

Collective Bargaining by Nurses in Canadian Health Care: Assessing Recent Trends and Emerging Claims

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I. Introduction

Since the late 1990s, health human resource (HHR) policy in Canadian health care has been a mixture of consensus and conflict. Consensus appears to have emerged about the broad policy goals for Canadian HHR planning: immediate recruitment and retention goals, and long-term goals of greater cost-effectiveness and productivity from the health care workforce. This consensus has heightened in the wake of the 2003 SARS crisis and other episodes that reminded the broader public — and not just patients — of the courage and dedication of health care workers. This sunny consensus, however, contrasts starkly with the other trend: increasingly rancorous conflict between governments and health professionals on how to achieve these goals. And nowhere has it been as rancorous as in nurse collective bargaining.¹

Throughout most of the 1990s, a time of fiscal constraint and restructuring across the Canadian public sector, health care unions gained little at the bargaining table. In large part, they did not demand much either, sensing a political climate hostile to ambition on the part of public sector employees.² Thus, the 1990s was a period of relative quietude in Canadian health care labour relations. Since the late 1990s, however, ambitions have revived among all health care unions, particularly nurses' unions. Emboldened by more favourable political and labour market conditions, nurses' unions have demanded more hires, higher wages, reduced workload, less overtime, less casual staffing, and other contract improvements. Despite increased resources, governments have been reluctant to meet these demands, citing short and long-term cost consequences. Thus, Canadian health care since 1998 has seen more labour disputes than any other time in recent memory. And these disputes — often involving nurses' unions — have been far more intractable.

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¹In this paper I will use registered nurses as my lead example, though many trends in nursing are typical of, if not central to, HHR policy challenges. I am not dealing with registered practical nurses or licensed practical nurses. In general, RNs and RPN/LPNs in all provinces are represented by different unions.

²Gene Swimmer & Mark Thompson, eds., *Public Sector Collective Bargaining in Canada: Beginning of the End or End of the Beginning?* (Kingston: IRC Press, 1995).

In such disputes, labour law in Canadian health care has traditionally prescribed one of two ways out.³ In one scenario, the parties — and the public — would endure a work stoppage, though usually one in which key essential services are maintained. Whether lawful or unlawful, health care strikes have seldom lasted long before a settlement is reached, or governments legislate an end to the strike and impose the second scenario: binding interest arbitration. Under interest arbitration, a neutral third party decides the outstanding issues in dispute between unions and governments. Since 1998, however, governments appear to be dissatisfied with this traditional script, and some are abandoning collective bargaining altogether in ending disputes.

Among the most colourful of these disputes erupted in Nova Scotia during the summer of 2001. This dispute embodied many of the themes in collective bargaining in the post-1990s health care system. In this paper, I focus on one such theme: an apparently increasing government frustration (not only in Nova Scotia) with collective bargaining at a critical juncture in health care reform, and particularly during a serious health human resources crisis.

With a detailed review of the Nova Scotia dispute and brief outlines of some disputes in other provinces in mind, I explore a deeper issue raised by these episodes: Is collective bargaining the right labour law model for Canadian health care during the HHR crisis? If governments are prepared to abandon collective bargaining in ad hoc, reactive ways — with all the labour relations harms that creates — then they are inexorably drawn to this fundamental question, even if only reluctantly.

This reluctance shows clearly in the utter lack of any direct health policy analysis of this question, something unfortunate yet understandable. For raising the sensitive issue of whether collective bargaining remains the appropriate labour law mode for a “reinventing” system — or even less radical questions — would quickly provoke serious political conflict with nursing and other health care unions. Yet despite governments’ reluctance to address it directly, the question remains important. More claims, albeit mostly spurious and dispute-specific, about the pros and cons of unions in health care are accumulating with each passing labour dispute since the late 1990s. Because such claims appear to be central to the bitterness of recent government-nurse union conflicts, and to radical changes to the labour law model in health care, it seems appropriate to try to gather and consider these claims. That is what I propose to do here.

In my view, while all of these claims are at first appealing, at least in the episodes of conflict they often emerge from, none can act as a reliable basis for prescribing a labour law model for health care. At the least, they do not justify the kinds of radical changes governments are prepared to make in episodes like the Nova Scotia dispute and others like it.

³ Bernard Adell, Allen Ponak & Michael Grant, *Strikes in Essential Services* (Kingston, Ont.: Industrial Relations Centre Press, Queen’s University, 2001).

II. Background: Collective Bargaining in Canadian Health Care

Presently, most Canadian nurses are represented by unions, if only because most of them work in hospitals, which are overwhelmingly unionized. Almost all terms and conditions of their employment are set in central collective bargaining processes in each province. In these structures, governments, employer representatives and unions bargain toward central agreements in the hospital and other health care sectors. These agreements cover most key labour relations issues, although local employers and unions still retain control over minor matters.

A longstanding problem in health care collective bargaining, particularly with nurses, has been reconciling the right of the public to essential health care services with free collective bargaining's insistence on the strike or lock-out as the way to resolve disputes.⁴ In most provinces, the right to strike remains in health care. In some of these provinces, legal restrictions are in place to ensure the maintenance of essential services during work stoppages; others, like Nova Scotia, have no restrictions. Only three provinces — Alberta, Ontario and Prince Edward Island — prohibit strikes with standing legislation. In these provinces, binding interest arbitration is the ultimate method of dispute resolution.⁵ Of these three, however, only Ontario's system (enacted in 1965) has had any significant usage. Alberta has a younger (introduced in 1983) system than Ontario, and to date the parties have never resorted to arbitration.⁶

In Nova Scotia, the province under focus in this paper, two unions currently share representation of the province's nearly 6,000 registered nurses. The first is the Nova Scotia Government and General Employees' Union (NSGEU), which dominates the Halifax area, particularly its new (since 1996) amalgamated Queen Elizabeth II Health Sciences Centre (QEII). The Nova Scotia Nurses' Union, a nurses-only union, represents nurses elsewhere in the province. Although the NSGEU dominates in Halifax, representing 2,300 nurses, the NSNU is still larger overall, with 3,600 members at 38 hospitals in all nine districts. This split in nurse representation makes Nova Scotia somewhat unique. In most provinces, one large nurses' union or a federation of unions bargains with the government at a central table.

⁴Larry Haiven, "Industrial Relations in Health Care: Regulation, Conflict and Transition to the 'Wellness' Model" in Swimmer & Thompson, eds., *Public Sector Collective Bargaining in Canada*, *supra* note 2 at 237: "The holy grail that combines the right measure of 'free collective bargaining' and essential services provision is still being sought."

⁵Alberta *Labour Relations Code*, R.S.A. 2000, c. L-1, ss. 94-102; Prince Edward Island *Labour Act*, R.S.P.E.I. 1988, c. L-1, s. 41; Ontario *Hospital Labour Disputes Arbitration Act*, R.S.O. 1990, c. H.14 [HLDAA].

⁶Adell, Ponak & Grant, *supra* note 3 at 186. The authors' research showed that every bargaining round in Alberta since the no-strike law was introduced "... has proceeded on the assumption that there will be a strike." In that period, the parties had many disputes, including the well-known illegal walkout by nurses in 1988, but the union has steadfastly rejected the interest arbitration process, and it has never been used to settle any disputes.

III. Contexts

a. The Health Human Resources Crisis

It is clear that Canada does not have enough physicians, nurses and many other professionals to meet our growing population's health care needs. Here, and internationally,⁷ the human resource crisis is among the greatest challenges facing health care. It is rapidly growing as a focus of study and concern for health economists and other researchers.⁸ The need for immediate action, including greater public investment, is a refrain familiar to every medicare inquiry in the last five years. While Quebec⁹, Saskatchewan¹⁰ and Alberta¹¹ have all produced comprehensive reports, the most prominent recent studies at a national level have been the *Kirby Report*¹² from the Senate, and the report of the Commission on the Future of Health Care in Canada, chaired by former Saskatchewan premier Roy Romanow.¹³

On HHR policy, Romanow's report warned of shortages and other disturbing labour market trends. Although recognizing that Canada's health professionals remained, despite the wage restraint of the mid-1990s, among the best paid among all OECD nations, Romanow noted that cost containment measures and restructuring "have taken their toll on Canada's health workforce."¹⁴

Nurses make up 35%¹⁵ of Canada's health care workforce, and all the HHR problems that plague the system in general can be found in the nursing profession: shortages, increasing workloads, the "downward" substitution of nurses with

⁷Linda H. Aiken *et al.*, "Nurses' Reports on Hospital Care in Five Countries" (2001) 20:3 Health Affairs 43.

⁸Several health law and policy journals in Canada and abroad have devoted entire issues to HHR problems. See *e.g.* R. Alvarez *et al.*, "Planning for Canada's Health Workforce: Looking Back, Looking Forward" 3:2 Healthcare Papers 12; and responding papers in the same volume.

⁹Québec, Commission d'étude sur les services de santé et les services Sociaux, *Emerging Solutions — Report and Recommendations* (Québec: The Commission, 2001).

¹⁰Saskatchewan, The Commission on Medicare (Kenneth J. Fyke, Chair), *Caring for Medicare: Sustaining a Quality System* (Regina: The Commission, 2001), online: Saskatchewan Health <http://www.health.gov.sk.ca/mc_dp_commission_on_medicare-bw.pdf>.

¹¹Alberta, Premier's Advisory Council on Health (Don Mazankowski, Chair), *A Framework for Reform: Report of the Premier's Advisory Council on Health* (Edmonton: PACH, 2001), online: Premier's Advisory Council <http://www.premiersadvisory.com/pdf/PACH_report_final.pdf>.

¹²Standing Senate Committee on Social Affairs, Science and Technology (Hon. Michael J.L. Kirby, Chair), *The Health of Canadians — The Federal Role: Final Report. Volume Six: Recommendations for Reform* (Ottawa: Senate of Canada, October 2002), online: Parliament of Canada <<http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/repoct02vol6-e.htm>> [*Kirby Report*].

¹³Commission on the Future of Health Care in Canada (Roy J. Romanow, Chair), *Building on Values: The Future of Health Care in Canada — Final Report*. (Ottawa: Commission on the Future of Health Care in Canada, November 2002), online: Health Canada <http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf> [*Romanow Report*].

¹⁴*Ibid.* at 91.

¹⁵*Ibid.* at 92.

lower-paid and less-regulated providers and high absenteeism rates due to illness, injury or stress-related burnout. The Romanow report noted that enrolments in nursing schools are stagnant, and recruiting and retaining nurses is becoming more difficult. Put simply, nursing is less attractive as a career, and the system is suffering as a result.

On the other hand, the Romanow and Kirby reports both stressed that HHR policy involves not only increasing human resources, but using them more efficiently as well. Greater spending must be accompanied by investments in changes in how care is delivered. In his report, Romanow perceived a resistance by entrenched health professions to accept changes in their scopes of practice aimed at greater organizational efficiency. Senator Kirby, in his report, urged reforms to increase the “productivity”¹⁶ of health professionals. In both reports, it is clear that innovation in HHR planning is no less important than increasing public spending to implement it. A return to pre-1990s spending levels on health care must not, goes this view, herald a return of modes of delivery that are technically inefficient.

These twin tensions in HHR policy — investment and innovation — underpin most recent nursing labour disputes. Nurses’ unions are bringing ambitious demands to the bargaining table, most notably more hires, higher wages, reduced workloads and an improved practice environment. They root these demands in HHR values, saying they are necessary to recruitment and retention and to ensuring what they call “quality workplaces” for Canadian nurses.

By the time of the Romanow Report, governments had been acceding to these demands. Since 1998, wage increases for nurses had leapfrogged from coast to coast. In British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, and Newfoundland, nurses secured significant “catch-up”¹⁷ wage increases and new hires. However, this giving spirit did not last, and labour disputes resurfaced.¹⁸ Governments are no longer prepared to meet all the nurses’ unions’ demands. While sharing the unions’ basic HHR goals, governments are beginning to question whether their demands are affordable, or in any case represent good HHR policy. More nurses are needed, but how many? Higher wages are important, but how much higher? What are ideal workload levels from a patient care perspective? What scheduling arrangements are most cost-effective? All of these vital HHR questions are the foundation for most of the collective bargaining conflict witnessed today.

¹⁶ Kirby Report, *supra* note 12 at 186-187.

¹⁷ A reference to the relative wage stagnation in health care — and the broader Canadian public sector — in the 1990s. By 1999, nurses (and most other employees) in some provinces had not had a raise in over five years, and some even longer.

¹⁸ Larry Haiven & Judy Haiven, “The Right to Strike and the Provision of Emergency Services in Canadian Health Care” (Canadian Centre for Policy Alternatives, 2003), online: Canadian Centre for Policy Alternatives <<http://www.policyalternatives.ca/publications/right-to-strike.pdf>>. The authors provide the best available overview of the widespread labour unrest in Canadian nursing since the late 1990s.

b. Managerial and Professional Perspectives on HHR Policy

In most of this conflict, two distinct interests — and perspectives — are in competition: one managerial, one professional.¹⁹ Many of the claims each side puts forth in bargaining can be traced back to one perspective or another. Because they figure prominently in the debate about collective bargaining and health policy, it is useful to explain how each perspective approaches HHR issues and how they clash on particular HHR issues.

First, the professional interests; because health care is inherently labour and skill intensive, professionals are the front-line assets of the system, giving them significant influence over the delivery of care, and over policy. Managerial interests include political parties, governments, bureaucrats, employers and middle managers. These groups are equally committed to delivering timely, effective care, but are also ultimately accountable for the financing and cost-effective management of the system as a whole. Thus, they are acutely concerned with allocating resources among competing and increasing demands for health services.

Among other things, these perspectives differ on the meanings and proper roles of efficiency and cost control in HHR planning. Take, for example, the nebulous concept of “quality of care”.²⁰ The managerial perspective gives more emphasis to bottom-line “health outcomes” in measuring quality, such outcomes including measures of patient satisfaction with the process of care. In the HHR context, this means management decisions at all levels in the system decisions should be measured by their cost-effectiveness; that is, they must have a demonstrably positive impact on health outcomes relative to the resources spent on them.

The professional perspective tends to be at least partly skeptical of such a utilitarian approach to quality, doubting whether “quality” in HHR decision-making can — or should — be measured in a scientific way. To avoid the risks to health outcomes inherent in efficiency-driven HHR policies, goes this view, we ought to — as we traditionally have in Canadian HHR policy until now — focus less on outcomes and more on resource inputs. For these reasons, nurses’ unions generally tend to equate quality with hiring more nurses, paying them more, and resisting casualization and other controversial workplace changes.

¹⁹The managerial-professional dichotomy I offer here is a parallel borrowed from health economist Robert Evans’ dichotomy between two distinct perspectives — which he termed “Naïve Economic” (which in this case I see aligning with managerial perspectives) and “Naïve Techno-Medical” (aligning with professional perspectives) — with differing assumptions about how to determine need in health care and how to model economic analyses in health care more generally: Robert G. Evans, *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworths, 1984) at 21-26.

²⁰A. Donabedian, “Evaluating the Quality of Medical Care” (1966) 44:2 *Milbank Memorial Fund Quarterly* 166. The Donabedian formulation is an oft-cited analysis of quality in health care. He identified three different ways to measure quality in health care: structure (number of providers, their skill), process (how the care is delivered, such as length of visit), and outcomes (objective clinical health results).

Managerial-professional tensions also underpin the gulf between the parties on a good number of collective bargaining issues. Wages are too high or too low, workloads too great or small, all depending on one's role in the system. Less prominent than these examples is the emerging controversy surrounding "flexible" work arrangements in health care. These arrangements include the emergence of "elect-to-work" and other instances of "casualization" in nursing employment. "Casual" employment is distinct from part-time employment in that it does not have regular patterns. A study released in June 2001 reported that only half of Canadian nurses work full-time, down from 75 per cent a decade ago, and that some health institutions have casualized as much as 70 per cent of their nursing hours.²¹

"Elect-to-work" models are a form of casual scheduling in which employees devise their own work schedule according to employer needs. From a managerial perspective, if nurses prefer casual employment and it controls spending without impairing patient accessibility, what is the objection to it? The professional perspective, however, emphasizes the risk that in some cases — in their view, too many — nurses in this employment model may be coerced, overworked or otherwise disadvantaged by such "flexible" arrangements.²² As well, the profession states that casual employment compromises the quality of care by interrupting the continuity of the patient-nurse relationship.²³

Unionized health care employers — most notably hospitals — have long been held by collective agreements to traditional full- and part-time scheduling patterns. In some non-union health care employers, however, casual employment arrangements like these are common. Such employers include the growing number of for-profit firms operating in Ontario's competitive tendering process for in-home nursing care. For these employers, collective bargaining poses a direct threat to these arrangements, and thus to the cost-effectiveness of the care they deliver. In a bitter 1998 dispute at one eastern Ontario for-profit home care firm, the nurses' union's opposition to "elect-to-work" was the central issue. Ultimately, the union won, and the employer closed its operations soon afterward.²⁴ It preferred not operating at all to operating with a union.

²¹ Andrea Baumann *et al.*, *Commitment and Care: The benefits of a healthy workplace for nurses, their patients and the system* (Ottawa: Canadian Health Services Research Foundation, 2001) at 16.

²² The lack of full- or part-time employment in health care was cited by 62.7% of nurses surveyed by the Registered Nurses Association of Ontario as a reason for their decision to leave Ontario for the United States. See Registered Nurses Association of Ontario, "Earning Their Return: When & Why Ontario RNs Left Canada, and What Will Bring Them Back" (Toronto: RNAO, 2001), online: Registered Nurses Association of Ontario <<http://www.rnao.org/html/pdf/survey.pdf>>.

²³ Baumann *et al.*, *supra* note 21.

²⁴ For more detail on this dispute, see Tom Archibald, "Labour Law Under Managed Competition in Health Care: The Ontario Home Care Experience" (2003) 28 Queen's L.J. 581.

IV. Nova Scotia, 2001: Emerging Discomfort with Collective Bargaining²⁵

a. Legislation v. Resignations

By October 2000, when their collective agreements expired, Nova Scotia's unionized nurses were the lowest paid in Canada. The government led by Premier John Hamm, himself a physician from rural Nova Scotia, was facing two determined nurses' unions seeking significant wage increases. While the government was ready to increase wages to recruit and retain more nurses, its opening offer, six per cent over three years, was far less than the unions wanted: the NSNU and NSGEU demanded 25 per cent and 22.5 per cent over three years, respectively.

By May 2001, the government had increased its offer to 8.5 per cent to the NSGEU, and to 10.5 per cent to the NSNU. The NSGEU leadership urged its members to reject the government's offer, while the NSNU urged its members to accept it. The NSNU offer, which would have made Nova Scotia nurses the highest paid in Atlantic Canada, contained a "me-too" clause, guaranteeing the NSNU wage parity with the NSGEU if the NSGEU later secured a higher wage increase.

On May 18, NSGEU nurses followed the union's recommendation and rejected the government's offer. More significantly, NSNU nurses defied their union leadership in rejecting the tentative settlement by a 75% majority. Both votes had very high turnout rates, and by late June, both unions had also taken strike votes showing overwhelming support for strike action to back their demands. In response, Nova Scotia hospitals cancelled over 200 surgeries and closed over 400 beds in just two weeks.

On June 14, the government introduced legislation to pre-empt what appeared to be a looming health care strike. The *Healthcare Services Continuation (2001) Act*²⁶ applied only to Halifax-area health care workers, dividing them into four groups: (a) nurses represented by the NSGEU, (b) other health care workers represented by the NSGEU, (c) Halifax-area nurses represented by the NSNU, and (d) other health care workers in the Halifax area. As originally drafted, Bill 68 removed the right to strike from these employees until March 31, 2004 and prescribed fines against unions and employees for breach.²⁷ It bolstered these penalties by expressly reserving the government's right to seek a court injunction to enforce the legislation,²⁸ and to seek further remedies against unlawful strikes under the *Trade Union Act*.²⁹

²⁵ Information on the Nova Scotia dispute was drawn from the author's research of numerous news reports from local and national media at the time. For the sake of brevity, I will only reference materials on key factual points.

²⁶ S.N.S., 2001, c. 27 [Bill 68].

²⁷ *Ibid.*, s. 9.

²⁸ *Ibid.*, s. 9(4).

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Further, and most controversially, the original draft of Bill 68 gave Cabinet the power to impose collective agreement terms if they could not be bargained.³⁰ The government, in other words, rejected the traditional script of health care collective bargaining by rejecting interest arbitration, the usual alternative to the right to strike. And it was candid about why: a fear that an interest arbitrator would fail to properly account for constraints it faced in health care funding, produce a costly settlement and jeopardize that year's plans to balance the provincial budget and cut taxes.

As poll results showed significant opposition to an imposed settlement, however, the government's predicament worsened. In late June, Ipsos-Reid polled 500 Nova Scotians on the dispute. According to the poll, 75% felt that the government's most recent offer to nurses was inadequate, 62% thought a 25 per cent increase was appropriate, and 78% said nurses were being more reasonable than the government.³¹

Ultimately, only a small part of Bill 68 ever became law. With only one dissenting government vote, the legislation was finally enacted on June 27, but was proclaimed in force only in respect of one group: non-nursing staff represented by the NSGEU. This was prompted by the NSGEU's threat, one day before Bill 68 passed, to take these employees on a wildcat, illegal strike. Registered nurses, very few of whom belonged to this group, were not subject to Bill 68, and thus still had the lawful right to strike. Indeed, bargaining continued throughout the Bill 68 rancour, although the prospects for settlement on wages remained dim. By July, nurses in both unions were poised to commence strikes, causing further disruptions in hospitals and further political challenges for the government.

Far more than any strike threats, however, the relatively extreme tactic of *en masse* resignations broke the bargaining impasse. At a meeting in late June, the NSGEU passed resolutions for its nurse and health care worker bargaining units to set its mass resignation campaign in motion. Under the resolution, the union sent *pro forma* resignation letters to its members for them to sign and return. Those who signed letters had two days to change their minds before the letters became final and binding. If 75% of the total membership did so, the resolution required the union to tender the letters to the government and call on all remaining members to resign as well. NSGEU nurses tried to raise this threshold to 80 per cent, but their amendment was voted down. Further, the turnout for this meeting was mild: less than half of the NSGEU's 2,300 nurses, and less than one-third of its 2,900 other health care workers, attended.

As such, it cast some doubt on whether registered nurses in the NSGEU — a union dominated by non-professional staff — really supported the NSGEU's

²⁹ *Ibid.*, s. 10.

³⁰ *Ibid.*, s. 6., until March 31, 2004.

³¹ Shawn MacKinlay "Nova Scotians side with nurses: poll" *Halifax Daily News* (27 June 27 2001) 4.

radical threat. The head of Halifax's regional health board, the Capital Health Authority, expressed concern that some nurses were being "coerced and intimidated by their union to sign."³² But this doubt vanished when the union reached the 75% threshold in the nurses' unit in less than a week. "None of us wanted to do this mass resignation, but none of us could stand to go on with this dictatorship, either," said one militant NSGEU nurse.³³

b. "Final-Offer" Selection

Facing mass resignations from one nurses' union and a lawful strike from another, the Hamm government relented and agreed to settle the wage dispute by binding arbitration. It entered into an agreement with the unions under which it agreed not to proclaim Bill 68 in force, or enforce it, against them in exchange for their consent to settle the issue by a form of arbitration called "final offer selection" (FOS).

Under conventional interest arbitration, both parties make submissions on the remaining issues in dispute, and arbitrators fashion awards that reflect their judgments of a fair compromise between the parties. Under FOS, the jurisdiction of the arbitrator (sometimes called the "selector") is limited to choosing between the final offers of each side. "Package" FOS only permits selectors to choose one side's offer in its entirety, whereas "issue-by-issue" FOS allows selectors slightly more freedom to choose the employer's offer on one issue and the union's on others.

Final-offer selection struck a compromise between the two sides on how to determine the wage question. For the unions, neutral adjudication was essential. For the government, no form of arbitration was acceptable at first. Indeed, both the Premier and Minister of Health at that time candidly expressed concerns that leaving the question to conventional interest arbitration was too financially risky.³⁴

The appeal of FOS stems from two traditional complaints by labour law practitioners about conventional interest arbitration: first, that it acts as a drag on settlements, and second, that its settlements are seldom satisfactory to the parties.³⁵

³² Shawn MacKinlay "Any backup plan inadequate in face of exodus — authority" *Halifax Daily News* (4 July 2001) 4.

³³ Shawn MacKinlay "Nurses, health workers breathe sigh of relief" *Halifax Daily News* (6 July 2001) 5.

³⁴ Pat Connolly "Tories reached too far: We would have accepted Bill 68 if it had allowed arbitration" *Halifax Daily News* (7 July 2001) 2. A senior Nova Scotia cabinet minister remarked that arbitration was rejected because of "the risk factor involved in any settlement that would cost more than the government can afford to pay in our present circumstances."

³⁵ For a review of the labour relations implications of interest arbitration, see D. Johnston & I. McKenna, "Public Interest Disputes and Compulsory Arbitration: A Case Study of Hospitals in Ontario" (1975) 7 *Ottawa L. Rev.* 503. See also the trilogy of articles in [1994-95] *Labour Arbitration Yearbook*: Janet Solberg, "The Pros and Cons of Interest Arbitration: A Union Perspective" [1994-95] *Labour Arbitration Yearbook* 409; Douglas C. Stanley, "The Pros and Cons of Interest Arbitration: An Arbitrator's Perspective" [1994-95] *Labour Arbitration Yearbook* 417; and Thomas G. Schulz, "The Pros and Cons of Interest Arbitration: An Employer's Perspective" [1994-95] *Labour Arbitration Yearbook* 429.

By limiting the potential arbitrator's discretion to a choice between final offers, FOS increases the risks of non-settlement for both sides. Notionally, this will encourage each side to negotiate "better" (in other words, to make concessions). As well, limiting an arbitrator's discretion in this way may go further than conventional arbitration in lending credibility to awards. Certainly, any selection will disappoint the losing party; but it will equally please the other. Moreover, limiting arbitral discretion to choosing between positions lessens the perception of third-party interference. Only under FOS can it be said that the agreement resulted only from "the parties", even if this really means only one side's proposal.

The Nova Scotia FOS simply involved one issue: wages. Clearly, decisions about compensation rates for nurses are vital health policy issues. Though not the only factors in nurse recruitment and retention trends, wage levels can nevertheless have profound effects on the supply and distribution of nurses, both within and between provinces. Indeed, wages represent the coldest of bottom-line health policy decisions. If they are too low, the nursing shortage will persist; if excessive in relation to actual need, they waste valuable public resources that could be allocated to other parts of the health care system, or to investments in meaningful structural reform.

With a controversy like this, it was not surprising that, finding a willing and qualified adjudicator to answer this issue proved difficult for the Nova Scotia Department of Labour. Above all, the adjudicator had to be someone agreeable to both parties and who had no personal connection to the health care sector, whether through personal or professional relationships. The first two adjudicators approached refused, citing connections to health care or, in one case, to feeling "under the weather."³⁶

The FOS process failed to produce an agreement. Prior to the FOS on July 5, the NSNU had maintained its 22.5% demand. The NSGEU actually increased its demand to 27.5%. The government held fast to its offer of 10.5%. Their official final offers on the eve of the FOS hearings were 17% and 12%, respectively.

To select between these offers, the Minister of Labour ultimately turned to an established labour lawyer and arbitrator, Susan Ashley. Soon after her appointment on July 17, the parties met to determine procedural matters. Hearings were held August 3 and 4, at which extensive briefs were submitted and argued by both sides. The agreement appointing Arbitrator Ashley required her to select the wage rates for three groups: registered nurses (in both unions), licensed practical nurses (in both unions) and non-professional health care workers (in the NSGEU). It required Ashley to ensure "general equity in wages" as between employees in each of the three groups.

³⁶Brian Flinn "Province can't find arbitrator: Few Nova Scotians seem interested in lucrative job settling health-care dispute" *Halifax Daily News* (12 July 2001) 4.

Arbitrator Ashley found in favour of registered nurses, and against all other groups.³⁷ In reaching her decisions, Ashley considered a number of traditional labour law principles concerning how interest arbitrators — or final-offer selectors — decide. One is “replication”, which means the arbitrator must strive to replicate “as closely as possible the agreement that would have been reached if the parties had engaged in free collective bargaining with the right to resort to a work stoppage.”³⁸ However, she recognized the difficulty of doing so in such a unique dispute:

...none of the above [replication] cases deal with a situation where, as here, legal and/or illegal strikes had taken place, where legislation had been passed not only to end the strike but to impose the terms of the contract without resort to some sort of arbitration mechanism, and where the parties had not bargained with the anticipation that outstanding issues would ultimately be resolved by FOS. Rather, FOS was introduced into the collective bargaining relationship of these parties at the very last hour.³⁹

Thus, Arbitrator Ashley rejected the strict replication test in favour of a “reasonableness” analysis.

The “reasonableness” principle requires an arbitrator to “find against the party that advocates the less reasonable offer.”⁴⁰ This refers to how reasonable each party’s positions are (or ought to be) in the eyes of the other. Arbitrator Ashley’s analysis of reasonableness took into account four “objective factors”: (1) comparability, (2) recruitment and retention, (3) economic indicators, and (4) ability to pay. On these points, both sides submitted extensive briefs containing research into the current state of nursing in Nova Scotia and current challenges, foremost among them the shortage of nurses.

On “comparability”, the unions argued that Nova Scotia nurses ought to have wage parity at least with nurses in other Atlantic provinces, if not with those in the rest of Canada. The government urged the broader Nova Scotia public service as a comparator group. On “recruitment and retention”, Ashley underscored the seriousness of the nursing shortage in Nova Scotia, and thus adopted the union’s broader, occupational approach to comparability, stating that “...it may be more

³⁷ *Nova Scotia Government and General Employees’ Union v. Nova Scotia (Final Offer Selection)*, [2001] N.S.L.A.A. No. 13 (Ashley) (QL) [Ashley Award].

³⁸ *Ibid.* at para. 19. Other leading arbitration awards on this point are: *Re Building Service Employees, Local 204 and Welland County General Hospital* (1965), 16 L.A.C. 1 (Arthurs/Wren/Cromarty), *Re Canadian Union of Operating Engineers, Local 101 and Grace Hospital, Toronto* (1966), 17 L.A.C. 233 (Arthurs/Miller/Middleton), and *Re Canadian Union of Public Employees, Local 576 and Trustees of Ottawa Civic Hospital* (1969), 23 L.A.C. 145 (Schiff/Wright/Reid).

³⁹ *Ashley Award*, *ibid.* at para. 22.

⁴⁰ *Ibid.* at para. 24.

appropriate to use a broader standard of wage comparison were recruitment and retention of the particular workers are a concern.”⁴¹

In submissions on “ability to pay”, the government strongly urged Ashley to give great weight to its current fiscal situation, particularly in relation to public funding for health care. The unions argued that interest arbitrators are generally reluctant to be bound by such criteria, and cited a line of awards to support this claim. To the unions, and many in the labour arbitration community as well, “ability to pay” and other criteria lessens interest arbitration’s legitimacy as a dispute resolution process by appearing to make arbitrators agents of broader government fiscal policy.⁴²

Arbitrator Ashley’s approach to ability-to-pay fell somewhere between these views. While taking notice of the province’s fiscal circumstances, she cautioned against adopting its position without holding governments to account for their funding decisions in health care:

While a Government has considerable scope in the political choices it can make in determining what to fund and to what extent it will be funded, it must be seen to exercise those choices responsibly, fairly and on the basis of some rationally based criteria. One must not accept the Employer’s ‘ability to pay’ argument without careful scrutiny, but it is a factor which, like the other factors, must be considered and given the appropriate weight in the circumstances.⁴³

Unfortunately, Arbitrator Ashley did not develop this point further to delineate what criteria and circumstances would be used to assess the government’s economic claims. Still, it represented a departure from traditional hostility to external guidelines in the labour arbitration process.

Ultimately, Arbitrator Ashley found that the government’s economic claims did not outweigh the province’s nursing recruitment and retention problems. In reaching this conclusion, Ashley noted that the province was already “...willing to put a considerable amount of money forward to address the very real problem of recruitment and retention.”⁴⁴ No such crisis existed in regard to LPNs and other health care workers, she observed, so she selected the government’s final offer to these groups.⁴⁵ Ashley recognized that this decision would further widen the wage gap between registered nurses and LPNs, and expressed concern that this may encourage employers to shift more work from RNs to LPNs.⁴⁶

⁴¹ *Ibid.* at para. 29.

⁴² Two leading labour arbitration awards on this point are *Re Newfoundland (Treasury Board) and N.A.P.E.* (1995), 52 L.A.C. (4th) 250 (Buffett/March/Powell) and *Re McMaster University and McMaster University Faculty Assn.* (1990), 13 L.A.C. (4th) 199 (Shime).

⁴³ *Ashley Award*, *supra* note 37 at para. 39.

⁴⁴ *Ibid.* at para. 48.

⁴⁵ *Ibid.* at para. 53.

⁴⁶ *Ibid.* at para. 55.

c. Aftermath

Arbitrator Ashley's award was received warmly by nurses and decried by LPNs and other health care workers. Though the government was slightly disappointed with the nurses' award, it was able to manage the cost increase by reconsidering its tax-reduction policies and other spending priorities. However, the political and labour relations costs of the dispute itself were considerable. Premier Hamm conceded in an interview after the dispute that he had lost "political capital" with voters because of the 10-month crisis, and that repairing relations with the nurses' unions and the profession itself would not be easy. In his view, the unions would not have accepted FOS if Bill 68 had originally provided for it, because of their strident objection to the Bill's removal of their right to strike. Thus, when it was offered, FOS became a concession to the unions in exchange for calling off the mass resignation. However, the Premier denied that this was a bargaining tactic, saying that throughout the dispute the government was leery of any form of arbitration.⁴⁷

The dispute soon raised questions about how to prevent such a rancorous conflict in future. However, the wide divergence of opinion between the government and nurses' unions on how to resolve their dispute did not bode well for the prospects of designing a model for future disputes. Well before the Ashley award, the government announced plans to enact standing essential services legislation to replace Bill 68, but had not yet drafted it. After the dispute, the government convened a special inquiry to consider changing the collective bargaining system.⁴⁸ Chaired by labour lawyer and arbitrator Milton Veniot, the inquiry was mildly welcomed by the nurses' unions.

d. Other Episodes

The most unique thing about the Nova Scotia dispute was the government's candid and adamant opposition to resolving the dispute by conventional interest arbitration. As noted above, collective bargaining disputes in Canadian health care have generally ended by some combination of strikes, settlements or neutral arbitration. Here, the government was decidedly opposed to these options, and thus to collective bargaining in health care itself. It may be tempting to suggest that the Nova Scotia government's radical posture resulted more from its "have-not" status than from any deeper concerns with collective bargaining itself. However, much wealthier provinces have done similar things, in different ways, before and since the 2001 dispute in Nova Scotia.

⁴⁷D. Rodenhiser "Hamm on the Bill 68 fiasco: It was worth it: The premier says the unions would never have gone for Thursday's arbitration deal if he hadn't first threatened them with the anti-strike legislation" *Halifax Daily News* (8 July 2001) 17.

⁴⁸C. Nicoll "Health unions grudgingly approve of lawyer hired to run inquiry" *Halifax Daily News* (18 August 2001) 8.

In 1998, the Ontario government showed a clear discomfort with its existing interest arbitration system by choosing arbitrators in a new way. Ontario public hospitals bargain in a voluntary central bargaining structure with each of the main unions representing nurses, allied health professions and support staff.⁴⁹ Under the Ontario statute, the Minister of Labour must appoint a chairperson for tripartite interest arbitration boards where the parties fail to do so consensually.⁵⁰ There are no legislative constraints on the Minister's choice, but for many years Ministers of Labour had followed several conventions in making *HLDA* appointments. One of these conventions was to select a chairperson from a group of familiar and trusted Ontario labour arbitrators. This group is sometimes called the "Section 49" roster.⁵¹ In the 1998 central round of hospital bargaining, however, the Minister ignored the Section 49 convention and offered the appointments to four retired judges. This led to judicial review proceedings by the unions, which culminated in a recent Supreme Court of Canada decision.⁵² In that case, the Court held that the government's appointments were patently unreasonable.

In 2001, where Nova Scotia relented in the face of a mass-resignation threat, Premier Gordon Campbell's Liberal government in British Columbia did not. At roughly the same time as the Nova Scotia dispute unfolded, B.C. nurses also threatened mass resignations if the government went ahead with plans to reject arbitration and unilaterally impose terms by legislation. But the B.C. government did not flinch. It passed statutes ending the dispute and imposing the government's final offer as the new collective agreement.⁵³ In other words, the British Columbia government abandoned the entire collective bargaining process in 2001.

Most recently, in late 2003, a serious dispute emerged between Alberta's nurses' union and the province's health authorities. The key points of conflict were not wages, but management demands to reduce collective agreement restrictions on new, more flexible scheduling policies they wish to implement. In his mediation report, Arbitrator Alan Beattie remarked at the dim prospects for settlement on these issues, and at the likely outcomes of the dispute.⁵⁴ Without a settlement, the only

⁴⁹The main unions in Ontario hospitals at present are the Ontario Nurses' Association (representing registered nurses), the Association of Allied Health Professions of Ontario (allied health professions), the Ontario Public Service Employees' Union, Canadian Union of Public Employees and the Service Employees' International Union (support staff and registered practical nurses).

⁵⁰*HLDA*, *supra* note 5, s. 6(5):

Where the two members appointed by or on behalf of the parties fail within ten days after the appointment of the second of them to agree upon the third member, notice of such failure shall be given forthwith to the Minister by the parties, the two members or either of them and the Minister shall appoint as a third member a person who is, in the opinion of the Minister, qualified to act.

⁵¹After Section 49(10) of Ontario's *Labour Relations Act, 1995*, S.O. 1995, c. 1, Sch. A, under which the roster emerged.

⁵²*C.U.P.E. v. Ontario (Minister of Labour)*, [2003] 1 S.C.R. 539, 304 N.R. 76, 226 D.L.R. (4th) 193.

⁵³*Health Care Services Continuation Act*, S.B.C. 2001, c. 23 [repealed August 9, 2001]; *Health Care Services Collective Agreements Act*, S.B.C. 2001, c. 26.

⁵⁴The key issues are outlined in the mediators' report: Alan V. M. Beattie, *Re Negotiations for the Collective Agreement between the United Nurses of Alberta and Provincial Health Authorities of*

options appeared to be either binding interest arbitration, or an illegal strike (threatened or real) followed by special legislation imposing the final terms of the collective agreement. Alberta's nurses' union, however, has never accepted nor participated in the binding interest arbitration process, a tradition continued by the 97% rejection of Arbitrator Beattie's settlement proposal, which awarded many of the changes asked for by management.

As of this writing, then, the 2003 nurses' dispute in Alberta is poised to continue the serial labour conflicts plaguing Canadian health care. As in British Columbia in 2001, Alberta's 2003 dispute is unfolding in a decidedly wealthy province. It arises not out of any serious pinch in public funding, nor a wide gap on wages. At stake are fundamental issues of how to organize and manage the health care workforce, and on these questions both parties appear prepared to join in a political clash of wills. Unless a settlement emerges, the grim prospect of Alberta adopting what Arbitrator Beattie called the "British Columbia approach" (imposing a settlement unilaterally) looms nearer.

Like the Nova Scotia dispute, these episodes show a clear intention by some governments to circumvent collective bargaining not for "exceptional" reasons, but to further their health policy goals. Certainly, there is nothing new in government suspension of collective bargaining in health care or other public services, but all previous instances of it have generally involved "exceptional" episodes of fiscal restraint premised on the need to address concerns with budget deficits, inflation or other discrete crises.⁵⁵ In health care at present, this apparent urge to confront collective bargaining is unfolding at a time of relative resource plenty. As a rationale for challenging or suspending collective bargaining in health care, it has far more sustainability than those offered in earlier episodes of "exceptionalism" in public sector collective bargaining.

V. Collective Bargaining: Possible Health Policy Claims Against — And For

What governments really think of collective bargaining in health care is obviously an exercise in speculation, because direct references to collective bargaining, labour law or even unions are rare in mainstream health policy discourse. No wide ranging clamour has emerged against unions in health care, and governments are leaving the subject of collective bargaining alone for the moment — aside from the radical, ad hoc measures outlined above. This is understandable, given the controversy any wide-ranging project of labour law reform would provoke with health care unions and the union movement generally.

Alberta: Recommendations of the Mediator (July 18, 2003), online: Provincial Health Authorities of Alberta <<http://www.phaa.com/Bargaining/index.htm>>.

⁵⁵ See Leo Panitch & Donald Swartz, *The Assault on Trade Union Freedoms: From Wage Controls to Social Contract* (Toronto: Garamond Press, 1993).

Yet, the question remains important, because if our labour law model regulates the health care labour market in ways inimical to emerging HHR policy goals, then reforming it should be a part of the health reform agenda. On the other hand, there may be no convincing basis for reform. Here I will sketch out some of the possible claims that might emerge if it this question were made an explicit part of health policy.

a. Against Collective Bargaining

It is fair to say that, from a strictly managerial perspective, collective bargaining represents a fundamental incursion into employers' otherwise unfettered management rights to control and direct their workforce. When employers undertake large-scale workplace restructuring to enhance productivity or contain costs, their freedom to do so can be seriously impeded by the constraints of a collective bargaining relationship. As similar kinds of restructuring now emerge in Canadian health care, governments and health care employers seem similarly concerned about the regulatory barriers posed by collective agreements and nurses' union power to the success of these health reform measures. In short, control over the health care workplace is now a hotly contested terrain and where nurses' unions are strongest — in the hospital sector — it is becoming the source of ongoing controversy.

Further, governments seem to be concerned that health professions may use collective bargaining to retrench their roles in the system and translate their already formidable political and economic strength into financially unsustainable wage increases and other contract improvements.

Yet it is not only governments who seem uncomfortable with collective bargaining. In his 2002 report, Roy Romanow singled out large wage increases for nurses in certain provinces for criticism, saying they not only increased costs but also increased the recruitment and retention problems for less affluent provinces that cannot keep pace.⁵⁶ Both the Romanow and Kirby reports also called for wide-ranging reforms to streamline and reduce the cost of health care work. In line with these views, some health policy analysts have also warned that “catch-up” wage demands and the overall power of professional groups are likely to complicate the attainment of the systemic changes needed to make health care sustainable in the long-term.⁵⁷

These analyses resemble the “reinventing government”⁵⁸ school of thought, a popular trend in public policy for a time in the 1990s. Even a casual reading of

⁵⁶ *Romanow Report*, *supra* note 13 at 101-102.

⁵⁷ Carolyn Tuohy, “The Costs of Constraint and Prospects for Health Care Reform in Canada” (2002) 21:3 *Health Affairs* 32.

⁵⁸ David Osborne & Ted Gaebler, *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector* (New York: Plume, 1993).

almost any writings from this body of work will quickly disclose a clear antipathy to unions, collective bargaining and regulation in public sector enterprises. From this perspective — which gained the attention of some Canadian law-and-economics scholars in the early and mid-1990s⁵⁹ — public sector unions are slow moving, self-interested special interests standing in the way of progress. As much as “reinvention” has dominated Canadian health policy, it has not yet aimed such barbs at unions. Rather, it has merely portrayed certain trends in collective bargaining — wage increases, less flexibility and productivity, and resistance to change from “special interests” — as inimical to the financial health of the system, and left the broader labour law system in which they unfold unaddressed.

There is little doubt that Canadian nurses gain a lot of political strength through collective bargaining. There is also little doubt that most traditional collective agreements in health care currently contain restrictions on many of the structural changes called for by HHR policy. Achieving greater flexibility in scheduling, work organization and the allocation of various providers within an increasingly integrated health care system would be a great deal easier, goes the managerial viewpoint, without these restrictions.

Another claim against collective bargaining might say it’s redundant in light of the nursing profession’s current economic and political strength outside the collective bargaining system. That is, collective bargaining runs the risk of giving nurses too much power in the system as a whole. Therefore, this argument goes, a decline in collective bargaining power for professionals would restore a much-needed balance of power between governments, employers and the nursing profession.

b. For Collective Bargaining

Although they have some intuitive appeal, these critiques remain unconvincing as a basis for removing collective bargaining altogether. Their main weakness is in drawing a direct causal link between collective bargaining and the soundness of HHR decisions. This error occurs at both workplace- and system-level attacks on collective bargaining.

At the workplace level, it is tempting to draw links between collective agreement rules and organizational efficiency in health care firms, but difficult to establish them. First, it must be established that a particular rule — such as traditional scheduling patterns or restrictions on assigning nursing work to non-nurses — results in a particular set of practices or modes of work. Then, it must be established that these practices are not “best practices”. To draw a causal link from rules to practices, and from practices to the cost-effectiveness of care, is not always

⁵⁹For an analysis of “reinvention” strategies for Canadian governments, including contracting out and privatization, see Michael J. Trebilcock, *The Prospects for Reinventing Government* (Toronto: C.D. Howe Institute, 1994).

easy, given the inherently value-laden nature of most HHR decision-making. For issues like “elect-to-work” models and other flexible work structures, whether these links are convincing or not will depend on who you ask. Both managerial and professional interests can marshal evidence showing that casual employment models are, or are not, good HHR ideas.

So too at the “political bargaining” level between these interests. Put simply, it is difficult to draw a causal link between collective bargaining and any labour market trends. This is particularly true in the HHR crisis. Currently, the raw demand for nurses is pushing the price of their labour up, so parsing out the impact of collective bargaining from these broader economic forces is impossible. The wage increases decryed by Romanow and others may well have happened regardless of collective bargaining.

In fact, a case might even be made, on no more evidence, that collective bargaining is actually a force of wage *restraint*. That is, in each province collective bargaining can be seen as a central price setting mechanism for health human resources. Without it, competition for HHR might well inflate wages far faster. Just as countries and provinces are competing to attract the “human capital” of health care (nurses and physicians), competition also exists between rural and urban regions within provinces, between hospitals within regions, and also between hospitals, other institutions and the growing home care sector. Without the economies of scale and stability afforded by collective bargaining on a province-wide basis, it might be argued, this multi-tiered competition could quickly escalate health care costs far faster than militant nurses’ unions. Further, this escalation may well occur in far more obscurity, as actual wage rates would be far more difficult to even measure, much less compare or assess, without the transparency and parity supplied by collective bargaining.

Also, to decry increased labour costs contradicts clear demands in the Romanow, Kirby and other reports for greater spending on HHR. It also contradicts a well-known fact about labour costs: they always rise, gradually or not, if only due to inflation’s impact on wage demands. After a certain point, despite cost control demands from governments, middle managers in the system cannot squeeze any more productivity out of their workforce within current funding levels without impairing the quality of care. There is a real risk that, after a certain point, savings generated by workplace restructuring and other innovation-driven measures will be negated and perhaps exceeded by an erosion in the quality of care. At the least, such austerity has so far directly caused the HHR problems witnessed across the health care workforce since the mid-1990s. To object to regulatory mechanisms solely because they might force the government to increase funding levels is, at the least, counterintuitive in this context.

Further, just as one can doubt the claim from nurses’ unions that the strength they gain from collective bargaining is necessary to enable them to “stand up” for patients, so too could one doubt the notion that greater managerial power is desirable. There is no reason why government HHR decisions taken in the absence of challenge by nurses’ unions are necessarily better. Just like professional organi-

zations, governments and health care employers also have incentives for self-serving behaviour.

Being a manager anywhere in the “reinvented” public sector today is difficult⁶⁰, and particularly so in health care. In the current environment, politicians, bureaucrats, firms and middle managers have incentives to show immediate cost control to political superiors and voters. As such, there is a temptation to portray as cost savings what are really a shifting of costs to providers and patients. Reducing spending by cutting back the number of nurses and the quality of their working lives may create short term savings when, in fact, the costs have only been shifted to nurses in the form of more overtime and increased workloads.

In this context, collective bargaining might actually be good for health policy by improving the political balance of HHR decision-making. The importance of preserving at least a rough balance of power between the managerial and professional perspectives at the workplace level flows from the fact that each interest is a necessary check on the other. Managers are needed to test the profession’s claims of medical need for a given HHR decision by asking for evidence of effectiveness in terms of health outcomes. However, collective professional voice in the workplace is an equally necessary — and ideal — counterpoint to management choices that they claim pose risks to the quality of care. Where one set of interests dominates a debate to the near-exclusion of the other, there exists an immediate danger of a conflict of interest between the public interest and the self-interest of the group dominating the decision-making.

Further, from a professional perspective, collective bargaining might be seen as an important (although far from ideal) “voice”⁶¹ mechanism for nurses that can improve recruitment and retention in nursing. While they currently enjoy strong political and economic power beyond the immediate setting of the workplace, their workplace-level voice will be far weaker if collective bargaining declines. Without it, immediate issues they raise about workload, skill mix and other aspects of their working lives may well go unheard. Being able to address these issues with management through collective bargaining or the grievance process offers voice as an alternative to exit, thus reducing turnover. In sum, there is no reason to prefer a professional workforce disenfranchised from collective bargaining to one that is not, because there is no basis to presume that the ascension of managerial dominance at the workplace level will necessarily lead to more progressive HHR decisions.

Yet, as with the claims against collective bargaining, those in favour of it also suffer from difficulties of causation. The difficulty in linking collectively bargained workplace rules to the interests of patients, mentioned above, equally faces the

⁶⁰ Harry Arthurs, “Mechanical Arts and Merchandise: Canadian Public Administration in the New Economy” (1997) 42 McGill L. J. 29.

⁶¹ Albert O. Hirschman, *Exit, Voice and Loyalty: Responses to Decline in Firms, Organizations, and States* (Cambridge, MA.: Harvard University Press, 1970).

professional perspective. The debate about casual employment displays this problem well. As mentioned above, to nurses' unions casual employment increases the cost-effectiveness of scheduling at the cost of continuity of care. Where work once performed by a single full-time nurse is divided among a number of casual nurses, patients become unfamiliar with their providers. Casualization, in other words, weakens the vital personal relationship between patient and nurse.⁶² To governments and employers, however, compelling evidence of links between casual employment and continuity, and between continuity and health outcomes, does not yet exist. In this and other examples, using "quality of care" as a basis for workplace design is a decidedly unscientific and value-laden process, if only because so many other factors besides work rules bear on patient health outcomes.⁶³

The same observation applies to arguments in favour of collective bargaining at the broader HHR decision-making level. While preserving a relative balance of power between nurses and governments at a sensitive time in health care reform makes intuitive sense, it is another question entirely whether this means collective bargaining is the best way to achieve this balance. First, does collective bargaining actually lead to an overall improvement in nurses' wages and working conditions? Probably. Yet this does not mean these improvements could not have been won without collective bargaining. That is, giving nurses more voice and respect makes health care sense, but whether collective bargaining is necessary for this is another matter again. As mentioned earlier, competition is currently rife in health care between provinces, regions and institutions to be the "employer of choice" in health care. Governments have more than enough incentives outside collective bargaining to give nurses most of what their unions are demanding. This may not make collective bargaining redundant and harmful, as governments may claim, but it does suggest that it may not be as central to improving recruitment and retention efforts as nurses' unions might claim.

VI. Conclusion

Health policy ought to be made explicitly. Here, I have tried to make explicit a policy theme that seems to run through disputes like those seen in Nova Scotia. While the relationship between health care labour market policy and the current regulatory model for those markets has remained off the formal health policy agenda, the repetition of such episodes suggests it is emerging implicitly. Despite the importance of HHR policy to health care's sustainability, and the preparedness of Romanow and others to carefully analyze the many factors that bear on HHR policy, labour law never makes the list. This may be due to the political risks involved in any labour law reforms, but this may be only part of the explanation.

⁶²Baumann *et al.*, *supra* note 21.

⁶³Robert G. Evans & G. Stoddart, "Producing Health, Consuming Health Care," in Robert G. Evans, Morris L. Barer & Theodore R. Marmor, eds., *Why Are Some People Healthy and Others Not?* (New York: Aldine de Gruyter, 1994) 27.

Because we have a traditional, familiar labour law model in health care, it has perhaps come to seem almost immutable. Health policy thinkers, like society generally, seem to see the current collective bargaining-centred labour law model as a “natural” part of the broader legal landscape. Health care employees are still employees, goes this view, and in our society they can form unions and go on strike to press their demands if they choose to.

Yet this view misses the important point that collective bargaining is but one of many possible approaches to labour law. Until health policy realizes there is a choice of models, and that this choice matters, the issue will remain unaddressed except in sporadic, reactive ways like those seen recently in Nova Scotia, B.C. and Ontario. Further, even if the deeper anti-collective bargaining urges that seem to drive government choices in these *ad hoc* episodes are well-founded in health policy terms, they still do not make these episodes an ideal way of going about reform. Changes as radical as unilateral imposition of terms represent a clear discomfort with collective bargaining. Rather than continuing to express this discomfort in sporadic, crisis-driven ways, governments ought to do what seems politically dangerous and approach the question of how labour law should look in health care in a coherent way. Evidence may someday convince us that change is needed, but for now all we have is a poverty of debate and a wealth of disputes in which untestable claims are traded.