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Health Human Resource Planning Values, "Reinvented" Delivery Structures, and Collective Bargaining in Health Care: The Ontario Home Care Experience*

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I. Introduction

In the last five years, the effects of labour law structures on the distributive goals of Medicare are touched on only tangentially in the plethora of studies and commissions on the topic. The November 2002 report of the Commission on the Future of Health Care in Canada[1], chaired by former Saskatchewan premier Roy Romanow (hereinafter "Romanow Report"), continued this tradition; labour law in health care remained largely in the background. Throughout Romanow's analysis of HHR problems, many of the disturbing trends he describes, and the resolution of "sensitive issues such as wage settlements, scopes of practice, and working conditions"[2] are *profoundly* affected by labour law; in particular, collective bargaining by health professionals. Against this background have occurred: increased strife between nurses' unions and provincial governments in the past five years, troublesome wage settlements from "have provinces" and interprovincial "poaching" of nurses – all with important implications for cost-effectiveness and sustainability. While decrying these trends, Romanow and his predecessors stop short of critiquing the background regulatory order in labour law in which they arise.

I propose to undertake this type of critique. Examining the implications of trends in policy spheres conceptually "external" to health care is nothing new to health policy; for example, Romanow[3] and others[4] looked closely at the impact of international trade agreements. In the same spirit, I believe labour law structures are also a worthwile focus of critique. Addressing labour market problems in health care and other sectors can benefit, I believe, from greater scrutiny of the background legal structures in which they arise. In short, health policy should care about labour law trends in health care.

In this connection, I make two claims. First, using Ontario in-home nursing under recently-instituted "managed competition" reforms as an example, I argue that the "reinvention" underway in Canadian health care

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[1] Commission on the Future of Health Care in Canada (Roy J. Romanow, Q.C., Chair). *Building on Values: The Future of Health Care in Canada – Final Report*. (Ottawa: Commission on the Future of Health Care in Canada, November 2002) [hereinafter "*Romanow Report*"], available on line at http://www.healthcarecommission.ca.

[2] *Ibid*. at 92.

[3] *Ibid*. ch. 11, at 235-50.

[4] T. Epps & C. Flood. *The Implications of the NAFTA for Canada's Health Care System: Have We Traded the Opportunity for Innovative Health Care Reform?* (Working Paper, Health Law Group, Faculty of Law, University of Toronto, 2002).

is inimical to the accessibility and effectiveness of collective bargaining for employed professionals. In line with "reinvention" thinking aimed at greater efficiency, more provinces are "buying" health services for citizens from private firms, rather than "making" them. These measures include contracting out with for-profit health care firms for delivery of publicly-funded home care, diagnostic, and even some hospital and surgical services. If the recent Romanow and other reports are a barometer, hospitals will be doing far less, and firms and institutions currently on the "periphery" of the system will be doing far more. Much debate has erupted around this shift; my concern here is not with its health policy merits *per se*, but instead its effects on collective bargaining for nurses and other employed professionals. The Ontario home care experience, I argue, suggests that the accessibility and influence of collective bargaining for employed professionals in Canadian health care will dramatically erode if managed competition or other market-based reforms continue to take hold in the system.

I then argue that this trend is, on balance, not desirable when measured against emerging HHR planning values in Canadian health care. I describe *substantive* and *procedural* HHR planning values that have emerged in Canadian health policy in the post-Romanow era. Since Romanow, the goals of HHR planning are now firmly rooted in values of innovation and cost-effectiveness. While the Romanow Report and its predecessors called for immediate funding increases to increase the supply of nurses, physicians and other providers, they also want provinces and firms to invest future increases in developing more cost-effective modes of delivery. In short, Romanow and others want the new money to "buy change", not just "peace" with governments and providers, leading to perpetuation of inefficient models of delivery. At the same time, "accountability" and "dialogue" have emerged as "procedural" values informing how HHR planning is carried out. That is, Romanow urged the creation of institutions to provide greater oversight and wider participation in HHR decision-making to ensure it meets the substantantive goals.

While the decline of collective bargaining for health professionals seems at first glance to to dovetail with such values, I argue that any benefits in this regard are outweighed by its conflict with procedural values of HHR planning. Unions and collective bargaining have sometimes come under fire from proponents of efficiency and reinvention in public administration as barriers to progress, so this perspective is predictable. As such, it may be tempting for provinces to ignore this trend and allow barriers like collective bargaining to vanish "naturally" and quietly. Also, collective bargaining can be seen as almost redundant in light of the the

desperate demand for professionals in health care and their general public support in the wake of the dramatic labour force upheavals and restraint of the mid-1990s. In this context, promoting collective bargaining for professionals in health care runs the risk of giving them still more political control on health care decision making. If professionals once enjoyed dominance over the system, the erosion of collective bargaining in these "reinvented" sectors of health care will certainly restore an apparent, if not real, "balance" of power between professionals and managers in the system.

On the other hand, I argue that any benefits gained by the retreat of collective bargaining are outweighed by two factors. Most immediately, this erosion segments the labour market in health care. As emerging sectors such as home care and primary care take up more care duties from hospitals, the entrenched collective bargaining structures in hospitals, side by side with the erosion witnessed in these sectors, creates a relative "magnet" effect, draining valuable human resources away from those parts of the system at a time when more patients are going the other direction. While it is clear that the entire professional workforce is in crisis, with workload and working conditions the most serious problems, those working in hospitals and other traditional sectors of health care generally enjoy better wages, benefits and working conditions than their counterparts in home care and other emerging sectors.

Second, and more importantly, I argue that this erosion eliminates an imperfect but workable internal accountability and dialogue mechanism between health care professionals and their employers. As governments shift from being producers of health services to buyers, oversight of HHR decisions and dialogue in how they are reached are becoming first-order values. As managers face increasing pressure to contain costs and innovate, the risks of self-serving (even profit-driven) behaviour increase. Thus, both managerial and professional interests have recognizable conflicts of interest that could impede innovation. Collective bargaining, properly structured, could supply a valuable internal accountability and dialogue mechanism so that each set of interests can test the positions of the others in a transparent dialogue responsive to the substantive values of HHR planning. However, if collective bargaining retreats, this function is lost. In light of increased skepticism that governments – fearing political costs - will ever voluntarily implement effective accountability and dialogue mechanisms, the importance of alternate institutions to fill the void increases. As well, enhanced internal voice mechanisms that promote "workplace democracy" can enhance efforts to recruit and retain

nurses by offering voice as an alternative to exit in the event of managerial-professional conflict.

I conclude by sketching some institutional design issues for collective bargaining in health care. While collective bargaining in its current design is far from the perfect mechanism, it remains preferable to an absence of internal voice for professionals. To "re-enfranchise" nurses and other health care professionals with collective bargaining access under reinvented delivery models, I sketch some institutional design issues that need to be confronted in terms of bargainin structure, organizing process and dispute resolution.

In my view, the erosion of access to collective bargaining for nurses and other professionals *is* a health policy concern. While conceding that forcing the issue by imposing the Wagnerist collective bargaining *mutatis mutandis* onto Ontario home care may not be the ideal approach, I suggest that until the search for an ideal joint-governance mechanism proceeds further, collective bargaining on the lines I propose offers the most immediate policy response to a pressing health care problem.

II. Emerging Values in Health Human Resource Planning

In Canada and internationally[5], the "human resource" crisis is among the greatest challenges facing health care. Not only is it rapidly growing as a focus of scholarly inquiry[6], the need for immediate and drastic action, including greater public investment, is a refrain familiar to every Medicare inquiry in the last five years. While Quebec[7], Saskatchewan[8] and Alberta[9] have all produced comprehensive reports, the most

[5] L. Aiken et al., "Nurses' Reports on Hospital Care in Five Countries" (2001) 20:3 *Health Affairs* 43.

[6] Several leading health law and policy journals in Canada and abroad have recently devoted entire issues to HHR problems. Most recently, see R. Alvarez *et. al.*, "Planning for Canada's Health Workforce: Looking Back, Looking Forward" 3:2 Healthcare Papers 12-28, and responding papers collected in the same volume.

[7] Québec. Commission d'étude sur les services de santé et les services Sociaux. *Emerging Solutions – Report and Recommendations* (Québec: The Commission, 2001). Available on line at http://www.cessss.gouv.qc.ca/page1_f.htm.

[8] Saskatchewan. The Commission on Medicare (Kenneth J. Fyke, Chair). *Caring for Medicare: Sustaining a Quality System* (Regina: The Commission, 2001). Available on line at http://www.health.gov.sk.ca/info_center_pub_commission_on_medicare-bw.pdf.

[9] Alberta. Premier's Advisory Council on Health (D. Mazankowski, Chair). *A Framework for Reform. Report of the Premier's Advisory Council on Health*. (Edmonton: PACH, 2001). Available on line at http://www.premiersadvisory.com/pdf/PACH_report_final.pdf.

prominent recent studies have been at the federal level: the "Kirby"[10] Report from the Senate, and the Romanow Report. The Romanow Report is by no means the Gospel of health policy values, nor the "end of history" for health care reform. Valuable health human resource (HHR) planning dialogue will use Romanow and the wealth of other reports and ongoing research as a stepping-off point. However, it does synthesize and speak for the vast array of the preceding and contributed research into Canada's HHR crisis. Further, Romanow's report stands apart from the rest because, quite simply, it is more popular with Canadians at a grassroots level. As one expert noted, having consulted a mix of citizen and expert constiutiences, it resonates with "the other 73% of Canadians"– patients and other non-expert, vulnerable groups in the system.[11]

On HHR planning, however, the Romanow Report echoed its predecessors in outlining a number of disturbing trends.[12] These include an immediate and long-term shortage of physicians and nurses, a continued resistance by professions to accept changes to scope of practice, excessive workloads and declining "quality of working life".[13] Although recognizing that Canada's health professionals remained, despite the wage restraint of the mid-1990s, among the best paid among all OECD nations, Romanow noted that cost containment measures and restructuring "have taken their toll on Canada's health workforce."[14] In making these conclusions, Romanow echoed most of the themes of his predecessor Commissions.

Nurses, which make up 35%[15] of Canada's health care workforce, have been routinely singled out for attention in this respect. All the HHR problems that plague the system in general can be found in the nursing profession: shortages, concerns about workload levels, "downward"

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

[11] Michael Decter, President, Canadian Institute for Health Information (CIHI), speaking at "Life After Romanow and Kirby: Will Real Change Happen?" Symposium by the Health Law Group, Faculty of Law, University of Toronto, December 10, 2002 [hereinafter *Life After Romanow and Kirby*]. Mr. Decter spoke, along with Hugh Segal, President of the Institute for Research in Public Policy, Kingston, Ontario, and Profs. Carolyn Tuohy, Colleen Flood and Sujit Choudhry from the University of Toronto.

[12] The Report focused on HHR problems in ch. 4. *Romanow Report*, *supra* note 1 at 91-115.

[13] *Ibid.* at 93-94.

[14] *Ibid*. at 91

[15] *Ibid*. at 92

substitution of nurses with lower-paid and less-regulated providers, stress and burnout, and other changes to the work environment. Romanow noted that enrolments in nursing schools are stagnant, and recruiting and retaining nurses is becoming more and more difficult. Put simply, health care seems less and less attractive as a career, and the system is suffering for it.

While attempting to divine what values will come to dominate health human resource (HHR) planning in the post-Romanow era is obviously difficult, early indications suggest that HHR planning will occur in line with new values, both substantive and procedural. "Substantive" means investment, cost-effectiveness and innovation: values that currently infuse our decision-making about "appropriateness" in HHR planning; that is, how we decide what are the "right" number, distribution, scope of practice, remuneration and working conditions of our health providers. Procedural values describe accountability and dialogue in how substantive choices are made in the system and how outcomes are measured against prescribed standards of quality, accessibility and cost-effectiveness.

(a) "Substantive" Values: Investment, Cost-Effectiveness, Innovation

Substantively, Romanow made it clear that the above-noted trends in nursing must be addressed immediately, and urged targetted funding for home care as an important short-term step.

However, Romanow also made it clear that cost-effectiveness and innovation are equally important, long-term values in HHR planning. "Reinvention"[16] to promote innovation, quality and cost-effectiveness in HHR planning will thus become a top priority. As some experts have noted, a major risk in the post-Romanow period of health care reform is that the $15 billion in new federal funding demanded by Romanow will be wasted on short-term "quick-fix"[17] solutions and agreements to "buy peace"[18] (whether between provinces and the federal government, or

[16] This term was first coined in D. Osborne & T. Gabler, *Reinventing Government* (New York: Plume, 1993), a well-known analysis and proposal for reforms in the delivery of public services. As governments have moved ahead with restructuring, "public-private partnerships" to deliver public services, and other strategies to cope with fiscal pressures in public administration, "reinvention" approaches have attracted more attention from governments in both Canada and the U.S. For an excellent analysis of "reinvention" strategies for Canadian governments, including contracting out and privatization, see M. Trebilcock, *The Prospects for Reinventing Government* (Toronto: C.D. Howe Institute, 1994).

[17] C. Flood, *International Health Care Reform: A Legal, Economic and Political Analysis* (London: Routledge, 1999) [hereinafter *International Health Care Reform]*.

[18] Hugh Segal, speaking at *Life After Romanow and Kirby*, *supra* note 11.

between provinces and their physicians, nurses and other providers). This time, say the experts, policy makers must give patients' interests top priority, over those of providers, governments and other powerful and entrenched groups in the system.[19] In the wake of $23 billion in new federal funding announced in September 2000, however, three "have" provinces (Alberta, Ontario and British Columbia) gave hospital nurses generous wage increases. Romanow specifically singled out these trends for concern in light of the aforementioned risks:

> …[T]he Commission strongly feels that the additional funds should not become a target for increasing salary pressures from health care providers. There is a serious political risk to all parties – governments, health care providers and their organizations, and regional health authorities – if the bulk of additional funds simply goes to pay more for the same level of service, the same access, and the same quality. This simply will not be acceptable to Canadians.[20]

That is, Medicare must prevent nurses and other professions from extracting "rents", whether through collective bargaining or other institutions (such as physician-government negotiations in some provinces). Wages and other trends are now going to be measured against new yardsticks of their impact on the quality, accessibility and cost-effectiveness of care. In light of this, the Report recommended that "a portion of [proposed new funding] should be used to improve the supply and distribution of health care providers, encoourage changes to their scopes and patterns of practice, and ensure that the best use is made of the mix of skills of different health care providers."[21]

In short, the post-Romanow message is that we need more human resources but also need to use them more efficiently. The pursuit of "best practices", cost-effectiveness, and other values is now well-entrenched in HHR planning. While they have always been ideals in health care and administration in other public sectors, the current "crisis" of health care prodding Romanow and his predecessors has made them central to the sustainability of Medicare. In line with this message, governments across Canada are ready to experiment with new delivery models, among them increased contracting-out with for-profit firms to deliver Medicare

[19] Prof. Colleen Flood, speaking at *Life After Romanow and Kirby*, *supra* note 11.
[20] *Romanow Report*, *supra* note 1 at 105.
[21] *Ibid*.

services. The reforms in Ontario home care described below fall squarely in this category.

(b) "Procedural" Values: Dialogue and Accountability

Procedurally, "accountability" and "dialogue" and have emerged as values from the Romanow Report and subsequent debate. "Accountability" connotes mechanisms of oversight, transparency and measurement against prescribed norms of quality, accessibility and cost-effectiveness. As the federal government will try to extract accountability from provinces for cost-effective use of transfer payments for health care, so too will provinces do so to the regional boards, institutions, contracting firms and providers (most notably physicians) to whom they dispense funds. Particularly in this rare and volatile "open" period of health care reform, in which the political risks of inaction outweigh those of action, these values tell us *how* we want HHR planning to occur. Where government shifts from a "maker" to a "buyer" of Medicare services from the for-profit private sector, accountability is necessary to ensure that the touted gains in quality, accessibility and cost-effectiveness are truly achieved. More broadly, accountability implies the burden of justifying a wide range of other notionally "private" contractual arrangements in the system along the same lines. Terms and conditions of employment fall squarely under this rubric, so labour market trends – particularly the contents of recent collective bargaining settlements in the hospital sector – are also coming under scrutiny.

"Dialogue" connotes the need for a more inclusive policy process in HHR planning, the need to acount for the interests of a wider range of interests, and the need to engage all stakeholders in evidence-based critiques of what Romanow termed "sensitive" HHR issues such as wages, working conditions and scopes of practice. To promote the most cost-effective HHR pllanning, Romanow recommended that his proposed Health Council of Canada (HCC) take a greater role in labour market research and planning.[22] He stated that

> [t]he [HCC], with expertise drawn from providers, is the best vehicle for addressing health human resource issues and driving the process forward over the longer term. It can serve as a focal point for facilitating co-operation among governments, health providers and the public. It can address sensitive issues such as demands from various health provider organizations and changing scopes

[22] *Romanow Report* , *supra* note 1 at 108.

> of practice through an arm's length, independent body.[23]

By recommending such an inclusive process, Romanow sees political dialogue between all affected parties as vital to sound HHR planning. By envisioning the HCC as the primary vehicle for HR planning, Romanow rejects HHR planning that happens in a haphazard, un-coordinated manner through the unfettered operation of collective bargaining and other labour market processes. Under these processes, "human resource issues go round in circles, never really getting to the heart of the matter."[24]

Further, Romanow's recommendations show a clear preference for more balanced and meaningful dialogue and participation between all affected parties to HHR planning: citizens, patients, providers, managers, governments and other experts. labour market to promote the quality, accessibility and cost-effectiveness of professional care, his recommendations recognize the inherent tensions between managerial, professional, patient and government interests, as well as the potentials for conflicts of interest, self-serving behaviour or regulatory "capture" by each group. Through a mechanism like the HCC, all affected groups would act as a political "check" on each other's proposals for planning.

III. Reinvented Delivery Structures and Nurse Collective Bargaining: The Ontario Home Care Experience

In this section, I isolate one labour law trend for analysis against these values. Since the advent of "managed competition" in Ontario's publicly-funded home care system, meaningful access to collective bargaining has dramatically declined for nurses. As I will argue, this is due to deficiencies in the background collective bargaining regime currently in home care – commonly called the "Wagner Act" model, or Wagnerism (named after the proponent of the *National Labor Relations Act* in the U.S. in 1935[25]). In particular, I argue that the Wagner Act model in Canadian health care cannot preserve meaningful access to collective bargaining for professional employees in the context of a rapidly changing delivery structure involving competition with for-profit firms. Based on these findings, I argue that if "reinvention" along the lines of Ontario home care's competitive contracting model spreads throughout health care, and as more care is delivered outside hospitals, collective bargaining – once

[23] *Ibid*. at 111.
[24] *Ibid*. at 110.
[25] *National Labor Relations Act*, 29 U.S.C. (1935).

firmly entrenched in the system – may well recede in importance as a driver of HHR trends and an internal voice mechanism for professional employees.

(a) Reinvention: "Managed Competition" in Ontario Home Care

More than ever, governments in Canada and across the Western world are seeking to "reinvent" how they deliver health care through measures such as contracting out and privatization.[26] Reinvention can also include changes in how care is delivered, by whom, and at what cost. In either case, the rationale is familiar: containing health care spending and protecting the sustainability of the system. Now that innovation and cost-effectiveness are dominant values in HHR planning, the incentive to experiment with new delivery structures is greater than ever.

One of the most controversial issues in health policy surrounds one increasingly popular form of reinvention: contracting with private-sector facilities, including for-profit firms, for the delivery of core Medicare services. First, it must be made clear that private, for-profit delivery is already entrenched in Medicare in the form of private physician practice funded on a fee-for-service basis. However, the arrival of privately-owned and for-profit firms to deliver other publicly-funded health services is a more recent phenomenon, and one likely to increase despite Romanow's admonition otherwise. [27] Recent measures in some provinces to contract with for-profit firms for publicly-funded surgery, diagnostic procedures such as MRIs, and cancer treatment have attracted much attention and sparked debate about the proper role of private, for-profit delivery in health care. More and more services may well be delivered in a wide range of smaller, more specialized, independent health facilities rather than hospitals. The extent to which such measures proliferate in the wake

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[26] Flood, *International Health Care Reform, supra* note 17.

[27] Romanow rejected arguments in favour of private, for-profit delivery on the basis that there was no evidence that such measures improve quality or enhance efficiency. Because of the sensitivity of this issue, Romanow's comments on this point bear reproduction here:

> Proponents of for-profit care may insist that the quality of care is not an issue, but there is evidence from the United States to suggest that the non-profit sector tends to have better quality outcomes than the for-profit sector in such things as nursing home care and managed care organizations and hospitals.More recently, a comprehensive analysis of the various studies that compare not-for-profit and for-profit delivery of services concluded that for-profit hospitals had a significant increase in the risk of death and also tended to employ less highly skilled individuals than did non-profit facilities.
>
> For those reasons, the Commission believes a line should be drawn between ancillary and direct health care services and that direct health care services should be delivered in public and not-for-profit health care facilities.

[References omitted] *Romanow Report* , *supra* note 1 at 7.

of the Romanow and Kirby reports is difficult to predict, but will depend greatly on federal-provincial relations and other political factors.

For my analysis, the "managed competition" reforms to Ontario home care provide an excellent example of this type of reinvention in health care, and its impact on collective bargaining. Since 1996, acute nursing, therapy and other "medical" home care services are now delivered through a competitive contracting model involving for-profit providers. Before describing this reform, the emerging importance of home care within Medicare ought to be outlined.

(i) Home Care: Definition and Importance

"Home care is the most urgent element of modernizing and enhancing medical care."[28] That was Canada's health minister in 1998. In the wake of Romanow, this is truer than ever.

Home care is "…an array of services which enables clients, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying or substituting for long-term care or acute care alternatives."[29] In Canada, home care's acute-care substitution function is rapidly growing. Home care's proponents say it is more cost-effective than hospitals or other institutions at treating the sick and elderly, and that the quality of care and health outcomes are superior when patients are treated in their own homes.[30] Medicare, the home was the predominant site for most medical care; for example, physician house calls were more common. However, as hospitals and physicians became the cornerstones of the various provincial medicare plans that arose under the *Canada Health Act*[31] and previous funding arrangements, home care's role in Medicare shrank. It is currently listed as an "extended health service" under the CHA, meaning provinces do not have to adhere to the CHA's five funding criteria (universality, comprehensiveness,

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[28] Federal Health Minister Allan Rock, cited in M. Anderson & K. Parent: *Putting A Face on Home Care*. Report prepared for the Canadian Association of Retired Persons. (Kingston, Ont.: Queen's University Health Policy Research Unit, 1999) [hereinafter *Putting a Face on Home Care*], p. iii.

[29] Health Canada. Home Care Development. Federal-Provincial-Territorial Advisory Committee on Health Services Working Group on Continuing Care. *Provincial and Territorial Home Care Programs: A Synthesis for Canada* (Ottawa: Health Canada, 1999) [hereinafter *Home Care Synthesis*], p. 10. On line at http://www.hc-sc.gc.ca, accessed May 2000.

[30] Health Services Utilization and Research Commission, *Hospital and Home Care Study. Summary Report No. 10* (Saskatoon: HSURC, 1998); L. Soderstrom et. al. "The health and cost effects of substituting home care for inpatient acute care: a review of the evidence" (1999), 160:8 *Canadian Medical Association Journal* 1151; K. Parr, Saskatchewan Health Services Utilization and Research Commission, *The Cost-Effectiveness of Home Care: A Rigorous Review of the Literature* (Saskatoon: HSURC, 1996).

[31] R.S.C. 1985, c. C-6, s. 2.

portability, public administration and accessibility) to receive federal health transfers, as they must with respect to hospital and physician services.

However, more nursing services once rendered in hospitals ang long-term care facilities are now provided in the home, and various forms of therapy and rehabilitation services have also been shifted. In addition to traditional holistic nursing care (e.g. monitoring health, wound dressing, and administering medication) technological advancements have facilitatedmore complex nursing care in the home, such as kidney dialysis. As of 1997, nursing services comprised the largest component of publicly-funded home care services, at 38.8%. With therapies comprising 26.5% of home care services, total acute and rehabilitative services now comprise almost three-quarters of all home care services.[32]

Romanow distinguished between the "medical" components of home care services outliined above, and the "supportive" components – support for daily living, hygiene, diet and other needs. While hospitals maintain a central place in the system, they are no longer envisioned as its cornerstone. They have pared back budgets, bed spaces and redefined their services in line with a reduced role - emergency, surgeries, and other highly acute, risky or complex care. Picking up the remainder of care are emerging sectors once at the periphery of the system, such as home care, primary care, and independent health facilities. "In effect, home care should not be seen as a distinct category of care, but as a key part of the health care system," declared Romanow[33]. Thus, he recommended more public funding, and the enshrinement of "medical" home care services – post-acute nursing or therapy services, rehabilitation services, mental health services, palliative care and medication management - in the CHA as essential components of Medicare.[34]

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[32] Health Canada, Profile of Home Care Statistics in Canada. "Number of Home Care Clients Served by Type of Service (1996-97)" on line at http://www.hc-sc.gc.ca, accessed February 2001.

[33] *Romanow Report*, *supra* note 1 at 185.

[34] The Report focused on home care in ch. 8, at 171-189. In Recommendation 34, Romanow specifically calls for the following measures:

> The proposed new Home Care Transfer should be used to support expansion of the *Canada Health Act* to include medically necessary home care services in the following areas:
>
> • Home mental health case management and intervention services should immediately be included in the scope of medically necessary services covered under the *Canada Health Act.*
>
> • Home care services for post-acute patients, including coverage for medication management and rehabilitation services, should be included under the *Canada Health Act.*

(ii) The Shift to Managed Competition in Ontario Home Care

"Managed competition" is increasingly popular in some industrialized countries as a way to make health care more efficient.[35] Though it can take many different forms, the idea behind competitive contracting is to encourage better management of public health care dollars by rewarding firms that deliver higher quality at a better price to the taxpayer.

Since 1996, Ontario has used managed competition to deliver all home care services – including nursing, therapy and other services Romanow deemed essential to Medicare. The "RFP" (Request for Proposals) process replaced the 74 Home Care and Placement Coordination programs that had provided home care services through a non-competitive delivery structure. Many other provinces contract with private agencies for the "supportive" components of home care, but the medical components are more often provided by staff employed directly by the government or by non profit firms that have secure funding.[36] Thus, by entrenching competitive contracting with an increasingly for-profit private sector as the delivery model for what are now deemed essential Medicare services, Ontario stands apart from other provinces.

Elected a year earlier, the Conservative government was swift to attack the non-profit "monopoly" it decried in home care. "When a Mike Harris government gets in, we're going to restore the balance between the private sector and the not-for-profit sector in this province," announced a Conservative health critic in 1994.[37] Thus, the RFP process was born, and the market opened up to for-profit firms. In 1998, even when the RFP process was fully implemented, the minister responsible for home care still decried the "monopoly" that non profit firms had once enjoyed, adding that the old system contained no incentives to control costs or monitor quality. "People who determined who got home care were in many respects the same people who provided care," he stated. The minister reportedly accused some non-profit providers of actually defrauding the province. Competitive contracting under the RFP process would, he argued, break up this monopoly, allow more competition by

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• Palliative home care services to support people in their last six months of life should also be included under the *Canada Health Act*.

Romanow Report, *supra* note 1 at 176.

[35] Flood, *International Health Care Reform*, *supra* note 16.

[36] *Home Care Synthesis*, *supra* note 29.

[37] Jim Wilson, quoted in Hansard, 21st Parliament, 1994, Legislative Assembly of Ontario.

for-profit home care agencies, save money and enhance the quality of care.[38]

Managed competition in Ontario home care works as follows. Currently, 43 regional bodies called Community Care Access Centres (CCACs) receive annual blocks of funding from the Ministry of Health and Long-Term Care. They use this money to contract, through the RFP Process, with private firms for almost all of the goods and services they used to deliver directly. In short, CCACs became "buyers" rather than "makers" of home care services. Contracting firms include the Victorian Order of Nurses (VON) who used to enjoy the "monopoly" broken up by the Harris government, St. Elizabeth Health Care, St. Elizabeth Nursing, Comcare, Bayshore, and WeCare. More and more for-profit, and U.S.-owned or based firms, are entering the Ontario home care market.

Until 2001, CCACs were governed by independent, incorporated, non-profit community-appointed boards that are accountable to the Ministry of Health through annual service agreements. With the passage of the *Community Care Access Corporations Act, 2001*,[39], however, CCACs became statutory corporations whose boards are appointed by the provincial government, and who operate under much stricter control and review by the Minister of Health than was previously the case.

For nursing services, CCACs issue RFPs every three to five years, or whenever a contract expires or terminates for other reasons. After receiving the proposals, CCACs award the contract(s) based on a range of factors comprising cost and quality of care. The RFP process has fostered greater variability and fragmentation in the cohort of firms that deliver home care. In 1997, the Ministry of Health issued guidelines for the RFP Process[40], but CCACs still retain wide discretion. As contemplated by the guidelines, CCACs commonly divide their nursing contracts among at least two or more firms. The result is a patchwork of firms working under contracts of varying size and duration. For example, a CCAC could divide a three year nursing contract among firms A, B and C, each receiving 33%. For that period, the CCAC has all three firms at its disposal to supply nurses. Patients enter the system either by referral or by contacting the CCAC themselves. CCAC case managers determine entitlement on the basis of need. After the plan of care is arranged, CCACs select one of the firms to provide it. While CCACs set the plan of

[38] Cam Jackson, quoted in J. Barber, "Saving 'an awful lot of money'" *The [Toronto] Globe and Mail* Dec. 14, 1998, A4.
[39] S.O. 2001, c. 33.
[40] Ontario. Ministry of Health, Long-Term Care Division. "Provincial Requirements for the Long Term Care Request for Proposals Process" (Ministry of Health, September 1997), p. 2 [hereinafter *RFP Guidelines*].

care, the contracting firms are the *de jure* employers of the the nurses who carry it out.[41] Contracting with multiple firms gives CCACs the flexibility to allocate tasks among them depending on need and other circumstances. In this example, if all of firm A's nurses are already assigned to patients, or if for other reasons (such as a labour dispute or the firm's financial condition) it is not able to meet the CCAC's needs, then the CCAC simply turns to firm B or C for nurses.

Further, after the three-year contract expires, the CCAC is free to award the contract among an entirely new set of providers. Thus, the number and identity of the employers supplying home care nurses to CCACs can change dramatically with each new round of competition. In our example, if firms A and B lost their contracts to firms C, D and E in the next contracting round, many of the nurses they employed would seek new jobs either with firms C, D and E, the hospital sector or elsewhere. Although there are no precise data yet, each RFP round can result in significant turnover. Thus, while the RFP Process has consolidated home care funding and administration into 43 regional boards, it has also created more fragmentation and variability among the provider agencies that actually employ nurses.

Some opponents of managed competition rest their critiques on *a priori* opposition to increased "private" involvement in health care, saying it pushes the Canadian system closer to "American-style", for-profit health care.[42] Others have criticized it for how it operates in practice, suggesting it poses risks to quality and accessibility without proper regulation.[43] Romanow's admonition against for-profit, private delivery of essential Medicare services suggests tacit sympathy for these concerns.

In response, its proponents point out that private sector involvement in health care is nothing new, and therefore that the *a priori* objection to private *delivery* of publicly funded services is misleading.[44] According to some experts, it matters not to patients how care is provided, by whom,

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[41] The Ontario Labour Relations Board recently affirmed this in *Durham Access to Care, infra* note 96, discussed in Part III below.

[42] The union movement has been the most vocal in opposing competitive contracting. See e.g., R. Sutherland, "The Cost of Contracting Out Home Care: A Behind the Scenes Look at Home Care in Ontario" (unpublished, Canadian Union of Public Employees, 2001).

[43] M. Anderson & K. Parent, "Care in the Home: Public Responsibility - Private Roles?" (Toronto: Dialogue on Health Reform, June 2000) [hereinafter *Care in the Home*]; A. Williams et. al., "Long-Term Care Goes to Market: Managed Competition and Ontario's Reform of Community-Based Services" (1999) 18:2 *Cdn. J. on Aging* 125.

[44] E. Witmer, "Bringing Healthcare Closer to Home: One Province's Approach to Home Care" (2000) 1:4 *Healthcare Papers*; Ontario Home Health Care Providers' Association, "The Competitive Process in Contracting for Home Health and Social Care Provision" (unpublished position paper, March 1999).

or for what motive, so long as the end result is quality and accessible publicly-funded care. On this view, managed competition is not *per se* objectionable; rather, the real problems are ensuring adequate funding levels and instituting proper accountability mechanisms for quality and cost. Despite Romanow's clear position on for-profit contracting, these debates will not end anytime soon.

(iii) Human Resource Problems in Ontario Home Care

Parallel to the above trends, the home care workplace itself has also been reinvented. While some trends in nursing work promise greater cost-effectiveness, others are causing some concern to health policy. All the HHR problems identified by Romanow exist in every province's home care system.[45] The most urgent: a dire shortage of nurses. While this plagues health care systems in Canada and abroad[46], it is particularly severe in home care. At a time when the number and acuity of home care patients[47] dependent on home care is rising, as of 2000 only 3.7% of employed nurses in Canada worked in home care.[48] The main factors cited by the nursing profession in a recent survey are underfunding, low wages relative to hospitals and other institutions, and poor working conditions.[49] Currently, comprehensive official data on home care wages and benefits are not available, but a recent federal government report concluded that home care wages are consistently lower than for comparable jobs in hospitals and other institutions. One source reported, for example, that in 2000 hospital nurses received between $20.50 and $30.24 hourly, while home care nurses earned between $18.71 to $24.86.[50] It also noted that wages in for-profit home care firms are often lower still. Many home care nurses do not receive significant fringe

[45] Human resource issues are identified by home care policy observers as their top concern, along with funding. See e.g. M. Anderson & K. Parent, *CARP's Report Card on Home Care in Canada 2001: Home Care by Default, Not by Design* (Ottawa: Canadian Association of Retired Persons, 2001) [hereinafter *Home Care by Default*] at 14.
[46] Aiken et al., "Nurses' Reports on Hospital Care", *supra* note 5.
[47] "Client" is currently in vogue to describe those who depend on home care. In light of Romanow and other reports, this term seems inappropriate due to the essential medical nature of many home care services. "Client" connotes a non-medical, voluntary consumer actor. It is consistent with a relationship of choice and the attainment of *wants*, rather than with a relationship of dependence and *need*. In my view, "patient" is preferable, as it recognizes the real vulnerability of those dependent on medical home care services.
[48] Canadian Institute for Health Information, Registered Nurses Database, *Supply and Distribution of Registered Nurses in Canada, 2000* (Ottawa: CIHI, 2000) [hereinafter *Supply and Distribution*], p.76, Table 6.0a.
[49] *Home Care by Default*, *supra* note 45 at 14.
[50] *Ibid*., at 15. Figures are for Registered Nurses.

benefits, and are some are not compensated for travel time.[51] A 2001 report commissioned by the Harris government showed these problems to be no less severe in Ontario. The report by Price Waterhouse Coopers ("the PWC Report") concluded that Ontario's home care system was underfunded, understaffed and plagued by waiting lists.[52] The cause is not in dispute. Both home care firms, nurses and CCACs all agree that the wage gap between home care and institutions makes it harder to recruit and retain nurses in home care.[53]

Other aspects of the reinvented workplace in home care may also be impeding recruitment and retention efforts for home care. Because of the travelling involved and the numbers of clients to serve, serious workload and safety issues also arise. In sprawling rural areas and sometimes dangerous urban centres, travel to a patient's home can be dangerous. As well, there are sometimes safety risks involved in serving a patient in their home while alone.[54]

Ontario nurses' organizations say the home care work environment is also deteriorating from both a personal and professional standpoint. Concern has been expressed, for example, about an increasing shift by home care employers from per-hour to per-visit as the mode of compensation. From a management perspective, this saves labour costs. However, the profession says that paying nurses on a per visit basis shifts to them the task of containing costs because more time with individual patients may well mean fewer visits, and less pay overall. It thus creates strong incentives to shorten patient contact. As one report concluded:

> Nurses bitterly complain that they must reduce the level of service they deliver in order to make enough calls to become cost-effective (when on salary) or make an adequate living when paid on a per visit model. Most disturbingly, nurses report that they are continually in a rush and not in a

[51] *Putting A Face on Home Care*, *supra* note 29 at 72.
[52] Price Waterhouse Coopers, *A Review of Community Care Access Centres in Ontario: Final Report* (Toronto: Ministry of Health, December, 2000) [hereinafter *PWC Report*].
[53] Registered Nurses' Association of Ontario, *Ensuring The Care Will Be There: Report on Nursing Recruitment and Retention in Ontario*. (Toronto: RNAO, April 2000) [hereinafter *RNAO Report*] at 50; Ontario Home Health Care Providers' Association, "Home Care Worker Compensation" (unpublished position paper, October, 2000); and Ontario Association of Community Care Access Centres, Human Resources: A Looming Crisis in the Community Care System in Ontario" (unpublished position paper, July 26, 2000) at 17.
[54] *Ibid*. at at 71-72. See also A. Steinberg, *A Survey of Personal Safety Risks and Strategies Among Saskatchewan Home Care Nurses* (M.N. Thesis, University of Regina, 1995).

> position to supply the amount of care which their professional judgement tells them is necessary.[55]

In complex acute care cases, which are becoming more common in home care as patients are discharged quicker from hospitals after surgery, childbirth or other treatments, per-visit pay can conflict with the profession's ideals of "holistic" nursing practice, which mandate attention – and the devotion of time – to all aspects of a patient's health.

As well, fewer nurses are paid travel allowances, or for time needed to document care, and fewer are provided with vital communication equipment like cellular phones. The itinerant and isolated nature of home care nursing creates health and safety concerns. Caring in the home in isolation from colleagues and support staff leaves nurses more vulnerable in the event of a violent patient episode. In addition, the risks inherent in travelling – usually driving – to the site of care can be significant in sprawling rural areas, especially in winter, as well as in high-crime locations in urban areas at night. While some nurses reportedly prefer the autonomy and flexibility of community nursing, the increased workloads resulting from the nursing shortage have made it much more challenging and less professionally rewarding. Because of travel time and the professional obligation to see all assigned patients in a given day, some nurses are working over 12 hours a day.

Relative to hospitals or other health facilities, the home may not be a sufficiently controlled setting for complex acute care. For instance, it may not contain necessary facilities and resources, it may not be clean or quiet enough to deliver proper care, and the physical remoteness of the patient (as compared to hospitals) reduces the nurse's ability to control and monitor the patient on an ongoing basis.

Scheduling arrangements aimed at cost-effectiveness have also raised some concerns for nurses. One prominent concern is about the increasing "casualization" of the home care nursing workforce. Casual employment is distinct from part-time employment in that it does not have regular patterns, and is less secure than full-time work. As such, some casually-employed nurses work for multiple employers. Figures from 2000 show that between that between 1990 and 1997, casual employment for all nurses employed in Canada rose from 14% to nearly 19%.[56] As well,

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[55] *RNAO Report, supra* note 54 at 50.

[56] Advisory Committee on Health Human Resources, *The Nursing Strategy for Canada* (Ottawa: ACHHR, 2000), [hereinafter *Nursing Strategy*] at 18. Figures do not include Quebec. The ACHHR was an *ad hoc* body formed by the provincial ministers of health in 1999.

15.4% of employed nurses worked for more than one health care firm; in Ontario, the figure stood at 14.9%.[57]

Casualization perfectly embodies the debates about the "reinvented" health care workplace. While casualization promises greater efficiency - it can save employers labour costs by giving them more flexibility to vary staffing levels quickly in response to fluctuations in service - it can be a double edged sword for nurses. On one hand, it can give them more control over their hours of work than they would have under regular full or part time schedules. Thus, it holds the promise of improving productivity and cost-effectiveness while permitting nurses to strike desirable work-personal arrangements. On the other hand, critics of casualization say that, without adequate legal protections, it can become unattractive to nurses. [58] For instance, nurses may work many hours one week, and none the next. As such, they may not accumulate experience as quickly as full or part-time nurses and thus be excluded from entitlement in workplace benefit plans and advancement in wage scales. Further, they may be called into work on short notice; despite their freedom to decline shifts, many feel compelled to say yes, affecting their ability to balance work and personal commitments. According to the Ontario Nurses' Association (ONA), the largest nurses' union in Ontario, casual employment may require some home care nurses to work for more than one firm because of uncertainty about income. One union official stated it was not uncommon for nurses to carry several uniforms of their different employers in their cars during their workday so they can change betweeen visits. According to the profession, the increasing contingency of home care nursing employment harms the "quality of working life" in nursing, and hence the ability of the home care system to attract and retain nurses.[59] Thus, home care experiences a high turnover rate in nursing staff, as nurses seek jobs in hospitals, leave Canada, or the profession altogether.[60]

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[57] *Supply and Distribution*, *supra* note 48 at 39, and Table 15.0a, p. 95.

[58] *Nursing Strategy*, *supra* note 57 at 10.

[59] The lack of full or part time employment in health care was cited by 62.7% of nurses surveyed by the Registered Nurses Association of Ontario as a reason for their decision to leave Ontario for the United States. See RNAO, "Earning Their Return: When & Why Ontario RNs Left Canada, and What Will Bring Them Back" (Toronto: RNAO, 2001). See also *Care in the Home*, *supra* note 44 at 8; and the recommendation for more full and part time positions in A. Baumann et al., *Commitment and Care: The benefits of a healthy workplace for nurses, their patients and the system* (Ottawa, CHSRF, 2001) [hereinafter *Commitment and Care*] at 16.

[60] Health Canada. Home Care Development. *Human Resource Issues in Home Care in Canada: A Policy Perspective* (Ottawa: Health Canada Home Care Development, 1999), on line at http://www.hc-sc.gc.ca, Section 3.6.3, "Wages and Benefits". See also see also

Some nurses also say casual employment can interfere with the "continuity" of care – stability in the identity of provider and patterns of treatment. Continuity of care is said to affect the quality of care inasmuch as disruptions and sudden changes harm the *process* of care – particularly for seniors - and may also affect health outcomes. In a recent report on home care, continuity was cited by home care patients as a vital concern:

> One of the bitterest complaints of of clients is the disruption and lack of confidence that occurs when many different workers enter their homes. Not only is it tiring for clients to repeatedly instruct new workers but important information about the client's condition may be lost…More so than in other health settings, continuity and reliability of home care workers are critical to the quality of the care delivered.[61]

To the extent they worsen the nursing shortage, these trends worsen access problems in home care. A 2000 survey of Canadian home care firms showed between 29 and 34% of those surveyed felt that difficulties in recruiting and retaining nurses had a negative impact on the accessibility of care.[62] To the extent the public system cannot meet patient needs, it shifts the burden to the patient or their informal caregiving support network in the form of time, unpaid labour and sometimes money. A disproportionate share of this burden has fallen on women, whether spouses, children or others in a patient's support network.[63] Thus, access problems in home care have a distinctly gendered character.

As well, even if supply problems are met with more funding, concerns are still increasing that poor working environments for nurses and other caregivers also harm the quality of care itself. Assuming a shared understanding of the goals of post-acute home care – of what "quality" means in this setting – debate will likely continue on the nursing profession's claimed link between their working conditions and the welfare of their patients. Emerging literature on this point, however, is

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Home Care by Default, *supra* note 46 at 18-19 for survey results showing difficulty recruiting, high turnover and increased workload.

[61] Health Canada. Human Resource Issues in Home Care in Canada: A Policy Perspective (Ottawa: Health Canada, 1998), section 6.1 Accessible on line at http://www.hc-gc-ca.

[62] *Home Care by Default*, *supra* note 46 at 23.

[63] M. Morris et al., The Changing Nature of Home Care and Its Impact on Women's Vulnerability to Poverty" (Ottawa: Status of Women Canada, November 1999).

tending to favour the nurse's position. A recent government-commissioned study reiterated the less controversial link between working conditions and recruitment, but went further to argue that it also affects patient health outcomes.[64] The study singled out six aspects of the nursing practice environment for scrutiny:

- workload levels
- job security and predictability
- managerial and collegial support and training
- the level of professional identity in the workplace
- the level of nursing participation in management decisions affecting care, and
- a balance between work and reward.

The report concluded that each aspect had a direct or indirect bearing on nurses' willingness and ability to meet the highest standards of care. While recognizing that these issues are difficult for health care managers to address under budget constraints, the report concluded that ignoring them altogether could lessen the commitment, professionalism and productivity of the nursing workforce. Similar arguments were advanced in a 2002 policy paper urging greater attention toward work environment issues for the health care workforce.[65]

Of course, this view has its skeptics. Long propounded by many in the public sector labour movement to justify better wages and working conditions, the "quality of work life - quality of care" theory is not entirely convincing to managers and economists in health care. On this view, just because a change in working conditions is seen as "unfair" by nurses does not always mean it is bad for patients as well. There is also some doubt whether actually achieving the "ideal" workplace imagined by the nursing profession will enure to the patient's benefit in all the ways the profession claims. For example, while the continuity problems caused by casualization may worsen the *process* of care for the patient, skeptics might ask whether this represents a real decline in the quality of care overall. That is, while having the same nurse visit every day may come to be a valuable part of the patient's process of care, it may not always be necessary to achieve desired health outcomes. If so, then nurses' criticisms of casualization ought to be more closely scrutinized.

In short, managers and health economists are concerned that, after a certain point, spending more to improve wages, the work environment and recruit more nurses may produce no meaningful improvement in

[64] *Commitment and Care*, *supra* note 60.
[65] M. Koehoorn et al., Creating High-Quality Health Care Workplaces. CPRN Discussion Paper Seres No. W/14 (Ottawa: Canadian Policy Research Networks, 2002), available on line at http://www.cprn.org/cprn.html.

patient care. However, none of these objections reject the workplace-quality of care theory outright; rather, they urge caution in its application. So long as there remains compelling evidence of a shortage of nurses and widespread concern for their workplace conditions, none of these objections warrant any less attention to it from health policy.

(b) Nurse Collective Bargaining Decline Under Managed Competition

The strength and accessibility of collective bargaining protection in Ontario home care has markedly receded since managed competition was introduced. In 1996, non profit firms held most of the home care contracts, and most were unionized, usually by the ONA. Today, nearly the reverse is true. Many non profit firms have lost their home nursing contracts, or significant shares of contracts. According to the ONA, some for-profit firms were able to submit excessively low-cost bids.in order to drive the VON out of the market in the early RFP rounds. Driven by budget constraints, CCACs often chose these firms. The result of the RFP process, then, has been the ouster of the near-monopoly of the VON on the delivery of in-home nursing care, and the entrance of more non-union, for-profit home care firms in its place. Many of the VON branches that the ONA had organized now simply have no contracts; they are unionized workplaces with no work.

Organizing the new, for-profit entrants has been almost impossible. the ONA says it simply lacks the resources at present to mount a concerted strategy to organize in this new environment. From all accounts, very little new nurse organizing has taken place in Ontario home care. Thus, most of the unionized firms operating in Ontario are the ones who were unionized before 1996, but who have clung to a share of the home care market. Although concrete evidence is not readily available[66], data from the ONA and the author's own research back up

[66] A caveat should be noted about the information I use. Obtaining precise data on the RFP processes and the union/non-union status of home care firms is difficult, due primarily to the confidentiality pressures inherent in the competitive process. Much of the research involved contacting each CCAC directly or searching each of their web sites. Because of legal obligations flowing from the tendering process, CCACs are wary of divulging any but the most basic information about the providers with whom they contract for nursing services; and some refused to answer even that question. The providers themselves are equally wary. The variance of RFP cycles between the 43 CCACs also mean that information may become dated; new contracts are being awarded across the province on a regular basis. Thus, the information reported here is based on telephone and Internet research by the author, together with information compiled by the Ontario Nurses' Association. Both accounts are, because of the foregoing exigencies, necessarily spotty on details but the overall picture of a decline in unionization remains intact. The barriers competition creates to obtaining labour market information about publicly-funded home care is, in itself, a

this finding. According to the ONA, there at least 77 for-profit and non-profit firms sharing home care nursing contracts across the 43 CCACs. Of these, 27 firms are organized by the ONA or other unions. This is affirmed by home care employers; while it lacked concrete data, their association characterized union penetration among member firms as "very low".[67]

(i) Legal Background: Wagnerism in Ontario Home Care

The legislative scheme for collective bargaining in Ontario home care follows the pattern of most industrial labour law regimes in the Canadian private sector. The purpose of the *Labour Relations Act, 1995*[68] is to "facilitate" collective bargaining where employees freely choose it.[69] Administered and enforced by the Ontario Labour Relations Board (OLRB), the LRA follows the Wagnerist model closely: enterprise-based, voluntary, and majoritarian certification procedures, coupled with protections for organizing, bargaining, strikes, grievance resolution, and other union activity.

Before describing key aspects of the home care collective bargaining system, it is important to recognize the already-entrenched system in Ontario hospitals. While emerging as the cornerstones of health care, hospitals became ripe targets for nurses' (and many other) unions. As well, their stable, publicly-funded, non-profit character made organizing them much easier, as questions of "competitiveness" and job security were much more remote. Thus, nuress in nearly every public hospital in Canada today are unionized, though with some notable exceptions.

Nurse collective bargaining in the Ontario hospital sector emerged much like it did across Canada, and also raised the same issues for nurses, governments and unions. While each Ontario hospital is individually organized, they bargain in a province-wide structure set up through agreement between participating hospitals and their unions. This mirrors the situation in most other provinces, where central bargaining – established by agreement or mandated by law – is the norm. As well, Ontario has addressed the question of the provision of essential hospital services during labour disputes by eliminating the right to strike and lock out in Ontario hospitals, replacing them with mandatory interest arbitration.[70] Prince Edward Island and Alberta are the only other

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concern for many researchers in the field, who see serious accountability and transparency problem for the regulation of home care.

[67] Interview with OHHCPA official, April 2002.

[68] S.O. 1995, c. 1, Sch. A. [hereinafter *LRA 1995*]

[69] *Ibid*., s. 2 para. 1.

[70] *Hospital Labour Disputes Arbitration Act* R.S.O. 1990, c. H.14. [hereinafter *HLDAA*]

provinces to outlaw hospital strikes; other provinces use “limited strike” models or have no strike regulation at all.[71]

In home care, as in hospitals, the basic procedures for organizing are the same. The LRA follows the traditional Wagnerist vote-based organizing procedure. Unions wishing to organize an employer may do so by voluntary recognition by the employer or, more commonly, by filing an application for certification with the Board. In its application, the union describes its proposed “bargaining unit”, its estimate of the numbers of employees in the unit, and its membership evidence.[72] The bargaining unit is the basic organizing concept for collective bargaining. It describes the group of employees of an employer that the union seeks to represent, usually along occupational and geographical lines.[73] In determining an appropriate bargaining unit, the Board is required to consider both the union’s and employer’s proposed descriptions, but retains ultimate discretion. It takes into account a number of traditional factors in determining whether a unit is appropriate, including the “community of interest” of the employees in the unit, past collective bargaining practice, desirability of separating white-collar from blue-collar workers, and other factors. The LRA prohibits employees acting in a managerial, supervisory or confidential capacity from inclusion in a bargaining unit, as well as certain professionals such as dentists and architects. Experience in the hospital sector shows that nurses have traditionally been organized in units separate from other employees. For the most part, the OLRB has found units of service, paramedical and nursing staff appropriate.[74]

Membership evidence in a certification application consists of a list of signatures of employees wishing to become members of the applicant union. Based on the information provided by the union in the application, if the Board finds that more than 40 per cent of the employees in the bargaining unit appear to be members of the union at the time the application was filed, it will order that a representation vote be held no later than five days after the application date.[75] If more than 50 per cent of the ballots cast are in favour of the union, the Board will certify the union.[76] The membership evidence requirement means that the union must first locate the employees and persuade them to become members.

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[71] B. Adell, M. Grant & A. Ponak, *Strikes in Essential Services* (Kingston: IRC Press, 2001).
[72] *LRA 1995*, ss. 7(12), 7(13).
[73] “Bargaining unit” is defined in s. 1(1) of the *LRA 1995* as a "unit of employees appropriate for collective bargaining whether it is an employer unit or a plant unit or a subdivision of them."
[74] *Pembroke Civic Hospital* [1993] O.L.R.B Rep. October 995, *Hospital for Sick Children* [1985] O.L.R.B Rep. February 266.
[75] *LRA 1995*, s. 8(2), 8(5).
[76] *LRA 1995,* s. 10(1).

The LRA provides employers an opportunity to contest the union's bargaining unit description and its estimate of the number of employees in unit, but usually only after a certification vote is taken. The employer may propose an alternate bargaining unit description[77], which the Board must take into account in determining the voting constituency.[78] In addition, employers may challenge the union's estimated number of employees in the unit by filing a notice with the Board.[79] Questions of the appropriateness of the bargaining unit and the accuracy of the voting constituency can be vital to the outcome of a unionization drive. However, the LRA requires that disputes regarding the description or composition of the bargaining unit be heard by the Board after a vote is taken. Where this occurs, the ballots are sealed and the contested ballots segregated pending the outcome of the hearings. This reflects the primacy placed on quick votes, which are seen as vital to ascertaining the true wishes of the employees free from undue influence from either employers or unions.[80]

The legislation also prohibits a number of other unfair labour practices in order to ensure that the true wishes of employees is ascertained by a vote. Employers are prohibited from interfering with the formation or selection of a union. They have the freedom to express their views in an organizing campaign so long as they do not use "coercion, intimidation, threats, promisees or undue influence."[81] In particular, employers may not engage in any reprisals or other alterations to the contract of employment of any employee for union activity.[82] Similar prohibitions apply to union intimidation or coercion in respect of an organizing drive. Where it finds employer or union misconduct that results in a representation vote that it considers does not reflect the true wishes of the employees, the Board may order a new vote and "do anything to ensure" that a new vote does reflect employee wishes.[83]

(ii) The Role of Labour Law: Mismatches Between Wagnerist Concepts and the "Reinvented" Home Care Sector

Deficiencies in the Wagnerist scheme outlined above play a key role in the decline of collective bargaining power for Ontario home care nurses.

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[77] *LRA 1995,* s. 7(14).
[78] *LRA 1995*, s. 8(1).
[79] *LRA 1995*, s. 8.1.
[80] *City of Toronto* [1996] O.L.R.B. Rep. July/August 552, app. for jud. review dismissed [1997] O.L.R.B. Rep. Jan./Feb. 169 (Div. Ct.).
[81] *LRA 1995*, s. 70.
[82] *LRA 1995*, s. 72.
[83] *LRA 1995*, ss. 11, 11(5).

These deficiencies flow from the basic concepts embedded in Wagnerism about the terrain it regulates. These concepts are, in health care and many other sectors, badly out of date. To explain the role of Wagnerism in the decline of collective bargaining, I will focus on three particular kinds:

(1) The “Classic” Employer
(2) The “Classic” Job
(3) Subordination and the Strike Weapon

These concepts fail to capture the emerging realities of “post-Fordism” in Ontario home care that have emerged since 1996, and how this mismatch contributes to the erosion of collective bargaining. This is because they flow from a decidedly “Fordist” rendering of labour markets. In the Fordist vision, relationships of production are assumed to be more or less the same as those prevailing at the time Wagnerism first appeared in North America. Specifically, Fordism describes employment settings in which large, vertically integrated firms with large workforces and internal labour markets employed people for long term relationships in stable, full-time jobs. Job classifications and ladders of promotion were clearly defined within firms. Firms are assumed to minimize contracting out, and ot engage in arms-length relationships with suppliers or purchasers. [84]

For many years in health care and the economy generally, Fordism dominated how goods and services are produced, firms are structured, and jobs designed. Thus, the Wagner Act model of collective bargaining appeared to flourish, inasmuch as meaningful access to unions was preserved. Canadian hospitals are the classic Fordist employer: large, stable, centralized, integrated, employing a wide range of professionals in more or less typical arrangements. Hence, they have been fertile settings for union organizing.

Briefly stated, “post-Fordism” describes the erosion of Fordism that has accompanied the vast economic and structural upheavals in both the public and private sectors. Since the mid-1980s, competitive pressures flowing from globalization, including pressures to cut labour costs, pushed firms to downsize their core workforces, contract out more of their production to smaller, specialized, often non-union firms, and rely on more part-time and casual labour. Many scholars have shown that in this environment, organizing for collective bargaining under the traditional single-employer, voluntaristic model becomes much more difficult.[85] Under this theory, smaller workplaces mean unions have less incentive to

[84] H. Arthurs, “Labour Law Without the State?” (1996) 46 *U.T.L.J.* at 11-20.
[85] See e.g. D. Drache & H. Glasbeek, "The New Fordism in Canada: Capital's Offensive, Labour's Opportunity" (1989) 27:3 *Osgoode Hall L. J.* 517; and D. MacDonald, "Sectoral Certification: A Case Study of British Columbia" (1998), 5 *Can. Lab. Emp. L. J.* 243.

invest in organizing campaigns. Workers, especially in more contingent arrangements, are more vulnerable to reprisals for trying to unionize. Competition drives firms to resist unionization more stridently. Under competitive pressures, unionizing can pose a direct threat to a firm, and hence to job security.

The emergence of competitive contracting in Ontario home care represents a shift to post-Fordism in health care. The fragmentation of work among many more and smaller home care firms under the RFP process, the increasing contingency of nursing employment, the disappearance of easily definable workplace constituencies, and the direct link between job security and competitiveness in home care firms all have created mismatches between Wagnerist concepts and the health care reality. As a result, collective bargaining access and power has greatly diminished, with no meaningful response from the institutions that support it.

In the following sections I will examine the three concepts outlined above, and show how their increasing mismatch with the emerging reality in Ontario home care is leading to this result.

(A) The "Classic" Employer

The first assumptions expressed by Ontario's collective bargaining law describe the "classic" employer. Firms are presumed to be large, stable, vertically-integrated entities - much like hospitals are (or were) in the health care system. Thus, organizing campaigns and the employee constituency at which they are directed are assumed to take place in large, singular and stable workplaces. Such campaigns can be expensive and time-consuming for both unions and workers, but the assumption of a large and stable employer implies two things: first, that multiple attempts to organize are neither necessary nor desirable; and second, that unionizing an employer will not usually, on its own, result in the termination of its business.

In Ontario, the single-employer assumption is reflected in the fact that the OLRB has no power to certify a multi-employer unit.[86] The requirement to organize on an employer-by-employer basis has a strong basis in North American labour policy[87], given the assumption that workers for different, and often competing, employers have little community of interest. Multi-employer bargaining units, in which

[86] *Harding Brantford Ltd.* [1966] O.L.R.B. Rep. July 245.

[87] R. Adams, *Industrial Relations Under Liberal Democracy: North America in Comparative Perspective* (Columbia, S.C.: University of South Carolina Press, 1995) [hereinafter *Industrial Relations Under Liberal Democracy*]; P. Weiler, *Reconcilable Differences: New Directions in Canadian Labour Law* (Toronto: Carswell, 1980).

employees of a number of different firms within a region or province are grouped together in one bargaining unit, are the exception. Some provinces, such as British Columbia, permit multi-employer bargaining structures, and all provinces use province-wide bargaining to some extent for the construction industry. Sector-wide bargaining occurs in the hospital sector, but only under the aegis of a side agreement called a Memorandum of Joint Bargaining between the Ontario Hospital Association and each of the provincial unions, such as the ONA, that have organized hospitals. In this Memorandum, the participating hospitals agree to incorporate terms agreed to (or resolved by arbitration) in a central bargaining process into their local collective agreements.

The assumption of employer stability - its likelihood of staying in business regardless of its union status - is also reflected and promoted through certain restrictions on the timing of organizing campaigns. The LRA imposes limitations on when and how often unions may attempt to organize for bargaining. It places restrictions on applications in circumstances where an employer is already organized[88] and where a union has already been unsuccessful in an organizing campaign. In particular, no union may apply for certification of an employer for one year where they lose a representation vote,[89] withdraw their application after a vote[90], or withdraw an application before a vote twice in a six month period.[91] These rules are designed to prevent a multiplicity of unionization drives at one employer, something seen as both undesirable and, more importantly, unnecessary in light of the assumption that only one campaign is needed to accurately divine the true wishes of the employees. Assumptions of the size and stability of a "classic" firm's workforce underpin this belief. These examples suggest that the rules governing organizing for collective bargaining make sense primarily in a world that mirrors their assumptions. That is, in a Fordist world, the freedom to choose collective bargaining is well-protected.

Since at least 1996, Ontario home care has dramatically departed from these assumptions. Large, stable, vertically integrated firms are nowhere to be found in the Ontario system, replaced instead by a fragmented patchwork of more, smaller and less stable firms in competition for public contracts. This creates a major barrier to organizing, even where a majority of employees may desire union representation. As confirmed in the *Durham Access to Care* decision discussed below,despite the close integration of work between CCACs and the agencies with whom they

[88] *LRA 1995*, s. 67, ss. 7(1)-7(6).
[89] *LRA 1995*, s. 10(3).
[90] *LRA 1995*, s. 7(10).
[91] *LRA 1995*, s. 7(9.1).

contract, they remain separate employers for the purposes of labour law. Current RFP guidelines urge CCACs to divide nursing contracts between at least two agencies.[92] Thus, if five agencies share a nursing contract, five separate certification applications would be required. Further, each RFP cycle - typically three to five years between tenders - can eliminate some firms and introduce new ones, thus creating new "employers" for the purposes of organizing. This fragmentation makes organizing nurses a much more costly and difficult task. The ONA claims it simply does not have the resources to invest in expensive organizing campaigns, particularly where they may face increased resistance from employers concerned about the effect of unionization on their chances in the RFP process.

"Classic employer" assumptions also explain the absence of relief from Ontario's labour law institutions to overcome these barriers. In particular, the application of the "related employer" provisions in the LRA by the OLRB has been decidedly modest in the home care context. Where the OLRB finds that two or more employers are "related" in their business activities, it will treat them as one for the purpose of organizing and bargaining. The tests for such a finding as set out in the LRA and applied by the Board are fairly stringent, requiring a significant degree of integration to be shown. Section 1(4) reads, in part:

> Where, in the opinion of the Board, associated or related activities or businesses are carried on, whether or not simultaneously, by or through more than one corporation, individual, firm, syndicate or association or any combination thereof, under common control or direction, the Board may…treat the [entities] as constituting one employer…for the purposes of this Act.

The jurisprudence under this section is rich.[93] The OLRB has set out a range of factors relevant to "common control or direction", namely: common ownership or financial control, common management, interrelationship of operations, representation to the public as a single enterprise, and centralized control of labour relations.[94] These factors indicate that, for the purposes of collective bargaining, every employer is deemed to be autonomous - and thus a separate target for organizing - until compelling evidence of common control emerges. As well, even

[92] *RFP Guidelines*, *supra* note 40.
[93] See J. Sack & M. Mitchell *Ontario Labour Relations Board Law and Practice* (Toronto: Carswell, looseleaf) [hereinafter *Sack and Mitchell*], paras. 6.76 *et seq.*
[94] *Ibid.* at para. 6.89; and *Walters Lithographing* [1971] O.L.R.B. Rep. July 406.

where the Board makes this finding, it still has the discretion to refuse the declaration.

Such a test may not properly account for new, more fluid business partnerships and corporate structures that are inimical to organizing campaigns yet fall short of the "common control" threshold. While labour law scholars have noted the growth of "boundaryless workplaces"[95] and "Moebius strip"[96] firm structures in the private sector in the wake of globalization, there has been no similar attention paid to such reinventions in the public sector. The fragmentation, instability and size of Ontario home care firms, together with the subcontracting model in which they operate, make Ontario home care closely mirror this picture.

The OLRB offered no assistance to overcome the challenges these trends pose for collective bargaining. *Durham Access to Care*[97], a 2000 Board decision, was a related employer application by several unions in home care, including the ONA. They asked Board to declare that the CCACs and the firms with which they contract are related employers. Durham Access to Care (DATC) is the CCAC serving the Oshawa and surrounding areas. The ONA already had pre-existing collective agreements with two non-profit firms (the VON and St. Elizabeth Health Care) that, prior to managed competition, provided all the nursing services for DATC. By 1999, however, DATC had apportioned this work under the RFP process between seven firms: the original two, one non-profit and four for-profit, private firms. The five new firms were non-union. It was a classic case of fragmentation, and the unions were asking the Board to undo it for the purposes of labour law.

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[95] The "boundaryless workplace" concept was developed by Katherine V.W. Stone, "Employment Regulation in a Boundaryless Workplace", presented at 5th meeting of the International Network on Transformative Employment and Labour Law, Toronto, 2000. This formed part of a larger paper: K.V.W. Stone, "The New Psychological Contract: Implications of the Changing Workplace for Labor and Employment Law" (2001) 48 *U.C.L.A. L. Rev.* 519.

[96] This term was coined by Charles Sabel. See C. Sabel, "Moebius Strip Organizations and Open Labor Markets: Some Consequences of the Reintegration of Conception and Execution in a Volatile Economy" in Bourdieu & Coleman eds., Social Theory for a Changing Society (1991){{****Tom to get fuller cite…}}Other in-depth treatments of post-modern firm structures' challenges for labour law include: M. Barenberg, "Democracy and Domination in the Law of Workplace Cooperation: From Bureaucratic to Flexible Production" (1994), 94 *Columbia L.R.* 753; J. Middleton, "Contingent Workers in a Changing Economy" (1996), *N.Y.U. Rev. L. & Soc. Change*. ***full cite to be gotten by Tom; ***and H. Wial, "New Bargaining Structures for New Forms of Business Organization" in Friedman et. al., *Restoring the Promise of American Labor Law* ***Tom to fix cite.

[97] *Durham Access to Care* [2000] O.L.R.B. Rep. September/October 855 [hereinafter *Durham #1*] (on *prima facie* case); and [2000] O.L.R.B. Rep. November/December 1108 [hereinafter *Durham #2*] (refusing related employer declaration).

The ONA submitted that DATC, despite being a separate legal entity, still exerted control and direction over the employees of all seven firms. In particular, it pointed to the close supervision and integration between the CCAC and the firms in matters of case management and care plans. It also noted their common source of funding (the provincial Ministry of Health and Long-Term Care), their representation to the public as a single entity providing home care services, and the DATC's centralized control of labour relations. The response from DATC and the firms was that the unions were simply seeking the declaration to "inoculate" themselves "against the vagaries of the competitive marketplace".[98] In turn, the unions argued that "serious labour relations problems" are emerging under the RFP process because they do not know who the "real employer" is in a context of subcontracting with the DATC. As well, they argued that the Board should use the related employer remedy to create a "viable bargaining structure" for the managed competition system in home care, meaning a multi-employer bargaining model similar to that in the hospital and other institutional sectors of health care.

Vice-Chair Brown rejected the claim. While finding that the unions had made out a *prima facie* case of common control, Brown still declined to exercise his discretion to make the declaration:

> It is one thing for organized employers to decide among themselves to engage in joint bargaining with a trade union, it is quite another for the Board to impose such a structure on heretofore unorganized entities…The hospitals that participate in central bargaining…are all organized by these unions and have long-established bargaining relationships. They have voluntarily decided to participate in central bargaining and have not had the Board impose a bargaining structure on them.[99]

In rejecting the union's case, Brown stated there was no evidence that managed competition was designed to thwart unions:

> The government, which provides most if not all of the funding in the long-term care sector, decided in 1996 that it wished to move to a managed competition model for the delivery of home care services…The impact of the move to a competitive bidding model may have the consequence of [the firms] losing some or all of the [work] that it

[98] *Durham #2, supra* note *** at para. 6.
[99] *Ibid*. at para. 19.

> presently has from the DATC, but that does not mean that there is some labour relations mischief the Board should rectify.[100]

Durham illustrates the erosion of collective bargaining access caused by the fragmentation of nursing work under managed competition, and the abstentionist posture of Wagnerism in response to it. The Board was asked to essentially dismantle the post-Fordist production model created under the RFP process by characterizing a CCAC and all its contracting firms as one entity for labour law purposes. The Board's declaration on this issue is thus pivotal to preserving the fragmented post-Fordist delivery structure that has emerged since 1996.

Nurses in home care also reportedly fear unionization's impact on their job security under the RFP process. The ONA has surveyed nurses working in Ontario home care regarding collective bargaining, and reports that while there is widespread dissatisfaction with wages and working conditions, there is little interest in organizing. The union attributes this largely to fears that unionizing could cause their employer to lose its contract, leaving them with a union but no job. Displaced nurses have no guarantee of employment with one or more of the remaining firms, and if they do transfer, they often lose recognition of their seniority, wage levels or benefits from the previous employer(s).

These fears are not contemplated to be as imminent in the Fordist paradigm. Clearly, job security is always a factor employees consider seriously in deciding whether to unionize. However, it is not contemplated that it will - or should - be the *sine qua non* of a campaign's success. The OLRB has repeatedly affirmed that threatened or actual closures after a unionizing drive can be unfair labour practices unless the employer can show it had no anti-union motivation. "It would be stranger still if an employer violates the Act by firing some of its employees for their union membership or activity, but not by firing them all," pronounced the Board in an oft-cited decision on this point.[101]

However, in a competitive subcontracting context the threat to job security remains palpable despite the absence of any explicit employer statements to this effect, because the loss of a contract – and hence a job – due to unionizing is implied by the very structure of managed competition. No single employer needs to articulate the possibility that unionizing may cost nurses their jobs; it is self-evident from the subcontracting scheme itself. Thus, employers need not engage in anti-union conduct in order to achieve an anti-union result.

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[100] *Ibid*. at paras. 32-33.
[101] *Academy of Medicine* [1977] O.L.R.B. Rep. December 783.

(B) The "Classic" Job

The second set of concepts embedded in Wagnerism relate to the nature of employment; that is, what a "classic job" looks like. Harry Arthurs succintly fleshed out some aspects:

> Most elements of our labour law system…are based on a paradigm of industrial employment which prevailed in key economic sectors during the 1930s and 1940s, when essential elements of the system were first introduced. The paradigm envisages that an ideal-type worker with relatively long job tenure will perform standardized tasks under the direction of hierarchical management within an expanding economy of relatively large-scale production units. Obvioiusly, this paradigm - and its ideal-type workers, employers, and jobs - never captured all of the varieties of employment to which postwar labour law applied.[102]

This "universal worker" prototype is the worker most recognizable to collective bargaining law, and therefore who it privileges with protection. Workers whose jobs and work environments depart from this model (sometimes called "atypical" work arrangements) are less recognizable and more difficult to organize for collective bargaining.

One barrier found in post-Fordist employment models is a lack of attachment to any single employer. More workers are changing employers more often, some are working multiple jobs, and the prevalence of full-time employment is waning. A lack of attachment to a single workplace diminishes a worker's expectation of long tenure, and thus their desire to go through the risks and effort of organizing a union that may remain in a workplace long after that employee departs.

Casualization, "elect to work" arrangements and the increase of multiple, contingent employment are key trends in post-Fordist employment models. In Ontario home care, these trends are giving the system a "just in time" or "lean production" character, borrowing from models that have emerged in other sectors.[103] Separate from whether or not these work patterns are desirable *per se*, however, the increased casualization of work has been cited as a factor in decreased employee

[102] Arthurs, "Labour Law Without the State?", *supra* note 84 at 11-12.

[103] See, e.g., M Hudson, "Flexible Workers and the Changing Boundaries of Work: Theory and Practice" in K. Purcell ed., *Changing Boundaries in Employment* (Bristol, UK: Bristol Academic Press, 2000); and K. Moody, *Workers in a Lean World* (London: Verso Press, 1997), ch. 5, "The Rise and Limits of Lean Production".

attachment with a workplace, lessening their incentive to organize for bargaining.[104]

The physical and social aspects of the work environment in Ontario home care also depart from the ideal model. Under the ideal model, workers had frequent interaction with each other and in many cases worked in the same physical space (i.e. a factory or hospital). Workers knew roughly the number and identity of their colleagues. In this scenario, organizing is easier. Thus, physical proximity and familiarity are implicit assumptions in Wagnerism. Unlike in the hospital sector, there is no physical bricks-and-mortar workplace in home care. Rather, it is the homes of patients spread across a geographical region. The ONA says many home care nurses have little idea how many co-workers they have, who their co-workers are or where they are working on a day-to-day basis. In many cases, in a given work week nurses work for two or more of the firms that have contracts with the CCACs, so identifying who their "employer" is for collective bargaining purposes can be difficult. The union reports that most home care nurses receive their daily assignments by fax from one or more of the contracting firms, and arrange their schedule accordingly. One union official claimed that some nurses in fact carry different uniforms in their cars so that they can change into that of a different employer between visits. This isolation of nurses from each other in the workplace and fragmentation of their employment relationships between various firms makes organizing for collective bargaining more difficult under the traditional rules.

(C) Subordination and the Strike Weapon

The final set of concepts are premises about the nature of the employment relationship and the importance of the right to strike. The first premise is that individual workers are in a weaker bargaining position than employers. Labour law sees employment as a relationship of subordination and hierachy. Thus, the right to strike is seen as the primary instrument of bargaining strength and voice. Without it, goes traditional labour law theory, collective bargaining can have little benefit for workers. The second premise is that, aside from the broad constraints of criminal law, workers who go on strike are, in the "classic" employee model, generally non-professional, and thus have no professional or ethical conflicts with a labour stoppage.

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[104] For a thorough review of the U.S. growth in part-time and casual employment and the difficulties of organizing in this labour market see J. Middleton, "Contingent Workers in a Changing Economy" *supra* note ***. See also G. Lester, "Careers and Contingency" (1998) 51 *Stanford L. Rev*. 73.

Neither of these premises hold true in Ontario home care nursing, thus making the strike a blunt, unwieldy, dubiously effective and ethically problematic voice mechanism. After outlining why the strike remains the only mechanism available to unionized nurses in home care, I will show how its persistence raises efficacy and ethical issues for nurses that may have a profound effect on their desire for unionization.

While hospital nurses in Ontario have never had the right to strike, those in home care always have. Home care remains outside HLDAA, which only applies to "hospitals", defined as:

> Any hospital, sanitarium, sanatorium, nursing home or other institution operated for the observation, care or treatment of persons afflicted with or suffering from any physical or mental illness, disease or injury or for the observation, care or treatment of convalescent or chronically ill persons, whether or not it is granted aid out of moneys appropriated by the Legislature and whether or not it is operated for private gain, and includes a home for the aged.[105]

In 2000, the ONA asked the Board to bring interest arbitration to home care by classifying home care firms as "hospitals" under HLDAA. InVON Metropolitan Toronto Branch[106] the Board refused. Vice-Chair Brown observed that nurses working for VON performed substantially the same work as their counterparts in conventional public hospitals. As well, he noted that the acuity of patients in home care had dramatically increased, further aligning in-home nursing with hospital nursing. The ONA argued that these similarities justified including home care under HLDAA on the basis that the deeper purpose of the legislation was to protect the continuity of medically necessary care from labour disputes. The VON countered that home care firms are not "institutions" as described in the legislation, and added that labour disputes would not disrupt patient care, since the CCAC could simply use other agencies in the event of a strike.

Brown agreed with the employers. He reasoned that HLDAA was only intended to apply to "institutions" - those where the client or patient is in a facility that has institutional control over their care or observation. Since the VON operates primarily out of patients' homes, the requisite

[105] *HLDAA*, s. 1(1)
[106] *VON Metropolitan Toronto Branch* [2002] O.L.R.D. No. 239 [QL] [hereinafter *VON Toronto*].

institutional control, and hence character, is lost. In rejecting the ONA"s submissions on the purpose of HLDAA, Brown remarked:

> …actual vulnerability is not determinative of whether an institution is a "hospital" under HLDAA. Once it is established that an organization or agency is an institution and is operated for observation, care or treatment, it is not necessary to show that the clients or patients would ACTUALLY be vulnerable in the event of a strike or lock-out. The legislature has already in effect deemed the clients or patients of HLDAA institutions to be vulnerable, even if they might actually be quite unaffected by a work stoppage. Conversely, the fact that clients or patients of an agency or organization ARE vulnerable does not automatically mean that the agency or organization must be a "hospital". The purposive approach to interpreting the Act does not transform an organization that is NOT within the "class" of institutions into one that is.[107]
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> (Emphasis in original)

With this ruling, the Board ensured that home care remains under the traditional strike-based bargaining model.

The entrenchment of the strike as the only dispute resolution mechanism available in home care has several effects on nurses' access to collective bargaining. Nurses face serious ethical and professional concerns about the withdrawal of services. Professional concerns about using picket lines and jeopardizing patient care thus take nurses well outside the second premise noted above, in that they face additional disincentives to unionizing not applicable to the classic non-professional worker envisaged by the legislative scheme.[108]

Second, contrary to the first premise of subordination and vulnerability in employment, nurses currently enjoy greater labour market and political

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[107] *Ibid*., para. 78.

[108] For good overviews of the unique approach taken by professionals to collective bargaining, see K. Swan, *Professional Obligations, Employment Responsibilites and Collective Bargaining* (Kingston: IRC Press, Queen's University, 1978); A. Ponak & T. Haridas, "Collective Bargaining Attitudes of Registered Nurses in the United States and Canada: A Wisconsin-Ontario Comparison" (1979), 34:3 *Relations Industrielles* 576; Ponak, "Unionized Professionals and the Scope of Bargaining: A Study of Nurses" (1981), 34:3 *Industrial and Labor Relations Review* 396; A. Baumgart, "The Conflicting Demands of Professionalism and Unionism" (1983), 30:5 *International Nursing Review* 150; and M. Grant & R. Foucher, *Unionism, Professionalism and Professionals: A Study in Perceptions* (Kingston: IRC Press, 1992).

power than before. The professional character of nursing work, a tight labour market and a measure of political influence in health care all tend to give nurses more voice in the workplace - and perhaps the system - than is contemplated by the classic employment model. Nurses are in high demand, and firms are paying close attention to staff issues; again, however, budget constraints make this a challenge. In this context, nurses may not need collective bargaining as much; however, given the cyclical nature of the nursing labour market, these circumstances may change.

Third, even if nurses do unionize and go on strike against a home care employer, their results are often disappointing. Since 1996, labour disputes in Ontario home care have been protracted, bitter, and have realized little benefit for those involved. Because of the fragmentation and instability of home care firms under the RFP process, nurses' strikes have only hit one firm at a time. Many CCAC contracts (which are currently held in confidence by CCACs) are reported to contain forfeiture clauses that terminate an agency's contract in the event it is unable to continue to deliver services; hence strikes and lockouts raise the spectre of immediate contract termination. Also, without the considerable strength of a central bargaining structure and the prospect of a multi-firm strike, struck home care firms have had little incentive to settle, CCACs have had few concerns about maintaining services, and the nurses have gained little in bargaining. Registered nurses are, of course, not the only workers who have struck in Ontario home care; there have been strikes by homemakers, support workers, and other providers in the system. The following summary, however, is confined to a number of local disputes involving RNs and RPNs.[109]

1.Disputes with Non-Profits

In July, 1998, nurses in 13 VON branches across Ontario engaged in a two-week strike that centred on their demands for improved travel allowances.[110] In this case, the union was the Practical Nurses Federation of Ontario (PFNO), representing Registered Practical Nurses. RPNs, sometimes called registered nursing assistants, are different from RNs in the level of training and responsibility they take on in patient care. They are commonly paid less than RNs and are often used in place of RNs for many home care tasks. During the walkout, the VON claimed patient care

[109] The information on these dispute is gleaned from local and regional media reports, cited accordingly, and some interview information.

[110] S. Morrison, "Wage losses blamed on Mike Harris" *The Spectator (Hamilton),* July 24, 1998 A5, H. Greenwood and T. Boyle, "Patients reject replacement RNs; Oshawa VON denies strike affecting care" *Toronto Star* July 8, 1998 B3.

was not jeopardized and used RNs to substitute for the striking RPNs. However, the PFNO claimed that some patients were refusing care from the substitute nurses as a protest against the treatment of the RPNs in the bargaining dispute. RNs reportedly wore green ribbons in support of their striking colleagues. After two weeks, however, the strike ended with the nurses receiving a substantial drop in their travel allowances, from 28 cents per kilometre to 17 cents, and in some places a wage freeze and a cut in benefits. According to the PFNO, the cut in travel allowances alone cost each nurse between $2,000 and $8,000 per year.

In September 1998, a lock-out of ONA members at four branches of the VON in Eastern Ontario arose from the VON's increasing needs to cut costs. As with most VON branches, those in the Lanark, Brockville/Leeds/Grenville, Renfrew County and Eastern Counties branches had long-standing bargaining relationships with the ONA. However, the competitive process forced the VON to seek concessions on wages and benefits, and, most contentiously for the ONA, the elimination of travel allowances altogether. About 175 nurses were affected. After ten weeks of the lock-out with no resolution in sight, three VON branches had terminated their visiting nursing programs.[111] Thus, the locked-out nurses lost their jobs and while these branches remain unionized, they currently have no contracts with their respective CCACs.

On August 31, 2000, about 200 nurses at the VON Hamilton began a 33-day strike.[112] Represented by the Ontario Public Service Employees' Union (OPSEU), the nurses demanded wage parity with hospitals, improvements to job security, benefits and travel allowances. According to the union, the starting salary for a home care nurse was $17.61 an hour, compared with $21.31 for their hospital counterparts. The union claimed that underfunding and the managed competition system was the culprit behind the shortage of nurses and wage gap with hospitals, and aimed much of its rhetoric at the provincial government. During the strike, 600 of the VON's 1,800 clients were transferred to other agencies contracting with the Hamilton-Wentworth CCAC, 600 others received telephone check-ups, and another 600 short-term clients were

[111] "Lock out of VON members continues; three branches terminate nursing services" *ONA News*, December 1998 p. 7.

[112] "Patients could be left without home care if Hamilton nurses strike" Canadian Press Newswire, August 25, 2000; "Union recommends Hamilton home care nurses begin strike on Thursday" *Canadian Press Newswire*, August 29, 2000; "Home care nurses await written agreement from province to end walkout" *Canadian Press Newswire*, Sept. 1, 2000; "VON nurses in Hamilton-Wentworth agree to new contract ending 33-day strike" *Canadian Press Newswire* October 2, 2000.

discharged. After the strike, the nurses received improved benefits and travel allowances.

Another protracted strike occurred in June, 1998 at the St. Elizabeth Health Care branch in Durham.[113] Like the VON, St. Elizabeth's is a non profit nursing firm with a long history across Canada. In December 1996, the ONA organized the roughly 130 nurses employed by St. Elizabeth's in the Durham region and commenced bargaining toward a first agreement. The union demanded improvements on the issues of wages, scheduling, travel allowances and other benefits. After the parties failed to reach an agreement, the ONA applied to the Board for a first contract arbitration. In October 1997 the Board dismissed the application, saying that the parties had not reached impasse. On June 18, 1998, the ONA took about 110 nurses out on a strike that lasted 20 weeks. In the end, St. Elizabeth's and the ONA reached a settlement that contained some of the union's demands, leading one official to call it a "wonderful first collective agreement".[114]

2. Disputes in the For-Profit Context: The Comcare Strike

The strike by nurses at Comcare in Kingston in the winter of 1997/98 was in many ways a key moment in the decline of collective bargaining under the RFP process. The ONA began a 19-week strike at Comcare that embodied many of the union's fundamental complaints about managed competition and the entry of for-profit firms into the home care market. In particular, the Comcare strike symbolized the controversy surrounding casualization, “elect-to-work” models, and other post-Fordist trends in health care employment. The strike attracted media attention[115] and spawned much litigation before the OLRB before it was settled by first contract arbitration.[116]

Comcare is a private, for-profit firm that secured a contract with the Kingston and area CCAC to provide in-home nursing services. The CCAC work constituted about 60 per cent of Comcare's business, with penitentiary nursing taking another 30 per cent and 10 per cent to private clients.

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[113] "VON branches locked out; St. Elizabeth workers continue their job action" *ONA Newsletter* (Fall 1998); "Long Strike Finally Over" *ONA Newsletter* (December 1998).
[114] "St. Elizabeth nurses reach deal" *Toronto Star* October 29, 1998 B2
[115] A. Chamberlain, "Home care nurses strike for contract with private firm" *Toronto Star* January 21, 1998 A8; A. Chamberlain, "Nurses win battle with home-care firm" *Toronto Star*, March 11, 1998 p. A9.
[116] Information on the Comcare strike was obtained from media research, OLRB decisions and interviews with ONA officials.

The ONA was certified to represent the roughly 80 nurses employed by Comcare in November 1996, and negotiations started soon afterward. The union's key demands were improved wages, benefits and working conditions. In particular, ONA took issue with Comcare's "elect-to-work" scheduling policy. Under this policy, Comcare considered all nurses “casual” – available on an as-needed basis with no fixed scheduling. According to the ONA, this policy denied nurses important benefits and job security, and compromised their ability to balance work and personal schedules. It reportedly led to some nurses working as many as 48 hours a week with no overtime pay and no recognition of experience. In response, Comcare said that the policy was quite acceptable to many nurses for its flexibility, and was common in many other home care firms because it enhanced the cost-effectiveness and continuity of patient care. It also cited concerns about the cost of paying the benefits that would flow from using the traditional full-time/part-time scheduling policy that ONA demanded. Throughout the dispute, Comcare's insistence on the elect-to-work policy remained the key issue.

By September, 1997, nine negotiation meetings had taken place with no settlement. Soon afterward, the ONA applied to the OLRB for an order that their dispute be settled by way of first-contract arbitration. Under the *Labour Relations Act, 1995*, the Board has the power to order first-contract arbitration where it finds, among other things, that one of the parties has made collective bargaining unsuccessful because of an "uncompromising" position adopted without "reasonable justification".[117] The parties had agreed there would be no strike or lock-out until the Board had decided the application. After it was denied[118], the ONA began its strike on November 7, 1997. During the early days of the strike, approximately fifty nurses continued to work. To deal with the disruption in service, Comcare assigned more work to those nurses not on strike and to other non-union Comcare nurses in Kingston as well as replacement nurses it brought in from Comcare branches elsewhere in Ontario. To these nurses, it paid travel, lodging and other expenses in addition to the wages it had paid to the striking nurses. These measures permitted Comcare to maintain its service during the strike.

Soon after the strike began, Comcare sent letters to the striking nurses that provoked the ONA to bring an unfair labour practice application to the Board. In the letters, Comcare pointed out the consequences of being on strike, including the loss of benefits. As well, it mentioned that it would be issuing Records of Employment to the striking

[117] *LRA 1995,* s. 43(2)(b).
[118] *Comcare (Canada) Ltd.* [1997] O.L.R.D. No. 4036 [QL].

nurses, a move the ONA charged was an attempt to intimidate the nurses by suggesting they could be fired for engaging in a lawful strike. However, the Board disagreed, finding that Comcare was entitled to inform employees of the consequences of striking and to exert economic pressure through denial of benefits during the strike.[119]

While the ONA signalled its intention to make the Comcare dispute a high priority by giving $250,000 in support to the striking nurses, the strike dragged through early 1998 as the parties reached a stalemate on the scheduling issue. In February 1998, the ONA filed another first-contract-arbitration application. This time, on March 9, the Board ordered in the union's favour, finding that Comcare's intransigence on the scheduling issue was an uncompromising and unreasonable position that had effectively stalled meaningful bargaining. Vice-Chair Lee Shouldice stated that

> In my view, the employer's insistence on adopting an "elect to work" model was without reasonable justification. The evidence establishes that the employer is insisting on maintaining its position on the basis only of an assertion that the cost of moving off that position would make it uncompetitive in Kingston. It is unwilling to provide any information of substance to the union. Has the employer put any evidence before the Board to permit for the conclusion that there is a legitimate basis for its assertion? Merely asserting such a position before the Board in the context of a proceeding under section 43 of the Act is unsatisfactory. The employer must, when faced with such an application, establish some evidentiary basis-before the Board so as to support its assertion that cost is a real and legitimate factor. The employer did not do so in this case.[120]

As a result, the ONA ended the strike immediately. How many of the nurses who originally struck returned to Comcare remains unclear.

Over a year and a half later in September 1999, Arbitrator Graeme McKechnie issued his first-contract arbitration award.[121] It contained a

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[119] *Comcare (Canada) Ltd.* [1998] O.L.R.B. Rep. March/April 159.
[120] *Ibid*., para 65 .
[121] *Re Ontario Nurses Association and Comcare Health Services (Kingston Branch) (Interim)* (February 11, 1999); and *Re Ontario Nurses Association and Comcare Health Services (Kingston Branch) (Final)* (September 8, 1999) (McKechnie), unpublished, copy on file with author.

retroactive wage increase and other improvements the ONA was seeking. During the arbitration hearings, Comcare told the ONA it was losing more money than ever and that there was a real possibility it would have to stop operations in Kingston if this trend continued. In part this was due to the fact that the CCAC had not increased its reimbursement rate to Comcare since 1995 while its labour costs had increased over the same period. In fact, the CCAC had reduced the volume of work it gave to Comcare in 1998/99 because of "the labour relations dispute incurred"[122] Nevertheless, McKechnie sided with the ONA on the “elect-to-work” issue, awarding conventional collective agreement language that rigidly regulated hours of work and made clear distinctions between full-time, part-time and casual shifts. McKechnie also awarded a small retroactive wage increase, though it brought Comcare nowhere near to parity with the hospital sector. He supplied no written reasons for his award, but the nominees for the employer and union weighed in with their views. The ONA nominee felt there was a “solid basis” for a higher wage increase than McKechnie awarded, while the Comcare nominee was pleased with I, saying that hospital wages are “reflective of a model of care delivery which is not parallel to community care”, are the product of interest arbitration, and that “the hospital funding model is very different than the C.C.A.C. competitive bidding process in the community care environment.” The Comcare nominee also was disappointed with the rejetion of the “elect-to-work” model, citing its incorporation into the collective agreement of a nearby for-profit firm as “a mature collective agreement”[123]

None of these concerns became relevant. Soon after the McKechnie award, Comcare shut its doors. Though it was under contract with the Kingston and area CCAC until March 2000, by October 1999 it had forfeited its nursing (and other) contracts to the CCAC. The arbitration award had increased its operating costs to the point where it could no longer remain competitive in the RFP process. In ruling on a subsequent unfair labour practice application brought by the ONA which alleged that the closure was a reprisal for the strike, the OLRB found :

> What is clear…is that the economic consequences of the collective agreement…were severe for the employer. The awards put the company's nursing services operation in Kingston, which prior thereto

[122] *Comcare (Canada) Ltd.* [2001] O.L.R.B. Rep. January/February 48 at para. 18.
[123] *Ibid*., Dissent of Marianne Love, Comcare nominee.

> was barely profitable, into a significant loss situation.[124]

In the result, the Board found no anti-union *animus* in Comcare's decision to return the contracts. In fact, it noted that Comcare had submitted a failed bid in the next RFP round in 2000, indicating a genuine intent to reacquire the CCAC work. At present, then, Comcare remains unionized but its only work remains with its private clientele, about 10 per cent of its total before the strike.

(D) Intimacy of Law and Collective Bargaining

The foregoing experience suggests that collective bargaining will face new challenges if managed competition, contracting out and other "reinventions" become *de rigeur* in Canadian health care. That is, the primary internal voice mechanism supplied by labour law will recede, leaving a default legal order lacking access to any such mechanism. It has been observed that adverse wages and working conditions in home care provide "ideal" incentives to unionize.[125] Indeed, if the ONA's surveys are any indication (though one must recognize the potential for union bias), many nurses in Ontario home care would seek unionization but for the barriers created by the post-Fordist model in which they practice. If so, then the persistence of legal rules that do little to protect nurses' efforts to organize voluntarily must be seen as a tacit policy to limit their access to collective bargaining regardless of nurses' real level of desire for it. The problem is not that unionization rates are low *per se*; the problem is that the current level of unionization does not reflect what it would be if collective bargaining access were meaningfully protected.

Certainly, the immediate causes are "non-legal" factors such as increased resistance to unionization among health care employers, and the inability of the labour movement to adapt its strategies to the post-Fordist trends and atypical work arrangements described above.

However, these factors arise – and are influenced by – the background labour law order in health care. As I have tried to show, some of the background concepts of Wagnerism, and their resulting doctrines, have an important bearing on the accessibility and effectiveness of collective bargaining for nurses. In my view, the decline of collective bargaining witnessed since 1996 is better seen as a result of the conceptual mismatches outlined above. between labour law's assumptions about the setting in which it claims regulatory purchase on one hand, and the reality of that setting on the other. While it is important to account for

[124] *Ibid*. at para 25.
[125] *Putting a Face on Home Care*, *supra* note *** at 75.

the role of unions, employers and governments in explaining a decline in unionization, an analysis that ignores the role of law is oversimplified.

This claim engages a deeper debate about the link between law and labour markets. One view, sometimes called a classic economic perspective, envisions a sharp distinction between the two. Law is what we traditionally recognize as “law”: legislation, regulations, common law. Labour market “events” are separate phenomena, comprised of the totality of private arrangements between workers and employers. This view disputes an analysis that sees law as a central factor in labour market “events”. Hence, law is limited in its potential to regulate the labour market.

A competing view, however, gives more weight to legal rules in explaining labour market outcomes. A more deterministic view of law in labour (and other) markets has been advanced by scholars in the Legal Realist tradition.[126] This perspective rejects the law-market distinction, and starts from the premise that because labour markets are constructions of law to begin with, it is misleading to speak of an "unregulated" labour market. All transactions between workers and employers - including employee incentives to organize for collective bargaining and employer responses to such efforts - occur against a backdrop of legal rules that shape each party's choices and constraints.

This claim has particular force in the context of access to collective bargaining. For example, rules prohibiting employer reprisal against employees seeking to unionize, backed with meaningful remedies, clearly influence worker decisions about whether to embark on an organizing campaign. Similarly, rules requiring an employer to bargain in "good faith" may influence an employer's level of resistance to unionizing drives. Writing in the U.S. context, Paul Weiler posited an intimate link between collective bargaining law and the prospects for organizing:

[126] My understanding of legal realism derives in large part from the work of scholars Karl Klare, Duncan Kennedy and others. Their work gives a much more enriched account of this perspective than I can offer here, but suffice it to say that the legal realist tradition has a long heritage stretching back to the 1920s work of John Commons, Robert Hale and Michel Foucault. For a good review of the development of the legal realist tradition, see D. Kennedy, *Sexy Dressing, Etc.* (Cambridge, MA: Harvard U. Press, 1993), ch. 3, “The Stakes of Law, or Hale and Foucault!” 83-125. See also K. Klare, “The Public/Private Distinction in Labor Law” (1982) 130 *U. Penn. L.R.* 1358; “Traditional Labor Law Scholarship and the Crisis of Collective Bargaining Law” (1985) 44 *Maryland L.R.* 731; “Labor Law as Ideology: Toward a New Historiography of Collective Bargaining Law” (1981) 4 *Ind. Rel. L. J.* 450; and “Legal Theory and Democratic Reconstruction: Reflections on 1989” (1991) *U.B.C. L. Rev.* 69; and D. Kennedy, “The Role of Law in Economic Thought: Essays on the Fetishism of Commodities” (1985), 34 *Am. U. L.R.* 939 [hereinafter “Fetishism of Commodities”].

> It is a mistake, though, to assume that NLRA rocedures have an impact only with respect to situations in which they happen to come into play and in which, by counting up *ex post* the number of potential members lost in unsuccessful petitions, one can estimate the significance of that variable in the larger picture. In truth, our perception of how well the NLRA performs when it is actually utilized has a further important influence, *ex ante*, on the incentives and actions of the protagonists outside the legal procedure - unions, employers, and workers.[127]

The Supreme Court of Canada recently adopted a similar view in justifying its activism to protect collective bargaining for farm workers in Ontario. In *Dunmore* v. *Ontario (Attorney-General)*[128], the issue was whether Ontario's exclusion of agricultural workers from the protections of collective bargaining legislation violated guarantees of freedom of association and equality guaranteed by the *Canadian Charter of Rights and Freedoms*.[129] Prior to Dunmore, the Court had ruled against Charter protection for collective bargaining and the right to strike.[130] McLachlin J., writing for the majority, held that the *failure to include* farm workers under the legislation amounted to a violation of their associational rights. However, the Court also made clear that the Charter does not protect collective bargaining, but rather places an obligation on governments to give legal protection to vulnerable groups who would otherwise have no realistic chance of pursuing group goals. As Ontario's counsel argued, McLachlin J. held that removing such protection would not offend the *Charter* where employees already had sufficient economic or political power to exercise their associational rights without statutory protection. In this way, McLachlan J. was able to reconcile her reasoning with that in *Delisle* v. *Canada*[131], an earlier decision involving collective bargaining rights for RCMP officers.

However, McLachlin J. rejected Ontario's argument that because the *Charter* did not apply to "private" conduct, such as employer reprisal

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[127] P. Weiler, *Governing the Workplace* (Cambridge, MA: Harvard U. Press, 1990) at 276.
[128] [2001] S.C.J. No. 87 [QL]; 207 D.L.R. (4th) 193, rev'g. (1999) 182 D.L.R. 4th 471 (Ont. C.A.), aff'g (1997) 155 D.L.R. (4th) 193 (Ont. Gen. Div.) [hereinafter *Dunmore*].
[129] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, Sch. "B" of the *Canada Act, 1982 (U.K.),* 1982, c. 11, ss. 2(d) and 15 [hereinafter *Charter*].
[130] See e.g. *Reference Re Public Service Employee Relations Act (Alberta)* [1987] 1 S.C.R. 313; and *Delisle* v. *Canada* (Deputy Attorney General) [1999] 2 S.C.R. 989.
[131] *Delisle*, *ibid*.

prohibited by the LRA, the government's legislative choice cannot be scrutinized. McLachlan J. rejected the claim that law is a minor factor in the accessibility and effectiveness of collective bargaining. To the contrary, she concluded that the "freedom" to organize for collective bargaining – as with any other kind of association - is closely dependent on the background legal order. McLachlan J. wrote:

> The history of labour relations in Canada illustrates the profound connection between legislative protection and the freedom to organize. It may be suggested that legislative protection is so tightly woven into the fabric of labour relations that, while there is no constitutional right to protective legislation per se, the selective exclusion of a group from such legislation may substantially impact the exercise of a fundamental freedom…the appellants' exclusion from the LRA functions not simply to permit private interference with their fundamental freedoms, but to substantially reinforce such interferences.[132]

In the result, governments that fail to take steps to protect freedom of association for vulnerable groups in settings where private resistance by employers prevents its exercise are in violation of the *Charter*.

Because *Dunmore* involved an explicit *removal* of collective bargaining from a vulnerable group, it will not require governments to offer any greater collective bargaining to workers than they already do. In particular, it is not likely to assist unions where the barriers to collective bargaining arise from structural mismatches like the ones outlined above. Further, nurses are not likely to be viewed as a "vulnerable" groups, particularly in the current health care climate. Still, the Court's recognition of the real contingency of "free collective bargaining" on legal protections from notionally "private" factors justifies analyzing the impact of law on collective bargaining trends more generally, as I have tried to do here.

Following this analysis, the decline of unions in Ontario home care can be attributed to a dramatic mismatch between the assumptions about the labour market embedded in the statutory scheme for collective bargaining and the new realities of the home care labour market. In essence, this mismatch denies nurses meaningful access to collective bargaining in much the same way as the outright legislative exclusion found in *Dunmore*.

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[132] *Dunmore*, *supra* note 128 at para. 35.

IV. Implications of Collective Bargaining Decline for Health Human Resources Policy

In light of the procedural and substantive values described in Section II, should the decline of collective bargaining access and power for health care professionals predicted above matter to HHR planning? One view might see this trend as "health policy-neutral", in that collective bargaining and other labour relations matters are, as in any sector, purely private matters that affect only the immediate parties to the relationship. As noted at the outset, this may explain why the background labour law structures in health care remain off the health policy radar screen. Put simply, unionization rates and collective bargaining trends in health care really ought not to be queried by health policy; better to leave these issues to the "specialists" that administer and study labour relations as a discrete vocation.

However, given the intimate connection between labour law trends and HHR issues, perhaps more attention is now warranted. My goal in the foregoing narrative has been to illuminate the decline of collective bargaining in "reinvented" health care sectors; my task now is to draw some implications of this trend for health human resource planning. In particular, I will reflect on this trend in light of the substantive and procedural HHR planning values outlined in Part II above.

(a) Benefits of Decline: Innovation, Cost-Effectiveness?

It must be made clear that the nursing profession does not suffer from a lack of *external* voice - at high levels of policy making. A tight labour market, rising public sympathy, and close involvement in high-level policy reform have augmented their already strong voice in the system. Here ,though, I am focused on the *internal* voice – that within the conceptually "private" sphere of the workplace – supplied by collective bargaining.

Because hospitals have dominated health care for so long, internal voice *via* collective bargaining remains a powerful voice political and economic mechanism for nurses. All hospital employees in Canada have long enjoyed the economic and political power supplied by collective bargaining, particularly in a publicly-funded, non-profit, hospital-based system. Indeed, prior to the onset of cost control and restructuring policies in the 1990s, the nursing profession had made slow but steady progress in improving their terms and conditions of work through collective bargaining – including gaining greater professional recognition and wage levels. Now, after the restraint and restructuring of the 1990s,

during which all health care wages remained mostly stagnant[133], nurses are again making gains, both politically and at the bargaining table in the hospital sector. Recent hospital wage settlements in Ontario, Alberta and British Columbia, together with increasing political power in other disputes in Nova Scotia, Quebec, Saskatchewan and elsewhere, point to a significant degree of power for nurses' unions at the moment.

However, as the foregoing narrative suggests, this power may well rapidly erode if hospitals continue to lose pride of place in the health care system. In fact, it might be said that the vast bulk of nurses' unions' power depends on the persistence of Fordism – hospitals – in health care. If more care shifts to the home care, primary care, independent health facilities sectors - or even to a currently-rejected parallel private health care system – the penetration of nurses' unions and their collective bargaining power will both diminish.

In the current HHR environment suffused with values of cost-effectiveness, flexibility and innovation, this trend may be welcome. Collective bargaining, with its perceived strictures and inefficiencies, is sometimes decried as hostile to these values. The clearest example of this was the centrality of casualization and "elect to work" arrangements to the Comcare strike in Ontario home care. To Comcare, the imposition of a collective agreement mandating traditional, Fordist work patterns (full- and part-time distinctions, regular scheduling, classification rigidities and other traditions in the Fordist industrial model) would impede innovation and cost-effectiveness. On the other hand, nurses claimed that casualization worsened their working lives, recruitment and retention efforts and the quality of patient care.

Further, the classic stigma of collective bargaining in the public sector – that it leads to unsustainable increases in wages and other labour costs at the expense of those who depend on the system – has been reinforced in light of recent hospital collective bargaining trends. The recent "catch-up" settlements for hospital nurses in Ontario, Alberta and British Columbia have drawn fire from "have not" provinces, and from other sectors such as home care that are losing nurses to hospitals in these provinces. Further, seniority restrictions and costly "bumping" provisions made hospital restructuring – considered a species of innovation – very costly as systems in Ontario, Quebec and elsewhere faced great costs in reallocating personnel to what they viewed as more appropriate

[133] Cite stats re wage trends in 90s;

settings.[134] The undertone of these critiques is, quite simply, that collective bargaining is hostile to cost-effectiveness and innovation.

Unions can also be seen as almost redundant in light of nursing's current economic and political strength. The desperate demand for professionals in health care – the human capital of the system – and their general public support in the wake of the dramatic labour force upheavals and restraint of the mid-1990s. In this context, promoting collective bargaining for professionals in health care runs the risk of giving them even *more* political control on health care decision making. Worse, fears may arise that collective bargaining will be used to extract unsustainable wage increases and lead to greater interprovincial "poaching" of human resources, both worrisome trends to Romanow. If professionals once enjoyed dominance over the system, the erosion of collective bargaining in these "reinvented" sectors of health care will certainly restore an apparent, if not real, "balance" of power between professionals and managers in the system.

A Rebuttal

However, any presumption that lifting the "yoke of regulation" represented by collective bargaining will enure to the system's benefit seems more self-serving and rhetorical than convincing, and has been hotly contested in academic circles. Many years ago, "classical" economic theory held that markets – the capitalist order – operated autonomously from systems of regulation; hence, the dichotomy between law and markets emerged. As Professor Duncan Kennedy has observed, the intrusion of law into markets was thus stigmatized because

> [t]hey advert to the 'justice' or 'fairness' both of the rule of freedom and of the 'natural' outcomes of economic activity. Finally, they emphasize that these 'natural, free, and just" outcomes make everyone better off than they could be under any 'unnatural' (or artificial or distorted) system that might be created by interferiong with freedom of production and exchange.[135]

This stigma is reflected in more contempary rherotical flourishes found in some (less-than-elegant) reinvention rhetoric incanted by neo-liberal political parties and their media organs. Regulation is often accused of promoting "red tape", "special interests", "rent-seeking behaviour" and

[134] T. Archibald, "Health Care Restructuring Under Different Labour Law Approaches: The Ontario and Quebec Experiences" (1998) 24:1 *Queen's L.J.* 61.
[135] Kennedy, "Essays on Fetishism", *supra* note 127 at 944.

other economic felonies. The Mike Harris Conservatives who introduced managed competition to Ontario home care fall squarely in this camp with their rhetorical flourishes on monopoly abuse and even accusations of fraud by non profit providers. Less employment regulation is better, goes this rhetoric, especially where the payers and beneficiaries of the labour in question are, as in health care, all of society. In sum, the market exists independently of the state, and operates best when left alone.

Absent from such rhetoric is any recognition of the long line of economists and legal scholars who reject the state-market dichotomy and the stigma against regulation it supports. I will not digress into a discussion of institutional economics here. In a recent paper outlining possibilities for labour law to promote "competitiveness" in a rapidly changing global economy,[136] U.K. Professor Hugh Collins contested the view that, In searching for the right regulatory answer to facilitate innovations in production and work processes, "the best policy for governments is one of deregulation of the employment relation."[137] Collins disagreed with the view that all regulation imposes net costs on employers and impedes innovation, saying there is no *a priori* reason to assume "that the private law of contract can support the necessary institutional arrangements for the creation of the flexible model of employment" any better than an alternate regulatory mode.[138] By approaching labour law as a potential force of competitiveness and productivity – goals firmly rooted in current Canadian HHR planning – Collins' points urge caution in making assumptions about the effects one labour law model or other have on the economic sectors they inhabit. It cannot be good health policy to welcome an erosion of collective bargaining access for health care professionals solely on the basis of an uninterrogated intuition that health care is better off with less labour market regulation. A case *must* be made for why a non-union health care system is preferable to one where unions are accessible.

I do not see any. To rest a case on the fact that the interests of patients and taxpayers are well served by this erosion is misguided. First, greater *access* to unionization in no way guarantees that nurses will *actually* unionize. Under Wagnerist theory, if employees are satisfied with their level of voice without unionizing, then they will elect against it. That is, collective bargaining access – if it is seen as a "punishment for bad management" more than a democratic right - ought not to concern health care firms who provide meaningful voice mechanisms voluntarily.

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[136] H. Collins, "Regulating the Employment Relationship for Competitiveness" (2001) 30:1 *Ind. L. J.* 17 [hereinafter "Regulating for Competitiveness"]
[137] *Ibid*. at 33-34.
[138] *Ibid*.

Second, to label an increase in labour costs a health policy "bad" contradicts clear calls in Romanow, Kirby and other reports for greater spending on HHR. Contrary to a lot of policy rhetoric in health care since the early 1990s, "better management" is not the panacea it once was. After a certain point, despite continuing cost control demands from governments, middle managers in the system cannot squeeze any more "productivity" out of their workforce within current funding levels without impairing the actual quality of care available. There is a real risk that, after a certain point, savings generated by workplace restructuring and other innovation-driven measures will be negated and perhaps exceeded by the costs (more difficult to quantify in dollar terms) to the quality of care. At the least, such austerity has so far directly caused the HHR problems witnessed across the health care workforce since the mid-1990s. In Ontario home care, for example, there is a wide consensus among both nurses, home care firms and CCACs that funding levels are sorely inadequate. To object to regulatory mechanisms solely because they might force Queen's Park (now under the increasingly spendthrift Ernie Eves) to increase funding levels is, at the least, counterintuitive to this reality. In this light, the Ministry's 2001 freeze of CCAC funding (prior to Eves' arrival in the Premier's office) represents a large step backwards in addressing the current HR problems home care faces. In short, "better management" may no longer be the magic bullet allowing governments to avoid more fundamental resource-allocation issues in health policy.

That collective bargaining has resulted in significant wage hikes and labour cost increases is no justification for now completely countenancing its erosion as the system transforms. There is no reason to conclude that labour law is incapable of conceiving an effective and balanced voice mechanism such as (but not necessarily) collective bargaining in which debates about HHR issues can improve funding, contracting and other management decisions in the interests of patients. about funding. There is no reason, in short, to believe that decisions taken in an *absence* of such a dialogue would be health policy-"better" than those resulting from it.

Just as critics doubt the claim from nurses' unions that their strength is somehow good for patients, so could they doubt the notion that greater managerial power is always preferable. Most of these voices are either managers (firms, contracting agencies like CCACs, regional boards and provincial governments) or those who would entrust vital public interest questions entirely to management. Surely, the absence of internal checks and balances on management decisions makes the task of *implementing* policy much easier, but it guarantees neither the *soundness* of the policy,

nor that the taxpaying and service-using public will somehow benefit by the added flexibility.

(b) Costs of Decline: Segmentation & Deficits of Accountability and Dialogue

In this section I offer two reasons why the erosion of collective bargaining for professionals in reinvented health care models could pose a problem for sound HHR planning and labour market oversight. The first problem is fairly straightforward: the current erosion of collective bargaining in reinvented sectors will create a "segmented" health care workforce in which unionized hospitals will remain human resource "magnets" relative to emerging sectors where collective bargaining is in retreat. Nurses will continue to drain back to health care's Fordist employers – hospitals – while more patients are going in the opposite direction - to home care and other sectors.

Second, I am also interested in what has been *lost* than what has appeared. What is lost is an institutional voice mechanism that could provide valuable political dialogue between two competing yet dominant perspectives in health care: the managerial and professional interests. During a time of reform, upheaval and restraint in health care, the risks of self-serving behaviour by all actors in the system can increase, as resource distribution and structural design are up for reconsideration. Powerful stakeholders in the system – professionals, their unions and associations, managers, political parties, pharmaceutical companies and the for-profit private sector always lurking on the periphery of the system – have great incentives to exploit a period of uncertainty to further their interests in a continuing atmosphere of financial restraint. [139] The one group left out of this jostling is, of course, the one most profoundly affected: patients. At bottom, checks and balances on such behaviour that do not unduly silencing or privileging one group over others would be a useful mechanism in such a context. The ideal, then, is to protect patient interests from being marginalized in favour of one interest or other. In my view, institutions like collective bargaining that can provide meaningful checks and balances between managerial and professional

[139] As Professor Carolyn Tuohy noted after the release of the Romanow Report, a "window of opportunity" has now opened for meaningful health care reform. However, the danger is that powerful groups such as these will move quickly to "close" it and impede changes that might affect their self interests. Indeed, Tuohy's "accidental logics" theory of health care policy development and reform dynamics in Western nations holds that major systemic decisions in health care are profoundly shaped by the relative balance of power of the state, professions and the private sector at various "open" periods in history. C. Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (Toronto: Oxford U. Press, 1999) [hereinafter *Accidental Logics*].

interests in the system are an ideal way to ensure that neither enjoys an absolute veto on HHR planning decisions.

This is an ideal familiar to labour law – "equal bargaining power" to enhance decision-making. In health care, promoting and protecting political "equilibrium" and dialogue between all these groups – including patients – dovetails with Romanow's values of pluralistic, inclusive HHR planning. To the extent that reinvention fosters more entrepreneurial, competitive management strategies – including profit motives – the current external voice enjoyed by nurses in the system may not suffice to safeguard HHR planning decisions from domination by potentially self-serving managerial behaviour. Such domination runs the risk that poor decisions are not discovered until well after their worst effects – a nursing shortage, poor working conditions – become clear. At that point, external accountability mechanisms like those mentioned above highlight the need for change. However, this is too late for those patients and family memberswho have already suffered from a lack of access or a drop in quality. By supplying nurses and other workers meaningful internal voice – with appropriate checks and balances to ensure dialogue and transparency - collective bargaining or a derivative institution could address these problems on an ongoing basis before they cause undue harm. Certainly, this rests on the premise that reposing absolute legal control for HHR planning to managerial interests is undesirable, and that good management requires consultation and joint decision-making, particularly in a labour-intensive, professional setting like health care.

Managerial-Professional Dialogue : A Health Policy Value?

Recurring HHR debates often reveal a fundamental a tension between managerial and professional perspectives on the meaning of "quality", "cost-effectiveness" and other substantive HHR values, and tension on how to achieve them. Because health care is so labour- and skill-intensive, professionals are the capital assets of the system, giving them significant influence over policy. The managerial set of values in health care governance, generally held by those accountable for the financing and cost-effective management of the health system or health care firms, are primarily concerned with allocating scarce resources among competing and increasing demands for health services.[140]

[140]The managerial-professional dichotomy I offer here is borrowed from health economist Robert Evans' dichotomy between two distinct perspectives: "economic" and "professional/medical" assumptions about how to determine need for health care: R. Evans, *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworths, 1984) [hereinafter *Strained Mercy*] at 370. Evans described two competing economic models of health care utilization: the "Naïve Medico-Technical" model and the "Naïve Economic Model".

In this section I will suggest that neither perspective is a wholly satisfactory approach to HHR planning in the interests of patients. As noted, there is a risk that the new $15 billion called for by Romanow Report will be wasted on "peace" agreements between governments and providers that substitute wage hikes for meaningful structural changes and improvements to workloads and patterns of practice, and allow them to evade accountability for real change. Real reform can be impeded by an absence of meaningful, inclusive and transparent HHR planning mechanisms. At the least, the interests of patients are greatly affected by the interplay of these two groups.

The managerial-professional tension underpins many of the debates surrounding health human resources issues. For example, "quality" in a human resource context means slightly different things to each perspective. The "Donabedian" formulation is an oft-cited analysis of "quality" in health care. In a seminal 1966 article, Professor Donabedian identified three different ways to measure quality in health care: *structure* (number of providers, their skill), *process* (how the care is delivered, such as length of visit), and *outcomes* (objective clinical health results).[141] The managerial perspective may be seen to stress quality in terms of health outcomes and believes in the reliable measurement of them. Conversely, the professional perspective stresses quality in terms of structure – technical inputs (meaning more spending on HR issues) to care.

These competing visions of quality inform each perspective's view of the proper role of cost-effectiveness values in HHR planning. To governments, CCACs and home care firms, for example, quality has an efficiency factor. That is, the quality of a service is measured by the

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The former corresponds to the professional perspective I am describing; the latter to the managerial. Neither model, says Evans, is entirely satisfactory when applied to the exclusion of the other.

The Medico-Technical Model assumes that utilization and supply of health services – meaning spending – depends on provider-determined need, and thus gives professional providers wide latitude to determine the appropriate levels of resource inputs. Cost considerations are not a factor in this model, and if allowed to operate unchecked can risk the waste of scarce health resources. The Economic Model, by contrast, assumes that need is determined by consumer – or purchaser – demand, which is determined by a combination of price and outcome factors. In this model, medical need is not the dominant factor in determining supply except where it coincides with purchaser demand. Evans describes the Economic Model as a response to the Medico-Technical model's relative ignorance of cost considerations, and while no country has adopted it as a complete basis for policy, it is an important component of the search for cost-effectiveness in health policy.

[141] A. Donabedian, "Evaluating the Quality of Medical Care" (1966), 44:2 *Milbank Memorial Fund Quarterly* 166; also see Donabedian, *The Definition of Quality and Approaches to its Assessment* (Ann Arbor, MI: Health Administration Press, 1980).

effectiveness it has on a health condition relative to the resources spent on it. For nurses' associations, unions and nurses, however, quality may have a more "technical" emphasis. On this view, quality increases when more skill, technological capacity and overall resources (including human resources and skill) are invested. Still, it is not fair to say that professionals *never* consider cost-effectiveness or efficiency in their analyses of HHR problems. For example, the nursing profession is debating the value of "evidence-based nursing" in which constant innovation and improved cost-effectiveness are sought through research-based methods.[142] While this dovetails with larger values of "evidence-based decision-making", health professions remain decidedly input-driven in their analyses of HHR problems.

From a managerial perspective, the sustainability of health care *requires* innovation, which in turn requires experimentation with new models of delivery – such as elect-to-work arrangements and redistribution of functions among profession. The debate about elect-to-work models illustrates this well. If the reality is that most home care nurses prefer casual employment and it controls spending without impairing patient accessibility, what is the objection to it? The professional perspective, however, emphasizes the risk that in some cases – in their view, too many – nurses in this model may feel coerced, overworked or otherwise disadvantaged, particularly relative to their counterparts in hospitals. This, says the profession, may impair the quality of care by hurting continuity.

Despite their divergent values, the professional and managerial interests must be balanced at all levels of health policy decision making. In describing the tension between them, Evans stressed that neither is a wholly satisfactory basis for health policy decisions, and that most policy decisions embody a compromise between them. Similarly,the managerial and professional values described here each represent valid yet competing visions of quality, and valid collective and individual interests in health policy decision making. If so, then it would be unwise – from the interests of patients and taxpayers - to give one or the other policy ascendance in the system.

If this is accepted, then there is strong public interest is in a balanced and transparent process in which their dialogue occurs. Ideally, we want the arguments and evidence marshalled by each perspectiv to be afforded a fair hearing within transparent political accountability institutions that structure their debate and ensure that its resolution is evidence-based and in accordance with clear and consistent standards of

[142] Cite EB nursing paper

accessibility and quality. Of course, this is only an ideal; it is far from realization in health care. But the core premise remains intact: that dialogue and accountability are valuable in health care. Now more than ever, there is a serious risk that patients' interests in quality, accessibility and cost-effectiveness in health care – in real structural change - will be overlooked and subordinated to the interests of those who run and work in the system. This is part of the impetus toward legislative "bills of rights" for patients: ensuring adequate voice for patient concenrs about comprehensiveness (rights *to* health care), access, quality and cost (rights *in* health care).[143]

In the interests of patients, then, health policy must be careful not to let one perspective dominate HHR planning, particularly at a time of systemic reform and uncertainty. Dialogue must be structured and transparent, and include the interests of *all* parties affected by HHR planning decisions. Ceding decision making to one set of interests or the other outright creates risks that they may overlook the full consequences of their decisions, or even abuse their control over policy, to advance their material or political self interests over those of patients'. Certainly, some health professions have been accused of extracting excessive "rents" from the system to further their self-interests. Professions have always been cloaked in the mysteries of medical science, and for many years used their technical monopoly to engender public trust in their decisions.[144] However, as cost containment became more important, governments and employers gave less deference to professional expertise in HHR planning. Further, there is little doubt that professions currently have an opportunity to "rent seek" during a time of system reform. In this context, the erosion of collective bargaining may be seen as a "rebalancing" of power between the managerial and professional interests.

However, like the professions, managerial interests also have a lot at stake in health reform. Not only is public sector administration becoming increasingly difficult, the political risks of failure are higher than ever, particularly in health care. In short, managerial interests (governments, funding agencies and employers themselves) are not in an enviable position. In this environment, the incentives to show immediate cost control to political superiors (and to the electorate) are very high. This creates incentives to masquerade cost-shifting to nurses and patients as

[143] T. Epps & C. Flood, "Can a Patients' Bill of Rights Address Concerns About Waiting Lists?" (Draft Working Paper, Health Law Group, Faculty of Law, University of Toronto, October 9, 2001).
[144] Tuohy, *Accidental Logics, supra* note 42.

real cost-saving. Professor Colleen Flood expressed this concern in the following terms:

> If one is truly concerned with efficiency (as opposed to just reducing government spending), then it is not just direct government health costs that must be counted but also the costs to society at large. It is the wider societal costs that are often overlooked and discounted by policy-makers.[145]

That is, reducing spending by cutting back the number of nurses and the quality of their working lives can appear to save money, when in fact the costs have only been assumed by the nurse in the form of more overtime and increased workload.

Thus, both professionals and managers have motives and opportunities for self-serving behaviour at a time of system upheaval. The importance of preserving the dialogue between the managerial and professional perspectives at all levels of health care governance lies in the fact that each interest is a necessary check on the other. Managers are needed to audit professions' claims to medical need by asking for evidence of cost-effectiveness; professionals are needed to illuminate the costs that are sometimes overlooked, whether by inadvertence or self-interest. Where one set of interests dominates a debate to the near-exclusion of the other, there exists an immediate danger of a conflict of interest between the public interest and the self-interest of the group that dominates the decision making.

These examples illustrate the importance of preserving a measure of checks and balances in the policy process, both at the central level of a government commission or collective bargaining and the micro-level of the workplace. It guards against each side from using its political voice for self-serving purposes. To illustrate: If unions or professional associations demanding large pay hikes to satisfy their constituents rather than to improve nurse recruitment, it is bad policy. Similarly, where for-profit home care firms adopt low-wage, low-skill practices to maintain a competitive foothold in the market, or where CCAC managers seek savings at every turn to show a balanced budget to their superiors in the provincial government (who, since Bill 130, can terminate them at will), it is bad policy.

Dialogue and internal accountability may also improve the operation of the health care labour market. By "improve" I mean generate outcomes –

[145] C. Flood, "The Structure and Dynamics of Canada's Health Care System" in J. Downie & T. Caulfield eds., *Canadian Health Law and Policy* (Toronto: Butterworths, 1999).

particularly a reduction in turnover rates - that promote appropriate HHR planning. If nurses lack internal voice in the workplace, the issues they raise about workload, skill mix and other aspects of their working lives may well go unheard. The result, then, is exit from the system or, for those who remain, lower morale, commitment and even competence levels. These trends cannot enure to the benefit of patients. If additional voice mechanisms are in place that institutionalize dialogue on issues of appropriateness, these may act as a "safety valve"[146] of sorts that forces confrontation with divergent views and mitigates resort to exit strategies.

If internal voice mechanisms are available to nurses and other professionals, issues like wages, staff levels and working conditions will receive adequate consideration, and act as a check against funding, contracting or firm management decisions that may affect the accessibility, quality and cost-effectiveness of care. For example, if there is no debate about "elect-to-work" models within an institutional framework like collective bargaining, their real costs and benefits may not receive sufficient scrutiny. Similarly, issues such as wage rates, benefit levels, professional support structures and skill-mix ratios deserve to be debated as public interest questions. If employers and CCACs believe these models improve quality and save money, then they should, as a matter of public policy, be required to make that case in a transparent forum. If nurses' perspectives are muted on these crucial questions, then there is an increased risk that funding levels, contracting choices and other managerial decisions will occur without accountability for their impacts on the supply of nurses and the environment in which they work.

Some labour relations scholars have argued that increased participation in decision-making via internal voice mechanisms such as collective bargaining can also enhance productivity and competitiveness.[147] In line with emerging "Quality of Working Life" theories in some economic sectors, this view sees workplace "democracy" as instituted by collective bargaining as a good business strategy. If the point of "reinvention" in health care is to make the system more competitive, then labour policy measures that promote competitiveness ought to be welcome. As noted earlier, the work of Hugh Collins and other scholars suggests that labour law has the potential to facilitate new,

[146] This phrase is borrowed from Robert Hebdon's work. See R. Hebdon, "Ontario's No-Strike Laws: A Test of the Safety-Valve Hypothesis" in *Proceedings of the 28th Conference of the Canadian Industrial Relations Association* (1991) at 347-356.

[147] The most forceful argument for the productivity benefits of unions was made in R. Freeman & J. Medoff, *What Do Unions Do?* (New York: Basic Books, 1984). Roy Adams has echoed this view in his work, most notably in R. Adams, "Labour Ppolicy, Cooperation and Competitiveness: Recasting the Vital Links" *Policy Options* (March 1994) 33-38.

more cost-effective modes of production and work relations.[148] In Collins' view, appropriate employee protections against some of the risks inherent in post-Fordist work models – job insecurity, increased skill demands – can permit us to realize the benefits of new work modes without causing unwanted labour market effects. Such a proposal might, for instance, create optimal regulatory conditions for the wider implementation of "elect-to-work" or other innovations in health care management. If so, health care would benefit from true cost savings without shifting undue cost to nurses. Indeed, the way is now clear to ask more of labour law in health care than we have before.

In sum, then, the erosion of collective bargaining under "reinvented" delivery models portended by the Ontario home care experience conflicts with the substantive and procedural HHR planning values described in Part II. There is no *a priori* reason to prefer a professional workforce disenfranchised from collective bargaining to one that is not, because there is no basis to assume that greater control of the system by managerial interests is "good" for HHR decision-making. Further, if reinvention continues to repose more decision-making power on HHR issues in the hands of management interests, the dialogue and accountability benefits supplied by professional access to internal voice mechanisms like collective bargaining are lost.

If so, an accountability and dialogue "deficit" may well emerge in which governments and managers dominate HHR planning. Recent commentary on the Romanow report has included doubts that governments will, on their own, cede meaningful decision-making power at a time of incredible political risk, set up accountability mechanisms for HHR planning, or promote meaningful and transparent dialogue to enhance the democratic character, if not the propriety, of HHR decisions themselves. If so, the loss of collective bargaining as a proxy for this function is, despite all its flaws, a loss for health policy.

V. Implications for Labour Law

If I am correct in these conclusions, then re-enfranchising the Canadian health care workforce requires us to change the legal order to overcome the post-Fordist barriers described earlier. By no means am I here prescribing any template for health care collective bargaining, but rather am touching on three areas that will arise in designing any such system. These are: bargaining structure, organizing process, and dispute resolution. I will situate the discussion in the Ontario home care setting,

[148] Collins, "Regulating for Competitiveness" *supra* note 137.

though the issues I raise likely have wider implications for Wagnerism in health care.

(a) Bargaining Structure

As the *DATC* case illustrated, the Wagnerist collective bargaining structure in Canadian health care is incapable of recognizing the fragmentation inherent in post-Fordist subcontracting arrangements such as the RFP process. In my view, the appropriate response would to reject the *DATC* approach and recognize each CCAC and its subcontracting partners as one employer for the purposes of collective bargaining. This would not impose unions on any given CCAC, but it would recognize that the proper constituency for collective bargaining in this sector is really the entire group of contracting partners. For example, if a majority of nurses in the system desire it, then regional-based (by CCAC region) bargaining could emerge in which all firms who win contracts with a CCAC would be bound by this agreement, regardless of whether they themselves are unionized.

This approach resembles sectoral bargaining proposals in other sectors and jurisdictions where workers face similar barriers to organizing. It has some intuitive appeal for its coverage and for its tendency to bring competitive parity as between the employers in the given geographical area. That is, if one employer is unionized, all others are as well. Hence, there is no competitive advantage for any given employer to resist or oppose organizing attempts. Wages and working conditions are, therefore, taken out of competition without an undue impact on the actual inter-firm competition within the bargaining structure.

(b) Organizing Process

I am not proposing the *imposition* of collective bargaining, but rather improving its accessibility. Within this structure, the vote-based certification approach should remain. As the experience in Ontario home care shows, the desire for unionizing can be thwarted by a lack of attachment to an employer, a lack of social familiarity with colleagues, and in general the difficulty of identifying who works for whom. To overcome these barriers, the law must abandon traditional Fordist notions of strong employer attachment and full-time employment to recognize the realities of casual, multi-firm employment in Ontario home care. Still, the choice to unionize must remain free. If a union seeks to organize all the nurses working in a CCAC region, then it must convince a majority of them to vote in favour of it. Likewise, nurses can decertify a union following parallel voting procedures. In this model, some CCACs may be unionized, while others not. This is an acceptable state of affairs

because the goal is not entrenching unions, but protecting freedom of access to them. To go further would, in my view, be bad for HHR planning because employers whose management decisions are in line with the procedural values of dialogue and accountability would not realize any benefit relative to those whose decisions are not.

(c) Dispute Resolution

Finally, the method of dispute resolution is crucial both to the social acceptability of my proposed system and to the accessibility of collective bargaining itself. As the Comcare and other disputes illustrate, the strike weapon is largely ineffective within a competitive contracting context. The replaceability of the nurses who struck by others from firms within the same CCAC made the Comcare strike virtually meaningless to management. For Comcare, it simply lost its contract and closed its doors, perhaps to open again another day. The CCAC suffered no noticeable interruption of service. Thus, the strike dragged on until administrative intervention by the OLRB and Arbitrator McKechnie forced the employer's hand. Thus, strikes remain largely ineffective under the RFP process. As such, they make collective bargaining that much less attractive as a voice mechanism.

As well, the ethical and moral concerns nurses have about having to strike to wield any voice also militate against organizing. While nurses may seek the voice promised by collective bargaining, some may resist the crude withdrawal of services as the way to achieve it. These concerns exist, of course, alongside the classic concerns about disruptions to essential services during public sector strikes. Nurses are typical of the "high trust" employees envisioned by Alan Fox;[149] workers who may not need the ultimate sanction of a work stoppage to exert voice in their workplace. Where nurses do seek voice, therefore, they are forced to use a mechanism that poses serious ethical and efficacy concerns. The alternative, then, is to reject collective bargaining – and hence voice – altogether.

Thus, in my view, the right to strike is not the ideal model for dispute resolution in Ontario home care. The VON decision was wrongly decided. By adopting a bricks-and-mortar approach, the OLRB completely ignored the increasing similarity of work between hospital and home care nurses. Nursing work is moving from hospitals to homes, and is no less essential. Interest arbitration is the only viable approach to resolving disputes, despite its flaws.

[149] A. Fox, *Beyond Contract: Work, Power & Trust Relations* (London: Faber, 1974).

There are many grounds to object to using the dispute resolution process supplied by Wagnerism to resolve managerial-professional disputes on issues that affect the public interests of quality, accessibility and cost-effectiveness. Among the most obvious are that neither the right to strike or interest arbitration contain any internal processes for resolving these issues on an evidence-based model. That is, the conventions of arbitration follow from the privacy principles of collective bargaining.[150] Interest arbitrators always regard their task as repugnant on the grounds of having to fashion a "private" agreement from outside the bargaining process. However, if the public interest nature of notionally "private" issues is accounted for, then this view of arbitration as an aberration has less validity. Instead, arbitration can be seen for its possibilities as a coherent, pluralistic process that attempts to align labour relations outcomes with the broader public interests in health policy. If adjudication is the preferable mode of dispute resolution, then the search for better interest arbitration procedures should begin.

(d) Conclusion

My main objective here has been to suggest that the demise of Wagnerism in Ontario home care equates to a demise of nurse enfranchisement to an internal voice mechanism. While serious debate must take place over what type of legal regime we want to govern our health care workforce, I have attempted to define some of the catalysts to this debate. The human resources crisis in Ontario home care is aggravated by the disenfranchisement of the nursing workforce from collective bargaining. At the least, reforms must have as their goal the re-enfranchisement of nurses so that they can exercise meaningful voice within a managerial-professional dialogue. What is unacceptable, as I have tried to suggest, is the persistence of a confluence of legal and structural factors that effectively eliminate any such voice. This, I believe, ought to inform the starting point of any discussion of health care labour relations in a reinvented era of competition, for-profit delivery and entrepreneurialism. Without professional voice, impairments to accessibility, quality and cost-effectiveness resulting from misguided or self-serving management chocies may remain unaddressed until it is too late. While law must heed concerns about cost-effectiveness when crafting the form, substance and strength of this voice – indeed, of a more robust managerial-professional dialogue – the need for voice itself seems incontrovertible.

[150] Archibald, *supra* note 134.