Dispute Resolution in Healthcare and Community Services Collective Bargaining

(including acute, long term, and continuing care as well as ambulance services)

Discussion Paper
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NOVA SCOTIA
Environment and Labour

Introduction

A system is necessary to ensure that collective agreements are renegotiated and settled fairly without putting the public at risk or either party to negotiations in the position where they must choose between their bargaining position and their obligations to patients or to the clients of community services programs. This issue affects approximately 200 collective agreements and 32,000 employees represented by various unions who work in acute care, long term care, home support/care, ambulance service (air and ground transport), and Homes for Special Care under the mandate of the Services for Persons with Disabilities Program in the Department of Community Services. It also affects all Nova Scotians.

Both the 2001 and 2007 acute care strikes and several strikes in the long term care sector since 1998 have prompted a need to explore alternatives in dispute resolution. The most recent strike at the IWK further raises questions about the current collective bargaining system. The IWK provides tertiary, primary, and secondary care to women, children, youth, and families in the Maritime provinces and beyond. The value of the IWK is incalculable.

All workplace disputes include competing interests, and in this particular situation the employees exercised their legal right to strike on April 30, 2007 in an attempt to meet their interests. Given the value that all Nova Scotians place on healthcare, particularly for our children, everyone involved was conflicted by the recent work stoppage. Nova Scotians understand the vulnerability that a strike creates for them and loved ones. Healthcare workers face ethical and moral dilemmas related to choosing between patient care and their loyalty to their co workers and union which cannot be easily reconciled. Government has multiple roles but ultimately, it is accountable to ensure the ongoing provision of healthcare services while preserving a system of free collective bargaining. It also must fund the employers who negotiate the collective agreements.

Government must protect the health and safety of the public. Acknowledging that union and employers make arrangements to provide for the continuing availability of emergency services, disruption of service and even the preparations for a disruption of service puts health and safety at risk. The government must also maintain a system that preserves collective bargaining and ensures a fair and an impartial outcome for all interested parties. There are no doubt challenges in finding a dispute resolution model which balances these interests. Under the current system, achieving this balance is very difficult – bargaining must be conducted in a way that respects the rights of workers to withdraw their services and yet the protection of public health and safety can provide a compelling rationale for legislative intervention to bring disruptions to an end or to prevent them from happening.

The current system of resolving impasses which provides for a legal right to strike or lockout out in the unionized health (including ambulance services) and community services sector has been in place since the late 1940s. Since 1969 when tracking was started by the Department of Labour, there have been approximately 100 work stoppages in the health and community services sectors, each one interrupting patient care prior to, during and following a strike.

Prior to re-structuring of hospitals into regional and then District Health Boards in the 1990s, the Victoria General Hospital (VG) fell within the mandate of the *Civil Service Collective Bargaining Act* and therefore, there was no right to strike at the VG. The VG therefore acted as a safety valve for patient care services in situations where work stoppages occurred in other provincial and metro facilities. In addition, the IWK Health Centre was not unionized until after the merger with the Grace Maternity Hospital in the 1990s. Healthcare to children was therefore not disrupted in the pre-merger days either. Similarly, in the mental health area, The Nova Scotia Hospital was part of the Civil Service until the late 1990s when the Capital District Heath Authority was established.

In addition, the acute care system has been re-structured so that almost 50 district hospital employers have been replaced by nine district health authorities and the IWK. One result has been that a system where many workers were not unionized has been replaced with one where virtually all employees who are eligible for unionization are in fact unionized. It has also meant that strikes are no longer as likely to be limited to particular hospitals. They are instead certain to affect all the hospitals across a healthcare district. Indeed, because much of the bargaining in the sector is now conducted through a lead table, strikes are more likely to affect hospitals in multiple districts. Because of the structure of the provincial healthcare system and the unique and specialized services that are provided through the institutions that make up the Capital District Health Authority, a strike in that district is certain to have far-reaching impact province-wide.

More fundamentally, other changes in the healthcare services delivery system have increased the risk that is unavoidably associated with labour disputes. For many reasons, the level of acuity of patients in hospitals and residents in nursing homes and other residential facilities has greatly increased. Many Nova Scotians are highly dependent on home care and home support services that did not exist or that were less widely used in earlier times.

Government intervention in work stoppages has been limited and determined on a case by case basis and the nature and extent of the intervention has varied. This was demonstrated by the one day strike that occurred in the spring of 2001 when approximately 1200 healthcare professionals and nurses went on strike. Bill 68 was introduced legislating the workers back to work. The dispute was resolved by the parties however when they agreed to a form of binding arbitration known as "Final Offer Selection" prior to the bill being proclaimed in its entirety.

The Issue

The recent strike at the IWK Health Centre illustrates systemic problems in the current framework for the collective bargaining process for the healthcare sector. The current industrial model confers the same legal right to strike on healthcare workers as is conferred on employees in other industries including the para-public and private sectors. It also gives employers the option of locking out employees, though this option has only been exercised once in Nova Scotia in 1992. The starting point for this discussion paper is the belief that strikes (and lockouts) are incompatible with the realities of the modern healthcare and community services systems. Equally important is the conviction that a fair system of collective bargaining for healthcare and community services that does not involve strikes can be developed and implemented.

All Nova Scotians rely on the delivery and continuity of health and community services and when work stoppages erupt or are threatened they are negatively impacted. This issue goes beyond the collective bargaining interests of employers, unions, workers and government.

It has to be understood and accepted that if strikes are allowed....strikes will sometimes happen. The only alternative would be a system where all demands are met or where strikes were outlawed by back-to-work legislation one strike at a time. Even in workplaces where there are excellent management and labour relations, there will be issues upon which the parties simply cannot agree. When the parties' interests are conflicting they will revert to their legal right to strike or lockout when it is available.

Modern healthcare adopts an integrated approach of multi-disciplinary care utilizing a variety of healthcare professionals. Therefore, for such a system to work effectively, all workers/classifications must be present at all times; when one or more groups are on strike, all services are adversely impacted.

Background Information

Work stoppage statistics maintained by the Department of Environment & Labour (DEL) confirm that there have been approximately 100 work stoppages in these sectors since the early 1970s (See Appendix **A**). There have been 20 strikes since 1997; 15 legal and 5 illegal.

It should be noted that the majority of collective agreements are renegotiated without a work stoppage. Our data indicates that 97% of all conciliation requests made pursuant to the *Trade Union Act* (including public and private sector, not just healthcare and community service providers*)* have resulted in ratified collective agreements without a work stoppage.

It should also be acknowledged that the vast majority of strikes were of short duration in part due to the intense pressure from the public on all parties to find a resolve. A synopsis of some of the more historically well known and longer disputes in this sector are set out below.

1) Nurses Strike 1975

On June 12, 1975, 1500 registered nurses went on strike in twelve hospitals throughout the province after the parties were unable to reach an agreement through an Industrial Inquiry Commission. Although the government introduced back- to-work legislation on June 12th, the parties continued to negotiate and they reached an agreement.

The government withdrew the back-to-work legislation on June 25th. It should be noted that this legislation would have forced the workers back to work and imposed binding arbitration as a means to resolve the dispute. This was the first time government had contemplated such a measure for this particular sector (previously binding arbitration had been legislated in the construction sector).

2) The "Common Front "Hospital Strike 1981

Hospital unions initiated a "Common Front" in 1981 to develop a co-operative approach to negotiations for classifications including clerks, technicians, certified nursing assistants, general workers in 36 unionized hospitals in the province. It was agreed that no local would sign an agreement until all groups were satisfied with the offer.

The nurses in the province were in contract negotiations while discussions to form a Common Front were underway. They subsequently accepted the government's offer resulting in the Common Front losing some of its bargaining power.

Negotiations for the other classifications in the various locals had reached an impasse which was unresolved in conciliation. On September 24, 1981, twenty four hospitals in the province were faced with a withdrawal of services and most of the remaining unionized hospitals entered into legal strike positions during the next three weeks. Altogether 6,500 workers took part in the strike including approximately 300 NSGEU laboratory technicians and technologists at the IWK Hospital and the Halifax Infirmary.

The government announced a special commission to examine the situation and a tri-partite body was established. It met on two separate occasions with the parties and on October 16th, the parties accepted the proposed settlement.

The Common Front and the experience of this strike gave a renewed impetus to those who would remove the right to strike in essential services. Consequently, in December of 1981, Premier Buchanan announced that his government was seriously considering replacing the right to strike with compulsory arbitration.

3) The Keddy's Nursing Home Strike 1983-84

Keddy's Nursing Manor was a 110-bed nursing home in Halifax. When negotiations broke down in the fall of 1983, ninety nursing home workers went on strike. This work stoppage lasted for more than a year with some workers crossing the picket line and returning to work. The strike ended in June of 1984 when the parties agreed to a package deal. To date, this particular work stoppage, was the longest in duration for this particular sector.

4) The Cape Breton Hospitals' Strike 1990

This strike affected eight hospitals on Cape Breton Island in the summer of 1990. Over 1000 healthcare, support and clerical staff went on strike for approximately 10 weeks. The dispute was eventually resolved through an Industrial Inquiry Commission.

Following the settling of the above-noted strike in Cape Breton, the Minister of Labour in January 1991 appointed an Industrial Inquiry Commission to inquire into collective bargaining for Nova Scotia Hospitals covered by the *Trade Union Act.* The Commission was also mandated with making recommendations for change that it deemed appropriate. This request was initiated by the unions involved because they felt that the method of negotiating collective agreements in the province had been largely responsible for the strike.

Hearings were held with the respective parties and the Commission's Report was postponed so that the parties could attempt to mutually agree to a solution to improve the current bargaining process. The parties determined by November of that year, that they were unable to reach final agreement on how to improve the current process. Consequently, Bill Kydd prepared a final report in 1992 on behalf of the Commission for the Minister of Labour. A copy of the recommendations included in that report are attached as Appendix **B**

5) Long Term Care and Continuing Care Strikes - 1998/99

Unionized employees of nursing homes are represented by a number of different unions, including CUPE, CAW, and NSGEU . Negotiations are conducted separately for each individual home and union local. The result has been a variety of collective agreements with significant disparities relating to benefits, wages and operational provisions depending upon which union represented the group.

During a six month period, commencing in the fall of 1998, eight long term care and continuing care facilities went on strike. These strikes involved CUPE and the CAW which represented employees in classifications including PCWs, LPNs, Dietary Workers, Housekeepers, Activity Workers, etc. The duration of these strikes varied between two and 40 days. In one facility, there were two strikes within these time frames (See Appendix **C** for particulars).

Negotiations with CUPE were individually reaching impasse and it was apparent that the Union was planning concurrent strike action with multiple locals. In an attempt to find a resolution, the Minister of Labour appointed a team of Mediators to assist the parties. The negotiations were conducted at a "lead table" with representatives from Department of Health funded facilities and representatives from Community Services funded facilities. The table was convened to resolve the outstanding issues that CUPE had characterized as provincial. Once a tentative agreement had been reached, the union agreed to present the package of provincial issues to each of its locals for ratification together with any "local" issues which had been settled. Despite reaching a tentative agreement at the mediation, there were a few work stoppages on outstanding local issues. (See Appendix **C**; Breton Bay, New Dawn and Shoreham Village).

Following the introduction of a lead table concept in mediation in 1999, the parties agreed to adopt a similar model during their face-to-face negotiations in the next rounds of negotiations. Since then, there have been three work stoppages (See Appendix **A**).

6). Regional Residential Services Society (RRSS) and NSGEU Strike - 2003

Regional Residential Services Society provides community based services (i.e. developmental residences, groups homes and small options) for adults with intellectual disabilities in the Halifax Regional Municipality (HRM). In the spring of 2003, negotiations broke down between the parties and 250 employees including counselors went on strike on April 10, 2003.

The work stoppage continued and in June, 2003, the Minister of Environment & Labour appointed a Mediator to assist the parties with resolving the dispute. The parties jointly agreed that the Mediator's recommendations would be binding and the parties ratified a new collective agreement and the work stoppage ended on June 28th.

Current Situation in Nova Scotia

Collective Bargaining

There are five statutes that regulate collective bargaining in Nova Scotia: the *Civil Service Collective Bargaining Act*, the *Highway Workers Collective Bargaining Act*, the *Teachers' Collective Bargaining Act,* the *Corrections Act* and the *Trade Union Act*. Four of the statutes relate to specific employee groups: civil servants, highway workers, correctional workers, and teachers. All other groups and therefore, the vast majority of unionized employees in the para-public (including healthcare employees) and private sector of Nova Scotia, fall under the jurisdiction of the *Trade Union Act*.

Under the *Civil Service Collective Bargaining Act* , the *Highway Workers Collective Bargaining Act*, and the *Corrections Act*, interest arbitration is the mandatory dispute resolution mechanism. There

is no right to strike or lockout under these statutes. [1] There have been no illegal work stoppages under these particular statutes which have never included the right to strike and have instead always made interest arbitration compulsory.

With respect to the *Trade Union Act*, there is a right to strike or lockout. Two recent statutory amendments, however, replaced the right to strike or lockout for police and firefighters with binding arbitration. The rationale for these amendments was the significant danger to the health and safety of the public if a work stoppage occurred in either policing or firefighting. The legislature recognized that emergency service delivery for police and fire services would not be an acceptable level of protection for the public.

When the *Highway Workers Collective Bargaining Act* was enacted in 1997 to formalize their collective bargaining rights, government mandated interest arbitration, not the strike/lockout model. This recognized that provincial highways are the primary and essential access routes for emergency vehicles for transport of necessary products (such as oil, food, and medical supplies). In many cases, there is no alternative source of transport due to rail line closures, and limited air and/or ferry coverage.

Nova Scotia is one of two jurisdictions in Canada where employees in the healthcare sector have an unfettered right to strike or lockout without some kind of essential services limitation set out in legislation. In every other province except Saskatchewan, the law either substitutes the right to strike/lockout with interest arbitration or restricts the right to strike/lockout by requiring the provision of "essentials services".

These two alternatives to what currently exists in Nova Scotia and Saskatchewan are described and discussed later in this document. Here, it is worth noting that "essential services" gets used in two different ways. One is to describe any public service which is factually essential because of the impact that the unavailability of the service would have on the public, particularly regarding health and safety. The second way in which "essential services" gets used is to describe the legislation that five provinces and the federal government have put in place to limit the right to strike by requiring the continuing provision of a level of service that is deemed essential.

Current Dispute Resolution Processes under the *Trade Union Act*

The *Trade Union Act* imposes a duty on the parties to make every reasonable effort to conclude a collective agreement. Several options exist to assist the parties if they reach an impasse in their face-to-face bargaining. The collective bargaining process set out in the *Trade Union Act* anticipates the

[1] Teachers are prohibited from striking on issues which are negotiated with their local school boards but are permitted to strike on provincial issues as set out in the *Teachers' Collective Bargaining Act*.

escalation of pressures upon the parties. The options are designed to focus the pressure on each party to reconsider its position rather than face a prolonged labour dispute. These options are summarized below:

1. Conciliation

The conciliation process starts with the appointment of a Conciliation Officer by the Minister and culminates in an Officer's report to the Minister if the parties are deemed by the Conciliator to have reached an impasse in their bargaining. The Officer's report triggers a mandatory 14 day countdown period before a strike or lockout can commence.[2] In addition, a party that intends to strike or lockout must submit written notice of their intention to strike or lockout at least 48 hours in advance to the Minister. Neither the Conciliator nor the Minister has any power to order the parties back to the table or to impose a settlement. Lawful strikes cannot occur until the 14 day countdown elapses and before the 48 hour notice is given and lapsed[3]. But once these preconditions are met, the *Act* imposes no limit on the extent or scope of the strike.

2. Conciliation Board

This option is open only to those parties who are currently within the 14 day countdown period following conciliation and prior to a legal work stoppage. These three person boards (1 union nominee, 1 employee nominee and a neutral chair) can be appointed by the Minister of Environment & Labour but only if both parties request it. The *Act* provides that the parties may, but need not, agree to be bound by the Conciliation Board's report. Neither the Minister nor the Board has the statutory authority to make the decision of the Board binding. Unless the parties mutually agree to the appointment of a Board and to make its decision binding. The right to strike applies even after the Board has been appointed and has rendered its decision[4].

3. Mediation

The Minister has the discretion to appoint Mediators under the provisions of the *Trade Union Act.* The Mediator does not have the authority to make a binding decision upon the parties, unless s/he is given that authority by mutual agreement of the parties. The Mediator's role ends with a report to the Minister. Mediators are not typically appointed in work stoppages, except in high profile, complex cases where there is a significant public interest. In Nova Scotia in recent years, several strikes in healthcare or in community services have been resolved or avoided with the assistance of a Mediator, but it is important to recognize that mediation is not arbitration and is only capable of producing outcomes that are binding if the parties mutually agree to give mediation that capacity, as the parties did in the recent IWK dispute.

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[2] Crown Agencies must wait 30 days after notice is given

[3] A strike vote is also required under subsection 47(3) (a) of the *Act*

[4] The parties must wait an additional 7 days following the non binding decision of a Conciliation Board before they can strike or lockout (section 47 (d) of the *Act).*

4. Industrial Inquiry Commission

The Minister has the discretion to appoint Industrial Inquiry Commissions. Historically, it has been rarely used. The Commission can use broad powers to investigate and recommend solutions, but it does not have the authority to make a binding decision upon the parties. Where a Commission is appointed its role ends with recommendations to the Minister. These recommendations end the dispute only if they are accepted by the parties.

5. Arbitration

The *Trade Union Act* does not include binding arbitration except for police and fire. It should be noted however, that binding arbitration, through mutual agreement of the parties, is not prohibited by the *Act.* In several cases in recent years, the parties voluntarily agreed to be bound by an arbitrator's award. For example, police, fire, ambulance, and some healthcare workers in recent years have settled their collective agreements through binding arbitration. In addition, in the recent IWK strike, the parties agreed to authorize the appointed mediator to conduct final offer selection mediation, under which the mediator acted like an arbitrator.

Additional case information is attached as Appendix **D**.

Guiding Principles for Change

Given the concerns for public health and safety, there is a need for a process of health and community services bargaining that achieves two objectives: one is to protect public health and safety while the other is to ensure fairness, equality and impartiality in the resolution of labour relations disputes.

The Department of Environment & Labour recognizes that there is a tension between these two objectives. It also recognizes that there is no magic solution that will provide the perfect solution to the resolution of this tension. The choice is not between good and bad options but between options that have different strengths and weaknesses. The goal must be to design a system that best balances two equally important objectives in the context of the operational realities of modern healthcare and community services programs.

The following guiding principles should be considered to ensure acceptability by all interested parties:

- Recognition that public health and safety and continuity of care is a shared objective;
- The parties' interests need to be maintained by preserving their right to freely negotiate a collective agreement; and
- Any changes and processes must be fair, open, and transparent.

Emphasis must be placed on the fundamental need for a dispute resolution process that is independent in the sense that it is not controlled by either side and protects both sides from being subject to dictation by the other.

Any changes should focus on dispute resolution only when the parties cannot reach consensus and ultimately negotiate a collective agreement on their own. Success will depend upon maintaining and achieving an appropriate balance among these principles.

Alternative Models for Change

In Canada, there are two alternative models to what is currently in place under the *Trade Union Act*: essential services or interest arbitration. Each of these models would require legislative changes. In the former the right to strike is maintained but qualified by the obligation to maintain essential services during a work stoppage. In the latter, the right to strike no longer exists and it is replaced with binding arbitration. Each of these alternatives is examined in more detail below.

1. Essential Services

Although this model attempts to balance the values of public interest and service delivery with those consistent with self determination in collective bargaining, essential services legislation is extremely contentious for both unions and employers.

Under an essential services model, a staffing level is established that will permit the continuous delivery of a level of services while permitting strike action to function as meaningful for the achievement of employee-union objectives. Consequently, when strikes are permitted, legislative provisions compel the union to provide a certain level of essential service during a strike. It needs to be emphasized that for such a model to work the level of "essential services" must be established before the strike, and if the parties cannot agree, there must be a process of adjudication to decide what level will be provided.

All provinces with the right to strike in the healthcare sector have essential services legislation except Nova Scotia and Saskatchewan. The nature of "essential services" provisions and the process to determine the level of service varies by jurisdiction.

In some jurisdictions (for example, British Colombia and New Brunswick), the unions and employers first attempt to negotiate an essential services plan by designating which employees will stay on the job during a strike. If they cannot agree, an independent third party decides (Labour Relations Board or Arbitrator). In other jurisdictions, (Manitoba and Newfoundland), the employer designates "essential"employees and if the union disagrees it appeals to the Labour Relations Board. In Quebec, the law fixes a percentage range as "essential" depending on the type of healthcare institution.

Ontario also has essential services legislation in the *Ambulance Services Collective Bargaining Act*. An essential services agreement must be negotiated for ambulance services and employees cannot strike without one.

See Appendix **E** for detailed jurisdictional information**.**

Pros and Cons

Pros:

- Attempts to balance the interests of the parties with public interest by adopting a fair process while addressing health and safety issues;
- Preserves basic principle of self determination in collective bargaining;
- Patients/residents at less risk because some services are secured;
- Consistent with six other Canadian jurisdictions;
- May avoid unpredictable and inconsistent ad hoc back-to-work laws; and
- May be less contentious than interest arbitration if viewed as "middle ground".

Cons:

- No guarantee of resolution of key workplace issues and still a possibility of negative impact on quality of care and service to consumers;
- Process of determining/ designating "essential services" is difficult:
  - provision of "essential services" is not static; dependent on daily institutional operations which are dynamic and constantly changing;
  - consensual agreement on adequate service level is not likely; and
  - third party intervention is problematic - experts in labour relations should not be enlisted to decide health and community care service delivery.
- Provision of essential services may prolong strikes because it alleviates pressure on parties to come to a speedy resolution;
- Parties may lack confidence that this model balances interests fairly;
- Effectively running an institution during a strike is problematic; even with clear provisions in place for essential services;
- Long term damage to organizations:
  - the employer/employee relationship could become fractured;
  - government could be blamed when some strikes are protracted because management is able to cope with extra help.
- Safety issues may surface especially if strike is prolonged;
- Possibility of job action and/or work to rule by employees who are deemed "essential";

- No experience with this model;
- Does not eliminate illegal strikes or other informal power strategies (mass resignations, work to rule); and
- What if employees/union do not comply?

Does "Essential Services" legislation work?

The inherent challenge of an essential services model is to balance the protection of the health and safety of the public by providing minimum essential services with preserving an employee's right to a meaningful model to negotiate a collective agreement. The experience of jurisdictions who have this model suggests that the efficacy of this model falls short of the intention contemplated by legislators. Experience over the past eight years in the healthcare sector in the Atlantic provinces appears to support this.

Newfoundland

Newfoundland legislated essential services provisions in the *Public Service Collective Bargaining Act* in 1983. Notwithstanding this statutory mandate, the province enacted the *Health and Community Services Resumption and Continuation Act* in the spring of 1999 to end a nine day strike of 4500 Registered Nurses. Despite the provision of essential services, the government was required to act given the public interest. As a result, the striking nurses were ordered back to work and the contract terms were imposed (based on the last offer the union membership had rejected).

New Brunswick

New Brunswick had a similar situation in 2001 when the New Brunswick Labour Relations Board determined that in excess of 75% positions were 'essential'. A strike occurred involving hospitals in seven regional health authorities. Despite the Labour Board's ruling, employers determined that they were unable to maintain adequate services. Consequently, the threat to public health and safety resulted in the consideration of back-to-work legislation by the government. The dispute ended after a five day strike when a collective agreement was reached through mediation, while back-to-work legislation was being debated in the legislature.

In the summer of 2001, the support staff (nursing assistants, maintenance, and food service workers) of thirty five nursing homes in New Brunswick went on strike. The strike lasted two days and the government considered passing back to work legislation. The parties were able to settle the dispute making that unnecessary.

Nova Scotia

Currently there is no essential services legislation in this province. However, in some instances, the parties in their collective agreement may require that some form of "emergency services" be negotiated prior to a work stoppage to ensure that a minimum level of service is provided. While such a system may be helpful with an impeding work stoppage and resulting service disruption, these types of agreements are vulnerable; i.e. they do not modify the rights that currently exist under the *Trade Union Act* and more importantly, may not even be enforceable. "Essential Services" agreements were in place in two recent work stoppages which are discussed below.

During the spring of 2001, negotiations broke down between the Capital District Health Authority (CDHA) and the healthcare professionals and registered nurses represented by the Nova Scotia Government and General Employees Union (NSGEU). The provision of emergency services was provided for in their respective collective agreements**.** The union commenced strike action on June 27, 2001. The government had introduced legislation (Bill 68) on June 14th which removed the right to strike and gave cabinet the right to impose a wage settlement. After demonstrations at the legislature, a media campaign including a series of pro union advertisements, TV interviews and bulletins, and resignation letters from nurses, the government did not fully proclaim Bill 68. The parties agreed to submit their outstanding issues to a form of binding arbitration known as " Final Offer Selection" .

In April of 2007, negotiations broke down between the IWK Health Centre and NSGEU affecting approximately 630 employees in the healthcare classification (i.e. Lab technologists, X Ray technicians, mental health workers, occupational therapists). The provision of emergency services was provided for in their collective agreement and ultimately determined by an arbitrator prior to the work stoppage. The parties could not agree to resolve their dispute through binding arbitration. Upon receipt of notice of the union's intention to strike, the Minister of Environment & Labour exercised his discretion under the *Trade Union Act* and appointed a Mediator to assist the parties with resolving the dispute. Mediation talks were held but the parties were still unable to reach an agreement. As a result, the union initiated strike action on Monday April 30, 2007. The strike ended in less than a day when the parties agreed to binding mediation.

These examples further demonstrate that this model (whether mandated or not) is problematic. Notwithstanding the provision of a minimum level of emergency services, government has felt compelled to intervene in the interest of public health and safety on one occasion and to contemplate it on another. In other situations, the parties themselves have agreed to an alternative to a continuing strike.

Analysis

Based on the foregoing, it is difficult to conclude that the essential services model effectively balances the public's expectation for the delivery and continuity of health and community services with the employees' and union's right to fair and free collective bargaining.

The efficacy of such a model is premised on the determination of a minimum level of service provision which is in and of itself problematic given that there are two conflicting interests. The employer's (and the government's) interest in protecting health and safety of the public through continued healthcare services creates the tendency for it to err on the side of caution by over estimating required service standards. This is diametrically opposed to the union's interest in maintaining its bargaining power to have a meaningful strike. It can also be contrary to the common interest in an effective system of collective bargaining since a system that is based on an unfettered right to strike is liable to be imbalanced.

Because consensus is unlikely, mechanisms have been legislated to ensure that the determination of minimal service levels is made prior to a work stoppage. Consequently, a third party (Arbitrator or Labour Relations Board) decides the issue and the parties' negotiating power is significantly restricted. There are real questions as to whether labour relations adjudicators can adequately discharge this responsibility.

The recent work stoppages in New Brunswick and Newfoundland illustrate that there are complexities with determining a mutually acceptable standard of "essential services" . There are similar experiences in other provinces where as much as 90% of the workers in healthcare bargaining units have been designated as essential. Consequently, government intervention to resolve the dispute may be necessary notwithstanding legislation requiring the provision of essential services. Conversely, essential services legislation may have the consequence of lengthening strikes, thereby extending the period during which the public is exposed to disruption.

There are other complexities with an essential services model particularly in the health and community services sector given the very nature of the work performed. There is a significant moral/ethical dilemma facing employees who must choose between their loyalty and commitment to patient care and their loyalty and commitment to their co workers and their union.

In addition, there could be long term damage to the labour-management relationship. The nature of this model requires striking employees who are deemed essential "to cross the line" to provide patient care and/or deliver services while their co workers continue to picket.

It is important to note that this model was put in place in the 1970s and 1980s before the pervasive changes in the healthcare and community services sector that arguably make any right to strike system less compatible with the public interest in continuity of care than may have been the case historically.

One could conclude that this particular model has failed to adequately balance the objectives of all interested parties (government, the broader public, the employer, the union and the employees).

2. Interest Arbitration

Under this model, strikes and lockouts are prohibited and collective bargaining impasses are referred to binding arbitration better known as interest arbitration. " Interest Arbitration" (as distinguished from rights or grievance arbitration) is a tool used to resolve collective bargaining disputes whereby a neutral third party renders a decision which is binding on the parties. The new collective agreement includes the issues agreed to between the parties together with the issues resolved by the arbitrator's decision. Interest arbitration is also known as binding arbitration.

Interest arbitration is currently not mandatory under the *Trade Union Act* except for fire and police. It is mandatory, however, under the other four statutes that regulate collective bargaining in Nova Scotia for highway workers, correctional workers, civil servants and teachers (local bargaining). In addition, contract negotiations between doctors and the Department of Health are settled by interest arbitration when an impasse results. The *Canada Health Act* requires the provinces to settle contract disputes with doctors through arbitration. In addition, binding arbitration is used by agreement between the Province and Crown Attorneys to resolve collective bargaining disputes.

As noted previously, there is nothing in the *Trade Union Act* that prohibits the parties from mutually agreeing to use interest arbitration to resolve their collective bargaining disputes. In the past, it has been used successfully by several groups including ambulance, healthcare, police (pre 2004) and fire (pre 2006).

The NSGEU as bargaining agent for four bargaining units of employees of the CDHA, and the CDHA entered into an agreement in advance of the last round of collective bargaining to proceed with binding arbitration to resolve outstanding bargaining issues for each collective agreement. Negotiations reached an impasse for two bargaining units (Nurses and Healthcare) and two subsequent interest arbitrations were conducted to conclude collective agreements in 2004 and 2005 (see Appendix **D** for further details)**.**

Three provinces (Ontario, Alberta and PEI) have legislation prohibiting the right to strike or lockout in the healthcare sector entirely (see Appendix **E.**). In Ontario, binding arbitration is compulsory for hospitals and homes for the aged under the *Labour Relations Act*. It is interesting to note that the definition of "hospital" in Ontario is broad and it also includes a laundry or stationary power plant operated for one or more hospitals (See *Hospital Labour Disputes Arbitration Act* , footnote #6, Appendix **E)**. In Alberta, this applies to hospitals and employees under the Regional Health Authorities. In PEI, this applies more broadly.

In Alberta, the government may also declare a public emergency when a strike or the possibility of a strike puts the health and safety of the public at risk. The parties may be forced to binding arbitration to resolve the dispute.

The federal law applies to the federal public service and would include employees working in federal health services. Under that legislation, the union may choose binding arbitration to resolve a collective bargaining dispute. Alternatively, if the union chooses to retain the right to strike, it is required by legislation to have an essential service agreement with the employer (see Appendix **E** for further details).

Pros and Cons

Pros:

- Aligns with core objectives and public expectations while protecting fair and free collective bargaining by appointing a credible neutral third party;
- Parties participate at every stage of the process including the appointment of the arbitrator;
- Protects the public interest by guaranteeing that there will be no legal work stoppages (services remain available and accessible to all);
- Less likely to be an interruption of service;
- Aligns with existing process for civil servants, highway workers, correctional workers, police, fire and teachers (local bargaining);
- Consistent with three other Canadian jurisdictions;
- May avoid unpredictable and inconsistent ad hoc back-to-work laws;
- Addresses outstanding collective bargaining issues and guarantees new collective agreement and;
- Aligns with and builds on Nova Scotia experience, both in and outside health and community services sectors.

Cons:

- May be perceived as expensive for employers and governments;
- Viewed as likely to favour "splitting the difference" outcomes;
- Potential to delay the bargaining process; disliked by collective bargaining specialists;
- May act as a disincentive to the parties to make earnest attempts to resolve their disputes through the negotiation process;
- Does not eliminate illegal strikes or other informal power strategies (mass resignations, work to rule);
- Arbitration may not address workplace issues that may need to be fixed and that are not likely to be addressed through arbitration; and
- Perception of giving up right to self determination to a third party with no ongoing commitment to workplace.

Does "Interest Arbitration" work?

The challenge is to conclude a collective agreement that both parties accept as being fair and reasonable. If the right to strike or lockout is removed, it must be replaced with a fair, open, and

transparent dispute resolution process which reaches a settlement acceptable to the parties. The model needs to balance the parties' interests - protection of the health and safety of the public with the parties' right to a meaningful model to freely negotiate a collective agreement.

Historically, in Nova Scotia, some parties have mutually agreed on a voluntary basis to use interest arbitration to conclude their collective agreement. In the past, several groups including fire, police, paramedics and healthcare have successfully used this model on more than one occasion to resolve their disputes. While arbitration may not achieve all things for either party, this demonstrates that the parties often regard this model as an acceptable and credible dispute resolution process.

Alternatively, government may impose interest arbitration to resolve a dispute and has in fact done so in the past. Negotiations between Emergency Medical Care Incorporated (EMC) and the NSGEU broke down in the fall of 1999 and approximately 650 emergency medical technicians and ambulance attendants went on strike. The strike lasted approximately eighteen hours and the legislature passed legislation which ordered the employees back to work and to proceed to binding interest arbitration (see *Ground Ambulance Services Act, R.S. 1999, c.2)*

It is important to note that since that time, the parties in the ambulance sector have agreed in three consecutive rounds of collective bargaining to resolve their impasse through voluntary interest arbitration.

Finally, as noted above, in the recent IWK dispute, less than twenty four hours into the strike, the parties agreed to binding mediation to resolve their dispute.

Analysis

Interest arbitration does not displace fair and free collective bargaining. The parties continue to collectively bargain to determine the terms and conditions of their employment as they always had upon the expiry of their current agreement. It is only when those negotiations break down and the parties are at an impasse that interest arbitration may be the next step. In addition, parties may participate at every stage of the process including the appointment of an arbitrator. If fairly designed, there is no reason to expect that arbitration will be more favourable to one side than the other. It may mean that some issues that unions would like to address are less likely to be addressed. But equally, it may mean that the cost of some settlements to employers and to government may be higher than would otherwise be the case.

What is more certain is that the parties to collective bargaining will be given a dependable and predictable mechanism for resolving disputes that does not call upon Nova Scotians to accept disruption in the delivery of essential public services.

As indicated above, it would appear that in certain instances the parties themselves recognize they are not able to get "the deal" on their own to conclude a collective agreement without some sort of third party intervention. Parties have voluntarily mutually agreed to use this mechanism to resolve

their disputes and in some instances, have done so repeatedly. Consequently, one could conclude that interest arbitration is a credible and workable solution to resolve disputes whether mandated or not.

With respect to the interest arbitration model, one is led to the conclusion that it is not a panacea. There are and there will continue to be interests that are competing and that at times there will be outcomes which do not support them. Given that the only other option is back-to-work legislation once in a crisis situation, this is an acceptable model which also preserves some balance and is consistent with the "Guiding Principles" previously identified.

It must also be recognized that illegal strikes and/or other informal power strategies (such as work to rule and mass resignations) have happened in the past and could occur again. Consequently, whatever model is chosen cannot effectively deal with these situations because unions have the ability to exercise this power. We should not however be discounting a model based on the conclusion that it will not prevent illegal activity, for indeed, no model can prevent illegal activity. Instead, we should be trying to choose and implement the model that is best for Nova Scotia because it has the highest potential for balancing public protection with free and effective collective bargaining.

Next Steps.....

Dialogue needs to occur with our stakeholders (employers and unions) in these sectors as well as other key players including the Departments of Health and Community Services to ensure that all stakeholders are provided with a full opportunity to provide honest and candid feedback. We want to hear from our stakeholders regarding their respective views keeping in mind that they are not committed to the outcome.

The department also wants to hear from Nova Scotians. We invite all interested Nova Scotians to send their comments to the Policy Division of Nova Scotia Environment and Labour. We look forward to receiving these submissions which will be carefully considered and reviewed. Once this has occurred, the department will summarize and report on the feedback it has received regarding this important issue.

Appendix A

Nova Scotia Work Stoppages (1970 - Present)
Health and Community Services, Ambulance

Note: May not be an Inclusive List Prior to 1995

	EMPLOYER	UNION	DATE/DURATION OF WORK STOPPAGE	Person Days Lost
	HOSPITALS			
1	Halifax County Hospitals	CUPE, Local 1028	July 17, 1971 and July 24, 1971	571.43
2	St. Rita's Hospital	NSNU	June 15, 1971 and July 17, 1972	2,875.72
3	St. Rita's Hospital, St. Joseph Hospital, Northside General Hospital, Harbour View Hospital, New Waterford Consolidated Hospital, Glace Bay Hospital, Glace Bay General Hospital, Sacred Heart Hospital	Canadian Brotherhood of Railway Transportation and General Workers, Locals 606, 514, 600, 601, 603, 604, 609	July 27 to August 9, 1979	7,621.43
4	St. Elizabeth's Hospital	NSNU	June 15 and 19, 1972	150.00
5	Sydney City Hospital	CUPE, Local 1613	June 16 and 27, 1975	278.57
6	Sydney City Hospital	CUPE, Local 756, 1613	September 21 to October 18, 1981	3100.00
7	Sydney City Hospital	CUPE, Local 756, 1613, 2431	August 15 to 16, 1990*	89.29
8	Dartmouth General Hospital	International Union of Elevator Constructors	February 9 to 10, 1976*	2.86
9	Dartmouth General Hospital	NSNU	October 6 to 15, 1978	764.29
10	Dartmouth General Hospital	Canadian Brotherhood of Railway Transportation and General Workers, Local 606	October 9 to 18, 19	330.00
11	Various Hospitals (province wide)	NSNU Locals	June 12, 13, 19, and 24, 1975	7,575.00

*illegal strike ** all strikes except number 57

EMPLOYER		UNION	DATE/DURATION OF WORK STOPPAGE	Person Days Lost
12	Various Hospitals (province wide)	CUPE 741, 919, 1028, 921, 1798, 834, 1472, 1711	July 12, and September 7, 1976	27,880.01
13	Northside General (North Sydney), Harbourview Hospital (Sydney Mines), Glace Bay General Hospital, Glace Bay Community Hospital, Sacred Heart (Cheticamp) Hospital, New Waterford Hospital, Victoria County Memorial Hospital (Baddeck), Inverness Memorial Hospital	Canadian Brotherhood of Railway Transportation and General Workers	August 13 to October 19, 1990	47,857.16
14	Northside General Hospital	Canadian Brotherhood of Railway Transportation and General Workers	September 21 to October 18, 1981	2,400.00
15	New Waterford Consolidated Hospital	Canadian Brotherhood of Railway Transportation and General Workers	September 21 to October 18 1981	1,470.00
16	Harbourview Hospital	Canadian Brotherhood of Railway Transportation and General Workers	September 21 to October 18, 1981	871.43
17	Cape Breton Hospital and Braemore Home Corp	CUPE, Local 756, 1478	September 21 to October 18, 1981	2,142.86
18	Camphill Hospital	PSAC, Local 5	September 21 to September 22, 1981*	680.00
19	Aberdeen Hospital	CUPE, Local 1646, 1741	September 22 to November 8, 1981	3,594.29
20	Glace Bay General Hospital	Canadian Brotherhood of Railway Transportation and General Workers	September 23 to October 18, 1981	1,506.43
21	Glace Bay Community Hospital	Canadian Brotherhood of Railway Transportation and General Workers	September 23, to October 18, 1981	1,438.57

*illegal strike ** all strikes except number 57

EMPLOYER		UNION	DATE/DURATION OF WORK STOPPAGE	Person Days Lost
22	Glace Bay Community Hospital	Canadian Brotherhood of Railway Transportation and General Workers	April 29, 1985 *	11.79
23	Glace Bay Community Hospital	CUPE, Local 2336	August 14 to 15, 1990 *	35.71
24	Victoria County Memorial Hospital	Canadian Brotherhood of Railway Transportation and General Workers	September 24 to October 18, 1981	36.43
25	St. Rita's Hospital	Canadian Brotherhood of Railway Transportation and General Workers	September 24 to October 18, 1981	1,542.86
26	Inverness Consolidated Hospital	Canadian Brotherhood of Railway Transportation and General Workers	September 24 to October 18, 1981	1,007.86
27	IWK Health Centre	Canadian Brotherhood of Railway Transportation and General Workers	September 24 to October 18, 1981	850.00
28	IWK Health Centre	Izaak Walton Killam Hospital Employees Association	October 9 to 26, 1981	1,200.00
29	IWK Health Centre	NSGEU	April 30, 2007 to May 1, 2007	449.29
30	Sacred Heart Hospital	Canadian Brotherhood of Railway Transportation and General Workers	September 24 to October 18, 1981	400.71
31	Kings County Regional Health and Rehabilitation Centre	CUPE, Local 1472	September 24 to October 18, 1981	1,590.72
32	All Saints Hospital	CUPE, Local 919	September 24 to October 18, 1981	388.57
33	Grace Maternity Hospital	Canadian Brotherhood of Railway Transportation and General Workers	September 24 to October 18, 1981	1,141.43

*illegal strike ** all strikes except number 57

EMPLOYER		UNION	DATE/DURATION OF WORK STOPPAGE	Person Days Lost
34	Dawson Memorial Hospital	International Union of Operating Engineers, Local 968 - 968B	September 24 to October 18, 1981	1,153.57
35	Halifax Infirmary Hospital	Canadian Brotherhood of Railway Transportation and General Workers	September 24 to October 18, 1981	8,269.29
36	Highland View Hospital	CUPE, Local 920	September 24 to October 18, 1981	1,214.29
37	Digby General Hospital	CUPE, Local 1027	September 25 to October 18, 1981	720.00
38	Yarmouth Regional Hospital	CUPE, Local 835	September 25 to November 17, 1981	5,591.43
39	Queens General Hospital	CUPE, Local 1777	September 26 to October 18, 1981	246.43
40	Colchester Hospital	Canadian Brotherhood of Railway Transportation and General Workers	October 5 to October 18, 1981	1,107.14
41	Eastern Memorial Hospital	Canadian Brotherhood of Railway Transportation and General Workers	October 8 to 18, 1981	80.00
42	Abbie Lane Memorial Hospital	International Union of Operating Engineers	October 9 to 26, 1981	1,028.57
43	Fishermen's Memorial Hospital	CUPE, Local 1933	October 10 to 18, 1981	192.86
44	Camp Hill Medical Centre	Canadian Brotherhood of Railway Transportation and General Workers	February 15 to 16, 1990*	28.57
45	Cape Breton Regional Hospital	CUPE, Local 2336	August 13, 1990*	30.00
46	Cape Breton Regional Hospital	CUPE	July 10 to July 11, 1996 *	121.43
47	Sydney Community Health Centre	NSNU	August 15 and 16, 1990*	5.00
48	Cape Breton Regional Hospital	CUPE, Local 2336	August 13, 1990*	30.00
49	Cape Breton Regional Hospital	CUPE	July 10 and 11, 1995*	121.43

*illegal strike ** all strikes except number 57

	EMPLOYER	UNION	DATE/DURATION OF WORK STOPPAGE	Person Days Lost
50	Cape Breton Health Care Complex	CUPE	June 27, 1997*	85.71
51	Capital District Health Authority	NSGEU	June 25, 2001*	857.14
52	Capital District Health Authority	NSGEU	June 27, 2001*	714.29
53	Halifax County Regional Rehabilitation Center	CUPE	July 5 to August 28, 2002	3,305.72
	AMBULANCE			
54	EMC Emergency Inc	NSGEU, Local 911	October 29, 1999	464.29
55	Unity Ambulance	National Automobile, Aerospace Transportation and General Workers of Canada	March 19 and April 12, 1997	240.00
56	Kelly's Ambulance 1982 Ltd	CUPE, Local 920 ** Lockout	September 4, 1992 to December 31, 1993	1728.57
57	Metro & District Ambulance	CUPE, Local 3264 (Dispatchers and Attendants)	January 8 to 24, 1992	530.36
58	MacDonald Brothers Ambulance Ltd	CUPE, Local 3281	January 15 to 19, 1990	35.71
	NURSING HOMES/HOMES FOR SPECIAL CARE			
60	Cumberland County Transition House	CUPE, Local 4326	August 8 to December 12, 2003	971.43
61	Regional Residential Services Society	NSGEU	April 10 to June 28, 2003	13,928.58
62	Queen's Home Support	CUPE, Local 3885	April 20 to July 11, 2001	2,342.86
63	Shoreham Village	CUPE, Local 34 54	May 21 to 23, 1999	107.14
64	New Dawn Guest Home	CUPE, Local 3067	May 7 and 11, 1999	57.14
65	Breton Bay Nursing Home	CUPE, Local 1183	April 4 to May 14, 1999	7,314.29

*illegal strike ** all strikes except number 57

EMPLOYER		UNION	DATE/DURATION OF WORK STOPPAGE	Person Days Lost
66	Victoria Haven Nursing Home	National Automobile Aerospace Transportation and General Workers Canada	November 2 and November 23, 1998	570.00
67	Cove Guest Home	Canadian Brotherhood of Railway Transportation and General Workers	October 18 to 22, 1989	211.43
68	Cove Guest Home	National Automobile Aerospace Transportation and General Workers Canada	November 2 1998 and November 13, 1998	707.14
69	Northwood Manor	National Automobile Aerospace Transportation and General Workers Canada	August 19 to 29, 1998*	42.86
70	Northwood Manor	National Automobile Aerospace Transportation and General Workers Canada	November 2 to 8, 1998	1,842.86
71	Victoria Haven Home	Canadian Brotherhood of Railway Transportation and General Workers	September 16 and September 21, 1993	128.57
72	Extendicare Armview	CUPE, Local 2784	August 27 to 28, 1991*	71.43
73	Maple Hill Manor	NSNU	May 29 and June 12, 1991	110.00
74	Maple Hill Manor	CUPE, Local 2756	May 30 to 31, 1991*	50.00
75	Gables Lodge	CUPE, Local 3215	February 8 and February 22, 1990	517.86
76	Cove Guest Home	Canadian Brotherhood of Railway Transportation and General Workers	October 18 and October 22, 1989	211.43
77	Villa St. Joseph-du-Lac	CUPE, Local 3064	July 3- 4 1989*	42.86
78	Villa St. Joseph-du-Lac	CUPE, Local 3064	April 9 and April 19, 1999	471.43
79	Villa St. Joseph-du-Lac	CUPE, Local 3064	May 23 and May 26, 1999	141.43
80	Seaview Manor	CUPE, Local 2094	September 21 and September 24, 1988*	177.86
81	Seaview Manor	CUPE, Local 2094	November 24 to 25, 1989*	4.29
82	Seaview Manor	CUPE, Local 2094	April 5 and April 13, 1999	571.43

*illegal strike ** all strikes except number 57

EMPLOYER		UNION	DATE/DURATION OF WORK STOPPAGE	Person Days Lost
83	Seaview Manor	CUPE	April 16, 2004*	21.43
84	Annapolis Royal Nursing Home	Service Employees International Union	November 2, 1986 to January 19, 1987	1,523.57
85	Glen Haven Manor	CUPE	August 2 to October 20, 1986	7,900.00
86	Inverary Manor	CUPE	June 12 to June 13, 1975	42.86
87	Inverary Manor	CUPE	October 23 and October 27, 1985*	148.57
88	Riverview Home Corporation	CUPE	July 17 and August 4, 1985	678.57
89	Keddy's Nuring Manor	CUPE	January 30, 1983 to June 26, 1984	27,462.87
90	Villa St. Joseph's Nursing Home	CUPE	June 7 and July 2, 1982	895.72
91	East Cumberland Lodge	CUPE	December 24 and December 31, 1981	167.86
92	Sunset Adult Residential Centre	CUPE	October 16 and October 18, 1981	214.29
93	Fairview Villa Nursing Home	CUPE	September 21 to September 22, 1980*	142.86
94	Ocean View Manor	CUPE	April 9 and April 25, 1975	696.43
95	Ocean View Manor	CUPE	September 8, 1980*	32.14
96	Mortiman Home	Labourers International Union	June 16 and June 19, 1975*	97.14
97	Alderwood Rest Home	NSNU	October 5 and October 18, 1981	28.57
98	Victorian Order of Nurses (Central)	NSNU	March 28 to April 29, 1996	700.00
99	Spring Garden Villa	CUPE	June 4 to June 28, 1975	1,571.43
100	Spring Garden Villa	CUPE	March 19 and March 22, 1976*	21.43
101	Miner's Memorial	IUOE	October 29, 1998*	18.57

*illegal strike ** all strikes except number 57

Appendix B

INDUSTRIAL INQUIRY COMMISSION - 1992
Summary of Recommendations
Report prepared by Bill Kydd

1. That the problems connected with negotiating collective agreements in the hospital sector can best be dealt with by the parties negotiating a more efficient procedure. Amendments to the *Trade Union Act* that have been suggested by some of the parties would likely cause more problems than they would solve. It is therefore recommended that no amendments be made to the *Trade Union Act* to address the areas that were the subject of this commission's mandate.

2. That all of the unions in the hospital sector should negotiate with the Association of Health Organizations to establish a protocol for two-tiered province-wide bargaining.

3. That the two-tiered structure should be composed of five centralized bargaining tables representing the four classes of workers designed in the Labour Relations Board's guidelines and an additional table representing the Certified Nursing Assistants.

4. That separate preliminary negotiations should take place between the union with a view to standardizing the classifications of groups of workers to facilitate negotiating province-wide settlements.

5. That no later than six months before negotiations are due to commence AHO should obtain participation agreements committing all of those hospitals who wish to engage in centralized collective bargaining. The participation agreement should then be signed by those unions who wish to engage in centralized bargaining.

6. That the parties should agree in the participation agreement to engage in the negotiations for the provisions of essential services.

7. The need for, and the content of any essential services provision should be left strictly to the parties to the collective agreement, including decisions on balancing the numbers of personnel who can work to provide adequate essential services and the numbers that should be withdrawn in order to give the unions an adequate strike sanction.

8. That the settlement of collective bargaining negotiations can best be encouraged by the absence of any specific emergency services legislation, and the absence of a reason to enact ad hoc emergency legislation whenever a hospital strike looms. Public reassurance is the best means of discouraging such ad hoc legislation. The public can best be reassured by knowing that the parties have already negotiated arrangements to provide essential services so that there is no need for the government to interfere.

9. That any essential services arrangement should make provision for some sort of binding dispute resolution panel to deal with problems that the negotiated agreement does not address.

10. That upon the signing of an initial agreement with hospitals to participate in two-tiered bargaining, the unions should apply to the Labour Relations Board to restructure their locals so that the local only represent workers within one of the Labour Relations Board's guideline classifications, or CNA's.

Appendix C
Health and Community Services
(Long Term and Continuing Care 1998-1999)

Employer	Union	Strike Dates
Miners Memorial	IUOE	October 29, 1998
Northwood Manor	CAW	November 2-8, 1998
Cove Guest Home	CAW	November 2-13, 1998
Victoria Haven	CAW	November 2-13, 1998
Breton Bay	CUPE	April 4-May 14, 1999
*Villa St. Joseph	CUPE	April 9-19, 1999
*Villa St. Joseph	CUPE	May 23-26, 1999
New Dawn Guest Home	CUPE	May 7-11, 1999
Shoreham Village	CUPE	May 21- 23, 1999

1. Mediation for Oceanview Manor and Braemore Home conducted February 1999
2. Mediation for Breton Bay conducted May 1999

*These two strikes were not premised on the negotiated settlement but were related to our work place problems.

** See also Appendices A and D for further particulars including person days lost

Appendix D
Dispute Resolution Processes
Trade Union Act

Industrial Inquiry Commissions		
Employer	**Union**	**Date**
Northside General (North Sydney), Harbourview Hospital (Sydney Mines), Glace Bay General Hospital, Glace Bay Community Hospital, Sacred Heart (Cheticamp) Hospital, New Waterford Hospital, Victoria County Memorial Hospital (Baddeck), Inverness Memorial Hospital. (Represented by NSAHO)	Canadian Brotherhood of Railway, Transport and General Workers, Locals 514, 600, 601, 603, 604, 607 and 609	1990-1991
Northside General Hospital New Waterford Consolidated Hospital Harbourview Hospital Cape Breton Hospital and Braemore Home Corp, Camphill Hospital, Aberdeen Hospital, Glace Bay General Hospital Glace Bay Community Hospital, Victoria County Memorial Hospital, St. Rita's Hospital, Inverness Consolidated Hospital IWK Health Centre, Sacred Heart Hospital Kings County Regional Health and Rehabilitation Centre, All Saints Hospital Grace Maternity Hospital, Dawson Memorial Hospital, Halifax Infirmary Hospital, Highland View Hospital, Digby General Hospital, Yarmouth Regional Hospital, Queens General Hospital Colchester Hospital, Eastern Memorial Hospital, Abbie Lane Memorial Hospital Fishermen's Memorial Hospital. (Represented by NSAHO)	Common Front CUPE, NSGEU, PSAC, IUOE, CBRT - Special Commission	1981

Employer	Union	Date
St. Rita's Hospital, St. Joseph Hospital, Northside General Hospital, Harbour View Hospital, New Waterford Consolidated Hospital, Glace Bay Hospital, Glace Bay General Hospital, Sacred Heart Hospital (Represented by NSAHO)	Canadian Brotherhood of Railway Transport and General Workers, Local 514, 600, 601, 603, 604 and 609	1979-80
Grace Maternity, Halifax County, Abbie J. Lane Memorial Hospital, CB Hospital, Glace Bay General Hospital, Harbour View Hospital, New Waterford Hospital, St. Elizabeth's Hospital, St. Rita's Hospital, Sydney City Hospital	Nurses' Staff Association	1975
Mediation		
Employer	**Union**	**Date**
QEII Health Sciences Centre	NSGEU	Feb. 1998
Northwood Care Inc.	CAW-Canada, Local 4606	Nov. 1998
Victoria Haven Nursing Home	CAW-Canada, Local 4600	Nov. 1998
Cove Guest Home	CAW-Canada, Local 4620	Nov. 1998
Ocean View Manor	CUPE, Local 1245	Feb. 1999
Braemore Home Inc.	CUPE, Local 3515	Feb. 1999
Breton Bay Nursing Home	CUPE, Local 1183	May 1999
QEII Health Sciences Centre	NSGEU	June 2001
Regional Residential Services Society	NSGEU, Local 66	June 2003
Isaac Walton Killam Hospital	NSGEU	Apr. 2007
Interest Arbitration ***no mandate under the *TUA* for interest arbitrations to be forwarded to the department however arbitrators may forward them to the department out of courtesy**		
Employer	**Union**	**Date**
EMC Emergency Medical Care	NSGEU	Jan. 19, 2000

Employer	Union	Date
South Shore District Health Authority, South West Nova District Health Authority, Annapolis Valley District Health Authority, Colchester/East Hants Health Authority, Cumberland Health Authority, Pictou County District Health Authority, Guysborough/Antigonish/ Strait Health Authority, Cape Breton District Health Authority	CUPE, Local 2431, 2525, 4150	May 13, 2002
EMC-Emergency Medical Care	International Union of Operating Engineers, Local 968B	July 2, 2003
Capital District Health Authority	NSGEU (Healthcare)	Aug. 18, 2004
Capital District Health Authority	NSGEU (Nursing)	Sep. 20, 2005
EMC-Emergency Medical Care	International Union of Operating Engineers, Local 968	Sep. 27, 2006
	Conciliation Boards	
	Date	**Total Number of Boards**
	1979-1980	9
	1980-1981	5
	1981-1982	8
	1982-1983	3
	1983-1984	0
	1984-1985	1
	1985-1986	2
	1986-1987	0
	1987-1988	1
	1988-1989	4

	Date	Total Number of Boards
	1989-1990	1
	1990-1991	0
	1991-1992	0
	1992-1993	0
	1993-1994	0
	1994-1995	0
	1995-1996	1
	1996-1997	1
	1997-1998	0
	1998-1999	1
	1999-2000	1
	Total Conciliation Boards	38

Appendix E

JURISDICTIONAL REVIEW

Essential Services/Interest Arbitration

Healthcare, Community Services, Ambulance

Jurisdiction	Right to strike	Essential Services	Interest Arbitration	Legislation	Specific Employee Groups? / Comment
Nova Scotia	√			*Trade Union Act*	N/A
Saskatchewan	√			*Trade Union Act*	N/A
Manitoba	√	√		*Essential Services Act*	No specific group. Defined as services that are necessary to enable the employer to prevent: danger to **life, health, and safety**; the destruction of **machinery**, equipment, or premises; serious **environmental** damage; or the disruption of the administration of the **courts** or of **legislative drafting**. Attached as Schedule A to the Act is a list of government services declared to be essential services. Same as Ontario's definition.
British Columbia	√	√		*Labour Relations Code*, ss.72 and 73	No specific group. The Minister may direct the board to designate as essential services those facilities, productions and services that the board considers necessary or essential to prevent immediate and serious danger to the **health, safety or welfare** of BC residents or threat to educational programs.
Quebec	√	√		*An Act to ensure that essential services are maintained in the health and social services sector*	The Act applies to a detailed list of services, including **health and social services** institutions and, **ambulance** operators.
New Brunswick	√	√		*Public Service Labour Relations Act*, S.43.1	Services affecting **health, safety or security** of the public are essential. [1] This includes all public hospitals, nursing homes, and ambulance operators.
Newfoundland	√	√		*Public Service Collective Bargaining Act*, S.10 *Interns and Residents Collective Bargaining Act,* S.10(same wording)	Both Acts define essential services as those necessary for the **health, safety, or security** of the public. **Interns and residents** are a specific group. [2]

Jurisdiction	Right to strike	Essential Services	Interest Arbitration	Legislation	Specific Employee Groups? / Comment
Federal	√	√		*Canada Labour Code*, ss.87.4 to 87.7	Those who supply goods, operate facilities, or produce goods which affect the **safety and health** of the public. [3]
	√	√	√	*Public Service Labour Relations Act, March 2003 s103-104, 119-134*	Applies to those working in the federal health services; choice of resolution of a dispute and if not arbitration, there is an essential services requirement for service, facility or activity of the Government of Canada that is or will be, at any time, necessary for the safety or security of the public or a segment of the public. Employer has right establish level at which an essential service must be provided and an essential service agreement is negotiated. Right to strike is not permitted until 30 days after agreement is concluded.
				The Public Service Modernization Act - March 2003	
				Government Services Act, *1999 c.13* One time, back-to-work, emergency legislation	This *Act* prohibits a strike by those employees employed in the Public Services who were bound by a group specific agreement including but not limited to firefighters, and those who provide utilities, hospital services and correctional services.
Prince Edward Island			√	*Labour Act, Section 41(5)*	Prohibits police officers, full time fire department employees, hospital employees, nursing home employees, employees of community care facilities and non-instructional school personnel from striking.[4]
Alberta			√	*Labour Relations Code*, s.96-98	Interest Arbitration. Prohibition against strike/ lockout for firefighters, employees of hospitals under Hospitals' *Act* and employees under Regional Health Authorities. [5]
				Labour Relations Code s.112	Emergencies - The Government may declare a strike a public emergency when the health and safety of the public is at risk for services affecting **utilities** (sewage systems, plants, or equipment, or water, heating, electrical or gas systems, plant or equipment and **health services.**
Ontario	√	√		*Ambulance Services Collective Bargaining Act (June 29, 2001)*	Essential services agreement must be negotiated and employees cannot strike without one.
				Labour Relations Act	Binding Arbitration is compulsory for hospitals and homes for the aged.
			√		Prohibits strike for broad definition of "Hospital". [6] Exemption for employers funded under the *Developmental Services Act.*
			√	*Hospital Labour Disputes Arbitration Act*	

End Notes:

1. Subsection 92(4) of *Industrial Relations Act* prohibits a full time fire department employee from striking; and subs.(5) prohibits a police officer from striking.

2. a)Newfoundland enacted the *Health and Community Services Resumption and Continuation Act*, S.N. 1999, c.37.2, which ordered striking nurses to return to work in light of "a serious and deteriorating situation in the provision of health care to patients and the public". Additionally, the purpose of the statute was to foster resolution of the dispute on terms and conditions consistent with other collective agreements in the public sector. Pursuant to S.6, terms and conditions of employment approved by the Lieutenant-Governor in Council constituted a collective agreement.
b) Section 45 of the *Royal Newfoundland Constabulary Act* prohibits officers from belonging to a union and from going on strike.
c) Section 30 PSC.11 *Bargaining Act* - Where House of Assembly resolves that a strike could cause harm, it may declare a state of emergency or forbid strike of all employees in a unit and order them to return to duty.

3. a) Another provision states: "During a strike or lockout not prohibited in this part, an employer in the long-shoring industry, or other 'federal work, undertaking, or business', its employees and bargaining agent shall continue to provide their normal services re: grain vessels".

4. Ambulance services are not included in this prohibition under the *Labour Act* because five privately owned operators. However, consolidated to EMS in 2006 and the PEI government is reexamining this.

5. If an ambulance service is operated out of a hospital it does not have the right to a strike or lockout and is covered by the legislation that covers other health care workers.
Ambulance services run by Municipalities and private operators do have the right to strike and lockout. The Alberta government is looking at putting all ambulance workers under compulsory interest arbitration. In the past, where there has been the a threat of an ambulance strike, government has put a Disputes Inquiry Board in place which has usually resolved the dispute.

6. s.1 (1) "hospital" means any hospital, sanitarium, sanatorium, nursing home or other institution operated for the observation, care or treatment of persons afflicted with or suffering from any physical or mental illness, disease or injury or for the observation, care or treatment of convalescent or chronically ill persons, whether or not it is granted aid out of moneys appropriate by the Legislature and whether or not it is operated for private gain, and includes a home for the aged; ("hospital")
   (3) Laundry that is operated exclusively for one or more than one hospital shall be deemed to be a hospital for the purposes of this Act. R.S.O. 1990, c. H.14, s.1(3).
   (4) A stationary power plant as defined in the *Operating Engineers Act* that is operated principally for one or more than one hospital shall be deemed to be a hospital for the purposes of this Act. R.S.O. 1990, c.H.14,s.1(4).