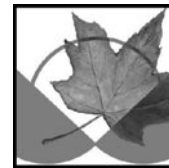


The Right to Strike in Nova Scotia Series



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“The Right to Strike in Nova Scotia Health Care: Issues and Observations” is a 3-part series that examines the right to strike for public sector workers in the context of Government of Nova Scotia’s stated intention to introduce legislation to remove that right from health care and community service workers.

In our first article “A Tale of Two Provinces”¹ we compared Nova Scotia (where health care strikes are legal) and Alberta (where they have been outlawed since 1983). Over the twenty-four years there has been more than fifteen times as much strike activity in Alberta acute-care as in Nova Scotia (proportional to their populations). Study of several other provinces and sectors also underlines the folly of hoping to prevent strikes by banning them.

The third article, to come, will deal with the efficacy of arbitration, especially in dealing with one of the most challenging problems in health care today – the recruitment and retention of key professional staff.

The present article, the second in the series, addresses beliefs by strike-ban proponents about the level of disruption to health care caused by labour disputes, particularly in light of their assertions that the system is stretched too tightly to tolerate strikes.

Health Care Strikes: “Pulling the Red Cord”

Judy Haiven and Larry Haiven

Introduction

To reinforce the Nova Scotia government’s decision to ban strikes, Labour Minister Mark Parent says that the province’s health care system has such “tight tolerances”² that it cannot withstand any labour disruption. This article addresses that contention in four ways:

First, we examine precisely those tight tolerances of health care delivery and conclude that they constitute what can be described as “management-by-stress,” an approach totally antagonistic to effective health care delivery and to preparation for the uncertainties to which health care is susceptible. Where once financial and physical resources were the main buffer against system failure, this role is now borne by health care workers. We contend that the right to threaten or implement a work stoppage is the only effective mechanism workers now have to warn employers and the public of impending problems – a mechanism that the government and employers wish to remove.

Second, we dispel the notion that strikes are total withdrawals of labour. All strikes involve the provision of emergency services. We discuss a recent example of such an agreement, in precisely the dispute touted by the proponents of the total legislative ban to justify their initiative – the April 2007 stoppage at the Izaak Walton Killam Health Centre (IWK) in Halifax.

Third, on the topic of emergency services, we explore the use of compulsion to designate who shall remain at work during strikes, and conclude that more, rather than less, voluntarism better protects the public interest.

Finally, we question just how disruptive labour disputes are to the health care system and determine that it is too easy to

confuse inconvenience with disruption and to overstate the level of disruption. It is far better for governments to acknowledge that strikes in health care are a fact of life and to use that as a basis for cooperation between unions and employers. This will do much to ensure that these events are not only manageable but well managed.

Tightening Resources

While Minister Parent warns of the tight tolerances in the health care system, he mentions only the disruptions caused by labour disputes.³ Computer glitches, winter storms, and other non-medical emergencies arguably disrupt health delivery far more.⁴

Yet in stressing the tight tolerances, the Minister is not wrong. Around the province there is much evidence that important services are indeed overloaded. A few examples demonstrate just how critical the situation is. Exhausted doctors in rural intensive care units last summer threatened to withdraw their services⁵ and the situation has proven to be not just a summer occurrence.⁶ As of last November, in the pain clinic at Queen Elizabeth II Health Sciences Centre, “the waiting list grew to 1,400 patients, some of whom had been waiting up to five years to get in.”⁷ People in Digby and other centres have had only limited access to their hospital’s emergency room due to staffing shortages.⁸ The system is so taut and fraught that the *Halifax Chronicle-Herald* felt justified in entitling a front-page article “Staffing shortages now a hospital epidemic.”⁹

To emphasize the disruptive impact of the IWK strike, strike-ban proponents claim that the cancelled appointments at the IWK had taken a year and a half to schedule. If in fact this is true, the question that really begs to be answered is not whether we should ban strikes but why the health care system is operating on such painfully tight tolerances.

It should be noted that the pressures have occurred not because we can no longer afford any more slack in our health care system. GDP per capita is a common way of measuring just how wealthy a political entity is. Using that measure, Nova Scotia is more than 66% richer

than we were twenty-six years ago, in health care’s heyday,¹⁰ when few complained that the system was not affordable. If we could afford public health care in 1981, we should be better able to afford it now. The major problem is that Canadian governments have deliberately starved our public services, and Nova Scotia is no exception. Health care economist Robert Evans has calculated that by cutting personal and corporate income taxes over the seven years since 1996, federal and provincial governments slashed \$170.8 billion from public sector revenues.¹¹ While Nova Scotia has not been the biggest tax-slasher,¹² our resourcing of the health system is still not adequate.

Evans concludes, “There is...no basis whatever for a claim that health care is ‘crowding out’ other provincial programs by taking up a growing share of provincial revenue.”¹³

The greatest downsizing of health care occurred in the mid-90s. Then, with the economic recovery in the late 90s, provincial governments began to put more resources into health care. But the growth in resources has grown more slowly than the growth of patient demand.¹⁴ Even so, one group of analysts has concluded that for the country as a whole (and there is no reason to believe Nova Scotia is significantly different)

“Down sizing” of health delivery was particularly severe over 1992-98, but subsequently significant growth has been restored. Notwithstanding the recent recovery, growth of the population weighted by age and sex for health expenditures (a rough approximation of the underlying demographic determinants for growth of patient numbers) suggests that “patient” numbers have grown 5 per cent more rapidly in 1992-2004 than has real service delivery (or more exactly, the real human, capital and other inputs needed to deliver service).¹⁵

In other words, health care employees are doing more with less. With the system so burdened, it is predictable that governments and employers would see strikes as simply more trouble. Yet precisely because of the strains upon the system, work stoppages and their threat by labour could

be seen not as a burden but rather as therapeutic, indeed, an essential warning mechanism in an overstretched system.

Management-by-Stress

Regardless of the intent of health care officials, the type of health care system administration practised for the past decade or more could well be labelled “management-by-stress.”¹⁶ The term has been used to describe a management technique called the “Toyota Production Model,” or variants under the rubric of “lean production,” which began sweeping through manufacturing workplaces in the late 1980s. Lean production is a metaphor or lens through which we can view developments in the management of health care.

Pioneered by Toyota executive Taiichi Ohno in the 1950s, the key principle is relentless reduction of “waste” (unnecessary resources). The key strategy is to reduce resources in the workplace deliberately to the point that breakdowns will actually occur. By analyzing the breakdowns, management is consequently better able to keep production going with the greatest speed and the fewest resources possible.

Older systems of management were designed to accommodate natural glitches, unexpected occurrences and emergencies that are part of any operation. Under management-by-stress, however, glitches and emergencies are not avoided, but allowed to happen. That way management can make the system leaner and more “efficient.” As Parker and Slaughter say:

Stressing the system can be accomplished by increasing line speed, cutting the number of people or machines, or assigning workers additional tasks. Similarly a line can be balanced by decreasing the resources or increasing the work load at those positions which always run in the green [operate without emergencies]. In management-by-stress systems, extra resources are considered as wasteful as producing scrap.¹⁷

Of course, no system can work totally without buffers. Under the old system buffers included larger inventories, slower production speeds,

sufficient numbers of workers and backup procedures. Under management-by-stress, the buffer is the individual worker, made to work harder, faster, longer, with less employment security, with fewer backups. The resource buffer narrows down to the human buffer. Human beings can be seen as amazingly flexible and resilient machines and for a while the human buffer can be made to bear the stress without mishap. But humans are not machines, and with enough stress they will inevitably break down and/or rebel.

The gospel of lean has expanded well beyond private-sector auto manufacturing. It has migrated into our public services. At first so popular in manufacturing, lean was hard to resist in the service sector, fuelled by consultants, especially in the profit-making, efficiency-seeking private hospitals in the US.¹⁸ In the public sector, it became known as the “New Public Management.” As Canada moved into the fiscal panic of the 1990s, the model was irresistible to our public sector.¹⁹ The public health care system, too, succumbed to the relentless “cult of efficiency.” And even acute care institutions adopted the general approach of management-by-stress.²⁰

As one leading researcher concludes:

Health care reform is important because it is associated with a particular style of management that has introduced private sector, industrial practices into largely professional areas of work for which such a narrow, often mechanistic conception of management may not be appropriate. In particular, it is at risk of substituting low-trust relations for high-trust ones which could over time fundamentally transform not only health care systems but the whole notion of professionalism.²¹

What used to be a pervasive “hospital model” of human resource management, based on the values of public service, high morale, the importance of training, good pay and benefits, and employment security for all health care employees, has split to add a “hospitality model,”²² based on the example of the hotel and tourism industry, with low pay, few benefits and precari-

ous employment. Indeed, many ancillary services (like laundry, dietary and housekeeping) have been either outsourced to the private sector or treated internally as different from the work of “real” health care providers.

But soon the efficiency imperative was extended even to direct providers and professionals. The work of some of these employees was subdivided between higher-level tasks and the more mundane duties, and new occupations burgeoned. Thus, some of the work of nurses was broken up and apportioned to lower-paid licensed practical nurses and health care aides. While the work of registered nurses tended toward upskilling, this was accompanied by a work intensification. In another example, some of the work of registered technologists was hived off to lower-paid technicians and assistants. Even the work of the remaining professionals and para-professionals became more precarious and subject to a process of codification and over-routinization.²³ The work of nurses and other care providers became more susceptible to monitoring, measurement, limitation and specification, and “caring work” or “emotional labour” was increasingly eliminated or not reimbursed. As patients came to be discharged “quicker and sicker,”²⁴ those remaining in hospital required even more demanding care. Working with sick people is stressful to begin with; these new modes of management made it ever more stressful.

A very recent Statistics Canada study reveals high levels of stress among health care professionals, and concludes:

This multivariate analysis indicates that health care providers are far more likely than employed people in general to feel that their jobs are highly stressful. Physicians and nurses report the most stress, even when influences outside the job are taken into account. Because doctors and nurses bear a major responsibility for delivering health care, these findings should concern all Canadians.²⁵

While efficiencies can be achieved, health care, of all sectors, should not be subjected to management-by-stress. By its very nature, health care requires careful work, backup sys-

tems, room for repetition, and built-in provision for emergencies and unexpected occurrences. And, especially because of the overwhelming importance of workers in the system, loyalty, high morale and commitment, and a high level of training are crucial to the outcome of healthier patients. Introduce any more pressure (like an outbreak of mumps or legionnaire’s disease) into the system and it can falter or even collapse catastrophically.

A good example of what happens when a vulnerable health care system is subjected to unexpected stresses occurred in 2003 with the SARS outbreak in Toronto, where forty-four people, including several health care personnel, died. While the disaster could not have been foreseen or avoided, the fact that it became so calamitous can be in large part attributed to the lack of back-up resources. As Mr. Justice Campbell wrote in his report on the crisis, “More financial and professional resources are needed, otherwise all the legislative changes and programme reforms will prove to be nothing but empty promises. The test of the government’s commitment will come when the time arrives for the heavy expenditures required to bring our public health protection up to a reasonable standard.”²⁶

One of those testifying before the Campbell Commission was Dr. Bernadette Stringer, an epidemiologist from the University of Western Ontario and former emergency and critical care nurse. Stringer argued that health care workers under stress are less effective than they should be in such a crucial environment. Indeed, she contended, the well-being of patients is intimately connected to that of their caregivers: “When a hospital is made safer and healthier for the people who work there, it also becomes a better facility for the people who are being treated or who are recovering there. The health and safety of patients and healthcare personnel are two sides of the same coin.”²⁷

Furthermore, other industries crucially concerned with the care and safety of clients often succeed, not through an obsession with leanness, but its opposite.

It has long been recognized in other sectors, such as the aviation industry, that interven-

tions targeting the system, that is, interventions such as reducing workload or increasing the amount of time off between work shifts to decrease fatigue or creating standardized procedures are the most effective ways of addressing medical errors.

These interventions make the aviation industry safer and healthier for air crews and passengers. There is every reason to believe that similar approaches in the healthcare industry would make it safer and healthier for workers and their patients.²⁸

In summary, health care should not be run under a system of “management-by-stress.” It is totally inappropriate where human lives are at stake, where the unexpected is normal and where the technology of service delivery is rapidly changing. But if lean is the way our politicians and administrators insist it be done, they are forgetting one very crucial lesson of the lean production technique.

Pulling the “Red Cord”

A critical part of many lean production lines is called the “Andon System.”²⁹ Above production lines, especially those run by Japanese manufacturers, from Yokohama to Mississippi to Ontario, there are often three lights – green, amber and red – which indicate the status of the line. A key management principle *is to give line workers power over the lights*. The Toyota originators, like Taiichi Ohno, believed that nobody, not even management, knew when the system was failing better than the front-line workers.

Here’s how the Andon System works. When the line is running smoothly, the green light glows. But lean management’s goal is not to have the green light glowing all the time. If that is happening, management either speeds up the line, or withdraws resources, or both. When the line comes under stress, the workers are supposed to pull a cord so that the amber light glows. This alerts management that line failure may follow. If the line becomes overburdened and serious quality issues will ensue, workers are often not only empowered, but encouraged, to pull the other cord. A red light goes on and work on the production line stops until the situation can

be rectified. If the switch from green to amber signals that the line is approaching maximum efficiency, the switch from amber to red signals that the line is overloaded. But if workers cannot activate the red light, then it is much more difficult to know if the pursuit of production efficiencies is in fact compromising the quality of the product.

A health care system is not a car factory. But, if anything, the need for warnings of impending overload are more important in health care, not less.

Health care workers must have a way of indicating that the conditions under which they work do not overstress them or the quality of health care delivery. Thus, in the health care system, the red cord can be said to be the power of health care workers to threaten to, and if necessary, withhold their labour. *The proposal by the Nova Scotia government and the health care employers to take away the right to strike is analogous to taking the red cord away from health care workers.*

But, of course, whether it is legal or illegal, sanctioned or not, workers under stress will withdraw their labour anyway, to signal that the system has overloaded them.³⁰ Physicians, who are not afforded collective bargaining rights like other health care personnel, are a recent Nova Scotia example. Last summer, rural physicians threatened to shut down emergency and intensive care units. Dr. Don Pugsley, president of Doctors Nova Scotia, is reported to have “said he knew of one rural doctor who was on call 24 hours a day, every second day, for all of last month. Dr. Pugsley suggested such situations are common. ‘You can’t sustain the health-care system on the basis of the devoted activities of a small number of physicians,’ Dr. Pugsley said.”³¹ And, of course, other health care workers will signal in a similar way whether the government sanctions it or not. The argument is not whether there can be a red cord, it is whether the red cord is better placed inside the system or outside.

Emergency Services Agreements

A major problem with unsanctioned or illegal withdrawal of labour is that it can be unilateral, unpredictable and even anarchic, especially

if management refuses to cooperate with the workers and their union. If the power to “stop the line” is an essential part of lean management, then even this disruption is best exercised in an orderly fashion. This brings us to another assumption made and promoted by proponents of a strike ban – that service breaks down unacceptably during a strike.

In the public discourse surrounding the May 2007 strike at the IWK Hospital, an important point was ignored or given little attention – the provision of emergency services by union personnel during the strike.

In the months and weeks leading up to the strike, there were two bargaining tables. One dealt with the substantive issues of the dispute (compensation, working conditions, etc). The other involved emergency services. Both the hospital’s management and the union had spent many hours fashioning an emergency services agreement specifying what kinds of and how many workers would work during a strike. When the strike hit, the agreement was firmly in place and no workers strayed from its provisions. So it would be useful to examine this agreement in some depth.³²

The collective agreement between the IWK and NSGEU contains a clause³³ specifying that:

- a) Notwithstanding an employee’s right to strike, the Union agrees that during a legal strike, a sufficient number of bargaining unit employees will be provided to assist the Employer where there are insufficient numbers of excluded persons to provide emergency treatment or care of any patient, if, in the opinion of the majority of the Emergency Services Evaluation Committee, a patient’s life would be endangered or where the discharge of a remand patient would endanger public safety.
- b) The Emergency Services Evaluation Committee shall consist of equal representation from the Employer and the Union.

Separate from the main negotiating table, and with a separate group of negotiators, union and management hammered out an emergency services agreement. This agreement voluntarily

went far beyond the language in the collective agreement. Part of the negotiation protocol was that if they were unable to agree on staffing in any particular area, the parties would voluntarily refer such dispute for a binding decision to an impartial third party. In this case the third party was Mr. William Kydd, a local lawyer with long experience in dispute resolution. They also voluntarily agreed that if, during the course of the strike, the designated numbers required changing (upwards or downwards), they would meet, daily if necessary, to revise those numbers. Failing agreement, Mr. Kydd would provide resolution at very short notice.

The group of workers threatening to strike the IWK (a tertiary care hospital) has an almost bewildering array of employees: at least sixty different specialized worker groups (such as laboratory technologists, youth care workers, anaesthesia technicians, bereavement coordinators and biomedical techologists). Of these, union and management were by themselves able to agree on designation for all but eight groups. In the eight disputed instances, the Emergency Services Committee met with Mr. Kydd, providing arguments pro and con, with area specialists advising them. For example, in the medical laboratories, pathologists and senior technologists were consulted.

With the overall welfare of patients in mind, Mr. Kydd made a final decision on each of these disputed areas. The result was an eight-page general memorandum of agreement on the process and content of designation. This was supplemented with a twenty-three page detailed list of the rotation schedule of who would work during the strike in the designated groups as well as two pages of “guidelines” for managers and employees. The hospital’s CEO estimates that 20% of the union’s members were working during the strike.³⁴

Because the process was voluntary, the union was much more prepared to cooperate. For example, in the case of one group of youth care workers, the employer argued that a minimum of four workers be designated to work during a strike. The union argued for three. After hearing the arguments of both sides, the arbitrator sided with the union. However, pondering the question, the union determined that the employer’s

arguments were valid and voluntarily agreed to up the number to four.

In fact, the strike lasted only one day whereupon the union agreed voluntarily to submit remaining substantive issues to a third party.³⁵

Short of ensuring that strikes will never happen (which, we argue, is an impossible dream) the process of voluntary designation works to make strikes manageable. Other health care unions in Nova Scotia, especially those representing professional personnel, have initiated similar agreements. During the health care disruptions of 2001, all of the unions involved had emergency services provisions in place.

Given the chance to negotiate emergency services provision, there are tremendous incentives for unions to do so. Every health care strike involves them crucially in the court of public opinion and they can ill afford to allow a tragedy involving human life to happen. Indeed, it is our observation over a quarter of a century that, given the opportunity, unions often over-designate, rather than under-designate.

When it comes to protecting patients, the folly of banning health care strikes has demonstrated itself dramatically in Alberta. That province banned strikes in acute care institutions in 1983. We have shown how this did not result in a decline, but rather a rise in strike activity compared to a province where strikes were legal like Nova Scotia.³⁶ However, making strikes illegal has also led to major problems in the provision of emergency services when strikes do happen.

For example, let us look at nurses' strikes in Alberta. Prior to the 1983, when strikes were widely legal, there were a small number of Alberta hospitals where strikes were legally banned. When the nurses' union went on strike prior to 1983, it always respected that prohibition. The union also negotiated emergency services agreements with the managements of hospitals where they did legally strike.

However, that changed when the government banned strikes entirely. When the nurses union defied the strike-ban legislation in 1988, its members struck all of the hospitals in the province where they worked. To make matters worse, because the strike was illegal, many hospital managements refused to negotiate emergency services agreements, depriving the union

of essential information as it struggled to decide which of its members should work.

An interesting footnote drives the point home more forcefully. In legal strikes before 1983, the Alberta nurses union always had more than a few members crossing the picket line against the union's wishes or "scabbing," citing their professional obligations. In the 1988 illegal strike, this number dwindled to a handful.³⁷ Despite the great risks of defying the law, the sense of beleaguerment enhanced, rather than diminished the feeling of solidarity within the nurses' ranks. Just such a sense of solidarity borne of common desperation appears to have motivated Nova Scotia nurses to threaten mass resignation in the 2001 dispute in that province.

Making strikes illegal presents almost insurmountable difficulties in the negotiation of emergency services provisions. This is just what occurred in 2000, when the Alberta Union of Provincial Employees (AUPE) threatened an illegal strike by 10,000 licensed practical nurses and other occupations. Former AUPE president Dan MacLennan recounts³⁸ that before the strike he approached employers across the province asking to negotiate emergency services. "Pretty well all of them said they couldn't or wouldn't negotiate," he says, "because it would be taking part in an activity that wasn't legal." The union was left to its own devices in designating staff who would work during the strike. Many hospitals cancelled services unnecessarily rather than accept the union's offer.

In all of these cases, the inability and unwillingness of employers to negotiate emergency services agreements arguably made a bad situation much worse.

Choice versus Coercion in Emergency Services Designation

Strikes by unionized health care providers are legally permitted in all but three jurisdictions in Canada. The legal situation regarding strikes in health care is shown in table 1.

If orderly bilateral negotiation of emergency services agreements is so important in health care strikes, why not impose them by law? Unlike Nova Scotia, which currently leaves these nego-

Table 1: Legal Position Regarding Strikes by Province in Canada

Province	Strikes legally permitted?	Note on emergency services provision
British Columbia	Yes	Joint designation before compulsion
Alberta	No	
Saskatchewan	Yes	Voluntary negotiation
Manitoba	Yes	Employer designation
Ontario	No	
Quebec	Yes	Specified by legislation and Essential Services Commission
New Brunswick	Yes	Joint designation before compulsion
Nova Scotia	Yes	Voluntary negotiation
PEI	No	
Newfoundland & Labrador	Yes	Employer designation
Federal	Yes	Joint designation before compulsion

tiations to the parties, several provinces where strikes are still legal have instituted so-called “essential services”³⁹ provisions. We argue below that none of these legal-imposition regimes is as effective as voluntarism in handling disruption.

The legally imposed provisions come in three regimes:

1. In some jurisdictions (Federal, BC, New Brunswick) the unions and employers themselves try to designate who will work during a strike. Failing agreement, a third-party must award a binding decision on who will work. We will call this the “joint designation before compulsion” regime.
2. In some jurisdictions (e.g., Manitoba, Newfoundland) the employer has the power independently to designate those who must work. If the union disagrees, it can appeal to the Labour Relations Board. We will call this the “employer-designation” regime.
3. In Quebec, a special law designates that between 60 and 90 percent of employees in health care institutions (depending on the type of institution) must work. This law authorizes an Essential Services Commission to interpret disputes within these guidelines. We will call this the “Quebec regime.”

So what is wrong with these provisions? Are they not a convenient compromise between banning strike entirely on the one hand and allowing them to just happen, on the other? To the layperson, these regimes appear to be fair because they do not outlaw strikes and appear to

submit the threat to benevolent intermediation. They appear to temper the right to strike with the assured provision of emergency services. But appearances can be deceiving. Like much in industrial relations, the devil is in the “ifs”: *If* the process of designating “essential” employees is acceptable to the parties, *if* the process is truly voluntaristic, *if* the process is not open to abuse by management, and *if* the process does not end up causing the strike to actually last longer.

Starting from the most basic point, it is a fundamental principle in industrial relations lore, borne out by facts, that good labour-management relations thrive through voluntarism and wither from compulsion. The core of Canadian labour law compels union and management merely to recognize each other and to bargain in good faith. It does not usually impose an outcome upon them. This holds true for negotiations over the substance of a collective agreement and it also holds true for negotiations over who should work during a strike.

Left to rely on their own expertise without excessive legal compulsion, the negotiating parties themselves will fashion the most practical and workable solutions to problems where they are. Allowed to freely negotiate, unions are surprisingly practical and responsible. Negotiating and making agreements is what they do best. The emergency services agreement in the IWK strike is a good example. Other Nova Scotia unions and those in Saskatchewan, the other province which does not impose compulsory designation, have managed to negotiate similar

Table 2: Three Dimensions of Third Party Intervention

	Less effective	More effective
Appointment of 3rd party	compulsory	voluntary
Content of 3rd party's assistance	binding	directive
Length of 3rd party intervention	permanent	temporary

agreements for decades.

The more we remove voluntarism, the more we infantilize the parties, especially the union, the less practical and responsible we require the union to be.

This is not to say that union and management don't need outside help from time to time. They do, and Canada has a long and mostly successful history of third-party intervention in disputes. Government-appointed and independent labour relations experts have helped employers and unions solve innumerable disputes. But intervention works best when it follows certain criteria. The key, we submit, is the amount of free choice, as opposed to coercion, present. To look at the coercion-choice nexus in more depth, we could consider a continuum along three dimensions of any intervention process (table 2).

Dimension number 1 refers to the appointment of the third party. Voluntary means that the third party intervention is freely chosen by the parties (and that they can freely leave at any time). Compulsory means that the intervention is thrust upon them and they cannot withdraw. Examples of both voluntary and compulsory intervention can be found in Nova Scotia. An example of voluntary third party intervention came in 2004. The two parties involved were Capital District Health Authority and the Nova Scotia Government Employees Union. For that particular set of negotiations, the parties agreed voluntarily to submit all unresolved collective agreement issues to an arbitrator. Once the arbitrator delivered his decision, his mandate expired and the parties could return to a strike/lockout regime. An example of compulsory intervention involves the same union and the government of Nova Scotia with regard to direct government employees (civil servants). Legislation makes strikes illegal and *all* bargaining impasses must be submitted to arbitration every single time.

Dimension number 2 refers to the content or

substance of the third party's decisions. Directive means that the decision is not legally binding. The suggestions of the third party are meant as helpful assistance in settling the dispute. For example, as do most other provinces, the government of Nova Scotia appoints conciliators in all union-management bargaining impasses before a strike can ensue. The government can also appoint a mediator during a strike. The conciliator or mediator is a person who, with expertise and experience, encourages, cajoles and otherwise nudges the parties toward an agreement. But that person does not have the power to impose an agreement upon them. At the other end of the continuum ("binding"), a third-party has the legal power to impose terms upon the parties. In other words, the arbitrator actually formulates the settlement and the parties are legally obliged to abide by these terms.

Dimension number 3 refers to the long term, over many years. A permanent form of third-party intervention lasts forever. A temporary form of intervention lasts for only a limited amount of time.

Thus, third-party intervention in and of itself is not the problem. Given how valuable it has been, it would be foolish to forego it in the resolution of labour disputes. Nor would labour or management suggest foregoing it. In the use of intervention, however, choice is more effective than coercion.

As we see it, the most effective intervention processes are those that tend toward the voluntary, directive and temporary. The most ineffective are those that tend toward the compulsory, binding and permanent.

The problem with all three above-mentioned legally imposed "essential services" regimes is that they are, at the same time, compulsory and binding and permanent. They give the appearance of allowing the strike weapon while effectively removing most of its effect. And two of the three regimes take any meaningful par-

ticipation in the designation process away from the union. Given how important union involvement is, this is dysfunctional.

Of course, the Quebec regime is the worst. With 80% or more of staff not allowed to strike in most health care institutions, the so-called “right to strike” is meaningless and has been generally treated as such by Quebec unions. The level of staffing required during a strike is sometimes so high that it is not uncommon for more workers to be designated “essential” during a strike than work under normal conditions. Thus groups of workers regularly defy the law and the rulings of the Essential Services Commission and provide more modest emergency services. Despite the prodigious artillery at its disposal, the Commission has found it difficult to impose punishments that will effectively deter unions from doing this.

For example, in 2000, the Commission declared a nurses’ strike illegal and the union delivered its own version of emergency services. The threat of fines (to both the union and individual nurses), loss of seniority, loss of union dues and other punishments, was as ineffective in preventing the strike as it had been in a strike nine years earlier. Even many management people in Quebec agree that it is not workable. As one employer representative says:

The quotas, as they stand, are completely unrealistic. The legislation conveys the message that everything is essential. How can we say that when we’re making major cuts in the whole health system? This approach just invites radical action [by the unions.] Why can’t we base our essential services on how we staff the hospital on weekends and summer holidays?⁴⁰

On several occasions, the Quebec essential services regime has proven so ineffective that the government has stepped in to pass legislation making the strike illegal. In the Montreal transit mechanics’ strike in the spring of 2007, the Commission ruled that transit services had to be provided during rush hours and late night. And still the Quebec government was poised to outlaw the strike.

The “employer-designation” regime is only

marginally less coercive. In this regime, the employer gets the first shot at designating “essential” workers. We have mentioned how employers often assume, against all evidence, that a strike cannot or will not happen. It is difficult for management to accept that a strike is not “business as usual.” Left to its own devices, management has a powerful incentive to over-designate the number of employees it deems “essential.” Management does this for three reasons. First, running an institution during a strike is a big headache (though not by any means impossible). It is simply easier to operate with a full complement than with a reduced complement, so why not designate as many people as possible? Second, employers fear that lack of staff might lead to patient harm, a consequence for which they are ultimately responsible. But employers are notoriously incapable of distinguishing between annoying inconvenience to themselves and harm to patients. The fact that Canadian employers have over the past twenty years regularly predicted disaster in strikes and then managed to cope is proof of this.⁴¹

Third, adopting an extreme position is a convenient bargaining strategem. Knowing that a third-party will make a binding ruling on all issues in dispute, why not over-designate? Knowing that the arbitrator may come down somewhere in the middle is a great spur to exaggerate, especially if the whole process is compulsory, binding and permanent. The fact that the initiative in this regime begins with the employer puts the union at a disadvantage, removing an essential element of cooperation. The regime makes it difficult, if not impossible, for the union to talk directly to the employer on who should and should not be working. The opportunity for the union to make its arguments occurs only when the parties appear before the third party, which is too late for it to be effective.

For example, as Manitoba nurses approached a strike deadline in 2002, management at one hospital designated as “essential” 125% of its normal complement. Similar situations were reported across the province. Whether this was a cynical move by management, hoping that the Labour Relations Board would reduce it on appeal to 100%, or some sort of perverse political

statement is not known. In any case, one can imagine that such a move would be met with an opposing cynicism on the union side.

Finally, the “joint designation before compulsion” regime is only marginally less coercive than the “employer-designation” regime. Union and management are allowed to talk to each other directly at the first step. But whatever voluntarism may exist in the first step, there is no voluntarism by the end of the second. Given the compulsory, binding and permanent nature of even this regime, cooperation will not flourish. Cooperation must be continuously nurtured by healthy doses of voluntarism. And it is damaged and ultimately destroyed by compulsion.

Weathering Strikes

Another problem with designating too many workers as “essential” is that this may actually prolong a strike. As well as inflicting some pain on the employer, strikes are meant to spell hardship for workers, to induce them to settle earlier rather than later. But a strike in which a majority of strikers are actually working (and contributing part of their salary to support those who are not) defeats this purpose.

As mentioned above, a broad assumption is that the health care system simply cannot tolerate strikes at all. This is a convenient rhetorical device but it pales in the light of facts. First, emergency services, described above, are performed by members of the striking bargaining unit.

Second, not all health care staff are equally “essential” to be on the job 24/7. The absence of cleaners is clearly not as threatening as that of technologists or nurses. It is so easy to confuse inconvenience with danger to life and limb.

Third, even the more professionalized staff are not as immediately essential as proponents of a strike ban suggest. Obviously effective health care delivery requires a healthy complement of nursing, diagnostic (e.g., laboratory and imaging) and therapeutic (e.g. respiratory, physio-) specialists. But how long can health care institutions risk operating temporarily without them? The answer lies somewhere between no time at all and forever. But the truth is that hospitals can operate and have operated without the full com-

plement and not recklessly endangered those in their care. In more than a few strikes in recent years by these employees, health care managers have claimed that they could not operate more than a few days, or even hours. Yet the strikes have happened anyway, both legally and illegally, for anywhere between several hours and several weeks (and, in some cases, a month).⁴² In every case, the health delivery system survived without catastrophic collapses.

For example, prior to the 1999 Saskatchewan nurses’ strike, the health employers’ association lobbied the government to step in and declare the strike illegal. The association claimed, exactly as Nova Scotia Minister Parent is claiming now, that changes in health care (the tightening of the system, the winnowing of supervisory staff, the integration of individual institutions into health districts) had rendered the provincial health care system incapable of tolerating a strike. When the Saskatchewan nurses’ strike began, the government summoned the legislature and passed a bill ordering the nurses back to work. The nurses refused to return. And the strike lasted ten days.

On the subject of Saskatchewan, we had the opportunity of observing a legal strike in 1991 at close range. We observed that in those hospitals where management worked closely and cooperatively with the nurses’ union, care levels by striking nurses *during emergencies* were extremely high, higher even than under non-strike conditions. We also observed several hospitals where management refused to accept the union’s contingent approach to emergency services provision. In these cases, patient care was much reduced and in many cases, patients were discharged. In general, then, the efficacy of care during a strike depends crucially on labour-management cooperation. An essential part of cooperation is a willingness by management to accept the fact of the strike and to work with the union on a day-to-day, even hour-to-hour basis.

Fourth, there are substitutes for striking workers. While other unionized employees are loath to perform the exact tasks of their striking colleagues, those not on strike sometimes have overlapping skill sets for real emergencies. As well, there are managerial and non-union staff who are trained and capable of filling in. Phy-

sicians can and do perform several procedures usually performed by striking nurses, technologists and therapists. Such substitution is not simple to organize. But it is not impossible.

The key is acceptance that strikes are an inevitable and manageable occurrence in the life of the modern health care institution and that they are not “business as usual.” Which brings us to the fifth point.

Methodical and statistical studies of the actual effect of strikes by health care workers are rare. Not least of the problems is that it is difficult to isolate and quantify outcomes, like patient health and safety. But doctors’ strikes have been studied. Evidence indicates that, while emergency procedures continue, short-term postponement of elective procedures may actually cut mortality rates (because every elective operation carries mortality risks). Thus, it is not mere folklore that mortality rates actually decline during doctors’ strikes.⁴³ Of course, postponement of elective procedures carries more serious risks as a strike wears on, but immediate catastrophe need not occur. Likewise, while short strikes by other health personnel may not result in *better* outcomes, they need not result in catastrophes.

A study of reduced staffing sheds more light on the matter. An examination of 3.8 million emergency-department admissions in Ontario over ten years found that weekends had a significantly higher death rate than weekdays.⁴⁴ But it would be wrong to conclude that lower staffing alone contributes to raised mortality. The authors suggest that lack of supervision and adequate communication are as important a factor as the quantity of staffing. The greatest danger to patients comes not from a short-term depletion of staff but from the tendency to treat weekend staffing deficiencies with complacency, as “normal” or “routine.” Strikes, on the other hand, are quite different than weekends. They are tumultuous events demanding and getting the full attention of managers, employees, governments, patients and their families – indeed all stakeholders. It is impossible to pretend that they are routine, and all personnel involved,

strikers included, are keenly attuned to emergencies.

In summary, then, strikes and strike threats in health care can be, must be and are managed. Like a myriad of other serious human resource challenges, like worker absences, employee recruitment and retention, misbehaviour, training and health and safety, they cannot be wished away or legislated away.

Conclusions

The purpose of this series of essays is to hold up to critical scrutiny the contention that health care strikes simply cannot be allowed to happen. The first essay argued that they do happen, whether they are legal or not. Indeed, as Alberta’s experience shows, they sometimes occur more frequently where they have been banned.

The present essay has explored how health care systems cope with those strikes. We have tried to show that strikes are not just an irritant; they may well be an essential bellwether of the general health of the system. We trust we have shown that mechanisms abound whereby strikes can be withstood. It is far better for governments to acknowledge that strikes in health care are a fact of life and to use that as a basis for cooperation between unions and employers. This acknowledgement will do much to ensure that these events are not only manageable but well-managed.

We are not suggesting that strikes in health care are child’s play. They are serious business. But if politicians and health care administrators insist on running a system so close to the bone, then the ability of workers to strike, to pull the red cord as it were, it is an essential system mechanism to ensure patient safety in the long run. Moreover, unions, if not coerced, and where management reciprocates with cooperation, can and do provide services that allow the health care system to weather the occasional labour disruption and the inconvenience that threats occasion. As in all industrial relations, voluntarism works.

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Notes

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- 24 Although the precise origin of this phrase is unknown, among many other sources see Coyte, Peter C., and Patricia McKeever (Home and Community Care Evaluation and Research Centre, University of Toronto). 2001. Submission to the Standing Committee on Social Affairs, Science and Technology. October 17. retrieved November 17, 2007 at www.hcerc.utoronto.ca/PDF/report2.pdf, especially the following, found on page 3: "These changes in the health care landscape mean that hospitals and long term care settings are no longer the dominant site of care; rather, their role in health care has narrowed from the provision of a broad range of care to the provision of mainly acute and surgical interventions that require close, on-going surveillance and the physical presence of the patient. Much care formerly provided in hospitals, such as preparation for surgical procedures (e.g. blood and stress tests for cardiac surgery), many diagnostic procedures (e.g. blood pressure, pregnancy tests, etc.), and some hospital procedures (e.g. renal dialysis) are now performed in various sites in the community. The acuity of care has increased in hospitals and in the home and the community as "step down" clients are moved out of hospitals earlier in need of higher levels of care."
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- 30 See Haiven, Judy and Larry Haiven. 2007. *A Tale of Two Provinces: Alberta and Nova Scotia*. The Right to Strike in Nova Scotia Series. Canadian Centre for Policy Alternatives. 18 October.
- 31 Visser, Josh. 2007. "Rural doctors threatening ICU strike; Exhausted MDs complain pressure of general practice, hospital duties too much." *Halifax Chronicle Herald*. 28 July. A1.
- 32 The description of the emergency services process here emerges from interviews conducted by the authors.
- 33 With the expiry of the collective agreement, the emergency services clause would also have expired. However, the fact that the union and management continued to honour their commitments is testimony to the strength of voluntarism.
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- 37 The authors observed these events at the time and have confirmed them in discussions with union leaders.
- 38 Interview with MacLennan, 23 September, 2007.
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