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SUPPLEMENTAL SUBMISSIONS TO THE ONTARIO CHANGING WORKPLACES REVIEW

Sectoral Bargaining in the Health Care Sector

Changing Workplaces Review
Employment Labour and Corporate Policy Branch
Ministry of Labour
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Toronto

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I. Introduction

ONA represents approximately 60,000 front-line registered nurses (RNs), nurse practitioners (NPs) registered practical nurses (RPNs) and allied health professionals and more than 14,000 nursing student affiliates across Ontario, providing front-line health care in hospitals, long-term care facilities, public health units, residents' homes and the community, clinics and industry.

In September 2015, ONA provided submissions to the Changing Workplace Review panel which set out the restructuring of health care work and proposals for change to the *Employment Standards Act* and *Labour Relations Act, 1995* to ensure working conditions that enhance dignity and respect for nurses and allied health professionals. This in turn will achieve maximum efficiency and maintain acceptable standards of patient care. In those submissions we advised that we would be making further submissions which focus directly on the recommendation that sectoral certification and bargaining should be introduced in the context of the current restructuring of the health care sector.

In our earlier submission we said:

> The Consultation paper, Question 12, asked whether sectoral or broader bargaining structures are required generally or for certain industries. In ONA's submission, the *Act* should be amended to provide a broader or sectoral mechanism to reflect who funds and controls the work to ensure that bargaining takes place with the true employer.
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> If the goal of the *Act* is to provide employees with a democratic voice in their work to bring balance to the unequal power relations between the employee and the employer the status quo does not achieve these goals. The current definitions and jurisprudence dealing with "the employer" and "a related

employer" simply do not reflect the organization of many private and public sectors.

For example, in the health care system, the publicly-funding CCACs distribute work through a competitive bidding process between providers of "nursing services" for home care and care in ambulatory care clinics. As a result, the provision of nursing services is contracted out to for-profit companies, particularly in the ambulatory care sector, and not-for-profit organizations. These companies and organizations often then rely upon temporary agency nurses.

The organization of nursing services in the home care and ambulatory care is a hollow pyramid. The work is controlled by the CCAC, but the CCAC have fragmented the provision of nursing services to a network of "nursing service providers" who are subcontracted to provide either home-care or ambulatory clinic services. The formal employment relationship of the nurses is with a private company, a not-for-profit organization, or a temporary agency.

In fact, the organization of work in the home-care sector is more akin to the construction industry with a network of contractors and subcontractors.

In ONA's submission, the current approach to certification creates a barrier to meaningful collective bargaining with the true employer which ultimately directs the flow of funding and distribution of nursing services. The current bargaining unit structure, based upon a single employer and single "workplace" means that ONA may be required to organize and negotiate with a small private company which is relied upon by the CCAC. Such a private company may rely upon temporary agency nurses to provide care. Often, the right to bargain to impasse leads to a loss of work to another agency.

Similar work organization structures, based upon tiers of sub-contracted out work emerged in the 1980's in the private sector allegedly to save labour costs and produce on a "just-in-time" production schedule. The impact in the private sector is well documented to be one of lower wages and benefits and poorer working conditions.

ONA principle recommendations are:

1. That there be an examination of the bargaining structures and processes in the health care sector to reflect the significant restructuring that has occurred.

2. That the appropriateness of bargaining units be re-examined to reflect the significant changes in the distribution of work amongst classifications and to ensure that workers with the strongest

community of interest be in a position to bargain collectively within the same union.

3. That bargaining structures and processes be put in place to ensure that health care workers are bargaining with the "real" employers; i.e. those in control of the setting of standards, funding and distribution of work.

4. That bargaining for all nursing professionals be conducted on a provincial or regional basis. Not only is this a efficient bargaining mechanism it is consistent with equity within the profession ensuring that nurses positions in all sub-sectors of health care are equally attractive to professionals.

II. The Context to ONA's Recommendation: Fragmentation, "Managed" Competition and Changing Employment Relationships

There have been, in recent years, three significant transformations in health care which are largely driven by the goal to reduce overall costs. Each of these transformations has had a negative impact on the provision of the standards of health care for patients. They have also had a very negative impact on employees and their entitlement to the benefits of collective bargaining and job security.

(i) Fragmentation

The provision of health care is increasingly fragmented amongst workplaces as the services are downloaded out of the hospital sector. Some health care previously available in large publicly-funded hospitals is now provided in the client's home and or in a small clinic. Moving services out of the framework of the *Public Hospitals Act* into a regulatory framework of private agencies and clinics has had a mixed to poor record regarding the impact on the quality of patient care.

The shifting of services from larger workplace to a proliferation of smaller ones has certainly had an impact on health care workers. With smaller, often privately owned facilities, certification is more difficult to obtain. Furthermore, as the work shifts from a steady reliable work setting to one in which, work may be moved to yet another provider it becomes much more precarious; it becomes more difficult to achieve the benefits of unionization and collective bargaining. Poor and precarious working conditions lead to demoralization, frustration and potential negative impacts on patient care.

The current definitions of "the employer" and "a related employer" simply do not reflect the organization of work in health care, particularly in the home-care subsector. In home care and ambulatory clinics, the work is controlled and paid for by the CCAC, but the CCAC's distribute the provision of patient care services to a network of "nursing service providers" who are subcontracted to provide either home-care or ambulatory clinic services. While the formal employment relationship of the nurses is with a private company, a not-for-profit organization, or a temporary agency, the CCAC controls the funding, the practice standards and the access to work. However, the OLRB has determined that the related employer provisions, do not apply to the relationship between CCACs and nursing service providers.[1]

The OLRB has also found that the home-care facilities do not fit within the HLDAA definition of hospital and therefore these workers have the legal right to strike. This

1 See Service Employees International Union, Local 204 v. Durham Access to Care, 2000 CanLII 12981 (ON LRB

legal right to strike is rendered meaningless by practices in the sub-sector. Should the parties reach an impasse in negotiations and apply for a "no-board' report, the CCAC intervenes to make alternate care arrangements and patients go to other providers. The nursing work performed by ONA members is reallocated away from the unionized nursing service provider. Therefore, given this reality plus the precariousness of the work and the disinclination of nurses to leave their vulnerable clients the right to strike for these workers is a limited one: while the nurses in this sub-sector have access to collective bargaining, it is an extremely truncated version of collective representation which does little to balance the unequal bargaining relationship in the workplace.

(ii) Managed competition in the home-care and community sector

Managed competition, the process whereby the lowest bidder in the home or community sector becomes the service provider, drives a low-wage, non-union strategy in this sub-sector. ONA has observed the trend where nursing work is increasingly concentrated with a few for-profit, agencies who may reach the economies of scale required to be the lowest bidder. The work itself, however, is done by itinerate nurses in the client's home or a small private clinic which, as discussed above, is not conducive to the benefits or collective bargaining.

There are significant total compensation inequities between the hospital sector and other sectors such as for-profit nursing homes, home care providers, CCACs and Family Health Teams or Community Health Centres. Fragmentation has also made it

more difficult to achieve province-wide equal job rates for a nurse and to maintain pay equity for these predominantly female job classes.

(iii) Changing scope of practice and skill mix

The inclusion/exclusion of classifications within health care bargaining units has remained essentially unchanged since the 1970's. In this same timeframe there has been: significant changes in the way that work is distributed amongst classifications. The consequence is that historical bargaining units are not necessarily the most appropriate or reflective of the community of interest. This in turn leads to labour conflict and a proliferation of legal proceedings which are a distraction to a restructuring exercise that maximizes efficiency.

Health care facilities are increasing relying on less skilled employees to provide patient care. As a result of changes made by the nursing regulators and educational facilities roles within nursing have evolved over the last several decades. Historically in Ontario the system educated and recognized Registered Nurses (RNs) and Registered Nursing Assistants (RNAs). RNs did the majority of the "professional" duties with the assistance of RNAs. The later had a limited scope of practice and list of skills. With the passage of the *Regulated Health Professions Act* (RHPA) the RNA designation disappeared. The new *Act* recognized Registered Practical Nurses (RPNs) and Extended Class nurses or Nurse Practitioners. Gradually RPNs have been given increasing education and scope of practice. While they are less qualified and have a more limited scope of practice than RNs they are professional nurses with independent accountabilities. The major

differences in the scope of practice of RNs and RPNs relate to their ability to problem solve, assess and care for patients with acute or complex conditions and to work independently,

Given the increased acuity of patients that are being care for in hospitals, long term care homes and in the community, this would suggest that there should be an increase in reliance on RNs. However, this is not what has happened. The changes have been made to the scope of practice of RPNs and RNs has led to RNs being replaced by RPNs and RPNs being replaced by PSWs. Although the College of Nurses, on paper, suggest that the right nursing provider be in place to provide the right care at the right time this principle is seldom enforced. Accordingly, the low wage strategy of Employers has resulted in the replacement of RNs with RPNs and health care aides resulting in layoffs of registered nurses. Hospitals have also increasing replaced employed registered nurses with agency nurses who are paid significantly less in total compensation as a just-in-time parallel nursing workforce (Agency nurses are not included in ONA's bargaining units). In the midst of these trends, it is not surprising that Ontario has the second worst ratio of RNs-to-population in Canada.

Furthermore, in the home-care and community care sectors some nurses working in clinics or with agencies are required to become self-employed, independent contractors rather than employees. The result is a parallel contingent workforce within the health care sector.

While the province has supported the education and certification of an Extended class of RNs or Nurse Practitioners the funding of health care facilities has, in recent months led to the reduction of NP positions in some facilities. These advanced practice RNs can work independently to assess, treat and prescribe to patients and care (similar to a physician) However, the current hospital funding model does not promote their use. Instead, the funding model has driven a replacement of NPs by unregulated Physician Assistants.

In long term care homes, NPs are now being funded by the Ministry of Health and Long Term Care. The intent of the program was that these NPs were to have an employment relationship with the home and therefore a unionized job with good wages and benefits. However, the homes are not be hiring Nurse Practitioners as employees but are instead planning to engage their services as independent contractors to provide consulting services to our various homes. This is another form of precarious work.

iii. The History of Labour Relations in the Healthcare Sector in Ontario

Historically, there were four main subsectors that deliver healthcare services in Ontario; each subsector is subject to specific legislation:

- Public hospitals are regulated through the *Public Hospitals Act,*
- Long-term care facilities are regulated through the *Long-Term Care Homes Act*, 2007,

- Home care and community services are regulated through the *Community Care Access Corporations Act,* 2001, and the *Home Care and Community Services Act*, 1994, and,

- Public health is regulated through the *Health Protection and Promotion Act*.

Recently, there has been a proliferation of smaller work places such as Family Health Teams, Community Health Centres, Speciality and Ambulatory clinics which provide health care services previously provided in the more traditional sub-sectors. Many of these smaller workplaces are non-union.

Each subsector has a distinct history of bargaining and, to a certain extent, bargaining structures. The hospital and long-term care sub-sectors are subject to the provision of the *Hospitals Labour Disputes Arbitration Act* (HLDAA) and thereby have no strikes or lockouts. The home care and community sub-sector as well as the public health have the right to strike under the *Labour Relations Act*.

The History of Labour Relations in the Hospital Sector

The hospital sector has historically employed the vast majority of health care workers. It has a long history of unionization and bargaining which was influenced by the 1974 Report of the Hospital Inquiry Commission headed by D.L. Johnson. The Minister of Labour established the Commission to examine the wages, salaries and other benefits of hospital employees in Ontario. As part of this inquiry, the Commission considered the

feasibility of province-wide collective bargaining in respect of hospital employees being conducted on other than an individual hospital basis.

The Commission identified that the hospital employees should be grouped into three categories as bargaining units (service, nursing and paramedical) for the purposes of bargaining and any future union certification should recognize these broad classification categories.

The Commission recommended that bargaining for hospital employees should ultimately take place on a province-wide basis for central issues, and local issues should be settled with the individual hospital. The Commission recommended that centralized bargaining should not be forced on the parties, but the Ministry of Labour should use its persuasive powers to develop regional-wide bargaining as the first step. However, in the case of nurses, province-wide bargaining should be realized as soon as possible.

The Commission further recommended that the public hospitals should designate for themselves an accredited bargaining agent.

The Commission based its recommendations on two fundamental principles:

(i) any structure should operate in a manner consistent with the objective of providing uninterrupted health care to users, and;

(ii) the structure should operate in a manner that facilitates the expeditious settlement of fair standards of compensation for employees.

The Commission concluded that the proliferation of unions in the hospital sector was not advisable as scarce resources should not be spread over multi-jurisdictional boundaries.

It is noteworthy that, in its submissions to the Commission, ONA called for province-wide bargaining in public hospitals in Ontario based on the key principle that a nurse performing an occupation should be paid the same for the job regardless of the hospital or geographic area of their employment. The Commission agreed with ONA's principle as the basis for recommending province-wide bargaining. The Commission noted that the prevailing practice in the majority of Canadian provinces was province-wide bargaining.

To a large part, the Johnson Commission recommendations have been followed in the hospital sub-sector. In most hospitals there are separate bargaining units for nursing, paramedical, service and office-clerical employees. With regard to nurses, ONA has the bargaining rights for nursing units in all but a very few hospitals in the province.

While not all hospital unions participate in province-wide central bargaining, ONA does. Through successive Memoranda for Joint Bargaining the parties have engaged in central bargaining since 1981 with the resulting collective agreements having central provisions that apply across virtually all hospitals where ONA has bargaining rights. The local parties engage in local bargaining on issues such as scheduling. Hospitals have agreed to have the Ontario Hospital Association act as their bargaining agent on a voluntary non-accredited basis.

Through central bargaining and the resolution of outstanding issues under HLDAA the principles identified by the Hospital Inquiries Commission have been substantially achieved in the hospital sub-sector. It is ONA's submission that these principles remain valid today and should be applied to the other subsectors in health care. The recommendations of the Commission, including the need for province-wide bargaining should be used as a starting point for recommendations by the Changing Workplace Review for the other subsectors in the health care.

Changes in the Hospital Sector

Starting in 1997 with the passage of the *Public Sector Labour Relations Transitions Act* (PSLRTA) there have been a significant number of mergers between hospitals. The University Health Network, for example, has absorbed the pre-existing TGH, TWH, TRH and PMH. As a result, there has been a proliferation of bargaining units within some institutions. At the UHN, for example, there are now 23 collective agreements covering 27 bargaining units resulting in questionable efficiency in use of labour relations resources.

Increasingly, patient care historically provided in hospitals has been transferred to other agencies. Some examples include:

- Transfer of sub-acute and chronic patients to long term care facilities,
- Transfer of intellectually disabled and psychiatric patients to long term care facilities,

- Provision of post-surgical care through home care services,
- Creation of speciality clinics for services such as fertility and cataract surgery, and,
- Provision of paramedical and other services through Family Health Teams.

Since the Johnson Commission, there have been significant changes in the roles and responsibilities of various positions occupied by health care workers. For example, a number of changes have been made to the nursing profession through changes to the *Regulated Health Professions Act*, 1991 (RHPA). Not only has the extended class of Nurse Practitioner (NP) been added to the profession, the designation of Registered Practical Nurse (RPN) has been established. In 1974, when the Johnson Commission made its recommendations, there were two nursing designations under the *Health Disciplines Act*. The first was "Registered Nurse" (RN); the second was "Registered Nursing Assistant" (RNA), a limited role that performed specific limited tasks under the supervision of a RN. Since the passage of the RHPA, while the designation of Registered Nurse remains, the Registered Nursing Assistant has been replaced by the "Registered Practical Nurse" (RPN). The RPN is a much expanded and more independent role than the predecessor designation.

Accordingly, when the Johnston Commission set out the appropriate bargaining units for hospital, the "nursing" bargaining unit consisted only of RNs. RNAs were appropriately included in the service unit. Despite significant evolution to the role and

scope of practice of the RPNs, especially since 2005, RPNs remain in the service unit in most hospitals due to historical certifications. NPs are included in some but not all "nursing units".

Nurses have been recognized to be a craft unit for purposes of the LRA s. 9 (3) and PSLRTAs. 22 (2) as set out in *Ontario Nurses' Association v. Pembroke Civic Hospital*, 1993 CanLII 7911 (ON LRB) at para 55 and 56,

> The dividing line which has been drawn by the Board with respect to nurses working in the health care sector can be likened to the line which the Board has drawn around craft bargaining units, under section 6(3) of the *Act*, and in the construction industry. In *Porcupine General Hospital*, supra, the Board accepted the idea that the standard nurses' unit is a craft bargaining unit for which ONA could rely on section 6(3)[2].

Nurses have been long recognized to have a community of interest in respect of the nature of the work they do. This long-recognized community of interest should continue as the bargaining unit structure for the purposes of sectoral certification and bargaining.

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2 Section 9 (3) of the *Ontario Labour Relations Act* defines a craft unit and as one of,

Any group of employees who exercise technical skills or w*ho are members of a craft by reason of which they are distinguishable from the other employees* and commonly bargain separately and apart from other employees through a trade union that according to established trade union practice pertains to such skills or crafts shall be deemed by the Board to be a unit appropriate for collective bargaining if the application is made by a trade union pertaining to the skills or craft, and the Board may include in the unit persons who according to established trade union practice are commonly associated in their work and bargaining with the group, but the Board shall not be required to apply this subsection where the group of employees is included in a bargaining unit represented by another bargaining agent at the time the application is made.

However, changes to the scope of practice of RPNs has led to RNs being replaced by RPNs in many nursing positions in hospitals. Despite the College of Nurses of Ontario requirement that the right nursing provider be in place to provide the right care at the right time, the hospitals' low wage strategy replaces RNs with RPNs resulting in layoffs of RNs and negative impacts on patient care. These consequences have led to numerous workload complaints, grievances and jurisdictional disputes which in turn has resulted in labour relations unrest.

Much of the traditional work of the RNAs has in turn been downloaded to PSWs in furtherance of the hospitals low wage strategy.

Recommendations:

1. Mechanisms should be put in place to allow a review of bargaining unit structures in hospitals to ensure that the bargaining unit structures are appropriate in light of consideration of contemporary community of interest, current practices in the distribution of work; bargaining unit structures should also minimize fragmentation and reduce labour relations conflict.

2. There should be an accredited bargaining agent responsible for province-wide hospital bargaining.

3. Mechanisms should be available to ensure that bargaining units are modified to incorporate employees in any satellite operations of a hospital or in related employers including agencies.

The History of Labour Relations in Long-Term Care Sector

Although all long-term care homes in Ontario are now operating under a unified, legislative and administrative scheme as provided in the *Long-Term Care Homes Act*, this has not always been the case. Historically, there were three categories of homes: the municipal homes for the aged, regulated through the *Homes for the Aged and Rest Homes Ac*t, the privately run nursing homes which fell under the *Nursing Homes Act*, and the charitable homes covered by the *Charitable Institutions Act*.

There has been extensive unionization across this subsector for some time. The bargaining units typically consist of nurses units and service units which include RPNs, with some homes having wall to wall units. For the historical reasons outlined above, RPNs are typically included in the service units with ONA representing RNs and NPs. Centralized bargaining has not been nearly as successful in this subsector. This is partly because of historical statutory distinctions between the groups and partly because of a lack of a desire on the part of private, for profit nursing home owners to negotiate together with the publically funded homes for the aged. While ONA now participates in centralized bargaining with a majority of private nursing home owners (151), negotiations with the municipal and charitable homes proceeds on a home-by-home or municipality-by-municipality basis. In that the ONA bargaining units in this sub-sector are typically very small with less than 15 full-time permanent employees and a larger group of part-time and casual-status members. The lack of central bargaining makes for inefficient, time-consuming and costly labour relations.

Changes in Trends in Long-Term Care

1. Patient acuity in long-term care facilities is much higher than it was historically. Residents enter homes older, frailer and with more chronic and complex needs. Many of these patients would have previously been cared for in hospital settings.

2. Long-term care homes have taken over the institutional care of significantly impaired, younger adults with physical or mental health challenges.

3. Changes to the scope of practice of the RN and RPN has further exacerbated the fragmentation of nursing work as many duties have been transferred from RNs to RPNs to PSWs in this sector; this has led to labour relations unrest and resulting litigation.

Recommendations:

1. As with the hospital sector, central bargaining should be implemented across this sector. As this has not occurred on a voluntary basis, it would need to be achieved through legislation. The central/local split of issues used in the hospitals and in the participating nursing homes negotiations provides a model that would work on a sub-sector basis.

2. Mechanisms should be put in place to allow a review of bargaining unit structures in homes to ensure that they are appropriate in light currently workplace roles, communities of interest, and that they minimize fragmentation and reduce labour relations conflict.

The Home Care and Community Services Sector

In 1970, Ontario formally recognized publically funded home care. It has evolved into the most rapidly growing sub-sector in health care. As the Auditor-General detailed in the most recent November 2015 Annual Report, the home care sector which once was intended to service clients with low-to-moderate care needs, "now serves clients with increasingly more complex medical and social-support needs."[3] In an attempt to reduce costs to the long-term care sector, the provincial government has shifted resources to keep residents in their homes longer.[4] The Ontario 2012 budget allocated a 4% spending increase to the community sector while there was a 0% growth for hospital base funding.

Prior to the *Home Care and Community Services Act*, 1994 (HCCSA), home care services were organized in a variety of ways across the province. In some areas, they were administered through hospitals and in others through various community and charitable organization. With the passage of the HCCSA, home care services were delivered through the 43 newly created Community Care Access Centres (CCACs). Each CCAC administered home care services as well as providing placement services for the long-term care homes.

[3] Auditor-General of Ontario, 2015 Annual Report at page 70.

[4] Ontario Association of Non-Profit Nursing Homes and Services for Seniors, Municipal Delivery of Long-Term Care Services: Understanding the Context and the Challenges. July 2014 at page 11

Although the HCCSA allowed for direct employment of service providers by the CCACs, the government imposed a system of "managed competition" whereby the provision of direct services to home care clients was provided through various service providers. Accordingly, while the CCACs directly employed case managers, placement coordinators and administrative staff, the health care workers providing the home care were employed by other agencies. This created a proliferation of employers, including many for-profit facilities who directly employed the nurses, the PSWs, the homemakers, etc., who provide the home care services. While there are numerous service providers, it is the CCAC which controls both the funding of the services and sets the very strict performance standards to be met. In many respects, it is the CCACs that meet the criteria of "employer" for the home care health workers.

The next restructuring of home care came in 2006 with the establishment of the Local Health Integration Networks (LHINs) in 14 designated areas of the province. Coincident with that change, the 43 CCACs were merged to create 14, one in each LHIN. The system of managed competition which fragments the direct care provided through home care was continued.

While there has been a high penetration of unionization for the employees directly employed by CCACs, this is not the case with the health care workers employed by the service providers. From a unionization point of view, the fragmentation of the work amongst many employers has made unionization extremely difficult. Not only are the bargaining units small, there is no fixed work setting for employees. Rather, they move from place to place in the community. Organizing such a group is exceedingly

challenging. These workers have no meaningful access to the benefits of unionization. Negotiating a collective agreement with small bargaining units with the right to strike in a managed competition setting further erodes any meaningful right to organization.

With the introduction of LHINs, the challenges of organizing home care workers remained unchanged. While the existing CCACs were amalgamated to reflect the geographic structure of the 14 LHINs, the fragmentation of the home care services amongst numerous health provider agencies remain the same. The work in this sector is precarious and does not offer the benefits of unionization to its workers in any meaningful sense. Attached is a document from the Toronto Central CCAC which demonstrates the number of service providers amongst which the health care workers are provided.

Bargaining in the Home Care Sector

The unionized employees in this sub-sector have the right to strike under the *Labour Relations Act*. Given the small work places and the tendency of nurses not to want to interrupt services to the vulnerable patients for whom they provide care this is a right that has not be frequently used. ONA represents bargaining units in 10 of the 14 CCACs. While there was one round of central bargaining in 2012, this process fell apart and the parties resorted to one-by-one bargaining in the next round. This resulted in a 17-day strike in the winter of 2015. After intervention from the Minister of Health, the parties resolved their outstanding differences through arbitration.

With home care service providers, negotiations have been compromised by the vulnerability of the patients. Should the parties reach an impasse in negotiations and apply for a "no-board' report, the CCACs intervene to make alternate care arrangements and patients are reassigned to other providers. The nursing work performed by ONA members is re-allocated away from the unionized nursing service provider. While the nurses have access to collective bargaining, it is an extremely pale and truncated version which does little to balance the unequal bargaining relationship in the workplace; the right to strike is an illusory right.

Changes in the Home Care and Community Services Sector

There has been and will continue to be a significant downloading of services, previously provided both in hospitals and long-term care homes, to the community. Patients previously cared for in hospitals are being moved to long-term care homes or the community. Similarly, due to bed occupancy in long-term care homes by patients with increasing frailty and acuity, the home care sector is increasingly relied upon to provide health care.

In a recent development, ambulatory clinics are being established to provide services that were previously provided in patients' homes, (i.e. patients are required to find their way to a clinic to receive health care services). As with in-home care, this work is being distributed to private for profit service providers. The workplace for a worker in this sector is a client's home or a small privately-operated clinic. The current definitions of "the employer" and "a related employer" simply do not reflect the organization in health

care, particularly home-care. The OLRB has determined that s. 1(4), the related employer provisions, do not apply to the relationship between CCACs and nursing service providers.[5]

Some workers in the home-care and community care sectors, particularly those working in clinics or with agencies, are required by their employer to become self-employed, independent contractors rather than employees. The result is a parallel contingent workforce within the health care sector.

Recommendations:

1. Broader based bargaining structures need to be put in place to replace the current fragmentation. While the service providers are the employer in the sense of some of the traditional indicia of employment such as hiring, firing and writing pay cheques, they are not the ones who either control the purse strings or set the standards and requirements of care. This currently is the CCACs, although that structure of organization of work is currently under review.[6] The current definitions of "the employer" and "a related employer" as found in the *Labour*

[5]See Service Employees International Union, Local 204 v. Durham Access to Care, 2000 CanLII 12981 (ON LRB)

6see: Patients First Discussion Paper, December 17, 2015. The Ministry of Health is consulting on whether the CCACs will transfer to the LHINs as a sale of business. The LHINs are prescribed crown agencies and employee's unionization and bargaining rights are set out in the C*rown Employees Collective Bargaining Act*.

Relations Act simply do not reflect the organization of work in the home care sector. The Ontario Labour Relations Board has determined that s.1(4), the related employer provisions, do not apply to the relationship between CCACs and nursing service providers.[7]

2. ONA submits that there should be a central bargaining process at the provincial level, with a designated employer agency to represent the LHINs, the CCACs, and the service providers at a common table. While it may be appropriate to have a separation of central and local issues, a centralized bargaining structure should be put in place.

3. ONA has made recommendations for the expansion of the OLRB's powers to consolidate bargaining units and the need to consider sectoral certification and bargaining procedures.

IV. Purpose of Changing Workplace Review: what values should the panel take into account

The Changing Workplace Review has the overall goal to protect workers in a modern economy. Access to effective collective representation through unionization is central to the protection of workers' livelihood and well-being. In the context of an increasingly fragmented health care sector, the protection of workers' access to decent work and

7See Service Employees International Union, Local 204 v. Durham Access to Care, 2000 CanLII 12981 (ON LRB)

unionization requires serious consideration of models which exist in other sectors in the province such as the construction sector or other jurisdictions such as British Columbia or Nova Scotia.

(i) The purpose of the existing legislative: the Labour Relations Act and the Public Sector Labour Relations Act

The first and the core purpose of the *Labour Relations Act* is "to facilitate collective bargaining between employers and trade unions that are freely designed representatives of the employees".[8]

The primary purpose of the *Act* is replicated in the *Public Sector Labour Relations Act* (PSLRTA) which has two purposes: (i) to facilitate the establishment of effective and rationalized bargaining unit structures in restructured broader public sector organizations; and (ii) to facilitate collective bargaining between employers and trade unions that are the freely-designated representatives of the employees "*following restructuring in the broader public sector and in other specified circumstances*." PSRLTA enables unions to follow the restructured work and maintain certification through a health services integration which is broadly defined.

8 *Labour Relations Act, 1995*, S.O. 1995, c. 1, Sched. A s. 2 (1) and the P*ublic Sector Labour Relations Transition Act,* 1997, S.O. 1997, c. 21, Sched. B s. 1 (2) and (3).

(ii) Restoring balance and increasing transparency

Neither the LRA nor the PSLRTA are up to the task of enabling nurses to continue to access collective representation in the midst of the significant health care transformation.

As noted above, access to collective representation is hampered as the CCACs, the centralized regional agency which directs the provision of nursing services, are not recognized as the true employer for labour relations purposes. ONA is unable to bargain with the multitude of nursing service providers, often temporary agencies, in the home-care and community sectors where the CCAC has contracted out the work. Where ONA does represent the nurse home-care providers, they negotiate in a right-to-strike environment where the employees have no real option to strike. If home-care nurses reach a no-board report, the CCAC allocates work elsewhere.

Moreover, as hospital work is transferred out to home-care providers, neither the hospitals nor the home-care nursing service providers are required to provide information to the nurses about who is now providing the nursing service work. Neither the LRA or PSLRTA require transparency of information to identify to where the work is transferred. Rather, the union is literally required to follow the work patient-by-patient, home-by-home.

In order to restore an appropriate balance between employers and workers, the legislative framework should be based upon two foundational principles.

(a) Processes and procedures that truly facilitate an employee's ability to enable in collective representation and bargaining, and

(b) the key principle of transparency is added to both the LRA and PSLRTA so that unions are provided with access to information about the transfer and rationalization of work in the home-care and community sector.

V. Sectoral Bargaining in the Health Sector

The question becomes what new or remodelled legislative structures may truly facilitate access to certification and collective bargaining.

As referred to above, the 1974 Report of the Hospital Inquiry Commission is useful for the Changing Workplace Review panel. In light of the shift to home-based and community care, the principles set out in that report should be extended to all areas of the health care sector beyond the public hospitals. In ONA's submission, a recommendation for province-wide bargaining should be adopted and applied to the entire home-based and community care sectors in the province as well as to long term care.

Furthermore, the health care sector lends itself to a sectoral bargaining model and recommendations should be made to establish such a model particularly in the community sub-sector. A sectoral certification and bargaining regimes could be applied across the entire health care sector. Alternatively, it could be organized by sub-sectors as these sub-sectors reflect the unique features of work in each workplace whether it be a public hospital or a patient's home.

The key point is to develop innovative certification and bargaining structures to enable employees to have a democratic voice in their labour relations based upon negotiations with the true employer or multiple-employers.

There is an existing precedent to draw upon.

1. Ontario's construction industry, particularly the ICI sector, is based upon a sectoral, province-wide model for both certification and bargaining. The ICI sector, which applies to large scale public projects, is governed by mandatory trade, multi-employer and provincial wide bargaining. Certification applies to all operations of a single employer.

2. The *Industrial Standards Act* and the Quebec *Decrees Act*are models to respond to the fragmentation sub-contracting in the home care sector to establish a base set of standards.

3. In 2014, and effective April 1, 2015, the province of Nova Scotia, through the *Health Authorities Act*, collapsed nine former district health authorities to one provincial health authority with four management zones.[9] Health care employees in Nova Scotia are now employees of the provincial health authority. Bargaining in Nova Scotia now takes place on a province-wide basis. All acute care and public health care employees are the direct employees of the provincial health authority.

9 See *Health Authorities Act*, SNS 2014, c 32 section 49 and 50.

Conclusion:

In ONA's submission recommendations should be made to achieve the following objectives:

1. That there be an examination of the bargaining structures and processes in the health care sector to reflect the significant restructuring that has occurred.

2. That the appropriateness of bargaining units be re-examined to reflect the significant changes in the distribution of work amongst classifications and to ensure that workers with the strongest community of interest be in a position to bargain collectively.

3. That bargaining structures and processes be put in place to ensure that health care workers are bargaining with the "real" employers; i.e. those in control of the setting of standards, funding and distribution of work.

4. That bargaining for all nursing professionals be conducted on a provincial or regional basis. Not only is this a efficient bargaining mechanism, it is consistent with equity within the profession ensuring that nurses positions in all sub-sectors of health care are equally attractive to professionals.

A new model of sectoral, broader-based certification and bargaining procedures will serve to correct the imbalance between employers and employees and enable health care employees to have an effective collective voice in their workplace as the province goes forward with restructuring in this sector.