

Submission

Regarding the Review of Employer
Representation in Health Sector
Collective Bargaining and Labour
Relations Administration

Presented by the Canadian Union of
Public Employees (CUPE)

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Introduction

Thank you for this opportunity to present our views on a new model for employer representation in the health care sector. On several occasions we have raised various concerns on this matter with the Minister of Health and other officials within Saskatchewan Health. Therefore we welcome this review and are hopeful that the discussions with stakeholders will generate concrete recommendations and result in positive changes to the structure and role of the Employer bargaining agent in the health care sector.

CUPE has participated in provincial bargaining since the early 1970s firstly with the Saskatchewan Hospital Association (SHA) and later with the Saskatchewan Association of Special Care Homes (SASCH). We now bargain a provincial collective agreement that covers all hospital, long-term care and home care workers with the Saskatchewan Association of Health Organizations (SAHO), which was formed on July 1, 1993. Our union currently represents over 12,000 health care workers in five regional health authorities.

Since the early 1970s we have seen many changes in health care bargaining, and we believe that many of those changes came about because we, as a union, had a vision for bargaining in this sector. Provincial bargaining was a tremendous achievement for health care workers that came about as a result of intense lobbying and political pressure from the unions starting in the late 1960s. Provincial bargaining also became a reality because the newly formed government at the time had the political will to make it happen.

The merging of our provincial hospital and long-term care collective agreements was another important achievement as was the achievement of wage parity between the same jobs in the different sectors. With the reorganization of bargaining units under the Dorsey commission we faced yet another challenge of

merging quite drastically different collective agreements and fighting for wage parity at the bargaining table.

We mention these accomplishments to demonstrate that it has been possible to make incredible advancements in provincial health care bargaining in the midst of constant health care changes. We believe that we can improve labour relations in the health sector even more by revamping the current structure and clarifying the role of SAHO. This review of the employer representation in bargaining is timely and will hopefully lead to the creation of a more effective model for the upcoming round of healthcare negotiations.

The current structure and role of SAHO

The Saskatchewan Association of Health Organizations (SAHO) is a non-profit, non-governmental organization representing regional health authorities, independent hospitals and special care homes and other employers in the health care sector. According to its own website and documentation, SAHO provides the following services to its members:

- Communication and advocacy
- Support and education for boards and administrators
- Human resources
- Payroll services
- Pension, dental, group life and disability income plan
- Materials management
- Workplace health and safety
- Education and professional development

SAHO is funded partially from membership fees, government grants and fees for services.

The Health Labour Relations Reorganization Act and Regulations designate SAHO as the exclusive agent to bargain collectively on behalf of all or a group of employers. SAHO, as the Representative Employers' Organization, is also responsible for providing advice and interpretation of the collective agreement to employers.

Problems with the existing structure/role of SAHO

Our union would like to outline what we see to be the ineffective or problematic aspects of the current employer association structure. We will also discuss what we consider to be the appropriate roles of a representative employer association and the provincial government.

Bargaining issues

- **No direct communication with the provincial government during bargaining.** One of the main problems we face when bargaining with SAHO is the absence of the provincial government at the bargaining table. SAHO receives a mandate from the provincial government that is not always clearly communicated to the union's bargaining committee. Bargaining has, in the past, become drawn-out and messages not clearly communicated as SAHO representatives go back and forth between its discussions with the government and the bargaining table with the union.

From the union's perspective, we never know whether SAHO representatives are accurately presenting our message to the government or whether the government's position is accurately relayed back to us. In the last round of bargaining, for example, SAHO misrepresented the cost of implementing a vacation improvement in our collective agreement to both the government and CUPE. The outstanding bargaining issue was referred to an arbitrator who concurred with CUPE.

We believe that the present format for bargaining is ineffective and has led to prolonged and difficult negotiations. In fact, CUPE has been unable to conclude an agreement with SAHO without taking strike action in the last twelve years. Our bargaining experience with the Public Service Commission during those same years has been vastly superior. SAHO has a poor track record in avoiding major strikes with other health care unions as well.

The provincial government holds the purse strings and ultimately makes the financial decisions yet the government becomes a “ghost” at the bargaining table. Clearly provincial health care bargaining would be more effective if the provincial decision-makers were at the bargaining table or if we could bargain directly with the Cabinet Committee on Public Sector Bargaining or a committee of the Treasury Board.

Having a direct role in provincial bargaining would not be something new for the government. In provincial bargaining with the teachers, the provincial government does sit at the table with voting power along with the Saskatchewan School Trustees Association (SSTA). Although the SSTA has publicly expressed its unhappiness with the presence and vote of the government at the table, it is important to point out that the majority of school boards’ funding is from the property tax base whereas the provincial government funds almost all of health care. As the primary funder of health care, it makes sense for the provincial government to be directly involved in the bargaining of collective agreements.

- **Unwillingness of SAHO to negotiate on a provincial basis between bargaining rounds.** Apart from the negotiation of collective agreements, at times certain issues arise that should be negotiated on a provincial

basis with the employers bargaining agent. Our union has been frustrated with the unwillingness and inability of SAHO to assume this role.

One example of this is the reclassification of Licensed Practical Nurses (LPNs) who were facilitated to work at an expanded scope of practice after the government passed amendments to the *Licensed Practical Nurses Act* in 2000. CUPE attempted to negotiate with SAHO to move those LPNs with expanded scope of practice to a different wage rate but SAHO refused and insisted that we bargain the reclassifications with each separate health care employer.

Another example is SAHO's refusal to bargain with us for a market adjustment for technologists in order to recruit and retain people into these jobs experiencing high shortages. Instead of sitting down with the union and cooperatively developing a provincial strategy, SAHO unilaterally created a Provincial Market Supplement (PMS) committee that determined -- with only employer input -- which classifications would receive the adjustments. CUPE filed an Unfair Labour Practice against SAHO stating that SAHO did not have the right to unilaterally determine wages and the Labour Relations Board found SAHO guilty of an Unfair Labour Practice.

- **Poor cooperation at disclosing information relevant to negotiations. Inability to cost.** CUPE has difficulty in obtaining information we regard as relevant and necessary to our negotiations with SAHO, such as payroll and benefits costs. We are uncertain whether these difficulties stem from an unwillingness to fulfill the obligation of disclosure or the inability to provide the requested information. Equally troubling is SAHO's inability to cost bargaining proposals. Such expertise is crucial to negotiations where millions of dollars are under consideration and both parties should be confident that decisions are based on accurate figures. Whenever critical costing of proposals was required in the past, it has been

necessary to bring in experts from the department of health because SAHO could not provide this service.

The analysis required may be beyond SAHO's expertise. These difficulties may also result from inadequate or inefficient information sharing between regional health authorities, SAHO and the department of health. In any event, a representative employer organization needs centralized knowledge of the workforce and the ability to cost any proposed changes to terms and conditions of employment.

Labour relations issues

- **Inconsistent interpretation and lax enforcement of the collective agreement.** CUPE believes that SAHO, or a new Representative Employer Organization, needs to play a stronger role in the interpretation and enforcement of the collective agreement. Even though SAHO is a signatory to the collective agreement, it will not force regional health authorities to enforce the provincial agreement in a consistent and fair manner. The result of this is that health care workers are experiencing unequal working conditions and enjoyment of rights even though they fall under the same provincial collective agreement.

For example, as a result of the most recent round of restructuring of health districts, workers in some identical technologist classifications in the same Regional Health Authority are working for different wages. Despite the fact that two of the former health districts who are paying lower wages in rural communities are prepared to move to the higher rates paid by the third former district, SAHO has said no to this wage harmonization. This has resulted in some technologist staff leaving these hard-to-recruit rural positions and moving to higher paid urban jobs.

Our union ensures that our local presidents and shop stewards are trained so that they understand and can interpret the provincial agreement. We are not aware of similar training provided by SAHO to human resource managers in the health authorities. In his report to the provincial government in September 2000, Allen Backman recommended that SAHO “enhance training for managers so that collective agreements are understood and managers can effectively manage within them.”¹

It is interesting to note that the Health Employers Association of British Columbia states that one of its role is to “ensure a consistent employer approach” on issues relating to human resources, research, compensation and bargaining. We believe that it is imperative that the Representative Employer Organization in Saskatchewan health care provides a consistent approach and leadership on labour relations and human resources issues.

- **Lack of leadership to regional health authorities.** It is our view that SAHO does not provide strong and consistent leadership to the regional health authorities on labour relation matters. This might be expected of other kinds of employer associations that have voluntary membership and no mandate for provincial bargaining. In a large sector such as health care, where SAHO is designated as the exclusive agent for bargaining collectively a number of provincial agreements, it only makes sense that SAHO should provide leadership and direction to regional health authorities.

For example, in a meeting between CUPE and SAHO, SAHO’s CEO and former head of Human Resources acknowledged that the ambulance employees in Lampman were, in fact, employees of the Health District, but

¹ Recommendation # 6.7 in: Allen Backman, *Job Satisfaction, Retention, Recruitment and Skill Mix for a Sustainable Health Care System: Report to the Deputy Minister of Health for Saskatchewan*, September 2000.

SAHO refused to ensure that the Health District complied with the terms of our collective agreement respecting these employees. SAHO allowed the Health District to continue to consider these employees as volunteers and CUPE was forced to file an unfair labour practice application against the Health District. This issue has yet to be resolved due to SAHO's intransigence.

SAHO's capacity for dealing with arbitrations is deficient, to say the least. Their in-house counsel is unavailable until 2006.

- **No leadership on Occupational Health and Safety**

CUPE has been attempting to implement the joint training provision in our collective agreement for approximately five years. Numerous agreements have been reached with the Department of Labour to utilize the Train the Trainer program and certify members from all unions and SAHO's OHS staff.

The Worker's Compensation Board funds SAHO as a Health and Safety Association and part of the agreement is that they have to work jointly with the unions. At a recent meeting attended by a WCB representative the unions were informed by SAHO that in fact they had not even started work on the modifications to the Department of Labour materials even though the unions had been informed the work was well under way. In fact, it was disclosed that they do not even have a consistent program amongst their five staff.

The validity of the SAHO programs have to be questioned, when the statistics clearly show that health care has the highest number of injuries and workers compensation claims. Numerous employers are in the WCB surcharge bracket and listed as "bad actors" in the top 40 and top 500 employers in the Province of Saskatchewan.

The Department of Labour has given extension after extension to employers in the Health Sector to reach compliance with the provision for an Occupational Health and Safety program (Act section 13, Regulation 22). Violence in the workplace is at an all time high, along with harassment and workload. All of these areas are contributing to the high rate of injuries and diseases, and SAHO shows little or no leadership in assisting employers to reach compliance with the *Occupational Health and Safety Act and Regulations*.

The high rate of workplace injuries in health care is so critical that the Provincial Auditor expressed his alarm on the issue in his most recent 2003 Report. The Provincial Auditor noted that health care injury rates are higher than that of the construction industry and that “preventing injuries keeps the services of skilled workers available and it saves money.²”

Our union has been trying to take action on the high rate of injuries in health care for over a decade but we have encountered resistance from SAHO every step of the way. Here again is an example where provincial leadership from the employer association would make it possible for us to make tremendous gains in improving workplace health and safety.

Human resources/administration

- **Incapacity to provide administrative and technical support.** We have had frustrations with the incapacity of SAHO to maintain accurate payroll systems and provide administrative services. Our best example of the problems we experience is that of the Joint Job Evaluation process.

² Statement to the media by Fred Wendel, Provincial Auditor, June 3, 2003.

The inability of SAHO to administer the Provider Group Joint Job Evaluation program on behalf of the Joint Steering Committee has caused numerous delays, frustrations, and additional costs. Throughout the Job Evaluation process there were several serious errors made at SAHO that added additional costs to the project, and delayed the roll-out of the results to the 24,000 employees covered by the project. Most of SAHO's failures involved providing incomplete or inaccurate data and documentation to the Committee and were the result of inadequate computer systems and lack of IT expertise.

For example, the Facilitator and the KPMG consultant directed the Evaluation Committee to change the way a factor was evaluated and defined. This action resulted in two weeks of extra work for the Evaluation Committee to re-evaluate the jobs. When the change was discovered by the Joint Steering Committee, it took an additional two weeks to change everything back to the original evaluation.

Upon completion of the Job Evaluation Committee's work, the data was turned over to the Joint Steering Committee for an extensive "sore thumbing" process. It became evident at an early stage that the data we were given to work with was incorrect. The computer equipment utilized by SAHO failed to save the last three weeks of the Evaluation Committee's work and no one proof read the documents prior to distribution. This resulted in the Evaluation Committee being called back and with the help of some of the Steering committee members to proof read and re-enter the data, and therefore the project experienced a further delay of four to six weeks before the sore thumbing process could begin.

No Accountability for services. We have been dissatisfied throughout the Joint Job Evaluation project that budget information has not been fully disclosed to the Provider Group Steering Committee. Since November

2000 the committee has been asking for a “line-by-line” budget so that we can do an analysis of where the money is being spent and what SAHO is billing the project for. The last budget statement received in October 2002 once again gave total dollar figures and not details of the actual line-by-line expenditures. Are they intransigent or incompetent or both?

Implementation of the Joint Job Evaluation Program has been halted by the inability of SAHO to negotiate a timeframe and the necessary language. SAHO has informed us verbally and in writing that they do not have the mandate from the Department of Health and therefore cannot bargain with us. This illustrates the need for a representative employer organization that has the technical and administrative expertise and the authority to fulfill its bargaining commitments with the union.

CUPE’s Recommendations

1. **Create a new Representative Employer Organization.** CUPE would like to see the creation of a new, more accountable model for the Representative Employer Organization in health care. In bargaining, we would like to have direct representation from the provincial government and a clear mandate from the employer organization to bargain money issues.
2. **Develop clear roles and responsibilities of a Representative Employer Organization.** The new structure would have clearly mandated roles and legal authority to bargain, interpret and enforce the collective agreements in health care. A new structure must be able to resolve the problems that exist as a result of tensions and competing interests between the health care employers and SAHO. A single regional health authority should not be able to ignore a provincial interpretation of the collective agreement without repercussions. CUPE

maintains a consistent interpretation of the language we have bargained and so should the employer representative.

3. **Ensure the composition of a new Representative Employer Organization is both accountable to regional health authorities and the province.** The organization must include decision-makers from the health regions who can balance a province-wide perspective with regional needs. This body must have the legal authority and ability to implement policy within the regions. One possibility is that a new REO be structured as a management board of appointees from each regional health authority. These appointees would oversee human resources in their respective health authorities and report to their CEO. A government appointee/advisor would also sit on this board.

4. **The new Representative Employer Organization would provide leadership to health employers.** The new structure would be responsible for providing leadership and direction to regional health authorities on human resource and labour relations issues. Human resources managers would receive consistent training and support on the collective agreement and human resource issues. The new Representative Employer Organization would have the technical and administrative capacity to support health care employers and provincial initiatives such as joint job evaluation.