Blaney McMurtry LLP

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Bargaining in the Healthcare Sector: Towards a New Model

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Lawyers You Should Know: Mark Geiger

Introduction

Since the introduction of universal Medicare throughout Canada in the late sixties and following passage of the *Canada Health Act* in 1984, Healthcare has become a defining characteristic of what it means to be a Canadian. When we look to our neighbours to the south we see a situation where considerably more public money per capita is spent on healthcare, and yet millions of Americans have no insurance and can be subjected to personal bankruptcy in the event of a medical emergency. In fact in the United States commencing in the last few years, governments at all levels spend more per capita on healthcare then we spend here in Canada, and yet the amounts spent only covers a minority of the population. In the last several elections, healthcare has been one of the most, if not the most important issue in both Provincial and Federal elections. All of these factors in my view have a significant impact on Labour Relations and Collective Bargaining in the healthcare sector.

In 1975 approximately 25% of the Provincial budget was spent on healthcare. Today more than 50% of the Provincial budget is dedicated to this Ministry. Notwithstanding these enormous increases in costs, many observers of the healthcare system have concluded that we are facing a crisis. Nurses are getting old and retiring and there are insufficient numbers of new recruits to the profession according to many reports. Physicians are in a similar situation. The profession is simultaneously aging and being replaced by a much higher percentage of female physicians. For reasons canvassed in detail in submissions before the Romano and Kirby commissions, female physicians perform between two thirds and three quarters of the services performed by their male colleges. In 1982, as a result of the Barr Stoddard Commission report, governments across Canada reduced the number of medical school training positions by between 10 and 15 percent. The result of these initiatives has produced a shortage of physicians, and a greater shortage in those areas that require after hours commitments such as surgery, obstetrics, and emergency medicine. Costs continue to grow at rates significantly greater than the rate of inflation and many observers both in and out of government have suggested that the situation, as it is now in Canada, is simply not sustainable. These cost pressures have a significant affect on Labour Relations and Collective Bargaining in the healthcare sector.

The Structure of Healthcare Institutions in Ontario

Passage of the *Canada Health Act* in 1984 had a significant impact on the way in which healthcare was to be financed in Ontario and throughout the rest of Canada. By that year, the Federal government was making significant contributions towards healthcare expenditures in what is primarily a Provincial responsibility. The *Canada Health Act* established principles and rules with which the administration of healthcare in each province must comply in order to obtain Federal funding.

Section 7 of the Act sets five criteria which must be satisfied in order for the province to be eligible for full funding. They are as follows: public administration, comprehensiveness, universality, portability, and accessibility. Section 8 requires that the healthcare insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province. Section 9 requires that in order to qualify for Federal funding, the healthcare insurance plan of a province must insure all "insured health services" provided by hospitals, medical practitioners or dentist, as well as any similar or additional services the province decides to cover that are provided by other healthcare practitioners. Thus provinces are given some discretion as to what services other than insured hospital service and insured services provided by physicians must be paid for, but all "medically necessary" treatment provided by medical practitioners and provided in hospitals must be publicly paid for under the insurance schemes in each of the provinces. Medically necessary is not a defined term, but in every province the vast majority of services provided by physicians are treated as medically necessary and therefore paid for by the province. It is now unlawful for a physician to privately bill an insured patient for a medically necessary service. No other Western Democracy restricts hospitals or physicians to this extent.

In Ontario, virtually all hospitals are public hospitals that operate on a not for profit basis. Although many of them have funding which they obtain by private donations and by parking concessions and other concessions within the hospital, the vast majority of the revenue received by almost all hospitals comes directly from the Provincial government. The amount that is allocated to each hospital is based on complicated formuli developed by the Ministry of Health that measure overall hospital output and provide what are know as "global budgets" to the hospital. Legislation over the last several years has made it 'unlawful' for the administrators of a hospital to operate with a deficit. This legislation was required because over a number of years hospitals would simply operate with a deficit, and once the deficits reached levels which threatened their continued existence, the government found itself in a position where it was required to bail them out. The government tried several methodologies to avoid this and finally brought in new funding rules which simply prevent hospitals from operating at a deficit, and create individual liability on officers and directors if the hospitals do not meet these obligations.

Impact on Labour Relations and Collective Bargaining

Thus we have a situation where hospitals have limited control over their revenue and are provided with essentially a fixed budget from which they must provide all of the services, including the services provided by their unionized and non-unionized staff.

Physician Services Within Hospitals

With only a few exceptions, physician services provided in hospitals are paid for out of a separate fund referred to as the OHIP Physician's Pool. The government of Ontario negotiates with the Ontario Medical Association with respect to the amounts to be paid to physicians for insured services rendered in public hospitals and elsewhere. These amounts are set out in the OHIP Fee for Service Schedule, a regulation under the *Health Insurance Act*. The Schedule contains many thousands of entries that govern all of the various procedures carried out both in and out of hospitals by licensed medical practitioners. Recently in Academic Health Science Centres, and in various Primary Care Delivery Models, more complex funding arrangements have been developed known as Alternative Funding Plans. These plans blend fee for service payments with other payments that are dedicated to research and training of new physicians, or in the case of Primary Care, are partially capitation based and include incentives to provide preventive care. Currently these provincially funded expenditures for physician services, amount to in excess of eight billion dollars per year in Ontario. Payments by hospitals to physicians for professional services rendered as physicians are generally not allowed.

Thus the professional services rendered both in and out of hospitals is funded separately from the hospital global budgets, and negotiated directly between the Government of Ontario and the O.M.A. . This has significant impact on the way in which these negotiations are conducted, and more importantly for my purposes, on the ability to introduce meaningful change into the system.

Other healthcare providers and employees in hospitals are paid by the hospital from the amounts received from the government as part of their global budgets. In this way, the Provincial government controls the cost of overall, non-physician hospital care, but leaves the allocation of the funds to the individual hospitals. In recent years there has been greater control over line by line items within overall hospital budgets, and the Ministry has exerted greater and greater control over the allocation of actual funds within the hospital, but there is still a great deal of latitude within the hospital administration as to where funds are spent. The Government therefore attempts to control Health Care spending by strict allocation of budgets to hospitals, but is not directly involved in managing or negotiating terms and conditions of engagement or employment, except with physicians.

Any hospital administrator will tell you that it is a daunting task to provide the services hospitals are required to provide within the budgets given to them by the Provincial government. Most hospital workers in most hospitals are unionized and therefore their terms and conditions of employment are determined by collective bargaining between the various unions involved, and the hospitals. Not surprisingly all of these factors create a situation where Collective Bargaining is much more complex and very different than collective bargaining in the private sector.

The Hospital Labour Disputes Arbitration Act

The *Hospital Labour Disputes Arbitration Act* (commonly referred to as HLDAA) regulates the way in which hospitals, as defined in the legislation, negotiate with unions. Hospitals are broadly defined. They include 'normal' hospitals as well as sanatoriums, nursing homes and any other

institution which is operated for the observation, care or treatment of persons afflicted with or suffering from any physical or mental illness. This includes chronic care facilities, convalescent facilities and it also includes institutions which are operated privately such as homes for the aged as well as other institutions which do not receive public funding but that meet the definition. Hospital employee means a person employed in the operation of a hospital, but because of the provision of Section 1 (3) of the *Labour Relations Act*, does not include physicians. Although Physicians are not allowed to unionize and are not treated as employees under the *Labour Relations Act*, they engage in very complex and far reaching negotiations directly with Government through the Ontario Medical Association, a body the Government recognizes by contract as the sole representative of the Medical Profession in Ontario.

For non physicians working in Hospitals, as defined by HLDAA, the legislation establishes an alternative and mandatory method for dispute resolution apart from strikes and lockouts. Any employee of a hospital, as defined in the Act, is precluded by law from engaging in a strike, and the hospital is precluded by law from locking out such employee. This legislation was passed in 1965 following a bitter labour dispute at the Trent Memorial Hospital and has been in place in Ontario since that date. Some other provinces in Canada have similar legislation, but currently only Alberta and Prince Edward Island prohibit strikes with standing legislations. Several other provinces allow strikes but only after certain positions are designated as “essential” and therefore employees in these positions are not allowed to participate in a strike. In Ontario, since 1965, all disputes in hospitals and other institutions who meet that definition under the Act have had their disputes decided either by agreement between the parties or by compulsory third party arbitration under HLDAA.

The Process

Bargaining between hospital employees, their unions and hospitals proceeds notionally in the same fashion as bargaining in the private sector. Both the hospital and the unions in question bring forward proposals for changes to the Collective Agreement and those changes are bargained at the table for a period of time. However, both parties know that at the end of the day any issue not agreed between them will be decided by either a single arbitrator, or by a board of arbitration appointed under the Act. This makes for very different bargaining dynamics than those which occur in the private sector where strike and/or lockout are the normal dispute resolution mechanism. As anyone who has participated in bargaining under HLDAA will tell you, this creates dynamics and strategic considerations that would be wholly absent in a bargaining system where strikes and lockouts are the norm. Economic pressures that operate on both workers and employers in the private sector, because of the ultimate strike or lockout threat, are replaced by very different ‘strategic’ and public policy considerations.

Under the Act, following conciliation, the parties can agree to have a matter decided by a single arbitrator but failing such agreement each party appoints a member and those two members then agree on the choice of a arbitrator. Failing the agreement of the parties, the arbitrator is appointed by the Minister upon the written request of either of the parties. The Minister also has

the authority to name a nominee of either party to the Board if one of the parties to the dispute has not named their own representative.

Multi Hospital Negotiations

There are a number of unions who represent workers in hospitals throughout Ontario. They include ONA, SEIU, OPSEU, CUPE and few others of lesser importance. The hospitals of Ontario group themselves together under an organization known as the Ontario Hospital Association (the OHA). Starting in the late seventies, the OHA began to have significant influence in negotiation of contracts with the various unions. A practice developed whereby a large number of hospitals would group together under the auspices of the OHA and negotiate a master agreement that had application at all of the member hospitals who agreed to be bound by it. This resulted in very exstensive negotiations that governed thousands of employees at a time in many different locations. The practice developed that issues that were referred to as “central issues” would be decided by a central negotiating team. Where agreements could not be reached at the central level, those matters would be referred to a “central” Board of Arbitration appointed pursuant to the provisions of HLDAA. Local issues would then be decided at the local level between the local representatives and the hospital in question and any issues arising from those local negotiations would also be subject to final adjudication before a locally appointed board of arbitration under HLDAA.

Over the years similar approaches developed with respect to nursing homes. Many of the nursing homes in Ontario negotiate “centrally” and have both central and local provisions decided by arbitrators under the Act. Any hospitals or nursing homes which do not participate in the central bargaining are probably greatly affected by what results from the central bargaining because arbitrators appointed under HLDAA use the decisions reached in the central bargaining to establish precedents for those entities not participating in it. That is not to say that in every case what is decided at the central table will affect those local unions and local hospitals that have not participated in central bargaining. However, what takes place at central bargaining and in the central arbitration proceedings is clearly very important to all other non-central bargaining.

Thus the individual appointed as the arbitrator to a central bargaining Board has a enormous amount of power and influence over how hospitals allocate their funds and over what employees who work in those hospitals are paid and the other conditions under which they are employed.

This system of bargaining has now been in place in Ontario for more than 40 years giving ample time to evaluate its strengths and weaknesses. Many observers in the hospital sector and beyond have come to recognize significant problems with respect to this approach to Collective Bargaining. But alternatives are not easily designed or implemented.

Principles of Arbitration

Over the more than 40 years that this legislation has been in place, arbitrators have developed a set of “principles” which they purport to apply to their considerations when deciding the terms of a collective agreement they are mandated to determine. Although most arbitrators and most

decisions will discuss these principles, the application of the principle in specific cases is often very difficult to ascertain and subject to significant controversy.

Replication

Over the years arbitrators have determined that what they are attempting to achieve is a "replication" of what the parties would have agreed to had normal Collective Bargaining taken place. The problem with this principle is that nobody in the hospital sector (which encompasses the vast majority of the healthcare sector) negotiates in the normal fashion. All hospitals are subject to compulsory arbitration and therefore, especially after more than 40 years of disputes decided under compulsory arbitration, it is difficult to determine what would occur in Collective Bargaining if it occurred according to the "normal" rules. Often arbitrators will refer to agreements that had been negotiated without the necessity of reference to binding arbitration, but one can always argue that even in those situations, the fact the dispute would have been determined by an arbitrator, if not agreed to by the parties, had a significant influence on what was agreed to. Although arbitrators can and do have reference to the terms and conditions of similar employees in the private sector, few such examples exist. The work performed by many, if not most hospital workers is work that is generally unique to the hospital sector, in part because that sector is so broadly defined in the legislation.

Ability to Pay

Arbitrators have wrestled with the problem of "ability to pay" for many years. Generally speaking, arbitrators in the public sector take the view that ability to pay should not be an overriding consideration. Brown, H.D. put it this way in a decision regarding the board of governors of Ryerson Polytechnic Institute and the Ryerson Faculty Association in his decision in 1973 (4 LAC 2nd, 9)

The government which supplies the greatest part of the income for this institution cannot expect it to continue a loss and to hold that out as a barrier to justifiable increases for the employees of the institution. While the ability to pay is a factor to be considered in many situations, it does not have the same force or affect in public institutions and is not a proper basis to restrict an arbitration which must be made on objective facts. The cost of living factor is one of he essential elements which must be taken into account under current economic conditions and is a problem for the Faculty members as well as the Institution.

HLDAA now contains the following Section 9.11

In making a decision or award, the Board of Arbitration shall take into consideration all factors it considers relevant, including the following criteria

1. The employers ability to pay in light of its fiscal situation
2. The extent to which services may have to be reduced, in light of the decision or award, if current finding and taxation levels are not increased.
3. The economic situation in Ontario and in the municipality where the hospital is located.

4. A comparison, as between the employees and other comparable employees in the public and private sectors, of the terms and conditions of employment and the nature of the work performed

5. The employers ability to attract and retain qualified employees.

Notwithstanding this provision, Arbitrators appointed pursuant to HLDAA have recognized that although the individual hospital(s) may not have adequate resources, such resources are essentially determined by the Provincial government and there is therefore a tendency to recognize that, to some extent, fiscal limitations on hospitals might be considered to be "artificial" because the government allocating these resources has no such fiscal restraints. Although appointed pursuant to HLDAA arbitrator Hope in an unreported decision in re: BC Institute of Technology, (unreported October 19, 1983) summarized the view held by many arbitrators who have been so appointed.

In our view, we as arbitrators must recognize the Provincial government as being the quintessential public sector employer. The Provincial government stands behind every public sector employer as its fiscal board of directors and has financial control of that employer. Where public sector employers in the post secondary education field are concerned, it is the provincial government which dictates fiscal policy and determines the amount of money which will be available for capital and operating requirements, limitations on the manner in which those revenues will expand it and, effectively, whether there will be any funds available to finance increase wages and benefits.

Arbitrators in Ontario have reflected similar views when determining hospital employee awards under HLDAA.

The Albertyn Award

The arbitration between 147 participating hospitals and the Ontario Nurses Association before a board of arbitration chaired by Christopher Albertyn is a classic example of the type of issues and the importance of those issues to the parties, as well as the far reaching nature of decisions made pursuant to this legislation.

The hearing in this matter had participation of 19 people representing the Ontario Nurses Association, and 15 people representing the hospitals. Hearings were held in Toronto on June 26, August 15 & 17, 2006, with written submissions filed thereafter. Executive sessions were held on July 6, October 5, 17, 24, 26, November 9, 27 and December 4, 2006, January 20, February 13, 26, 27, March 1, 2007 and the award was issued on March 5 2007. [It should be noted that both the Arbitrator and the two side appointees are paid for each day of hearing and each day of executive session.]

The award, as indicated, covered 137 hospitals and more than 50 thousand members of ONA. That was the vast majority of all of the members of ONA in Ontario and this award was therefore a highly significant one for that organization and its members. Substantial representations were made; well researched and documented briefs were presented. The agreement that resulted

from the decision covered a period from April 1, 2006 to March 31, 2008. Therefore the award was issued almost a year following the expiry of the previous Collective Agreement. A number of significant factors were considered in the award including the significant increase in the number of nurses leaving healthcare in the next decade and a continuing acute shortage in nurses entering the profession. The replication principle is discussed in the award of the chair at paragraph 9 as follows.

Replication requires us to recognize that changes from the status quo need to be demonstrably necessary, and that a change to meet one parties need is often accompanying by change to meet the other parties need.

The award then proceeds to deal with a large number of issues, some of them quite complex. The issues decided included: the type of protective equipment that should be available for staff in hospitals in the event of a sudden disease outbreak; the establishment of a joint workload measurement committee; significant job security issues including the use of agency nurses; issues associated with the integration of hospitals as a result of the LHINS initiative (Local *Health System Integration Act* (Bill 37)); Significant changes to the HOODIP Plan (The Plan is the Hospital Insurance Plan Dealing with Short and Long term disability); rates to be paid for overtime and the circumstances under which overtime would be paid, benefits for part time nurses, and changes in benefits for all members; significant proposals with respect to changes in benefits, and perhaps most importantly, wage increases.

In a previous award, Arbitrator Keller had created a grid which provided increases at more senior levels including an increase in rates for nurses with 25 years experience. Albertyn improved these provisions. The main decision runs approximately 38 pages in length and there are also dissents from both the Hospitals' nominee, Roy Filion, and the nominee of the Ontario Nurses Association, Elizabeth McIntyre. Both nominees are closely connected with their respective parties and both wrote dissents criticising in significant ways the award of the arbitrator.

In his dissent, Mr. Filion criticises the award (at page 3 & 4) as follows:

Any award exceed 3% in each year of the Agreement offends the replication principle and sends absolutely the wrong message to all negotiating parties in the heath care field"

…"The overall affect of all of these numerous improvements, without meaningful set off is an award which totally offends the replication principle and creates increased cost well beyond the level which could be viewed as reasonably appropriate."

In a press release issued by the Ontario Hospital Association on March 5, 2007, OHA makes the following statement.

According to the HLDAA, the employer's ability to pay in light of its fiscal situation and the extent to which services may have to be reduced in light of the decision or award are to be given careful consideration by the arbitrator. In Ontario, hospitals are subject to legally binding, joint

Hospital Accountability agreements (HAAs) negotiated with the Ministry of Health and Long Term Care. These agreements set out specific funding levels for each hospital, and oblige each hospital to balance its budget out of that funding envelop. The arbitrator appears to have ignored this reality and, as noted above, has produced an award that is inappropriate in the current fiscal environment. As a result, the OHA is concerned that the sizable financial obligations imposed by this award may jeopardize the ability of certain hospitals to meet the balanced budget requirements of their legally binding hospital accountability agreements.

(and later) The interest arbitration process is designed to replicate results which could have been reached in freely negotiated agreements. As noted above, the OHA and five of Ontario's major hospital unions were able to conclude freely negotiated, long term agreements. This award in no way replicates those agreements. Awards such as the ones issued today bring the interest arbitration process contained in the HLDAA into disrepute.

On the other side, Elizabeth McIntyre is equally critical of sections of the award. She writes:

Unfortunately, the Chair felt constrain in his award by the settlement achieved by other healthcare unions for the period that will be covered by this collective agreement. I disagree that this should be the overriding consideration. The evidence of the retention and recruitment problems that are facing the nursing profession dictates a more generous monetary award, both on wage increases and premium improvements based on the criteria under the Hospital Labour Disputes Arbitration Act. If nurses currently had the right to strike, Labour Market Forces would result in higher increases for this group. This award should replicate that reality.

Although it is not surprising that individuals nominated by their respective parties criticize the award of the chair when submissions they accepted were rejected by the chair, their criticisms are reflective of those of others not necessarily directly involved in the process.

Criticism of the Process

In labour negotiations it is often said that a good agreement is one which neither side is happy with. If that is an appropriate criteria, it would appear that the Albertyn Award fits the bill. However, it is not just the result which is often criticized but also the process by which that result is achieved. Observers of the system over the years have criticized interest arbitrations on the following fundamental basis:

1. ***Failure to resolve issues.***

In the process of collective bargaining where strikes and lock -outs are a real possibility, the parties have an incentive to settle all of the issues in order to avoid economic sanctions. In most circumstances, both the company and the union have an incentive to avoid the economic dislocation and risk always inherent in a strike or lock out. In compulsory interest arbitration however, that is not the risk. Since there is no risk of either a strike or a lock out, and in the hospital sector little chance that the enterprise as a whole will cease to exist, both sides are often tempted to leave a matter on the table which might otherwise be settled in order to have a "give away" when the matter gets to arbitration. Because arbitrators tend not to give everything

to one side or the other, each side needs to have some issues that it doesn't care about particularly, left "on the table" for the hearing in order to hopefully obtain other issues which are more important to it. This can create an incentive to emphasize an issue more than would actually be warranted, but make it clear to your side nominee that that is an area that you are prepared to give on so long as you get something else that you really need. This incentive may also be present in normal negotiations, but usually by the end of the day, parties are well aware of what is truly important to the other side.

Interest based bargaining demands that each side have a realistic understanding of the importance of each of the issues to the other side. Many commentators have suggested that compulsory binding arbitration creates incentives that favour the opposite.

2. ***Leave it on the table - you never know what the arbitrator might do.***

Because ability to pay is a factor which the arbitrator is mandated to take into account by the legislation, unions are often tempted to leave other issues on the table which will be very meaningful to their members, but do not on their face involve increased cost to the employer. Often these are changes which would never be agreed to by management because they create significant difficulty in actually managing the facility and therefore have hidden costs that are not easily quantified. Often changes in hours of work or scheduling proposed by various unions involve costs that are not readily apparent to the ar