Nations, Youth and People with Low Income* (UBC Press, 2003) and *Global Turbulence: Social Activists' and State Responses to Globalization*, with S. McBride (Ashgate, 2003). She is a research associate and board member with the Canadian Centre for Policy Alternatives, and is co-director of a joint five-year research initiative of the CCPA and SFU, the Economic Security Project, which is studying how public policy changes in BC are affecting the economic security of vulnerable populations.

MARCY COHEN has an MA in Education from the University of Toronto. Over the past 20 years she has worked as a policy analyst and has directed a large number of research studies focusing on women's employment issues and work structuring in the public service. She has coordinated the research and health policy work of the Hospital Employees' Union for the past nine years. Marcy is also a research associate of the Canadian Centre for Policy Alternatives and Chair of its BC Board of Directors.

Acknowledgements

The authors wish to thank Anita Braha, Shannon Daub, David Fairey, Seth Klein, Marc Lee, Arlene McLaren, Stuart Murray, Mary Rowles, and Jane Stinson for their input and feedback on this paper.

Any errors and the opinions presented in this paper are those of the authors, and do not necessarily reflect the views of the Canadian Centre for Policy Alternatives.

This paper is part of a joint five-year research initiative of the CCPA and SFU, the Economic Security Project, which is studying how public policy changes in BC are affecting the economic security of vulnerable populations. The project is funded primarily by a grant from the Social Sciences and Humanities Research Council of Canada (SSHRC) through its Community-University Research Alliance Program.



Social Sciences and Humanities
Research Council of Canada

Conseil de recherches en
sciences humaines du Canada

Canada

CCPA BC Office

1400 – 207 West Hastings Street
Vancouver, BC V6B 1H7
tel: 604-801-5121
fax: 604-801-5122
email: info@bcpolicyalternatives.org



CCPA National Office

410 – 75 Albert Street
Ottawa, Ontario K1P 5E7
tel: 613-563-1341
fax: 613-233-1458
email: ccpa@policyalternatives.ca

Please make a donation...

Help us continue to offer our publications free on-line.

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 print and fill out the form at the back of this publication. Or you can contact the BC office at (604) 801-5121 for more information.

Suggested donation for this publication: \$10 or whatever you can afford.

Contents

Summary of Key Findings.....	4
Introduction	6
Pay Equity	7
BC’s Experience with Pay Equity	7
Pay Equity for Health Support Workers	8
Hospital Support Workers	10
The Backdrop to Privatization	10
Privatization Initiatives Unprecedented	11
The Rationale for Privatizing Health Support Services	12
The IWA and Multinational Contractors	14
The IWA and the Union Movement	18
Implications for Patients	19
Conclusions	20
Notes	22
Appendices	25

Summary of Key Findings

The BC government's actions to facilitate health care privatization have turned back more than 30 years of pay equity gains for women in health support occupations.

- From the 1960s to 2001, the pay equity gains won by women in hospital support work in BC were remarkable, but fair. The bargaining strategies used by health care unions were successful in bringing equity to the health support sector. During this period, a significant wage gap between female-dominated health support jobs and comparable male-dominated work was narrowed to between 11 per cent and full parity.
- This success appears to have attracted the provincial government's ire and encouraged it not only to reduce wages, but to reduce them to a point where they are the very lowest for this category of work in the country. The new rates for housekeeping (\$9.25 to \$11 an hour) are between 14 and 39 per cent lower than anywhere else in Canada and 26 per cent below the national average.
- The "partnership agreement" for the Vancouver Coastal Health Authority between the private multinational corporation Aramark and the trade union now representing Aramark's workers, the Industrial Woodworkers of America (IWA), is an example of how bad things have become for workers in the health support sector. Wages have been cut almost in half, and these workers have no pension, long-term disability plan, parental leave or

guaranteed hours of work. They do not know from one week to the next how many hours they will work, when those hours will be scheduled, or what their take-home pay will be.

- These new wages are so low that they place the purchasing power of health support workers at what it was in 1968. The Hospital Employees' Union (HEU)-negotiated wage for housekeeping in 1968 was equivalent to \$9.35 an hour in current dollars.
- These new wage rates and conditions are significantly lower than what the IWA has negotiated for similar work performed by males in other contracts with other employers. Under the IWA Master Agreement (2000-03) janitors are paid \$21.92 an hour, which is 2.1 times more than the wage rate negotiated for hospital cleaners. This completely rejects the concept that women and men should be paid equally for the *same* work, let alone for work of equal value (pay equity).

These very rapid changes in wages and working conditions are the result of a number of unprecedented actions by the provincial government, the multinational corporations winning contracted-out health support services, and one particular trade union, Local 1-3567 of the IWA.

- Bill 29 eliminated the employment security and "no contracting-out" provisions of negotiated health and social service contracts. There are only three other occasions in Canadian history where governments infringed on statutory or collectively bargained job security provisions. In all three cases, government interventions were intended to limit

or foreclose *future* bargaining on job security. They did not void collective agreement provisions during their term.

- The negotiation of “voluntary recognition agreements” between multinational service corporations (Aramark, Sodexo and Compass) and IWA Local 1-3567 is highly unusual. These agreements were completed before the corporations had signed contracts with the health authorities, before the HEU members had been laid off to make way for contracting-out, and before any new workers had been hired. The agreements eliminate workers’ right to choose their own union and to vote on the contents of their collective agreement.
- These so-called “partnership agreements” are for an unprecedented six years and include highly irregular commitments by the union to “joint responsibility” with the employer for corporate profitability levels.

The provincial government has justified its actions by claiming that hospital support workers were overpaid.

- While it is true that health support workers in BC achieved higher wages than elsewhere in Canada, these wages were in line with BC’s higher general labour costs and higher costs of living. These wages were also comparable to those paid for similar work done by male workers in the direct public sector.
- Before privatization, wages for hospital housekeepers were slightly higher than those paid in the private hospitality sector. These modestly higher wages reflected the more challenging nature of hospital work. The new wage rates (at \$9.25 to \$11 an hour) are dramatically lower than even the lowest negotiated contract in the hospitality sector.
- The province has pursued an ideological goal of shifting health care provision to the private sector. Health support workers, who are lower down on the health care hierarchy, are the most vulnerable. Most of these workers are women, and a higher than average proportion are older or from visible minority or immigrant backgrounds.

The province’s actions will have broader implications, both in BC and nationally.

- Rolling back pay equity gains through privatization sets a precedent for other provinces. Both Quebec and Ontario very recently passed legislation giving their governments the power to override existing collective agreement provisions, as was done by the BC Government with Bill 29. The legislation in Quebec and Ontario will be particularly detrimental for working class and visible minority women who have benefited from pay equity gains in the public sector.
- Privatization in BC is happening at a time when concern about the spread of hospital-acquired infections is high. Other jurisdictions (such as Britain and Scotland) are bringing cleaning work back in-house because of cleanliness and infection control problems that resulted from a privatized workforce that was poorly trained, inadequately paid and had high turnover rates. Prior to privatization of health support work in BC, the availability of steady employment at reasonable wages with decent benefits created a stable workforce that contributed to overall patient care. This is no longer the case.
- The privatization of health support work seriously undermines the economic security of a significant number of workers. Despite the fact that it is a predominantly older female workforce, HEU members share many characteristics typically associated with primary male wage earners. More than 50 per cent have one or more dependent children and one quarter support dependent adults. Many are either sole support parents or live with partners who do not have access to extended health and/or pension benefits.
- The repercussions are likely to go well beyond the public sector. As women’s wages in health and other public services are reduced as a consequence of Bill 29, it is a signal to the private sector that they too can set aside arguments about the need for decent wages for women’s work.

A Return to Wage Discrimination

Pay Equity Losses Through the Privatization of Health Care

The public health care system in Canada is stressed, in large measure as a result of the 1995 federal government initiatives that greatly reduced provincial health care funding. One way some provinces have coped with inadequate funding has been to pursue privatization of the health care system.

Since Canadians strongly support public health care, attempts at outright privatization of medical services have met with considerable opposition. But the more invisible aspects of health care, mainly those dealing with hospital and community support work, are much more vulnerable to privatization initiatives – primarily because this work is considered less significant than the more medically focused aspects of health care.

For some governments, like British Columbia's, the health care funding crises provides an opportunity to pursue their ideological goals of shifting health care provision to the private sector. The parts of the system that employ workers lower down on the health care hierarchy are the most vulnerable. These are the cleaners, laundry workers, care aids, food services workers, trades and information systems workers, security personnel and clerical workers. Most of these workers are women, something that is not incidental in the privatization scheme. A high proportion of these women are older, or from visible minority or immigrant backgrounds, and many are the primary wage earners for their families.

Until recently, health support workers had well-paying and secure employment (i.e. wages relatively equiva-

lent to BC's average industrial wage). This was largely a result of the efforts of unions to redress the historical gender-based wage gaps that existed in the health support sector. It was a long, hard struggle that had to be won, for the most part, at the bargaining table because BC (unlike other provinces in Canada) did not

have pay equity legislation. As a result of these successes, health care support workers in BC had the highest wage rates and lowest wage gap between males and females of any jurisdiction in the country. This achievement not only affirmed the value, skill and responsibility of women's less visible care work: it also ensured that the health support sector had a very stable, well-trained and committed workforce.

These pay equity achievements have been eliminated through the privatization of health support services. Wages have been cut almost in half, benefit provisions eliminated or drastically reduced, and guaranteed hours of work abolished. While these actions reflect the specific agenda of BC's current government, the mechanisms used to bring about privatization have common features with privatization processes occurring elsewhere.

In BC, the significant feature undermining pay equity was the introduction of provincial legislation with sufficient power to void protections against contracting out in existing collective agreements. Once the legislation was in place, finding and exploiting the historical differences between public and private trade unions, between those that organize women and those that organize men, and

between different classes of health care workers became an important element in successfully undermining worker solidarity. All of this was made possible by a campaign to devalue the significance of care work – particularly the work done by a population of workers that was vulnerable because of gender, race, ethnicity, and class.

This paper documents the pay equity achievements among health care support workers and shows how these have been undermined by the actions of both federal and provincial governments. It also explains the role of the different trade unions involved in both achieving pay equity and in undermining its success. Finally, it shows how the very significant organizing ability and rights of women workers were compromised through the privatization processes.

Pay Equity

The under-valuation of women’s work, particularly in areas where it closely resembles domestic work, is both well documented and acknowledged by governments. According to the BC government’s 2002 Task Force on Pay Equity, “there is no dispute that substantial sex-based wage disparities (also referred to as gender pay gaps) exist in British Columbia and across Canada, or that they adversely affect women in a number of ways.”¹

The feminist revival of the 1970s made “equal pay for work of equal value” (“pay equity” or “comparable work” in current parlance) an important issue for very good reasons. Most provinces in Canada had laws on the books from the 1950s stating that employers had to pay women the same as men when they did the same work. (BC enacted such legislation in 1953.) These laws had little effect, however, on the entrenched practice of paying men higher wages than women. This was because employers tended to segregate work into male-specific and female-specific jobs, which allowed them to continue the practice of paying less for “women’s” jobs.

In contrast, pay equity initiatives and laws put forward in the 1970s focused on the value of the work performed. They were based on the principle that where the value of the work performed by a woman is the same as the value of the work performed by a man the two should be paid

equally. By evaluating work on the basis of the knowledge, skill, effort, responsibility and working conditions required to do a job, comparisons between different kinds of work can be made, making it possible to determine where wage inequalities exist.

While the term “pay equity” focuses on wage differentials between males and females doing comparable work, it can also examine other areas where different treatment in compensation seriously disadvantages women. Women in public sector employment in particular have benefited from the inclusion of benefit packages in pay equity considerations (i.e. pensions, sick leave, medical and dental coverage, disability provisions and vacation pay that go beyond minimum employment standard regulations).²

The idea of pay equity, or equal pay for work of equal value, is really nothing new. It was a feature of the Treaty of Versailles early in the 20th century, which became the basis for its inclusion in the Treaty of Rome, which in turn established the European Union’s approach to pay equity. The International Labour Organization (ILO) had a 1951 convention on pay equity signed by Canada. And, in 1977, Canada included equal pay for work of equal value in the Canadian Human Rights Act. It is also in effect in Quebec (1975), Ontario (1987), Manitoba (1985), New Brunswick (1989), Nova Scotia (1988), Saskatchewan (1997), and the Yukon (1985).

BC’s Experience with Pay Equity

Although pay equity is the law in most jurisdictions in Canada, it is not the law in BC. This is surprising because for most of the 1990s a New Democratic Party (NDP) government was in power and generally NDP governments are more associated with women-friendly legislation than are other governments. While some form of pay equity legislation had been established in most other provinces by the early 1990s, a lack of public support and complications arising from Ontario’s legislation led the new NDP government to a prolonged period of ‘studying’ the issue. The result was an approach that focused on the introduction of pay equity guidelines in the public sector.³ In 1995 the government introduced the *Pub-*

Until recently, health support workers had well-paying and secure employment. This was largely a result of the efforts of unions to redress the historical gender-based wage gaps that existed in the health support sector.

lic Sector Employers' Council Pay Equity Policy Framework. It was a proactive policy requiring the direct public service, the education sector and crown corporations to develop pay equity plans, to file these plans with the government, and to pay up to one per cent of payroll for pay equity adjustments.⁴

The measures to institute pay equity within the public sector had a significant impact on the wage gap between males and females in the public sector. However, as the government approached an election that it clearly could not win, it realized that without legislation the existing Pay Equity Policy Framework would not be sufficient to protect women's wage gains. In the face of this impending election defeat women within the party urged that some kind of legislative action be taken. Ultimately, and very late in its term, the NDP government passed an amendment to the Human Rights Code to add a pay equity provision.⁵ However, this amendment was never implemented. One of the first acts of the new Liberal government was to repeal the legislation and to instead create a task force to study the possibility of instituting pay equity for the private sector.

The results of this task force were very disappointing for pay equity advocates. Its recommendations were decidedly opposed to pay equity legislation and instead called for "equal pay for equal work," (something that had been in effect since 1953), and "study, education, industry participation, and voluntary measures over a period of time."⁶

Ironically, when this same government introduced public sector wage controls under the Public Sector Employers Act (Bill 66) in October 2002, it retained the provisions from the Pay Equity Policy Framework. As a result, the pay equity policy remains on the books and funding continues to be made available to some sectors despite the very concerted efforts to reverse the gains of pay equity in the health support sector outlined below.

Pay Equity for Health Support Workers

Given the absence of legislation in BC, many individual trade unions, particularly those representing women in the public sector, bargained specifically for pay equity.⁷ In the health care sector the Hospital Employees' Union (HEU) represents more than 90 per cent of health support workers in BC's hospitals and long term care facilities. It is a trade union with a long history of fighting for wage equality, using several negotiating strategies over time to advance that goal. Its members have been the primary focus of the provincial government's privatization initiatives, although other unions, such as the BC Government and Service Employees' Union (BCGEU) have been affected as well.

HEU's first steps toward pay equity were made in the 1960s when wage rates for similar jobs were standardized across the province and discriminatory 'male' and 'female' job classifications were eliminated.⁸ Although these changes were important, they were not sufficient to end the bias against fair compensation in female-dominated jobs. During the first half of the 1970s, HEU pursued several strategies in its efforts to achieve pay equity, including bargaining for pay equity provisions in collective agreements, initiating human rights complaints, making submissions to government, and seeking arbitrated settlements. Of particular significance was a successful human rights complaint filed on behalf of radiology attendants at Vancouver General Hospital. Collective bargaining successes included winning equal pay for specific classes of workers (i.e. between female practical nurses and male general orderlies), as well as a specific monthly anti-discrimination adjustment for the more

than 8,000 hospital workers earning less than the cleaner rate.

These initiatives were largely stalled between the mid 1970s and 1980s with the imposition of first federal and then provincial wage controls. Once again the union was forced to shift tactics, focusing on the creation of a broadband classification system that would establish hospital wage rates comparable to those in similar classifications in the direct public service.

In 1991, after 20 years of concerted efforts by HEU, differentials of between 10 and 29 per cent remained (see Table 1, 1991 column). On the heels of significant pay equity gains achieved in 1989 by BCGEU in negotiations with the Social Credit government, HEU undertook a major strike in 1992 to make pay equity a reality in health care. The primary demands of the strike were related to closing the gender gap: a gender-neutral base rate for all workers to be established at the male entry level rate; across the board, rather than percentage, wage increases; the elimination of all increment steps; an industry-wide pay adjustment for all hospital workers as a recognition that even men in the sector were underpaid because the work had been undervalued; and comparability with direct public service workers. Supplementary demands included on-site childcare, paid maternity leave, and a ban on wage reductions resulting from pay equity.

As a result of that strike, 90 per cent of HEU's membership received pay equity increases on top of general wage increases. Although this did not establish full pay equity, it was a solid beginning gradually improved upon

throughout the 1990s. As part of this agreement a Job Value Comparison Plan was established with the provision that up to one per cent of payroll per year would be allocated for pay equity implementation until pay equity was achieved in each classification.

In addition, comparability with the direct public service was achieved through a long and protracted arbitration in which the rates paid to health care workers in specific job classifications were compared to rates paid to similar classifications in the direct public service. As a result, by 2001 the wage differentials for comparable male and female work in the health care sector had declined significantly. (See Table 1)

It is notable, as other studies have shown, that collective bargaining proved to be more effective in achieving pay equity for hospital support workers than the pay equity legislation in Ontario.⁹ A comparison with hospital workers in Ontario shows that pay equity adjustments in BC are greater in all categories, ranging from changes of 2.5 times greater for food service workers to 10 times greater for nursing aides. The overall average improvement for hospital support workers in BC is almost five times greater than in Ontario.¹⁰ Perhaps the most significant difference is that while pay equity adjustments greatly reduced the differential between the low and high wage earners in BC's health support occupations overall, in Ontario it increased the differential. This was because women at the top of the wage scale received larger pay equity settlements than women at the bottom of the wage scale.¹¹

Table 1: Gender-Based Wage Differentials, 1991 and 2001

(Wages in female-dominated jobs as a percentage of value of comparable male work)

Job classification	Gender based wage differential	
	1991	2001
	%	%
Housekeeping aide	16	3.7
Nursing assistant	29	11
Food service worker	10	0.2
Laundry worker	14	1.9
Clerk II, medical records	14	1.1

Source: HEU Job Value Comparison Plan

Hospital Support Workers

Hospital support work is primarily women’s work and HEU is primarily a women’s union. In March 2002, 85 per cent of HEU’s 46,000 members were women. Compared to the working population as a whole, a larger proportion of the members of HEU are also older, immigrant and/or visible minority women (see Table 2).¹² These groups are recognized as especially disadvantaged in the labour force and therefore most likely to benefit from pay equity initiatives.

An independent survey of HEU members conducted in March 2002 shows that these workers did indeed achieve reasonable incomes, job security, and benefits.¹³ Despite the fact that this is a predominately older female workforce, HEU members share many characteristics typically associated with primary male wage earners. For example, the majority of HEU members live in families that are entirely dependent on the HEU-negotiated extended benefit plan (68 per cent), and close to half (48 per cent) are dependent solely on HEU pension entitlements. In other words, many HEU members are either sole support parents, or live with partners who do not work in jobs with extended health and/or pensions benefits. In fact, when asked about the security of their partner’s employment, only 18 per cent of HEU members living with an adult partner reported their partner’s work arrangements as “very secure.”

The availability of steady work at reasonable wages, combined with benefits – including pension benefits –

provided a stable workforce for BC’s health care sector. Two-thirds of HEU members are employed full-time and stay in their jobs for long periods. Full-time employees have held their jobs for an average of 11.6 years, while part-time employees average 6.1 years. Over 50 per cent have one or more dependent children and one quarter support dependent adults. As the next sections of this paper show, the BC government’s decision to nullify the workers’ negotiated contract, an action that set the stage for privatization, leaves these workers without the means to ensure long term economic security for themselves and their families.

The Backdrop to Privatization

Privatization is an important policy objective of BC’s current government. This objective is based on an ideology that assumes privatization will stimulate business activity and result in more efficient management than that offered by the public sector. But privatization is also a pragmatic objective for the government in the sense that it will help reduce expenditures because the private sector is in a better position to control labour costs.¹⁴

What is occurring in BC is not unique. Governments are responding both to the imperatives of a shift in ideology and the pressures associated with global competition. In Canada, the shift to neoliberal policies by many provincial governments has been bolstered by the federal government’s actions, which together have produced an overall “conditioning framework” to encourage the privatization of care work.

One of the most significant actions of the federal government has been its reduction in financial support of health care. The federal government’s cash transfer to the provinces has decreased from a high of 47 per cent of hospital and physician expenditures in 1977 to a low of less than 15 per cent in the late 1990s.¹⁵ According to the Romanow Commission on the Future of Health Care in Canada, “the federal government has successfully

Table 2: Ethnicity, Gender and Age

(Proportion of BC population and HEU membership)

Category	BC %	HEU %
Visible minority	19	27
Immigrants ¹	20	31
Women	50	85
Average age of workers	39 years	47 years

¹This category designates people born outside Canada.
Source: McIntyre & Mustel Research, HEU Member Profile Survey, March 2002.

moved the risk of growing health expenditures to the provinces,” both through its reductions in cash and through the elimination of an escalator when the Canada Health and Social Transfer (CHST) was established.¹⁶ Also significant has been the expansion of the provincial health care system to cover some drugs, home care, and other services for an aging population without a corresponding expansion of federal coverage under the Canada Health Act.

Funding shortfalls have opened the door for corporations that have long been interested in securing a foothold in the public health system. These corporations argue that they can improve access and reduce waitlists through the development of a parallel private health care delivery system. Recently their arguments have turned to the cost reductions made possible by redefining health support services as private sector “hospitality services” that employ a cheaper, more transient workforce.

The dismantling of pay equity through the privatization process is not the result of one jurisdiction’s actions alone. Local health authorities are on the front line in the privatization process. But they are responding to the pressure of reduced provincial funding and incentives that favour corporate partnerships. The provinces get away with privatization because the federal government is complicit through its reductions in funding and its indirect approval of privatization initiatives. In this process, all levels of government become allies in the downward spiral of women’s wages.

Privatization Initiatives Unprecedented

In 1995 the Fraser Institute published a slim, five-page “study” comparing the costs of ancillary support services in hospitals – cleaning, laundry, food services, trades and clerical – to “hospitality” services in hotels. It argued that hospital support workers are overpaid.¹⁷ This line of reasoning has since been taken up by a number of others, including influential people in the media and the BC Medical Association. They argue that high wages for “non-professional” and “non-essential” health support workers are starving the acute care system of resources that

The dismantling of pay equity through the privatization process is not the result of one jurisdiction’s actions alone. In this process, all levels of government become allies in the downward spiral of women’s wages.

should be going to direct care and professional services.¹⁸

The Fraser Institute “study” and the support it generated set the stage for the privatization of hospital support services. In January of 2002, nine months after taking office, the provincial government introduced Bill 29, the Health and Social Services Delivery Act, which unilaterally altered collective agreements negotiated between employers and workers in the health and social service sectors.¹⁹ This legislation removed key employment security and “no contracting-out provisions” for about 100,000 health care workers during the life of the contracts. In particular, it facilitates hospital and long term care closures, makes the privatization of support services within the health care sector much easier to achieve, and eliminated HEU’s members’ ability to “follow the work” once it is contracted out to a private employer. This legislation also makes it possible for employers to lay off their current workforce with minimum notice, and then restructure the workplace with an entirely new workforce paid much lower wages and with far fewer benefits.²⁰

While government intervention in labour relations has a long history, legislation aimed at altering collective agreement provisions is rare and, where it does occur, it is usually limited to wage rollbacks.²¹ In an affidavit submitted on Bill 29, Joseph Rose, a professor in the Faculty of Business at McMaster University, noted only three other occasions in Canadian history where governments infringed on statutory or collectively bargained job security provisions. In all of these cases government inter-

ventions were intended “to limit or foreclose” future bargaining on job security; they did not “void collective agreement provisions during their term.”²² In this respect the provisions of Bill 29 are unprecedented.

As a result of the unprecedented scope of Bill 29 and its impact on a very vulnerable group of primarily women workers, HEU, BCGEU and other unions affected by Bill 29 have launched a Charter of Rights court challenge under three provisions of the Charter: equality rights (Section 15), freedom of association (Section 2) and security of persons (Section 7). This challenge was turned down at the BC Supreme Court in September 2003, but the unions will take the case as far as the Supreme Court of Canada. A positive ruling there would be significant: it would establish a legal precedent for the recognition of gender-based wage discrimination as a violation of equality rights under the Charter.

The Rationale for Privatizing Health Support Services

With Bill 29 in effect, health authorities are privatizing their housekeeping, security, laundry and food services work. According to the health authorities, the primary reason for contracting out health care support services is to save money on labour costs in response to reduced funding from the provincial government.²³ One of the very specific requirements outlined by the provincial government in each of the health authorities’ “performance contracts” is the stipulation that by 2004/05 administrative and support costs must be seven per cent below 2001/02 levels.²⁴

Private long-term care providers, primarily in the Lower Mainland, have been especially quick to take advantage of the new legislation in response to funding shortfalls from the health authorities. Some private long term care operators have contracted out their direct care staff (i.e. care aides) as well as support staff, while others have convinced their staff to accept lower wages and decertify in order to maintain their employment. Many non-profit long term care facilities, faced with similar funding reductions, have instead negotiated facility specific and time limited concession agreements with the health support unions to avoid contracting out.

By June 2004, more than 9,500 HEU members and approximately 500 BCGEU members will be laid off from their jobs due to a combination of contracting out and facility closures. Another 1,000 workers, primarily in long term care, have responded to pressures for lower wages by decertifying from HEU. The largest outsourcing contracts, for housekeeping and food services, are with the three largest multinational service corporations in the world – Compass, Sodexho, and Aramark. None of these corporations are Canadian; all operate internationally with head offices in the U.S., Britain or France. All have reputations for poor labour relations and/or union bashing.²⁵

The provincial government and health authorities claim that health support workers in BC are considerably more expensive than in other provinces. This is true. But as Tables 3 and 4 show, while the wage rates in BC are higher, they are in line with BC’s higher general labour costs and higher costs of living. For example, while a hospital cleaner in BC has been paid almost 11 per cent more than a hospital cleaner in Ontario, housing costs are more than 12 per cent higher in BC than in Ontario (See Tables 3 and 4). Similarly, while a dietary aide in BC was paid 26 per cent more than her counterpart in Alberta, BC housing costs were 34 per cent higher.

When the need to save on labour costs arose, neither the relationship between prices in different provinces, nor the consideration of support workers’ wages in BC relative to other public sector workers, were a compelling argument for the government. This is in stark contrast to the provincial government’s view that additional funding is required for doctors and nurses to ensure that compensation rates are equal to or better than those in the rest of Canada.²⁶ In a recently-distributed household flyer outlining the actions being taken to improve health care, the government boasts that compensation for BC doctors has increased on average \$50,000 annually for the past two years.²⁷ This is more than the total yearly full-time wage and benefit package for an HEU health support worker. While the case has been well made that neither doctors’ nor nurses’ wages should fall – and in fact should be increased – to protect the integrity of this work, a similar argument fell on deaf ears when it came to hospital support workers.

The very nature of the work – “housework” – enables those trying to “fix” the health care system to view hospital support workers as dispensable. This is, surprisingly, also the position of the Romanow Commission report, *Building on Values: The Future of Health Care in Canada*. It is surprising because it is a report applauded for the strong position it takes against privatization of health care. Yet, it makes exceptions. According to the report:

It is important to distinguish between two types of services: direct health care services such as medical, diagnostic and surgical care; and ancillary services such as food preparation, cleaning and maintenance. An increasing proportion of ancillary services provided in Canada’s not-for-profit hospitals are contracted out to for-profit corporations. Canadians seem to find this role for private sector companies acceptable...²⁸

With no substantive research evidence to back up its claim, the report goes on to say that because the quality of these services is relatively easy to judge, privatization can easily be evaluated and, presumably, kept under con-

The government and health authorities claim that support workers in BC are more expensive than in other provinces. This is true. But their wages are in line with BC’s higher general labour costs and higher costs of living.

trol.²⁹ The commission also assumed (incorrectly and again without evidence) that health care facilities can easily change suppliers if they perform badly. For these reasons, and presumably to save money, the commission stated that “a line should be drawn between ancillary and direct health care services and that direct health care serv-

Table 3: Wages, Minimum Wage and Housing Costs Comparisons 2001/2002

(BC’s percentage above other provinces)

	Ontario	Alberta	Canada
Housing costs	12.6%	33.5%	26.3%
Median wage (full-time)	3.8%	11.8%	9.1%
Median wage (part-time)	15.4%	35.6%	10.5%
Minimum wage	16.8%	35.6%	24.6%

Note: See Appendix 1 for dollar amounts and percentages for all provinces, and sources.

Table 4: Inter-provincial Wage Comparisons of Hospital Workers’ Wages, January 2003

(BC’s percentage above other provinces)

Job category	Ontario	Alberta	Canada
Cleaner	10.6%	31.8%	31.2%
Cook	16.5%	24.1%	28.6%
Laundry worker	12.9%	42.0%	31.2%
Dietary aide	6.5%	26.2%	27.1%

Note: See Appendix 2 for complete interprovincial comparison in dollar amounts and percentage differences from BC’s rates, and sources.

The assumption that any contractor can immediately provide a crew to do the work – without health-specific training and experience and for very low wages – indicates that the work requirements are not well understood.

ices should be delivered in public and not-for-profit health care facilities.”³⁰

This is unfortunate and reflects a point of view that sees certain types of work currently being performed within medical establishments as not integral to the success of health care performance. While this paper cannot document the extent to which ancillary health care services directly contribute to the successful operation of the health care system, it is an issue that has gained considerable attention with the increased spread of diseases that resist antibiotic treatment (antibiotic resistant organisms, ARO).³¹ For example, the prevention of the spread of diseases of this type, including SARS, requires very professional cleaning related specifically to hospitals.³² In Britain, where the contracting out of cleaning services was the norm in the 1990s, many hospitals are now bringing services back in house because of problems with sub-optimal levels of cleanliness, rapid turnover of staff, and deterioration in infection control standards that were the result of poorly trained and inadequately compensated housekeepers.³³

Other kinds of support work within hospitals, such as plumbing and electrical, laundry, clerical and dietary work are also specialized and require workers specifically trained for a hospital setting. The assumption that any contractor can immediately provide a crew to do the work – without health-specific training and experience and for very low wages (as is the case in BC) – indicates that the work requirements are not well understood.

The IWA and Multinational Contractors

An important part of BC’s privatization initiative has been the successful bid by a largely male trade union, Local 1-3567 of the International Woodworkers of America (IWA), to provide health support services previously provided by HEU members in the Health Services and Support Facilities Subsector (a grouping of several unions providing health support services under a similar collective agreement).³⁴

The ways in which this occurred are distinctly unorthodox within the trade union movement in Canada. The IWA entered into “voluntary” agreements with multinational corporations *before* the new workforce was even in place, depriving the workers of a choice of trade union. But most significantly, the IWA negotiated wage rates and conditions of work that are significantly below what it had negotiated for similar work performed by males in other contracts with other employers. An examination of how this happened, and how workers have been stripped of important rights of representation, is significant in order to understand how the privatization process was organized and why wages and benefits fell so dramatically.

The new multinational employers needed the cooperation of trade unions, particularly considering the high density of trade unionism in BC. Under the provisions of Bill 29 (the bill that voided the Health Support Subsector contract), multinational companies bidding for health support service contracts were not required to hire the same workforce or recognize the union’s successorship rights. To limit the possibility that HEU in particular would organize these workers, the multinational employers took the unprecedented step of approaching a number of other trade unions to offer them “voluntary recognition agreements.”³⁵ In these agreements the terms and condition of employment are established by mutual agreement between the union and company *prior* to hiring the workforce. The overwhelming majority of BC Federation of Labour affiliates recognized the HEU’s right to organize this work, and refused to cooperate with the outside contractors. There is, however, one notable exception: Local 1-3567 of the IWA signed “voluntary recognition agreements” with each of the three largest private service

providers – Sodexo, Compass and Aramark. Until this point, the IWA’s main role had been to represent workers in forest industries who are overwhelmingly male. In this respect, the IWA’s experience with women’s issues and health care has been very limited.³⁶

The agreements signed by IWA Local 1-3567 and each of the multinational employers are quite similar. They were all signed prior to the signing of the contracts between these multinationals and the health authorities, and prior to HEU members being laid off from their jobs. It is worth examining one in detail because it serves as a template for further privatization in BC and elsewhere. It illustrates the very rapid changes in wages and working conditions that can occur through privatization, and the ways in which a trade union can take advantage of the situation to expand its membership.

Local 1-3567 of the Industrial, Wood and Allied Workers of Canada (IWA) signed a “partnership agreement” with Aramark on July 17, 2003.³⁷ Thirteen days later, on July 30, 2003, Aramark was awarded the housekeeping contract for the Vancouver Coastal Health Authority.³⁸ At recruitment fairs held by Aramark, new employees were required to sign a union card with the IWA prior to

The “partnership agreements” established substandard wage rates that the IWA has never tolerated for its core, male membership.

the completion of hiring. Workers hired by Aramark clearly have had no opportunity to choose a union to represent them, nor to have any say in the terms of the agreement itself.

Virtually the same strategy of voluntary recognition agreements and job fairs was followed by the other multinationals, Compass and Sodexo, and by the other health authorities (i.e. the Fraser Health Authority and the Provincial Health Authority) in contracting out housekeeping jobs. In each case the “partnership agreement” established substandard wage rates – ranging from \$9.25 to \$11 an hour – that the IWA has never tolerated for its core, male membership.

Table 5: Wage Comparison of Hospital and Long Term Care Housekeepers, Interprovincial (Union) Rates and /IWA Rates, April 1, 2003

	Cleaner \$ per hour	% more than IWA/Aramark
IWA/Aramark Van Coastal Health Authority	10.25	
BC’s Health Support Sub-Sector	18.32	44.0
Alberta	13.60	24.6
Saskatchewan	13.22	22.5
Manitoba	12.74	19.5
Ontario	16.82	39.0
Quebec	14.29	28.2
New Brunswick	12.73	19.5
Nova Scotia	11.92	14.0
Prince Edward Island	13.40	23.5
Newfoundland	12.28	16.5
National Average (Union) Wage Rate 2003	13.93	26.4

Wages for housekeepers (cleaners) have decreased by 44 per cent from what had been bargained under the Health Support Subsector contract. This is 26 per cent lower than the national average for this same work

The severe wage reductions contained in these agreements are clearly unorthodox, if not exploitative, particularly for workers in a province with such a high cost of living. For example, the Aramark/IWA wages for housekeepers (cleaners) have decreased by 44 per cent from what had been bargained under the Health Support Subsector contract. This is 26 per cent lower than the national average for this same work (Table 5 and Appendix 2).

Under these new rates, BC will drop to the lowest pay scale in the country for housekeepers – and not by a few percentage points, but by substantial amounts (i.e. between 14 and 39 per cent). Even relatively low wage prov-

inces like Newfoundland, PEI, and New Brunswick pay 16.5 to 23.5 per cent more an hour than the wages negotiated under the Aramark/IWA “partnership agreement” (Table 5). These wages are so low that they place the purchasing power of housekeepers, for example, at what it was for an HEU member 30 to 35 years ago (see Table 6).

What is even more unusual and disturbing is that the IWA signed a six year agreement with Aramark with wages for housekeeping staff increasing to only \$11.32 an hour in the sixth year (Table 7).

This represents a tremendous loss for women’s earnings by any standards. It is even more disturbing when one compares the wages negotiated by the IWA under the Aramark “partnership agreement” to current wages for the same occupations under a standard IWA contract for male cleaners. Under the IWA Master Agreement (2000-2003) janitors are paid \$21.92 an hour, which is 2.1 times greater than the wage rate negotiated for hospital cleaners. In this context, the Aramark/IWA agreement is not only a setback for pay equity (equal pay for work of equal value), it is also a complete rejection of the concept that women and men should be paid equally for the *same* work – an understanding that has been in place in Canada since the 1950s. Even as far back as the IWA Master Agreement of 1983-1986, wage rates for cleaners were not as low as those negotiated for the women working at Vancouver General Hospital. In the mid-1980s – almost 20 years ago – the IWA negotiated \$13.48 an hour

Table 6: Current Value of Past HEU Housekeeping Wages

	HEU housekeeping wage \$ per hour	In 2002 dollars
1954	0.83	5.88
1964	1.15	6.98
1968	1.76	9.35
1974	3.53	13.46
1984	9.48	15.59
1994	14.90	17.32

See Appendix 3 for more details.

Table 7: Aramark/IWA Schedule of Wages July 2003 to July 2009

Years (July to July)	Housekeepers’ hourly wage
2003/2004	\$10.25
2004/2005	\$10.46
2005/2006	\$10.67
2006/2007	\$10.88
2007/2008	\$11.10
2008/2009	\$11.32

Source: Partnership Agreement, Aramark/IWA, Appendix A.

for its janitors (male) – \$3. 23 an hour more than it is willing to negotiate for its cleaners (female) today (Table 6).

As Table 8 shows, the wages paid by Aramark are also substantially lower than current wages for housekeepers who work in BC’s hospitality sector.

There are other ways that the Aramark/IWA “partnership agreement” represents a backward step for the rights of women workers. As stated earlier, hospital support workers made important advances in the 1960s through the standardization of wage rates across the province. Under the new contract, standard wages can now be ignored at the employer’s discretion. The employer is not only paying housekeepers different wage rates (Article 13, Section 1 of the “partnership agreement”), but is specifically allowed, at its “sole discretion,” to raise the wages for individual workers. Historically, this is the type of activity that unions have fought. It has undermined women’s wages, particularly in circumstances where the employer wants to reward certain workers or punish others, or when an employer simply has a ‘preference’ for some workers over others.

The reduction of wages by almost half is the most dramatic and obvious change under the IWA/Aramark agreement. But additional concessions eliminate many of the hard-won gains that are particularly significant to women in keeping them out of poverty – both when they are working and when they retire. The following are some of

the most significant changes to working conditions and benefits that occurred when the work shifted from the Health Support Subsector contract to the Aramark/IWA “partnership agreement.”

Pensions: The Health Support Subsector contract provides for pensions for all full- and part-time regular employees. Employees and the employer both contribute to the plan. The Aramark/IWA agreement has no pension plan.

Vacations: The Health Support Subsector contract provides 20 days of vacation and after five years of service one day is added for each year of additional service. The Aramark/IWA agreement offers no more vacation than is mandated under the Employment Standards Act – two weeks after one year and three weeks after five years.

Parental Leave: The Health Support Subsector has provisions for 17 weeks of paid parental leave and up to 52 weeks of unpaid parental leave. There are no provisions for parental leave under the IWA agreement.

Benefits: Under the Health Support Subsector contract all employees, regardless of hours worked, are eligible for benefits. Under the Aramark/IWA agreement employees who work less than 20 hours a week on a regular basis are not eligible for benefits. The Health Support Subsector contract provides for medical, dental, long term disability, injury on duty pay, vision care and Pharmacare. The premiums for these benefits are fully paid by the employer.

**Table 8: Private Industry Wage Comparison: Service Occupations Pay Rate Comparison¹
January 1, 2003**

Union and employer name	Housekeeping aide / cleaner
CEP Pulp & Paper Master	21.92
IWA Master Agreement 2000-2003	21.92
BCGEU – Coast Canadian Inn	14.47
CAW Local 3000 – Pacific Palisades	15.29
CAW Local 4234 – Coast Inn & Ramada Hotel	13.21
HERE Local 40 – Hyatt Regency Vancouver	15.02
HERE Local 40 – Westin Bayshore Hotel	15.42
Aramark	10.25

¹ Top step rate used.

Additional concessions eliminate many of the hard-won gains that are particularly significant to women in keeping them out of poverty – both when they are working and when they retire.

The Aramark/IWA agreement does not offer long term disability or injury-duty benefits. And employees pay 50 per cent of the premiums for those benefits they do receive.

Sick Leave: Under the Health Support Subsector contract all regular full-time employees receive 1.5 sick leave days a month and can accumulate sick leave benefits up to 156 days. Under the Aramark/IWA agreement employees receive 10 days of non-cumulative sick leave a year.

Scheduling and Hours of Work: Under the Health Support Subsector contract employees must be given 14 days' notice of schedules. Scheduling preferences are based on seniority and position. If for some reason 14 days' notice is not given, overtime pay is required. In addition, hours of work cannot be changed without following a process of notice and consultation outlined in the collective agreement. The Aramark /IWA contract states that the employer "does not guarantee hours of work to any employee and reserves the right to schedule work, including overtime work."

Transfer Between Work Locations: Under the Health Support Subsector agreement the transfer of employees to new locations is based on seniority and negotiated with the union. Under the Aramark/IWA agreement the employer has the sole discretion to assign people to various locations with no transfer of seniority between work sites.

Taken together, these changes in benefits and working conditions make support work in hospitals and other health care facilities significantly more precarious. One

of the most important changes is the elimination of guaranteed hours of work – workers no longer know from one week to the next how many hours they will work, when those hours will be scheduled, or what their take-home pay will be. This is an intolerable situation for all workers, but is particularly hard on women and men who have family obligations. It is one of the factors that will very likely lead to high turnover of staff.

The IWA and the Union Movement

The "partnership agreements" negotiated on behalf of women by IWA Local 1-3567 set a number of destructive precedents both in terms of the relationship between trade unions and their workers and among trade unions themselves. These new agreements are being negotiated for an unprecedented six year period and include highly unusual commitments to the "joint responsibility" of the trade union and the employer to corporate profitability. In the "statement of partnership" at the beginning of the agreement, the commitment of the IWA goes well beyond what is normally negotiated in collective agreements. In it the IWA accepts "joint responsibility for the profitability and competitiveness of ARAMARK." With this in place, negotiating higher wage rates and improved benefits will be especially hard.

Traditionally, trade unions in Canada are independent of employer or government influence. In stark contrast to those countries where "company unions" (employer-dominated unions) are typical (such as Mexico), Canadian workers have had the right to choose their own union. They have also had a say in setting the terms and conditions of their collective agreements. Exceptions to this exist in the building trades and forestry, where work is short-term and specific trade unions have long-established records in protecting workers' rights. In these limited cases setting up a "voluntary recognition agreement" between the employer and the trade union before the work actually begins protects workers from having to build a union from scratch at the beginning of each new, short-term job. In fact, it guarantees them the wages and benefits already standard in the sector. But this is a very

different circumstance from the work in hospitals, where “voluntary recognition agreements” are undercutting wages in an established sector and where an ongoing work relationship with a different union already exists.

Not surprisingly, HEU has developed a number of strategies to address its concerns with the role of IWA Local 1-3567. For one, it has sought sanctions against the local for violating the constitution of the Canadian Labour Congress. The HEU case against IWA Local 1-3567 is based on Article IV, Section 4 of the CLC constitution, which states that “each affiliate shall respect the established work relationship of every other affiliate.” And that:

*No affiliate shall by agreement or collusion with any employer or by exercise of economic pressure, seek to obtain work for its members as to which an established work relationship exists with any other affiliate, except with the consent of such affiliate.*³⁹

An impartial umpire, Victor Pathe, was appointed by CLC president Ken Georgetti. Pathe found that IWA Local 1-3567 had violated the CLC constitution. In his decision he noted that “many of the IWA actions complained of occurred while HEU members were still performing the work, and in all cases the one year right of rehire had not elapsed and there is therefore an employment relationship and an established work relationship.”⁴⁰ Following this decision, Georgetti wrote to IWA president Dave Haggard, giving him an opportunity to reply in writing to indicate “what steps” he would take “to come into compliance with the CLC Constitution.”⁴¹ There was no response from the IWA. In November 2003 the CLC executive council passed a motion directing the IWA not to sign any further voluntary recognition agreements in health care related to Bill 29. IWA Local 1-3567 has, however, ignored this directive and continued to sign voluntary recognition agreements with the multinational corporations contracted to provide privatized health support services. On March 26, 2004 the CLC applied a first level of sanctions against the IWA.⁴² These sanctions could be escalated up to and including expulsion from the CLC, although it is not clear this will deter IWA Local 1-3567 from organizing in this sector.

HEU is also challenging the legality and validity of the “voluntary recognition agreements” themselves. In hearings before the BC Labour Relations Board, HEU is ar-

guing that there has been collusion between the union and employer, intimidation and coercion of the prospective employees, and irregularities in the “partnership agreement.”⁴³ At this point, it is uncertain how the LRB will respond. If the “voluntary recognition agreements” are declared invalid, HEU could once again organize in this sector.

However, even if HEU is able to do so, it is clear that as time passes, multinational service corporations are becoming firmly entrenched within the health support sector, and lower wages and benefits for contracted-out support services are becoming the norm. This is, in turn, putting tremendous pressure on the health care unions to negotiate significant concessions, as employers use the threat of contracting out or decertification to pressure workers to accept lower wages and inferior working conditions.

Implications for Patients

The availability of steady work at reasonable wages, combined with pension and other benefits, has built a stable workforce in BC’s health sector that contributes positively to the overall quality of care patients receive.

One of the strongest arguments against privatizing work in hospitals and long-term care facilities is the potential it has to adversely affect health care outcomes for BC’s population as a whole. Hospital cleaning is a good example. Because of the unique requirements and dangers inherent in a hospital setting, this type of cleaning requires a level of knowledge and skill that is acquired through years of on-the-job experience as well as special training.⁴⁴ This kind of training is not typically offered by the private sector, and a workforce destabilized by low wages and working conditions is unlikely to build specialized knowledge over time. This was the case in Scotland where the Auditor General noted that under privatized conditions “hospital cleanliness was adversely affected by poor staff retention and problems recruiting staff.”⁴⁵

The extremely low wages being offered by the IWA/Aramark “partnership agreement” will encourage high job turnover. Under this agreement, a housekeeper will earn from \$10.25 an hour with no guarantee of full-time

work. If she manages to work 30 hours a week, her yearly earnings would be \$15,980. If she works 40 hours a week, she would earn about \$21,315.

These are extraordinarily low wages for workers anywhere in the country, but they are particularly problematic in BC, where living costs are high. Examinations elsewhere of the relationship between wage levels and turnover rates confirm what most people would suspect: very low-wage work has much higher turnover rates than work that is well paid. This is especially true in the health care sector, as the following examples illustrate:

- In California, where the hourly average wage for nursing assistants is about \$11.56 (\$7.50 U.S.) an hour, the turnover rate is close to 80 per cent.⁴⁶
- In community-based rehabilitation in Alberta, the turnover rate for staff who earned less than \$10,000 a year was about 200 per cent. When workers earned between \$15,000 and \$20,000 the turnover rate decreased to 32 per cent, but if they earned between \$35,000 and \$40,000 the turnover rate declined to 11 per cent.⁴⁷
- A survey of 12 community hospitals in the U.S. found that the turnover rate for health support staff was approaching 100 per cent because of the combination of low wages and a tight U.S. labour market in late 1990s.⁴⁸

The high turnover rates of contracted health support staff in hospitals and long term care facilities, combined with lower staff levels and the unstable conditions of their work, will likely have an impact on the quality of the work performed. Adequate health care is as much an issue of cleanliness as it is of direct patient care, particularly as it relates to the increased risk of hospital-acquired infections.⁴⁹ In Britain, serious hospital cleanliness problems arose following the contracting out of publicly run services.⁵⁰ The attempt to reduce costs through privatization resulted in reduced staff levels and an overall deterioration in cleaning levels.⁵¹ Similarly with food services, higher costs and poorer nutrition have been attributed to the contracting out of food service production.⁵²

The Vancouver Coastal Health Authority Bulletin announcing its privatization plans states that the new initiatives will not only mean doing things differently, but

that “it will also mean improvements in quality to our health care consumers and improvements in the working environment for our clinical staff.” This is highly unlikely, given the worsening conditions that have accompanied the privatization of hospital services elsewhere.

Conclusions

Achieving pay equity in the health care sector not only raised the wages of women workers, it affirmed the value, skill and responsibility involved in the care work they perform. It also reflected recognition on the part of employers (through a series of negotiated agreements and arbitrations) that this work should command wages equal to comparable work performed by both males in the hospital sector and other employees working directly for the provincial government.

The pay gains for women made health care support work in BC the best paid in the country. The provincial government claimed these wages were excessive, but as this paper shows, they can only be considered excessive if they are compared to discriminatory wages in the private sector; they are not excessive when compared to the general wages and cost of living in BC, or the wages paid for similar work done by male workers in the public sector.

With the privatization of health care support work, BC workers will go from the top of the scale for this type of work in Canada to the bottom. The pay equity gains won by women doing hospital support work were remarkable, but fair. It appears that this very success has attracted the government's ire – to the point that it did not simply reduce wages, but reduced them to the very lowest in the country.

As this paper shows, the privatization of health support work was the direct result of government action. The province introduced legislation that specifically undermined a predominately female trade union and encouraged health authorities to contract out work to very low-wage companies. The actions of a predominantly male trade union, which broke ranks with union solidarity, abetted private employers in the elimination of pay equity gains women had made.

The government's actions set a precedent that will have repercussions far beyond health care. When public sector wages and conditions of work deteriorate significantly, it sets an example for the private sector. When the government reduces women's wages, it is a signal to the private sector that they too can set aside arguments about the need for decent wages for women's work.

The BC government's actions are also influencing other governments. In both Quebec and Ontario, the new Liberal governments have very recently passed legislation modelled on Bill 29. In Ontario, Bill 8 (the so-called "Commitment to the Future of Medicare Act") was introduced in November 2003. The third section of this bill gives the health minister broad, binding and unprecedented powers to intervene in health facility administration, including the ability to issue directives that override collective agreement language and force facilities to contract out health support services.⁵³ In Quebec, changes to the provincial labour code passed by the National Assembly in December 2003 are even broader: Bill 31 covers all unionized workers, overrides job security provisions, removes successorship rights, and eliminates provisions requiring new employers to retain the terms of existing agreements for a minimum of one year.

In Canada, prior to Bill 29, government intervention to void contract language in existing collective agreements was highly unusual. Recent actions by the Quebec and Ontario governments point to the fact that Bill 29 established a new precedent that is taking hold across the coun-

The pay equity gains won by women doing hospital support work were remarkable, but fair. It appears that this very success has attracted the government's ire – to the point that it did not simply reduce wages, but reduced them to the very lowest in the country.

try. Government legislation to facilitate privatization of public sector support services appears to be the emerging strategy for reducing wages and working conditions in the public sector. This trend will be particularly detrimental for working class and visible minority women who have benefited from pay equity gains in the public sector in Canada over the last 30 years. 🍷

Notes

- ¹ Nitya Iyer, *Working Through the Wage Gap*, Report of the Task Force on Pay Equity, (Victoria: Government of BC), February 28, 2002, p. i. This task force was established to determine whether pay equity legislation that focused on the private sector would be feasible in BC.
- ² Ernest B. Akyeampong, “Unionization and Fringe Benefits,” *Perspectives on Labour and Income*, Autumn 2002.
- ³ There are no guidelines, regulations or legislation covering pay equity in the private sector in BC.
- ⁴ The health sector was not covered under this framework ostensibly because pay equity language was already written into collective agreements in the health support sector and nurses had agreed to other improvements instead of pay equity.
- ⁵ Many voters understood this move to be an attempt to convince women that the NDP would be better than the Liberals, but it was interpreted as a rather cynical attempt on the part of the NDP to undertake legislation that it should have passed much earlier in its mandate.
- ⁶ Iyer, p. 100.
- ⁷ Sylvia Fuller, *The Case for Pay Equity*, Canadian Centre for Policy Alternatives – BC Office, Submission to the BC Task Force on Pay Equity, December 2001, p. 7.
- ⁸ Information for the historical information comes from David B. Fairey, “HEU’s Wage Equity Bargaining History,” unpublished paper; Patricia G. Webb, *The Heart of Health Care: The First 50 Years* (Vancouver: Hospital Employees’ Union, 1994).
- ⁹ The implementation of pay equity legislation in Ontario, for example, experienced some serious obstacles that prevented it from achieving its full potential. For a discussion of this see Jane Stinson, “Ontario Pay Equity Results for CUPE Services Workers in Ontario Hospitals: A Study of Uneven Benefits,” unpublished paper, Carleton University.
- For a comparison between the effectiveness of Ontario and BC approaches see David B. Fairey, *An Inter-Provincial Comparison of Pay Equity Strategies and Results Involving Hospital Service & Support Workers*, revised ed. (Vancouver: Trade Union Research Bureau, Jan. 2003).
- ¹⁰ Fairey, op. cit.
- ¹¹ Stinson, pages 67-72 and Fairey p. 9.
- ¹² Information for this section comes from McIntyre & Mustel Research Ltd., HEU Member Profile Survey (Vancouver: McIntyre & Mustel, March 2002).
- ¹³ Ibid.
- ¹⁴ The government has placed itself in a bind by promising to have a balanced budget, something that is difficult to do since it reduced its income by \$2 billion each year through a tax cut that benefited those in the higher income tax brackets most.
- ¹⁵ Romanow Commission on the Future of Health Care in Canada, Final Report: *Building on Values: The Future of Health Care in Canada*, November 2002, p. 66.
- ¹⁶ Ibid., p. 67.
- ¹⁷ Cynthia Ramsey, *Labour in the Hospital Sector* (Vancouver: The Fraser Institute, 1995). For a critique of this paper see Marjorie Griffin Cohen, *Do Comparisons Between Hospital Support Workers and Hospitality Workers Make Sense?* (Vancouver: HEU, 2001).
- ¹⁸ Vaughan Palmer, “NDP policies depleted the health system,” *Vancouver Sun*, January 15, 2001; “Redistribute funds and privatize non-essential services says BCMA President,” *Sounding Board Vancouver*, Feb. 29, 2000.
- ¹⁹ “The Health and Social Service Delivery Improvement Act,” January 28, 2002.
- ²⁰ Ibid.

- ²¹ Affidavits of Joseph B. Rose in The Supreme Court of British Columbia in reference to Plaintiffs: The Health Services and Support-Facilities Subsector Bargaining Association, The Health Services and Support-Community Health Bargaining Association, The Nurses' Bargaining Association, The Hospital Employees' Union, The British Columbia Government and Service Employees' Union, The British Columbia Nurses' Union, Josephine Chauhan, Janine Brooker, Amaljeet Jhand, Leona Fraser, Marguerite Amy McCrea, Sally Lorraine Stevenson and Sharleen G.V. Decilla; and Defendant: Her Majesty the Queen in Right of the Province of British Columbia, page 15.
- ²² *Ibid.*, page 17.
- ²³ The province has refused to fund the negotiated wage increases for the health care workforce.
- ²⁴ In the "Performance Agreement" for April 2002 to March 2003, prepared by the Ministry of Health Services, all health authorities were required to reduce administrative support costs for 2004/05 to seven per cent less than what they were in 2001/02, exclusive of information costs.
- ²⁵ Tom Walker, *Who is Sedexo?* (Vancouver: HEU), May 2002; Tom Walker, *Profile of Aramark Worldwide Corporation* (Vancouver: HEU), June 2002; Tom Walker, *Profile of the Compass Group, PLC*, (Vancouver: HEU), June 2002.
- ²⁶ Ministry of Health Services, "Health Care Today and Tomorrow," www.healthservices.gov.bc.ca/BCHealthCare, Feb. 2004.
- ²⁷ *Ibid.*
- ²⁸ Romanow Commission, *op. cit.*, p. 6.
- ²⁹ The only reference provided by Romanow for the above quote was a book by Lawrie McFarlane and Carlos Prado. This article has one paragraph on ancillary services and no references to empirical studies looking at the impact on quality or costs of the contracting out of health support services.
- ³⁰ *Ibid.*, p. 7.
- ³¹ For an elaboration of this issue see Marjorie Griffin Cohen, *Do Comparisons Between Hospital Support Workers and Hospitality Workers Make Sense?* (Vancouver: HEU, 2001). The literature on the relationship between modern hospital cleanliness and diseases is extensive. See, for example: S.J. Dancer, "Mopping up hospital infection," *Journal of Hospital Infection* 43 (1999), pp. 85-100; A. Rampling et al., "Evidence that hospital hygiene is important in the control of methicillin-resistant *Staphylococcus aureus*," *Journal of Hospital Infection* 49 (2001), pp. 109-116; G. Ayliffe, J. Babb, L. Taylor, *Hospital-acquired infection: Principles and Prevention*, 3rd ed. (Oxford: Butterworth-Heinemann, 1999).
- ³² Taipei Times, *Outsourcing Played Role in Outbreaks: CDC Head*, Tuesday June 10, 2003. In the article the Director for the Centre of Disease Control, Su Ih-jen, is quoted as saying that "control of nursing aides, cleaners and laundry workers in hospitals should be a key part of preventing the re-emergence of SARS." He goes on to say that "the SARS outbreak has revealed the impropriety of hospitals outsourcing these jobs."
- ³³ Chris Perry, Chairperson of the British Infection Control Nurses Association, *Cleanliness Matters!* Presentation to infection control nurses and family physicians at Vancouver Hospital, March 10, 2003.
- ³⁴ The Health Services and Support Facilities Subsector includes eight unions: 92 per cent of members are in the Hospital Employees' Union, four per cent are in the BC Government and Service Employees' Union, and two per cent are in the International Union of Operating Engineers. The other five unions have the remaining two per cent of the workforce.
- ³⁵ Trade unions that have been approached to enter into a "voluntary recognition agreement" in the hospital sector include BCGEU, UFCW Local 1518, Hotel and Restaurant Employees' Local 40, United Steelworkers, CAW, SEIU, and RWU. None of these trade unions agreed.

- ³⁶ At the IWA's national convention in 2000 the existence of a Women's Committee was recognized for the first time by the constitution. Until 2002, when a woman became the first president of a local – Local 324 in Manitoba – no woman had ever been elected to a position that would entitle her to serve on the National Executive Board. While there was a resolution passed at the 2002 convention related to women, it was an organizational-type of resolution; there were none that dealt with substantive issues significant for women, such as pay equity or childcare. The Women's Committee's objectives for 2000/01 were also related to IWA organizational goals: what is conspicuously absent from these goals is any recognition of women's issues that should be included as bargaining issues.
- ³⁷ Aramark and IWA Local 1-3567, Partnership Agreement, July 17, 2003.
- ³⁸ This includes all sites from Powell River to Vancouver, including Vancouver Hospital, UBC Hospital, Lion's Gate Hospital, St. Paul's Hospital and many long term care and smaller acute care hospitals.
- ³⁹ Decision of Impartial Umpire, ID#207/2003 Allegations of Violations of the CLC Constitution, Canadian Union of Public Employees (CUPE) VS Industrial Wood and Allied Workers of Canada (IWA), September 17, 2003, page 2.
- ⁴⁰ Ibid., page 11.
- ⁴¹ Letter from Kenneth Georgetti at the CLC to Dave Haggard at the IWA, Sept 17, 2003.
- ⁴² Letter from Kenneth Georgetti at the CLC to Dave Haggard at the IWA, March 25, 2004.
- ⁴³ Letter to the Labour Relations Board from Hospital Employees' Union lawyer David Tarasoff, January 22, 2003.
- ⁴⁴ For details on the skills, effort, responsibilities and working conditions of hospital support work see Marjorie Griffin Cohen, *Do Comparisons Between Hospital Support Workers and Hospitality Workers Make Sense?* (Vancouver: HEU, 2001).
- ⁴⁵ Auditor General of Scotland, "A clean bill of health? A review of domestic services in Scottish hospitals." Audit Scotland, www.audit-scotland.gov.uk. The Auditor General found that average staff turnover was higher among external contractors (40 per cent) than in-house staff (23 per cent).
- ⁴⁶ California Advocates for Nursing Home Reform, *The Advocate: Staffing in California Nursing Homes: A Crisis in Care*, 2001. <http://www.canhr.org/publications>.
- ⁴⁷ Sonpal-Valia, Nilima, "Staff Turnover in Rehabilitation Services in Alberta for 2001," *Rehabilitation Review* 13 (5), pg. 1.
- ⁴⁸ Eileen Appelbaum et. al, "The Effects of Work Restructuring on Low-Wage, Low-Skill Workers in U.S. Hospitals," (unpublished, prepared for the Russell Sage/Rockefeller research volume, December 2003).
- ⁴⁹ Janice Murphy, *Literature Review on Relationship between Cleaning and Hospital Acquired Infections* (Vancouver: HEU, 2002).
- ⁵⁰ Chris Perry, *Cleanliness Matters*, March 10, 2003.
- ⁵¹ S. J. Dancer, "Mopping up hospital infection," *Journal of Hospital Infection* 43: 85-100, p. 86.
- ⁵² J.W. Singleton, "Urban Shared Services Corporation: Implementation of shared food services." *Manitoba Provincial Auditor's Value-For-Money Audits*. June 2000: 1-37. For information on an integrated approach to hospital food services see, *The Public Assistance – Paris Hospital Experience (France): Situation, outlooks and lessons learned*. 11995 Poincare Street, Suite 19 Montreal, Que., H3L 3L6, May 1997.
- ⁵³ Sack Goldblatt Mitchell, Memorandum re: Bill 8, the Commitment to the Future of Medicare Act, December 15, 2003, pp. 6-7.

Appendices

Appendix 1: Inter-Provincial Comparison of Wages, Minimum Wages and Housing Costs

WAGES AND HOUSING COSTS					BC'S PERCENTAGE ABOVE OTHER PROVINCES			
Province	Median wage full-time	Median wage part-time	Minimum wage	Housing cost ^a	Median wage full-time	Median wage part-time	Minimum wage	Housing cost ^a
	\$				%			
BC	18.17	10.50	8.00	1,538	0.0	0.0	0.0	0.0
Alberta	16.25	9.25	5.90	1,152	11.8	13.5	35.6	33.5
Sask ^b	15.00	8.05	6.35	980	21.1	30.4	26.0	56.9
Manitoba	14.50	8.53	6.50	1,022	25.3	23.1	23.1	50.5
Ontario	17.50	9.10	6.85	1,366	3.8	15.4	16.8	12.6
Quebec	15.71	10.00	7.00	995	15.7	5.0	14.3	54.6
NB ^c	13.27	7.25	6.00	891	36.9	44.8	33.3	72.6
NS ^c	13.73	7.69	5.80	891	32.3	36.5	37.9	72.6
PEI ^c	12.26	8.00	6.00	891	48.2	31.3	33.3	72.6
NFLD ^c	13.39	6.75	5.75	891	35.7	55.6	39.1	72.6
Canada	16.65	9.50	6.42	1,218	9.1	10.5	24.6	26.3

Notes:

Median wage for full-time and part-time workers reflects the median wage of all workers (both sexes) over age 15 in all industrial sectors.

^a Housing costs are monthly.

^b Saskatchewan figures are an estimate based on the report's bar charts.

^c Atlantic housing costs are aggregated. One figure corresponds with all Atlantic provinces.

Sources:

Wage data from the Labour Force Historical Review 2001 CD-ROM, Statistics Canada, Ref: 71F0004XCB.

Minimum wages are from CCH Canadian Ltd. Canadian Labour Law Reports. Effective July 2002.

Housing cost data is from Leiato, Carlos. Housing Affordability Index. RBC Financial Group – Economics Department, June 2002.

Appendix 2: Comparison of Hospital and Long Term Care Workers' Wage Rates, BC and Other Provinces (with other provinces as the dominator), April 2003

	BC	AB	Sask	Man	Ont	Que	NB	NS	PEI	Nfld	National average
Cleaner											
hourly rate	18.60	14.11	13.62	12.74	16.82	14.57	12.73	12.16	13.84	12.58	14.18
% difference with BC		31.8%	36.6%	46.0%	10.6%	27.6%	46.1%	53.0%	34.4%	47.9%	31.2%
Cook											
hourly rate	21.02	16.94	16.41	14.77	18.04	18.22	13.74	15.54	15.14	13.65	16.35
% difference with BC		24.1%	28.1%	42.3%	16.5%	15.3%	53.0%	35.3%	38.8%	54.0%	28.6%
Laundry worker											
hourly rate	18.37	12.94	13.70	12.70	16.27	14.16	12.73	12.72	13.84	12.58	14.00
% difference with BC		42.0%	34.1%	44.6%	12.9%	29.8%	44.3%	44.4%	32.7%	46.0%	31.2%
Dietary aide											
hourly rate	17.80	14.11	13.43	12.74	16.71	14.57	12.73	11.36	14.01	12.58	14.00
% difference with BC		26.2%	32.5%	39.7%	6.5%	22.1%	39.8%	56.7%	27.1%	41.5%	27.1%

Note: Wage rates on April 1, 2003.

Wage rate sources:

BC: Health Services & Support Facilities Subsector Collective Agreement, expires March 31, 2004.

Alberta: Wage derived from average of CUPE Multi Employer Agreement, expires March 31, 2004.

Saskatchewan: Wage derived from average of CUPE Saskatchewan and SEIU Saskatoon. Both agreements expire March 31, 2004.

Manitoba: Wage derived from weighted average of these CUPE hospitals: Brandon, Central Region, Concordia, Grace, Seven Oaks, RDF, Health Sciences Centre (4 year and 26 month agreements, expiring April 30, 2006 and June 3, 2004).

Ontario: Average rates of Ontario CUPE (OCHU) and independents (info source SALAD, CUPE Research).

Quebec: CUPE (Quebec Federation of Labour) master collective agreement, expires June 30, 2003.

New Brunswick: Average wage of the NB/CUPE Hospital Agreement, expires June 30, 2003 and NB/CUPE Nursing Homes Agreement, expires October 15, 2004.

Nova Scotia: CUPE rates: Clerical, Service, and Healthcare Agreements, expire March 31, 2004.

PEI: Average of CUPE Master (expires March 31, 2004), IUOE 942 Master (expires March 31, 2003) and PEI Public Sector (expires March 31, 2003 [Care aide and LPN rates end March 31, 2003]).

Newfoundland: CUPE/NAPE and Hospital Boards, expires March 31, 2004.

Appendix 3: Current Value of Past HEU Housekeeping Wages

	HEU hskpg. wage ^a	Today's value of hskpg.
1954	16.8	\$ 0.83
1960	18.5	\$ 0.98
1964	19.6	\$ 1.15
1968	22.4	\$ 1.76
1972	26.1	
1976	37.1	\$ 4.92
1980	52.4	\$ 7.37
1984	72.1	\$ 9.48
1988	84.8	\$ 10.93
1992	100	\$ 13.78
1996	105.9	\$ 15.93
2000	113.5	\$ 16.80
2002	118.6	\$ 17.77

Notes: ^a 118.6 is used as the CPI reference for the years 1971 to 2002 because the CPI numbers used are local (Vancouver); 119 is used as the CPI 2002 reference for calculating 1954 to 1970 as the CPI numbers used are national (CDN). ^b In 1974 the hours of work decreased to 37.5 hours/week from 40 hours/week. ^c In 1993, the hours of work decreased to 36 hours per week. ^d Prior to 1964 a "housekeeper" was called a "maid" and is now classified as a BMW1. ^e The starting first year rate was selected for the wage rates.

Membership

Annual Individual Membership

\$300 Sponsoring Member (or \$25/month)

Receives *The Monitor*, all new publications (approximately 15 books and research reports each year), and a \$75 tax receipt.

Sponsoring Members can also choose to receive a larger tax receipt instead of receiving publications (you still receive *The Monitor*, but no books, monographs, or *Our Schools, Our Selves*). Please check here if you would prefer to receive a \$275 tax receipt instead of receiving publications _____.

\$100 Supporting Member (or \$8.50/month)

Receives *The Monitor* and a \$75 tax receipt.

\$25 Student / Low Income Membership

Receives *The Monitor*.

\$175 Education Membership (or \$14.75/month)

Receives *The Monitor*, *Our Schools/Our Selves*, *Missing Pieces*, all books on education, and a \$75 tax receipt.

Please note that all individual membership renewals are due on January 1st. All tax receipts, including for monthly donors, will be issued in December.

Please send me your catalogue of publications.

I do not wish to become a member, but here is my donation of \$_____.

Annual Organizational Membership

Sponsoring Organization

\$12,000 plus

Sustaining Organization

\$2,000–\$11,999

Contributing Organization

\$500–\$1,999

Low Income Organization

\$300–\$499

Organizational Membership Benefits

One free copy of every publication the Centre puts out over the year—*The Monitor*, *BC Commentary*, and approximately 15 original research reports and books.

Additional Copies

Limited additional copies of our material are available to Sponsoring or Sustaining organizational members. Please contact our membership department at 613-563-1341, ext. 305, or email <membership@policyalternatives.ca> for more information.

Please return your completed membership form to:

Canadian Centre for Policy Alternatives
· 410-75 Albert St · Ottawa · ON · K1P 5E7

Contact Information

Name _____

Organization _____

Address _____

City _____ Prov. _____

Postal Code _____

Tel. _____ Fax _____

Email _____

Do not trade my name with other like-minded organizations.

Payment Options

Monthly \$_____ (monthly amount)

For automatic monthly payments, please enclose a voided cheque or fill out your credit card information below. You can stop payments at any time by contacting the CCPA office.

Annually \$_____ (annual amount)

Please enclose a cheque (made out to "CCPA") for your annual contribution, or fill in your credit card information below.

Visa, or Mastercard Card #: _____

Exp: _____ Signature: _____

Become a
monthly donor!

www.policyalternatives.ca

The best source of free, progressive, on-line opinion in Canada.

- news
- publication downloads
- fact sheets
- opinion pieces

- news releases
- policy briefs
- *Monitor* articles
- on-line publication purchases



about the

Canadian Centre for Policy Alternatives

The Canadian Centre for Policy Alternatives is an independent, non-profit research institute funded primarily through individual and organizational memberships. 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 public events and lectures.

www.policyalternatives.ca

A great resource. The Centre makes most of its reports, studies, commentary and opinion pieces, backgrounders, and policy briefs available free on its website.

National Office

410-75 Albert St.
Ottawa, ON K1P 5E7
Tel: 613-563-1341
Fax: 613-233-1458
ccpa@policyalternatives.ca

Manitoba Office

309-323 Portage Ave.
Winnipeg, MB R3B 2C1
Tel: 204-927-3200
Fax: 204-927-3201
ccpamb@policyalternatives.ca

BC Office

1400-207 W. Hastings St.
Vancouver, BC V6B 1H7
Tel: 604-801-5121
Fax: 604-801-5122
info@bcpolicyalternatives.org

Nova Scotia Office

P.O. Box 8355, 6175 Almon St.
Halifax, NS B3K 5M1
Tel: 902-477-1252
Fax: 902-484-6344
ccpans@policyalternatives.ca

Saskatchewan Office

2717 Wentz Avenue
Saskatoon, SK S7K 4B6
Tel: 306-978-5308
Fax: 306-922-9162
ccpasask@sasktel.net



**CANADIAN CENTRE FOR POLICY
ALTERNATIVES – BC OFFICE**

CANADIAN
CENTRE FOR
POLICY
ALTERNATIVES