Discussion Paper

Standard Health Care Bargaining Units

January 24, 2002

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Discussion Paper
Standard Health Care Bargaining Units

Executive Summary

INTRODUCTION

The Alberta Labour Relations Board administers collective bargaining legislation in the health care field and elsewhere. That legislation is found under the *Labour Relations Code* and the *Public Service Employee Relations Act*. When the Board certifies a union, the union becomes the exclusive bargaining agent for a unit of employees (a "bargaining unit") that the Board says makes sense to group together for collective bargaining.

The Board, on its own initiative and after consultation with the community, began moving towards standardized health care bargaining units in the 1970s. It adopted standard bargaining units in 1977 and has used those standard units since then. There are currently five standard bargaining units in hospitals and nursing homes. These units are based upon employee function. For example, employees providing direct nursing care are in one unit while those providing paramedical technical services are in another. Three standard bargaining units exist in community health. There are 594 certified bargaining units in the health care industry.

With regionalization of health care in 1993, the industry began asking if the Board would re-examine the standard bargaining units. In 1996, the Board hosted a health care conference, again touching on the topic. The Board adopted a cautious approach to change during regionalization, in part because the parties said they needed time to adjust to regionalization and to find solutions and direct the course of change.

In 2000, several applications to the Board prompted the Board to reopen the broader discussion of reviewing the standard bargaining units in health care. The Board's January 24, 2002 discussion paper is one step in the process. It makes a number of specific recommendations and asks for community feedback.

The Board believes the time has come to re-examine the standard health care bargaining units and bring certainty to the Board's policies affecting health care bargaining units for the foreseeable future. The broad discussion up to now has not enabled the Board to obtain the fullest picture of the state of labour relations in health care. Consequently, the Board has chosen to identify specific recommendations for change and to solicit support or objection to those recommendations, with the parties providing detailed information to support their respective positions. The process will provide the Board with detailed information for its decision making process.

SUMMARY OF RECOMMENDATIONS

The recommendations fall into four key areas: a confirmation of many existing policies and practices; a change to the number of standard bargaining units; a return to wider geographic boundaries of bargaining units; and processes to implement all the policy recommendations.

- **Recommitting to Previous Policies:** A number of recommendations merely confirm and recommit to long-standing Board policies and practices in dealing with standard bargaining units in health care.

- **Bargaining Units:** The Board recommends a move towards four standard bargaining units in all sectors except labs, ambulances and possibly community health. Certain exceptions will remain for "all employees" units for some employers. These four units will be all employees employed in:

    1. a paramedical professional or technical capacity;
    2. auxiliary nursing care;
    3. general support services; and
    4. direct nursing care or nursing instruction.

Currently, there are five standard bargaining units in acute care, continuing care (auxiliary hospitals and nursing homes), mental health hospitals and cancer treatment. This policy would combine employees working in paramedical technical and paramedical professional capacities into one bargaining unit.

Community health currently has three units (nurses, paramedical technical and professional, and support services). Depending upon the community's feedback, the Board may adopt the four-unit model outlined above (effectively splitting the support services unit into two) or maintain the status quo.

- **Employer-wide Units:** The Board recommends a return to its policy of bargaining unit boundaries that are employer wide.

- **Processes to Implement the Policies:** The processes allow the parties to negotiate their own resolutions by December 31, 2003 and then enable the Board to work with the parties to implement those policies that it adopts after this consultation. Three notable aspects of the processes affect:

    - *Non-Standard Units***:** For the 47 bargaining units which do not match the standard functional unit description, the Board will work with parties to ensure these units conform to the standard functional bargaining units by December 31, 2003.

    - *Multiple Certificates by a Single Union*: Where a union holds more than one certificate for the same functional bargaining units with one employer within a health region, the Board will work with the parties to ensure their consolidation into one certificate by December 31, 2003.

    - *Multiple Certificates by Different Unions*: Where two or more unions hold certificates for the same functional bargaining units of a single employer within a health region, the Board will work with the parties to ensure their consolidation into one certificate by June 30, 2004. An exception will be

in general support services functional units where the Board will allow two certificates per employer.

RATIONALE

The community has generally indicated its desire to move to four standard units, which is why the Board has recommended this change.

The Board has historically advocated employer-wide standard functional bargaining units but exceptions have developed for various reasons. The Board is again recommending the reemphasis of standardized functional bargaining units that are employer-wide. It appreciates that this will result in realignment of bargaining relationships and fewer bargaining units in health care. This will create a period of change for the health care industry. Some of the considerations underlying this recommendation are:

- ***Increasing Unionization*****:** Small units allowed employees to more easily unionize if that was their desire. The health care system is now highly unionized and concerns about the accessibility of unionization have given way to concerns about industrial stability. The greater the number of bargaining units, the greater the number of parties engaging in collective bargaining which creates a greater potential for industrial unrest and conflict.

- ***Union Market Share*****:** In acute care (the largest health care sector), one union has emerged as the clear choice of employees in each functional group except general support services.

- ***Regionalization:*** As a result of regionalization, there are fewer employers in the health care industry. Those employers are also changing the way that employees work and interact as they change the methods of delivering health care services.

PROCESS

In June 2000, the Board began a community consultation process on the state of standard bargaining units in health care. Responses to our questions were compiled and distributed in November 2001. By making recommendations in this discussion paper, the Board hopes to generate pointed and helpful discussion about the merits of the proposed changes.

To this end, the Board plans to hold two information forums (one each in Calgary and Edmonton in April 2002) to explain the recommendations and stimulate discussion. Support for or objections to the recommendations are due by May 31st with supporting documents to follow by September 30th. Based upon the community's feedback, the Board will determine and communicate a case management process that might include:

- immediately implementing those recommendations for which there are no objections;
- immediately amending or deleting recommendations where there is consensus in the responses;
- dealing with all or some of the objections on the basis of written submissions;

- assigning Board staff and members to informally resolve some or all of the disputes over particular recommendations;
- scheduling a hearing to deal with the unresolved objections; and
- implementing the decision of the Board on any objections.

I. Introduction

This discussion paper is the next step in the review process. It includes current information and reference to Board policies as well as recommendations for future action. It covers health care bargaining units under the *Labour Relations Code* and the *Public Service Employee Relations Act.*

The paper goes beyond the specific limits of the five questions previously posed to the community because the questions were framed in the context of three active applications before the Board. The paper draws on the information obtained from those questions. The questions and responses will not be repeated here.

The recommendations in this paper are premised on preserving the bargaining rights of employees, but not necessarily their choice of bargaining agent. Although this paper sets each recommendation out separately, they are intended to integrate into a comprehensive picture at the end, rather than being applied independently of other recommendations. References to the statute (except in quotations) use the section numbers in the *Labour Relations Code* RSA 2000.

The discussion paper was reviewed by the health care sub-committee of the Board's caucus for input and copies have been sent to all Board members. However, the Board members have not taken a position either in support of or opposition to the recommendations in this report. This is so that they may give an unbiased consideration to the responses of the community.

As noted later, the consultation process provides an opportunity for the community to provide input on items raised that were not previously canvassed. The community will have an opportunity to respond to all the recommendations in this discussion paper. The Board will then take steps to implement the recommendations as accepted or amended. The details of the process from here are set out under the heading "Next Steps".

During the consultation and implementation phases, the status quo of current bargaining units and certificates is frozen as of the date of this report unless the Board otherwise directs. This means that the recommendations will be implemented based on the information contained in the Board's current active certificates (errors excepted), not on any changes resulting from applications processed in the transition period.

II. The History of Health Care Bargaining Units in Alberta: A Summary

Standard health care bargaining units emerged as part of the Board's policy as early as 1977. The Board developed the standard units after consultation with the industry. The following time line identifies some of the notable activities in this continuum.[1]

➢ *Pre 1972* A proliferation of craft-style occupationally based organizing occurred. Bargaining unit descriptions used the occupational classifications of the individual employer. The Board's approach to "proper bargaining agent" required that trade unions be constitutionally capable of representing the workers in question. This further cemented the occupationally restricted bargaining units.

➢ *1972* Board held public hearings to determine its future policy on certifying bargaining units in health care. Health Sciences Association of Alberta applied for certification of a unit of all the paramedical classifications. The Board split the unit into two: paramedical professional and paramedical technical, specifically because the professional group was against collective representation. Otherwise the Board noted they could all be included in one unit.[2]

➢ *1975* Board moved away from a narrow "certified nursing aides" bargaining unit and towards a broader, functionally based unit of "auxiliary nursing care".[3]

➢ *1976* Board adopted the "general support services" bargaining unit description, removing the narrow trade-based units.[4]

➢ *1977* Board published Information Bulletin No. 4 outlining the five standard functional bargaining units in hospitals and nursing homes: direct nursing care, auxiliary nursing care, paramedical professional, paramedical technical and general support services. Hospitals began to amalgamate into hospital districts. The Board recognized the hospital district as the employer.

➢ *1978* Board decided five standard units will not apply to community health, because community health is not part of the hospital and nursing home industry.[5]

➢ *1982* Board held a public hearing on community health bargaining units. Board adopted policy for community health to certify unions only for all employees of

[1] *What Makes an "Appropriate" Bargaining Unit?* [1997] Alta.L.R.B.R. DP-002, *Functional Bargaining Units in Alberta's Health Care Industry* [1997] Alta.L.R.B.R. DP-003, *Geographical Limits in Health Care Bargaining Units* [1997] Alta.L.R.B.R. DP-004
[2] *Health Sciences Association of Alberta v. Misericordia Hospital* (Alta. L.R.B. No. 72-024, Nov. 28, 1972, D'Esterre, Chair)
[3] *Alberta Certified Nursing Aide Association v. Bethany Auxiliary Hospital* (Alta. L.R.B. 75-032, July 26, 1975, D'Esterre, Chair)
[4] *CUPE, Loc. 41 v. Misericordia Hospital* (Alta. L.R.B. 76-028, June 4, 1976, Laird, Acting Chair).
[5] Information Bulletin No. 9 (April 1, 1978)

the employer. Board adopted three standard community health bargaining units: nursing, professional, and support. [6]

➢ *1977 – 1986* Board policy was to certify unions only for all employees of a district in a standard unit, except where the district was partially organized.[7] Board gradually amended existing bargaining units to comply with the standard units. Public Service Employee Relations Board adopted the five standard functional units. Province-wide bargaining began to flourish.

➢ *1986* Board undertook a limited review of the five functional units and confirmed the previous approach. Board rejected a proposal to identify standard units by qualifications or job titles rather than functions.[8]

➢ *1994* Health care regionalization occurred. Individual hospitals, hospital districts and health units merged into 17 health regions. Provincial organizations created for mental health and cancer. Board issued Information Bulletin T-2, to deal with the transition to regions.

➢ *1995* Board approved two region-wide units of community health professional/technical and support. [9]

➢ *1996* Board created new municipal bargaining unit of "delivery of pre-hospital care".[10]

➢ Board ordered multiple site-based hospital bargaining units combined into region-wide bargaining units – one for general support services, one for paramedical technical employees and one for paramedical professional employees. Board maintained district-based community health support units but consolidated several community health paramedical units into a single region-wide unit. First comment that employees with the right to strike should not be in bargaining units with employees who do not have the right to strike.[11]

➢ Board merged multiple community health nursing units into a single region-wide unit.[12]

➢ *1997* Board approved region-wide units for paramedical professional employees and paramedical technical employees in hospitals.[13]

➢ *1998* Board approved a consolidated, virtually region-wide hospital unit of paramedical technical and paramedical professional employees.[14]

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[6] Information Bulletin 9-82
[7] Information Bulletin No. 4 (April 1, 1978)
[8] *UNA Locals v. Alberta Hospital Association et al.* [1986] Alta.L.R.B.R. 610.
[9] *HSAA v. Regional Health Authority 5* [1995] Alta.L.R.B.R. 460.
[10] *Edmonton Firefighters v. City of Edmonton* [1996] Alta.L.R.B.R. 449.
[11] *HSAA et al. v. Chinook Regional Health Authority et al.* [1996] Alta.L.R.B.R. 289
[12] *David Thompson Health Region v. Staff Nurses Association* [1996] Alta.L.R.B.R. 347.
[13] *HSAA et al. v. Chinook Regional Health Authority et al.* [1996] Alta.L.R.B.R. 289

- Board approved some site-specific hospital unit descriptions to read "at or out of a site".[15]

- Board approved municipal boundaries for rural hospital units as "employees in town/municipality".[16]

- Board approved single "all employee" unit for mental health clinics.[17]

- *2000* Board found that employees in bargaining units, which combine facilities with the right to strike with those that do not have the right to strike, cannot strike.[18]

[14] *CHA v. UNA, SNA, CHCG, HSAA, CUPE 41 and AUPE Locals* [1998] Alta.L.R.B.R. LD-019.
[15] *CHA v. UNA, SNA, CHCG, HSAA, CUPE 41 and AUPE Locals* [1998] Alta.L.R.B.R. 13.
[16] *UNA Local 126 v. Palliser Health Authority* [1998] Alta.L.R.B.R. LD-060.
[17] *AUPE v. Provincial Mental Health Advisory Board and the Crown in right of Alberta* [1998] Alta.L.R.B.R. LD-081.
[18] *AUPE v. PHAA and Various Regional Health Authorities et al.* [2000] Alta.L.R.B.R. 338.

III. Current State of Affairs

A. The Current State of Health Care Bargaining Units: A Summary

There are 594 active certificates in health care. Over the years, the Board has approved 47 non-standard bargaining units. This represents 7.9% of all health care bargaining units. Non-standard means the unit description does not exactly match one of the current five hospitals and nursing homes units or three community health units, other than including a geographic limitation.

The reasons these non-standard bargaining units exist include:

- **Historical Reasons**

The majority of non-standard bargaining unit descriptions that exist on current certificates can be tracked back to the initial certification of the unit. Before the Board had standard bargaining unit descriptions, unions could apply for any unit that qualified as "an" appropriate unit. During the replacement certificate process, the Board attempted to grant standard bargaining units. In most cases, the standard bargaining unit description would accurately reflect those classifications included as part of the original certification. In some cases, however, the standard bargaining unit description alone would imply the inclusion or exclusion of certain classifications that had not actually been contemplated in the original certification application. As a result, the Board granted standard bargaining unit descriptions with an express inclusion or exclusion of a classification to reflect the original intent of the parties at the time of certification and to maintain existing bargaining relationships.

- **Consolidation of Certificates**

As the same union became certified for more than one bargaining unit of an employer, the parties would sometimes apply to the Board for consolidation of certificates. If a union became certified for a group of employees of an employer where there were already bargaining relationships in place for other units, the parties would sometimes apply to roll the new employees into an already existing certificate.

- **Application to the Board**

In some cases, parties had difficulty agreeing on the wording of a unit. Where a standard bargaining unit description did not work, the parties applied to the Board for assistance in determining the wording of a unit.

- **Agreement of the Parties**

While the Board strove to maintain the standard bargaining unit descriptions so as to maintain some consistency and degree of predictability for the parties, it acknowledged that parties sometimes had specific reasons for wanting to deviate from the Board's standard unit descriptions. Where the parties had agreed on the wording and the Board did not see any potential problems from a labour relations stand point, the Board approved the proposed bargaining unit description.

- **Employer Operation**

In some cases (e.g., Calgary Regional Health Authority), the employer developed new sites or locations. Employees then transferred from a number of other bargaining units to work at this new location. Usually a run-off vote occurred to determine which union would represent the employees at this new location and often the bargaining unit description awarded would refer to the new location.

Since regionalization, the Board has approved bargaining units in hospitals and nursing homes that are:

- site based;
- municipal or town based;
- region / employer wide;
- occupational groupings for less than standard functional units;
- a combination of any of the above.

All current bargaining units in community health, except six (6), are region wide. These exceptions are explained in decisions of the Board.[19]

B. Current Certificates and Breakdowns of Number of Units

Appendices "A", "B" and "C" give an overview, by employer, of the number of bargaining units in each functional bargaining unit category. Appendix "A" covers hospital and nursing home bargaining relationships. Appendix "B" covers community health bargaining relationships. (**Note:** Appendices "A" and "B" portray information currently in the Board's database and do not reflect or imply a decision of the Board on any outstanding applications, which may vary that information.) Appendix "C" shows a further breakdown of bargaining units by trade union for the 17 regional health authorities.

Appendices "A1-5" and "B1-4" provide the details of the specific bargaining relationships, including employer name, union name, bargaining unit description and certificate number.

Appendices "D", and "E" deal with the non-standard units. Appendix "D" identifies the details of all the active "non-standard" bargaining units, including employer name, union name, bargaining unit description and certificate number. Appendix "E" explains the origin of each non-standard unit.

Note: Parties should check this information and bring any discrepancies or errors to the attention of a Board Officer.

[19] *AUPE v. PHAA and Various Regional Health Authorities et al.* [2000] Alta.L.R.B.R. 338.

IV. Factors Affecting Standard Functional Bargaining Units in Health Care

A. General Principles

The Discussion Paper "What Makes an Appropriate Bargaining Unit" outlines the general principles applied by this and other labour boards when considering the appropriateness of bargaining units. It states in part:

> The purpose behind the concept of the "appropriate bargaining unit" is easy to state: it is "an effort to inject a public policy component into the initial shaping of the collective bargaining structure, so as to encourage the practice and procedure of collective bargaining and enhance the likelihood of a more viable and harmonious collective bargaining relationship". *Hospital for Sick Children* [1985] O.L.R.B. Rep. Feb. 266.
>
> …
>
> General principles
>
> The case law tells us that an appropriate bargaining unit should have these qualities:
>
> - it should be drawn so that employees have reasonable access to collective bargaining;
> - it should be large enough to make the unit a viable vehicle for collective bargaining;
> - it should not be drawn in a way that unduly interferes with the employer's operations;
> - it should associate employees having enough of a "community of interest" that the collective bargaining process is not unduly impaired by the conflicting interests that the bargaining agent is called upon to represent. The concept of "community of interest" in turn encompasses a host of reasons why a given group of employees should or should not bargain with their employer as a group;
> - it should promote industrial stability in the long term; and
> - its boundaries should be precise enough to minimize disputes over who is and is not in the bargaining unit.
>
> These objectives in a bargaining unit description often conflict, and the final shape of the unit must be the product of a balancing of the conflicting objectives.

Information Bulletin #9 identifies some of the general criteria the Board considers when determining whether a bargaining unit is appropriate or remains appropriate for collective bargaining. The bulletin also sets out the Board general guidelines that apply to all bargaining units. Three of those guidelines apply to health care.

1. Include full-time and part-time employees in the same unit. Indeed, the Board also includes casual employees in that unit.

2. Bigger bargaining units are generally better, provided employees share a community of interest. Therefore, a unit of all employees of an employer will generally be an appropriate unit.

3. A unit may be inappropriate if it leaves unorganized a small number of employees that would create a "tag-end" unit.

The Board should confirm that these guidelines will apply in the future.

RECOMMENDATION #1

The Board continue to apply its general guidelines concerning appropriate bargaining units to health care bargaining units.

The Board recognizes that different objectives may take on different importance at different times in a bargaining relationship. In first certifications, and particularly in highly unorganized industries, the focus is on granting employees access to bargaining. As a result, the Board takes a very lenient approach to what constitutes an appropriate bargaining unit. In subsequent certification applications for the same employer or as an industry becomes more unionized, the emphasis shifts towards long-term objectives of industrial stability and avoidance of fragmentation. Alberta's health care industry is highly organized, even more so than it was at the time of regionalization. This is borne out by the statistics in Appendices "A" to "F". In addition, a significant amount of the collective bargaining occurs at provincial or multi-employer bargaining tables or is influenced by pattern bargaining established at those major tables. As a result, the Board should adopt an approach that emphasizes the long-term objectives rather than access to bargaining.

RECOMMENDATION #2

When processing applications for certification or reconsideration of or amendment to a bargaining unit in health care, the Board continue its practice and confirm its policy that places greater emphasis on long-term objectives of industrial stability and avoidance of fragmentation than on the short-term objective of access to collective bargaining.

B. Guidelines Applicable in Health Care

Information Bulletin #10 summarizes the Board's approach to standard units in hospitals, nursing homes and community health. The principles here can be summarized as:

- for senior-citizens lodges, group homes and group shelters the normal appropriate unit is "*all employees*";
- applicants for certification must apply for a standard unit or bear the onus to persuade the Board that a non-standard unit is appropriate;
- where a service formerly provided by a hospital, nursing home or community health employer is shifted to another type of employer, the Board will apply its general bargaining unit appropriateness principles (Information Bulletin #9);

- the basis for a unit description in health care is job function, and employees will be assigned to bargaining units based on job function, not occupational terminology or qualifications; and
- boundaries of the bargaining units in hospitals and nursing homes are employer wide and unions applying for certification are to apply for the standard unit even though non-standard units currently exist.

The *Code* speaks of "an" appropriate unit for collective bargaining when the Board considers the merits of a certification application. However, in health care the Board has consistently said that "an" appropriate unit will be the one that fits within the standard functional units adopted by the Board. The Board should retain these specific policies.

RECOMMENDATION #3

The Board continue to apply its specific health care industry guidelines concerning appropriate bargaining units in health care.

Recommendations #1, #2 and #3 apply to all of the specific recommendations which may follow and are not ousted or waived by a specific recommendation.

C. Medical and Health Laboratories

Information Bulletin #9 (not Information Bulletin #10) outlines the Board's approach to describing units in medical and health laboratories. Until now, the Board has separated the standard units in labs rather than formally recognizing them in Information Bulletin #10 as part of the standard bargaining units in the health care industry. The Board currently says it will find an "all employees" unit appropriate in smaller labs and may find two units appropriate in larger labs: "all employees except office and clerical personnel" and "office and clerical personnel". In practice, most labs are larger and have more than one bargaining unit.

This historical approach to bargaining units in laboratories has proven workable and should be retained for both certification applications and any applications to modify or amend existing bargaining units in labs. In addition, the labs should be included in any standard health care bargaining unit bulletin.

RECOMMENDATION #4

The Board continue its policy concerning appropriate bargaining units for medical and health laboratories and include those units as part of the Information Bulletin on standard functional bargaining units in health care.

RECOMMENDATION #5

When considering the appropriateness of the bargaining unit in applications for certification or reconsideration of or amendment to a bargaining unit in the labs, the Board apply its policy concerning appropriate bargaining units for medical and health laboratories.

RECOMMENDATION #6

The Board initiate a review of all current medical and health laboratory certificates and encourage the parties to negotiate a process to bring any non-conforming certificates within the policy governing standard units in labs by December 31, 2003. If the parties are unable to negotiate and implement a resolution, the Board take steps to bring the certificates within the policy governing standard units in labs.

D. Health Care Sectors

1. Current "Sectors"

The Board has long recognized two major parts of the health care industry requiring standard bargaining units – "hospitals and nursing homes" and "community health". It refers to these parts as "sectors" of the health care industry. In practice, we also have province-wide bargaining units in cases such as the Alberta Cancer Board and Alberta Mental Health Board, and other standard units, such as labs.

There are currently at least six different "sectors" in the health care industry. Each might identify varying labour relations issues and goals. Those sectors are:

(i) acute care – providing acute care or active treatment
(ii) community health
(iii) mental health
(iv) cancer treatment
(v) continuing care – providing longer term and palliative care
(vi) medical and health laboratories.

2. Ambulance Sector

Ambulance services could be recognized as a potential sector in the health care industry (Appendix "F"). Currently, municipalities or private providers provide ambulance services. As a result, the bargaining units tend to vary with the employer's operation. Where the employer is a private provider, the unit covers "*all employees."* Where the municipality is the employer, the ambulance services may be part of the firefighters unit or may be described as "emergency medical services" or "delivery of pre-hospital care".

The Board should begin by recognizing ambulance as a sector in health care and include reference to it in the bulletin on standard healthcare bargaining units. This will give the Board the future flexibility to

standardize these units if changes occur to shift the focus from a municipal service to a healthcare service.

3. Future Considerations on Sectors

Several considerations impact on how the Board should reflect health care sectors in the standard bargaining units in this industry:

(i) collective bargaining practices
(ii) changes in the methods and forms of health care delivery
(iii) right to strike or not
(iv) cross over of employee work
(v) sectoral issues.

We examine each in turn.

i) collective bargaining practices

The collective bargaining practices of the industry may result in distinct sectors being less important in the future. For example, the nurses have a single province-wide table that bargains for both acute-care nurses and community health nurses. Two collective agreements result – acute-care and community health – with large numbers of "local" provisions. Common tables such as this could see more homogeneity in terms and conditions of employment, decreasing the need for distinct sectors and different bargaining units, subject to other considerations such as right to strike or not. Results from the largest multi-employer table for auxiliary nursing care in the acute-care sector tends to become the pattern for the support workers in community health (which are largely workers in similar capacities). As the parties voluntarily move to more integrated bargaining structures, the need for distinct sectoral bargaining units may decrease.

ii) changes in the methods and forms of health care delivery

Changes have also occurred in the delivery of health care between acute care and community health, which suggests those sectors are moving towards stronger integration. In at least one rural health region, the employer has a nurse or auxiliary-care worker work half the time in a facility and the other half in the community health role. Clients tend to see a continuum of services in some cases. For example, a pregnant woman will see a community health nurse for pre-natal care. She may receive care from an acute-care nurse if she goes into hospital for the delivery of the baby. She then receives post-natal care for her and the baby from the community health nurse.[20]

As early as 1993, the Board recognized that changes in delivery of health care services may result in community health becoming a less distinct part of the industry. In Information Bulletin T-2, the Board signaled that, if an integration of community health and acute care were to occur, the Board would split the three community health units into the same standard functional units which exist in acute care. The

[20] Example provided by a PHAA representative

Board's policies should maintain this proactive approach but will also need to consider the impact of the right to strike – no right to strike issue. The specifics of splitting the units are discussed later in Recommendation #21.

iii) right to strike or not

As discussed later in *E. Reflecting the Right to Strike or No Right to Strike in a Bargaining Unit*, different sectors are impacted by the legislation requiring the parties to use different methods to resolve any collective bargaining disputes. In acute care, generally, employees cannot strike. Employers and employees in community health have the right to lockout or strike. Some parts of continuing care can strike or lockout depending on whether the facility name appears on the approved hospitals list referred to in Section 96 of the *Code*.

The Regional Health Authorities suggest combining the two sectors - community health and acute care. Two factors militate against the Board moving in this direction at this time. The first, and the most important consideration, is the difference in the legislated methods of resolving collective bargaining disputes (the right to strike or not). Second, although some the regional health authorities are experimenting with delivery methods, the Board has not received any significant information to suggest that the two businesses (both conducted by the regional health authority) do not continue to operate separately and independently.

iv) cross over of employee work

Acute care (hospitals) and continuing care (nursing homes), although grouped together in the Board's policies, have not always shared common labour relations issues or goals. Changes in health care reveal the increasingly distinct, yet inter-related, nature of the services provided by hospitals and nursing homes. Hospitals, (or facilities as they are commonly known as today), tend to focus on acute care while continuing care or long-term care is provided by auxiliary hospitals or nursing homes. Economic realities mean we frequently see parts of the same physical plant being devoted to more than one or all of these services. The employees in these combined sites may fall with acute-care bargaining units and bargain at those tables. As a result, the differences between the units and the need for separate units at integrated physical plants may continue to fall away.

v) sectoral issues

In other cases, a private-sector or quasi-private sector employer operates the nursing home or auxiliary hospital. Those employers may have smaller numbers of employees. They tend to seek the flexibility to compete in the private sector. They bargain separately from acute-care employers, either alone or in an employers' organization.

If the ambulance sector is recognized as a sector in the health care industry, the Board may need to recognize different issues affecting the ambulance employers, who are primarily municipalities, rather than regular health care providers.

vi) summary of future sectoral considerations

The Board's policies should acknowledge and identify the different standard functional bargaining units the Board uses in the various sectors. At the same time, they should provide sufficient flexibility to allow changes to occur as further integration occurs, without having to revisit the full scope of functional bargaining units. Finally, the sectors may be necessary as long as the legislation provides different methods for employees and employers to resolve collective bargaining disputes (discussed in more detail under "Reflecting the Right to Strike or No Right to Strike in a Bargaining Unit").

RECOMMENDATION #7

The Board amend Information Bulletin #10 to include all of the sectors of health care, namely:

- ***acute care – providing acute care or active treatment***
- ***community health***
- ***mental health***
- ***cancer treatment***
- ***continuing care – providing longer term and palliative care***
- ***medical and health laboratories***
- ***ambulance.***

RECOMMENDATION #8

The Board include the sector in the bargaining unit description where more than one sector uses the same or similar functional bargaining unit.

E. Reflecting Right to Strike or No Right to Strike in a Bargaining Unit

1. Current Situation

The legislation provides two different mechanisms for resolving collective bargaining disputes for employees in health care. Some employees and employers have the right to strike or lockout to aid them in resolving bargaining disputes. Other employees (of employers, who operate approved hospitals) and their employers must use binding interest arbitration and are not allowed to strike or lockout (see: section 96). This legislative difference is a factor that the Board should consider when determining the appropriateness of a bargaining unit. A recent case reveals how the legislated mechanism can impact employees and employers.

In May, 2000, as a result of an application[21] by Alberta Union of Provincial Employees to conduct strike votes, the Board considered how the application of the "approved hospitals" list affected different employees' rights to use the strike mechanism to resolve their bargaining disputes.

In the one unit where the Board found that employees of an approved hospital site were combined into a unit with employees who held the right to strike, the Board found all those employees were caught by the ban on strikes for employees in approved hospitals (now section 96). This certificate was originally issued in 1986 to the Cardston Municipal Hospital District No. 5. In 1996 AUPE applied to add in the employees of the Grandview Nursing Home, a separate facility operated by the District. The employer did not object, a vote was held and a single certificate issued. There is no mention in the Board's records that it considered the impact of combining the two sites.

In *AUPE v. PHAA and Various Regional Health Authorities et al*, the Board said:

> **Group III. More than One Facility - At Least One of which is an Approved Hospital**
>
> [42] There is one application where the bargaining unit covers both an approved hospital and a facility which does not appear on the DMO list. AUPE seeks a strike vote for the entire unit.
>
> [43] Grandview Nursing Home is not listed as an approved hospital. We have no evidence linking it to the approved hospital, Cardston Municipal Hospital. As nursing homes were not intended to be listed as approved hospitals, we would need evidence to conclude that the two are one facility.
>
> [44] The following chart demonstrates how the facilities, the DMO, the certificate and the application tie together.

Cert #	Name Of Employer On Certificate	Bargaining Unit Description	Site Employees Work At Per AUPE Application	Approved Hospital Site On DMO 4/97
Chinook Health Region				
Certificate No. 59-96	Chinook Regional Health Authority General & Auxiliary Hospital & Nursing Home District No. 35	*All employees when employed in auxiliary nursing care at the Cardston Hospital and Grandview Nursing Home.*	Cardston Hospital Grandview Nursing Home	Cardston Municipal Hospital (Milk River Hospital)

> [45] What should the Board do with this application affecting a facility, which is not on the DMO list but which forms part of the bargaining unit containing an approved hospital? In *Chinook supra*, the Board found that the employer's status as operator of an approved hospital would not necessarily sweep in all other employees of that employer that were not working in the hospital. We agree with that view. However, when the employer

[21] *Attorney General for the Province of Alberta v. Gares et al. and Board of Governors of the Royal Alexandra Hospital* 76 CLLC 14,016; Information Bulletin 4-78, 4-80, 4-82.

operates both an approved hospital and other facilities for which the employees are all in the same bargaining unit, the Board must also consider the impact on the entire bargaining unit.

[46] It does not make labour relations sense, and indeed would cause labour relations havoc, to have two different mechanisms for resolving collective bargaining disputes within the same bargaining unit. For example, if the employer operated two sites - one an approved hospital and the other not - the employer and the employees of the non-approved site would be able to resolve their bargaining disputes using the strike or lockout provisions of the *Code*. At the same time, the employees at the approved hospital site would be prohibited from striking and would be statutorily required to resolve any collective bargaining dispute by compulsory arbitration. The award of the arbitration board is obliged to form part of the collective agreement.

[47] The mere existence of two different resolution processes does not on its face necessarily cause difficulties because a collective agreement can comprise one or more documents and one or more agreements. However, there should only be one collective agreement for the bargaining unit. If part of the unit went to binding arbitration and the other part of the unit were able to negotiate their terms and conditions of employment, a collective agreement could result.

[48] The natural result of both processes demonstrates the potential difficulty. Employer/employees of the non-approved site could engage in strike/lockout action which continues to its statutory end two years later. In the meantime, the employees in the approved hospital site have a binding arbitration award. What are the employees who have a binding arbitration award to do in the interim while the strike/lockout lingers? Should the employer implement the award for those employees? How do the parties conclude a collective agreement at the end of the two years? Would it include more than the arbitrator's award? All these questions show the labour relations controversy which could arise.

[49] AUPE suggests we should give everyone in the unit the opportunity to vote and strike, unless everyone is prohibited from doing so. PHAA argues we would apply section 94 to all the employees in the unit. We prefer the latter approach.

[50] Section 94 mandates the Board to consider certain information and directs the consequences on employers and employees of the Minister of Health's actions to designate certain hospitals as approved hospitals. We cannot ignore that statutory direction and consequence. As a result, we must find that part of the bargaining unit is not allowed to strike.

[51] The logical progression of that process then, given the analysis of the labour relations results of combining two groups with different rights in the same unit, is to say the entire bargaining unit is not allowed to strike. This decision will result in less labour relations havoc and will better meet the intention of the Legislature to prohibit strikes in hospitals. Accordingly, we dismiss this application because the employees are caught by section 94.

2. Future Considerations on the Right to Strike or No Right to Strike Issue

This case reveals that, in certification applications or applications for reconsideration of or amendment to bargaining units, the parties and the Board need to consider the legislated mechanisms of resolving

bargaining disputes as one of the criteria for determining the appropriateness of the bargaining unit sought.

RECOMMENDATION #9

When determining the appropriateness of a bargaining unit sought in applications for certification or reconsideration of or amendment to a bargaining unit, the Board consider the legislated mechanisms of resolving bargaining disputes as one of the criteria in its deliberations.

RECOMMENDATION #10

The Board adopt a policy ensuring separation of employees who have the right to strike from those employees who do not have the right to strike into separate bargaining units.

RECOMMENDATION #11

The Board initiate a review of all current certificates and encourage the parties to negotiate a process to bring any non-conforming certificates within this policy of separating "right to strike from no right to strike" by December 31, 2003.

If the parties are unable to negotiate and implement a resolution, the Board take steps to bring the certificates within the policy that separates into distinct bargaining units those employees who have the right to strike from those employees who do not have the right to strike.

F. Geographic Boundaries of Bargaining Units

1. The Board's Historical Approach to Geographic Boundaries

The Board has, historically, used the employer's model of governance as the determining criteria for the geographic boundaries of bargaining units.

Between 1977[22] and 1994, geographic bargaining unit boundaries were generally "employer wide". For example, when the hospital was the employer, the Board's standard practice was to name the hospital as the employer and describe the unit as "all employees when employed in (functional group)". When hospitals grouped together to form districts, the Board moved to district-wide units, with the district

[22] *Attorney General for the Province of Alberta v. Gares et al. and Board of Governors of the Royal Alexandra Hospital* 76 CLLC 14,016; Information Bulletin 4-78, 4-80, 4-82.

identified as the employer. The Board approved individual exceptions to both scenarios, to either exclude parts of an employer's site operation (usually by classification) or to include or exclude specific sites within the district. In all these exceptional cases, the Board was dealing with historical anomalies and in so doing, focused on the right of employees to access collective bargaining.

2. The Impact of Health Care Regionalization on Geographic Boundaries

After regionalization occurred, the health care industry experienced a significant period of turmoil and uncertainty concerning the structure of employer operations and how that structure would affect bargaining units, collective agreements and trade union and employee rights.

Information Bulletin T-2 described the Board's anticipated two-step approach to this new reality. First, the employer's name would change as part of an administrative review, without substantive changes to the certificate. The Board would preserve implicit geographical or institutional limits by inserting those limits in the unit description. Second, the Board would deal with any successorship applications seeking substantive changes to unit descriptions once the nature of the new regional employer's operations became clear.

i) Changes to Employer Names

The Board has updated many of the certificates to reflect the new name of the employer and has used geographical terminology to restrict the boundaries of the units. A review of Appendices "A1-5" and "B1-3" show that not all the changes have been made as yet.

ii) Successorship Applications

The Board dealt with only a few successorship applications. The applications were filed early in the process. The decisions reflect the combination of limited evidence of change from employers and the Board's view that existing units were presumably still appropriate. The decisions flowing from those applications suggested that existing bargaining rights and existing bargaining structures are to be preserved unless the bargaining structure becomes inappropriate. Preserving bargaining units meant four things:

(a) maintaining a level of stability in the midst of the apparent turmoil in health care;
(b) identifying bargaining units by geographical limitations to mirror what the certificate covered before regionalization;
(c) preserving, where possible, employee wishes on their choice of bargaining agent or unorganized status; and
(d) creating more bargaining relationships by preserving bargaining rights for a multitude of trade unions or trade union locals within each region, rather than reducing the number of bargaining units as the diminishing number of employers might have allowed the Board to do.

3. Future Consideration on Geographical Boundaries

There are a number of different factors affecting geographic boundaries that the Board needs to consider. They include:

(i) the impact of regionalization;
(ii) structure of the trade union organization;
(iii) collective bargaining practices - multi-employer or provincial tables and pattern bargaining;
(iv) the access to bargaining versus industrial stability;
(v) extent of unionization of the industry;
(vi) extent of market share by particular unions;
(vii) historical policies;
(viii) competition among some unions; and
(ix) non-union sites.

We examine each separately.

i) the impact of regionalization

A significant side effect of the successorship decisions was that the Board temporarily moved away from its overarching approach of structuring bargaining units according to the governance model of the employer. This was seen in the replacement certificates and in the Board's approach to new certification applications – both of which tended to favour site or town based units. With the elimination of hospital districts and the creation of regions, the Board temporarily adopted narrower geographic boundaries (either site or town based), and the sectors tended to become more, rather than less, site specific in their bargaining unit descriptions. Most of the employer-wide bargaining units occurred in community health. In one case, HSAA v. RHA #5[23] the Board sent a fairly clear signal that it would not favour site-specific bargaining units unless the union was relying on the presumption of preserving bargaining rights. This was one of the increasingly rare cases of new certification applications in health care.

ii) structure of the trade union organization

An additional outcome of regionalization was that, in some cases, it brought together under the same employer a multitude of locals of a parent trade union that had previously dealt independently with different employers. It may be a natural desire for those locals to retain their legal standing and independence. The Board has not considered the structure of the trade union as a factor in determining the appropriateness of the bargaining unit. The structure of the trade unions should also not be a deciding factor in the review of health care bargaining units.

[23] *HSAA v. Regional Health Authority 5* [1995] Alta.L.R.B.R. 460.

iii) collective bargaining practices – multi-employer or provincial tables and pattern bargaining

A review of the collective bargaining processes discloses fewer and fewer employers and unions who are negotiating for a single collective agreement for a single bargaining unit at one time. In addition, certain key multi-employer tables tend to set the pattern for other smaller tables in similar functional groups. As more collective agreements become mirror images of each other, there may be less reason to maintain a multitude of bargaining units in the same functional group for each employer. Multiple bargaining units for the same functional group (even if with different locals of the same parent union or with the same local) create, at the very least, additional requirements for resources for administrative matters and often results in unnecessary duplication (e.g., the same notice to bargain prepared a number of times with only the local union number changing). Some trade unions structure their organizations to have individual locals for each bargaining unit, resulting in more resources being dedicated to administering those locals. Yet, the realities of today's bargaining often see the employees in those locals have less individual control over the process or results of bargaining or major contractual grievances.

Finally, the potential impact of regionalization on the collective bargaining process is significant. Currently, there are almost 600 separate bargaining relationships affecting fewer than 130 different employers. Under the *Code*, each bargaining relationship could legally result in a separate set of collective bargaining at a separate table and result in a separate collective agreement (or appropriate arbitration, strike or lockout to resolve any disputes if agreement is not possible). Currently it is only the goodwill of the parties in using joint tables and province wide bargaining which reduces the collective bargaining work load and cost for the industry.

Looking more closely at just the 17 Regional Health Authorities, the numbers are even more staggering. There are 117 different facilities in those regions. Current expectations in the community (resulting from the site-based preservational and transitional approach since 1993) would see five units in each facility – meaning potentially 585 different bargaining units. Add to that number the 51 community health units and potentially, the 17 Regional Health Authorities alone could have to bargain over 630 different collective agreements.

On the other hand, in continuing care or mental health, where some employees have the right to strike, employers may argue they prefer site based bargaining units so that they can deal with operational issues and minimize risks arising from strikes or lockouts.

iv) the access to bargaining versus industrial stability

Geographic boundaries of a unit can be a significant factor in influencing the stability of the bargaining relationship. The 1996 discussion paper [24] elaborates in detail about the impact of geography and its role in creating an appropriate bargaining unit. Smaller units tend to facilitate employees obtaining unionized status where none existed. Large units generally tend to foster industrial stability both in collective bargaining and changes to the bargaining agent.

[24] *Geographical Limits in Health Care Bargaining Units* [1997] Alta.L.R.B.R. DP-004

v) extent of unionization of the industry

The Appendices disclose the high degree of unionization in the health care industry. With the exception of pockets, almost all the employees in the active treatment, mental health, community health and cancer treatment sectors are unionized. Continuing care is 69% unionized.[25]

vi) extent of market share by particular unions

Appendix "C" identifies the extent of the market share held by the various trade unions (or parent trade unions) for employees of the 17 Regional Health Authorities. The overwhelming trends are for nurses to belong to United Nurses of Alberta, for professionals and technical employees to seek representation by the Health Sciences Association of Alberta and for employees in auxiliary nursing care to seek representation by Alberta Union of Provincial Employees. As more issues around professionalism, etc. arise, employees of similar backgrounds tend to seek out the same bargaining agent. Applications for certification tend to focus less on seeking a different trade union of choice and more on being represented by the predominant trade union in that field. The same is true in community health, mental health and cancer treatment. In continuing care, there tends to be more diversity of representation of employees in auxiliary nursing care and general support services.

vii) historical policies

As pointed out earlier, the Board's practice since 1977 has been generally to follow the governance model of the employer when setting bargaining unit boundaries. Generally, bigger is better. A trade union might argue that the old policy approach derived from a time when the employer only operated a single facility and employees were not entrenched in their representation. When considering the public policy aspects or labour relations policy aspects of the geographic boundaries of bargaining units, the policy remains as valid today as it did in 1977. The recent change to regions and the changes in collective bargaining patterns demonstrate that employers do not operate their facilities independent of one another or without regard to the trends in industry terms and conditions of employment. A policy of broader bargaining units would provide the flexibility to withstand these industry changes with minimal disruption.

viii) competition between some unions

Another reality in health care, supporting employer-wide units, is the competition that exists between certain trade unions, particularly in the general support services category (not including community health).[26] This competition is evident in both collective bargaining and in the "raid" applications for certifications the Board receives.

A number of different unions represent the employees in the general support services category in acute care. In both large urban centres (Edmonton and Calgary), two unions (AUPE and CUPE) each represent about 50% of the general support services employees. These two unions appear to be the bargaining agent of choice of the majority of employees in general support services in acute care.

[25] Information from responses to June, 2000 questions.
[26] Appendix "C"

The possibility of forcing employees in the general support services functional units to choose between two unions would likely be disruptive to the workplaces and the unions. At the same time, the Board should take steps to reduce the number of different bargaining agents and bargaining units in this functional category. This will bring future stability to the workplace and result in fewer Board applications dealing with "raids". As a result, this is one area where the Board will need to consider some measure of temporarily exempting some bargaining relationships. As well, in continuing care, the Board may also have to balance the impact of some employees in sites having the right to strike.

ix) non-union sites

If the Board returns to its broader based bargaining unit policy, it will need to consider the impact of such a policy on the non-union work sites. What should happen to these sites and the employees at them? If employees actually work at the site, one option is to preserve the non-union site as an exclusion in the unit description. If there are no employees in the standard unit at that site, the site should not be excluded. This option would recognize the rights of those non-union employees to stay non-union until the bargaining agent sought their support. Another option may be to include the non-union sites in the certificate where the union and the employer agree. A third option may be to identify the percentage of non-union employees at any sites compared to the number of union employees in the unit and to sweep in the non-union employees if they are only a small percentage. This is consistent with the Board's approach under successorship applications. Yet another option would be to conduct a vote, under section 15(2), of all non-union sites and to bring in those sites if a majority of the employees vote to be covered by the certificate. (This could be done site by site or on a composite vote in each functional unit for each employer in each health region.)

4. Summary and Recommendations on Geographic Boundaries

The Board's policies on standard bargaining units in health care should recognize these trends and changes which impact the geographic boundaries of the standard functional bargaining units. The numbers, the trend towards a single trade union (or parent) representing almost all the workers in a particular functional group, and the existence of major bargaining tables and patterns demonstrate that smaller units are or should no longer be appropriate units for collective bargaining in health care. The Board should return to its long-standing philosophy of defining the boundaries of bargaining units in accordance with the governance model of the employer.

This would result in standard functional bargaining units moving towards employer-wide units once again. Employer-wide units would keep employees of different employers separate (for example, Capital Health Authority and Caritas or Capital Care Group). "Employer wide" would reflect the nature of the employer's operation. Several examples can illustrate this concept. For the Alberta Cancer Board, the operation is province wide, so an employer-wide unit is province wide. For the Alberta Mental Health Board, the mental health clinics are part of a province-wide operation so the unit would be province wide. Alberta Hospital Edmonton or Ponoka, however, are independent operations and each unit would by policy cover all employees working for the Alberta Mental Health Board in the geographic boundaries of either Capital Health Region or David Thompson Health Region. The policy, not the unit description, would set these limits, much the same way that the construction bargaining unit policy sets geographic limits on bargaining units held by construction trade unions.

RECOMMENDATION #12

When processing applications for certification or reconsideration of or amendment to a bargaining unit in health care, the Board return to and reaffirm its policy of bargaining unit boundaries following the governance model of the employer.

Returning to wider bargaining units and consolidating certificates means the Board will have to recognize and deal with the non-union sites that currently exist. Rather than using unit descriptions that limit by including sites, the Board should return to a policy that limits unit descriptions by excluding sites, just as it excludes employees covered by other certificates or in certain classifications. This approach takes a broader view of the bargaining relationships, rather than the narrower view. Should the existing trade union seek by reconsideration to add in the employees in a non-union site, the certificate can be merely amended by removing the site reference, rather than attempting to reword a certificate to include another site or otherwise describe the add-on employee group.

RECOMMENDATION #13

When writing unit descriptions, the Board use the broad approach and identify non-union sites as exceptions, rather than granting certificates by site.

The application of this recommendation would mean that unit descriptions would not contain listings of sites or municipalities, except to the extent necessary in the transition and after to recognize non-union sites. In keeping with its broad and general practice, certificates held by other unions could be listed as exceptions by referring to the certificate number, rather than by site or job function. To illustrate this recommendation, units in general support services could read: *For Regional Health Authority "A" and Trade Union "A" "all employees when employed in general support services except those covered by Certificate No. 1234 and those employed at <site 1 and site 2>. For Regional Health Authority "A" and Trade Union "B" "all employees when employed in general support services except those covered by Certificate No. 5678 and those employed at <site 1 and site 2>.*

RECOMMENDATION #14

The Board return to and reaffirm its policy that says, that where non-union sites or groups exist, the current bargaining agent may apply for reconsideration under section 12(4) to bring those sites or groups into its current certificate site by site or group by group or in groups.

RECOMMENDATION #15

The Board return to and reaffirm its policy that says, that if another union wants to represent the employees in that functional bargaining unit for that employer or if the current union wants to "raid" itself, it must apply for the standard functional bargaining unit, meaning all employees (union and non-union) of the employer in that functional unit.

As the industry is highly organized already, the possibility of non-standard units will decrease. The policy decisions and process to implement the policy decisions will involve a number of orderly steps. For the purposes of these recommendations, the following terms have specific meanings:

- bargaining agent – means the union (either parent or local) certified as shown on the certificate.
- local – means different locals of the same parent union, for example: CUPE Local 32 and CUPE Local 1022 or UNA Local 92 and UNA Local 121.
- parent union – means the main body which may or may not have locals which hold certificates (eg. CUPE, UNA, HSAA, AUPE, USWA).
- trade union – refers to separate unions (eg., AUPE and CUPE). It does not refer to a parent or locals of the same union.

RECOMMENDATION #16

The Board initiate a review of all current certificates to identify those that do not comply with this policy on geographic boundaries of bargaining units and take the following steps to implement the policy on geographic boundaries, except in the case of the general support services functional units, which shall be governed by Recommendation #17.

1. Where multiple certificates are held by the same bargaining agent (either a parent union or single local) for the same functional bargaining units of the same employer within a health region,[27] the Board encourage the parties to negotiate a process to consolidate those certificates into a single certificate held by the bargaining agent by December 31, 2003.

2. Where multiple certificates are held by different locals of the same parent union for the same functional bargaining units of the same employer within a health region, the Board encourage the parties to negotiate a process to consolidate those certificates into a single certificate held by the parent union or one local by December 31, 2003.

3. Where multiple certificates are held by bargaining agents associated with more than one trade union, the parties first move to implement steps #1 and #2 by December 31, 2003 to reduce the number of certificates to one per trade union (held by the parent union or a local).

4. As of January 1, 2004, where multiple certificates are held by more than one trade union for the same functional bargaining units of the same employer within a health region, the Board encourage the parties to negotiate a process to consolidate those certificates into a single certificate by June 30, 2004. [28]

[27] For Mental Health Clinics and the Alberta Cancer Board, units are employer wide and province wide. See below, "Summary of Recommended Standard Functional Bargaining Units in Health Care", D.3 and D.6.
[28] This may require run off votes between competing trade unions.

5. ***Where consolidated employer-wide certificates would sweep in currently non-union sites or groups, the Board:***

- ***identify those non-union sites or groups as exceptions to the employer-wide certificate,***
- ***conduct a vote of the non-union group to determine their wishes, or***
- ***include the non-union group in the certificate by agreement of the parties and employees.***

6. ***If the parties are unable under steps #1, #2, #3, and #4 to negotiate and implement a resolution by the dates indicated above, the Board take steps to bring the certificates within the policy on geographic boundaries. Those steps should include an officer's investigation and report to assist the parties and the Board in identifying the necessary factual context in which to make decisions. The Board may hold a hearing to receive submissions from the parties before making determinations on outstanding questions of implementation.***

7. ***During the transition and afterwards, the Board will apply the policies set out in Recommendation #14 and #15.***

Because of the number of bargaining agents and the risk related to full scale runoffs in the general support units, the Board should adopt a transitional and temporary exemption approach to the general support services units in all regional health authorities and, to the extent necessary for other health employers. The recommendation is to limit this temporary exemption to the general support services functional group because, with the exception of three (3) units (held by CUPE in auxiliary nursing care)[29] in two health regions, UNA, HSAA or AUPE is the only bargaining agent for the employees in the other functional groups. The exemption would last until the employees in the general support services bargaining units choose to follow the trend in other functional groups of overwhelmingly selecting one trade union to represent them. The exemption would allow a maximum of two certificates to exist in the general support services functional group for each employer.

RECOMMENDATION #17

As an exception to the general policy, the Board allow a maximum of two certificates to exist in the general support functional group for each regional health authority employer and any other employer that the Board determines that currently has more than one bargaining agent and more than one bargaining unit for employees engaged in general support services.

RECOMMENDATION #18

The Board initiate a review of all current general support services certificates to identify those that do not comply with this policy on geographic boundaries of

[29] See Appendix "C"

bargaining units and take the following steps to implement a temporary exemption to the policy on geographic boundaries for general support services units.

1. Where multiple certificates are held by the same bargaining agent (either a parent union or single local) for the same general support services functional bargaining units of the same employer within a health region[30], the Board encourage the parties to negotiate a process to consolidate those certificates into a single certificate held by the bargaining agent by December 31, 2003.

2. Where multiple certificates are held by different locals of the same parent union for the same general support services functional bargaining units of the same employer within a health region, the Board encourage the parties to negotiate a process to consolidate those certificates into a single certificate held by the parent union or one local by December 31, 2003.

3. Where multiple certificates are held by bargaining agents associated with more than one trade union, the parties first move to implement steps #1 and #2 by December 31, 2003 to reduce the number of certificates to one per trade union (held by the parent union or a local).

4. As of January 1, 2004, where multiple certificates are held by more than two trade unions for the general support services functional bargaining units of the same employer within a health region, the Board encourage the parties to negotiate a process to reduce the number of certificates and bargaining agents to no more than two certificates by June 30, 2004.

5. Where consolidated employer-wide certificates would sweep in currently non-union sites or groups, the Board either:

- ***identify those non-union sites or groups as exceptions to the employer-wide certificate,***
- ***conduct a vote of the non-union group to determine their wishes, or***
- ***include the non-union group in the certificate by agreement of the parties and employees.***

6. If the parties are unable under steps #1, #2, #3 and #4 to negotiate and implement a resolution by the dates indicated above, the Board take steps to reduce the number of certificates and bargaining agents to a maximum of two in each region. Those steps should include an officer's investigation and report to assist the parties and the Board in identifying the necessary factual context in which to make decisions. The Board may hold a hearing to receive submissions from the parties before making determinations on outstanding questions of implementation.

[30] For Mental Health Clinics and the Alberta Cancer Board, units are employer wide and province wide. See below, "Summary of Recommended Standard Functional Bargaining Units in Health Care", D.3 and D.6.

7. During the transition and afterwards, the Board will apply the policies set out in Recommendation #14 and #15.

V. Number and Description of Standard Functional Health Care Bargaining Units In The Future

Information Bulletin T-2 predicts the Board's approach on how many units might be appropriate in the future. That approach remains valid today.

A. Hospitals, Nursing Homes, Mental Health Hospitals, Alberta Cancer Board

Since 1972 the Board has used five standard functional units in hospitals and nursing homes. Bulletin T-2 suggested the Board might move from five standard functional units for hospitals and nursing homes to four units, by combining the paramedical professional and paramedical technical units. In 1972, the Board suggested a single merged professional and technical unit would be appropriate from the perspective of community of interest, but gave more weight to the fact that the professionals were, by and large, an unorganized group. Today, 10 of the 17 Regional Health Authorities have some bargaining relationships covering paramedical professionals. Access to collective bargaining and the right to choose their representation is no longer as significant a consideration as it was 30 years ago. Health Sciences Association of Alberta holds all or virtually all of the paramedical professional certificates and the paramedical technical certificates. This indicates that HSAA appears to be the representative of choice for these two groups of employees. HSAA and some of the employers have voluntarily moved to combine these two functional groups into one bargaining unit and to do so within a region-wide unit.

These recent moves indicate the time is now here to take the step contemplated in 1972 and again in 1994 – to combine the paramedical professional and paramedical technical groups into a single bargaining unit. This unit will mirror the unit which exists in community health. It will bring further stability to collective bargaining and result in reduced resources being expended in negotiating and administering a single collective agreement, rather than a minimum of two agreements, for each employer. The result would be the creation and adoption of four standard functional units in acute care.

Five functional units are also currently used in the mental health hospitals, the Alberta Cancer Board, and the continuing-care sector. The Board should move to four standard functional units in all cases.

RECOMMENDATION #19

The Board adopt a policy to have four standard functional bargaining units in acute care, continuing care, mental health hospitals and cancer treatment, being:

1. ***all employees when employed in [*sector*] direct nursing care or nursing instruction.***
2. ***all employees when employed in a [*sector*] paramedical professional or technical capacity.***
3. ***all employees when employed in [*sector*] auxiliary nursing care.***
4. ***all employees when employed in [*sector*] general support services.***

One remaining question is how to implement this new bargaining unit structure and yet respect the rights of those paramedical professionals or technical employees who remain unorganized. Consistent with the previous recommendations, the parties should first attempt to reach their own resolution.

RECOMMENDATION #20

The Board initiate a review of all current paramedical professional and paramedical technical units and encourage the parties to negotiate a process to merge all paramedical professional and technical certificates for the same employer within a health region by December 31, 2003. If the parties are unable to negotiate and implement a resolution, the Board take steps to bring the certificates within the policy of combining paramedical professional and technical certificates of the same employer within the same health region or within the governance model of the employer.

Where consolidated certificates would sweep in currently non-union sites or groups, the Board:

- ***identify those non-union sites or groups as exceptions to the employer-wide certificate,***
- ***conduct a vote of the non-union group to determine their wishes, or***
- ***include the non-union group in the certificate by agreement of the parties and employees.***

B. Community Health

The Board currently uses three standard functional units in community health. Those units are:

1. *all employees when employed in community health nursing.*
2. *all employees when employed in a community health professional or technical capacity*.
3. *all employees when employed in a community health support capacity* .

Those units have continued to function well for the Board and the parties.

In Information Bulletin T-2, the Board signaled that, if the acute care sector and the community health sector integrated, it would combine the sectors and the bargaining units, but in doing so would divide the three community health units into the five acute care standard units. The Board could either continue with these standard functional units or move now to restructure the community health units to match the four standard functional units used elsewhere in the industry. A change now would require splitting the community health support unit into two parts – auxiliary nursing care and general support services. Those units would become region-wide community health units. They would be flexible enough to allow the Board to later (as the industry develops) merge the community health and facilities units without much disruption.

RECOMMENDATION #21

The Board decide now to either maintain its policy of having three standard functional units for community health or move to four standard functional units in community health, being:

1. ***all employees when employed in community health nursing.***
2. ***all employees when employed in a community health professional or technical capacity.***
3. ***all employees when employed in a community health support capacity .***

OR

1. ***all employees when employed in community health nursing care or nursing instruction.***
2. ***all employees when employed in a community health paramedical professional or technical capacity.***
3. ***all employees when employed in community health auxiliary nursing care.***
4. ***all employees when employed in community health general support services.***

Within community health, there remain six (6) non-standard bargaining units. As part of this review, the Board should reconsider those units and reconfigure them to comply with the standard functional bargaining units in community health, both in terms of functions and geography.

RECOMMENDATION #22

The Board initiate a review of all current community health certificates and encourage the parties to negotiate a process to bring any non-conforming certificates within the policy affecting community health units both for functional descriptions and geographic boundaries by December 31, 2003. If the parties are unable to negotiate and implement a resolution, the Board should take steps to bring the certificates within the policy affecting community health units both for functional descriptions and geographic boundaries.

C. Continuing Care

The Board currently uses the five standard functional units in the continuing care sector. Employers in this sector fall within three groups – those that operate private single facility operations, those that operate private multi-facility businesses and those that are regional health authorities providing continuing care services. Each of these employers may approach the issue of appropriate bargaining units differently. In addition, employees in this sector fall within both legislated mechanisms for resolving collective

bargaining disputes. Some have the right to strike and some do not, by operation of section 96 (the "approved hospitals" list).

The Board should adopt the four standard bargaining units in this sector but should allow for the possibility that the business of a private employer operating a single facility may be small enough to mean that an "all employee" unit would be appropriate.

RECOMMENDATION #23

The Board amend its policy concerning appropriate bargaining units in the continuing care sector to have the four standard units for larger employers and to allow a single "all employee" unit for smaller employers.

D. Summary of Recommended Standard Functional Bargaining Units in Health Care:

This segment outlines the recommended wording of the standard functional bargaining units in each sector of health care. It also clarifies the geographic boundaries the Board intends to apply to those units.

1. Acute Care

This sector covers the active treatment facilities and other facilities or sites performing similar services. Some facilities also include auxiliary hospital and nursing home components.

There will be four standard functional bargaining units:

1. *all employees when employed in acute care direct nursing care or nursing instruction.*
2. *all employees when employed in an acute care paramedical professional or technical capacity*.
3. *all employees when employed in acute care auxiliary nursing care.*
4. *all employees when employed in acute care general support services*.

The detailed description of which job titles and job functions fit within each unit is the same as set out in Information Bulletin #10, except that the professional and technical descriptions are combined.

Functional bargaining units follow the employer's model of governance, being employer wide within a health region (in all cases "health region" refers to the geographic boundaries of one of the 17 health regions established by the province).

Non-unionized sites should be noted as exceptions to the employer-wide unit. For example, *all employees when employed in acute care general support services except those at ABC site.*

2. Community Health

This sector covers the community health functions only, formerly known as the public health units.

Depending on the reaction of the community, there will be either three or four standard functional bargaining units:

1. *all employees when employed in community health nursing.*
2. *all employees when employed in a community health professional or technical capacity*.
3. *all employees when employed in a community health support capacity*.

OR

1. *all employees when employed in community health nursing care or nursing instruction.*
2. *all employees when employed in a community health paramedical professional or technical capacity*.
3. *all employees when employed in community health auxiliary nursing care.*
4. *all employees when employed in community health general support services*.

The detailed description of which job titles and job functions fit within each unit is the same as set out in Information Bulletin #10, with the possibility of splitting the support unit into two units (auxiliary nursing care and general support services).

Functional bargaining units follow the employer's model of governance, being employer wide within a health region.

Existing non-unionized sites should be noted as exceptions to the employer-wide unit. For example, *all employees when employed in a community health support capacity except those at ABC site.*

3. Mental Health

This sector deals with all the functions under the Mental Health Board.

- **Mental Health Hospitals:**

There will be four standard functional bargaining units:

1. *all employees when employed in mental health direct nursing care or nursing instruction.*
2. *all employees when employed in a mental health paramedical professional or technical capacity.*
3. *all employees when employed in mental health auxiliary nursing care.*
4. *all employees when employed in mental health general support services.*

The detailed description of which job titles and job functions fit within each unit is the same as set out in Information Bulletin #10, except that the professional and technical descriptions are combined.

Functional bargaining units follow the employer's model of governance, being employer wide within a health region.

Non-unionized sites should be noted as exceptions to the employer-wide unit. For example, *all employees when engaged in mental health general support services except those at ABC site.*

- **Mental Health Community Clinics:**

There will be one standard bargaining unit: "*all employees*".

The bargaining unit will follow the employer's model of governance, being employer wide and province wide.

4. Continuing Care

This sector includes the nursing homes and auxiliary hospitals and similar facilities or operations providing care and long-term nursing services to residents and clients.

In smaller homes, hospitals etc, one unit could be appropriate:

1. *all employees.*

In larger homes, hospitals etc., four standard functional bargaining units would apply:

1. *all employees when employed in continuing care direct nursing care or nursing instruction.*
2. *all employees when employed in a continuing care paramedical professional or technical capacity*.
3. *all employees when employed in continuing care auxiliary nursing care.*
4. *all employees when employed in continuing care general support services*.

The detailed description of which job titles or job functions fit within each unit is the same as set out in Information Bulletin #10, except that the professional and technical descriptions are combined.

Functional bargaining units follow the employer's model of governance, being employer wide within a health region.

Non-unionized sites should be noted as exceptions to the employer-wide unit. For example, *all employees when employed in continuing care general support services except those at ABC site.*

5. Medical and Health Laboratories

This group includes all the medical and health laboratories.

There will continue to be three appropriate functional bargaining units, depending on the size of the employer's operation:

1. in smaller labs "*all employees*".
2. in larger labs "*all employees except office and clerical personnel*" and "*office and clerical personnel".*

6. Cancer Treatment

This sector covers all the services of the Alberta Cancer Board.

It will have four standard functional bargaining units:

1. *all employees when employed in cancer treatment direct nursing care or nursing instruction.*
2. *all employees when employed in a cancer treatment paramedical professional or technical capacity*.
3. *all employees when employed in cancer treatment auxiliary nursing care.*
4. *all employees when employed in cancer treatment general support services* .

The detailed description of which job titles and job functions fit within each unit is the same as set out in Information Bulletin #10, except that the professional and technical descriptions are combined.

Functional bargaining units follow the employer's model of governance, being employer wide and province wide.

Existing non-unionized sites should be noted as exceptions to the employer-wide unit. For example, *all employees engaged in cancer treatment general support services except those at ABC site.*

E. Non-Standard Units

Non-standard means the unit description does not exactly match one of the current five hospitals and nursing homes units or three community health units, other than including a geographic limitation. As a result of a structured and controlled application of its standard bargaining unit policies, the Board has only 47 non-standard units, being a small percentage of the total number of units. It makes labour relations sense, viewed both practically and from a policy perspective, to bring these non-standard units into the mainstream during this review. Otherwise, it will be difficult for the Board to justify why it would leave a non-standard unit when it seeks to change a number of other factors impacting other units and unions.

RECOMMENDATION #24

The Board initiate a review of all current non-standard units and, where those units are not already affected by earlier recommendations, encourage the parties to negotiate a process to make those units standard by December 31, 2003. If the parties are unable to negotiate and implement a resolution, the Board take whatever necessary steps to make the non-standard certificates conform to the policies on standard functional bargaining units.

VI. Recommendations: A Compilation

RECOMMENDATION #1

The Board continue to apply its general guidelines concerning appropriate bargaining units to health care bargaining units.

RECOMMENDATION #2

When processing applications for certification or reconsideration of or amendment to a bargaining unit in health care, the Board continue its practice and confirm its policy that places greater emphasis on long-term objectives of industrial stability and avoidance of fragmentation than on the short-term objective of access to collective bargaining.

RECOMMENDATION #3

The Board continue to apply its specific health care industry guidelines concerning appropriate bargaining units in health care.

RECOMMENDATION #4

The Board continue its policy concerning appropriate bargaining units for medical and health laboratories and include those units as part of the Information Bulletin on standard functional bargaining units in health care.

RECOMMENDATION #5

When considering the appropriateness of the bargaining unit in applications for certification or reconsideration of or amendment to a bargaining unit in the labs, the Board apply its policy concerning appropriate bargaining units for medical and health laboratories.

RECOMMENDATION #6

The Board initiate a review of all current medical and health laboratory certificates and encourage the parties to negotiate a process to bring any non-conforming certificates within the policy governing standard units in labs by December 31, 2003. If the parties are unable to negotiate and implement a resolution, the Board take steps to bring the certificates within the policy governing standard units in labs.

RECOMMENDATION #7

The Board amend Information Bulletin #10 to include all of the sectors of health care, namely:

- acute care – providing acute care or active treatment
- community health
- mental health
- cancer treatment
- continuing care – providing longer term and palliative care
- medical and health laboratories
- ambulance.

RECOMMENDATION #8

The Board include the sector in the bargaining unit description where more than one sector uses the same or similar functional bargaining unit.

RECOMMENDATION #9

When determining the appropriateness of a bargaining unit sought in applications for certification or reconsideration of or amendment to a bargaining unit, the Board consider the legislated mechanisms of resolving bargaining disputes as one of the criteria in its deliberations.

RECOMMENDATION #10

The Board adopt a policy ensuring separation of employees who have the right to strike from those employees who do not have the right to strike into separate bargaining units.

RECOMMENDATION #11

The Board initiate a review of all current certificates and encourage the parties to negotiate a process to bring any non-conforming certificates within this policy of separating “right to strike from no right to strike” by December 31, 2003.

If the parties are unable to negotiate and implement a resolution, the Board take steps to bring the certificates within the policy that separates into distinct bargaining units those employees who have the right to strike from those employees who do not have the right to strike.

RECOMMENDATION #12

When processing applications for certification or reconsideration of or amendment to a bargaining unit in health care, the Board return to and reaffirm its policy of bargaining unit boundaries following the governance model of the employer.

RECOMMENDATION #13

When writing unit descriptions, the Board use the broad approach and identify non-union sites as exceptions, rather than granting certificates by site.

RECOMMENDATION #14

The Board return to and reaffirm its policy that says, that where non-union sites or groups exist, the current bargaining agent may apply for reconsideration under section 12(4) to bring those sites or groups into its current certificate site by site or group by group or in groups.

RECOMMENDATION #15

The Board return to and reaffirm its policy that says, that if another union wants to represent the employees in that functional bargaining unit for that employer or if the current union wants to “raid” itself, it must apply for the standard functional bargaining unit, meaning all employees (union and non-union) of the employer in that functional unit.

RECOMMENDATION #16

The Board initiate a review of all current certificates to identify those that do not comply with this policy on geographic boundaries of bargaining units and take the following steps to implement the policy on geographic boundaries, except in the case of the general support services functional units, which shall be governed by Recommendation #17.

1. Where multiple certificates are held by the same bargaining agent (either a parent union or single local) for the same functional bargaining units of the same employer within a health region,[31] the Board encourage the parties to negotiate a process to consolidate those certificates into a single certificate held by the bargaining agent by December 31, 2003.

2. Where multiple certificates are held by different locals of the same parent union for the same functional bargaining units of the same employer within a health region, the Board encourage the parties to negotiate a process to consolidate those certificates into a single certificate held by the parent union or one local by December 31, 2003.

3. Where multiple certificates are held by bargaining agents associated with more than one trade union, the parties first move to implement steps #1 and #2 by December 31, 2003 to reduce the number of certificates to one per trade union (held by the parent union or a local).

4. As of January 1, 2004, where multiple certificates are held by more than one trade union for the same functional bargaining units of the same employer within a health region, the Board encourage the parties to negotiate a process to consolidate those certificates into a single certificate by June 30, 2004. [32]

5. Where consolidated employer-wide certificates would sweep in currently non-union sites or groups, the Board:

- identify those non-union sites or groups as exceptions to the employer-wide certificate,
- conduct a vote of the non-union group to determine their wishes, or
- include the non-union group in the certificate by agreement of the parties and employees.

6. If the parties are unable under steps #1, #2, #3, and #4 to negotiate and implement a resolution by the dates indicated above, the Board take steps to bring the certificates within the policy on geographic boundaries. Those steps should include an officer's investigation and report to assist the parties and the Board in identifying the necessary factual context in which to make decisions. The Board may hold a hearing to receive submissions from the parties before making determinations on outstanding questions of implementation.

[31] For Mental Health Clinics and the Alberta Cancer Board, units are employer-wide and province wide. See below, "Summary of Recommended Standard Functional Bargaining Units in Health Care", D.3 and D.6.
[32] This may require run off votes between competing trade unions.

7. During the transition and afterwards, the Board will apply the policies set out in Recommendation #14 and #15.

RECOMMENDATION #17

As an exception to the general policy, the Board allow a maximum of two certificates to exist in the general support functional group for each regional health authority employer and any other employer that the Board determines that currently has more than one bargaining agent and more than one bargaining unit for employees engaged in general support services.

RECOMMENDATION #18

The Board initiate a review of all current general support services certificates to identify those that do not comply with this policy on geographic boundaries of bargaining units and take the following steps to implement a temporary exemption to the policy on geographic boundaries for general support services units.

1. Where multiple certificates are held by the same bargaining agent (either a parent union or single local) for the same general support services functional bargaining units of the same employer within a health region[33], the Board encourage the parties to negotiate a process to consolidate those certificates into a single certificate held by the bargaining agent by December 31, 2003.

2. Where multiple certificates are held by different locals of the same parent union for the same general support services functional bargaining units of the same employer within a health region, the Board encourage the parties to negotiate a process to consolidate those certificates into a single certificate held by the parent union or one local by December 31, 2003.

3. Where multiple certificates are held by bargaining agents associated with more than one trade union, the parties first move to implement steps #1 and #2 by December 31, 2003 to reduce the number of certificates to one per trade union (held by the parent union or a local).

4. As of January 1, 2004, where multiple certificates are held by more than two trade unions for the general support services functional bargaining units of the same employer within a health region, the Board encourage the parties to negotiate a process to reduce the number of certificates and bargaining agents to no more than two certificates by June 30, 2004.

5. Where consolidated employer-wide certificates would sweep in currently non-union sites or groups, the Board either:

[33] For Mental Health Clinics and the Alberta Cancer Board, units are employer wide and province wide. See below, "Summary of Recommended Standard Functional Bargaining Units in Health Care", D.3 and D.6.

- identify those non-union sites or groups as exceptions to the employer-wide certificate,
- conduct a vote of the non-union group to determine their wishes, or
- include the non-union group in the certificate by agreement of the parties and employees.

6. If the parties are unable under steps #1, #2, #3 and #4 to negotiate and implement a resolution by the dates indicated above, the Board take steps to reduce the number of certificates and bargaining agents to a maximum of two in each region. Those steps should include an officer's investigation and report to assist the parties and the Board in identifying the necessary factual context in which to make decisions. The Board may hold a hearing to receive submissions from the parties before making determinations on outstanding questions of implementation.

7. During the transition and afterwards, the Board will apply the policies set out in Recommendation #14 and #15.

RECOMMENDATION #19

The Board adopt a policy to have four standard functional bargaining units in acute care, continuing care, mental health hospitals and cancer treatment, being:

1. all employees when employed in [*sector*] direct nursing care or nursing instruction.
2. all employees when employed in a [*sector*] paramedical professional or technical capacity.
3. all employees when employed in [*sector*] auxiliary nursing care.
4. all employees when employed in [*sector*] general support services.

RECOMMENDATION #20

The Board initiate a review of all current paramedical professional and paramedical technical units and encourage the parties to negotiate a process to merge all paramedical professional and technical certificates for the same employer within a health region by December 31, 2003. If the parties are unable to negotiate and implement a resolution, the Board take steps to bring the certificates within the policy of combining paramedical professional and technical certificates of the same employer within the same health region or within the governance model of the employer.

Where consolidated certificates would sweep in currently non-union sites or groups, the Board:

- identify those non-union sites or groups as exceptions to the employer-wide certificate,
- conduct a vote of the non-union group to determine their wishes, or
- include the non-union group in the certificate by agreement of the parties and employees.

RECOMMENDATION #21

The Board decide now to either maintain its policy of having three standard functional units for community health or move to four standard functional units in community health, being:

1. all employees when employed in community health nursing.
2. all employees when employed in a community health professional or technical capacity.
3. all employees when employed in a community health support capacity .

OR

1. all employees when employed in community health nursing care or nursing instruction.
2. all employees when employed in a community health paramedical professional or technical capacity.
3. all employees when employed in community health auxiliary nursing care.
4. all employees when employed in community health general support services.

RECOMMENDATION #22

The Board initiate a review of all current community health certificates and encourage the parties to negotiate a process to bring any non-conforming certificates within the policy affecting community health units both for functional descriptions and geographic boundaries by December 31, 2003. If the parties are unable to negotiate and implement a resolution, the Board should take steps to bring the certificates within the policy affecting community health units both for functional descriptions and geographic boundaries.

RECOMMENDATION #23

The Board amend its policy concerning appropriate bargaining units in the continuing care sector to have the four standard units for larger employers and to allow a single “all employee” unit for smaller employers.

RECOMMENDATION #24

The Board initiate a review of all current non-standard units and, where those units are not already affected by earlier recommendations, encourage the parties to negotiate a process to make those units standard by December 31, 2003. If the parties are unable to negotiate and implement a resolution, the Board take whatever necessary steps to make the non-standard certificates conform to the policies on standard functional bargaining units.

VII. Point Form Summary of Key Recommendations

A. Key Points

- maintain the general and specific health care policies
- recognize health care sectors and include labs and ambulance in the bulletin
- include the sector in the unit description where more than one sector uses the same standard units
- move to four (4) functional units by combining paramedical professional and technical
- return to employer wide units in each functional unit
- create an exemption to employer wide units in general support services to allow a maximum of two (2) certificates for different trade unions per employer
- write unit descriptions broadly and exclude non-union sites and other certificates
- move all non-standard units to standard units
- recognize 4 standard units in all sectors except labs, ambulance and possibly community health
- choose between 3 or 4 standard units in community health
- certified bargaining agents can add non-union sites one by one to the existing certificate
- raiding unions must take all employees in the standard functional unit (union and non-union)
- general recommendations apply as well as specific
- provide a three stage transitional period

    - ➢ time for the parties to negotiate a resolve;
    - ➢ time for the parties to implement a resolve; and
    - ➢ time for the Board to apply the policy if the parties don't resolve.

B. Demonstration of Implementation

1. General Policies

- if no objections, Board implements effective immediately or 30 days later (the "effective date")
- Information Bulletins etc. changed
- policies apply to all applications filed after the effective date

2. Nursing Care (Acute Care, Continuing Care, Mental Health Hospitals)

- consolidate all direct nursing care units employer wide within the health region (a single certificate)
- write unit description broadly (exclude non-union sites unless Board otherwise directs)
- future raids must take the whole unit, including any non-union sites
- bargaining agent can add in non-union sites one at a time

3. Professional & Technical (Acute Care, Continuing Care, Mental Health Hospitals)

- combine paramedical professional and technical
- consolidate all paramedical professional and technical units employer wide within the health region (a single certificate)
- write unit description broadly (exclude non-union sites unless Board otherwise directs)

- future raids must take the whole unit, including any non-union sites
- bargaining agent can add in non-union sites one at a time

4. Auxiliary Nursing Care (Acute Care, Continuing Care, Mental Health Hospitals)

- consolidate all auxiliary nursing care units held by the same trade union (parent or locals of) into one certificate for each employer
- consolidate all units held by competing trade unions employer wide within the health region (a single certificate) – may require run off votes
- write unit description broadly (exclude non-union unless Board otherwise directs)
- future raids must take the whole unit, including any non-union sites
- bargaining agent can add in non-union sites one at a time

5. General Support Services (Acute Care, Continuing Care, Mental Health Hospitals)

- consolidate all general support service units held by the same trade union (parent or locals of) into one certificate for that union for each employer
- give unions time to work out internally and with employer
- next, if more than two (2) trade unions hold certificates, consolidate the certificates into a maximum of two certificates employer-wide within a health region – (may require run off votes)
- Board will impose if required (run off votes, 80-20 rules, etc.)
- crystallization date is date of paper
- write unit description broadly (exclude other certificate and non-union sites in both certificates unless Board otherwise directs)
- future raids (by either one of the two bargaining agents or a new trade union) must take the whole unit, including all union and non-union sites
- either bargaining agent can add in non-union sites one at a time

6. Community Health

- consolidate any non-standard units into a single employer wide within each functional group (a single certificate)
- future raids must take the whole unit

7. Continuing Care

- follows the other 4 functional units model of implementation
- employer must establish grounds for (or employer and union can jointly apply for) “all employee” unit on case by case basis
- future raids must take the whole unit

8. Cancer Care

- follows the other 4 functional units model of implementation except that units are province wide (see 2-5 above)

- future raids must take the whole unit

9. Mental Health

- follows the other 4 functional units model of implementation in the mental health hospitals (see 2-5 above)
- clinics remain a province wide *all employee* unit
- future raids must take the whole unit

10. Labs

- no change to current policy
- employer must establish grounds for (or employer and union can jointly apply for) “all employee” unit on case by case basis
- future raids must take the whole unit.

VIII. Next Steps

The Board needs to provide the community an opportunity to review, consider and respond to the recommendations in this discussion paper. It will begin the process by distributing this discussion paper, have the employers post Board notices at the work-sites, and holding two information and discussion sessions in April, 2002 – one in Edmonton and one in Calgary.

The date for responses is **May 31, 2002**. Responses should be submitted in the form of acceptance or objection to the specific recommendations, (similar to the process used for Board Officer Investigation Reports in certification or revocation applications) including the following information:

- name, address, phone and fax numbers, and email address for the party;
- contact person for the party including name, address, phone and fax numbers, and email address;
- recommendation number or sub-number;
- whether the party accepts the recommendation or objects to it;
- identify the grounds for acceptance or objection and include particulars. (It is not sufficient to merely say “We accept” or “We object”.); and
- if the recommendation can be amended, include the proposed wording for amendment.

By **September 30, 2002** any responding party must provide the following additional information in support of its response:

- any documents which the party intends to rely on to support its position;
- the names and titles of all witnesses the party proposes to call to give evidence in support of its position including a description of the evidence each witness would give; and
- the amount of time which the party’s evidence and argument might take in a hearing.

The Board should then review all the documentary submissions and determine and communicate to the parties a case management process, which might include:

- immediately implementing those recommendations for which there are no objections;
- immediately amending or deleting recommendations where there is consensus in the responses;
- dealing with all or some of the objections on the basis of written submissions;
- assigning Board staff and members to informally resolve some or all of the disputes over particular recommendations;
- scheduling a hearing to deal with the unresolved objections; and
- implementing the decision of the Board after considering the parties’ submissions.

During the consultation and implementation phases, the status quo of current bargaining units and certificates is frozen as of the date of this report unless the Board otherwise directs. In other words, the crystallization date for determining rights in the future is the date of this discussion paper. This means that the recommendations will be implemented based on the information contained in the Board’s current (as of the date of this paper) active certificates (errors excepted), not on any changes resulting from applications processed in the transition period.

IX. Appendices

Appendix “A”	Health Care Certificates / Voluntary Recognition Agreements (Standard Bargaining Units – Breakdown by Employer)
Appendix “A –1”	Direct Nursing Care by Employer
Appendix “A-2”	Paramedical Professional by Employer
Appendix “A-3”	Paramedical Technical by Employer
Appendix “A-4”	Auxiliary Nursing Care by Employer
Appendix “A-5”	General Support Services by Employer
Appendix “B”	Community Health Certificates / Voluntary Recognition Agreements (Standard Bargaining Units – Breakdown by Regional Health Authority)
Appendix “B–1”	Community Health Nursing by Employer
Appendix “B-2”	Community Health Professional or Technical by Health Authorities
Appendix “B-3”	Community Health Support by Health Authority
Appendix “C”	Health Care Bargaining Units by Regional Health Authority and by Trade Union
Appendix “D”	Non-Standard Health Care Bargaining Units
Appendix “E”	Non-Standard Health Care Bargaining Units – Explanation of Unit Description
Appendix “F”	Ambulance Bargaining Units